

Public participation in health systems Report of a Regional Meeting

Dr Rene Loewenson
Training and Research Support Centre
Harare, Zimbabwe



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1. Background

Participation of communities is widely argued to be an to improve health outcomes and the performance of health systems. Despite this participation is often loosely designed and hardly evaluated for its contribution to health outcomes. Participation takes many forms, and reflects varying degrees of community control over decision making in health systems. These different levels of community authority depend also on where authority is located within health systems (over planning, resource allocation etc) and how far health workers and managers are willing to widen the inclusion of different social groups in decisions that have often been under their control.

The TARSC/EQUINET meeting on public participation in health systems (May 17-19) was held to exchange experience and information and identify key issues in relation to participation across various dimensions of health systems. The meeting will seek to:

1. Understand better the various experiences of participation currently taking place
2. Identify key and replicable features of 'promising practices' that could be more widely disseminated
3. Identify areas for follow up investigation/ intervention/ action that can be taken forward, either through continued networking of delegates or other means.

The meeting aimed to do this across different dimensions of participation, including participation in

- health policy and planning
- implementing health interventions
- mobilising and allocating resources for health, and
- monitoring health systems.

The meeting process involved:

- case study presentations
- group discussions around theme areas, and
- sessions using participatory tools.

These drew key features of promising practices, identified issues for follow up research and practice, and reviewed ways in which the network of delegates and institutions at the meeting could co-operate in future work. The meeting involved participants from several southern African countries, as well as from UK, and from international organisations. Delegates came from community, health sector, civic, non government and academic backgrounds. The list of delegates is shown in Appendix 1

2. Opening and discussions on participation

2.1 Opening presentations

The opening was chaired by Dr R Loewenson, who welcomed delegates, outlined the objectives of the meeting, and gave time for all delegates to introduce themselves. Dr D Dhlakama, Deputy Secretary in the Ministry of Health, welcomed the delegates to Zimbabwe and gave an outline of the health situation in Zimbabwe and the measures being put in place to enhance public participation. He noted that the MoHCW National Health Strategy "Working for Quality and Equity in Health" and the report of the Commission of Review into the Health Sector outline key policies and strategies within health in Zimbabwe. These note reversals of post independence health sector successes and deterioration in the quality of health services. They also both raise the importance of community participation in the health sector. Despite participation having been accepted in policy for some time, it has not been completely 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.

The Health Review Commission called for a revival of the community health movement through:

- empowering and working with communities,
- strengthening community based health workers, and
- improved local surveillance.

This calls for wider involvement in defining the priorities to be addressed, making people know their rights and responsibilities in relation to health, reintroducing the community (village) health worker and reorienting health workers towards community involvement. Structures for participation, such as the Public Health Advisory Board, Hospital Advisory Boards, Health Centre Committees, need to be strengthened, and to include the civic group participation which is getting stronger.

Dr Rufaro Chatora, Director Health Systems and Services Development, WHO (AFRO) officially opened the meeting. He noted the increasing complexity of health systems, and the fact that some measures have reduced, rather than increased client satisfaction with or access to health services. The demand for greater participation in health has been present since primary health care in the 1970s, and while it is accepted as a norm, much remains to be done to operationalise this. Hence people should be involved in defining the positive health outcomes they seek from health systems, and the approaches to service provision to achieve these. Health Services need to consider issues such as personal dignity and social norms. All social groups should have a role in deciding on how health systems should be organised and on fair financing arrangements. He welcomed EQUINETs work and called for its wider coverage both in terms of coverage and comprehensiveness of approaches advocated for.

2.2 Reflections on participation

Simone Goosens from WHO (AFRO) HSSD outlined issues relating to participation in the context of WHP priorities. She too noted the longstanding policy commitment to participation across a number of global health policies, including the most recent 'Health for All in the 21st Century' policy. Responsiveness of health systems was an important part of this policy, involving participation from individual level, in personal health decisions, to national level in policy and strategy formulation. WHO support for participation in health comes in a range of programmes and disease related activities. It is built on partnership between individuals, groups, organisations and health professionals.

Following the formal introductions and opening, delegates reflected on issues relating to participation.

Critical resources for health include:

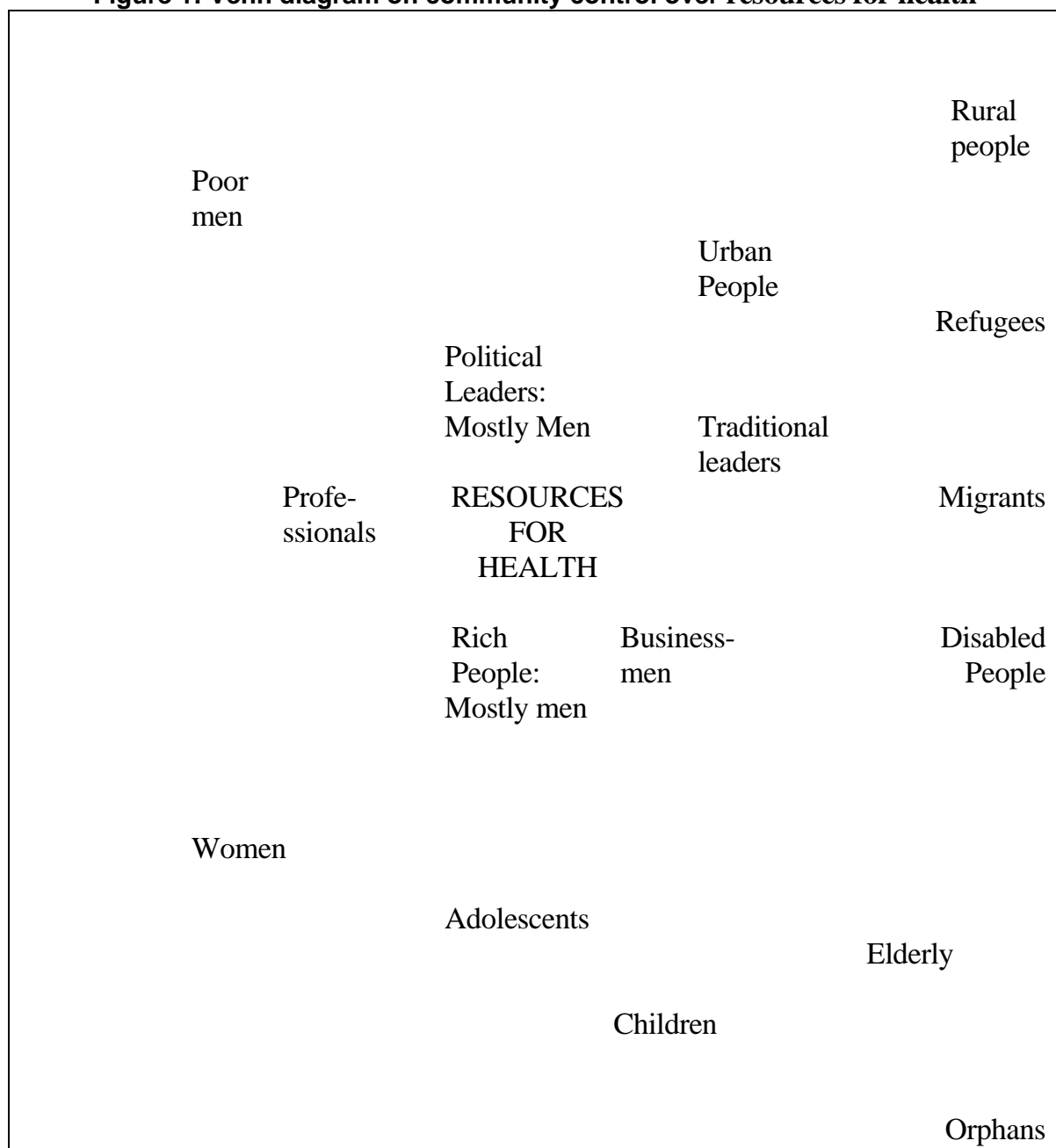
- Security, confidence, food, clean water, toilets, shelter, having a close friend and a peaceful and stable family.
- In terms of health sector inputs: health information, health services, vaccinations, essential drugs and so on.

How much control do different social groups have over these resources and how significant are these social groups. Figure 1 overleaf below shows the views of the delegates.

From the Venn diagram it was felt that those with greatest health needs, who are often large population groups, have least control over health resources. In this inequitable situation, it was agreed that 'participation' should not simply mean more activity within a social group, but activity aimed at enhancing control over health resources.

Delegates wrote down the way they defined participation. This was held until the last session for final discussion, and is presented in the last section of the report.

Figure 1: Venn diagram on community control over resources for health



Some of the key questions that people would want to address at the meeting included:

- What do we mean by participation? What rights and duties does it imply? Where should control lie at different levels of the health system?
- What are the benefits of participation to the individual, community and services?
- How do we change the attitudes of service providers and communities towards more genuine forms of participation?
- What activities and roles enhance participation, with what resource inputs?
- How can participation be sustained?
- Is health the right entry point for building participatory systems?

3. Participation in health policy and planning

"Kupanga Ni Kuchagua" (to plan is to chose)
Julius Nyerere, 1965.

The session reviewed experiences from national to neighbourhood level! Prof Noddi Jinabhai outlined management challenges in South Africa Health Systems Reform in the efforts to 'turn the hospital ship around' and reorient resources towards key public health challenges. From a situation assessment of the current health sector, a new policy and legal framework was developed that would emphasise district health services and redefine the role of the hospital. This would need to respond to poverty in the community as a key determinant of ill health and deal with the fact that hospitals consume in a relatively inefficient manner most current health care resources. Such shifts towards a new organisational framework involves concepts poorly understood (or accepted) by clinical professionals, is a political issue and demands links between service changes and budget plans and cycles. Prof Jinabhai outlined the measures taken in South Africa towards implementing health reforms, particularly the legal reforms, and the major focus on personnel and financial management. He questioned the real impact as yet on service delivery and whether the public private partnerships around management models would make the real changes needed in the public health system. Threats included powerful lobbies and pressures for less equitable systems of health care, and still weak systems for wider public accountability within reform processes.

Graham Reid (TEHIP) Tanzania discussed the process of health reforms in Tanzania, and the questions it raises, particularly in the context of decentralisation. Managing reforms places great focus on district health planning processes, in which TEHIP has tried to enhance evidence led planning on the burden of disease, the cost effectiveness of available interventions, community preferences and health system capacities. The planning system relates burden of disease information to interventions that can address various shares of the burden of disease, and the budget shares allocated to these interventions/ disease burdens as a means of influencing budget priorities. The system also tracks access, utilisation and service trends for health facilities as a means of enhancing health service performance. By making health planning a more transparent and evidence led process it is not only more efficient but also more accessible to wider participation.

John Milimo (PAGZAM, Zambia) focussed on participation at neighbourhood level. He outlined various forms of community participation currently taking place in Zambia, and particularly the ownership derived from such forms of participation. He focused on the neighbourhood committees as a tool for moving from contributing labour to more meaningful forms of participation in planning. Democratically elected committees performed better than appointed committees, and were more innovative in meeting health challenges. One obstacle to effective planning at neighborhood level is their lack of real resource control, and the inability of the district to respond to their resource demands. This calls for clearer definition of the partnerships from central to local level and between communities and health providers. It also calls for sharing of relevant information and training of democratically elected structures.

Tito Runganga (ZNFPC Zimbabwe) described a programme that aimed to respond to perceived needs of a more marginal group at community level - adolescent youth. The programme used existing resources in the community (extension workers, teachers etc) to act as links between services and youth, provided for youth and technical based assessment of priority needs, and sensitised and trained health service staff to provide more 'youth friendly' services. It highlighted the need for acting in both the community and the health system to enhance participation, and for intermediaries between marginal groups and services.

3.1 Discussions on issues arising

Two groups reviewed what we know about participation in policy and planning for health systems, and how this can be better implemented. Two groups reviewed gaps in our knowledge and how to address these. The summary of the discussions is shown below.

3.1.1 *What do we know about participation in health policy and planning*

- Health may not always be the best entry point for participatory work in health policy and planning. 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. Further communities may want to address priority issues around poverty before dealing with health service issues.
- Power relations are uneven in the interaction between health services and various fractions of the community and this will impact on the partnership implied in participatory systems. Technical power often over-rides elected power, and health workers may use their knowledge or technical status to over-ride community inputs. Political authority may marginalise civic input. Genuine participation needs to find structures, processes and tools that enable different forms of authority to interact productively.
- Resources need to flow to give substance to authority. Where central control over resources does not match local planning participation is undermined and discouraged. Given differences in the priorities of central and local level, there is need for budget processes that enable some local authority over budget allocation towards defined needs.
- Tools for priority setting need to involve communities, and link public perceptions to evidence-based processes.
- Policy often 'follows' rather than leading intervention - there is a need for processes that set and inform people on policy guidelines for local planning
- There is need for a minimum level of health service provision and standards to get the community buy in for their input and motivation for participation. Participation is not a substitute for poor services.

3.1.2 *What to do to better implement what we know?*

- If poverty and health are linked issues in community participation there is need to review the role of the village health worker to ensure that single purpose functions like health are linked to multisectoral poverty related work. Communities know and understand that health is linked to other dimensions of development/poverty - it may be the bureaucrats that miss the point! Hence donor and state systems need to link work on participation and health with wider development action programmes.
- Poverty related work calls for multisectoral approaches that conflict with sectorial bureaucracies. This is best overcome through bottom up, integrated planning with resources that can respond to such planning. More work needs to go into structuring and making accessible such social action funds.
- Structures for participation should be inclusive, involving civil, elected and traditional leaders, and all health providers. Processes within such structures will encourage participation if they include Participatory Reflection and Action tools, if specific input is made to reorient health worker attitudes and skills for this, if community members are literate, and if information sharing uses accessible forms of information for all social groups.
- Policy guidelines for participation should be clear and available to the public to facilitate their role. In particular investment should be made in capacities, tools and information for 'bottom up' planning, in community based needs assessment using PRA approaches within both communities and health systems, in literacy, in community level surveillance systems and in making information accessible in local languages.

3.1.3 *What are the gaps in our knowledge about participation in policy and planning*

- There are still gaps, particularly within health planning, in how to link health to wider issues of concern to communities, and in the way political and social structures work. This leads to a number of areas where the knowledge base is weak, such as in how to engage communities on health issues and draw out their experience and knowledge, how communities manage their health concerns, how decision making takes place outside

health in powerful groups and how to influence these decision making processes, and how the health system itself disempowers people.

- There are also areas where knowledge is weak in relation to mechanisms for participation, including how to include community priorities in health planning, how to link local planning with budget / resource allocation processes, how to link technical and community level information, and how to link health information and processes with those of other sectors.
- In addressing these gaps there are questions about whether health workers are themselves the best 'agency' for enhanced participation and accountability and for enhancing the struggle for health rights, or whether this comes from other quarters.

3.1.4 How can the gaps be filled?

- Greater use can be made of PRA approaches in drawing out and systematising community knowledge. At the same time investment is needed in simplified guidelines for budget analysis, health priority setting etc as a means of engaging communities on technical areas.
- Research is needed on the impact of participatory mechanisms to enhance their wider application. There is also need for social mapping of key stakeholders and their role in decisions and resource inputs to health.
- Greater information sharing is needed between health and other sectors, between civic groups, health worker organisations, and other related groups, to build a wider knowledge base and skills for intersectoral and participation work. Key research findings, for example, should not be kept within the health sector, but shared at a wider level.

This preliminary 'brainstorming' session of discussion was consolidated in later discussions of 'promising practices' reported in a later section.

4. Implementing health interventions

Catalysing participation for health can create social change more broadly. What are the most promising and effective interventions that can nurture these transformations?

M Bangser, Womens Dignity Project

A number of case studies at the meeting related to enhancing participation in implementing health interventions. The full papers are shown in Appendix 1.

Harun Kasale (TEHIP) Tanzania discussed further the TEHIP work on prioritising health interventions at district level. The evidence on where budget allocations were being made in relation to disease burdens and in relation to cost benefit analysis of different interventions was used to direct planning attention to key interventions. At the same time health workers were trained for clinical and management skills to support these interventions, and health service supervision was also strengthened. Community labour based methods were used to strengthen dispensaries. This has led to expansion of selected interventions within the districts and an increased utilisation of health facilities. Additional funding given by TEHIP for health interventions has been used to a limited extent (80c per capita out of \$2 per capita allocated), but the investment in health planning and management systems has enhanced the effective use of other funds invested in health interventions.

Dalphine Chirimuuta, (AMWUZ/CWGH Zimbabwe) described the work of the network of civic groups formed in Zimbabwe to act on health issues, called the Community Working Group on Health. The network involves about 25 civic organisations outside the health sector that have taken on a greater role in linking communities with key resources and authorities that influence their health and that support and inform communities in those links. She outlined work on farms and mines in Arcturus where primary health care issues were profiled and advocated for by the community and the CWGH, and health services and other authorities brought in by the CWGH to address these issues. Given the high degree of marginalisation

of farmworker communities, having a more powerful network of civic groups to facilitate their collective work and advocacy has strengthened their own interest and involvement in health issues.

Maggie Bangser (Womens Dignity Project Tanzania) described work with an extremely marginal group of young women and adolescents who suffered obstetric fistula. The project has in the first stages strengthened the capacity of the health system to manage fistula and is now at a stage where there are opportunities for wider community participation in researching with the community on prevention of fistula and reintegration of women with fistula into the community, engaging communities and health workers in the health service factors leading to fistula, and mobilising community action on reproductive health actions for prevention of fistula. The paper raised questions of how marginal groups are brought into planning, particularly where their health problems are poorly noticed, and of how these groups could be strengthened so that their participation goes beyond token acknowledgement of and response to their vulnerability. It also raises the question of how participation could act as a bridge between health inputs and the wider changes needed to transform the lives of poor women.

Bongiwe Mhlauli, Busisiwe Skrweqe and Wendy Hall (Mtwane Clinic, South Africa) presented a case study of how a clinic in an under-resourced area and the community it serves formed a partnership to address problems of access to health services. The community was brought in through a clinic committee which identified health problems and priority actions. The community mobilised their own resources and an outreach service was initiated, linking to the community through village health workers. The presenters noted that the programme success was derived from the string outreach services from the clinic, paid for by the community themselves, the support from voluntary health workers and the specific activities for groups such as the elderly and mentally ill, supported through strong communication between community leaders and health staff.

Willy Goma (Zambian Shanty Development Organisation, Zambia) outlined the origins of his organisation, and the manner in which an economic activity for poor urban dwellers integrated health and addressed health needs of their members. This was achieved through a mix of training of care givers, nutrition promotion, and strengthening links with the clinic in the area.

Helen Myezwa (GTZ Zimbabwe) reviewed community based rehabilitation programmes in Zimbabwe for their inclusion of participation. Key features of CBR involve social mobilisation and awareness raising, education and training, survey and needs analysis and implementation of activities in response to the needs assessment. She noted constraints to participation, including social attitudes and knowledge, community expectations, poverty, other overwhelming health problems, health worker attitudes, and the centralisation of health systems. Her analysis of both the Zimbabwean CBR programme and evidence from the literature pointed to a strong link between participation and sustainability of programmes, and a link with more acceptable and relevant approaches to rehabilitation. The issues as yet remained unaddressed, however, as to how to mainstream this into the entire health system.

5. Resource allocation and mobilisation

"Paying more, getting less - time to act!"

Community Working Group on Health Poster, Zimbabwe

Rene Loewenson (TARSC Zimbabwe) outlined issues relating to participation in resource allocation and mobilisation. She noted that recent pressures for participation relate strongly to resourcing health systems, both for clients and health providers. Hence reaching agreed and acceptable levels of shared control over resources between clients and providers is important for sustaining health systems and for other forms of community involvement in health. She outlined existing mechanisms for decision making on resources and highlighted a problem observed in other countries of responsibilities and planning roles not being

matched by authority over either resource mobilisation or allocation, particularly closer to community level. While communities were willing to contribute towards health systems, negative lessons from the history of user fees indicated that community contributions need to be locally organised, to address local priorities, with value placed on cash and kind contributions, with visible impact on quality and relevance of services, locally applied and collective measures for ensuring equity and organised and managed through representative structures such as health centre committees. At the same time community resource mobilisation depends on wider accountability and responsiveness in budget resource allocation systems. A review of the new Health Services Fund indicates that representation of low income groups on committees that decide on resource allocation and clear measures to earmark or ensure allocations for community and primary care activities may be necessary for accountability and responsiveness of such funds to community inputs.

Peter Magundani (Marondera Municipality, Zimbabwe) outlined the current health financing difficulties facing urban local authorities, particularly in the 1990s. Severely reduced government subventions to urban local authorities but continued central control over local revenue raising mechanisms put local authorities in a difficult financial position, with no alternative financing arrangements in place. This has led to declining quality of services, and community resistance to higher rates contributions. He observed that for wider community ownership and contribution to health services, representative structures of communities need to be more involved in local decision making on health, that services need to be more responsive to community preferences, and the budget processes and financing agreements with urban local authorities need to include on consultation with communities on their rights and responsibilities.

Bruce Mukwatu (Zambia Integrated Health Programme, Zambia) described the Zambia Central Board of Health's establishment of a Community Health Innovation Fund (CHIF) to provide financial resources to community health innovations. Further 2% of the district health grant is allocated for community health activities and 85% of user fees are used at the level of collection to support community action plans. He noted the framework of neighbourhood and health centre committees through which priorities are set and communities mobilise resources, including in kind inputs, user fees and the CHIF. These funds are banked and managed by the health committee members and health centre staff. Visits by health provider and community stakeholders supports effective use of resources. He noted that successful local resource mobilisation and use often attracts external participation.

6. Monitoring health systems

While we recognise that the clinic building has been nicely painted, we cannot drink paint as medicine when we are sick. We need drugs at our health facility.

Community views, Zambia client perception survey

Ruramisai Gandiwa (ZNFPC Zimbabwe) outlined the work of ZNFPC to respond to client demands for quality of care within family planning services in Zimbabwe. Key to this is the network of Community Based Distributors (CBDs) who are a link with the community, and the establishment of a rights based framework that clearly articulates client rights (such as to access, safety, information, choice etc) in relation to their services. The CBDs are elected by and report to the communities and their supervision incorporates community feedback. The CBD approach has been found to cater to client needs for access, information and privacy, as well as being a cost effective model for health services to expand coverage.

Thabale Ngulube (University of Zambia School of Medicine, Zambia) presented a review of how community perceptions of quality of care informed administrators in the Zambian Health Reforms. In the first stages of reforms quality of care indicators were defined by administrators and efforts made to improve on these indicators. However community perceived quality improvements also needed to be taken into account. Thabale thus described a survey monitoring process that interviewed residents, community focus groups

and health authorities on their views on community involvement, and particularly on how they felt user fees should be used for quality improvements. These views were incorporated in guidelines on user fees, which now require that increases in user fees must be associated with demonstrable improvements in one attribute of community perceptions on quality of care. Other client feedback mechanisms on quality included discussions in health centre committees, particularly on staff orientation and discipline, with resource to district structures for disciplinary action of warnings at health centre level failed. Review of user fee and quality issues at local level also facilitated new contributions to improve health systems, such as of food which could be sold to relatives for ill patients.

Antoinette Ntuli (HST South Africa) discussed the steps that have been taken in South Africa towards promoting advocacy for and monitoring of equity policies. A review with legislators identified the need to measure progress towards equity and the role that legislators have in this respect. The programme has since developed indicators useful to legislators in this role presented in an accessible form and accessible information on budget processes to support their roles. The programme has also facilitated visits by legislators to obtain a first hand view of primary health care and media dissemination of research findings. The work is currently being evaluated to assess its impact on and uptake by legislators, their impact on the executive and on equity in health care. It has faced constraints in the time that legislators have, in the limited data available for monitoring equity and the slow response of health outcome indicators to equity related inputs.

7. Key features of promising practices

The group discussion identified and reviewed key features of promising practices from the case studies presented. In general it was observed that **partnership** between health services and communities depends on an organised demand and contribution from communities that matches their own perceived priorities and a responsive or facilitating health system that is capable of responding to this demand or facilitating this contribution, and matching it with meaningful levels of service delivery, particularly at primary care levels. Sustained primary health care is essential for building community participation.

7.1 What builds this community contribution?

Promising practices in the community were found in:

1. Programmes that incorporate or use existing and trusted structures or community leaders, such as the neighbourhood committees in Zambia, or that build new structures for communication and joint planning between health workers and communities (such as the health centre committees referred to in Zambia, South Africa and Zimbabwe).
2. Mechanisms for ensuring that joint health sector-community committees can be regularly reviewed, involve all stakeholder (civil, elected and traditional leaders and health providers), are trained and supported with information for assessing health needs, identifying priorities, managing resources and monitoring health sector performance.
3. Processes that are intersectoral, accommodate demand from community level through responsive services, that use PRA approaches to draw community knowledge and views and that link these with technical inputs.
4. Promotion of partnerships between community health workers, non government and church health providers, other sector extension workers and community leaders. In this respect community health workers and more organised civic groups were noted to be important community voices in district planning. Civic groups may also play an important role in taking grassroots voices to national planning.
5. Provision of clear information on resources for health that can be accessed by communities, how to access it, backed by skills inputs for managing resources in an accountable manner.
6. Specific measures for giving voice to the most marginalised groups through their inclusion in community structures, through links with stronger community intermediaries, through participation in decision making, and encouragement to form special interest groups that facilitate a higher profile for their interests.

7.2 What builds a responsive health system?

Promising practices in health services were found in:

1. Receptiveness in health workers to community participation and recognition of the need for it, such as in enhancing resources for health systems and to ensure greater health equity.
2. Inclusion of information from non health sector organisations and collaborative work with other sectors and communities to implement programmes, such as in the Zambia Integrated Health Programme
3. Decentralisation of decision making within health services that enables decision making on resources at district level and that enables local mechanisms for payment of health costs (eg in kind)
4. Specific measures to train health workers to work with communities and with other sectors and identification of specific cadres for linking with communities within district systems, including Community Health Workers selected by and accountable to communities
5. Establishment in law and practice of health boards that include health sector and community representatives from local, to health centre to district and national level, with clear roles and responsibilities, training and information support and authorities to motivate participation.
6. A minimum and sustained standard of primary health care and district health services, covering promotive, preventive, curative and outreach services

Two critical areas of health system functioning were discussed further, as they emerged as important to building substantive partnerships. These were the ways in which resources flow in response to / support of community decisions and actions, and the way evidence and information is used in the interface between community and health system input and authority.

7.3 How do resource flows complement community decisions and inputs?

Promising practices in relation to resource allocation and mobilisation were found at different levels:

1. At **community** level, while user fees are acknowledged to be problematic, there are many positive examples of community mobilised resources where communities define the criteria for resource mobilisation, the objectives for use of the resources and manage the funds. In Zambia, charges raised must be linked to improvement in at least one community defined indicator of quality. Some community funds are general poverty reduction funds and others are specific to health (e.g. Community Innovation Fund (Zambia); Community Health Fund (Tanzania) Ward level health funds (Zimbabwe). These funds combine cash and in kind contributions and use locally defined and implemented exemption mechanisms. They are usually administered through community level structures.
2. To support and match these funds there are also government and donor supported social action funds, such as the Community Action Project Fund (Zimbabwe). These are often organised through local authorities, where communities raise a share of resources to tap matching funds, identify projects for use of funds, may be disbursed the funds directly and are monitored by the local authority.
3. At **district level**, promising practices include giving a role to structures- such as health centre committees in planning and use of resources, with clear mechanisms for accountability in the relationship between local authority, health services and local residents. 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 enhances accountability and ownership of services. It is also not clear from available data whether global budgets disbursed at district discretion or some level of earmarking of district budgets for preventive, community and other shares is preferable. Examples from Zambia of a 2% DHMT allocation to the community or earmarking of basket funds were however found to have positive impact.
4. 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.

5. Across these levels specific investments made in financial management, capacity building and monitoring and evaluation of funds use where budgeted for and implemented enhance the effective use of all funds.
6. Further it was observed that local knowledge and accountable mechanisms for national planning should supercede donor agendas or vertical programmes.

7.4 How does information and evidence support partnerships between communities and health services?

Promising practices in relation to evidence and information for health planning were found in

1. Key areas of information being made available to the public in a form accessible to them, including information on available sources of health funding for community priorities, budget allocation and expenditure information, programme performance and information on key health problems.
2. Mechanisms for linking community information to health service information (e.g. PRA and survey tools for assessing health system performance in Zambia, Zimbabwe), particularly in relation to linking health sector data and community views for priority setting. It was noted that further work is needed on this, including in relation to the implications for district planning systems and the link to health interventions. Further there is a need to link qualitative and community data from surveys with routine data systems in planning, such as through sentinel site surveillance systems.
3. Structures that enable joint review and discussion of community and health information (found in Zimbabwe, Zambia, Tanzania and South Africa) and that obtain adequate capacity input to work towards an integrated health and social sector plan. It was noted that such structures are stronger when they also include traditional health providers, when they are able to influence other sectors outside health and thus when health workers also see their role in advocacy for health.
4. Identification of benchmark indicators of participation itself and review of how this is developing as an indicator of health system performance.

8. Areas for future action

In the last session, the meeting reviewed the areas for follow up action. What inputs would be needed for these areas of promising practice to be taken forward, and what role could the institutions and delegates' participation play in this? Across the different dimensions of participation were some common demands for 'tools' and capacities to support work on participation and health.

8.1 Key inputs

Key tools, materials or other inputs for work on participation and health raised included:

- Participatory Reflection and Action (PRA) methods for community sensitisation, community priority setting and for defining health actions. These would also include visual, radio, TV and drama tools for promotion of reflection on health and community health interventions
- Health indicators and use of district health information in ways that are accessible for community level review and to drive equity in health. A community based health information system that can also be used for monitoring health performance. Formal indicators that reflect levels of participation.

- Guidelines, standards and laws from different countries on structures for participation, roles and responsibilities in participatory processes and authority and responsibilities of participatory structures.
- Accessible information for community groups on budget processes, on how to read a budget, and how to monitor budget spending.
- Case study information on promising practices that can be used to encourage formation of community networks, community learning and action and that can provide concrete information on methods and results of participation.
- Information and advocacy materials on community participation for sensitisation of health services, other sectors and decision makers.
- Training materials to support participation, e.g. for health workers to facilitate and respond to participation, for community health workers, for communities to organise inputs, for PRA skills in health systems, for local government officials, for neighbourhood, health centre committees and district health boards, for legislators on key areas of health sector performance and advocacy and so on.

These tools generally fall into broad categories of:

- PRA methods for drawing and organising community input
- Information, evidence and assessment tools for priority setting and monitoring
- Guidelines, norms and standards relating to participatory structures and mechanisms
- Tools for promotion of health awareness and health skills
- Training materials

The meeting also identified key capacities needed for enhanced participation in health systems, across health services, community groups and other sectors. Two key targets of capacity support are the District Health Team and the Community representatives at neighbourhood, sub-district and district level.

Areas for **skills / capacity development** in these groups were identified as:

- | | | |
|----|---------------------------|---|
| 1: | For District health teams | Team building, Communication, facilitation
Planning and management, including financial management
Use of information / evidence for planning and prioritisation
Understanding of participation, roles and responsibilities
Skills and understanding for intersectoral collaboration |
| 2: | For community members: | Team building, Communication, facilitation
Planning and management, including financial management, understanding budgets and budget processes
Interpreting and using information / evidence for planning and prioritisation
Understanding of participation, roles and responsibilities
Community organisation, how to hold meetings,
Literacy and basic survival skills
Mobilisation and advocacy skills |

8.2 Future networking

Delegates to the meeting raised a number of ways that they themselves sought support from any future networking in their own work on participation and health. These included:

1. Sharing of experiences and tools in PRA and participatory approaches
2. Partnerships, networking and dissemination of good practice
3. Ways to enhance links between different community groups/ representatives and health systems
4. Training materials from community based programmes
5. Resource support and funding sources for community based health programmes
6. Ways of using (health) information in advocacy for equity / participation goals
7. Information on community perceptions on health, social and economic status

8. Research skills and information on participation
9. Information on decentralised budget and planning processes, management skills for participation
10. Monitoring and evaluation tools

These 'wants' generally fall into broad categories of:

- Exchange of information, experience and case studies on 'good practice'
- Information, health assessment, priority setting, budget and monitoring tools
- Research skills and methods for work on participation
- Training materials
- Resource and funding support

Delegates could equally offer inputs to regional networking on participation:

- Links with communities/ field programmes
- PRA and tools for participatory approaches
- Information sources and dissemination
- Technical support/ skills for research, programmes and training, tng materials
- Operational guidelines for HC Cttees and district teams
- Field tested tools for district health planning and management
- Advocacy materials
- Links to regional/international networks and donors

These 'capacities' generally fall into broad categories of:

- Links with programmes, communities and key groups
- Information, health assessment, priority setting, budget and monitoring tools
- Research skills and methods for work on participation
- Training materials
- Links to information, resource and funding networks

It was apparent after the discussion that as a network, collectively in the institutions present there was a reasonable capacity to exchange and build the information and capacity support needs for enhancing work on participation and health. This is likely to be even more true when considering the wider range of institutions working in this area not present at the meeting.

8.3 Practical areas for follow up

As priorities for practical follow up of the meeting, it was agreed to take forward some specific areas of work:

1. Continued information exchange through a mailing list
2. Sharing and creating links between relevant discussion lists and websites,
3. Wider exchange of information that can be taken to district level through the SHARED electronic information system and through Afronets.
4. Further develop links with wider stakeholders through meetings of/with key stakeholder groups such as local authority associations, legislators etc to review and discuss information on participatory systems.
5. Networking between institutions on like areas of activity , through mentoring, exchange visits and joint work in future areas of common work
6. Circulation of the report from the meeting
7. Development of a manual of promising practices on participation and health using materials from the meeting and wider inputs as a basis for disseminating positive experiences and methods on participation and health
8. Development of materials eg: advocacy materials, resource packs on different skills areas etc.

9. Closing

The definitions of participation noted on the first day were displayed on cards and reviewed. The meeting had given a wider focus for some, brought specific dimensions into sharper

focus for others, and identified key resources, tools and gaps to be addressed in moving from concept to practice. All the different definitions are shown in the box below.

Delegates definitions of participation

- The right and capacity to engage in meaningful and effective process that lead to equitable allocation of resources.
- Participation: Stakeholders each playing the respective roles, and each being involved in planning, implementation and monitoring.
- Participation is involvement in all processes concerning a particular issue or area from which I will benefit e.g. Health its conception, inception and sustenance.
- Participation should imply a socially appropriate balance between people and health systems in power and decision making.
- Participation: Activity, Accountability, Enabling, Rewarding(not nec.finance), Helps us and them grow.
- Equitable double way sharing of needs- experience skills-information.
- Participation is involvement to ensure access and control over resources.
- Partnerships of different stakeholders at all levels of health systems resulting in actual influence on organisation / management priority setting
- Partnership, Contribution and shared responsibility into an agreed plan.
- This can be partial, total or at any level of the following: Problem / Need identification, prioritizing, planning for solutions, implementation, evaluation and monitoring.
- Group of people working together to solve some problems within the community aiming to reach the goal.
- Participation: Working jointly with communities stakeholders and health workers to achieve stated goals.
- Community having say in accountability for control of their own environment health security development.
- A stakeholder involvement in generating ideas, planning implementation, monitoring and evaluating a common plan. This involves control of resource accountability, partnerships, leadership and sustainability.
- Sharing of ideas through practical interaction and development of common causes, values etc.
- Getting involved in doing
- Having a say and some form of control.
- Participation is genuine interest to enhance the improvement of life of the under privileged.
- Community identify their problems and look for strategies to solve that problem and participate in solving it. Participation is involvement of willing to participate in any activity.
- Involvement of the community from grass-root in dialogue with intersectoral groups in identifying priority problems in their area and solution to them.
- Sharing ideas contributing what you think and being a stakeholder within the forum. What to be done.
- Working together for a common good/end.
- Contributing to the identification of needs, prioritization of needs, development strategies to address identified needs.
- Involvement of stakeholders in health planning and monitoring and resource mobilisation for the betterment of community health status.
- Community and stakeholders share their ideas together on planning, information and budgets etc.
- Involving every player in the process of solving a problem.

As a summary, the composite view of the meeting was to build participation in health that involves genuine and voluntary partnerships between stakeholders from communities, health services and other sectors; based on shared involvement of, contribution to, ownership of, control over, responsibility for and benefit from agreed values, goals, plans, resources and actions around health. The meeting also defined that commonly agreed goals of participation

should include equitable health systems, accountability in health systems, and improved community health status.

Appendix 1: Delegates list

Name	Institution and address
DR GRAHAM REID	TEHIP/MoH Tanzania, Tanzania Essential Health Interventions Project Box 78487, Dar es Salaam TANZANIA Tel:255-51-130627/ Fax 255-51-112068 email:greid.tehip@twiga.com
DR HARUN KASALE	TEHIP/MoH Tanzania, Project Co-ordinator, Tanzania Essential Health Interventions Project Box 78487, Dar es Salaam TANZANIA Tel:255-51-130627/ Fax 255-51-112068 email:Kasale.tehip@twiga.com
DR RENE LOEWENSON	Training and Research Support Centre, 47 Van Praagh Avenue, Milton Park, Harare ZIMBABWE Ph 263-4-708835 Fax 263-4-737 220 email: rloewenson@healthnet.zw
CNR W CKIKWIRA	Rural District Council Members Community Services Nyava secondary school Nyava Ward, Bindura RDC P O Box HG168 or P O Box 382, Hre Highlands ZIMBABWE Tel: 074 2906
MRS DELPHINA CHIRIMUUTA	AMWUZ, Community Working Group on Health, Nursing Sister in Charge Associated Mineworkers of Zimbabwe Arcturus Mine Clinic, P bag 7395, Greendale, Harare ZIMBABWE Tel: 074 2331-3(w) 074 2372(h) Fax: 074 2334
MR PETER MAGUNDANI	Municipality of Marondera, P O Box 261. Marondera ZIMBABWE Tel: 079-24941-3 Cell: 091 317 370 Fax: 079 24944 email:maronderamunicipality@global.co.zw
MAGGIE BANGSER	Womens Dignity Project (Until August 2000):118 Highland Rd, Somerville, MA.02144 USA) P O Box 536, Mwanza TANZANIA (Until August 2000)Tel:1-617-625-7758 Fax:1-617-625-7784 email: mbangser@hotmail.com
ALFRIDA KABAKAMA	Zonal Reproductive and Child Health Co-ordinator / Lake Zone Tanzania Midwives Association - Member c/o Buganda Medical Centre Box 1370, Mwanza TANZANIA Tel: 00-255-68-40610(w) 41716(h) Fax: 00-255-68-500799
PROF C JINABHAI	Community Health, Faculty of Medicine University of Natal, P Bag 719 Umbilo Rd SA or, Congella, 4013, Durban SOUTH AFRICA Tel:27-31-2604383 Fax: 27-31-260 4211 email: jinabhai@med.und.ac.za
ANTIONETTE NTULI	Director Health Link, Health Systems Trust 4th Floor Maritime House, Salmon Grave, Durban South Africa Tel: 27-31-307 2954 Fax: 27-31-304 0775 email: ant@healthlink.org.za
MRS BONGIWE H MHLAULI	Mntwana Clinic Mt Frere Health District Toleni Location, P O Box 18 Mt Frere 5090 South Africa Tel: 027 39 2550556 2550012 Fax: 27 039 2550559
MRS T B SIKRWEQE	Mtwana Community Health Worker Address: Mntwana Clinic Box 533 Mt Frere 5090 SA SOUTH AFRICA Tel: 27-39-2550556 2550012 Fax:27 39 2550559
MR THULANI MASILELA	Health Systems Trust 8th Floor NORVIC House 93 DE Korte Street, Braamfontein, 2001, Jbg SOUTH AFRICA Tel: 27 11 40325415\7 Fax: 27 11-4032447 email: hstthul@jbg.lia.net
WENDY HALL	Health Systems Trust 135 Morcom Road Prestburg, Pietermaritzburg 3201, SOUTH AFRICA Tel: 27-33-3441368 Fax:27-33-3441368 email: hstwendy@pmburg.co.za
MRS RURAMISAI GANDIWA	Service Delivery Co-ordinator, ZNFPC 1 Bradburn St Masvingo Box 632 Masvingo ZIMBABWE Tel: 039 62237 / 63889 / 62237 Fax: 039 64233 Cell: 091 367 728
MR TITO	Senior IEC Officer, ZNFPC Masonaland West Province

RUNGANGAH	No 69 Midway St, P O Box 363 Chinhoyi ZIMBABWE Tel: 067 22656 Fax: 067 23218
MR BHIBHI	Hurungwe Rural District Council Box 46 Hurungwe ZIMBABWE Tel:064 6881-3
WILLY S GOMA	Co-ordinator HIV Programme Zambia Shanty Development Organisation, Plot 139A Ngwerere Fritz Phanor Memorial Roma Township Lusaka,PO Box 310095 Lusaka 15301 ZAMBIA Fax: 260-1-252 728 email: willygoma@hotmail.com
SIMONE GOOSEN	WHO DSD,Medical School Parirenyatwa Hospital, Box BE773 Belvedere, Harare ZIMBABWE Tel: 263 4 706 951/703 580 ext g345 Email: goosens@whoafr.org
DR MIGUEL KIASEKOKA	WHO DSD,Medical School Parirenyatwa Hospital, Box BE773 Belvedere, Harare ZIMBABWE Tel: 263 4 706 951/ 703 580 Email:kiasekoka@whoafr.org
DR KAENDI MUNGUTI	WHO MAL,Medical School Parirenyatwa Hospital, Box BE773 Belvedere, Harare ZIMBABWE Tel: 263 04 706 951/703 580 Email:kaeddim@whoafr.org
JOHN T MILIMO	Participatory Assessment Group, Director 4 United Nations Ave, Long Acres Lusaka,P O Box 51080 Lusaka ZAMBIA Tel:260-1-255182 /254801/ 783876 Fax:260-1-254801 email: pagzam@zamnet.zm
DR ROSEMARY KUMWENDA-PHIRI	Lusaka Urban District Health Management Board 5231 Makishi Road, Box 50827 ZAMBIA Ph: 260-1-238 173 / 235 554 702047 Fax: 236 429 Rosekumwenda@hotmail.com/DHMT@COPPERNET.ZM
DR THABALE JACK NGULUBE	Senior Lecturer,School of Medicine, University of Zambia Box 50110,Lusaka OR Chessore P O Box 32168 Woodlands PO Lusaka ZAMBIA Tel: 260 1 293029/263201/772977 Fax:260-1-263201 email: chessore@zamnet.zm
DENISE DEBY	IDRC Box BP8500, Ottawa, KIG 3H9 CANADA Tel: 00-1-613-236 6163 Fax: 00-1-613-587 7748 email: ddeby@idrc.ca
HILARY STANDING	Institute of Development Studies, University of Sussex Falmer Brighton Brighton BN1 9RE UNITED KINGDOM Tel:44-1273-606261 Fax: 44-1273 - 621202 email: H.Standing@ids.ac.uk
MONICA MURAMBWA	Training and Research Support Centre 47 Van Praagh Avenue Milton Park,Harare ZIMBABWE Ph: 263-4-708 835 Fax: 263-4-737 220 email: tarsc@icon.co.zw
DEBBIE CHOONGO	Central Board of Health Ndeke House Box 32588, Lusaka ZAMBIA Tel:260-1-253179-82 Fax:260-01-253173 Email:hritsika@zamnet.zm
BRUCE MUKWATU	District Intervention Co-ordinator ZIHP, Add:CARE-ZIHPCOM, Red Cross House, Los Angle Blvd, Long Acres P O Box 37230 Lusaka ZAMBIA Fax 260-1-253839 Tel: 260-1-254552 / 253 728 (h) 260-1-312361 email: bruce@zihp.org.zm
GILL BOECKMANS	Medius Mundi 47 Lawson Avenue, Milton Park, Harare ZIMBABWE Tel: 263-4-727744 Fax: 263 4 790935 email:gmb@africaonline.co.zw
DR A BOON	Tsholotsho District Hospital Box 100, Tsholotsho, ZIMBABWE Tel: 087 8216 / 8207 Fax:087 8203 email:bplaetse@healthnet.zw
HELEN MYEZWA	Regional Co-ordinator, GTZ Health Systems Research, Eastern and Southern Africa Harare, ZIMBABWE Tel: 263-4-733 696 Fax: 263-4-733 695 Cell: 011 202490 email: hmyezwa@healthnet.zw