The right to health in South Africa: A study of the policy making process in community participation
Detailed Proposal
Leslie London & Benjamin Mason Meier

Community participation is a crucial asset for achieving human rights in public health, yet many health systems do not have policy in place to establish the required frameworks that enable functioning participation. In South Africa's Western Cape Province, community health committees (HCs) were formally established through the National Health Act of 2003 but have not been fully realized due to delays and difficulties in implementation. A Policy Framework for Community Participation/Governance Structures for Health has been approved to outline the roles and duties of HCs, but is still in draft form. To predict the future strengths and weaknesses of this policy, a thorough study of the policy development process is needed. This proposal adds to the previously approved protocol, "Learning by doing and doing by learning: A civil society network to realise the right to health" (PI: Leslie London). Complementing the work of this project and its Learning Network, interviews with key informants and in depth research of community participation policy will provide greater understanding of the policy making process, further insight into the best practices necessary for interaction between providers and community members, and new models for realizing rights to health.

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Research Objective

The purpose of this project is to document and analyze community participation in health services. This project aims to study the process of the development and formation of South Africa's Western Cape Draft Policy Framework for Community Participation/Governance Structures for Health in order to better understand the relationship between policy frameworks and realization of community participation in health. This study plans to highlight best practices to develop policy that advances the right to health using a rights-based community participation approach to advance health systems.

Successful community participation depends on proper implementation of effective policy, which remains incomplete and unrealized in much of South Africa. This proposed project furthers the policy goals outlined in the White Paper on Transformation of the Health System in South Africa and the Draft Policy Framework for Community Participation by developing resources for understanding the policy making process and ensuring community participation in health services through research to:

1. Interview ten to twelve key informants regarding the Policy on Health Committees, including examination of the:
    a. Process of the development and formation of the draft policy,
    b. The current status of the policy, and
    c. Predicted obstacles and faciliatory factors to implementation.
2. Educate those interested in improving community participation (public health professionals, the legal community, public health advocates, and others) to apply rights-based policy as an effective tool for meaningful community participation.
3. Collaborate across the Learning Network, UCT School of Public Health and Family Health and Human Rights program through Professor Leslie London, and University of North Carolina through Professor Benjamin Mason Meier.
4. Create a manuscript for publication based upon the analysis of this study.

Background and motivation for the study

1. Review of the literature

Greater community participation in health systems is an important aspect to any rights-based health policy. With increased public participation, individuals have more autonomy to assess their health needs and problems, collaborate with others to create solutions specifically tailored to their community and evaluate the success and continued adjustments to health care programs (Dujardin, 2004). This participation allows for a sustainable health policy that better addresses the local community and greater achievement of the right to health for all. Benefits to community participation include increased community awareness of health related programs and activities, wider dissemination of knowledge and health education and increased equity of health care provisions (Zakus and Lysack, 1998). If mechanisms for participation within the health system are created, community participation has the potential to reach these intended goals and have a positive impact on realization of rights to health.

Yet creating a policy that effectively implements valuable community participation is made difficult in addressing and defining the complex realities of the process of community participation (Askew and Khan, 1990). In order to create policy that truly realizes community participation and leads to greater achievement of the right to health, one must look at the way in which community participation is structured, functions and relates to other sectors of society (Mandan, 1987).

In defining the process by which representatives are elected, appointed or assigned to HCs, policy makers assume that HCs provide an accurate assessment of the community's needs, resources and values in order to build partnerships within the health system and increased community participation (Jonas, 1978). However, this cannot be accomplished if minority and disadvantaged groups are not accurately represented or do not have substantial authority within the HCs. Politics and social structure may dominate community participation; if these issues are not explicitly addressed in policy creation, existing social structure of inequality will only be reinforced (Jonas, 1978). Thus, the operational aspects of community participation must be understood before rights-based health outcomes are achieved, as the selection of HC members—by direct election from the entire community, election from specified interest groups, or appointment from local government—is crucial to the future success of any HC (Jonas, 1978). In order for community leaders to be seen as legitimate spokespeople in the eyes of the community, the method of selection must be perceived as valid and just.

Beyond the selection process, determining who is a legitimate representative of the community is a difficult task. Community participation requires individuals to possess sufficient health knowledge, as well as willingness to donate time and energy to these projects (Zakus and Lysack, 1998). The nature of participation creates a series of opportunity costs that many community members cannot afford, including lost pay, travel costs, and training difficulties (Zakus and Lysack, 1998). Rather than true representatives, people who can afford to participate in the HC are often part of the elite class and may not be seen as legitimate spokespeople for the community at large. Without meaningful participation from minority or impoverished groups, community

participation cannot adequately achieve its intended benefits (Zakus and Lysack, 1998). Even when minority groups or other groups generally left out of the participation process do find ways to participate, the political and social environment may not create an environment where they feel they are adequately represented. Therefore, policy makers must carefully study of who is included in the community and who could potentially be excluded through community participation policy.

In implementing this policy, goals, expectations and methods of participations must be clearly established and defined to ensure positive links between the local government and HCs. Significant community input should be used when creating the infrastructure and organizing bodies, as these organizational structures must be mutually accepted to sustain positive working relationships (Lysack, 1996). In order to avoid implementation problems, careful and specifically defined objectives and member powers and responsibilities must be defined in a transparent and interactive way within the community (Lysack, 1996). Meaningful participation can only be achieved if the process is transparent and seen as effective and legitimate representation of the community's needs.

Where the creation of HCs alone will not ensure the benefits of community participation, a transparent, just and carefully defined policy must establish a process in which each committee members' specific roles and responsibilities are clearly defined. More importantly, each committee member must be perceived as valid representatives of the community and must appropriately address the community's concerns and values. Community participation is vital to addressing the human right to health, and it is crucial that policy addresses the process in which these HCs are established and maintained.

2. Participation in the context of South Africa

Over the past ten years, several southern African governments have worked to create executive and legislative measures to include community participation in health systems. Recognizing community participation as an important aspect in realizing the right to health, formal structures for participation were designed to promote community involvement and improve health for all. These community participation structures were identified as health center committees (Boulle et al, 2008).

In the aftermath of the Apartheid regime, the new democratic government worked to reform the inefficient and unequal health system and create a unified District Health System based on the values of decentralization, participation and equity (Levendal et al 1997). In 1997, these objectives and principles were explicitly stated in the White Paper on Transformation of the Health System in South Africa (White Paper) (Department of Health, 1997). The White Paper emphasized South Africa's commitment to community participation, stating as one of its goals "to foster community participation across the health sector," and established mechanisms to

improve communication between the community and health services (Department of Health, 1997). However, the extent to which the White Paper's goals would be achieved and contribute to promoting community participation remained unclear (McIntyre and Gilson, 2002).

Community Health Committees (HCs) became the formal structure for community health participation under the National Health Act of 2003 (Department of Health, 2004). The legislation required that every health facility be linked with a HC and have community-elected representatives, including a health facility manager and a local ward councilor (Department of Health, 2004). Although the National Health Act sought to define HC roles and powers under provincial legislation, the National Act is not fully developed with regard to HCs and has not been implemented in most of the nine provinces (Paradath and Friedman, 2008). In the Western Cape, a policy framework for community participation has not been fully established, despite a commitment for community participation in the Provincial Health Plan of 1995 (Ministry of Health and Social Services, 1995). Although a policy framework for community participation has been written, it remains in draft form and thus has not been implemented (CMHF, 2009). After the National Health Act of 2003 was implemented, policy makers began outlining the specific frameworks for community participation, with the roles and responsibilities of HCs described and defined in the Policy Framework for Community Participation/Governance Structures for Health. The ability of this Policy Framework to provide much needed mechanisms for meaningful community participation has not been studied, and it is unclear how effective it will be once implemented.

Through the creation of HCs, it is clear that South Africa has acknowledged the importance of participation in the Health Care system, but this commitment has not reached so far as to create tangible policy results at the provincial level. In fact, a 2003 survey found that HCs were established in only three out of five Primary Health Care facilities in the country (Reagon et al, 2004). Recent studies bear similar discouraging findings, concluding that many HCs are ineffective, poorly functioning or that the HCs members felt their opinions were neither valued nor considered within the health service system (NNMU, 2006).

The reasons for this policy failure in facilitating effective community participation needs to be studied. Studies found that community participation was significantly hindered when participation in decision-making was not fully supported by governance structures and where public participation was absent from the first stages of implementation (Baez and Baron, 2006). Other studies note that the scholarly literature has not fully described the complex factors that facilitate and impede community participation, including power relations within communities, bureaucrats and the health services. If these factors are not addressed in a comprehensive approach to community participation, meaningful participation through South African HCs will not be realized (Paradath and Friedman, 2008).

This proposal complements an extends Professor London's larger project, "Learning by doing and doing by learning: A civil society network to realise the right to health," which seeks to address the high levels of health inequality in South Africa by understanding the complex relationship between community participation and rights-based health system reforms. The project seeks to improve the interactions between health care providers and community members by developing training materials on human rights, best practices for community engagement in health facilities, and new models for realizing rights to health. By identifying needs and monitoring outcomes of community and health worker training, this project plans to develop best practices for organizational leadership, document training materials and increased functioning of HCs.

3. Policy relevance

Previous research, case studies and observations strongly suggest that community participation is a key factor in advancing the right to health. Yet evidence also suggests that community participation is largely absent from many health systems; even in systems where a form of community participation is established, considerable problems in implementation impede the functioning of participatory mechanisms and and the realization of health equity (Brownlea, 1987). Further research is needed to understand how participation through South African HCs can be implemented in practice. The proposed research will help clarify the relationship between community participation and the right to health by exploring this in the context of the Western Cape HCs and the Draft Policy Framework for Community Participation/Governance Structures for Health. This study intends to describe the process of development and implementation of the community participation policy framework and to predict the future problems and successes of the policy in achieving true community participation. The conclusions from this study seek to guide future development and implementation of policy on Western Cape Health Committees, as well as other policy mechanisms for participation nationally and internationally. The study findings will also contribute to a growing body of literature attempting to understand the relationship between participation and the right to health.

Project design

1. Study setting

The study will take place within communities possessing community health facilities and operational HCs in the Cape Metropolitan area of South Africa's Western Cape Province.

Currently, the Cape Metro Health Forum (CMHF) constitutes a single health district with 8 sub-district health fora and 86 clinic committees; the Draft Policy Framework for Community Participation/Governance Structures for Health seeks to coordinate and formalize these community participation structures within the District Health System (DHS) in the Western Cape. By focusing on partnerships with other stakeholders, this Draft Policy seeks to enforce the quality of care at all levels of the health system and to establish mechanisms to improve public accountability and promote dialogue between the public and all relevant stakeholders.

The CMHF executive consists of 1 representative from each of the 8 sub-districts in the Cape Metro, and 1 representative each from the management of City Health and the Metro DHS. The executive coordinates the effectiveness of the sub-district health fora, create strategies for optimal community participation structures and evaluate the effectiveness of the health committees and hospital boards across all 8 sub-districts.

Each sub-district health fora consists of 1 representative from each health committee within the sub-district, 1 representative from each district hospital board, 2 managers from the sub-district health management team, and representatives from relevant civil society organizations. Each sub-district is responsible for coordinating the effectiveness of the CHC committees and hospital boards within the district, implement sub-district strategies for optimal community participation structures and evaluate their effectiveness.

In accordance with the Draft Policy Framework for Community Participation/Governance Structures for Health, each community health committee (CHC) must include one or more local councilor, one or more members of the community served by the health facility and the head of the facility. Three to eight members are to be elected by patients and communities, as well as the head of the facility served by the committee and a local ward councilor. The main role of the CHCs is to take steps to ensure that the needs, concerns and complaints of the patients and the community are properly addressed, as well as to foster community support for the programs of the facility.

2. Relevant experience and expertise

This project builds on the Learning Network's ground-breaking work in studying the practice of human rights of health care providers and how the interaction between providers and community members can generate new models for realizing rights to health. Combined with the expertise of Leslie London of the University of Cape Town, Benjamin Mason Meier of the University of North Carolina at Chapel Hill, and various public health and legal professionals, this project is uniquely positioned to add to the scholarly literature, to develop policy resources concerning community participation and to educate organizations in applying this work.

3. Three Month Plan

The project will identify all policy related to community participation in the health system in the Western Cape Province, and through a combination of online research and interviews with key informants known to the researchers, examine legal community participation initiatives throughout the nation and the policy implications derived from them.

The research team will explore, through analysis of the collected information, the degree to which health policy has been implemented for community participation, how effective these initiatives have been, and future implications of drafted health policy frameworks. This will allow examination of how various policy approaches have addressed challenges to community participation and what problems and obstacles to implementation various informants predict in the future. This study of the process of policy making and challenges in community participation will add to the existing knowledge and assist to inform policymakers.

This project is proposed for a three-month period, beginning June 3, 2010, with major project activities and deliverables carried out in the five overlapping objective presented in Table 1 and described below:

Table 1: Objectives

	Month 1				Month 2				Month 3			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1	Identify policies											
Objective 2	Identify and contact key informants											
		Interview key informants										
Objective 3						Analyze Data						
							Develop best practices model					
Objective 4									Create Educational Materials			
											Disseminate Educational Materials	
Objective 5	Consultation with policy makers and compilation of findings											

Objective I. Policy Identification: Using web- and informant-based resources through collaborating partners, the project staff will determine key policies that provide community participation in the health system and the implications that have arisen from the Draft Policy Framework for Community Participation/Governance Structures for Health.

Objective II. Interview key informants: Using the information compiled from objective I, the project staff will interview key informants about the policy making process and the specific policy framework for community participation in the Western Cape Province.

Objective III. Data analysis: Employing all assembled data, the project staff will analyze findings to identify the best practices for community participation and the process of building public policy support for such rights-based regulation.

Objective IV. Education: Using this data and analysis, the project staff will develop and disseminate materials for assisting organizations in understanding the underlying issues determining the success or failure of community participation in health.

Objective V. Compilation of data analysis in a report manuscript: This report will identify and describe best practices for policy making to increase effective community participation.

Methods

1. Population

The study population consists of key informants, HC members and service providers at corresponding health facilities (Nutbeam, 1998).

Key Informants: These are individuals who are considered to have substantial knowledge of and experience with Western Cape HCs and those involved in the policy making process. These informants will be selected from the District Health Services in the Metro.

HC members from the community: These are individuals who live in the facility catchment area and who have been chosen to sit on the HC as 'community representatives' (Bastian, 1996).

Health Service Providers: For this study, these individuals are defined as the clinic staff responsible for providing medical services and staff responsible for the operation and/or management of health facilities where HCs are operational or were previously operational. Service providers include: facility managers, nurses, doctors, pharmacists, social workers, occupational therapists and physiotherapists (where

relevant). Service providers will be selected for interviews on the basis of a combination of factors: long service at the facility (over 5 years), greater knowledge of or contact with the community HC, representation of the range of occupational backgrounds at the clinic.

2. Data Collection

Interviews: Interviews lasting 1-1.5 hours will take place at a location chosen by the participant and will be tape recorded or noted in detail. Interviews will be semi-structured in order to enable a more free-flowing dialogue; however, a topic guide will be used in order to ensure that key topics/questions are covered. All recorded interviews will be transcribed to the greatest extent possible. As data collection and analysis will take place concurrently, topic guides can be revised to explore emerging themes related to the study objectives.

Documentation: Policy documents, reports from the MCHF executive in addition to reports and minutes of meetings held by individual HCs and the MCHF executive will be used to supplement interviews and other data sources.

These in-depth descriptions will include details on the process undertaken to assess existing laws, the specific changes enacted, and subsequent changes in practice, as well as lessons learned (Rifkin et al, 1988). These semi-structured interviews will take place with key informants from the state, including:

      a. public health officials,
      b. legislators or legislative staff.
      c. policy staff, and
      d. representatives of health-related advocacy groups.

The questions will address the:

      a. role of the informant in the legal/regulatory changes,
      b. problems and challenges the changes were intended to address,
      c. challenges and strategies used to achieve the changes,
      d. subsequent changes in public health regulation, organization or programs,
      e. expected changes in health outcome, and
      f. anticipated difficulties in implementation.

Through qualitative analysis—employing coding and content analysis—the research team will identify policy themes and draw out findings for a written manuscript.

3. Management and Staffing Plan

The research team will be composed of the principal investigator, Leslie London, an internationally recognized expert in public health within a human rights framework, and co-investigator, Benjamin Mason Meier, with expertise in international human rights, public health law, and law reform. The team will be supported by Caitlin Pardue, an undergraduate Public Policy student, as a research assistant. Ms Gabriela Glattstein-Young, Ms Nicole Fick and Ms Hanne Haricharan, who are researchers involved in the Learning Network, will support Caitlin in conducting her field research.

Leslie London, MB ChB, BSc Hons (epid), DOH, MD, M.Med. (Comm Health), is a senior specialist in public health at the School of Public Health and Family Medicine in the University of Cape Town, South Africa. He is Head of the Health and Human Rights Programme in the School of Public Health and Family Medicine and Portfolio Manager for Transformation and Equity for the Faculty. Professor London has extensive experience in areas of the right to health, dual loyalties and human rights, and environmental justice. In addition, he serves on the National Health Research Ethics Council and the Advisory Committee to the Health Professions Council on Human Rights, Ethics and Professional Practice.

Benjamin Mason Meier, JD, LLM, PhD, is an assistant professor of Global Health Policy at the University of North Carolina at Chapel Hill and a Scholar at the O'Neill Institute for National and Global Health Law. His research focuses on the intersection of international law, public policy and global health, advancing legal frameworks for rights-based health policy. He has written extensively on the development and evolution of the human right to health in global health governance, studied health system reform in the United States and through the World Health Organization, and consulted with several sub-Saharan governments in drafting health legislation.

Gabriela Glattstein-Young is a postgraduate student who is graduating (Masters in Public Health) in June 2010. Her thesis addressed questions of community participation and health committees as vehicles for realizing the right of access to health care.

Nicole Fick is the Research Co-ordinator for the Learning Network on Health and Human Rights in the School of Public Health and Family Medicine at UCT. She has a background in Research Psychology and has been actively liaising with the CMHFs.

Hanne Haricharan is a social anthropology graduate who is currently conducting field work for the Learning Network with Health Committees under the CMHF. Her focus is on auditing the skills and capacity of health committees in the region.

Ethical Considerations

1. Risks to participants

The project relies substantially on documentary review of materials in the public domain. Where participant interviews are required, these will be conducted with the full informed consent of participants, following the guidelines of the Department of Health provisions for informed consent (Department of Health, 2004). Participants will be assured of confidentiality of their comments. They will be offered the opportunity to check the transcripts of their interviews. The final report will make sure that individuals cannot be identified from their responses. Feedback to all participants will be provided, either in the form of being supplied with the written report, or in the form of an opportunity to attend a feedback meeting or both.

All participants will be given the name and contact information of the principle investigator, the field researcher and the secretary of the ethics committee should a participant have further questions or feel that he/she has not been treated well within the study.

2. Benefits to participants

Individuals will not receive financial or material reward as a direct result of their participation in the study. However, as the study findings will be used to generate training materials, research participants will have the opportunity to learn directly from the research. It is hoped that the findings from this study will help to facilitate the implementation of a progressive policy framework for HCs in the Western Cape.

3. Anticipated gains in knowledge

This study will describe the process of development and implementation of the community participation policy framework and predict the future problems and successes of the policy in achieving true community participation. The conclusions from this study will seek to guide future development and implementation of policy on Western Cape Health Committees, as well as other policy mechanisms for participation nationally and internationally.

Sample Forms

1. Project Information

Study Title: **The right to health in South Africa: A study of the policy making process in community participation**

You have been asked to participate in a research study that is being conducted as part of a larger project on the right to health in South Africa. Before you agree to participate, I would like you to understand why this research is being done, what I hope to achieve from it and what I will be asking of you as a participant.

Why is this research being done?
Community participation is a crucial asset for achieving human rights in public health, yet many health systems do not have policy in place to establish the required frameworks that enable functioning participation. In South Africa's Western Cape Province, community health committees (HCs) were formally established through the National Health Act of 2003 but have not been fully realized due to delays and difficulties in implementation. A Policy Framework for Community Participation/Governance Structures for Health has been approved to outline the roles and duties of HCs, but is still in draft form. To predict the future strengths and weaknesses of this policy, a thorough study of the policy development process is needed.

As a result, Health Committees are a part of South Africa's plans to change the health system and lessen unfair differences in health but research suggests that the Committees still need a way to engage meaningfully with the health services. To make these Committees effective, so that their participation is beneficial to community health and responsive to community needs, research must be done to better understand the relationship between policy frameworks and realization of community participation in health.

What do I hope to achieve from this study?
- To learn about the relationships between Health Committees and policy frameworks
- To learn about the factors influencing this relationship.
- To learn why some aspects of community participation are not taking place.
- To learn how community participation is linked to successful policy implementation.

What research methods will be used?

1. **Interviews**   To get more detailed information about the policy development process

2. **Observations**   At meetings and during in-depth interviews.

Anticipated time commitments? In-depth Interviews: Last approximately **1 hour**

What are the benefits of participation?
You will not receive money or material rewards by participating in the study. However, we anticipate that the findings from this study will provide information that can be used to improve the relationship between communities and the health services. Please note: the improvement of South Africa's health system and the improvement of community participation in health are **not** guaranteed outcomes of this study.

What are the harms/risks to you by participating?
There are no anticipated risks to you as a participant. The information collected from you will not be shared with anyone outside of the research team (it is confidential information). You should note that in all reports/publications, your name will not be used nor will information be linked to you personally (you shall remain anonymous).

Consent to Participate:
The **Consent Form** will further explain your rights and responsibilities in the research process and emphasis a few important points. Please read the form and if you are willing to participate, we will ask to sign that you agree to participate.

Contacts:

Caitlin Pardue   Tel:
Research assistant   Email:

Professor Leslie London   Tel: 021 406 6524
UCT   Email: leslie.london@uct.ac.za

Questions or concerns for the University of Cape Town Research Ethics Committee
Lameez Emjedi   Tel: 021 406 6492

2. Consent Form

Study Title: The right to health in South Africa: A study of the policy making process in community participation

You should know that if you do not wish to participate, you do not have to. You can withdraw from this study at any time during the process (either during the interviews, discussions or at any other time in duration of the research). If you withdraw, the health care of you or your family will not be compromised in any way.

If you do agree to participate, I may invite you to take part in an **interview**—lasting about 1 hour

Any information collected for this study will be kept **confidential**. This means that only I and members of the research team will have access to questionnaires, tapes from recorded interviews and to the notes made from these tapes. The information collected from you will not be shared with anyone other than the research team without your permission.

What you say in questionnaires and in the interview will be kept **anonymous**. This means that in report/s, no individual names will be included nor will anything you say be linked to you personally in any way.

You will not be paid for your participation in the research. There are no anticipated risks to you as a result of the research. However, if you feel the need for support following the interview, I can give you a list of service providers that you can contact.

Please note that you should only agree to participate if you feel that you have a good understanding of the study and your role as a participant in this study. This means that you should take the time read the information sheet carefully and ask me any questions that you have.

Contact for additional information:

Contacts:

Caitlin Pardue   Tel:
Research assistant   Email:

Please complete the following if applicable to you

Declaration:

I, _____ **(name)**
have read the information sheet and/or it has been explained to me. I understand what the study is about and what is expected of me as a participant. I agree to take part in the research.

(Please x the boxes that apply to you)

I agree for notes of the meetings to be taken ☐

Yes	No

I agree for the interview to be tape-recorded

Yes	No

Participant: _____

            (Name and Surname)   **(Signature)**

Researcher: _____

        (Signature)

Date: _____

3. Feedback and Reporting

You may request to receive a copy of the transcript to check-over. A meeting will be held during the write-up phase of the study so that I can report-back to you on the findings and you can provide feedback. Once the report is complete, you may request to receive a copy.

I would like to receive a **copy of the transcript** to check it

I would like to **attend the report-back meeting**

I would like to **receive a copy of the completed report**

If you have ticked any of the boxes above, please provide your contact details below so that we can contact you to arrange feedback:

Name: _____

Cell No: _____   Work No: _____

Email: _____

If you do not have an email address and have requested a copy of the transcript or a copy of the completed report, please provide:

Mailing Address: _____

_____

_____

PLEASE NOTE: **The personal information that you have provided will not be used for anything other than for purpose(s) you have selected above. By providing this information, your confidentiality and anonymity within the study will not be compromised.**

4. Interview Guide

In-depth Interviews with service providers / HC members

1. **Description of the policy**

2. **Role of the informant in the legal/regulatory changes**
   Probes:
   - *Frequency of contact*
   - *Purpose of contact*
   - *Meetings – who attends? How often?*

3. **Challenges and strategies used to achieve policy changes**
   Probes:
   - *How were decisions made? What was the decision making process*
   - *What research was done?*
   - *Were there conflicting findings? How were they resolved?*

4. **Subsequent changes in public health regulation, organization or programs**
   Probes:
   - *What specific changes does this policy address?*
   - *Is the community aware of these changes?*

5. **Expected changes in health outcome**
   Probes:
   - *How do you expect this policy to change community behavior in health?*
   - *What is ideal impact of this policy?*
   - *What things prevent this ideal impact from taking place?*

6. **Anticipated difficulties in implementation**
   Probes:
   - *What sorts of things make the implementation difficult to achieve?*
   - *Do you think this policy does not adequately address any certain areas relating to community participation?*

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