Public Participation in Health Systems in Zimbabwe

Rene Loewenson

IDS Bulletin Vol 31 No 1 2000

1 Background

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 as a factor in itself is often poorly operationalised and evaluated, both in planning and implementing health systems.

Participation can be viewed as a means to enhancing health goals in terms of coverage, access and effective utilisation of health care, as well as improved prevention of disease. It is also conceived of as an end in itself, building networks of solidarity and confidence in social groups, building institutional capacity and empowering people to understand and influence the decisions that affect their lives. Table 1 shows the varying degrees of control by communities over decision-making and resources. As the level of community control increases, there are shifts in authority from health workers and managers to communities – shifts that may not always be trusted or welcomed. In carrying out work on participation in Zimbabwe, it has become evident that one task is to define and reconcile the views of communities, health workers and other key groups on where the locus of control should be.

Even where there may be agreement on the level of participation sought, a number of other barriers to participation have been identified in health systems:

- Conventional public health planning tends to be a top–down process, based on expert identification of priorities and the strategies to address them
- Communities may themselves lack cohesion, organisational structures and capacities for effective participation
- The paternalistic attitude of health workers and mystified nature of health information may discourage community inputs
- Donor agencies may promote and finance piecemeal health projects that result in uncoordinated and confusing demands on communities.
- The bureaucratisation of health care can distance services from people and communities

Table 1: Levels and forms of community participation

Degree	Community Participation	Example
High	Has control	Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Has delegated power	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept.
	Plans jointly	Organisation presents tentative plan subject to change and open to change from those affected. Expect to change plan at least slightly and perhaps more, subsequently.
	Advises	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Is consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.
	Receives information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
Low	None	Community told nothing

Source: 'Community participation for health for all'. London, Community Participation Group of the United Kingdom for All Network, 1991

- Health workers may be poorly trained in organising and supporting participation, including the techniques that effectively organise it
- Participation in planning is often not matched by authority over resources, weakening community interest in planning processes.

A review of documented experience in different countries indicates a wide range of areas where public participation has been incorporated into health systems (Loewenson 1999). These are outlined in Table 2. This article highlights how participation is currently structured across these key dimensions of health systems in Zimbabwe, the changes perceived to be necessary by different social groups and the issues to be addressed in pursuing these changes.

There have been a number of pressures for a review of participation in the health sector in Zimbabwe, which shape the motivations for, and forms of future public participation.

- *Policy reform* Shifts from redistributive, equity-oriented health policies in the 1980s towards more market-influenced reforms have reduced real per capita public budget allocations for health and increased pressure on households to finance health needs, despite high levels of poverty. Policy review within the health sector has motivated different groups to seek greater influence in decision-making in health.

- *Decentralisation* policies have led to a review of the manner in which authority, responsibility and resources are devolved from central to local government level, and within local government. While decentralisation proposals claim to enhance participation and service accountability, reduce public expenditure, and improve quality of services, this is by no means an automatic outcome, and the opposite has often been found (MoHCW/SDU 1997; Mogedal and Hodne Steen 1995; Owino and Munga 1997; Gilson *et al.* 1994; Lauglo and Molutsi 1995), particularly where constituents at the local level themselves have a weak understanding of the content or implications of decentralisation (CWGH 1997).

- *Resource Mobilisation* Perhaps the most powerful motivation for a review of public participation in health is the issue of increased community contributions to health, while for communities the issue appears to be one of an

Table 2: Roles of participatory structures within key health processes

HEALTH PROCESS	ROLES OF PARTICIPATORY STRUCTURES
Health promotion; prevention and care of illness	Promote primary health care, health awareness and goals Coordinate health providers and sectors on agreed health goals Identify and mobilise community inputs in health interventions Oversee the administration of health programmes, including staffing, supplies
Information gathering and exchange	Gather and organise community information for local government and health system Report to communities and different providers on health policies and programmes Investigate and report on specific health problems
Policy, priority and standard setting	Assess health and health development needs Propose, review and monitor policy goals and strategies Identify and communicate health system and public health priorities, targets, and standards Review equity impacts of health strategies
Mobilisation of resources	Raise health revenue (cash: taxes, levies, fees) and resources (food, supplies, labour) for investments in the health sector Identify household resource contributions to health and exemption mechanisms Mobilise co-financing and in-kind inputs to agreed health programmes from sources outside the public sector Negotiate and propose incentives and subsidies for co-financing inputs Call for tenders for specific areas of work
Allocation of resources	Prepare health development and budget plans Allocate available health resources to health plans and programmes Monitor health expenditure against agreed allocations Monitor resource allocations in relation to equity and efficiency goals Ensure contractual standards are met in private purchasers Negotiate agreements and codes of conduct with health personnel Ensure accounting and independent audit of finances
Monitoring quality of care	Review service performance against health standards and plans Monitor and report on quality of care Review and make recommendations based on client inputs, feedback and grievances on health services Convene public debate and input on health system performance

Source: Loewenson 1999

increased say in how resources should be contributed and used (Lessing 1999).

- *Technical efficiency* The need for cost containment in the health sector has motivated discussion of how individuals, households and health providers can work in a more complementary manner to make best use of available health resources and to ensure the technical efficiency of health interventions (Loewenson *et al.* 1999).

- *Liberalisation of providers and consumer awareness* The growth of private health providers has made the issue of informed consumers animportant element both in financing private care and in ensuring standards of care and effective management of health problems.

This pressure for participation can translate into different outcomes, depending on how different social groups and the state conceptualise and implement their roles within the health sector. As a means of better understanding the perceptions and goals of different groups within the health system, the author carried out a programme of participatory action research carried out in consultation with the Community Working Group on Health (CWGH) and the Ministry of Health and Child Welfare. The former, a consortium of national and local constituent civic organisations in Zimbabwe, identified that public participation in health needs to be enhanced, and called for more information to propose how this should be done, particularly if such participation is to be built from the bottom up (CWGH 1997, 1998a).

In response to this call, research was carried out by TARSC in four districts of Zimbabwe (two rural and two urban councils) involving social groups from civil society, elected leadership, traditional leadership and health systems, supported by IDRC (Canada) under the Southern African Network on Equity in Health. The work gathered the current experiences of participation across the different dimensions of health systems, and the ways in which the various groups felt that public participation in health could be strengthened. The details of this fieldwork and the findings are reported elsewhere (Loewenson *et al.* 1999), and this article identifies some of the key issues arising for enhancing participation in the implementation and governance of health services.

2 Dimensions of Participation in Zimbabwe

Fieldwork indicated that participation is perceived to be limited currently and more likely to be found in implementing health actions (prevention, care and information-sharing). Decisions made at higher levels continue to have weak public input or consultation. Participation in the *governance* of health systems was indirect, through health or elected structures, with the public a step removed from the negotiations and choices that are being made increasingly in the context of limited resources. The weakness of such indirect systems was evident in the fact that most people did not know what was taking place in relation to health budgets, in the priorities set for health services, or in improving quality of care. This resulted in a range of ways of people coping with problems, including bypassing services, or moving between different service providers and self-help. Despite this, people (particularly poorer, lower income groups) preferred *not* to take up issues individually, and most health issues raised by low income communities came through collective mechanisms such as community meetings, or meetings that involved health authorities or local government officials (Loewenson *et al.* 1999).

This preference for collective mechanisms made structures for participation such as development committees critical for public participation. Despite this, many of these structures were not functional, having become weaker or grown defunct due to:

- Their lack of meaningful feedback to communities
- Non-attendance and disinterest in the structures by health staff who do not see themselves as accountable to these structures
- Exclusion of some key groups who play a role in health, including churches, other health providers, traditional, civic and social leaders
- Lack of reimbursements for costs of participation
- Lack of training of committee members in health matters
- Lack of procedures for and regular renewal of the committees.

There was, however, general agreement from most groups that public participation *should* be strengthened across all dimensions of health systems, and particularly in relation to decision-making on health priorities, budgets and monitoring quality of health services (Loewenson *et al.* 1999).

In relation to prevention and management of illness, there is ample evidence that the expansion of community and primary care services and the organisation of community-based health workers and programmes had strong positive impacts on morbidity and mortality in Zimbabwe in the 1980s. With declining public sector investments in the health sector, pressure grew in the 1990s on building complementary and informed relationships between community interventions and health sector management of common diseases (Loewenson and Chisvo 1994; MoHCW 1997). The HIV/AIDS

epidemic has also increased the burden of caring in the community (MoHCW 1997).

The fieldwork in Zimbabwe indicated that these roles imply a need to look at how people are supported to take such actions (through education, material support and supervision); how communities mobilise their own collective resources for health actions, and how primary and secondary level services support them. Rather than being a substitute for poorly funded or poor quality health services, community-based prevention and care in fact demand investment in reliable and appropriate primary care and health service outreach activities.

One of the key motivations for health sector encouragement of participation is to enhance resource contributions from communities towards health, motivated in part by falling per capita resource allocations to health. Attempts in the late 1990s to enhance fee revenue had to deal with issues of local fee retention; inadequate discussion with communities or local government of charges; poor performance of individual screening approaches for exemption; and consumer resistance to significantly increased costs without corresponding increases in quality or reliability of services (Mutizwa-Mangisa 1997; CWGH 1998a; Kaseke *et al.* 1993; Hongoro and Chandiwana 1994).

While communities in rural and urban Zimbabwe have indicated their willingness, in principle, to mobilise resources for health, future resource mobilisation strategies would need to pay attention to a number of issues. These include: consultation with affected communities; demonstrating a visible impact of additional revenue collection on quality and reliability of services; taking measures for protecting equity; and enhancing local control of revenue collection. This was linked in community discussions to a need for pre-budget consultation processes at local and central level, and for consultative mechanisms at health centre and district level. These would define resource mobilisation approaches, manage locally generated resources, and act as a mechanism for public accountability on how budgets at higher levels of the health system are allocated.

Surveys show that households do already make substantial contributions to health activities, in cash and in kind, through material, labour and production contributions to community services, household and community caring activities, household investments in prevention and infrastructures, and voluntary work on health activities. The fieldwork indicated that these community inputs are less easily mobilised when the public services fail to provide their own inputs or to meet transport costs to reach communities. Resource mobilisation organised through local community structures, with reliable supportive inputs from elected leaders, public services and non-government organisations, appears to cultivate high levels of ownership and responsibility, and signals the willingness of communities to pool reasonable forms and levels of resources for identified needs in health. Case studies on malaria control and water supply initiatives indicate that communities are willing to take over costs of programmes with proven effectiveness, provided they can control these programmes and the funds collected (Loewenson *et al.* 1999; Integrated Rural Water Supply and Sanitation (IRWSS) National Coordination Unit 1997/8).

Hospital Advisory Boards have also recently played a role in mobilising resources for hospitals, with some HABs making a significant contribution to hospital equipment and upkeep. While not all HABs have such an impressive record of resource input, the positive examples indicate the potential that can be unleashed if communities are given more direct ways of contributing to their own health services.

In the face of declining allocations to health, local government and civic groups have called for clear, publicly disseminated health service standards at each level of care, and for a resource allocation formula that allocates tax revenues in a manner that is sensitive to poverty levels and income-generating potentials between districts, and that can be publicly monitored.

Recent experience of the Health Services Fund (HSF) in Zimbabwe, initiated in 1996 and made up of local retained fees and donor allocations, indicates some of the issues at stake. What emerges is that decentralising resources without clear mechanisms for monitoring how allocation guidelines are met, without public information on the fund or its use, and without mechanisms for allocation and

management of such funds at primary care services, can lead to resources not reaching clinic or community health interventions. The absence, noted earlier, of informed and effectively functioning ward and health centre committees was identified in the field surveys as one negative factor in community allocations to health. Another was the reluctance some health staff felt about giving communities greater control over resources. Health personnel may feel alienated by the apparently 'political' demands of committees, and turn their attention more to those technical activities where they feel they have some measure of control. This means that capacity building for participation in health planning not only requires new skills in community structures, but also new attitudes and skills within health service providers at all levels.

Action on quality of care issues such as negative attitudes and poor communication between health workers and the public is also weakened by lack of mechanisms for public monitoring and lack of public information about health services and patient rights. At the same time, health workers face their own concerns on their conditions of service, lack of resources to deliver adequate quality care and occupational risks in the face of rising levels of HIV/AIDS, TB and other communicable diseases (CWGH 1997; Lessing 1999; Loewenson *et al.* 1999b). Again, these limitations were seen to call for a mix of public education (such as on health standards and on patient rights), joint health provider and public fora to raise and review quality issues, stronger supervision and support by higher level health services and improved coordination between different health service providers.

3 Conclusions

Many of the proposed actions for participation and accountability raised by communities called for strengthened joint mechanisms involving civic and elected leaders and health providers with clear terms of reference, roles and authorities and adequate training and resources for their functioning.

The interest in, and concern over health services in Zimbabwe found across many communities is clearly an opportunity for all groups to reshape the way the public and health services act and interact. There is almost universal agreement of the positive contribution of public participation in health, and of the need for it to be supported and enhanced.

To do this there is a need for more than simple activity from communities, but a deeper process of empowerment to take control and initiative on health problems. This would include developing capabilities to enhance responsiveness, so that appropriate, early and informed action could be taken on health problems. It would also involve the capacity to identify and organise collective action on priority problems without waiting for an outside push. Through a more active engagement, communities would be more able to develop effective and accountable interactions with service providers, mobilise local resources for priority interventions and lever necessary outside inputs.

This implies a change in capacities within civic and elected groups, and in processes of information-sharing and decision-making within health systems and local government. It also implies changes in structures, from local (ward/health centre) level, through district level upwards, so that they are more inclusive of the various public groups and health providers and have the resources, authority and technical support to make specific decisions/take agreed actions. Making an investment in these processes and structures would seem to be an important step towards encouraging many of the aspects of participation noted earlier.

Enhanced community participation in health interventions demands more informed and active communities, and a more effective and restructured health input at local level. This not only calls for a renewed commitment to the allocation of health resources to prevention and accessible primary health care, but also investment in health sector capacities to plan, implement and support community health actions in a manner that motivates and facilitates community initiative.

Government and the health ministry have always voiced their commitment to community participation, and continue to do so in the current policy reform. In exploring what is meant by such 'participation', it would appear that communities in Zimbabwe are calling for greater ***control*** not only over how resources are raised for health, but also over how they are allocated and what health

services do. They clearly seek more *authority* within health systems. Health workers concur with the need for participation, but their view is mainly directed by the need for communities to take more *responsibility* for health, and to *contribute* more resources towards health systems. Given the essential contribution of both towards sustainable health systems, one challenge is to reconcile both sets of goals in future health systems.

References

Community Working Group on Health, 1997, 'Health in Zimbabwe: community perceptions and views', research report, Zimbabwe, November, supported by Oxfam and TARSC.

Community Working Group on Health, 1998a, 'Health in Zimbabwe: views of community-based organisations', Zimbabwe, March, supported by Oxfam and TARSC.

Gilson L., P. Kilima, and M. Tanner, 1994, 'Local government decentralisation and the health sector in Tanzania', *Public Administration and Development*, 14: 451–77.

Hongoro C. and S. Chandiwana, 1994, 'Effects of user fees on health care in Zimbabwe', Blair Laboratory/MoHCW, mimeo, Harare.

IRWSS National Co-ordination Unit, 1997/8, *Annual Report of the Integrated Water Supply and Sanitation Programme*, Vol. 1, Harare.

Kaseke, Edwin and Maxwell Ndaradzi, 1993, 'A situation analysis of the Social Development Fund', study report for the Government of Zimbabwe and UNICEF, Harare, July.

Lauglo, M, and P. Molutsi, 1995, 'Decentralisation and health systems performance: the Botswana case study', DIS Centre for Partnership in Development and University of Botswana, Botswana.

Lessing, C., 1999, Community participation in drug management, masters thesis, Royal Danish School of Pharmacy, 1999.

Loewenson, R. and M. Chisvo, 1994, 'Transforming social development: the experience of Zimbabwe', report prepared for UNICEF, Harare.

Loewenson, R., 1999, 'Public participation in health: making people matter', *IDS Working Paper* No. 84, IDS (UK) and TARSC (Zimbabwe).

Loewenson, R., T. Chikumbirike, F. Chikomo, L. Rusike, S. Muchapondwa, and A. Ndambe, 1999, *Public Participation in Health in Zimbabwe*, TARSC monograph, September.

Mogedal, S. and S. Hodne Steen, 1995, *Journal of International Health Development*, 7(3):349–67

MoHCW (Ministry of Health and Child Welfare, Zimbabwe), 1997, 'National Health Strategy for Zimbabwe, 1997–2007', Ministry of Health and Child Welfare, May.

MoHCW/SDU (Ministry of Health, Strategic Development Unit Zimbabwe), 1997, 'Proposals for health sector reform (decentralisation) roles and relationships', Harare: Government Printers, November.

Mutizwa-Mangiza, D., 1997, 'The opinions of health and water service users in Zimbabwe experience', in University of Birmingham Series 'The role of government in adjusting economies', Paper 24, UK, November.

Owino, W. and S. Munga, 1997, 'Decentralisation of financial management systems: its implementation and impact on Kenya's health care delivery', *Institute of Policy Analysis and Research Discussion Paper* No. 6/97, Nairobi.