

Participation and accountability in health systems: The missing factor in equity?

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1. Introduction

The EQUINET Steering committee, in its introductory paper to the conference, notes that with the intensifying political struggle around scarce health resources, “equity related work needs to define and build a more active role for important stakeholders in health, including communities, health providers and funders, health professionals and other sectors. This would need to incorporate the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health” (EQUINET Steering Committee 1998).

This view reinforces that expressed by UNDP in its 1999 World Development Report, that technical knowledge has raced ahead of the governance and social systems that will enable its application across the wide majority of social groups, particularly the poor (UNDP 1999).

The increasing gap between current knowledge and practice has generated tension within health systems. Health professionals have expressed dissatisfaction over services and conditions that do not provide adequate resources to reflect their professional capacities. Many communities have expressed dissatisfaction with the gap between what they know to be possible (and what they see some communities accessing in preventive and curative health) and their own health services. Perhaps the most recent and visible appearance of this is in the terrible inequality between north and south in access to therapies for AIDS. It has also however been present for a much longer time in relation to access to known therapies for many preventable diseases, or more importantly to the water supply, sanitation or other inputs needed to prevent them.

The solution to this problem lies in part in the development of cheaper and more cost effective technologies. But there is a bottom line to ‘low cost’ and it usually exceeds the US\$5 per capita that some populations of the region access for health, even while others access significantly more. It must therefore also lie in the manner in which different social groups are able to direct resources towards their health needs and to access existing technical options.

This paper examines the features of social and governance systems that support vertical equity in health and their current application within health systems. It proposes measures and mechanisms that need to be included or strengthened within health

systems if we are to enhance the relationship between citizen and state towards enhancing vertical equity. Finally it suggests further work towards strengthening the social dimensions of equity in health.

The paper draws from three main sources: published literature, findings of action research work in Zimbabwe and experiences shared and conclusions from an EQUINET/ TARSC/ WHO/ IDRC southern African regional meeting on public participation in Health systems held in May 2000 (EQUINET/ TARSC 2000). The participatory action research was carried out by TARSC in consultation with the Community Working Group on Health (CWGH) and the Ministry of Health and Child Welfare in four districts of Zimbabwe (2 rural and 2 urban councils) involving social groups from civil society, elected leadership, traditional leadership and health systems. It used participatory appraisal techniques to map social conditions and priority health issues, experiences of participation and views on where and how it should be strengthened. A participatory approach was deliberately used to enable communities to share information **during** the research process, and to lay the foundation for the enhanced forms of participation they identified. The tools, process, and their review results are reported in more detail elsewhere (Loewenson et al 1999).

2. Social dimensions of equitable health systems

It is commonly stated that people are the centre of health systems and services (WHO 2000). People play many roles, as producers of health inputs and providers of goods and services for health; as consumers of health and health care inputs; as contributors to the financing of health systems, and as citizens in defining and guiding the implementation of the norms, standards and policies that shape health systems. Despite the centrality of this role, we live in a world where the majority of people are *de jure* citizens but continue to be excluded from participation in social, political and economic life, whether through economic deprivation, or through centralisation of political power or bureaucratic authority. This exclusion intensifies when people lose access to health services. Used to strong state driven policies and systems, when health systems declined in countries of the region, many of the poorest people turned to self-help and became spectators of a collapsing national asset. As noted in the recent Health Review Commission in Zimbabwe, "The system is characterised by apprehension and uncertainty about its future among the general public and health workers." (Health Review Commission 1999).

What are the dimensions of social and health systems that enable social groups to influence policy and direct resources towards their health needs? This paper proposes that for vertical equity, health systems need to pay attention to three major dimensions: social networking, participation across all aspects of health systems and measures for enhancing informed stakeholder involvement in and accountability of governance in health.

2.1 Social networks

It has been evident for some time that social factors such as female education are critical for health outcomes, but there is a growing body of evidence that social exclusion and isolation is itself unhealthy. In contrast, social norms and networks appear to improve

household welfare and to enhance the efficiency of society by facilitating co-ordinated public action (Putnam quoted in Meltzer 2000). Equitable forms of health financing, for example, are based on risk pooling and solidarity, which at community level depend on social networks. A World Bank study in Tanzania found for example that membership in groups and networks was a key contributor to household social welfare even after taking account of the size of the household, male schooling, female schooling, household assets, market access and after controlling for other human, natural, physical capital variables. Village level networking or participation in groups had a stronger relationship with household wellbeing than female education or market access. Organisational and associational infrastructure appeared to be an important vehicle for improvements in household wellbeing (World Bank 1996). Conversely one dimension of poverty and deprivation, as shown in the paper by McIntyre and Gilson (2000) at this EQUINET conference, is social isolation. Similar associations between social organisation and positive household health and welfare outcomes have been found in other studies (Marmot 1998; Kawachi et al 1997; Wilkinson 1997).

2.2 Participation

‘Community Involvement in Health’ (CIH) or ‘participation’ has been recognised as a critical dimension of health systems for many decades. The 1976 Alma Ata declaration made participation a central feature of primary health care. The 1987 WHO Harare declaration endorsed direct public involvement in health systems and the reorientation of political and health systems to support such participation. A review of literature indicates a number of ways in which participation has been included in health systems, shown in Table 1 below.

Despite longstanding policy support and experience, the term ‘participation’ appears to have many meanings, to be poorly operationalised and often ambiguously used in health systems. For vertical equity, those forms of participation that promote health knowledge, health seeking behaviours, inclusion of community preferences in health systems and enhance responsiveness of health systems in low income communities would need to be promoted. In doing this ambiguities in the use of ‘participation’ would need to be addressed.

Firstly, there appear to be a number of elements to incorporate in analysis of participation beyond the simple implication of a more active public role in health. Hence for example, the definition put forward by the Regional meeting on public participation in health systems of participation as:

“involving

- *genuine and voluntary partnerships*
- *between different stakeholders from communities, health services and other sectors; based on*
- *shared involvement in, contribution to, ownership of, control over, responsibility for and benefit from*
- *agreed values, goals, plans, resources and actions around health.” (EQUINET/TARSC 2000)*

TABLE 1: ROLES OF PARTICIPATORY PROCESSES IN HEALTH SYSTEMS

HEALTH PROCESS	PARTICIPATORY ROLES
Health promotion; prevention and care of illness	Promote primary health care, health awareness and goals Co-ordinate 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 govt 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)

Secondly, there is need to be explicit about the variation in the levels of participation, as shown below in Figure 1. These changes reflect shifts in the relative degree of control between communities and health systems in decision making and over resources. This shift in control changes the balance of different spheres of authority - medical, political, traditional, civil, bureaucratic and financial, and brings different types of knowledge, experience and values to bear in decision making.

FIGURE 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

2.3 Governance

The wider definition of participation leads into the third dimension, which is the nature of governance systems in health. This refers to the relationship between the state and citizens, whether the latter is organised as private sector or through civil society. It incorporates how different social groups articulate their interests, the way political, economic and administrative authority is exercised; how social groups exercise their rights and obligations and how power is exercised in managing the economic and social resources for health (World Bank, UNDP cited in Meltzer 2000). Of importance to equity it concerns both the measures that citizens use to articulate and insert their interests in policy, the measures that the state uses to protect national interests and public goods within a diverse range of social interests and the systems through which these policy measures are negotiated and applied.

These elements of governance are clearly changing. In many countries, state driven welfare systems and government sponsored associations going down to grassroots level were used to build trust and legitimacy around policies and programmes that were essentially developed at central level. As liberalisation policies have widened the roles, responsibilities and burdens of social actors outside the state, it has also led to a refocus on the relationship between state and non-state actors in shaping and implementing public policy. This is a response to many real pressures, including

- citizen dissatisfaction with erosion of basic public health rights and standards and with quality of care
- increased citizen access to information and education
- a growing diversity of contributions to and channels of service delivery
- increased direct burdens of care on citizens due to AIDS, rising costs of care and declining service coverage
- a growing demand from citizens to hold bearers of public office responsible for their performance and the results of their decisions (Cornwall et al 2000; CWGH 1998a,b, Zimbabwe Environmental Health Practitioners Association 2000; Loewenson 1999).

Equity policies imply many choices, and particularly pro-poor choices. There is 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, or the wealthier urban elites, 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; Bennett et al 1995). This is particularly the case during periods of policy reform. 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. Hence in addition to enhancing the evidence base for equity policies, attention needs to be given to the systems of procedural justice through claims within policy reforms are judged (Kalumba 1997; Lafond 1991; Storey 1989).

3. Current issues in social networking, participation and governance

As noted in the previous section, in a context of significant new threats, such as high HIV/AIDS related illness and poverty, ensuring that health systems that meet priority health needs in a time of scarce resources demands choices: Choices on how national resources are to be shared and the weighting given to health, choices within health systems on where and how to spend public resources, choices on how to motivate and direct private health spending and choices on how household contributions will be balanced against state contributions. Social networking influences the ability of people and households to make and act on their choices, levels of participation influence their interaction with public services while the system of governance influence the way societal resources are distributed to support those choices. How have social networking, participation and governance systems affected health equity in southern Africa?

3.1 *Social networking*

In the Zimbabwe research, participants mapped their areas and features that impact on health. Many of these were social and economic infrastructures, such as clinics, transport routes, water points, schools, dip tanks, informal trading sites and business centres. Vulnerable social groups with greatest health needs were noted to have least access to these infrastructures and to health services (See Table 2 below). From civil society mapping these groups were also least organised into civil associations and social networks (Loewenson et al 1999).

TABLE 2: SOCIAL GROUP FEATURES, ZIMBABWE ACTION RESEARCH, 1999

	ALL DISTRICTS
Most vulnerable groups:	Unemployed, elderly, female youth, children under five years, disabled people, squatters, street children
Gap between need for and access to health services widest in:	Elderly, children under five years, female youth, squatters, Disabled people, youth

This is despite the fact that equity in health, or directing public health inputs towards those with greatest needs has been a policy in Zimbabwe for almost two decade. The research highlighted the need to explicitly examine how the most marginal social groups are given a voice in and greater access to health inputs, including through their own social networks. Communities participating in the research felt that this could be best done through extending the reach of existing community based structures, such as churches, women’s groups and residents associations, as they had greatest access to vulnerable groups. "They live in our community and are part of us". This issue of strengthening horizontal links between vulnerable groups and the wider social networks in the communities they live in has been poorly addressed in more segmented and targeted poverty reduction approaches.

The research highlighted the many existing social networks in both rural and urban areas, as well as the inadequate direct investment being made towards using these networks for achieving health goals.

In all areas there were a range of civic groups and community institutions that were or could be acting on health, some specifically dealing with health related issues. These included burial societies; traditional institutions; church groups; non government service organisations; membership based civic groups, such as womens groups, farmer groups; disabled persons groups; residents associations; and local development groups. Many of these groups were poorly linked to the health services, or even to each other. Where

links existed these were often through community health workers and environmental health technicians, or through local government councilors (Loewenson et al 1999).

The Zimbabwe research would thus seem to signal that

- social networking and access to infrastructures is weakest in the most vulnerable groups
- horizontal links between vulnerable groups and community networks are perceived as important vehicles for enhancing service outreach but
- existing community networks are themselves underutilised for health and often depend on links through people with least authority in health systems, and
- national civic networks and local government systems are underutilised as vehicles for enhancing social networking and health access in vulnerable groups.

This should not be read to imply that health services have not organised communities. Across the region communities have been organised into community health groups, water user groups, community home based care initiatives and so on. Many such social networking initiatives have been carried out through Non government organisations (NGOs), particularly in relation to specific vulnerable groups in remote areas and often through participatory approaches (WHO 1997; Robinson and White 1997; WHO, Govt Ireland 1997)

Paradoxically, states have often built stronger collaboration with such NGO service organisations, including international NGO providers, than with their own membership based civic organisations, such as womens groups or trade unions. This has weakened the involvement and capacity development of these institutions in health sector work. In contrast to well-funded international NGOs, many national civic and grassroots organisations struggle around issues of

- how to access their own national public resources
 - their capacities to manage and sustain programmes
 - negative attitudes from and non participation of health workers
 - poverty and pressures on communities from other social problems
 - difficulties in combining and balancing the roles of health providers, traditional, civic and elected leaders
 - how to build strong and active links with their own members
- amongst other problems (Loewenson 2000, Myezwa et al 2000).

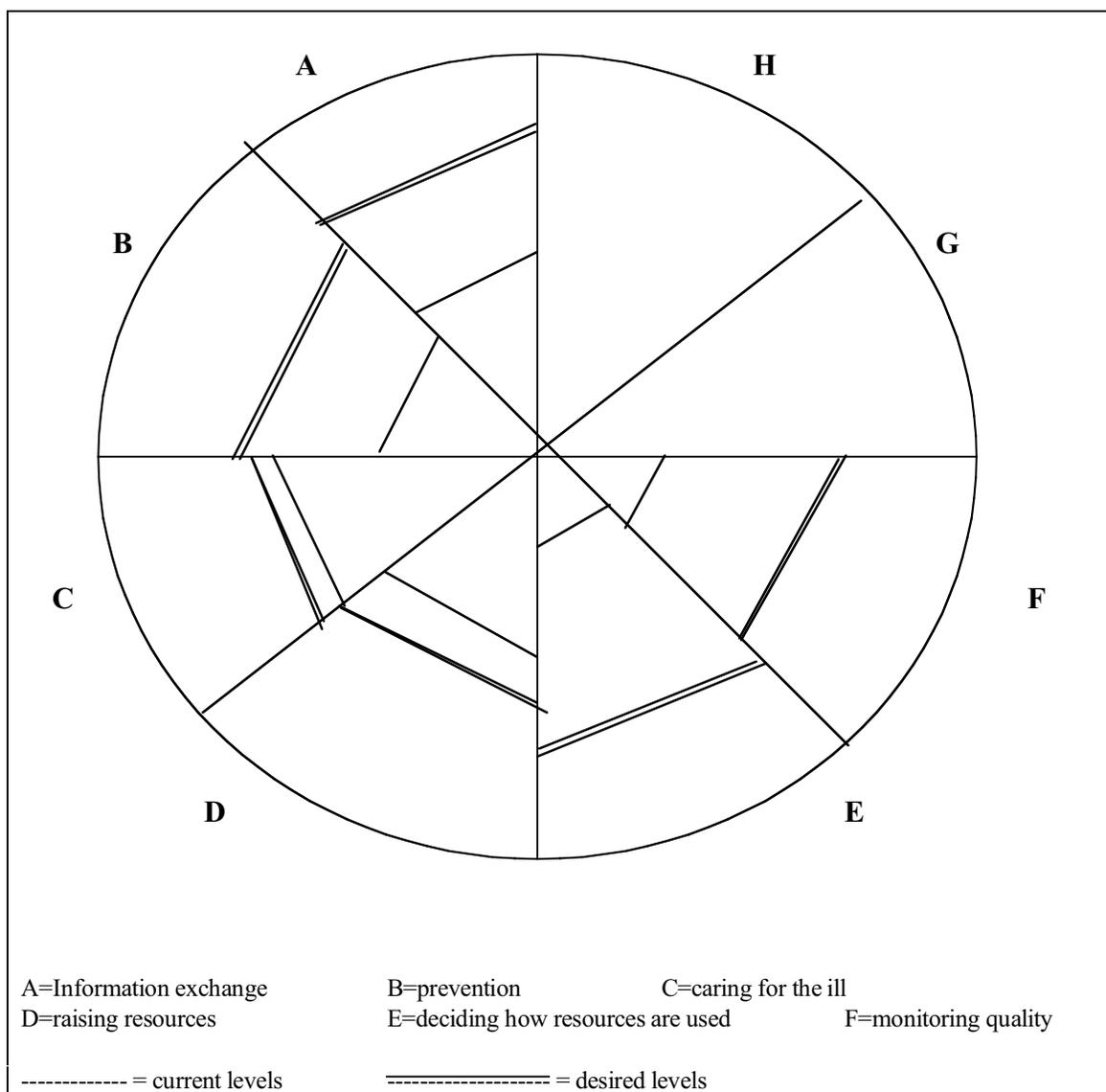
It was also noted in the regional meeting that health may not always be the best entry point for enhancing social networking. Where poverty is a greater priority, or where health issues are difficult to separate from poverty related issues, then broader work on poverty may be a better entry point. Communities may want to address priority issues around poverty before dealing with health service issues. This draws attention to the manner in which the health sector works through other sectors to enhance social networking for health (EQUINET/TARSC 2000).

3.2 Participation

The research in Zimbabwe indicated that health service personnel, elected leaders and communities felt that they currently participated at a relatively low level across many areas of health system functioning. The wheel chart in Figure 2 highlights the gaps between the

reported current and desired level of participation aggregated for all groups and areas in the study. Disaggregated data is available in the research reports (Loewenson et al 1999).

FIGURE 2: WHEEL CHART OF PERCEPTIONS OF CURRENT AND DESIRED LEVELS OF PARTICIPATION, ZIMBABWE ACTION RESEARCH 1999



Participation was reported to be higher in implementing health actions, (prevention, care and information sharing), and more in caring activities than in prevention. Public participation in resource mobilisation was noted to be low in rural areas and higher in urban areas. Communities were felt to have little or no current role in deciding on how budgets are used or in monitoring health service quality. Low levels of participation were attributed to the lack of organised prevention and caring activities; lack of information sharing with communities; negative public attitudes towards taking responsibility for health; weak inputs from communities to health, weak consultation with communities on health services and ineffective functioning of ward and district level mechanisms for dialogue, consultation and information flow between community members and interest groups, councillors and health services (Loewenson et al 1999).

Communities stated a preference for raising problems through meetings. Many local structures such as health centre committees and ward health committees had however become non functional over time, with weak access to resources and low participation by health personnel. This was seen to weaken the effective channelling and resolution of health service issues coming from the community (and vice versa) (Loewenson et al 1999).

The Zimbabwe Health Review Commission (2000) endorsed these findings, noting that despite participation having been accepted in policy for some time, it had not been realised, particularly in relation to participation in decision making. Constraints included:

- * poor health worker appreciation of the value of participation
- * poor health worker skills in facilitating community involvement
- * weak methods for re-orienting health workers towards community involvement
- * weak political commitment towards community involvement
- * lack of stable planning structures for joint planning between communities and health services (Dhlakama quoted in EQUINET/TARSC 2000).

These often poorly structured and somewhat ad hoc relations signal a deeper problem of how participation is viewed and structured within health systems.

Public health planning has historically tended to be a top-down process, based on expert identification of priorities and the strategies to address them. This is intensified by curative medical systems that are hierarchical, mystified and paternalistic to clients, that have been built on traditions of clinical autonomy in decision making and that are poorly prepared to take on other interests in decision making. More recently management and financial control in health systems has become a more important influence in decision making, sometimes exercised through international donors, sometimes alienating both health workers and communities.

Communities on their side often lack the 'language', information, cohesion, organisational structures and capacities for effectively engaging in these competing spheres of authority, and can become disempowered and distrustful in the process.

These problems were noted to a greater or lesser extent in the regional meeting. Despite this, many positive case studies exist of participation in health, leading the meeting to propose that a compilation of such case studies would enable the horizontal dissemination of promising practices (EQUINET/ TARSC 2000). Many of the case studies are however also ad hoc, strongly linked to NGOs, weakly rooted within health systems, and appear to lack the institutional framework and sustained investment to scale them up or support them in the longer term. The Zimbabwe meeting also noted the need for a minimum standard and level of health service provision to get the community 'buy in' for their motivation for and inputs to participation. Public participation is not a substitute for poor health services (EQUINET/TARSC 2000).

The participation 'gap' has perhaps become most visible as resource scarcities have grown, and more attention has been focused on the mobilisation and allocation of public and private resources for health. Market reforms across the region have increased the costs of care and reduced tax based spending on health relative to individual out of pocket

spending, not only increasing inequity in health financing, but also shifting collective forms of payment to individual forms, weakening solidarity and social networks. Underfunded health services have looked to clients to ‘take more responsibility’ for health, including contributing more funds towards health systems. This has led to a variety of initiatives to lever greater community contributions. In the 1990s, many countries introduced or intensified ‘cost recovery’ measures, primarily through user fees. These measures claimed a number of positive health system outcomes, such as

- increasing revenues through charges on services
- improving coverage and quality of care through applying increased revenue to service improvements
- enhancing equity through targeted spending on the poor
- improving service utilisation patterns and the referral system by controlling frivolous demand and directing choice through prices and levels of provision
- increasing efficiency by making providers cost conscious and encouraging cost effective techniques of providing care (Equinet Steering committee 1998).

In practice, they led to a range of negative outcomes on access and equity in health services, mainly because of

- poor functioning of exemption mechanisms (leakage of non exempt groups into free care and groups meriting exemptions not accessing them) due to lack of information, excessive bureaucracy, lack of formal proof of earnings etc);
- reduced use of care in the poorest groups, associated in some cases with an increase in damaging health behaviour and negative health outcomes;
- depletion of household assets to meet health costs, increasing expenditure on future health risk;
- little improvement in quality of care at primary care levels, or of increased budget allocations to or retention by these levels;
- insignificant additional revenue generated
- weak or temporary impacts on the use of the referral system without corresponding changes in quality of care (Equinet Steering committee 1998; Mutizwa-Mangisa 1997; CWGH 1998a; Kaseke et al 1993; Hongoro and Chandiwana 1994).

In Zimbabwe, for example, national cost recovery rates remained low, particularly in the poorest areas. Central hospitals also continued to have a very poor cost recovery performance, although they served in the main a higher income urban community (See Table 3 below).

TABLE 3: COST RECOVERY PERFORMANCE BY FACILITY LEVEL, ZIMBABWE

Level/Type	Cost recovery ratio 1989/90	Cost recovery ratio 1993/94
Central hospitals	7.0	7.0
Provincial hospitals	11.0	16.0
District hospitals	1.1	1.4
Mission hospitals	1.2	1.2

Municipalities	12.7	15.0
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Source: Hongoro and Chandiwana 1994

More importantly for this paper, weak consultation, falling quality service delivery and increased price stress for consumers made fee measures unpopular and even made the discussion of contributions to social health insurance politically sensitive, delaying further resource mobilisation strategies. The credibility of cost recovery measures was reduced by the ineffective design and implementation of exemption policies, due to the difficulties noted earlier. Increased fees were criticised for not being associated with improved quality or reliability of services, particularly when people were charged equally for services whether drugs or other facilities were present or not (Mutizwa-Mangiza 1997; DAG 1997; Loewenson et al 1999). The imposition of fees without adequately strengthening service delivery at primary care level in fact exacerbated the flow of patients **past** the primary care level direct to district level, as people calculated the cost effectiveness of transport and fee costs in terms of service quality returns.

Communities criticised the lack of consultation in deciding on cost recovery policies and levels. Local authorities also criticised central government imposed fee levels that make it both difficult to finance services, and negotiate appropriate revenue strategies with their own communities. A ministry of health study observed the weakness of 'thinking for the people instead of thinking with the people' (Zigora et al 1996).

In contrast, the action research indicated that people no longer accepted political messages of 'free health services' when their services were collapsing, were willing to make fair contributions towards public health systems, and were in many places taking on inputs that they themselves planned and controlled. In Nyava ward, Bindura, for example, after people identified their priorities through the PRA process, they decided to implement actions towards addressing them, such as the construction of a waiting mothers shelter at the clinic, and contributed both funds (\$20 / household) and bricks towards its construction. The contribution levels and management systems were defined by the communities themselves (Loewenson et al 1999).

Such initiative has existed at an ad hoc level for some time, and is widespread across the region. Three issues emerge, however:

Firstly, there is almost no assessment of the real level of contribution from communities inputs to health, whether directly to health services or in community / household based activities. One study of home based care estimated Z\$539- \$824 spent over a three month period, with 2,5-3,5 hours a day spent by care-givers caring for patients, but this was noted to be an underestimate of full costs as it excluded costs to extended families and opportunity costs of items foregone due to diversion of funds to caring (Hansen et al 1998). Without this information, it is difficult for negotiations on complementary inputs to health to adequately recognise and plan for the inputs coming from household level.

Secondly, localising community level decisions on fee levels and management systems needs to take the additional step of ensuring that local level decision making is not simply dominated by local elites or that budget resources earmarked for community

level are not swallowed up by spending in curative priorities of health personnel at district level (Loewenson 2000).

Thirdly, resources need to flow to give substance to authority. Where central control over resources does not match local planning participation is undermined and discouraged. Cost recovery is not a substitute for budget processes that enable some local authority over budget allocation towards defined needs.

3.4 Governance and decentralisation

The discussion on participation in relation to resources for health leads to wider concerns around the governance systems within which policy reforms are defined and shaped. The most significant shift in governance within health systems in the past decade has been around decentralisation. It has generated significant public expectation of shifts in authority and responsibility, including widening participation in governance in health. Decentralisation policies have also claimed potential outcomes of improvements in quality and access, and reduced expenditure (even though it would appear that some of these are mutually incompatible (Mogedal and Hodne Steen 1995)).

In fact, there is weak evidence of promised benefits in accountability or in increased public participation (Gilson et al 1994, Gaventa and Robinson 1998). These seem to relate to a number of unaddressed constraints:

- local level planning being linked with centrally imposed budgets, with little room for local discretion (Gilson et al 1994).
- inadequate inclusion of specific measures to enhance accountability, community participation or intersectoral co-ordination (Lauglo and Molutsi 1995).
- weak support of measures for local public health surveillance and planning based on population indicators, leading to greater bureaucratic inputs to decision making
- poor communication on or understanding of the content or implications of decentralisation (CWGH 1997).
- central government appointed boards with little accountability to the public, or 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)

Decentralisation has in many situations taken place in a poorly defined legal framework, with inadequate resources, qualified personnel, transport and other inputs for planning and monitoring health activities. Under-resourced health workers in this situation are likely to regard public demands for accountability and greater control as a burden rather than an asset.

It would appear that it is not sufficient to provide for structures for planning and managing health systems, but that attention needs to be given to who is involved in them, and the processes and procedures that take place within them.

In Zimbabwe, there are many planning structures in policy, but field research indicated that these faced a number of problems in practice, undermining their role in health systems, particularly in raising the priorities of low income communities. These problems included top down nomination of members; lack of regular elections; lack of direct participation of many civic and traditional leaders; ambiguities in authority and roles; lack of control of any meaningful level of resources at lower levels; limited powers for raising local revenue; weak capacity for planning; dominance of technical over elected personnel, low levels of beneficiary participation and feedback; weak relationship between district / provincial plans and sectoral budget allocations; disinterest in these structures by health staff who do not see themselves as accountable to these structures; lack of meaningful feedback to communities; lack of incentives or reimbursement for local committee members (Stewart et al 1994; Mutizwa-Mangiza 1990; Loewenson et al 1999a).

The regional meeting on participation endorsed the need to invest more attention to designing governance systems in health. Uneven power relations in the interactions between health services and various fractions of the community were observed to impact on the partnership implied in participatory systems. Technical power often over-rides elected power, and health workers may use their knowledge, technical status or budget controls to over-ride community inputs. Political authority may marginalise civic input. The meeting observed the need for structures, processes and tools that enable different forms of authority to interact productively (EQUINET/TARSC 2000).

4. Enhancing the social dimensions of equity

The literature, field work, and regional exchange indicate a co-existence of initiative and promising practice with significant institutional weaknesses in the structuring of the social dimensions of equity. What measures can be taken within the region to strengthen these dimensions?

4.1 Use and enhance social networks for health

There are a range of existing social networks such as neighbourhood committees, womens groups, religious groups, farmers groups that can be tapped and strengthened to:

- transform public understanding, information and attitudes and promote healthy public choices
- inform health systems on community perceptions, preferences and actions and enhancing the social and cultural appropriateness of health actions
- extend the outreach of health systems to underserved groups
- build more effective interactions between health services and clients at individual and collective level
- extend the continuum of health management and outreach into the community
- enhance community control over and commitment to health interventions.

Health sector work with such networks strengthen the networks and health outreach, and represent a 'win-win' situation.

For vertical equity, focus would need to be given to how do the poorest groups, who are often least organised, obtain a voice and representation in health and social processes.

Their primary preoccupations generally lie outside health, and relate more to survival issues of employment, incomes and access to infrastructures. Obtaining sustained representation from and networking in such groups is difficult, particularly given their limited resources. Special interest groups that have greater focus on health may have more resources for participation, but may also be far less representative of the real voices of the poor or of constituents generally. Sustained networking in the most marginalised groups demands specific measures, such as giving resource and institutional support to special interest groups that give a higher profile for their interests. There is a risk of co-option when health services take on this role, and other community or local government intermediaries may better networking in vulnerable groups. Hence, for example, the Community Working Group on Health in Zimbabwe networks about twenty-five membership based groups in Zimbabwe covering 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 group enables weaker groups and stronger to develop a combined voice on health policies, for solidarity to grow across groups, such as across rural and urban areas, in relation to people with disability or HIV/AIDS or across gender, and to use such networks to strengthen informed participation in local health planning (Loewenson 1999).

Social networking calls for specific investments in supporting these networks, perhaps not only in what they do around health, but around the employment, social, income and other concerns that they have. Adolescent reproductive health programmes that work through youth groups have for example increasingly taken on issues of vocational training and job creation to sustain health outreach.

Social networks are also reinforced by processes that do not dominate them, but that seek to draw out, recognise, use and add to their experiences and skills. Participatory approaches are recognised for their effectiveness in doing this as they explicitly aim, whether through processes of research, education or action, at social transformation. The process follows a cycle (or spiral) of steps that are important for social consciousness and transformation, viz:

- listening to and drawing out local community experiences and views
- systematising individual experiences and perceptions into collective forms and subjecting it to collective validation
- identifying the problems that need to be addressed (problematizing)
- collecting and organising information relevant to identified problems
- recovery of popular knowledge, use of other sources of knowledge and creation of new knowledge,
- identification of actions,
- implementation of actions and
- reflection on actions.

Innovation that supports social networking has also taken place, for example, through the establishment of social funds that are bottom up, demand driven and that incorporate some level of community control. They are a pool of funds, sometimes earmarked for specific sectors or specific areas of high incidence of poverty, that are used by communities to support local infrastructural and programme investments. These funds have been used in the main to finance small public works projects, attracting primarily

donor fund support. In health, they have been applied in areas such as water supplies and sanitation, nutrition, HIV/AIDS prevention and management, health centre development, waste management, food hygiene and school health. Use of the social fund is triggered by project requests coming from communities, and require some form of matching community contribution (labour, material, cash).

These innovations represent an important opportunity to locate control over resources at the level of affected communities. They imply however that the poorest communities will be able to network to exercise effective demand over these funds, and will effectively negotiate their own interests with powerful bureaucracies and service providers. This is probably not a fair assumption, without either the state or civil society contributing to the community networking and capacities needed to identify needs and programmes, make organised demands on the funds or monitor their use. When state and civil society actors take on these roles, they need to do so without usurping the role of the community (Firgenti et al 1998).

EQUINET could usefully map the civic groups that can support work in enhancing social networking for health. Equally, research is needed to identify ways of measuring social isolation and networking as a factor in resource allocation mechanisms and in studies of health equity.

4.2 Integrate health into wider development or poverty reduction programmes

As noted earlier, health may not be the only, or even the best entry point into communities for enhancing social networking or addressing community priorities. Linking the health sector to multisectoral actions around poverty and economic development calls for stronger articulation of health-poverty links, and measures for incorporating health interventions into economic policies and poverty reduction strategies. The regional meeting suggested that communities know and understand that health is linked to other dimensions of development/poverty – but bureaucratic systems miss the point!

It would be useful for EQUINET in its future work to develop further the conceptual understanding of these health-development-poverty links, and how they can be operationalised within health systems and economic measures.

4.3 Build structures and processes for participation

Interactions between services and citizens call for stable, transparent structures and processes. These exist at various levels of health systems, and need to be revitalised and consolidated in a more systematic manner. It is suggested that they should be inclusive of elected, civil, traditional and health sector representatives, and that measures be put in place to ensure that such committees are regularly reviewed, trained and supported with information for their roles. It is not clear whether putting health services under the local authority or in a parallel system works better, but in both cases the inclusion of community representatives on health boards, particularly those from low income groups, enhance accountability and ownership of services (EQUINET/TARSC 2000).

The literature documents problems when there is inadequate structural support, weak information access, limited authority and vague roles. Community - service interactions are weaker when there are too many poorly co-ordinated, poorly resourced issue specific forums; with weak abilities and procedures for resolving conflict; poorly supported by information, and with weak legitimacy. They are undermined when managers and service providers have weak incentives to respond to directions given by participatory structures and are resistant to or poorly prepared for changes in authority or for using non medical inputs. Equally weakened citizen interest, paternalistic cultures, illiteracy and weak civil capacities also undermine these interactions (Kahassy et al 1997; Kahassy and Baum 1996; Bennett et al 1995; Gilson et al 1994). Such structures thus need to be given clear roles and mandates, supported by information and evidence, by legal authority over resources and by responsive health services (further discussed below).

Hospital boards are, for example, 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).

In part this relates to the capacity and willingness of the state to move from direct to indirect ways of ensuring national goals, such as equity. The state has a number of tools at its disposal to ensure consistency with public health priorities and goals in activities by non state actors. National priorities and essential public health measures can be built into social contracts through legal mandates, tax incentives, subsidies and grants for prioritised areas, matching grants, directing complementary state resources towards particular outcomes or setting up performance contracts and building in budget rewards and penalties for particular outputs. The state may also use its powers of supervision and inspection to monitor public health practice and standards of such work. The demand from stakeholders for use of such indirect approaches comes at a time when the state has weak resources for defining and implementing them. This may lead to imposition of measures that should in fact be negotiated, and that are thus poorly complied with. It may also lead to weak state use of the tools it has for equity goals, widening inequity in the public-private mix. It may be useful to disseminate information on such tools and support capacity for their development and use.

4.4 Enhance information exchange between communities and health systems and integrate community information in planning

Information flow between the public and health systems is the circulatory system of enhanced governance. Information flow has in the past been largely limited to dissemination of health promotion information, but communities today also need systems information, such as on resources for health that they can access and how to access them.

Some of the vehicles for information flow between health systems and communities are outlined in Table 4 below.

TABLE 4: MECHANISMS FOR INFORMATION FLOW BETWEEN HEALTH SYSTEMS AND THE PUBLIC

INFORMATION FLOW	MECHANISMS
Mechanisms for gathering information on public needs and preferences	Surveys, Opinion surveys, ideas competitions, key informant input, use of print and electronic media, PRA approaches, Participatory health appraisals
Mechanisms for communicating information to the public on health profiles, policies / activities	White papers; charts and posters in health and public facilities, discussion documents, 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 public feedback to health planners	Advertising decisions with -procedures for people to lodge objections; public inquiries; public hearings; holding public meetings, lectures and discussion sessions;

Source: Loewenson 1999

Health systems need themselves to be more systematic and transparent in how evidence is used in decision making if wider stakeholders are to be involved, which is positive in itself. Hence for example, the Tanzania Essential Health Interventions Project, has strengthened the use of health systems evidence (disease burden, cost effectiveness of available interventions) , thus enabling the health system to take on community preferences and priorities in a more transparent manner (Reid and Kasale 2000). Evidence on public opinion can be included in health planning through opinion surveys (as has been done in Zambia), anonymous postal surveys, focus groups, PRA tools and citizens juries. This is often done as a parallel process to the budgeting or decision making process, as a means of ensuring that decisions are in line with public values. More direct integration of community preferences with health system information is an area where methods are weak. There is still room for innovation that EQUINET can support.

One of the most important areas to address is the building of a 'common language' between health professionals and civil society groups. PRA approaches enable this by systematising community knowledge, as do civic organisations who act as intermediaries and blend public views with available data and technical information. Health services can organise health information through various forms of mapping and charts to visually represent trends and distributions. Medical terminology can be simply put. It is important to recognise and take active measures to overcome the profound disempowerment observed

bureaucrats. For constituent groups that represent low income communities, participating in state/civil interactions may demand parallel processes to ‘prepare for partnerships’, where groups can frame their issues, understand more about health information and specify clear positions and inputs to joint agendas. For health service providers it implies presenting health information and choices in publicly accessible forms and building communication and negotiation skills. The work of the Health Systems Trust in South Africa to support parliamentarians as key actors in the budget process to measure progress towards equity gives evidence of how information on budgets and health equity measures can be demystified to facilitate the role of representative structures in resource allocation in a manner that supports equity goals (Health Systems Trust 1998).

4.5 Link representative structures with authority over resources

The tension around decision making over resource allocation and mobilisation signal that there is a need to revisit these processes within health systems. Fiscal decentralisation, or devolution of authority over revenue or expenditure decisions to lower levels of government or health systems is one option for strengthening local participation, and making systems more accountable to local communities. As noted earlier, however, this only happens if done in a manner that specifically provides for participation of all groups and protects the interests of vulnerable groups. Hence for example measures are needed that make localised revenue control more transparent and accountable and for ensuring that expenditures match wider public priorities (Litvak et al 2000).

Revenue raising strategies need to pay attention to consultation with and ownership by affected communities, value placed on both cash and in kind contributions, local control of revenue and materials collected, the visible impact on quality and reliability of service inputs, and the measures for protecting equity. They also need to work through structures that involve community representatives.

At central level promising practice is found an evidence based resource allocation criteria that enable greater transparency and equity in district allocations, with provision for wider public information, input and debate on budget allocations to and within health. In Tanzania and South Africa, for example, breaking budget processes into stages and allowing for public input between stages enhances accountability. Where planning is evidence led (eg TEHIP Tanzania, this is noted to enhance public accountability. Accountability is further noted to be enhanced where funding benchmarks are expressed as per capita information, and where health financing is related to policies and programmes through national health accounts systems. Further examples exist of budget monitoring in relation to children, gender issues, (eg: the womens budget South Africa) that may be informative for budget monitoring for health (Klugman and McIntyre 2000).

District and sector wide funds do present an important opportunity for more innovative approaches towards linking community planning and inputs with accessible resources. Analysis of the performance of the first two years of these funds in Zimbabwe indicated problems of slow uptake due to uncertainty about procedures for their use; variable levels of fee collection; weak application of allocative guidelines, particularly in terms of community based interventions, strong demand from large hospitals and weak community

knowledge of the funds (Loewenson 2000). Such problems noted earlier indicate that they need to

- more clearly earmark, encourage and monitor the share of the funds for community programmes, preventive inputs and clinic level inputs; . Examples from Zambia of earmarking of basket funds were however found to have positive impact on allocations to community level (EQUINET/TARSC. 2000)
- provide clear guidelines for and actively inform all relevant community level, rural council, non government groups on how to access the funds, particularly through demand driven processes that demonstrate and respond to community initiative;
- provide intermediary support to communities to identify needs and programmes through local structures that can be supported by such funding.
- ensure low income group representation on health and hospital boards and on committees that manage health funds;
- enhance management capacities at health centre level to decentralise management of earmarked shares of funds to this level.

Work is needed to integrate health evidence on deprivation and community preferences into resource allocation formulae and measures. There is also scope for wider regional exchange of experience on the performance of district funds, particularly in relation to vertical equity.

4.6 *Strengthen primary health care services*

It has already been noted that effective participation cannot substitute for and can best be levered by a minimum level of health service provision. In the Zimbabwe research, community, local government and health workers felt that community inputs to prevention and promotion could be doubled if:

- * people could access in a sustained and reliable manner the right balance of technical and material resources to match their own efforts and halt the decline in these inputs;
- * people could access adequate information, and health services recognise and use people's knowledge to a greater extent;
- * health services paid more attention to prevention, to transport for outreach work and increased the level and support of community based/ field personnel (Loewenson et al 1999).

There are further also challenges for health systems in moving from 'supply' to 'demand' driven health programmes. Compromise and flexibility is needed. Health systems need to accommodate and work with community perceptions that may not be shared by health workers, to take the time to develop shared perceptions. Community based health workers are critical to the interface, and their provision, skills, outreach resources should not be left to ad hoc or donor allocations.

Health workers themselves need supportive inputs to facilitate more productive interactions with their clients. At minimum community interactions should not be a matter for only personal reward, but one that is reinforced through institutional reward and through signals and incentives sent from policy and planning levels of health systems. Health workers need themselves to be supported to manage change. In South Africa, the Health Workers for Change (HWFC) programme, facilitated through the

Womens Health Project, a University based NGO, used a change management methodology aimed at building health worker morale and positive attitudes towards health system functioning. Health workers are supported to identify health system problems, identifying causes and impacts of gender inequality on health systems, to identify problems in health worker-client interactions and to solve these problems collectively (Klugman and McIntyre 2000). In Zimbabwe, the Essentials Drug Programme has built on its training of health workers in more 'client friendly' approaches by linking with the civil society based Community Working Group on Health to generate joint health worker-client dialogue on ways of improving health services for *both* clients and health workers.

4.7 Provide for community roles in enhancing the responsiveness of health systems

Quality of care is an issue that has preoccupied people as 'consumers' of health services, and led to campaigns such as that of Consumers International to profile patient rights as a means of drawing attention to deviations from acceptable standards of care, as perceived by the public. The patient rights charter provides a 'rights based' approach, but often one that depends on individual willingness to take legal or other remedies. This is weaker in poorer groups, who may fear being victimised if they take up disputes with health services. It also often targets attention on individual services or health workers, when the problems raised may relate back to decisions on health systems and resource allocations that are taken at much higher levels.

Hence while the patient rights charters are a necessary intervention, they are often not sufficient, and more proactive and collective approaches are needed to ensure quality of care and responsive health systems. Surveys can raise issues that reflect community /client satisfaction with health services, and used these in joint health-civil-local government committees or meetings to discuss the measures that should be put in place to enhance health service performance in these areas. In Zambia, for example, surveys of perceived quality have used to partly link user charges to health service performance as perceived by communities. Zambian health reforms structure partnerships between health services/workers, communities and NGOs through legislated neighbourhood health committees, health centre committees, district health management boards and the national Central board of health. A survey of the performance of health reforms indicated that communities felt that their fee contributions to health services should be matched by quality improvements in areas that they prioritised more highly, including drug availability, food for patients, patient comfort and staff attitudes. To respond to the community issues raised, guidelines now stipulate that increases in user fees must be associated with demonstrable improvements to at least one attribute of community perceptions of quality of care at local level decided at the local health facility in consultation with community representatives (Ngulube 2000).

It would be useful to develop and disseminate the protocols for such surveys, ensure that their application includes vulnerable groups, and possibly incorporate measures of community satisfaction, participation and access in more regular sentinel site surveillance that links to planning systems.

4.8 Build capacities for enhancing the social dimensions of equity

Introducing change to support the social dimensions of equity call for capacities within health systems, such as information management and communications skills, legal capacities, negotiation skills, or the facilitation skills needed for participating in wider social mobilisation. The regional meeting on participation prioritised team building, communication, facilitation, planning and management, including financial management, use of information / evidence for planning and prioritisation and skills and understanding for intersectoral collaboration.

Equally, community, elected and civil leaders need range of capacities to play a meaningful role. Some of these are shown in Table 5 below.

TABLE 5: CAPACITIES FOR CIVIC ROLES IN HEALTH

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

The regional meeting proposed that community groups also need basic skills in community organisation, how to hold meetings, literacy, survival skills and mobilisation and advocacy skills. It was observed that all of these capacities exist within the region, and that what is needed are the exchanges, tools, materials and institutional networking for wider capacity development.

Finally,

This paper highlights three social dimensions of equity that need greater policy and programme attention, if vertical equity and pro-poor policies are to be achieved. It

proposes the principles that can inform measures for addressing these dimensions. These are drawn not only from technical review, but also from communities within the region. It also highlights the fact that there is promising practice within the region and capacities on which to build. It is a social investment well within our grasp, and to quote from one civil society programme in Asia:

“In a world best by vicious cycles and downward ecological, economic and political spirals, we can use some virtuous cycles and upward spirals in which the ‘poor get richer’” (Brown and Ashram 1996).

Bibliography

Bennett S, Russell S, Mills A (1995) Institutional and economic perspectives on government capacity to assume new roles in the health sector: a review of experience in University of Birmingham Series 'The role of government in Adjusting Economies' Paper 4, UK, November 1995

Community Working Group on Health (1997) HEALTH IN ZIMBABWE: Community perceptions and views Research report Zimbabwe, November 1997, Supported by OXFAM and TARSC

Community Working Group on Health (1998a) HEALTH IN ZIMBABWE: Report of a Meeting of Community Based Organisations Zimbabwe, January 1998, Supported by OXFAM and TARSC

Community Working Group on Health (1998b) HEALTH FINANCING IN ZIMBABWE Penguin Printers, Harare

Community Working Group on Health (1998c) REPORT OF A LOCAL MEETING OF Community Based Organisations: GWERU August 1998, TARSC, Zimbabwe

Community Working Group on Health, Essential Drug Programme MoHCW (1998d) REPORT OF A MEETING of Community Based Organisations on communication and information on Health, Harare, October 1998, TARSC, Zimbabwe

Cornwall A, Lucas H, Pasteur K (2000) Accountability through participation: Developing workable partnership models in the health sector IDS Bulletin Vol 31, No 1 January 2000

Development Administration Group (DAG) (1997) Zimbabwe: reforming the health sector: does government have the capacity? Paper 20 Development Administration Group, UK

EQUINET/TARSC (2000) Report of the TARSC/Equinet regional meeting on Public Participation in Health, in co-operation with IDRC (Canada) and WHO (AFRO/HSSD) Equinet policy series no 5 Benaby printers Harare

Frigenti L, Harth A, Huque R (1998) Local solutions to Regional Problems: The growth of social Funds and public works and employment projects in Sub-Saharan Africa, World Bank, Washington

Gaventa J Robinson M (1998) Influence from below and space from above: non elite action and pro-poor policies, IDS Sussex, Mimeo

Gilson L, Kilima P, Tanner M (1994) Local government decentralisation and the health sector in Tanzania Public Administration and Development 14(451-477)

Hansen K, Woelk G, Jackson H, Kerkhoven R, Manjonjori N, Maramba P, Mutambirwa J, Ndimande E, Vera E (1998) The cost of Home Based Care for HIV/AIDS Patients in Zimbabwe, memio report, Harare

Health Services Review Commission (1999) Inquiry into the health services in Zimbabwe, Government Printers, Harare, April 1999

Health Systems Trust (1999) The budget process; A guide for South African Legislators, The press Gang, Durban

Hongoro C and Chandiwana S Effects of User Fees on Health Care in Zimbabwe, Blair Laboratory / MoHCW, Mimeo Harare, 1994

Kahssay HM (ed) (1991) Community Involvement in District Health Systems , WHO SHS/DHS/91.4, Geneva

Kahssay HM and Baum F (1996) The role of civil society in District Health Systems , WHO/ARA/96.3, Geneva

Kalumba K (1997) Towards an equity-oriented policy of decentralisation in health systems under conditions of turbulence: The case of Zambia Discussion Paper No. 6 World Health Organisation: Zambia

Kaseke, Edwin, Maxwell Ndaradzi, 1993. A Situation Analysis of the Social Development Fund. Study Report for the Government of Zimbabwe and UNICEF, Harare, July.

Kawachi I, Kennedy BP, Lochner K, Prothrow-Stith D (1997) Social capital, income inequality and mortality American Journal of Public Health 87:1491-8

Klugman B, McIntyre D (2000) From policy, through budgets to implementation: Delivering quality health services, Report for the Womens Budget Initiative, May 2000

LaFond A (1995) Sustaining Primary Health Care Earthscan Publications Ltd London

Lauglo M, Molutsi P (1995) Decentralisation and health systems performance: The Botswana Case Study DIS Centre for Partnership in Development and University of Botswana, Botswana

Litvak J, Ahmad J, Bird R (2000) Rethinking decentralisation at the World Bank <http://www1.worldbank.org/wbiep/decentralisation/litvack.htm>

Loewenson R (1999) Public Participation in Health: Making People Matter IDS/TARSC Working paper no 84, Sussex March 1999

Loewenson R et al (1999) Public participation in Health systems: Report from participatory research in four districts of Zimbabwe with support from IDRC (Canada) TARSC/CWGH Monograph 18/99

Loewenson R/TARSC (1999b) Public participation in Health systems: Report of a national review meeting with support from IDRC (Canada) TARSC/CWGH Monograph 20/99

Loewenson R (2000) Putting your money where your mouth is: Participation in mobilising and allocating health resources Paper presented to the TARSC/Equinet regional meeting on Public Participation in Health, Harare, May 2000

Marmot M (1998) Improvement of social environment to improve health Lancet 351: 57-60

Meltzer J (2000) The Micropolitics of Civil Society and Citizen Participation, Report for IDRC (Canada), Canada

Mogedal S, Hodne Steen S (1995) Journal of International Health Development 7(3) 349-367

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 1997

Myezwa H, Mkumbuzi V (2000) Participation in Community Rehabilitation Programmes: Where are we? Paper presented to the TARSC/Equinet regional meeting on Public Participation in Health, Harare, May 2000

Ngulube TJ (2000) Monitoring and ensuring quality of health services: Impact of Community participation in Zambian Health Reforms Paper presented to the TARSC/Equinet regional meeting on Public Participation in Health, Harare, May 2000

Reid G, Kasale H (2000) Tanzania Essential Health Interventions Project Paper presented to the TARSC/Equinet regional meeting on Public Participation in Health, Harare, May 2000

Richardson R, Waddington C (1996) Allocating resources: Community involvement is not easy, *International Journal of Health Planning and Management* 11;307-315

Robinson M, White G (1997) The role of civil society in the provision of social services: the non market, voluntary sector, Mimeo, IDS (Sussex), UK

Smithson P, Asamoah-Baah A, Mills A (1997) The case of the Health Sector in Ghana experience in University of Birmingham Series 'The role of government in Adjusting Economies' Paper 26, UK, November 1997

Stewart F, Klugman J, Helmsing A (1994) Decentralisation in Zimbabwe UNDP Human Development Report Office Occasional Papers No 15, UNDP, New York

Storey P (1989) Health care in South Africa: the rights and responsibilities of the community *Medicine and Law* 7(6):649-655

UNDP (1999) World Development Report, New York

Van Rensburg H C, Fourie A (1994) Inequalities in South African health care. Part II Setting the record straight *South African Medical Journal* 84(2):99-103

Wilkinson RG (1997) Income inequality and social cohesion *American Journal of Public Health* 1504-6

World Bank (1996) Social Capital, Office Memorandum, Washington

World Health Organisation (1997) A new global health policy for the twenty first century: An NGO perspective, WHO, Geneva

World Health Organisation, Govt Ireland (1997) Poverty and Ill health in developing countries: Learning from NGOs, Meeting Report, Kildare, Ireland June 1996

World Health Organisation (2000) The World Health Report 2000: Health systems – Improving performance WHO Geneva

Zigora T, Chihanga S, Makahamadze R, Hongoro C, Ropi T (1996) An evaluation of the abolition of user fees at rural health centres and rural hospitals, Ministry of Health, Blair Research Laboratory, Mimeo

Zimbabwe Environmental Health Practitioners Association (2000) Memorandum to Parliamentarians, mimeo, Harare

Zimbabwe Essential Drugs Action Programme (1997) Next is not enough: A training manual to strengthen the interpersonal communications skills of health workers, ZEDAP, Harare