

A photograph of a group of women in a community meeting. In the foreground, a woman wearing an orange headwrap and a grey patterned cardigan stands and holds a black handbag with a gold 'G' logo. Behind her, another woman is partially visible, wearing a blue and white patterned headwrap. In the background, many other women are seated on the floor, some wearing colorful headwraps. The room has wooden floors and a doorway in the background.

FACILITATING CIVIC ENGAGEMENT THROUGH CONSULTATION

**Learning from local communities
through the NHI-Accountability
Project in South Africa**



A publication supported by Oxfam Australia,
Monash University, and Monash South Africa

Practice

	LP	MF	Se J.	K-S	Aray	Papa	Long	McKale
bokamasing	✓	✓	✓	✓	✓	✓	✓	✓
ela memo	✓	✓	✓	✓	✓	✓	✓	✓
eboba (sa nako)	✓	✓	✓	✓	✓	✓	✓	✓
motho hoba	✓	✓	✓	✓	✓	✓	✓	✓
sea kopana	✓	✓	✓	✓	✓	✓	✓	✓
De-brief	✓	✓	✓	✓	✓	✓	✓	✓
sea kopana ho	✓	✓	✓	✓	✓	✓	✓	✓
litlopha pele	✓	✓	✓	✓	✓	✓	✓	✓
la litaba hare	✓	✓	✓	✓	✓	✓	✓	✓
SALT visit	✓	✓	✓	✓	✓	✓	✓	✓
kahana e kereke	✓	✓	✓	✓	✓	✓	✓	✓
clinic	✓	✓	✓	✓	✓	✓	✓	✓
pana le marena	✓	✓	✓	✓	✓	✓	✓	✓
councilor	✓	✓	✓	✓	✓	✓	✓	✓

“If you talk to a man in a language he understands, it goes to his head. If you talk to a man in his language, that goes to his heart.”

— Nelson Rolihlahla Mandela





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Published by Oxfam Australia in South Africa

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TABLE OF CONTENTS

Endorsement	2
Acknowledgements	3
Introduction	4
Acronyms	5
What’s this all about?	6
Background: where did this come from?	9

 1. THEORY OF CHANGE	14
 2. STEPS	18
 3. PRACTICES	26
 4. PRINCIPLES	32

Concluding thoughts	58
Bibliography	59

ENDORSEMENT

We as *The Alliance Centre for HIV, Health and Rights of Key Populations*, hosted within Positive Vibes, are proud to be associated with the work of Oxfam Australia in South Africa and this document, and find it an honour to support their valuable work with this endorsement.

This publication advocates for principles of approach to stimulate, support and learn from communities, based on the belief they have inherent strengths to respond.

These principles resonate with the belief system that Positive Vibes and the International HIV and AIDS Alliance champions: the firm belief that communities have the ability to drive the solutions for problems, and that our role as intermediaries is to sit alongside those conversations in supportive and stimulating ways.

As Positive Vibes, we pride ourselves on a long legacy of solidarity action alongside communities. Through supporting the fight for Namibian independence and transformation post South African occupation, we have built a

successful trajectory of community engagement that underpins our values of hope, respect and voice. We are passionate about meaningful and personalised involvement of people in communities on the challenges they face.

We see the applications of these principles to a variety of contexts and audiences, where marginalised populations need to be engaged around issues that will best benefit from their active citizen engagement and personalised responses. We are confident that the principles advocated for through this piece of work will live in our practice as we continue to support communities around the world.

Flavian Rhode

Director – Alliance Centre for HIV, Health and Rights of Key Populations



The Alliance Centre for HIV, Health and Rights of Key Populations is an initiative of The International HIV and AIDS Alliance, to locate thematic expertise and technical leadership for work with key populations – in particular, Commercial Sex Workers, LGBT people, and People Living with HIV – within the global South. The Alliance is a global partnership of some 40 civil society organisations working on HIV, Health and Human Rights across four continents who, in turn, support thousands of in-country Implementing Partners. In its work, The Alliance exercises a bias towards most vulnerable populations, promoting a human rights programming approach amongst the marginalised, socially excluded, and disproportionately vulnerable; its vision: “ending AIDS through community action”. The Centre aims to build the capacity of national civil society and regional organisations to promote equality and rights, to generate intelligence for advocacy, and to facilitate improved access to health services for key populations. It prioritises learning from good practice, in order to develop, promote and popularise transferable methodologies and principles effective for responsible, high-quality Key Populations Programming.

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- Professor Peter Nyasulu, Jacqueline Witthuhn and Clive Newman from the School of Public Health at Monash University in South Africa,
- Wendy Lubbee and Urvarshi Rajcoomar from Oxfam Australia,
- The Oxfam-Monash Partnership, Professor Geoffrey Setswe, Dr Ravayi Marindo, Kevin Roussel, Anne Strode, Cecile Manhaeve and Allan Moolman

who through their guidance, insight, technical support and expertise greatly assisted in bringing this project to its completion.

We are especially grateful to the Pietermaritzburg Agency for Community Social Action (PACSA) and its partners from local community-based associations, Sophakama, and the HIV and AIDS Prevention Group (HAPG) for sharing their knowledge and experiences with us so that their learning can be carried forward to influence other individuals, programmes or organisations.

And lastly, we would like to acknowledge with gratitude the author, Ricardo Walters for his continuous support and valued input and for embarking on this wonderful journey with us.

– **Oxfam Australia** in South Africa



INTRODUCTION

What does it mean to be a functional democracy?

Of its many benefits, democracy makes ordinary citizens able to access their rights and to confidently hold duty bearers and elected officials to account.

And yet, despite strong democratic institutions in place to protect people's rights in South Africa, and robust legislative frameworks, systemic barriers and poor governance inhibit citizens from fully exercising their capacities. In the glaring shortfall of delivery of effective and efficient services to citizens around the country the disconnect between policy and real-world implementation is sharply exposed.

Low levels of public participation in processes where policy is developed is a critical contributing factor to this disconnect, coupled with poor monitoring necessary to keep policymakers accountable for delivery.

It could be assumed, in a democracy whose ideals are so highly prized as South Africa's,

that participation by citizens in decision-making processes material to their own development might be more common, and that social and political spaces for formal and informal engagement by ordinary people might be increasingly accessible.

Trends and anecdotal evidence, however, emerging from the work of Oxfam Australia in South Africa and its partner organisations, suggested this was not the case, attributing these low levels of participation, at least in part, to:

1. Communities most in need of services being **intimidated** by the policy development process and associated legal and technical jargon, leading to their disengagement.
2. **Tokenistic consultation** processes by public officials, with very little authentic opportunity created for widespread distribution and understanding of policy proposals, for local-level debate and proposition-making, and for feedback by communities. Very little effort seems to be made by those in power to engage responsibly with people at community level, hampering effective and meaningful consultation.

-
3. Well-meaning organisations being engaged with policy on behalf of communities without necessarily including communities themselves in the process of consultation, inadvertently **limiting participation**.

This environment provided an opportunity to explore the questions around appropriate practices and approaches that would make community consultation and participation effectively meaningful.

The development process of the National Health Insurance policy in South Africa offered a lens through which to filter that experience, form conclusions and propose strategies.

This publication is the first in a series exploring the principles and practice of approach for successfully and responsibly facilitating active civic engagement, this time through the example of participation in health policy formation. Subsequent volumes will reflect on experiences drawn from service-delivery programmes, water and sanitation projects, gender and HIV responses, and human rights advocacy amongst key populations.

ACRONYMS

AIDC	Alternative Information and Development Centre
AIDS	Acquired Immune Deficiency Syndrome
ARV	anti-retroviral
CBO	community-based organisation
CSO	civil society organisation
DoH	Department of Health
HAPG	HIV and Aids Prevention Group
HBC	home-based care
HIV	Human Immunodeficiency Virus
MEC	Member of Executive Council
NHI	National Health Insurance
PACSA	Pietermaritzburg Agency for Community Social Action
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary healthcare
PHM	People's Health Movement
PLHIV	People living with HIV
SAPHU	South African People's Health University

WHAT'S THIS ALL ABOUT?

This publication is closely based on a technical report examining public consultation in the National Health Insurance (NHI) discourse. The report, *Governance and Accountability in the Health Sector: A People's Policy for Health in South Africa* was prepared in 2015 for the Oxfam-Monash partnership, following the conclusion of its project.

Based on learning from the actions and experiences of three community-based partner organisations that facilitated community consultation around the NHI, the booklet supports the case that good practice in development is characterised by communities taking action, and by organisations responsibly and respectfully supporting that action through facilitation of community response.

It is hoped that this content might offer insight to programmers and policy-makers about practices and principles that stimulate responsiveness in citizens and communities, especially amongst those who are traditionally marginalised owing to socioeconomic and political status. The material begins to explore pertinent questions for organisations and governments seeking to contribute to social transformation in the post-2015 development era: “How do we work better to tap into community experience, knowledge and resourcefulness?”; “How do we work with communities to promote their leadership and response to issues, and to learn from them?”; “How do we better promote active civic engagement, and build personal agency for action?”

In particular, the document reflects on the experiences and strategies of two distinct types of organisations involved in supporting community consultation through the NHI Accountability Project. It draws on those experiences in order to propose effective, legitimate approaches – STEPS, PRACTICES and PRINCIPLES – that might be useful to:

Intermediary organisations who play a supporting role to organisations that, in turn, work directly with people in communities. Intermediaries act in solidarity with community-based organisations, offering technical assistance, capacity-building, financial resources, programme advice or advocacy support to strengthen the ability of local organisations to work properly and deliver on their objectives.

In the experience of the NHI project, Oxfam Australia and Monash University in South Africa were examples of intermediary organisations.






Community-based organisations (CBOs) that work directly within specific local communities; contributing to transformation by delivering programmes and services that meet the development, health and justice needs of people in the places where they live.

In the experience of the NHI project, three CBOs contributed to the local action of consultation: HAPG, Sophokama and PACSA.


The document is organised around several components, based on the lessons learned about consultation after examining the NHI Accountability Project experience. The components are complementary; interrelated but not linear or sequential; a way to think about how consultation happens and what impact it produces.

Components include:

1.  A **THEORY OF CHANGE**, recognising consultation as one stage in a sequence of stages leading towards active, mature civic engagement by communities. The Theory of Change can be thought of as “What we believe”.
2.  A sequence of **STEPS** for primarily intermediary organisations wishing to support communities towards engagement, response and action, based on the presence of certain environmentally enabling pre-conditions necessary for effective facilitation.

3.  A set of common **PRACTICES** – essentially, replicable ways of working for primarily CBOs operating at the community level. These practices appear to contribute to successful consultation in every instance, despite significant differences in the process design and activities employed by each of the three partner organisations participating in the NHI Accountability Project.

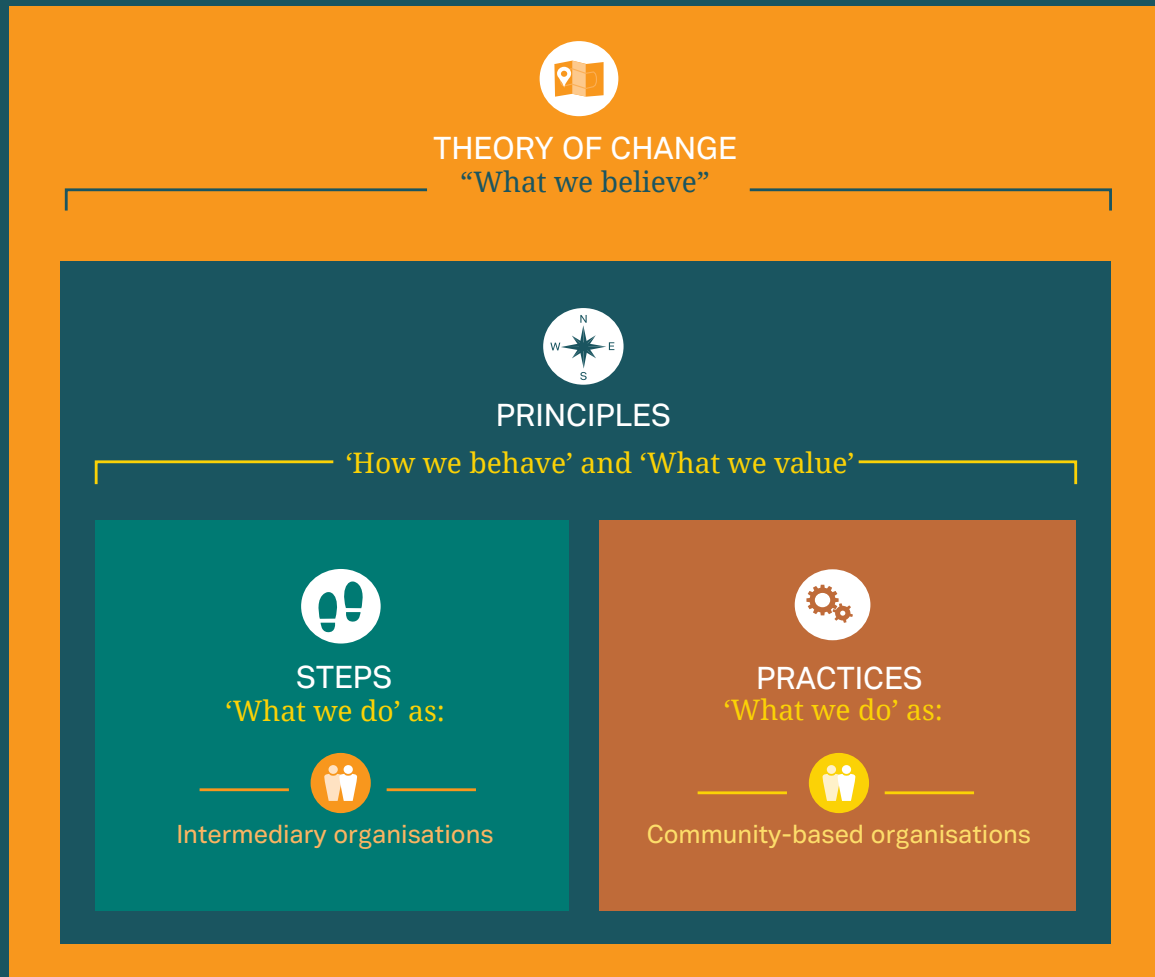
Collectively, the steps and practices can be thought of as “What we do”.

4.  Reflecting on the many stories shared, an assortment of **PRINCIPLES** emerges: essentially, transferable ways of thinking about how the work happens; the character of the approach. The principles describe a simple theory for community consultation that achieves predictable outcomes: that if we apply a certain action according to a particular value, then we can anticipate certain results in the way that communities respond, across a range of issues, topics and themes. The principles can be thought of as “How we behave” and “What we value”.

It is hoped that this content might offer insight to programmers and policy-makers about practices and principles that stimulate responsiveness in citizens and communities, especially amongst those who are traditionally marginalized owing to socioeconomic and political status.

THE FOUR COMPONENTS

The components are complementary, interrelated but not linear or sequential, a way to think about how consultation happens, and what impact it produces.



BACKGROUND: WHERE DID THIS COME FROM?

A joint research proposal effected the collaboration between Oxfam Australia in South Africa, the Global Health Unit at Monash University in Melbourne, and the School of Health Sciences at Monash. This proposal resulted in a grant to facilitate the NHI Accountability Project.

The project operated in South Africa between 2011 and 2013, and focussed largely on governance and accountability in the health sector, from the perspective of public participation in the development and implementation of the NHI. It aimed to explore how democratic processes for the introduction of the NHI in South Africa might be more participatory, inclusive and representative of civil society.

Three local community-level partner organisations were identified to participate.

1. **The HIV and AIDS Prevention Group (HAPG)** has operated in the small rural town of BelaBela in Limpopo since 1996, providing high-quality and well-administered comprehensive HIV and AIDS services in a context of considerable poverty and social exclusion, through the collective action of largely volunteer community members and lay-people supported by trained HIV specialist clinicians. HAPG reaches over 30 000 people per year with information and awareness initiatives, offers counselling and testing to over 600 people per month, supports home-

based care services to ill people and their families, and administers a highly successful ARV treatment programme linked to a general health and wellness clinic.

2. **Sophakama** is a 13-year-old CBO in Joe Slovo in the Nelson Mandela Municipality of the Eastern Cape Province. The organisation is largely a care-coordinating organisation. Carers describe their work to include “looking after the sick people in their homes”; monitoring clients on treatment; educating neighbours about care for each other; awareness-raising on health issues through door-to-door visitation; clinic support and health education; support to vulnerable children through a childcare forum that works with members of the community to identify, assess and monitor vulnerable children; and support groups for people living with HIV, caregivers and parents.
3. **The Pietermaritzburg Association for Community Social Action (PACSA)** is a faith-inspired social justice and development organisation that has been operating in KZN since 1979, with a core focus on enhancing human dignity and participation through socioeconomic rights work, gender justice, youth development, and engagement on HIV and AIDS. PACSA works in relationship with local community organisations around public health care and participation in democracy. The organisation is process oriented by nature, with a commitment to “radical

equality” and accompanying “social justice activism” amongst those in struggle. For the NHI project, PACSA worked as an intermediary partner, supporting the direct action of an implementing team drawn from a number of community-based associations, including uMphithi Men’s Network, Springs of Hope HIV Support Network, and the Abanqobi Men’s HIV Support Group.

Each organisation was an existing partner of Oxfam Australia in South Africa; each had considerable pre-existing experience of working in health and social development in its respective communities; and, interestingly, each designed and implemented its own unique process for community consultation within its respective communities – not prescribed by the Oxfam-Monash project management team.

The project resourced each of the three partners to develop and implement an approach that would make the emerging NHI discourse accessible to the local community in a way that promoted engagement and dialogue.

The NHI Accountability Project served to highlight the concern that both ordinary people – who are end users of public health – and more formal, well-established civil society organisations (CSOs) are not actively engaging with the state, to an

adequate degree, about changes within the health sector. At the same time, the project sought to explore barriers to the proper utilisation of social and political spaces by the public to interact on health policy reform, and to surface transferable principles and practices for making public participation more accessible and effective to local communities.

Designed as an action-research process, the project sought to contribute towards an extensive set of results. It was envisaged that the NHI Accountability Project would support communities to gain a better understanding of the debates around general health reform and, specifically, the NHI; that communities would have access to plain language information on the NHI, and use their learning on policy to articulate their own positions on health; that local people would participate actively in an open and transparent process of policy engagement and formulation; and that Oxfam and Monash would benefit from emergent learning that informs future programming around health in South Africa. Of particular relevance to this publication, the action-research process aimed to “...test a model of public policy engagement to increase awareness of, and accessibility to, policy at a local level”.

In July 2015, Oxfam commissioned a process for learning, concept and process analysis, based in its experience of the NHI Accountability Project, seeking to surface major learning related to principles, practice, approach, ways of thinking, and ways of working. The intention was less to

describe the project itself; instead, it was to distil common essential practice that might begin to represent a concise, unified model for effective, high-impact community engagement, consultation and public participation in health policy reform.

What emerged strongly was a set of observations about two complementary dimensions of response:



Behaviours for intermediary organisations (e.g. Oxfam) supporting public participation that enabled communities to move towards greater local initiative, public accountability and action.



Behaviours for the facilitation of local community response at the community level itself by CBOs.


It became clear that:

- Contrary to common practice, consultation need **not be a stand-alone activity**, delivered as an external intervention by development organisations to demonstrate community involvement in projects. Conducted in the right way, consultation is in fact a catalyst for moving communities through a process of increasingly active citizenship, from disenfranchisement towards personalisation of issues, participation, ownership, monitoring of service delivery, and increased accountability of office-bearers and public officials.

- A quite systematic **sequence of steps and practices** can be described for intermediary organisations and CBOs, respectively, committed to supporting communities towards achieving higher levels of civic action and local response.
- Similarly, **a set of attitudes** – ways of thinking – can be described for effective stimulus and accompaniment of this local action by all organisations, whether community-based or intermediary.
- Potentially, these process steps and principles were **transferable across any number of thematic issues**, irrespective of the issue. The process emerging was not uniquely about public participation in health policy reform. It might apply similarly to, for instance, community responses to HIV, or water and sanitation, or gender rights, or service delivery.

Ultimately, the process became one of developing a “knowledge asset”, a “how to”, for consultation and public participation – surfacing a set of common principles, practices and steps that are drawn from a range of experiences, and ultimately illustrated by those stories.



A photograph showing a group of women in a meeting. In the foreground, a woman with her back to the camera wears a vibrant orange top and a black headscarf with large pink and white floral patterns. To her right, another woman is seen from the back, wearing a blue top and a black headscarf. In the background, a woman in a light-colored trench coat looks towards the camera, while another woman in a yellow headscarf and patterned top looks down. A red fire extinguisher is visible on the wall behind them.

“Consultation is a step to support people to get unstuck; to free up energy and personal resources for participation. We saw the role of our organisation to support people to drive their own change, not train them in pre-determined ways of engaging.”

– Julie Smith, PACSA







COMPONENT 1

THEORY OF CHANGE

At a fundamental level, development work is all about change. At the end of a development process, something is different – better – than it was before. Quality of life has improved. Attitudes have shifted. Laws have reformed. Systems have adapted.

Some aspect of transformation is always the goal.

If change is the result, a Theory of Change is an idea to explain how that result comes into effect, and how it might be produced.

Experience accumulating from the Oxfam-Monash NHI Accountability Project supports an emerging hypothesis – a Theory of Change – linked to community consultation and public participation, framed around several concepts:

1. **Consultation** need not be an end in itself, an isolated event. Instead, the ultimate goal of good consultation is active civic engagement by members of a community.
2. “Consultation” and “participation”, although commonly used as interchangeable terms are not the same thing. Consultation is an action, at its most authentic practised by those seeking to support, to stimulate and to include others who are most central to an issue. **Participation** is an effect, catalysed by successful consultation, and an indicator of increasing local ownership and initiative. Good consultation jumpstarts the process of active civic engagement.

3. Consultation and participation are separate stages along a sequence of responsiveness by members of a community, leading towards “**accountability**”.
4. If consultation is appropriately and effectively facilitated, it will lead to greater levels of participation – both in quality and in magnitude – by communities in framing health priorities and health policy; subsequently, if policies are framed by local communities themselves, if citizens have a legitimate opportunity to shape content, they will take **ownership** of the issues most important to them. Once they own their issues, they will take action to monitor progress around those issues, and grow in confidence, ability and expectation with which to hold duty-bearers to account for poor public service.

Simply put: Consultation leads to participation; participation builds ownership; ownership promotes monitoring; monitoring leads to accountability, and accountability is a demonstration of active engagement.

5. Organisations seeking to facilitate and support public participation so as to strengthen institutional **accountability** are more effective at moving communities through the continuum of response if they, themselves, are subject to the same Theory of Change within their organisational culture; that is, if their internal organisational environment demonstrates the principles of genuine consultation.



The ultimate goal of good
consultation is active civic
engagement by members
of a community.





COMPONENT 2

STEPS

*for intermediary
organisations*

Consultation at local level unfolds somewhat dynamically and organically, although sensitive attention and discipline are necessary; it is a process, best achieved through participatory, facilitative approaches. There is no “one-size-fits-all” prescription for a standard model.

The NHI Accountability Project experience, however, suggests that there may well be a series of systematic steps to guide an intermediary organisation seeking to support and stimulate CBOs to facilitate local consultation in ways that are strategic, responsive to local capacity and appropriate.

Several considerations should be noted.

- The STEPS-approach makes some assumptions about certain enabling pre-conditions, including relationships with local community-based partners, and a collaborative, multi-sectoral team approach.
- Linked to the pre-conditions is the internal environment of the organisations seeking to be involved in consultation at both the intermediary and local levels. This internal environment has implications for the character of the work – the way it is done. Intermediary

organisations seeking to support effective community-driven consultation should ideally be geared to work in a way that is in harmony with facilitation, accompaniment, participation with local communities and mutual learning. Should such organisations not be working or thinking in a suitable way, there may be an additional process-step necessary to cultivate that capacity within the organisation.

- The “model” as proposed in this publication is, by nature, a theoretical one, albeit that many of the steps are extracted from practice and experience generated throughout the project. Not all steps are supported by an equal weight of experience; some are based on learning from the project, where gaps have been recognised (e.g. the benefit of a stronger link between civil society organisations and local community consultation to accelerate and strengthen accountability).

Illustrating the STEPS

Theoretical steps have been extracted and synthesised, based on a range of practical experiences throughout the life-cycle of the NHI Accountability Project. Many of these illustrations are supplemented and complemented by similar, reinforcing stories in the later section of this document focussed on “Principles”.

A PRE-CONDITION:

We have developed credible relationships with local-level partners.

A PRE-CONDITION:

We don't work alone; we look around us to build a team with others, representing a mix of skill, experience, common vision and shared interest (a variety of sectors; a variety of stakeholders).



A PRE-CONDITION: We have developed credible relationships with local-level partners.

HAPG: “We were already a partner with Oxfam before this NHI project came about, in the areas of research around nutrition. By the time we met with Moeti in 2012, our work and the work he was looking at around consultation seemed to dovetail. It was a good fit. He realised we could be an asset to the Oxfam project.”

PACSA: “For us, the NHI project came at a time where the questions it provoked were very real for us. We were increasingly shifting from a training model to working with self-organisation in communities, and seeing our role as an

organisation to support people to drive their own change, not train them in pre-determined ways of engaging. We couldn't guarantee success, or that a particular model would emerge, and so we needed to work with an organisational partner like Oxfam, who knew us and our work, and who was keen to support advocacy and learning from local action, not simply looking for implementation. We seemed to share an appreciation that social change was complex, dynamic and didn't work out in a tidy, linear way. We needed to be equally committed to learning from it.”

A PRE-CONDITION: We don't work alone; we look around us to build a team with others, representing a mix of skill, experience, common vision and shared interest (a variety of sectors; a variety of stakeholders).

The NHI Accountability Project was a collaboration between Oxfam Australia in South Africa and Monash University, together with local partners in three provinces. The partnership sought to create real synergy between action and research with a view to improving the lives of people living in poverty. It was understood that collaboration of this nature held potential to bridge the theoretical and practical divide in understanding the role of accountability in addressing health in marginalised communities, and in understanding the health experience of people in South Africa.

The NHI Accountability Project set up a six-member Project Management Team (PMT) comprising both Oxfam and Monash representatives, who shared coordination, administration and research roles. Additionally, a four-member advisory team was selected by the PMT to offer counsel on national context, and to inform decisions about strategic direction of the project. Advisory team

members included the Director of one of the three local implementing partners, a human rights law expert from the University of KZN and a Health and Health Systems expert from the University of the Witwatersrand.

HAPG: “We had worked on the NHI before the Oxfam project came about, so we had some experience to build on. Between 2010 and 2011, the future of our work in home-based care seemed wobbly. Government wanted to do ward-based HBC, but HAPG were strong advocates for community-based HBC. We needed to assess whether there would be a continued role for HAPG if things changed. We understood from the work that was happening under PHC-reengineering that HBC would fit under this upcoming NHI, so we began to talk with the staff at our project about what the possible changes might be. As an organisation we were already trying to find ways to position ourselves in case things changed.”

1

We build our own understanding of the context: The policy itself; The environment for and experience of 'engagement'. We review (what does it say?) and analyse implications (what does it mean?).

Urvarshi Rajcoomar, Oxfam: “At the time, the only resources available to understand the NHI were the Green Paper and academic papers written by economists predicting a financial model for the NHI. We reviewed the Green Paper and realised that it was a paper of intention only, nothing yet conclusive, and with many gaps. But, it was something to start from. In 2012, we demystified the NHI Green Paper to make it into a user-friendly guide that local communities might understand.”

HAPG: “Around 2011/2012, we had already heard about the NHI, and had started to – on our own – find ways to position ourselves in case things changed in the health system. We

first gathered as much information as possible, from about 19 different sources, for a workshop. We had accessed booklets from government, online, and translated these into Setswana and Sepedi. We read these booklets first, as a team in groups of three, but didn't understand all the words – the content and the language. So we generated many questions around the content, things we didn't understand from the document – the membership, the financing, who would have access, how this whole thing was going to work. Part of that process was to share those questions with Oxfam to inform their thinking about their work, and make some contribution to the NHI Accountability Project.”

2

We generate thinking about potential impacts, and identify (a) opportunities for influence and (b) mechanisms for influence. We review and conduct research to test, to deepen and to verify our understanding of the issue.

In 2011, Geoff Setswe (Monash) conducted a desktop review around public participation in health policy, looking broadly at legislation passed, and how consultation had historically been facilitated around that legislation. In particular, Geoff considered the Choice of Pregnancy Act to explore how government promoted and facilitated consultation and public participation.

In 2012, Moeti Kgare, an independent consultant, undertook two research assignments on behalf of the Oxfam-Monash partnership in South Africa. He reviewed the National Health Act, 2003, mapping out any legal provisions that were in place for public participation, and tried to understand how these were framed, what the roles and

responsibilities were for various stakeholders and actors, and whether any provisions for how public participation should work were made in the law.

Moeti's finding was that provision was made in the Health Act to enable people to have a voice in the health care system through clinic committees and hospital boards. Moeti went on to conduct a study to test the functional operation of these structures (clinic committees and hospital boards as provisions for participation) in two health districts, exploring whether this legislative framework actually applied in practice. He found that most of these structures as prescribed in the Health Act had not been formed in health facilities and that, where they had been formed, they were not functional.

3

We transfer our learning into materials that expand public access to the policy content: simplified language and translation that is useful for education and information-sharing. We test these materials for efficacy and adapt accordingly.

Urvarshi Rajcoomar, Oxfam: “In 2012, we demystified the Green Paper to make it into a user-friendly guide on the NHI, and tested that resource with two communities, Bela Bela and Ingwavuma. We wanted to know whether it was appropriate to different literacy levels, and whether the content was clear. Was the information really easy to understand? Were people hearing this information for the first time? When we took it to the community level, we encountered some very low levels of literacy, and needed to adapt the booklet even more to make it more contextually appropriate. At the same time, this generated more learning for us about the capacity of our local partners to take the basic information, extract the core components of the content that mattered most for where they were

working, and package that for their local audience as an entry-point for more intensive consultation.”

HAPG: “When we first started gathering information about the NHI, we accessed booklets from government, online. We translated the information into Setswana and Sepedi. This brought it closer and made it more real.

But we still didn't understand all the words in the document. It wasn't only content that we didn't understand. It was also language, even after translation. The government in their booklet seemed to make up new words – using language specialists – to fit into their technical language. But these terms were not easy for us to understand.”

4

We support our LOCAL PARTNERS to facilitate consultation in their respective communities, applying our materials as appropriate.

Oxfam and Monash university did not engage directly with communities to facilitate consultation. Instead, three local community-level partner organisations were identified to participate in three provinces: HAPG, Sophakama and PACSA and its CBO partners.

Each organisation was an existing funded partner of Oxfam; each had considerable pre-existing experience of working in health and social development in their respective communities. Each was contracted to design, implement and

document a localised NHI consultation process* suitable for their respective community contexts; the process was not prescribed by Oxfam/Monash.

*Local consultation processes are described below in the sections Practices and Principles



PRACTICES
PAGE 26



PRINCIPLES
PAGE 32

5

We expand community participation processes to include and connect civil society organisations.

From 9–14 December 2013, The South African People's Health University took place at the University of the Western Cape, organised by the People's Health Movement in conjunction with NEHAWU. The event aimed to build capacity in community and organisational activists around health systems, health policy and health economics for more effective advocacy. The process addressed social determinants of health, primary health care, health systems in South Africa, the NHI and health activism. The Oxfam-Monash NHI project supported several local implementing team members to participate in the school, offering an opportunity to deepen thinking and learning, and connection to other civil society organisations.

Oxfam entered into a short-term consultancy agreement with the Alternative Information and Development Centre (AIDC) over the period 15 January – 15 July 2013 to further the call for budget justice through civic engagement, advocacy and campaigning, and constructive engagement with Parliament. One feature of the short-term campaign was a Budget Justice Seminar in April 2013 in Cape Town, convened and coordinated by the AIDC. Oxfam further supported the participation of several local implementing team members under the NHI Accountability Project in the Budget Justice Seminar, offering opportunity to participate and a space to contribute to higher-level policy discussion from the practical perspective of local community experience.

6

We support and build civil society alliances for engagement with the policy.

7

We monitor the strength and relative growth and solidarity of civil society movements around health policy reform.

In August 2012, the project convened a meeting of civil society organisations in Johannesburg, bringing together representatives from CSOs, Oxfam, Monash and government to engage in discussion about public participation within the health sector. The meeting was in response to the project's findings of low levels of active

engagement with the state by recognised, formal, well-established civil society organisations. Participants confirmed that issues of transparency, inclusion, monitoring, accountability and feedback are elements for close attention for future engagement between government and civil society organisations.

8

We periodically review consultation models and public participation approaches to improve efficacy, together with partners.

9

We synthesise community input, and facilitate a way for it to inform our cumulative policy-analysis, practice and programming.

Stemming from the NHI Accountability Project, Monash University is publishing two papers in 2015, informed by learning from local experience and action:

- “The new NHI policy in South Africa: public perceptions and expectations”
- and, drawn from the post-project evaluation,
- “Public Awareness and Knowledge of the NHI in South Africa.”

10

We reflect on our learning. Emerging learning – the product of our consultation – increases the evidence-base for action, advocacy and accountability.

Effectively, we come full-circle. We filter new learning back into the process to better understand the context, and deepen analysis by both organisations and communities alike.

The NHI Accountability Project has generated a large resource of rich learning, captured across multiple volumes of reports and papers, many of these developed by local implementing partners themselves by way of process-reflection on approaches for consultation, including:

- “The Final NHI Community Consultation Process Report” (PACSA)
- “A Contextually Appropriate Consultation Process on the NHI” (Sophakama)

- “Report on the NHI Community Consultation Process in the Bela Bela Community” (HAPG)
- “Final Report on the NHI Consultation Process in Bela Bela” (HAPG)

In addition to the research papers already described, further papers have been developed based on these experiences, including:

- “Empowering Community Voices: Research Studies from South Africa and Bangladesh” (Larry Stillman)
- “Exploring the Real Work of Social Change” (Julie Smith)



COMPONENT 3

PRACTICES

for CBOs

Through the Oxfam-Monash project management team, the work of an intermediary organisation to support consultation at community level was demonstrated through a series of STEPS.

One such step was supporting local partners to facilitate consultation in their respective communities. The approach for consultation was not prescribed by the intermediary organisations; this was left to the discretion of the local community-based partners to design and deliver through a methodology they felt would best suit their own context.

Unsurprisingly, at the local level, each of the three implementing partners – HAPG, Sophakama and PACSA – designed quite different consultation trajectories, although each location participated in a pre-intervention baseline survey and a post-intervention data-collection process, on either side of their respective consultation processes – coordinated and supervised by a consultant responsible for impact measurement.

In each local setting, the consultation process was preceded by the pre-intervention baseline process. This took the form of an orientation to the NHI for the local team, instruction on a data-collection process using a standardised questionnaire and cell-phone technology for data capture, and extensive door-to-door visits in the participating neighbourhoods. The effect of this survey process must not be underestimated as it was the first point of connection to the NHI project, and to the subsequent work of the local teams, for both the community and many of the team members themselves, who were engaging with the issue for the first time.

What is particularly interesting to note across the local implementing partner experience is the evidence of common practices and behaviours, despite the fact that the local models for consultation were not centrally coordinated or prescribed, and the three implementing locations did not interact with each other in order to



In Bela Bela, **HAPG** facilitated consultation through a combination of targeted focus-group discussions (schools, teachers, churches, municipal managers, clinic staff, game lodge managers) and door-to-door home visits in two communities.



In Joe Slovo, **Sophakama** facilitated consultation through the entry-point of its network of home and community-based care workers, meeting first with this group of stakeholders to discuss the NHI, before convening another gathering with the clients of the care-workers, and following up with door-to-door home visits. Focus-group meetings followed, discussing the NHI with teachers, traditional healers, community youth, traditional leaders, church leaders, and clinic staff.



In the uMgungundlovu District of KZN, **PACSA** supported its inter-CBO team to design and facilitate two large community gatherings, over two days each, focussing on youth and adolescents in one meeting, and on adults and the elderly in the second. Following the community-gatherings small focus groups were convened to invite reflection and feedback from community members about whether the meetings were helpful, whether they made sense, and how they might want to continue to work together.

harmonise design and approach or modes of delivery. Each local team deliberated and intuited the approach they felt would be most effective in their respective settings. A comparative analysis of these naturally occurring common practices is useful to surface a set of suggested “standard behaviours” – **practices** – for community-level consultation.








COMMON PRACTICES

























used by CBOs during the consultation process

In designing, developing and implementing their consultation activities, CBOs should:

1. Have some **prior knowledge** of the subject matter prior to facilitating public consultation around that topic.
2. Have a strong, long-standing, **quality relationship with the community** being stimulated to participate in the process.
3. Have some **existing experience** in health programming, service-delivery, social development and social justice.
4. **Support leadership by the local community**; enable facilitation of the consultation process by team members from the local community.
5. **Build the capacity of the facilitation team** throughout the consultation process: to reflect, to learn, to think, to be more conversant in the topic. Allow the team to take initiative and responsibility for its own learning and development.
6. Make after-activity **reflection and debriefing a routine behaviour** so that the facilitation team learns with and from the community, and can adapt their approach dynamically.
7. Stimulate consultation through **a combination of approaches**. Mix consultation through large public gatherings with consultation through small focus-group discussions, and with home visits.
8. Facilitate consultation so that the **private environment** (small group; home) links to the **public environment** (neighbourhood gathering).
9. Stimulate depth of consultation through **door-to-door visits in the private homes** of community members, before focus groups or community gatherings.
10. Facilitate **dialogue between community members – with each other**, not primarily directed towards the CBO.
11. Start the consultation process from a **personal, affective point of reference** instead of cold facts. Let households and communities feel what the issues would mean for them.

PRACTICE	PACSA	Sopha-kama	HAPG
<p>1. The organisation already had some acquaintance and experience with the NHI subject matter prior to the NHI Accountability Project.</p> <p><i>HAPG was the one local organisation that had previously conducted some exploratory work on the NHI prior to the Oxfam-Monash project. This gave them some helpful experience to build on, whereas the two other implementing teams admitted to “being clueless about the NHI before the project started.”</i></p> <p><i>Given the success and effectiveness of the consultation processes across all three implementers, it might be suggested that advance knowledge of subject matter is helpful, as it demystifies the issue and reduces its intimidation factor; but it is not an essential pre-condition to successful consultation.</i></p>			
<p>2. The organisation had a strong, high-quality pre-existing relationship with the community it was stimulating around the NHI.</p>			
<p>3. The organisation from which the local implementing team was constituted had a mature, current, highly active practice, with experience in health programming, service delivery, social development and social justice.</p>			

PRACTICE	PACSA	Sopha-kama	HAPG
4. Leadership of the consultation process was through a team of local people who are themselves members of that community .			
5. Prior to, during and after the consultation processes, the implementing teams formed themselves, of their own initiative, into dynamic, interactive learning groups to develop their own literacy around the NHI and its implications. Progressing, sustained capacity-building of the team itself, by the team itself, was an observed discipline.			
6. After-action reflection and debriefing is an institutionalised behaviour; team members were not positioned as experts on the NHI; they learned with the community, from the community, and from their own practice. Consultation design was responsive, adapting to and being informed by learning from local engagement.			
7. Consultation happened by convening large community-wide public gatherings . <i>PACSA was the only local partner to convene large community gatherings in this format. Even there, however, two meetings took place, separated by age and by “type”, to allow a focus on women, adolescents and the elderly. These community meetings were complemented by home visits and focus groups.</i>			

PRACTICE	PACSA	Sopha-kama	HAPG
8. Consultation was designed so that the private environment (small focus group; home) links to the public environment (neighbourhood gathering, community conversations). The two environments of home and neighbourhood were dynamically interconnected through a common narrative emerging from consultation.			
9. The consultation process was first stimulated/provoked through door-to-door visits. Visits stimulated community members around the issue through strategic questioning, not primarily through information sharing and education about the issue.			
10. The consultation process and events created an opportunity for people to think and speak, not to the local implementing team, primarily; but, instead, to each other. Consultation stimulated , without defaulting to educating.			
11. Consultation processes started from an affective point of reference , not necessarily an exclusively factual point of reference. Implementing teams did the work to allow communities to first think, "What does this mean for me?" and to personalise the issue, before introducing factual information.			



COMPONENT 4

PRINCIPLES

The STEPS and PRACTICES referenced earlier speak clearly to practical action. They represent a sequence of activity by intermediary or CBOs to systematically stimulate and strengthen public participation through consultation.

By contrast, PRINCIPLES speak to ways of thinking and ways of working, a certain character that defines an approach to the work. If STEPS and PRACTICES answer the question “What will we do?” PRINCIPLES answer the question “In what way will we work?”. Interaction with the teams involved in the Oxfam-Monash NHI project clearly reveals that these ways of working are a critical component to effective consultation, and to moving communities through the continuum from consultation to accountability. They are complementary to the practical steps, and quite indispensable considerations in the design of a consultation process.

The principles surface quite simply from story, emerging as implementers in different locations reflect on their work, and share their individual experiences.

As experiences accumulate, common themes and lessons can be recognised, organised around a certain simple, conditional logic: if this, then that. In the development of this document, implementers recounted their own stories, and collaborated to frame their own principles.

With particular respect to these principles generated from the NHI Accountability Project, the following may be noted:

- Twelve broad categories of principles could be defined, illustrated and reinforced by

experiences of the implementing partners across multiple locations.

- Some principles are internal, speaking to the values and behaviour of organisations. Other principles are external, speaking to the practice of consultation, and the theory of an approach.
- Principles are generated from a number of real-life, local experiences during the NHI Accountability Project. But, owing to the “if ... then” logic, they may be transferable and applicable to a range of other contexts beyond this project or subject matter. The principles become a way to link people to one another, to learn from each other’s experience.
- Principles link to stories that, in turn, are linked to organisations and people. It may, in fact, not be necessary to collect every piece of information available (and may actually be counterproductive); for the best learning, it may be more efficient and effective to simply contact the person who holds that experience.
- Experiences continue to accumulate, allowing for the ongoing, dynamic development of the principles. Better, more routine learning from experience predictably leads to more mature, better refined principles.
- Many principles are reliably supported by experiences. Some, however, are not yet fully developed that way; instead, they are “intuitive”, leaving room for experience to be added later, or for new experience to be generated. Ideally, the strongest principles come from the weight of experience, making them much more legitimate than opinion or hypothesis.

COMMON PRINCIPLES

emerging from organisations engaged in an effective consultation process

Emerging principles for CBOs and intermediary organisations wishing to support meaningful consultation include:

1. If we cultivate **integrity within our organisational culture**, then how we behave (internally amongst staff and externally with communities) is consistent, and matches what we say we believe and value. We learn from communities and each other, and are able to adapt.
2. If we facilitate meaningful **links between communities and other civil society organisations**, then public participation is made more effective, legitimate and authentic.
3. If we keep people connected to their own process through **routine feedback and follow-up after consultation**, communities sustain and expand their sense of ownership and investment in the issue, and take more confident decisions for action.
4. If we **make the subject matter personal** – allow communities to think about and feel their own reality instead of promoting our organisational agenda or educating with facts – then people are better able to access the topic, and feel motivated to actively participate.
5. If consultation is facilitated through a responsible approach, it becomes more than an isolated event: it is a **springboard for greater levels of public participation**, ownership, accountability and citizen action.
6. If we, **as organisations, participate appropriately alongside communities**, then their natural leadership and strength has space to emerge, without inappropriate dependence on organisations.
7. If consultation is **designed and facilitated by local people**, the process is accessible and relatable to many more people in the community, who feel empowered to integrate their own experiences into the process. The quality and effectiveness of consultation improves dramatically.
8. If we **link consultation in the private space of the home, with the public space of the community**, then everyone becomes involved. Intimacy, responsibility and solidarity come together through one process.
9. If we design our consultation process to **engage the emotional before the rational** (feelings before facts), people in communities are more likely to engage, participate and respond.
10. If we **stimulate communities with good questions**, instead of providing information only, people become engaged in discussion, participation increases, and organisations gain insight into how to adapt their consultation process.
11. If we have **established relationship and trust** with communities, they participate more freely in discussion and dialogue without suspicion or a sense of interrogation. Consultation is not an event; it is part of an ongoing conversation in the community.
12. If we make provision in our activities to accommodate the needs of people during public consultation (e.g. childcare), then they feel included; **inclusion** leads to greater participation.

1. ORGANISATIONAL CULTURE

If we are a learning organisation, then we will have in place systems and mechanisms for effective informative capturing, monitoring, reflection, learning and accountability; and application/transfer of our learning to other thematic areas.

If we apply the same values and ways of working within our organisation as we do with communities – listening, recognition, dialogue, validation – then consultation, internally, leads to greater levels of participation, ownership and accountability within the organisation.

If we follow the same Theory of Change within our organisation as we apply without, then we model a way of working for our staff that builds their capacity to engage well with communities.

If we utilise consultation to meaningfully learn from local action and experience, then we will become more responsive in our actions/behaviours. A learning culture makes the organisation more dynamic, more adaptable, more relevant and more strategic.



Sophakama: “Our first NHI survey process generated all kinds of questions from community members. We gathered together at the office and listed all the challenges we heard and compiled them. We laid them on the table, one by one, and discussed them. It dawned on us that we ourselves, administering the survey, did not know enough about the NHI, and needed to get better informed and educated.

So we began to learn. We accessed the NHI pamphlets. We did a lot of our own reading; did our own research as individuals and as a group. We listened to information on Morning Live TV; we checked the internet at the library; we phoned each other to tell each other when there was any mention of the NHI on TV or radio. And then we came together to discuss and to plan.”

Sophakama: “When we started this thing, we didn’t know the aims and the purpose of the NHI, or the long history of the NHI discussion before now. But we were eager to learn, and we wanted people to understand the NHI.

We learned during the survey process that the community had many questions. And we ourselves also had the same questions, but no clear answers.

So we committed to having regular “group chats” as a team, to put our questions down, and record the questions from the community, and to share and discuss our findings and our challenges.”

Sophakama: “We ourselves were visiting the clinics, but never thought about how long we

were waiting there, or the quality of how we were being treated. We just accepted that was how it was. But now we have become more aware of our rights. And of the health system we want. And it has changed our work. Before, we were not giving information on rights. As carers, we focussed on sicknesses and symptoms and services. We were not aware ourselves about rights. But now these things go together.”

PACSA: “Early in the process – when we first started administering the surveys – we realised that we needed to learn about the NHI ourselves. But we needed to be in charge of our own learning; we didn’t need another expert. We were so used to engaging with material someone else had already digested for us. So, we formed a study group. We met every week for 3–4 hours to share and reflect on what we’d

learned, to frame questions, to talk about how what we learned about the NHI affected us.

And we realised through that process that none of us had any good reference point for proper consultation, either. Our only experience was of meetings that were always about information, but not real engagement. Or rubber-stamping something someone else had already decided. It made us want to design a better process for consultation that was not about information, but was about experience.

And so we did: when we eventually developed a training manual and a process guide for how to do our consultations, we designed it in a way to incorporate first how people were affected by the issue, then information, then reflection on meaning, and constructive provocation.”

If we partner with academic institutions, then it affords us the rigour and credibility – through research and publication – to advocate, from evidence, for policy reform.

2. LINKING COMMUNITIES TO CSOs

If we facilitate linkage between local communities and civil society organisations, then local communities can feel better supported and accompanied in their advocacy/consultation/participation work, and be aided to escalate their influence to higher levels, without being overwhelmed, or distracted from their local implementation.

If we link local-level engagement with CSO-level engagement, it facilitates solidarity and supports sustainability – the movement can continue independently without us.

If we work with both local-level communities and civil-society organisations – and facilitate a linkage between them – then CSOs can act as a channel for locally generated evidence to higher-level policy processes.

If we link local-level engagement to CSO-level engagement, it builds capacity at local level for communities to increase their literacy around policy-reform, and have greater access to opportunities to participate.

If we link local-level engagement to CSO-level engagement, it makes possible a way for higher-level, technical advocacy to be more credibly informed by local experience and input.

3. FEEDBACK AND FOLLOW-UP

If we are committed to meaningfully engaging with and respecting communities, then we will be intentional and systematic about giving feedback to communities about their participation in the process.

If we are consistent, systematic and intentional about feedback to communities, it reinforces trust, builds relationship and solidarity, and expands and deepens the quality and opportunity and invitation for continued dialogue.

If people receive feedback on the process in which they've been involved, then they continue to feel connected to the process as it progresses; their interest, participation and hopefulness will be sustained.



PACSA: “After the consultations, our local team was determined that “we have to go back”. So we reconnected with people who had participated in the consultations, in small focus groups from three different areas. We wanted to talk with the people about whether the process had been useful to them, whether it made sense,

whether anything was changing, and what information needed to be updated.

And we continue to meet as a group about once a week, as well as meet informally with nurses and community caregivers to give feedback and reflect together.”

4. RELATING TO PERSONAL EXPERIENCE

If you run a consultation process where people can engage from their own experience, then spaces are created for people to really engage with the content of the process. (Experience is more effective than theory.)



PACSA: “As we were educating ourselves about the NHI, we realised that none of us had any good reference point for proper consultation, either. Our only experience was of meetings that were always about information, but not real engagement. Or rubber-stamping something someone else had already decided.

It made us want to design a better process for consultation that was not about information, but was about experience.

And so, in our process, we met together with community members over two-day stretches,

because we realised it would take time for people to really express themselves. We first asked people to speak about their experiences with accessing health care, and then to speak about their challenges. Then to imagine – to dream – about the kind of health care they would want to see.

Only after that did we introduce the NHI and the policy. It helped us to make the policy discussion relevant to the real lives of people. And it allowed us to question whether the policy speaks to our experiences, challenges and dreams.”

If we package our information/messaging in a way that represents and reflects the lived reality/experience of people – if we start from their experience, not our own agenda – then they can better internalise the need for change and engage with the process.

If people internalise (personalise; identify with) the reason for change, then they are more likely to engage with the process.



PACSA: “When we first started to investigate what people knew about the NHI using the survey form and process provided, people did not want to participate. And we realised that we were missing something. We had not anticipated working with people’s

deeper, unexpressed need to have a discourse around democracy and democratisation and governance. Without that, the NHI was just an isolated item on an agenda, an issue out of context.”

If people internalise (understand) the impact and implications of a policy, then they are more likely to engage with the process.



PACSA: “When we started with the project, and were trained on how to do the NHI research through the survey process, using the phones and the questionnaire, we were clueless about the NHI ourselves. We conducted the survey, but needed to sit together to reflect on the process afterwards. We realised that we didn’t know enough about the NHI to facilitate the next round of consultations, and so, as we were preparing to have the consultations, we continued to read and gather information and reflect together. We met once a week, and

started a reading club. We were also learners, with the community.

We gathered all the information we could find – from the internet, some materials from Oxfam, we even watched a movie about the NHI in the UK and Brazil – but we realised that information alone was not useful. We needed to think about what it meant, and what it meant for us individually and personally. We agreed that we needed to do the consultation amongst ourselves first, and think about what questions we might have about the NHI.”

If people have a familiar reference point through which to understand an abstract concept (like a policy), then it becomes easier for them to authentically engage in conversation; consultation becomes more inclusive, more accessible, and more effective.



HAPG: “If we don’t know what good health care is, how do we know/ imagine/dream about the ideal we are aspiring towards? It was difficult for our people to really understand what the NHI would look like, how it

would work. And our own local team had similar questions. But, when they started out with the idea of a medical aid – something familiar – it was easier to work from there to better understand the concept.”

If we work with communities, starting from their lived experience first, but going beyond that to make the personal political, then we stimulate and motivate passive community members towards constructive active citizenship.



Sophakama: “The project really helped us to be involved as citizens in a process in our own country: the young and the oldest. It made us more united as a community. We

realised that we’ve come from far – a long way to get to this point now. It got us back in touch with our history: we can see that some things are changing, but we also recognise

that we have rights that in practice are not being respected. We've become much more aware of such concepts as equality and dignity and respect."

Sophakama: "Before we were involved in this project, we were visiting the clinics, but never thought about how long we were waiting there, or the quality of how we were being treated. In the past, we just accepted it that this was how it was. But now we are more aware."

Sophakama: "I didn't know much about the NHI until I got involved here at Sophakama. I asked my peers about it, and they didn't know anything about it. So we had to find out more. It has helped me realise that as a youth in South Africa I must not be like someone who is lost, like so many of our youth. I need to be active in South Africa. And these dialogues about health are also dialogues about democracy."

5. EFFECTS OF CONSULTATION

If we are responsible in our facilitation, consultation stimulates increasing levels of participation towards local ownership that drives the accountability process forward; in turn, if local people feel an ownership of the process, they will take action to self-organise in order to monitor and to demand accountability.



HAPG: "We had been delivering HIV and TB care, prevention and treatment services in Bela Bela since 2001, with funding from President's Emergency Plan for AIDS Relief (PEPFAR) between 2004 and 2009. In 2009, when PEPFAR withdrew direct funding from the country for ARV distribution, they proposed that all HAPG patients be rerouted to the state hospital and the state PHC clinic. As a result, the HAPG ARV programme would need to be concluded, with responsibility handed over to the Department of Health.

The DoH set up containers at the clinic site, and informed HAPG to tell patients they would now receive their treatment through the

clinic. Community members, not satisfied with that decision, gathered at the clinic to decide what they would do. After three meetings, the community chose representatives to visit the Premier and MEC offices, but these attempts were not fruitful. People were very unhappy with having to now use the clinic services.

Over time, the community realised that there were lots of patients not taking their treatment. They organised themselves to visit every patient on the ARV list to monitor their adherence, and realised that 30% of patients had stopped treatment or died. They were simply not collecting their treatment because they did not want to access it from the clinic.

The data was forwarded to the Provincial DoH, and the community tried to talk about it at any available opportunity and platform. It reached the attention of the Provincial Health Director who visited Bela Bela to meet with the community, HAPG and staff. The Director intervened in the situation, and talked to the hospital management and district health management team.

He returned to Bela Bela three weeks later, with a request that HAPG restore its ARV programme, under an agreement that the state would pay for treatment for as many patients as HAPG could support.”

If we respectfully engage people in consultation, it stimulates hope and expectation; appropriate expectation is not a bad thing – people are provoked towards expecting “accountability for action”.



PACSA: When we did the first surveys in the community, I surveyed my mum. She didn’t want to go to the full community consultation meeting because she was caring for grandchildren in the home, and the goats.

When we next met with a small focus group, we met at my house. We were sitting in the kitchen when the group started talking; we were talking about the NHI, and about what nurses should be doing in the clinics. My mum suddenly jumped into the conversation – she had not even been invited!

After that conversation, the next time she visited the clinic, she did not join the queue like she normally would. She walked up to the security and told them “I have a stick, and I cannot walk, and now I have to join a long queue. I can’t stand in the queue because of my age.”

She went to the clerk, and told her “You know it is my day to be at the clinic, so why are my card

and file not out? I was told by the Oxfam people how the NHI should work in our clinic. So why do you not practise it?”

The staff were shocked, as they knew nothing about the NHI and most patients were pushing her to say more about it. She was assisted quickly, and received her medicine.

Now when she goes to the clinic, she does not join the normal queue anymore. And now I, her daughter, can collect her medication on her behalf. Before, she would have to collect that medication every month. But now, they dispense her medication in 3-month batches and remind her to visit the doctor for check-ups. She understands that she can ask for a reason why she does not get her medication as prescribed, if medicine is missing on the prescription.

She is now fighting for her rights.



Sophakama: When we first started talking with our communities about the NHI, people were hopeful and excited that there were plans to do something better for them.

People started asking questions: “What is the specific year this will start?” and “When will we start to see the changes in the clinics?”. They expressed dissatisfaction that these things are always promised, but take so long to be delivered. They didn’t care about the 14 years of discussion in the country to get this far. But, the conversation gave them some kind of determination.

“We are already ill; we are dying now; by the time it gets here, it will be too late. We want to see this now.”

Grandmothers were saying “We want to take part in this; it is important; it is our legacy for our children and grandchildren, even if we will not see it.”

And people began to expect more from government. “Why are the government officials

not coming themselves? They are afraid to talk to us directly, and they are using the NGOs to do their work. They come to us, meet in our halls, but then we do not see them again. Or they come and tell us what they will do, but they never ask what we need. Or, the items are already decided – there is no real consultation with us, just needing people to rubber-stamp at the meeting.

HAPG: The consultations really helped to prepare people for this future they can’t yet completely see, even before the final vision is realised. And it’s helped them adapt with less resistance. Even now, a long time before the NHI is officially implemented, in Bela-Bela, we can see at the clinic that teachers and other tax-payers (nurses, policeman) are coming to the PHC-clinic and sitting there with the poor. They are already avoiding private doctors.

At the clinic, services are beginning to look more integrated, with a doctor, a dietician, a psychologist all available. And even the nursing sisters at the clinic are noticing that the quality of medications are same – at lower cost – than at private doctors.

If consultation is done “the right way” (led by local people with local people; generating discussion through strategic questioning, not only giving information) then the process generates increased demand and invitation for more/deeper levels of consultation, for higher degrees of involvement and connection; participation expands from organisationally-delivered consultation to community-driven consultation. (responses can be “emergent” in the same ways diseases can be “emergent”).



HAPG: When our local team from Bela-Bela conducted a NHI-Focus Group session with the management and some staff of a local game reserve, they listened very carefully to the content about the NHI, and started asking questions. Initially, the process seemed to separate the group: the staff personalised the information immediately, thinking about what it meant for them; the management thought about the benefit to the business of having good care available to the staff. After the session, the game reserve management approached us: “Hey! This needs to be done with all our staff, but it would be better if you come to do this; they will accept it better from you than from us – we can’t do this the way you are doing this.”

We had the same experience after a workshop with the municipality managers and team leaders, who asked that our local team come back, and continue the conversation process with other levels of staff in the municipality.

After we did an NHI-session at the Methodist Church and Full Gospel Church, we left behind some information pamphlets. A few days later, that same week, members of those churches – who were not at the meetings but had found

the pamphlets – came to find our team at the office, asking for more information because the pamphlets were not enough. We were able to have a spontaneous “workshop” conversation right there about the NHI.

HAPG: In 2012, we did our first door-to-door visits around the NHI in the Old Location, Bela Bela. We covered about 3 streets, with families we already knew from our HBC-work and a few random houses. We left some information pamphlets with the households visited, and encouraged people to talk about it with their neighbours around them.

We started with homes we knew, but we got drawn into other homes by neighbours who wanted to know “what are you doing? Don’t skip us.”

Shortly afterwards, people from the other section of the community – Leseding – approached our local team at the office-premises. We had never visited Leseding, but people came to visit us at different times, sometimes individually, sometimes in groups, asking that we come to their location to do door-to-door visits.

We responded, and were able to visit about 50 households.

If our consultation process allows space for people to dream/imagine/envision the future they most wish to see, it elevates the energy around “possibility” and “co-creation” (doesn’t stay stuck in negative experiences). It generates hope; and hope is aspirational, inspirational; motivational.

Responsibility becomes owned – not externalised (eg. change lies not in the policy, but with people, with response, with local movement).



PACSA: We found that the process of imagining created a space for people to acknowledge safely what they found isn’t

working in their environment. And through that process, the distance between what is now and what is possible gets smaller.

6. APPROPRIATE PARTICIPATION

If we meaningfully participate with communities in their local experience – as citizens ourselves, not as technical experts – then open dialogue in a safe space is made possible.



PACSA: “We are an organisation in solidarity with those in struggle. And we believe in the autonomy of people: those who struggle, lead. This is a basic value for us, and a practice in the way we work.

Working with our partners, we share a dream of what the world could be. The intersection, the conversation, the process is an act of co-creation. We are not external or passive; we are also living in this world.

But the question of leadership is different from the question of participation. We participate as co-creators, but we choose to step back and let the local lead, supporting as is appropriate.

We actively participate, with confidence. We don’t timidly disengage or abdicate responsibility. But we are also always checking whether we are appropriate, through reflection.”

If we want to build power in people, we cannot do that by bringing something – some commodity or intervention. We can only build power from within people's own experiences and personal resources.



HAPG (Cecile Manhaeve, Director): “As an outsider – even though I had lived in the community for many, many years, and was respected and trusted – it was still more powerful when local people talked to local

people. I was there to give support and input from behind if, perhaps, the local team felt a bit stuck. But the leadership had to be local for people to really participate.”

In the initial gathering, if both parties are honest about their intentions, about what they can deliver; if they establish a relationship of “radical equality”, then expectations are not inappropriately raised, or projected onto someone else.

If we include ourselves in the process of imagining with people, then we don't raise expectations that we receive and implement on behalf of others; people feel responsible for their own action, and retain their agency.

If we provoke discussion around needs (“What do you need?”; “What do you believe you want?”), we shut down people from dreaming/imagining – their agency for response. We redirect towards provision and expectation, instead of towards response.

If we provoke around strengths, then people can plan/act towards change.

If we assume that everyone knows something (“everyone can think”) – people have their own assumptions and beliefs – then we don't approach consultation assuming we are the experts; we work with what people are saying, not our own expertise.



PACSA: “At the consultations we didn't start out with information on the NHI. Instead, we started to ask ‘What experiences have you had with your local health care system?’ and ‘What challenges do you face when you look for help?’. Then we started to understand where people were at. So that, when we introduced the NHI, we could frame it as something that responded to those exact

issues people were raising, and talk about whether the NHI was a match for their dream for health.

It also helped us eliminate a lot of unnecessary content that we might have intended to use, but now understood was irrelevant to the community.”

7. ENABLING LOCAL LEADERSHIP

If we are committed to supporting/promoting full, meaningful participation, leading to local ownership, then we need to invest in building skills, capacity and confidence in local communities to drive their own process of consultation and action.



HAPG: “We did two rounds of door-to-door visits, the first with our own project staff only, and the second using additional community youth volunteers to administer the NHI survey. But this second group didn’t come into the process with as much experience or orientation as the project staff, and they did not have the same basic information. We did not equip them in the same way, and we should have. They did not do as well.

We learned that if we increase space for participation, new people come into the process. And this adds to the effect: they talk informally with families and friends and neighbours. We reach more people.

But, if we want to include more people, we need to make sufficient provision for time for them to feel able to participate like everyone else.”

PACSA: “Three local associations were approached in June 2013 to consider involvement and participation in the process. The associations delegated representatives to participate. This inter-association team was trained through an Oxfam resource person, initially, on how to conduct the first phase of the NHI research, using cell phones and a survey-questionnaire. Following that initial survey process, PACSA supported the local team to meet weekly for reflection and to integrate learning from self-study about the NHI.”

If you run a consultation process designed and facilitated by a group of local people who had been actively involved in thinking about the process and content, then the process is delivered in the language people can relate to; it responds to their experience and it means something to them.

Expertise is related to experience that allows us to relate to a policy; it gives us the right to speak to this policy that is meant to impact on our lived experience.



Sophakama: “We have worked in this community for thirteen years. We ourselves are carers; we know what it will mean to have the health system we want.”

PACSA: “Before we could do the consultation with our neighbours in the communities, we first needed to think about what the NHI meant for us. We agreed that first we needed to do the consultation amongst ourselves in the team.

The information couldn’t have meaning for others if we couldn’t find a way for it to have meaning for us.

We realised that we needed to integrate our own experiences – and our process needed to help others do the same thing – so that the policy would be relevant to our lives. Our own experience – not the policy – needed to be the point of view that informed the process and content of the consultation about the NHI.”

If local people are adequately capacitated to participate – to take the lead, and own their own local process – then the quality of that process increases significantly: in rigour, in enthusiasm, in quantity and in uptake. (trust is good, but it isn't always enough; neighbours mean more. Co-creation is possible by organisations who participate with communities, but leadership is by locals)



HAPG (Cecile Manhaeve, Director): The local team had made arrangements with the Methodist Church to talk with the congregation about the NHI after church one Sunday. The team made the presentation, leading to lots of interaction and questions from the congregants. But, there were many unanticipated questions, where community members wanted more detail and more clarification. At the same time, there was some resistance from members of the church who also occupied positions in government.

I could tell that the team felt a little nervous with all these questions, and stepped in to support them where they were stuck, but the congregants kept directing their questions not to me, but to the local staff. They wanted to hear from their own people.

After the session, people shared their reflections.

“This would have been different if the government people did this. When they come, they talk over our heads, but we know you come

from within us. You stay here; you have the energy in you to help us.”

“People from outside go, and leave with the information; you stay here if we still have questions.”

“When you have more information, please come back...”

HAPG: It was very important that the people who drove the conversation and consultation process with the NHI-project were local community members themselves. It wasn't enough that the organisation was trusted because of its work; it mattered that the team members themselves were neighbours to the community. They became a symbol of reality in this conversation about the future. Community members took confidence from them that, if they're talking about it – these people who are our neighbours – then we can talk too; it is a real thing, not some theory or promise. It was common that community members would even come to the homes of the team members (care workers and project staff) at night to ask questions and talk more about the NHI.

8. GOOD CONSULTATION LINKS PRIVATE SPACE TO PUBLIC SPACE

If we do consultation through “mixed methods” – public consultation and private consultation (groups and home visits) – everyone becomes engaged. In public, people hear common concerns – solidarity; in private, it gives space for people to engage confidently and freely in their intimate space with no interruption. Home is an important component of a bottom-up approach.



Sophakama: “Sophakama has a long history of relationship with its community, and is familiar with raising health awareness and door-to-door visits. The initial door-to-door NHI survey experience revealed the need for further local team learning and education of the care-workers themselves which took place through routine ‘group chats’.

The team convened a workshop for a group of the care-workers’ clients, who came together at Sophakama to discuss the NHI together. But many clients were not able to come to this public gathering, so the local team conducted a second round of door-to-door visits to reach others who were not able or comfortable to attend the group workshop.

This combination of workshop and door-to-door visits led to separate small-group consultations

with teachers, traditional healers, youth, carers, clinic nurses, church leaders and political community leaders ... before another round of door-to-door visits for feedback to community members, and the expansion of visits to Joe Slovo West, a new community.”

HAPG: “We held conversations with a variety of different focus groups – teachers, the municipality, the game reserve, the clinic staff, churches – but we also visited people door-to-door in their homes. We started with the households and families of those we knew, where we were offering home-based care to sick people, but we also visited the homes of healthy people. And it was in these home visits where people talked most freely, not shy to ask questions, and without being dominated by other voices. And where neighbours saw us visiting, and invited us into their own homes.”

If you create space (allow time; proper process sequencing) for people to listen to each other’s stories and test/analyse those stories, a joint consciousness emerges that builds trust and solidarity, and allows people to identify, collectively, structural and institutional and systemic roots for their shared concerns (progression from individual to recognised collective experience).

9. EMOTIONAL BEFORE RATIONAL

If we only give people information, without caring about their feelings, consultation becomes ineffective; communication breaks down.



In their varied models of local consultation, each of the local implementing teams observed several common expressions of “care”: they conducted multiple rounds of door-to-door visits, speaking with people in their own homes where they felt most

safe; they met with small groups in a focus group format to give feedback.

People mattered. Care was a priority, not simply education.

If people feel genuinely listened to – validated, recognised, respected – then they are more likely to gain confidence to respond and participate. Dialogue creates the space for people to feel listened to.



PACSA: “It was important to us to approach the consultations in a way where people felt engaged with respect and dignity. Whatever we came up with needed to be of direct benefit to the group we were supporting. The questions we asked were

important; we did not want to be careless with our words. And the questions they asked in response were important. And the process we used to facilitate the conversation was important.”

If people have the opportunity to express themselves – not only to listen to our information – then the space for engagement and ownership and participation is opened. (When we only provide information, then people shut down; they keep to themselves; they don’t share; the information is received, but not digested or applied.)

If we only introduce facts and information, people can resist and feel disengaged. But if we can make that information personal (what this means for me, my friends, my family), then people are more receptive and engaged.



HAPG: “When we met with a group of teachers in 2013 to talk about the NHI, they were very resistant to the idea. They didn’t want to pay more money to subsidise the

poorest of the poor, and they did not want to be in the same queue at health facilities with people they felt were from a lower class. They were worried about status.

But, during the discussions, they started to realise that they themselves had family members who were poor and who would benefit; they realised it might save them all a lot of money they were spending on private medical aids.

After those meetings, the teachers themselves started to approach HAPG for more information, and began to increasingly use the Wellness Clinic at HAPG so that their medical aid wasn't exhausted.

Their attitudes were shifting when they made 'the poor' personal. One teacher said: 'I don't understand the attitudes of some of my colleagues. Success in life is not hereditary. Just because they are successful doesn't mean their children will be, automatically. What if that's my child who becomes one of those people who is not working, or poor, and needs help? This NHI will be a benefit to all of us, not just some. It will help me not have to pay more to support that child.'

10. QUESTIONS INSTEAD OF INFORMATION; STIMULATION INSTEAD OF SOLUTIONS

If we base our consultation process on asking questions first so as to understand the local context and experience (not start by giving education and information), then we gain insight that helps inform our strategies for engagement; questions stimulate their interest in the process, and help us know what people want to know.



Sophakama: "Our first NHI survey process generated all kinds of questions from community members. We gathered together at the office and listed all the challenges we heard and compiled them. We laid them on the table, one by one, and discussed them. Then we drew up the strategy for consultation and did the planning for how to facilitate the group-sessions.

We made sure in the workshop sessions to clarify language and definitions, so we didn't use 'insurance', but talked about a 'health service'. We clarified the NHI was not a 'medical aid'.

We decided to do different small groups; not just bring everyone together: teachers, politicians, clinic staff and, community leaders.

We realised it was important to translate the information so that it was relevant to the language needs and the cultural needs of special groups, so that they could feel included. So we translated from English to Xhosa. But, we also thought about how to translate the NHI to the context of, for instance, a traditional healer in the Eastern Cape."

PACSA: “Our local team first went out into the community with the survey tool where questions had been supplied and predesigned under the Oxfam project. But we found that people were not interested in the NHI. People were cynical and felt it was not useful to talk – they were dissatisfied with government and disillusioned; they had lost confidence that anything would be done with their input.

We realised that we were trying to have this conversation about the NHI at the same time

as another discourse was taking place, but in subtext. We were trying to talk about the NHI in the gap where a discourse on democracy wasn’t happening.

It meant we had to come back and redesign our approach, leading to our more rights-focused two-day consultation, a different approach that included our specific sequence of steps.

If we base our consultation on asking questions first, not giving information, then it stimulates more questions; people become curious to know more and start inviting information, and are keen to come together.

If consultation starts first with questions, not information, the right questions allow people to explore their own experiences and identify with the issues in a personal way. Then people begin to engage with and resolve their own questions.

If we stimulate, rather than simply educate through information, people become more interested in learning more, and invite consultation.



HAPG: “When we first introduced ARVs in 2001, we didn’t raise awareness through widespread information giving and education. At that point, no one really knew about ARVs, and there was a lot of suspicion and uncertainty. The government was still denying the link between HIV and AIDS, and the value of treatment.

One person in our team had been deteriorating quickly, but was open about his status, and volunteered to take the ARVs that had been

purchased privately before they were available through the state. He wanted to be a ‘test example’, a person for others to watch. And, when he improved, and others saw him get stronger, they began to ask questions and invite information.

This led to much broader consultation and conversation in the community, invited by the community itself. At the same time, it increased the demand for ARVs, and increased utilisation

of the health services. ARVs were not yet ready to be accessed publicly, but many more people were coming forward to be tested, and for treatment of opportunistic infections.

We learned that it was important to change the question and ask 'How do we stimulate?' instead of automatically asking 'How do we educate?' and starting a campaign."

HAPG: "When we did the door-to-door visits, we stimulated the conversation by asking questions, starting with what people may already have known: 'What do you know about the NHI? What have you heard? What's your understanding of what that means?' And this generated more questions that we could use as a way to go deeper with the conversation."

11. RELATIONSHIP AND TRUST

If we establish trust with people through relationship, then they are more free and willing to participate in consultation – it is part of an ongoing conversation. (Without relationships, people begin to feel interrogated and suspicious and resistant to conversation.)



Sophakama: "When we visited our own clients – who knew us in our own area – things were okay: they participated because they knew us and trusted us. We had been together a long time, visiting each other.

But when we visited a new area – Joe Slovo West – where people didn't know us, an area where people had been newly relocated, they responded very poorly to our visits. Some thought we were politically motivated and trying to manipulate them for votes. Some did not want to participate because our initial survey was long and asked for personal information and 'identity documents' and talked about 'insurance'. They were so suspicious. Some thought we were suggesting they were themselves sick. Some thought we were using their information to generate funds for ourselves.

They would not participate, refused to take the survey, shut their doors, made excuses, sent the team away. The cell phones we were using to track information caused so much anxiety. People felt intimidated by the technology. The procedure wasn't transparent. It was so difficult.

But, as an organisation, we always encourage our care-workers to participate in other community structures and events. Every Sunday, there are those community meetings, and we were there too. And people in Joe Slovo West got to know us, to see familiar faces and recognise us. Also, our teams started to do more health awareness and general door-to-door visits. Some care-workers themselves were living in this area, too.

By the time we did a second round of NHI visits, about three months later, consultation in that new community was better and different: people were much more positive. They supplied

their identity numbers, they participated in small focus groups with teachers and pastors and nurses and others. The relationships made the difference.”

If we have an existing programme (relationship, trust, integrity, quality), it facilitates easier implementation of new processes, and smoother consultation. A good start generates a good ending. It matters how we start.



HAPG: “We had a very good relationship with our community before the NHI project started. We had access to the community through direct contact, and they could easily access us. So, they knew us, they trusted us and

we had integrity with them. They believed that when we talked with them we wouldn’t talk nonsense, or unfairly raise their expectations. And we had routinely run awareness campaigns on many different issues since 1996.”

12. INCLUSION

If you want to include people, then you have to make provision for the circumstances (logistics, environment) that enable inclusion.



PACSA: “We realised that consultations often exclude the very people they are designed to include. We wanted to be sure that women were involved in the consultation process, and didn’t want to schedule the meetings when women couldn’t come. So, we selected the correct dates (on weekends so the children were not going to or coming home from school); we selected a venue that people could access and made sure there were arrangements for transport; we made sure everyone knew they were welcome to bring their children and that it was okay to be there with the children in the meeting; we arranged some activities

– with safe adult supervision – to occupy the children if their mothers wanted to be free in the meetings.”

PACSA: “We realised that to be really inclusive, we needed to strategically exclude some people at some stages. At one consultation, we had a person closely linked to government in the room, who saw himself as an ‘expert’ and knew everything about the NHI. He had no questions, but wanted to answer and solve everything. This really intimidated and alienated many people in the room, and limited their ability to participate and be included.

At another stage, we separated the consultations by age, so that we could focus the discussions as close to the 'target' groups as possible; to the service-users who could speak from experience, and not based on what they'd heard from others (e.g. the elderly and women, who were most likely to have experiences of service use). We had a two-day consultation with the 15–30 year olds, and a separate two-day consultation with those 31 and older. This also meant that we could accommodate greater numbers, and give more people the chance to speak.”

PACSA: “Government always creates space for people to engage with government, but never creates space for people to talk to each other – to their peers – before engaging with government so they prepare a position. We learned that consultation is really about the work of building power, and that you can't consult and build power when including people whose power oppresses others. At some stage, it is necessary to exclude the 'powerful' while the power of the excluded is being built; the presence of the powerful dilutes the capacity of others to fully engage with their peers.



*"We learned that consultation
is really about the work of
building power."*

- PACSA





CONCLUDING THOUGHTS

The experiences recorded in this document show that good consultation drives a more comprehensive process towards public participation and public-office accountability, and that it is possible to systematically facilitate consultation so that it catalyses deepening levels of responsiveness in households and communities. Ultimately, getting consultation right early on is a strategic springboard to achieving active civic engagement by ordinary people in the environments where they live.

The same evidence suggests, however, that a prescriptive “one size fits all model” in the traditional sense is overly simplistic and reductionist as a way to approach consultation. Instead, it is possible to observe a few basic practices, and pay special attention to the principles of “how” – the character of the approach – in order to design activities that positively provoke, animate, activate and accompany communities along a trajectory towards change.

Two dimensions of response have become evident: a pattern of response for intermediary organisations in their work of supporting public participation towards accountability, and a strategy for the facilitation of local community consultation by CBOs working directly with families, households and communities at the grassroots level. These two dimensions should, ideally, be concurrent and complementary in any public participation process.

The work need not be done; there are yet opportunities to deepen practice and learning.

In synthesising and analysing experience generated through the NHI Accountability Project, this publication attempts to make a sufficient start towards better understanding the mechanics that drive community response, active citizenship and broad-based civic engagement. It is hardly complete or exhaustive. Instead, it is a tool – a first round – from which to build a more robust knowledge asset of principles for approach, dynamically improving as new experience is identified and added, reviewed, refined, edited and adapted.

Committing to development that views consultation in this way can be lonely for intermediary organisations attempting to model this approach within civil society. And it is not without implications for such process-driven organisations, one being the experience of isolation within the sector because the practice seems uncommon and unfamiliar and inefficiently labour-intensive. There is a cost to genuine participation with those who are marginalised: it is often the experience of being marginalised oneself.

This publication has been developed with the hope that the lessons learned and reflected here will contribute to promoting a more supportive, appreciative, enabling environment within civil society and the public sector for organisations seeking to stimulate and facilitate authentic community consultation, and for local communities seeking to amplify their own voice on issues material to their own lives.

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Meaningful public participation in processes where policy is developed is a critical contributing factor to successful development in any functional democracy. In the absence of such robust civic engagement, the disconnect between policy and implementation becomes all too sharply exposed.

This publication is the first in a series exploring the principles and practices for effectively facilitating active civic engagement, beginning with genuine consultation. It draws directly on the experience of those organisations and communities participating in *Governance and Accountability in the Health Sector: a People's Policy for Health in South Africa*, an action-research project implemented between Oxfam Australia in South Africa, the Global Health Unit at Monash University in Melbourne, and the School of Health Sciences at Monash (2011–2013).

Stories emerging from that experience suggest that good practice in development is characterised by communities taking initiative for action, and by organisations responsibly and respectfully supporting that action through facilitation of community response, based around a few systematically applied steps, principles and practices. Democratic and developmental processes can, in fact, be more participatory, inclusive and representative of civil society and communities.

This content might offer insight to programmers and policy-makers about approaches that stimulate responsiveness in citizens and communities – especially amongst those who are traditionally or historically marginalised owing to socioeconomic and political status – and enable more confident expressions of their civic voice and agency.

