PUBLIC PARTICIPATION IN HEALTH: MAKING PEOPLE MATTER

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SUMMARY

Participation of communities is widely argued to be an important factor in improving health outcomes and the performance of health systems. This paper uses a review of past experience of participation in Zimbabwe's health system to propose that participation be strengthened along two dimensions: Creating realistic expectations between communities and health services in their contributions towards health, and in the governance of health systems. Various examples are outlined of the relationship between social participation and control and health outcomes. The paper also outlines the features of and factors in building participation in governance of health systems. It argues for a wider inclusion of social groups from civil society, elected leadership and health systems in structures and processes that set and audit health policies and priorities. It discusses issues to be addressed in enhancing participation, including the information, processes, capacities and resources required. Finally, it reviews the proposals for and issues to be addressed in enhancing participation and accountability in Zimbabwe's health sector at district, referral hospital and national level.

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EXECUTIVE SUMMARY

Participation of communities is widely argued to be an important factor in improving health outcomes and the performance of health systems. Despite this, and the common inclusion of 'participation' as both means or ends in health policy, participation is poorly conceptualised and operationalised, both in governance in health and in technical health interventions, undermining systematic analysis of its specific contribution to health and health systems outcomes.

Following positive gains in social mobilisation and health service delivery in Zimbabwe there has in the 1990s been mounting public and professional concern over declining quality, access and equity in health services and increasing demand on people to finance and contribute to health services. Local government mechanisms for participation developed post independence were weakened by centralised decision making and authority, the dominant input of administrative officials, the exclusion of civil society groups, and by limited capacity and authority. In health, participation was focussed on social mobilisation and compliance with centrally defined programmes, leaving social groups and health officials dissatisfied with the level and forms of community participation. It is thus proposed that participation be strengthened along two dimensions: Creating realistic expectations between communities and health services in their contributions towards health, and in the governance of health systems.

Various examples demonstrate a direct relationship between social participation and control and health outcomes. These indicate that enhanced prevention, compliance with treatment and rehabilitation demand dialogue between health services and communities on their mutual roles and the technical, resource and social inputs needed to fulfil those roles.

While participation in governance and increased public accountability is increasingly claimed as a goal of health systems, such as in decentralisation policies, it is poorly achieved in practice. Ambiguous or vague roles, limited authority, weak information access, weak representativeness amongst other factors have undermined the practical implementation of meaningful forms of participation. Participation is often directed at management and implementation of systems, when the major claim being made by many social groups is for policy making and its execution to be accountable to the public.

The paper argues for a wider inclusion of social groups from civil society, elected leadership and health systems in structures and processes that set and audit health policies and priorities. It discusses issues to be addressed in enhancing participation, including representation of the poorest least organised groups, ensuring that representation is mandated and credible and backed by adequate capacity for effective participation. The paper explores the information, processes, capacities and resources required for structures to function effectively.

If participation and accountability are to be strengthened in Zimbabwe's health sector, there is need for a review involving interest groups of current practice at district, referral hospital and national level, to

recommend changes that would enhance public accountability in governance at each of these levels. Recommendations for future practice should be supported by information on how different social groups have in the past raised and pursued health issues, how these issues and public concerns on quality, access and equity have been addressed within existing structures and the impact that participatory processes and structures have had on health systems.

Building participation in health is an inherently social and political process, that holds threats and opportunities for state and civil society, and that demands visible results. The simple assembly of stakeholder fora to elicit views or gather information does not constitute the form of participation in the governance of health systems that is increasingly being demanded. With the weaknesses outlined in current health systems and the changing responsibilities being proposed in health reforms, it is argued that the social investments in building participation and public accountability are an essential area of investment in health.

1 INTRODUCTION

Participation of communities, of both organised and unorganised public groups, is widely argued to be an important factor in improving health outcomes and the performance of health systems. Despite this, and the common inclusion of 'participation' as both means and ends in health policy, participation is poorly operationalised, both in governance and accountability in health and in technical health interventions, so that there is little systematic analysis of its specific contribution to health and health systems outcomes.

The term 'participation' has been loaded with many meanings and aspirations. To some it implies a mechanism for increasing the efficiency or reducing the costs of programme implementation, improving sustainability of programmes and building local skills and experience useful for future interventions. This form of participation is a means to other development 'ends', a way in which goals and objectives may be better achieved. Participation is however also conceived of as an end in itself, building networks of solidarity and confidence in social groups, building institutional capacity, empowering people to understand and influence the decisions which affect their lives, legitimising policy and practice, ensuring that they relate more closely to perceived public need and strengthening the incorporation of local knowledge (Marsden in Crook and Morten Jerve 1991). The manner in which participation is expressed is an important dimension of how a society conceives and practises democracy. It reflects the extent to which democracy extends to and beyond representative democracy, or the delegation of power through the election of representatives, to the systems of 'participatory democracy' that society uses to direct or control the exercise of power, establish accountability, communicate views and interests and contribute towards development *between* elections (Emery in Crook and Morten Jerve 1991).

The term 'community', as a social grouping with common characteristics, interests or identity equally needs to be unbundled to identify the interests or features that create that collective identity, and to recognise the conflicts or divisions that exist within groups. While broad interest groups are referred to in the paper, this is not intended to distract attention from the need to analyse more specifically the differences within groups.

This paper argues that the changes in health and health systems in the 1990s make it imperative to address these analytic and operational weaknesses. The persistent skew in resource allocations to urban, central curative facilities, the poor responsiveness of health services to users and poor quality of care are amongst the weaknesses in health services that have generated a momentum for reform. Public participation is being given greater attention as part of this reform, but directed at *what* level of decision making and accountability within health, with the involvement of *which* interest groups and in *what* processes? The paper explores the different dimensions of participation through documented international experience. It highlights areas where participation can be strengthened and explores options for doing this. In so doing it reflects on how the options raised apply in the current situation of health sector reform in Zimbabwe and poses the questions to be addressed in follow up work aimed at strengthening public participation in health.

The paper presents a brief outline of post independence developments in the health sector in Zimbabwe and the major issues arising in relation to the motivations for and forms of public participation in health. Drawing on documented international experience, the paper discusses how these issues have been addressed within the health sector in other countries. It concludes by raising the questions to be addressed in follow up work aimed at strengthening public participation in health in Zimbabwe.

2 HEALTH SECTOR DEVELOPMENTS IN ZIMBABWE

2.1 The Context for a Review of Public Participation

In 1980, the Zimbabwe government declared a policy of equity in health, incorporating explicit commitments to redistribute health resources, respond to health needs, prevent ill health and incorporate community participation. The investments made in health in the 1980s produced significant reductions in morbidity and mortality, reduced differentials between urban and rural communities and improved access to preventive and curative health services (Loewenson and Chisvo 1994). In the 1990s, the combined effects of AIDS, drought, poor economic performance and high levels of poverty have led to stagnation or reversal of some of these gains, raising new health challenges against a background of unresolved environmental, reproductive, communicable and non communicable disease risks (MoHCW 1997). During the 1990s, reductions in real per capita public budget allocations for health were associated with falling real incomes of health workers, and an increased pressure on households to finance health needs, despite high levels of poverty.

These conditions, together with a substantial increase in HIV/AIDS related mortality have generated protest from various quarters and demand for a renewed commitment to investing in the health of the nation. In late 1996, a widespread strike of junior doctors and nurses crippled central and urban public services for many weeks and highlighted the dissatisfaction within the health services. In the same year, the ZANU(PF) congress and the national labour centre (ZCTU) called for a commission of inquiry on the health sector. Professionals, civic groups and communities expressed discontent with declines in quality of care, imposed fee charges, unworkable exemption processes, inadequate drug supplies, long waiting times, negative attitudes of health staff, transport problems to and between health services and falling real pay of health workers. Public sector professionals reported disillusionment with their profession and also noted that falling real wages increased the likely abuse of state resources for private gain (Bassett et al 1997; CWGH 1997; Mutizwa-Mangiza 1997).

In 1980, the Ministry of Health was reported as providing 71% of health expenditure (MoHCW 1984). By 1994, the share of Ministry of Health expenditure on health had fallen to 29%, with 31% coming from individual direct payments, 12,2% from donor financing and a total private sector share of health expenditure of 48,8%. The growing share of out of pocket payments for health reflects increasing spending across all income groups, including the poor. Increased spending on health has made people more sensitive to the way their money is used and the quality of health services. Donors, whose share of health funding has also increased,

have also exerted pressure for for sector wide planning and reform in the health sector. In late 1997, President Mugabe swore in seven commissioners of a National Commission of Inquiry on Health to examine and make recommendations on the situation in the health sector. Also in 1997, the Ministry of Health published its first draft of a National Health Strategy (MoHCW 1997).
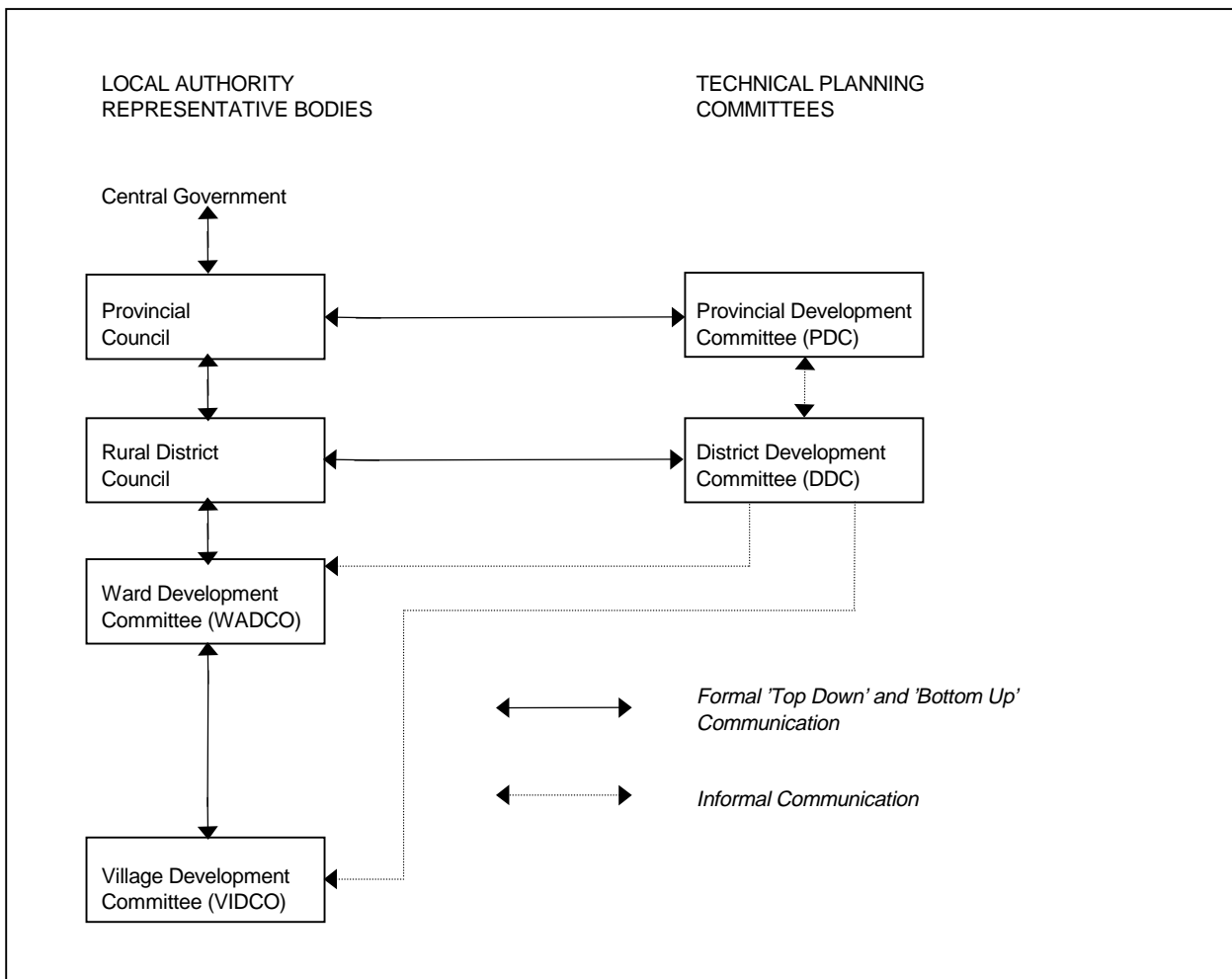
These public processes signal that a serious re-assessment of the health sector is taking place in Zimbabwe. Partly this is motivated by the evident mismatch between demand and resources in the health sector, and the level of public and professional dissatisfaction over health services. Partly it is generated by the wider local government and financial reform taking place, within a national policy of decentralisation of central government functions. Partly it emanates from international (and donor) pressures for health reform. This moment of reassessment offers threats and opportunities to different interest groups, and has opened a highly contested and politicised process. Forging a health system that meets demands for promoting health and preventing and managing disease in a sustainable, equitable and acceptable manner poses many technical questions around financing and organising health systems. It equally entails the negotiation in a politicised environment of a policy and programme that balances interests and to which key groups in the country can commit themselves. There has been a somewhat sporadic approach to stakeholder involvement in policy reform in the past, reflecting perhaps the longstanding distrust by the state of the often vocal urban civil lobbies over the less articulate poor and rural interest groups. The state has thus played a dominant role, taking inputs from interest groups directly and then deciding on 'what is best'.

There is however evidence that in the absence of an open, participatory system with procedures and mechanisms for reaching collective resolution, it can be the more powerful medical interest groups who exact concessions, sometimes at the cost of the poorer, less organised rural health workers, or the urban and rural poor. Van Rensburg and Fourie (1994) describe, for example, the role of the medical profession in supporting inequalities in health through implementing health care systems and forms of institutional care designed to suit their medical, vocational and professional interests, rather than more appropriate forms of care. According to critics, the dominant role of the medical profession in decision making generates both inefficient and inequitable consequences, with poor responsiveness to user perceptions and assessments (Bennett et al 1995). At the same time, wealthier, urban private sector clients can also exercise strong demand, through legal, financial and political systems. Rising demand by better off sectors for medical technology can potentially crowd out less effectively voiced demand by poorer sections for the health inputs they need. Given the relatively poor evidence base for some health policy reforms, it is important that systems of procedural justice exist for adjudicating subjective claims within policy reforms (Kalumba 1997; Lafond 1991; Storey 1989). Will the current mechanisms of participation build accountability in the health policy reforms taking place, and to whom?

2.2 Past Experiences of Participation in Health in Zimbabwe

While pre 1980 structures provided sometimes powerful instruments for making the state accountable to white minority interests, independence in Zimbabwe offered an opportunity for both widening and deepening participation in the governance of many spheres of public activity, including health. A series of institutional reforms were effected in local government to facilitate wider participation. Racial segregation in law was abolished and universal franchise introduced in all areas of local government. There was deconcentration of central government activities through ministry representation at local level and through outreach or extension workers. Organisational structures for participation in development planning were established in the Prime Minister's Directive on Decentralisation (1984 and 1985), which provided the basis for a hierarchy of representative bodies at village, ward, district and provincial levels (Stewart et al 1994), shown in Figure 1.

Figure 1: Local Government Hierarchy in Zimbabwe

In the Village, Ward, District and Provincial Development Committees elected representatives interacted with administrators to prepare local development plans and forward these to the next level.

i. Village Development Committees (VIDCOs) had four elected representatives and two nominated representatives of mass organisations representing women and youth, while Ward Development committees (WADCOs) covered VIDCO representatives from about six villages.

ii. The District Development Committee came under the Rural District Council (RDC), the local government representative body in rural areas, amalgamating large and small scale farming areas. Until 1998, farm workers had no legal right to vote for these structures as qualification in large scale farm areas was based on tenure (as a rate payer or renter). The District Development Committees (DDC) comprise two local councillors, 18-28 central government officials from sectoral ministries, the police, army and Central Intelligence Organisation, and are chaired by the District Administrator, a central government employee. In addition to development plans the DDC formulates estimates for the Public Sector Investment Programme (PSIP) and forwards these to the province.

iii. Urban Councils (UCs), constituted under the Urban Councils Act have powers to recruit staff, plan, provide and administer local infrastructure (including health), regulate and promote land use and property development, make by laws and raise local revenues. They raise revenue from land and property rates, service charges, rent, license fees, income generating projects and loans. While apparently more autonomous than their rural counterparts, the parent Ministry of Local Government can and have intervened in the appointment of personnel, removed elected councils and replaced them with interim central government administrations (Mutizwa-Manga 1991).

iv. The 1985 Provincial Councils and Administration Act gave increased powers to the province in planning. The Provincial Council consists of the chairperson and council member of each district, rural and urban council in the province, one member nominated by the ruling party and a representative of the Provincial Assembly of chiefs. It is chaired by the Provincial Governer, who is appointed by the President, enjoys Cabinet rank and sits in Parliament. The Provincial Development Committee (PDC) is composed of heads of ministries at provincial level, the police, army and Central Intelligence Organisation and co-opted leaders of industry and commerce. It is chaired by the Provincial Administrator, a central government employee. It produces provincial plans but does not itself have any source of finance.

These structures had various positive effects. They enhanced co-ordination between ministries at local level, generated capacity in local development planning and provided information for public investment programmes. They created channels for participation by political interest groups in self help projects, such as in rural water

supply and sanitation, village grazing and land reorganisation schemes. They appear to have facilitated some diversification of sources of local revenue (Mutizwa-Mangiza 1990).

They also had weaknesses undermining effective participation (Stewart et al 1994):

1. While the law provided for special representation of women and youth on these structures, this was through nomination of elected structures, while local constituent groups representing women, residents, workers, etc had no rights of participation. In the scenario of a single dominant party, and the absence of a secret ballot system for voting, the election of members to structures has been criticised for more closely reflecting nominees from higher levels of the party hierarchy than direct community interests. Villages identified on administrative grounds also did not always relate to traditional community boundaries, and traditional leaders who remained outside these structures remained influential. At higher levels, such as in ward and district levels, there was weak consultation with communities on decisions made, with many members of communities not aware of the structures or their powers and duties.

2. The allocation of functions between different levels of government have neither been well defined nor agreed between central and local government. This has led to swings in authority, such as in the takeover of district council powers to recruit and pay teachers by central government. Local decision making was also dominated by central government employees, both in their larger numbers on local planning structures and in their technical approach to issues.

3. Local authorities, particularly district councils, were strongly dependent on central grants tied to specific purposes, with the proportion of revenue raised locally up to 1991 only about 15% in District Councils, although higher in Urban Councils. DCs have had limited powers to raise local revenue, while UCs and RCs have in the past raised local revenue through rates on property and beer levies. As beer sales have been commercialised and housing sold to tenants, there has been a decline in local authority revenue from these sources without substantive new sources to replace them. Local authority financial figures also do not reflect the large extent of self help contributions that have gone into health, education and other facilities.

4. Provincial Governers and Administrators are nominated by the executive and central government, and thus have stronger accountability upwards, and councils have no directly elected members. While central control may have been motivated by the desire to neutralise the threat of provincial ethnic and political power blocks, it has weakened the transfer of decision making to locally elected structures.

5. District and provincial plans have in some areas been poorly conceived, formulated, prioritised or costed and poorly linked to any knowledge of prospective budget allocations. The planning process itself has been poorly supported with financial and technical resources.

6. Plans produced at district or provincial level had little or no influence in national planning, particularly in budget allocations which are generally carried out through budget requests made from sectoral ministries.

District and provincial plans were not by 1990 handled in any systematic way at central government level (Mutizwa-Mangiza 1990). Unpredictable timing of central fund disbursements weakened planning and implementation at local level, while foreign donors bypassing district councils through direct relationships with sectoral ministries or village level have weakened the capacity of the DCs to organise, manage and sustain the projects funded.

Except in larger urban areas, these weaknesses have reportedly led to elected local government officials largely rubber stamping plans emanating from central government and produced by administrators, with low levels of beneficiary participation (Makumbe 1996). In a review of decentralisation of local government in Zimbabwe, Stewart et al (1994) note three major factors to have weakened effective local government participation in Zimbabwe - 'the dominance of decision making structures by central officials, the tendency of a small elite to represent local interests, with limited popular participation, and the strong role of the Party".

Hence a health policy that from 1980 strongly endorsed community participation was implemented within a system where decision making was generally centralised and dominated by administrative inputs. The health sector expressed its policy through mobilisation of communities for primary health care programmes, community contributions to health infrastructures through support of clinic building, establishment and community support of village health workers and community organising towards child supplementary feeding and drought relief, amongst other initiatives. These programmes were primarily directed by strong state intervention, with community participation expressed as mobilisation for or compliance with state defined programmes, complementing strong technical and financial support from the state.

The health sector had at each local government level (village / ward, district and province) health executives and participated in the local government development committees noted above. Specific health committees were also set up in some districts, linked with health centres or hospitals. As noted earlier, these structures played a positive role in more 'self reliant' health interventions, such as the development of water supplies and sanitation. Such initiatives did not, however, make services planned and financed at central level more responsive to user demands or inputs, particularly given the weak district discretion on areas of spending or retention of revenue and lack of meaningful authority in planning, noted earlier.

In the absence of wider, more coherent powers and responsibilities given to local structures, some of the somewhat ad hoc roles given them have become a source of tension. User fees were, for example, imposed and defined at central government level, and until 1998, were not retained locally. Elected councillors were given the authority to provide exemption letters to citizens earning less then Z$400 a month, who were entitled to free health care in the public services. Complaints have been made however that councillors have misused this authority, refusing to issue letters on grounds that "there were too many unemployed people", or that "people had not voted in the last election" (Mutizwa-Mangisa 1997; CWGH 1998a). Hospital exemption certificates had to be obtained from the department of social welfare, while councillors provided certificates for clinics, adding

to the burden poor people faced in accessing health care. When user fees were scrapped in rural health facilities in 1995, it was evident that the system had been poorly conceived with inadequate consultation with and input from local communities (Zigora et al 1996).

Perhaps the most explicit strategy for engaging communities, and one that operated at village and ward levels in the 1980s in Zimbabwe, was through the work of community health workers (CHWs). As local, elected health workers, linked closely with the community, community health workers have in various countries been charged with mobilising health actions and enhancing information flow and effective use of health services.

Frankel et al (1992) provides a comprehensive analysis of the positive and negative features of community health worker programmes: CHW programmes have arisen from and reinforced more equitable distribution of health resources, enhanced positive relations between communities and health workers, have generated support groups within communities, enhanced appropriate referral patterns and provided community based information within the health system. CHW programmes have also, however, lacked adequate resources and supplies to sustain them, faced problems in joint accountability to communities and health services and lacked adequate technical support and supervision from the health system. CHWs have been exposed to personal danger in environments where the state or other powerful interest groups have been threatened by their roles, have worked for long hours at personal cost and have faced hostility from health workers threatened by their non professional status (Frankel et al 1992). Many CHW programmes have been *planned* at central level, leading to poor integration with other more community based healing systems. Some CHWs have found themselves marginal to *both* the health sector and the community.

The CHW concept was initiated in Zimbabwe during the liberation struggle, with village health workers (VHW) established in some liberated zones and guerilla medics carrying out CHW roles. After independence the concept was adopted as national policy by the Ministry of Health. The village health worker was initially viewed as a cadre elected by and accountable to the community, but trained and supported by the Ministry of Health. Their incorporation into health policy was based on the recognition of the need for social awareness and mobilisation as an input to health. By 1984, over 7000 VHWs had been deployed, as part of the promotion of primary health care. They were issued with bicycles and given allowances by the Ministry of Health, together with basic drug packs (analgesics, antimalarials etc). This support reinforced a perception of the VHW as the lowest arm of the Ministry of Health, with contradictory perceptions about who should meet their 'wage' costs. By the mid 1980s, the VHW programme began to face a number of problems, with VHW dropouts due to low pay, difficulties in defining VHW roles and less upward flow of information from the community to the health sector than from the health sector to the community. In the late 1980's, responsibility for the VHW was transferred from the Ministry of Health to the then Ministry of Community Development and Cooperatives, where they became the Village Community Worker (VCW). This made them into more multi-purpose cadres supporting community development at village level and reporting to Ward Community Coordinators who were,

in turn, responsible to their District Community Development Officers. The VHW/ VCW programme has been criticised for being a 'top down' programme and inadequately reinforcing the role of community mobilisation and representation in health systems (Loewenson and Sanders 1988; Loewenson and Chisvo 1994). In fact, as noted earlier, the VHW had a specific outreach role, and had no explicit role to make health services more accountable to users, nor to enhance community input in decision making over services.

More recently, as communities have taken on larger burdens of looking after the ill, home based care for dying people, paying for their health care and dealing with their health problems, community based health agents have become more important. Health providers, faced with problems of HIV/AIDS, increasing drug resistance, plateauing PHC gains and increasing levels of non communicable diseases recognise that informed participation is essential for effective health management. For example, overstretched by the demands of the AIDS epidemic, the Bulawayo City Health Department initiated with the co-operation of the residents associations and community groups in Bulawayo a home based programme on AIDS, working with community activists. These promoters had the scope of their work broadened by the community to include other areas of health work, and work closely with the local civic groups to raise or address health needs, in the face of increasing costs and scarcity of resources for health care in the urban area (Loewenson and Chisvo 1994). Home based care has been introduced in both urban and rural areas as a way of involving households and communities in the terminal care of people with AIDS. These initiatives have catalysed new debate on the future role of CHWs, and on mutual expectations between communities and health services on caring for the ill.

New strategies for public participation also need to take account of the roles and interests that have grown over the years in other organisations (civil society, NGO, etc) in meeting health needs. Recognising the need to add voice to rural peasant, formal and informal sector worker and unemployed people's health interests, and to enhance recognition of their roles, about twenty constituent (membership based) groups in Zimbabwe gathered to share experience and information on health, analyse their situation and put forward strategies based on the identified problems. The organisations include mainly national, but also local level civic groups, who organise members from, represent and take up grievances of specific interest groups, including private and public formal sector workers, small scale farmers, informal sector workers, youth, residents, women, churches, human rights, disabled persons, people with AIDS, traditional /rural environmentalists and consumers. The organisations vary in size and capacity, the combined membership of all the organisations covering over 3,5 million people. Two service sector organisations assisted with secretariat work for the group.

An initial core of seven of these organisations already involved in health issues first met in 1997 over their concerns on the health sector. The initial group included trade union, residents, consumers and church based organisations. They carried out a survey of civic (constituent) organisations in Zimbabwe, of the actions of these organisations and their membership views on health and the health sector. This survey identified and organised membership views on the health sector into 14 major clusters, with views expressed on the inadequacy of public funds for health, the declining quality of public service, the negative attitudes of providers

and the weakness of current mechanisms for expressing community participation in health. Technical papers were commissioned to obtain background information on the views raised (CWGH 1997). A wider meeting of about 20 constituent organisations reviewed the views expressed, examined the health and health care priorities they implied and suggested strategies for implementing these priorities. These civic groups agreed to form a network organisation called the Community Working Group on Health (CWGH) to add weight to their input in negotiations over health policy and to maximise scarce resource use in strengthening their health actions. The CWGH members took their draft strategy document on health back to their members for feedback, and met again to incorporate this response (CWGH 1998a, b). The group further discussed their views with health professional associations (nurses, doctors, other health professionals, mission, traditional state and private providers) to identify conflict or consensus over community views.

The summary of community views on strategies for the health sector was compiled and submitted to the National Commission of Inquiry on Health and the Ministry of Health review of the national health system, as well as to key Ministries related to health (eg: finance, local government) and the National Economic Planning Commission. The CWGH developed and disseminated to its members (in local languages) and to parliamentarians, councils, health professional groups, planning agencies and local government structures a position paper on health financing as part of a national advocacy strategy towards enhancing the per capita budget resource allocation to health, and within health to district, clinic and preventive services (CWGH 1998c). The CWGH also initiated district level meetings between health care providers and civic / constituent organisations in the area to promote and exchange dialogue at local level on promotion, prevention and management of health problems, and to strengthen informed participation in local health planning (CWGH 1998d).

While making these interventions, the civic groups identified public discontent with the manner in which community participation is being expressed in Zimbabwe and the need to strengthen the mechanisms for participation, transparency, consultation and accountability within the health sector from local to national level. The survey of membership views and constituent organisation discussion in the Community Working Group on Health (CWGH) consistently noted the dissatisfaction of communities with what was being termed 'participation' in the health sector. To a large extent, this was perceived to mean compliance with state defined programmes. It also appeared to exclude many civil society actors. In a meeting in Midlands province of constituent and service organisations convened by the Community Working Group on Health, none of the organisations present were represented on existing 'community' health structures, nor did they know what took place in them. This confirmed a view expressed during meetings by civic representatives and health officials that there is a persistent gap in structured communication with communities that acts as an impediment for health promotion (CWGH 1998d, MoHCW 1997).

At the same time, civic groups noted the willingness of communities to mobilise social contributions to health, particularly if more meaningful forms of participation could be developed to unleash and organise such

potential. For example, the Women's Action Group a national Zimbabwean organisation, organising urban and rural women, noted that "Community involvement can, if properly planned, strategised, with true and equal representation and consultation at all levels, enable people to get quality care and influence the existing health policy. However, currently there has not been any involvement of the community except at the implementation stage such as in primary health care immunisation programmes and feeding clinics." The Zimbabwe Farmers' Union, organising peasants, noted that "People will not hesitate to source materials to build a hospital if the end result will not alienate them." (CWGH 1997; 1998a; 1998b).

These experiences indicate that the establishment of local government and health structures did have positive consequences in Zimbabwe, both in strengthening local planning, raising local needs, organising local action and widening the base of sectoral ministry presence and intervention at local level. In health, this was associated with positive health outcomes in the 1980s. They also indicate weaknesses in the mechanisms for public participation. Weak technical capacity, weak budgetary powers, the dominance of central government officials and party hierarchies are reported to have led to local structures largely rubber stamping plans emanating from central government. Low levels of beneficiary participation, local elite participation, non involvement of traditional structures and poor engagement with civil society also limited popular participation. These negative features have weakened the possibilities for building a more 'bottom up' self sustaining approach to public input, and left people in a somewhat passive position with respect to organising for public health. Communities have expressed dissatisfaction both with how policy decisions are made and with how health services are managed at a time when they are being called upon to make greater contribution to and more discriminating use of those services. This indicates that participation in health needs to move from mobilisation for and compliance with centrally defined programmes to mechanisms through which communities can shape their health systems and make services more responsive to their interests.

The review of past experience, perceived and reported weaknesses in health systems indicate two critical dimensions along which public participation in health needs to be revisited and strengthened:

- *Creating realistic expectations between communities and health services in their respective contributions towards health, and*
- *In the governance of health systems, including in policy and priority setting and in building accountability in the management of health services*

These issues are further discussed in the next two sections, presenting evidence from available documented experience and raising options for enhancing public participation.

3 ENHANCING PUBLIC PARTICIPATION

3.1 Harmonising Expectations on Inputs to Health

Civic groups and communities have in various fora complained of the growing distance between themselves and the health services, raising problems of access to care and barriers such as cost of services, poor transport, negative attitudes of health workers and poor explanation or information on health problems (CWGH 1997, 1998c; Bassett et al 1997). This is verified by public health data showing that delays and barriers in accessing services are important determinants of ill health, even where services are physically provided. For example, long delays in seeking sexually transmitted infection (STI) treatments are an important factor in poor control of STIs in Zimbabwe. Longer in women than in men, these delays relate less to service availability than to social factors influencing health seeking behaviour and quality of care (Communication from NACP Zimbabwe 1998). Delays in seeking care was found to be the most common avoidable factor in maternal death in Zimbabwe (Fawcus 1996), due to poor knowledge in communities of signs of puerperal sepsis and other risk factors in pregnancy and delivery, and poor transport to services. Civic groups noted that user fees and doubling of medical costs with poorly functioning public exemption systems and negative attitudes in providers have further undermined contact with health services (CWGH 1997).

In contrast to these barriers to health seeking behaviour, the positive role of participation and social control in health outcomes is beginning to be more thoroughly explored in epidemiological studies (Wallerstein 1993). People have been found to have higher heart disease rates if they are lower in the hierarchy (Rose and Marmot in Wallerstein 1993), or have high work demands in combination with low levels of decision making control (Karasek and Theorell in Wallerstein 1993). At individual level, positive health outcomes have been associated with healthier behaviours and reduced stress, while at social level, positive health outcomes are related to enhanced lay helper capabilities, increased participation in health activities, and active social support (Wallerstein 1993). Social networking, trust and participation measured as dimensions of social capital have been associated with reduced mortality (Marmot 1998; Kawachi et al 1997). The relationship is not unidirectional - in a variety of studies inequalities in health have been documented to have a negative influence on social cohesiveness and political stability (Wilson et al 1997, Blau et al 1982, Wilkinson 1997). There is some evidence of these relationships in Zimbabwe: The consistently positive role of education, and particularly female education on health outcomes such as child nutrition and reproductive health may be an indicator of social control. Rapid transmission of HIV, in particular in adolescent females, has been widely ascribed to women's, and particularly young women's, poor control over sexual choice in an authoritarian, male dominated society (Bassett et al 1991). Non permanent farm workers, mainly female, had poorer health status than their permanent counterparts, with higher levels of reported personal and child ill health and lower use of health services during peak periods of contract work. At these times, despite increased earnings, they had least control over their time due to piece wage systems (Loewenson 1988).

Social factors, such as the cultural perception of disease causality, have equally been noted to influence health seeking behaviour and thus patterns of health care use. A magical interpretation of illness, for example, that places responsibility for disease transmission outside human control, such as in the case of Guinea worm disease in Ghana, undermines participation and effectiveness of preventive and curative interventions (Bermejo and Bekui 1993). Even where health infrastructures are available, providing information in ones own language, ensuring culturally appropriate care or supporting community networks for prevention and follow up of illness are all important factors in access to care (EQUINET 1998). Social participation influences health sector performance and health outcomes in health promotion programmes that depend on behavioural or social change, as well as where the management of disease demands community inputs such as case finding, partner notification or treatment compliance (Bermejo and Bekui 1993). Vertical mass campaigns, such as vaccination campaigns are designed to simplify this participation as a one-off input, while other more continuous services demand a deeper transfer of skills or understanding, such as in relation to TB treatment, or control of mosquito breeding in malaria.

Understanding these relationships is equally important in defining the balance between social engineering (law, public health intervention) and informed social action in dealing with public health problems. The widespread market promotion of unhealthy products (tobacco, certain foods, alcohol etc), as well as possibilities for health promotion through the social marketing of positive health products (condoms, bednets) both call for informed public choice. In Zimbabwe recently, the issue of control of breastmilk substitutes has highlighted the need for this. While strong regulatory control of labelling, information and advertising of such products have been legislated, passive warning symbols on labels must be complemented by consumer awareness, particularly if HIV positive women are to make informed choices around breastfeeding in a manner that does not exchange the risks of HIV transmission for morbidity and mortality risks from undernutrition and infection.

Table 1 overleaf shows some of the areas where recent Zimbabwe Ministry of Health strategy documents have highlighted public participation as a contributor to health interventions and outcomes (MoHCW 1997). These roles and their social implementation need to be discussed with communities in a manner that reaches the various groups that are expected to act. It would be useful to track the major public health interventions more thoroughly to identify the mutual expectations of health system and community roles, and to ensure that the technical, resource and social inputs are available to fulfil those roles. If such discussion of mutual roles were to extend to prevention, it may motivate stronger collective action over healthy environments and practices, rather than the practice of waiting to fall ill and then making demands of health services, a practice CWGH members felt had become common in the 1990s (CWGH 1997). Future work would thus need to structure dialogue between communities and health services on promotive, preventive, curative and rehabilitative health interventions to harmonise expectations on inputs needed. It would further be important monitor whether such

Table 1: Health Problems, Strategies and Community Roles, Zimbabwe

HEALTH PROBLEM	MANAGEMENT STRATEGY	COMMUNITY ROLE (Examples)
Acute respiratory infection	Improved housing and ventilation; Avoidance of indoor pollution Early reporting by signs of illness Recognition and management by symptoms and severity of illness	Building improved shelter and ventilation Management of minor illness Knowledge of more severe signs and reporting to health care
Malaria	Residual spraying Larviciding, use of bed nets and personal protection Rapid notification; Early reporting and clinical management Control of localised outbreaks	Larviciding, use of bed nets and personal protection Early reporting of illness
Tuberculosis	In patient TB treatment (2mths); New approach: DOTS Case tracing	Building improved housing and ventilation Early reporting; Case tracing ; Supervision of DOTS
Intestinal infections	Safe water supplies and sanitation; Food hygiene Sugar and salt solution Early reporting and treatment of bloody diarrhoeas Epidemic tracing and control	Safe water supplies and sanitation; Food hygiene Using sugar and salt solution Knowledge of more severe signs and reporting to health care
STIs	Safe sexual patterns; Condom use Early reporting of infection; Partner tracing and reporting Syndromic management; Prevention of reinfection	Safe sexual patterns; Condom use Early reporting; Partner notification Prevention of reinfection
HIV	Safe sexual patterns; Condom use Early reporting and syndromic management of STIs Early reporting and treatment of infections Promote improved diets Prevention of infection in newborns Discharge to home care	Safe sexual patterns; Condom use Prevention and early reporting of STIs Prevention and early reporting and treatment of infections Improved diets, hygiene and health promotion Care and support of people with HIV/AIDS Home care support of ill; Fostering orphans
Malnutrition	Maternal nutrition Manage recurrent infection Promote breastfeeding; Growth monitoring Drought relief; Supplementary feeding Salt iodisation Promote improved diets	Food production, purchase and preparation Promotion of healthy diets Breastfeeding; Growth monitoring Food production for supplementary feeding Social organisation for drought relief

Source: MoHCW 1997

dialogue yields improved health outcomes, including improved access, reduced delays in appropriate use of care and more informed community management of specific health problems.

Possible mechanisms for such joint community / health systems planning of interventions are discussed in the next section. While these structures may *enable* dialogue, however, they do not alone *guarantee* it. Communities have weak experience in expressing their needs and proposals and making inputs to planning, while health services have weak experience in listening and responding to community inputs. These weaknesses in the capacities of both state and civil society are recognised as one reason why participation, although articulated in policy, is poorly translated into reality (UN ECA 1991). This calls for work to create stronger possibilities of information sharing between communities and health services, also discussed later.

3.2 Participation in Governance of Health Systems

With health providers existing across public, private for profit, private not for profit and traditional sectors, the public sector is an important arena of policy making, regulation and co-ordination of providers (Kutzin 1998). The success of health reforms depends in part on the state's capacity to direct different providers through policy, regulatory and incentive systems (Bennett et al 1995).

This function may be carried out with varying levels of involvement of elected representatives and civil interest groups. Absence of credible public policies, weak involvement of civil groups, or poor satisfaction of their interests can lead to ad hoc arrangements, such as in union negotiated health management organisations and insurance packages in South Africa during apartheid (London 1993) or to local interventions by voluntary and non government agencies. Civic groups may pursue redress for health related grievances outside the health systems. In India, for example, the Supreme Court in 1995 decided in favour of a citizens action to use the Consumer Protection Act to defend their rights as patients against medical malpractice, when the state did not adequately fulfil this role (Mogedal and Hodne Steen 1995). These various forms of 'self protection' may be more accessible to affluent groups, leaving poorer groups poorly protected or served.

Does decentralisation on its own enhance public participation in governance in health? Evidence from experience questions some of the claims of decentralisation, particularly those that are mutually incompatible, such as reducing expenditure *and* improving quality and access (Mogedal and Hodne Steen 1995). Decentralisation in Kenya, for example, was associated with improved financial performance but significantly reduced access to MCH/FP services, outpatient and special services (Owinya and Munga 1997). Weaknesses in past performance of local level planning have often been linked with the existence of centrally imposed budgets, with little room for local discretion (Gilson et al 1994). Local planning may, however, continue to be weak, even where budget devolution takes place, in the absence of specific measures to enhance accountability, and there is weak evidence of promised benefits in equity, access, quality, accountability or in increased public participation (Gilson et al 1994, Gaventa and Robinson 1998). Decentralisation was found in Botswana to have

weakened links with the ministry of health, weakened public health surveillance and planning based on population indicators and led to greater bureaucratic inputs to decision making, with little evidence of enhanced community participation or intersectoral co-ordination (Lauglo and Molutsi 1995). Constituents at local level have reported poor communication on or understanding of the content or implications of decentralisation (CWGH 1997). Central government appointed boards were observed to have little accountability to the public. Mills (1997) noted that free of central control, hospitals may become more self interested, placing interests of local politicians above those of consumers. On the other hand, various reviews have noted that hospital boards have been delegated few responsibilities in practice, particularly over revenue raising and retention, financial controls and staffing, weakening their ability to make significant impacts on hospital performance (Bennet et al 1995; Smithson et al 1997).

Assuming, that quality, equity and participation are natural outcomes of decentralisation is thus clearly naive, and contradicts available evidence. There are further, criticisms that the decentralisation of participation weakens the ability to challenge national institutions and policies and may thus strengthen central control (Veltmeyer 1997). An immediate impression that emerges from published literature is that while devolution of authority lies at the core of many decentralisation policies, there is little documentation on the legal, institutional and procedural dimensions of such participation in planning and management structures. The experiences of decentralisation provide a strong indication of the need to back participation in the management of services with participation in setting and monitoring policies on the allocation of resources, on service standards and on how management authority is distributed at different levels of health services. Decentralisation, amongst other reforms, poses a challenge to and an opportunity for participatory structures at national and local level to move beyond roles of defining needs and disseminating information to making health policy and standard setting more accountable to public interests and ensuring the execution of policies by management structures. The discussion below highlights some of the issues that would need to be addressed in opening new dimensions of participation and in strengthening participatory processes.

3.2.1 Who should be involved?

Health development structures include different combinations of public and private (non government) health providers, elected local leadership, constituent organisations representing women, religious, youth, worker and cultural/traditional interests, informal sector groupings, government sectors outside health and non government service organisations (Kahassy and Baum 1996), broadly drawn from the following areas:

- Community: Constituent representation of worker/ peasant, formal / informal sector, residents, women, youth, religious/traditional groups, consumers, specific interest groups (eg: disabled, migrants, people with HIV/AIDS), non organised groups

- Political: Elected leadership, political party officials
- Financers/ purchasers: Central and local government, donors, employers, employees, insurers, churches, clients
- Providers: Public, private for profit, private not for profit, traditional
- Professionals: Health professional associations
- Regulators: Civil and traditional judicial systems, central and local government

Table 2 presents a range of possible interest groups at local or central level, and indicates their possible roles within the broad categories above. Clearly this would need to be tested against the perceptions and experience of different groups and the roles they feel they should play. The table indicates that issues relating to policy accountability, including the exchange of information, policy and priority setting and audit of performance of services appear to be of common concern across most interest groups. Structures that seek to enhance policy and management accountability should thus include the spectrum of community (civil), purchaser, provider, and regulatory institutions. If structures are not credible nor perceived as representative then different groups will continue to solve problems outside them (Kahassy and Baum 1996).

Civil society interests may be included together with elected representatives in decision making fora (as in the case of Zambia, Nigeria, Mexico) or may be structured in separate promotion or advisory councils (as in the case of Chile, New Zealand, Senegal) reporting to elected decision making structures. At local government (district) level there is wider experience of joint elected, technical and administrative structures, while at national level, except in circumstances where central health boards have executive roles (such as was the case in Zambia 1995-1998) there is often a separation between civil society structures, elected political structures and the state administration. The links between civil and elected structures at this level may be more feasibly achieved through joint meetings between national civil society / stakeholder structures and a parliamentary committee on health, rather than attempting to merge these two different structures.

Of the civil society groups, perhaps those who represent health professionals are already most organised and have the strongest legal and institutional links with health systems. Nursing, medical, dental and other practitioner groups have long histories of organising, significant political influence, and defined institutional roles through health professions councils and their regulation of private sector activity in health. Not surprisingly, such councils have sometimes been found to be more concerned to protect professional interests than clients, with various reports of state and civil society intervention to bring consumer and ethical issues into the public domain (Bennett et al 1995). Where dealings between the state and these professional groups are not transparent, consumer lobbies may be even more critical to ensure adequate care from private providers.

Table 2: Institutional Actors and Roles in Health Systems

AGENCY	Information exchange	Policy and priority setting	Standard setting/ regulatory	Service delivery & management	Audit of services	Resource mobilisation & budget allocation
Central Government Administration	+	+	+		+	+
Local government Administration	+	+	+	+	+	+
Elected political leaders	+	+	+		+	
Traditional leaders		+	+			
Public sector health providers	+	+	+	+	+	+
Private for profit providers	+	+		+	+	+
Private not for profit providers	+	+		+	+	
Third party purchasers		+		+	+	+
Traditional healers	+	+		+		+
Professional organisations	+	+	+		+	
Consumers, Clients, Individuals	+	+			+	+
Consumer organisations	+	+	+		+	
Specific public interest groups/NGOs	+	+	+		+	+
Constituent / membership based organisations	+	+	+		+	
Medical Suppliers				+		
Media	+	+			+	
Courts			+			

+ = Agency significantly involved in this role   Source only for (*) columns: Bennett et al (1993); Mogedal and Hodne Steen (1995)

One of the biggest challenges is thus in how to ensure representation of the poorest groups who are often least organised, how to sustain representation in organisations whose main preoccupations in fact lie outside health (such as constituent and consumer groups), how representative organisations are of their memberships and how actively they keep members informed.

The participation of groups may be limited by practical constraints, poor information inputs, inadequate resources and skills or other capacity constraints leading to a gap between perception and practice. Some of the factors that create this gap are listed in Table 3. These are factors that would need to be addressed if organisations are to meaningfully interact in health system development.

Table 3: Capacities for Organisational Roles and Participation

ROLE	CAPACITY
Information exchange	Access to information, literacy of members, capacities for obtaining and disseminating information, internal democracy and communication with membership
Standard setting, regulation and enforcement	Legitimacy, capacity to organise interests and mandates for negotiation of rights and standards, procedures for adjudication, compliance and enforcement
Health intervention, service delivery	Technical and managerial capacity, human, financial and capital resource base, financial accounting, efficiency and audit, abilities to obtain and incorporate consumer issues, networking and co-ordination with other providers
Audit, monitoring	Access to information, capacities to obtain, organise and collect information relevant to member interests, capacities for obtaining, analysing and disseminating information
Resource mobilisation, allocation, purchaser role	Capacities to mobilise contributions, pursue entitlements, negotiate with providers, ensure efficiency, quality, equity and accountability

Participation may also be affected by relationships beyond the health sector. As participatory structures involve power sharing, the background relationships of authority and power between proposed members will be relevant to their functioning. This will apply with respect to the relationships between, for example,

- central and local government
- bureaucratic and elected structures
- western and traditional health providers
- public and private providers
- civil, traditional and elected structures

For example, where there is perceived competition or distrust between purchasers and providers in the public sector and those in the private sector, or where non transparent exchanges of staff time and subsidies are taking place between the two sectors, this will affect the role, performance and procedures of structures that bring these groups together. Equally, the extent to which central government is willing to share authority with local level health services and local government influences the extent to which responsibility is backed by authority and resources, and thus the credibility of links between local planning structures, local providers and civil society (Kahassy et al 1997). The relationships between and ability to harmonise or organise the different inputs from technical, professional, political, business and administrative groups is also relevant. Not confronting these issues may lead to a gap between the roles as defined in law and those practised. This is demonstrated for example where technical inputs disempower rather than inform decision making by elected or civil structures, or where local planning takes place without corresponding budgetary discretion to implement plans, as was described earlier in local government planning in Zimbabwe in the 1980s.

3.2.2 Participatory structures and their roles

Public participation is often expressed through ad hoc, sometimes spontaneous processes but may also be built into more sustained forms. Many examples exist of participatory structures, including task forces, citizen juries (such as in the UK), advisory boards and community forums. These may be purely mechanisms for information sharing, they may be consultative fora, or may negotiate and reach decisions. They may be directed at advising state bureaucracies, institutional management structures, or at advising the political executive or legislature. On the understanding that elected (representative) structures superceed such civil society fora, the only, and most binding form of public participation, is the referendum. As practised in Switzerland, public referenda are binding and can overturn decisions of both parliament and the courts (Richardson and Waddington 1996; Bekker 1996). Where the latter occurs they place an obligation on the legislature to review the law in question.

The literature describes participatory structures at different levels of health systems: Standing health councils, committees or boards exist at local level, at national level, within specific health facilities and within specific areas of health functioning. In settings as diverse as Nicaragua, Mexico, Turkey and Brazil, and in Zimbabwe at national and institutional level, such councils have included constituent organisation representatives, with roles covering determination and communication of public needs and issues, audit of access and quality and motivation of public input and support in health promotion and disease control (Tatar 1996; Sherraden 1991). In Sao Paulo, Brazil, such citizen councils dealt with health, education, womens rights, culture and environment at municipal level (Gaventa and Robinson 1998). In the review by Kahassy et al (1997) of local government and health and Kahassy and Baum (1996) of civil participation in health, covering 18 different countries, the powers and responsibilities of participatory health development structures included:

POWERS

to decide priorities on health services

to create health posts

to select, finance and train certain categories of health personnel

to negotiate agreements and codes of conduct with health personnel

to purchase drugs

to mobilise resources for and make investments in the health sector

to make direct requisitions with government stores and other suppliers

to call for tenders for specific areas of work

to enforce specific areas of regulation in health

to formulate guidelines and standards in health services

RESPONSIBILITIES

to implement national policy

to ensure accounting and independent audit of finances

to assess health and health development needs

to prepare health development and budget plans

to ensure implementation of plans and evaluate performance

to ensure management of drug funds and other revenue sources

to ensure collaboration in health development and health services

to co-ordinate all health activities and providers in the area covered

to promote primary health care

to raise health revenue (through taxes, levies, fees)

to rent, repair and maintain buildings

to administer health facilities

to mobilise community participation and intersectoral co-ordination

to report to the Ministry of Health and provide a link to area health services

to mobilise resource (food, supplies, labour, monetary) contributions health

The review of experiences of participation can also be organised into the major health system processes shown in Table 4. The table indicates the possibilities of participation in governance abd management of health systems across a spectrum of health system functions, with various linkages to local and central government elected and administrative structures. If participation in governance is to be enhanced, then at a minimum civil society/ state interactions in health need to move beyond need or problem identification and information dissemination and take on the development of policies, prioritisation of areas for service delivery and resource

allocation, negotiation of standards, identification of expected levels of resource commitments for public health from different groups and audit and evaluation of the performance of the health system, particularly in relation to specific vulnerable groups.

Table 4: Roles of Participatory Structures within Key Health Processes

HEALTH PROCESS	ROLES OF PARTICIPATORY SYSTEMS
INFORMATION	– to obtain information on community views, needs and capacities in relation to health and health systems – to provide information to communities and different providers on health policies and programmes
POLICY AND PRIORITY SETTING	– to set and communicate agreed health system priorities, targets, and standards – to propose, review and monitor policy goals and strategies
STANDARD SETTING	– to review and monitor standards and systems for and equity impacts of out of pocket payments and prepayments – to define, propose and monitor minimum health service standards and benefits, and equity, access targets – to review and promote minimum public health standards
FINANCING AND BUDGETTING	– to prioritise and monitor public budget shares for and within health – to mobilise co-financing and in kind inputs to agreed health programmes from sources outside the public sector – to negotiate and propose incentives, subsidies and regulatory mechanisms for levering and directing co-financing inputs – to monitor financial contributions to health and their allocation in relation to agreed goals of equity and efficiency – to monitor shares of household income to health and medical services for different income groups – to monitor health expenditure against agreed allocations – to ensure public health, coverage and risk management and audit standards are met in private purchasers
SERVICE DELIVERY	– to review performance against health standards – to review performance of the referral system – to monitor quality of care, health service performance standards – to ensure co-ordination of different health providers on agreed health goals – to investigate or motivate investigation on specific health problems
AUDIT	In addition to financial, system performance and equity audits noted above: – to convene public debate and input on health systems – to audit the performance of the health sector against agreed standards of access, equity and quality – to report to elected structures and the public on audit outcomes

Reviewed experience also indicates that building stronger participation is not a simply matter of legal definition or policy directives on structures and roles. The literature documents many problems with such structures, including inadequate structural and systemic support, weak information access, limited authority and vague roles. This renders participation face value and weakens the sustainability and responsiveness of such structures (Kahassy and Baum 1996; Bennett et al 1995; Gilson et al 1994). Hospital boards, are a particular form of participation in the management of services that have suffered from ambiguity between their powers and responsibilities. Bennett et al (1995) noted that the power and roles allotted to the Board and degree of autonomy from the ministry of health were an important factor in their success. Where boards have had little influence over capital investment, financial and personnel policy, they have had limited impact on efficiency or service provision. Given that referral hospitals provide public services, central governments clearly need to continue to exercise some control over their performance. It would however appear that the best balance between arms length measures providing legal and performance standards and incentives and the more direct forms of control has generally not yet been found. Bennett et al (1995) also indicated weak responsiveness from boards to user needs.

In Mexico, structures are reported to have not achieved their stated aims and to have been co-opted by elites who used them for narrower interests. Mexican village health committees and municipal health councils were also reported to have been weakened by inadequate resources for them to play their role. Communities and constituent groups elsewhere are reported to have participated in structures with inadequate support, limited authority and vague roles, rendering the participation face value, weakening their innovative role and with poor continuity. Weak consideration of how their roles will be defined, resourced and operationalised, or linked to other participatory structures has led to a number of problems. These include the proliferation of a large number of poorly co-ordinated issue specific forums; weaknesses in abilities and procedures for resolving conflict; poor clarity of rights to information, weak acceptance by members of collective outcomes and weak legitimacy. The mangers and providers of services may have weak incentives to respond to directions given by participatory structures, and may relate more closely to professional hierarchies and career interests in technical services.

Two WHO reviews (Kahassy et al 1997; Kahassy and Baum 1996) note a further number of issues that have arisen in practice:

- struggles over changes in powers in resource allocation and decision making even where real shifts in such powers are provided for by law
- resistance from organised health professionals over decision making powers allocated to structures
- underestimation of changes / inputs implied and thus inadequate allocation of resources, training and system inputs to make structures effective
- weakened citizen / interest group input under paternalistic cultures
- community illiteracy, time and opportunity costs of participation, particularly in poor communities

- poor availability of adequate information to support roles.

While various issues relating to capacities of participant organisations and procedures of participatory structures merit further review, two aspects are highlighted for further discussion as they are indicative of two broadly different functions of participatory structures, that of information flow and of adjudication of competing claims. These two areas are taken up for further focus as health service accountability depends on the availability of information they have on service performance and how far different social groups can orient service providers towards their own interests.

3.2.3 Enhancing information exchange and dialogue between community groups and the health sector

The manner in which information exchange and communication is structured within joint fora is a central factor in building meaningful participation. Hence while analyses of participation often examine structures and the legal powers they hold, it is equally important to examine how those structures are informed and the processes that take place within them. This helps to assess whether the powers provided for on paper are exercised in practice, and how actively participation is fostered within them. Participatory structures need health system information and community based knowledge and views. Various ways in which information is communicated between the public and health systems on health policies, issues and interventions are shown in Table 5.

Table 5: Mechanisms for Information Flow between Health Systems and the Public

INFORMATION FLOW	MECHANISMS
Mechanisms for gathering information on public views	Opinion surveys, ideas competitions, key informant input, use of print and electronic media
Mechanisms for giving information to the public on health sector policies / activities:	White papers; mass publicity programmes, providing for citizen access to official information, agenda's and minutes; public audience on budget discussions; providing accessible policy/budget summaries to citizen groups; meetings, lectures, discussion sessions, joint committees, use of print and electronic media
Mechanisms for enabling public feedback to health planners	Advertising council decisions with -procedures for people to lodge objections; public inquiries; public hearings; holding public meetings, lectures and discussion sessions;
Mechanisms for building or using social capacities in health	Participatory health appraisals; support or contracting of community technical assistance and community development organisations

The effectiveness of any mechanism depends on its adequacy, comprehensibility, the mechanisms and capacities for public reaction, and the manner in which public feedback influences decisions made (Richardson and Waddington 1996). Many health systems have a poor record in feeding information back to communities, and may themselves have gaps in information from private providers and from community level. Building comprehensive information systems that are reported in a timely manner to all interest groups, and particularly to decision making structures must be one of the core building blocks of any participatory process.

On the other hand, in relation to technical interventions, the relationship between the health sector and the community has generally been one of the former giving information to the latter. The challenge in this area is to structure community views, knowledge and experience to enable community groups to inform health systems as well. Participatory approaches generally begin by stimulating communities to raise their own experience and knowledge, enabling groups to collectively frame the problems they seek to address, so that new knowledge is demanded and applied to identified problems. Using such participatory approaches are important to overcome the profound disempowerment observed when civic groups join into the often technical discussions of professionals and bureaucrats (Kahassy 1991). Hence, for example, the CWGH in Zimbabwe deliberately began its work by asking community groups and their members their opinions, experiences and ideas about health and health care in Zimbabwe, using these as the starting point for the discussion of commonly perceived health problems and the introduction of technical information. This process unleashed a wealth of information, even though it did miss information from less organised groups, such as migrants, the homeless and unemployed. The CWGH discussions raised, for example, income security, food and crop prices, access to housing and safe water and costs of education and health care as priority health issues for communities represented. In contrast to the preoccupation of professional and bureaucratic groups with weaknesses in the curative health system, the community views focussed more strongly on preventive health. Communities sought a renewed commitment to spending on preventive health, noting that many basic problems have not been adequately addressed, observing that "The impression being created in the community is that there is always a cure or a treatment for illness. But it is important to mobilise more responsible health practice and to organise prevention of illness" (CWGH 1998b).

The experience of this work indicates that for constituent groups that represent worker and peasant communities, participating in state/civil structures may demand processes external to those structures where groups can frame the issues, consult, decide and specify clear negotiating positions and agendas to inform their input to planning fora. For civic and elected structures, it demands time to consult and inform communities. This 'preparation for partnership', institutionally and in terms of skills development, includes steps to move beyond articulating need, as is often the case, to linking needs with strategies through a clearer understanding of the systems the groups seek to influence.

Public views and inputs are certainly not posed as a substitute for expert knowledge, and participatory structures and processes need to build mechanisms and adequate common language to be informed by available

scientific knowledge and bureaucratic experience, in ways that also allow for recognition of traditional knowledge and cultural values. There is evidence from the CWGH work in Zimbabwe and elsewhere that intermediary institutions (service or umbrella groups) such as the CWGH can play an important role in translating and interpreting information from health providers, convening internal discussions of issues and enabling relatively disbursed constituent groups with different levels of social power and authority to interact collectively with purchasers, providers and authorities and to enable dialogue over specific constituent concerns. Intermediary organisations such as the CWGH can enable links between constituent groups (whose main function is often NOT in health) and health organisations, to transform often inaccessible administrative or technical health information into forms that can be more easily analysed within civic groups. This may equally apply for elected officials, where umbrella organisations such as local government associations can play such a supportive or intermediary role.

3.2.4 Mechanisms for arbitrating claims

Bringing different interest groups around the table to debate issues that may be highly contested demands rules by which negotiations, arbitration, consensus and agreement to adopt majority positions are effected. Equally these issues demand skills in articulating informed positions, identifying and resolving conflict and harmonising different interests. Further, the ability of participatory structures to influence practice depends on how far their resolutions are translated into binding outcomes on providers, whether through legal or incentive systems.

Technical information is an important input in arbitrating on competing claims, but cannot be regarded as the only input. Technical information is used in the context of socially defined and agreed standards and rights in relation to health and health care. Indeed, one important role of participatory structures may be, as noted above, to debate and negotiate such standards and rights against which to test future claims and proposals, and to allow various population groups to assert their views on such norms. It is important to note that such norms and rights are equally accompanied by obligations, and thus form the basis on which different groups contribute singly and together to the achievement of local or national goals. Without this binding framework it would seem that social systems such as health, and particularly systems that call on collective inputs for public good, such as public health, would not have a base.

The way a society defines the right to health, constitutionally and socially, underlies and produces the dominant features of social systems for many decades. Hence for example, a social rights, solidarity based approach has led to principles defining universal, comprehensive, tax funded national health services that has been a consistent feature of health systems in the UK and a number of European countries. More dominant application of liberal traditions focusing on individual choice and civil and political liberties have provided the more free market, insurance and purchaser approaches of the USA. Whatever the underlying approach, the articulation of health rights commits states to action, and demands formal attention, particularly in situations of

great inequality and poverty. While there are debates about how to make social rights justiciable, this has not precluded their incorporation into constitutional provisions (Harvard 1995). Hence for example, in South Africa, explicit effort was invested in building wide social debate to capture and frame such social values in a highly divided and unequal society and to express them in the constitution.

The constitutional provisions in the Bill of Rights in South Africa provide an expanding floor of minimum rights, covering:

- equal protection - or the entitlement to equal benefits of public spending for all citizens
- equal opportunity - or measures aimed at enabling groups to break out of patterns of disadvantage, without violating the principle of non discrimination
- a minimum floor of rights in relation to certain basic entitlements (nutrition, shelter, education, health, employment, minimum income) with an obligation on the state to give effect to such rights to the maximum extent permitted by available resources, and thus establishing a priority in government spending on these areas (Sachs 1992).

In Zimbabwe there is a popularly driven constitutional debate that has the potential to raise issues of social and economic rights, although it has not done so to any significant extent to date. Despite this such social rights are widely valued. The withdrawal of various state subsidies on basic foods, health and education have generated for example a persistent social tension between widely held social values of equal protection, solidarity, equity and basic rights emanating from the liberation struggle and the current libertarian approaches that emphasise rights to individual choice in a 'free market'. National health policy documents have generally reflected a commitment to the social value placed on solidarity and equity. The most recent document, the National Health Strategy avoids conflict between more market led reforms and these values by incorporating a commitment to both, despite potential contradictions between policy elements.[1]

Such issues should be put for public debate, to elaborate the national expectations around fundamental values such as minimum social rights (and the obligation on the state to give effect to such rights) and rights to equal opportunity (and implied equity measures) equal protection (and implied access issues) and to participation. The outcome of such debate would not only 'root' national health strategy but would provide an important basis for the manner in which decisions are made over competing claims in health systems and to health resources at central and local level. The current movement for review of the constitution within civil society, parliament, the ruling party and the legal profession provides one opportunity to explore these issues.

The discussion above highlights that the underlying norms that govern arbitration of claims are not neutral, but stem from different approaches to how social rights will be achieved, and in particular to the inherent

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[1] For example, the aspiration expressed towards protection of the poor and enhancing access has potential contradictions with the withdrawal of tax based subsidies and greater demands for local financing and responsibility for health and greater private sector participation in health.

tension between a social rights, solidarity based approach over one that focuses more on individual choice within 'free markets.

There are other procedural issues relevant to arbitration of claims. These have been raised within Zimbabwe and more widely. For parties to willingly negotiate within these structures, participation must be seen to affect outcomes and produce visible results. Where structures do not adequately yield gain, groups resort to measures outside the structures, such as strike, protest or bilateral action. Operational rules are needed that restrain such actions while negotiations are proceeding inside structures, without limiting the possibility for outside action once agreed internal steps have been exhausted. This demands time and resources, and in some cases strategic approaches to balancing often slow processes of decision making in state-civic structures with membership expectations.

The discussion of these two procedural elements of information flow and arbitration of claims, highlight that it is incorrect to assume that the physical assembly of interest groups will alone achieve accountability in health systems. While the desired outcome may be shared power and accountability, the mechanisms for information flow, for expressing, negotiating and arbitrating on different interests, the legally defined and real functions and powers, the rewards and incentives for participation and the capacities and resources to effect it would all need to be specifically addressed for such outcomes to be achieved.

4 TAKING PUBLIC PARTICIPATION FORWARD IN ZIMBABWE: ISSUES FOR FOLLOW UP WORK

The discussion in this paper highlights the current challenges to health systems, and the opportunities they pose for public participation in health. The paper argues that structuring such participation is overdue and critical to create realistic expectations between health services and the public, to enhance access to health interventions and to enhance governance of and contribution to health systems.

The debate on how to strengthen participatory processes in health at both national and local level is, however, weakened by the paucity of empirical evidence on the functioning, strengths and weaknesses of current mechanisms. With strong political interests behind the debates, this lack of evidence may lead to subjective arguments or prescriptions that may lead to the persistence of prior weaknesses, or weaken efforts to enhance accountability, capacities and a downward shift of power and resources within health systems.

4.1 A Framework for Follow Up Work

The main hypothesis advanced and argued in this paper is that participatory structures enhance both positive outcomes of many promotive, preventive and curative health interventions and enhance the accountability, accessibility, quality and equity of health services.

While much focus on participation has in the past been in information sharing and in implementation of defined programmes, it is argued that public expectation and the demands of health reforms calls for participation in the governance of health services, particularly in relation to building public accountability in the development and execution of health policies.

It is further argued that such participation requires this structures and processes that

- include and are accountable to relevant interest groups, who themselves actively and capably represent membership interests
- are backed by unambiguously defined and synergistic powers and responsibilities and relationships with other authorities within key processes in health systems
- are supported by information, processes, capacities and resources that enable them to function effectively
- produce outputs that are used within health systems in a manner that satisfies the relevant interest groups.

Given the paucity of data noted earlier, a first step of empirical mapping is needed to identify how different social groups currently pursue their interests and grievances in health and how this relates to the legal provisions for governance in health, the operation of structures in practice and the perception of relevant social interest groups on what should be done to enhance the governance of health systems. It would also be important to map the information, capacities and resources available to structures and processes, the outputs that they produce and the manner in which these are used within health systems.

The data from such mapping provides information to analyse the manner and extent to which existing demand for policy accountability is met and where the shortfalls exist. If enhanced accountability is an explicit policy goal (as in the case of Zimbabwe) this would provide information for where changes should be made to enhance the performance of the system.

It would further be useful to analyse the relationship between the different dimensions of participation noted above and specific health system outcomes, including

- equity, access and quality of health services, including resource allocations for health
- improved allocation of resources for and access to promotive and preventive health interventions
- enhanced community capabilities for health (through improved health knowledge and health seeking behaviour , appropriate early use of services, enhanced mobilisation of resources for health and health services),
- enhanced access, utilisation of health services and capabilities for health in specific marginal groups (women, unemployed, migrants, youth, very poor) and thus improved equity in health

- improved quality of health care as perceived both by providers and users of services.

There are three levels at which this analysis may be best focussed in Zimbabwe, given the specific challenges that exist within health: these are

- at district level in relation to local government, including the village and ward inputs to this level
- within provincial and central referral hospitals, and
- at national level.

4.2 At District Level

The existing structures at district level have been described earlier. The most definitive policy statement on the review of these structures is provided in a 1997 Ministry of Health document (MoHCW/SDU 1997). It outlines proposals to 'cautiously ' transfer central government health functions and authority to local government, including the collection and retention of revenue, the hiring and management of personnel, and the provision of services according to policies and guidelines set at central level. The document proposes a District Health Management Board (DHMB), which is a substructure of local government that receives and disburses funds according to central government guidelines. Hence the rural district councils through the Health Management Board assume the role of service provider, with central government as 'institutional purchaser'. The district health management board is proposed to have ten members, appointed by the ministers of health and local government 'taking cognisance of the need for stakeholder representation'. The chief executive of council and district medical officer are members of the board, the latter providing executive responsibilities through the district health executive and reporting to the DHMB. While it is noted that district hospitals fall under this structure, the document simply observes that the role of their hospital advisory boards will need to be reviewed (MoHCW/SDU 1997). One element of this proposal has already drawn a response. Constituent groups in Community Working Group on Health have called for wider constituent membership of these Boards through nomination by membership based organisations in the area.

It appears that the current proposals seek mainly to open up management accountability within the districts, particularly in terms of the management of finances, personnel and service provision. Policies and guidelines are indicated, in the Ministry of Health document, to be set at central level. If this is the case, then two issues arise for the district and local level in relation to participation in the governance of health systems:

- how far do centrally defined policies and guidelines incorporate and reflect the views and issues of social groups within the district?
- how far are national policies and guidelines implemented and evaluated at district level, and does the outcome of this audit influence district and central level actions?

The description earlier in this paper of district planning without much impact on central policy or priority setting and of the weak response at central level to local outcomes of policies such as user charges indicates that there are problems across both dimensions. These weaknesses would need to be addressed if the proposed decentralisation is to have an impact on widening accountability in the governance of health services.

Hence follow up work at the district level would seek to identify from the perspective of the different social groups in the district (as outlined in Section 3.2.1)

- their views on the issues to be addressed within the health system, and experiences of issues that they have taken forward in the past;
- the past manner in which village, ward, health centre committee, district hospital board and district structures have incorporated and addressed these issues and inputs;
- the extent to which central level policy guidelines are known and reflect the issues raised within the district;
- the extent to which the local level health structures above have ensured, monitored and reported to the public on the implementation of health policy, particularly on issues of quality, equity and access;
- the extent to which the outputs (on priorities and monitoring) of local level health structures have influenced the delivery of services;
- their perceptions on how weaknesses in the above dimensions can be addressed.

4.3 Hospital Advisory Boards

The MoHCW/SDU proposal also outlines the proposals for 'autonomous management boards' of central and provincial hospitals, with ten or more members and a chairman appointed by the Minister of Health from lists submitted from 'various stakeholder groups', taking account of their ability to provide leadership and support to management (MoHCW/SDU 1997). The hospital superintendent is a full member with executive responsibilities reporting to the Board. The Board is delegated authority to develop the strategic framework for hospital management, support the hospital executive, liaise with stakeholder groups, purchase own and dispose of capital investments, mobilise and allocate resources, recruit and retain staff along national guidelines, ensure that national targets for spending and service delivery are met and report to the Minister and Permanent secretary of the Ministry of Health.

As discussed earlier, the major tension that is likely to arise in hospital boards relate to the different perceptions of the desired balance between 'arms length' approaches by central government to influence board performance and more direct forms of control. This makes both current practice (as set by law and in reality) and perceptions of major interest groups on the extent and form of Board autonomy an important issue for hospital boards. Equally it will be important to assess how public expectations on the role of and resources used by referral hospitals are reflected in guidelines for hospital management. Where Boards operate within defined

policy guidelines then accountability derives from how these are set and how they are monitored, and the role that different interest groups play in both of these processes.

4.4 The National Public Health Board and Parliamentary Committee on Health

Policy accountability at national level depends on the extent to which structures such as the Public Health Advisory Board or the Parliamentary Committee on Health or processes such as the Commission of Inquiry on Health facilitate wider public input in, information on and decision on the key policy decisions taking place in health, as well as ensuring that executive systems perform according to agreed policies and standards.

At national level, participation is being reviewed both through elected and civil society structures. The Parliamentary reform committee in its 1998 Report proposed the establishment of a Parliamentary Committee on Health, to provide a mechanism for the legislature to shadow and audit the functions of the Ministry of Health. At the same time the national Public Health Advisory Board is also being reviewed to strengthen its civil participation and role, given criticism of its weak role and effectiveness in informing and presenting public input. As a legally mandated structure under the Public Health Act, the Board has powers to act as a commission of inquiry on any public health matter, to negotiate and advise the minister on legal standards in public health, and to review other areas of activity that impact on health, including of sectors outside health. It has been proposed that the Board, while remaining a non executive structure advisory to the Minister of Health, strengthen its representative participation of civil society, health professionals, providers and purchasers, its accountability to the public and its ability to influence health policy.

The influence and accountability of the Board will depend significantly on the communication with the public, through representative organisations, in raising public concerns, in auditing public concerns of quality, equity, relevance and access in health sector performance, in setting standards and in arbitrating in potential conflicts around health. Concerns have been raised about the extent to which stakeholders will remain committed to a process that yields only advisory outcomes and has no power to bind parties to an agreement. Resolving the status of the Board also implies structuring its relationship and links with the parliamentary committee on health and with local authority level structures for participation.

As noted in this paper, there is a strong public perception of alienation from decision making over health policies, or from being able to influence those policies once applied. If national structures for participation are to meaningfully involve public participation in building accountability both in the development and execution of health policy, then follow up work should seek to identify from the perspective of the different social groups (as outlined in Section 3.2.1) at both national and local level

- their views on the goals and values that should inform health systems;
- the past manner in which these views have been pursued and incorporated into policy development, and in which health issues have been raised and taken forward;
- the extent to which national structures / processes for participation have ensured, audited and reported publicly on the implementation of health policy;
- the extent to which the decisions of these structures / processes have influenced the practice of private and public health systems;
- their perceptions on how weaknesses in the above dimensions can be addressed.

4.5 Opportunities and Threats

While this paper signals a number of issues to address in the state-civil society interface around health, the way they are taken forward and resolved depends on an inherently social and political process, that itself holds threats and opportunities. It is perhaps not coincidental that Janus, the god of doors and gates is two faced. Involvement in state-civil interface structures brings both opportunities and dilemmas for both state and civil society that need to be recognised and addressed if the interface is to work productively.

For the state, and the interest groups that have been protected through state patronage or support, there can be distrust of autonomous initiative, or attempts to limit it to predefined programmes or areas that are marginal to or too costly for state activity. The state may be equally suspicious of non government organisational inputs that are parochial or regional in framing national health standards and programmes. For officials within the state, putting policies through public scrutiny may lengthen the process of implementation in circumstances where there is pressure to deliver, and may be seen to duplicate decision making roles of officials.

Within civil society there is some concern and distrust of formal structures due to the possibility of their capture by elite groups, who are more articulate, more likely to participate and thus who risk distorting priorities (Siegel et al 1996). The disproportionate influence of such pressure groups has been used to support an argument that fora for public participation in health cannot replace elected structures (Richardson and Waddington 1996). Equal concern has been expressed about such structures being captured by professionals, who monopolise health knowledge and thereby decision making (Kahassy 1991). As noted earlier in the case of Zimbabwe, this can happen even within elected structures. Evidence that constituent groups prioritise preventive and promotive care issues, while many health professionals prioritise curative care concerns in health policy in Zimbabwe signal, for example, the implications of one or other group exclusively dominating the agenda. On the other hand, in many communities there are those who fall outside organised groupings, including the homeless, migrants or the unemployed. Equally, civil society institutions face issues to address of how participating in such structures commit them individually and collectively. The heightened energy in civil society is based to some extent on the feeling that the state has abandoned them, is neither all powerful nor

greatly concerned, and that people must take charge of their lives or become even more marginalised and oppressed (Friedmann 1992; Agbaje 1990). Professional associations and constituent groups have faced constraints with the state acting as patron, employer, manipulator, and engineering social consent in ways that have undermined the internal development of such groups. Civic groups are thus suspicious of the possibility of elaborating relationships with the state that both avoid co-option or submergence and yield tangible benefits to members (Miller 1994). Some social organisations have thus viewed the state with scepticism, and as public services have declined, have moved to meet needs without state support.

Confronting these concerns is important, as structures for public participation flourish better where there is a favourable political climate at the top and positive capacity and orientation within state bureaucracies and other providers (Kahassy 1991). These concerns become more difficult to address in an environment where relations between the state and some elements of civil society are adversarial or hostile, or where the state or government have set up competitive or disruptive relations with civil society.

For all groups, participation must be seen to affect outcomes and produce visible results. As noted earlier, where structures do not adequately yield gain, groups resort to measures outside the structures. Equally, participation should enhance the possibilities for meaningful public input, including from the poorest groups, rather than provide one more bureaucratic structure that distances systems from knowing, understanding and addressing pressing health issues.

This paper signals that the simple assembly of stakeholder fora, whether to elicit views or provide information, as often happens, does not constitute the form of participation that is being increasingly demanded in the governance of health systems. It discusses the context and dimensions of participation to be addressed if participation is to move beyond an ad hoc event, to a more sustained means of building public accountability in the formulation and execution of health policy.

It also signals that building participation and public accountability will not take place without significant investment in social capital, in networks of trust, in social organisation and state capacities and legitimacy to tap community potentials around health. Can we afford to make this investment? Reflecting on the weaknesses outlined within health systems, the pressures that have motivated health reforms and the proposed changes in responsibilities for health and health care, a better question may be, can we afford NOT to make this investment?

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