A critical analysis of community participation at the primary level of the health system in Goromonzi District, Zimbabwe

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Abstract

The adoption of the primary health care approach by Zimbabwe in 1980 signalled the government's intention to consolidate the gains of the liberation struggle by providing equitable health for all citizens regardless of race and class. This approach frames community participation as central to the design and implementation of responsive health systems. Having earned international recognition for its pro-poor policies in the social sectors after independence in 1980, the Zimbabwean government over the last three decades has overseen a progressive decline in the provision of health services and near collapse of the health sector.

Participation of communities, whether in the form of organised groups or as unorganised members of the public, is argued to be an important pillar in the effective performance of a health system. There has been extensive research conducted on Zimbabwe's implementation of primary health care in light of health status, accessibility and health services uptake. A few studies have been undertaken to demonstrate that the participation of communities in the health system is an important factor in improving the effectiveness of the health system in Zimbabwe.

This thesis analyses the existing mechanisms for community participation in the health system in Zimbabwe and brings out multiple perspectives on the underlying contradictions, tensions and processes at play between policy and practice. This thesis makes a contribution to the growing number of studies on participation in health by offering an empirically rich critical analysis of community participation in the health system in one ward located in Goromonzi District in Zimbabwe. In examining the structural and procedural forms of the health system, insights concerning the nature and form of community participation in primary health care are brought to the fore. The thesis concludes that the ways in which community participation takes place in the health system in Zimbabwe is influenced by a number of socio-economic, political and societal factors and this in turn has a bearing on how health policy expresses itself in practice.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMWZ	Association of Mine Workers in Zimbabwe
CHW	Community Health Worker
CSO	Central Statistical Office
CWGH	Community Working Group on Health
DDC	District Development Committee
DDF	District Development Fund
DEHO	District Environmental Health Officer
DFID	Department For International Development
DHE	District Health Executive
DHPO	District Health Promotion Officer
DHSA	District Health Services Administrator
DMO	District Medical Officer
DNO	District Nursing Officer
DP	District Pharmacist
EHT	Environmental Health Technician
ESAP	Economic Structural Adjustment Programme
EU	European Union
FGD	Focus Group Discussion
FPL	Food Poverty Line
FTLRP	Fast Track Land Reform Programme
GDP	Gross Domestic Product
GNU	Government of National Unity
GoZ	Government of Zimbabwe
GPA	Global Political Agreement
GRDC	Goromonzi Rural District Council
HCC	Health Centre Committee
HIV	Human Immunodeficiency Virus
HSF	Health Services Fund
HTF	Health Transition Fund
IMF	International Monitoring Fund
IRP	Intensive Resettlement Programme

LRRP	Land Reform Resettlement Programme
MCDC	Ministry of Community Development and Cooperatives
MDC-T	Movement for Democratic Change- Tsvangirai
MLGRUD	Ministry of Local Government Rural and Urban Development
MNCH	Maternal and Neonatal Child Health
MOF	Ministry of Finance
MOHCC	Ministry of Health and Child Care
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Non-Governmental Organisation
NHS	National Health Strategy
NIC	Nurse In Charge
NSSA	National Social Security Association
PCN	Primary Care Nurse
PDC	Provincial Development Committee
PF	Patriotic Front
PHA	Public Health Act
PHAB	Public Health Advisory Board
PHC	Primary Health Care
PMD	Provincial Medical Director
RBF	Results Based Financing
RDC	Rural District Council
SAP	Structural Adjustment Programme
STERP	Short Term Emergency Plan
STI	Sexually Transmitted Infection
TARSC	Training and Research Support Centre
TB	Tuberculosis
TNDP	Trans National Development Plan
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children Education Fund

USCDC	United States Center for Disease Control
USD	United States Dollar
VIDCO	Village Development Committee
VHW	Village Health Worker
WADCO	Ward Development Committee
WAG	Women's Action Group
WASN	Women and Aids Support Network
WHO	World Health Organisation
ZANU PF	Zimbabwe African National Union- Patriotic Front
ZAPU	Zimbabwe African People Union
ZCTU	Zimbabwe Congress of Trade Unions
ZDHS	Zimbabwe Demographic Health Survey
ZDHSIC	Zimbabwe Health Sector Investment Case
ZFU	Zimbabwe Farmers Union
ZMNHR	Zimbabwe Maternal and Neonatal Health Roadmap
ZNLWVA	Zimbabwe National Liberation War Veterans Association

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Chapter 1: Introduction and Methodology

1.1 Introduction

The health system in Zimbabwe was once a beacon of success in sub-Saharan Africa. The World Health Organization (WHO) cited by Woelk (1994) defines a health system as "all the activities whose primary purpose is to promote, restore or maintain health" (Woelk, 1994:1027). Health plays a vital role in people's lives and the lack thereof is a clear indicator of poverty in most developing nations (WHO, 2009). The transition of the Zimbabwean health system, from an urban based minority focused curative system to one which emphasized broad based health promotion and prevention as well as the provision of health care at an acceptable level for the majority rural population, was effective. This process exemplified the fruits of revolution which followed after the violent *Chimurenga* (i.e. guerrilla war) for the country's independence in the 1970s.

Participation of communities whether in the form of organised groups or as unorganised members of the public is an important pillar in the effective performance of a health system. Zimbabwe adopted the primary health care (PHC) approach at independence in 1980 to guide the country in working towards equitable health for all. The idea of equity in health for Zimbabwe formed the basis of the thrust to ensure a fair distribution of resources amongst all citizens and improving accessibility to health care and services after independence. Underlying the PHC approach in Zimbabwe is that, with improved socio-economic conditions coupled with mass participation contributing to the overturning of these conditions, the health system becomes more responsive to the people hence becoming 'people-centred'.

Having earned international recognition for its pro-poor policies in the social sectors after independence in 1980, the Zimbabwean government over three decades has overseen progressive decline in the provision of health services and near collapse of the health sector. Zimbabwe's journey towards addressing the colonial ills remnant in the post independent era has been a difficult one. It can be argued that the tragic collapse of Zimbabwe's social services, following the steady crumbling of the economy after 2000, was the result of various factors. Among these factors, the most important were the unwise economic and political

decisions of the ruling elite, which resulted in Zimbabwe being ostracized by the international community mainly in the global north for its blatant human rights violations coupled with the failure of public service delivery and veritable economic meltdown (Mlambo 2013). Attempts at finding a lasting solution to the political and socio-economic crises that hit the country from the 1990s and into the 2000s have had serious impacts on the implementation of PHC. With community participation being a critical pillar in PHC, it then becomes pertinent to analyse how Zimbabwe has fared in light of the socio-economic and political changes over three decades of independence.

There has been extensive research conducted on Zimbabwe's implementation of PHC in light of health status, accessibility and health services uptake (Sanders and Davies, 1988; Zigora, Chihanga, Makahamadze, Hongoro and Ropi, 1996; Mutizwa-Mangiza, 1997; Bijlmakers, Basset and Sanders, 1998; Gaidzanwa, 1999; Ropi, Loewenson, Sikosana and Zigora, 2001; Munjanja, 2007; Zimbabwe National Health Strategy, 2009; Zimbabwe Demographic Health Survey, 2011). A few studies have been undertaken to show that the participation of communities in the health system can widely be argued to be an important factor in improving the effectiveness of the health system (Sanders, 1990; Loewenson, 1994; Mararike, 1995; Loewenson, 2000; EQUINET, 2008; USAID, 2011). The intention of this thesis is to highlight the existing mechanisms for participation in the health system in Zimbabwe bringing out multiple level perspectives on the underlying contradictions, tensions and processes at play between policy and practice. The study seeks to contribute to the existing literature by providing empirically rich stakeholder perspectives on community participation in the health system from Mwanza ward in Goromonzi district in Zimbabwe. This entails a focus on community members organised in groups and those outside of formal groups and how they occupy spaces within and outside the health system to participate in health policy formulation, implementation and monitoring. In examining the structural and procedural form of the health system, certain insights concerning the nature and form of community participation in PHC and its implementation can be gained. The thesis concludes that the nature and form of how community participation takes place in the health system is influenced by a number of socio-economic, political and societal factors and this in turn has a bearing on how health policy expresses itself in practice.

This introductory chapter is divided into three main sections. The first section provides a brief overview of community participation in health in Zimbabwe from a political economy

lens. The second section sets out the research methodology underlying the thesis. And the chapter ends by providing an overview of the remainder of the thesis.

1.2 Community participation in health in Zimbabwe

Zimbabwe inherited a hybrid economy with a combination of a diversified modern economy and a rural subsistence farming sector which underpinned a highly unequal socio-economic and political system (Jirira, 1994). Political priority for the new government, inherent from the armed struggle that created a platform for self-determination, was to "reverse seven decades of racially biased inequalities in land and asset distribution, and to bestow fundamental civic and human rights on all its citizens" (Sachikonye, 2002:13). Through the Transitional National Development Plan (an action plan extracted from the early Growth and Equity strategy), the government emphasised people's participation in decision-making in relation to socio-economic development (Government of Zimbabwe, 1981; Chisvo and Munro, 1994; Makumbe, 1996; Raftopoulos and Mlambo, 2009). The 1980s were marked by the successful expansion of public services and basic infrastructure such as health and sanitation, water supplies, education and roads, and mainly to formerly neglected rural populations (Auret, 1990).

During the 1990s, however, Zimbabwe ushered in a number of neo-liberal economic reforms (Sachikonye, 1995; Gibbons, 1995; Jenkins, 1997; Gaidzanwa, 1999), focusing on stabilizing the economy through the adoption of restrictive fiscal and monetary policies and a poverty alleviation component intended to cushion "vulnerable" groups. The anticipated positive effects of the reforms were not realized (Bijlmakers, Basset and Sanders, 1998). The period from 1997-2008 (dubbed 'the crisis period') saw agriculture, mining and manufacturing suffering major setbacks due to escalating external debt (Raftopoulos and Phimister, 2004; Vasudevan, 2008). The economic meltdown was exacerbated by activities in the political realm including land occupations promulgated by ruling party supporters and the fast track land reform programme (Sachikonye 2002; Nyazema 2010; Mlambo 2013). The clearest evidence of the economic downfall's impact on health was the cholera outbreak in 2008 which quickly became a pandemic. The outbreak was a result of poor sanitation and contaminated drinking water due to the inability of the state through a parastatal to provide purified water and maintain sanitation facilities. Over 140,000 people were hit by the outbreak with more than 4,000 having died in the period 2008-09 (USAID, 2011). Serious political and economic crisis conditions continued until 2015 and these have had an impact

on the effective delivery of primary health care in Zimbabwe. Problems in health care delivery are in fact part of broader fiscal and administrative incapacities characterising the contemporary Zimbabwean state.

When looking at the evolution of post independent Zimbabwe, land and race, labour and state centralism stand out as critical themes. The role of the ruling party in the governance of Zimbabwe cannot be underplayed. Post 2000, mounting pressure on the state for economic redress, as well as ideological attacks on the ruling party, resulted in hasty decision making by the government especially with regard to land reform. Scholars such as Sam Moyo and Paris Yeros (2007) and Mahmood Mamdani (2008) are in agreement on the observation that the land reform measures have won the ruling party, the Zimbabwe African National Union-Patriotic Front (ZANU-PF), considerable popularity not just in Zimbabwe but throughout southern Africa. The most captivated are those who see the Zimbabwean government's actions as an attempt to deal with unresolved long-term historical grievances. At the same time, the land reforms have seen increasing levels of elite accumulation at the expense of the majority. Slower economic growth and deteriorating standards of living saw the labour movement shift polarised positions: from being aligned to ZANU-PF doctrine in the first fifteen years of independence to becoming assertive and giving birth to the strongest opposition party in the post-independence era. In the last three decades, the government has relied on coercive tactics brought forward from the liberation struggle to gain buy-in from the population as well as compliance under the guise of nationalism. This is supported by Makumbe (2009) who argues that the Zimbabwean government continues to rely on the commandist nature of mobilisation and politicisation developed during the *Chimurenga* war. These tactics emphasise the politics of intimidation and fear with opponents being viewed in warlike terms, as enemies and therefore illegitimate. This is so because the post-independence state has not tolerated political diversity and the voicing of criticisms (termed as dissent), and this is linked to a heavy reliance on force for mobilisation, and a narrow, monolithic interpretation of citizenship, nationalism and national unity (Raftopoulos, 2004:4).

National health policy in Zimbabwe is implemented through community level (ward and village) which is the primary level, as well through district, provincial and national level institutions of the Ministry of Health and of the Ministry of Local Government. At the primary care level, community health workers include village health workers, health literacy facilitators and home based carers, and health centre committees (HCCs). Community

participation in Zimbabwe has been confined overall to health promotion activities in line with preventative approaches to health management. At the base of the health service has been the village health worker (VHW), through whom democratization of the health system was to be attained. The role of the community was to nominate the VHW who then serves on various health and development committees created to facilitate community participation in the health systems at local level. For Loewenson (2000:17) "these structures played a positive role in more "self-reliant" health interventions, but did not make services planned and financed at central level more responsive to user demands or inputs". Local government mechanisms for participation were weakened by centralised authority and the exclusion of civil society groups, and by limited capacity (Sanders, 1995; TARSC and CWGH, 2009). In health, participation was focused on state-driven social mobilisation and compliance with centrally-defined programmes, leaving social groups and health officials dissatisfied with the level and forms of community participation (Mutizwa-Mangiza, 1997; CWGH, 1998a; Loewenson 2000; Loewenson and Chikumbirike, 2000; Ropi, Loewenson, Sikosana and Zigora, 2001; Loewenson 2004 et al.).

The unsatisfactory nature in which participation has been taking place in the health sector in Zimbabwe has since 1999 been tracked by a network of civic actors known as Community Working Group on Health. The network has captured the decline of the health system and the continued lack of community presence in health policy in the political and economic landscape that has characterised Zimbabwe in the last decade. According to the Ministry of Health (2009), the work of the network has confirmed a view expressed during meetings by civic representatives and health officials that there is a persistent gap in structured communication with communities that acts as an impediment for health promotion (CWGH 1998; MoHCW, 2009). The network together with the Ministry of Health embarked on a process of restructuring the way communities participate and contribute to national health policy through the Health Centre Committees (HCC). HCCs are a mechanism through which communities can participate at primary care level to support a people-centred health system (CWGH 2015).

The critical analysis of these joint service community mechanisms especially at the village and ward level is central to this study. How HCCs occupy legislated spaces for participation is critical to understanding in what way participation happens at the primary level in the health system. For the PHC approach, community participation is hailed to be the panacea of

health related developmental programmes. The intention is to move from centrally defined health interventions to having a health system that is structured to detect and subsequently respond adequately to what the people need the most at that time. This is important to my thesis, as understanding the role and form in which the state has created spaces for community participation in health determines the nature in which it happens and subsequently has an impact on implementation of national health policy.

1.3 Research methodology

1.3.1 Research significance and research goals

Literature reviewed shows that structures set for participation in Zimbabwe were designed as simultaneously a means and an end in health policy. However, participation is poorly conceptualised and operationalised both in health governance and in technical health interventions. However, as a body of literature, these studies have not focused sufficiently on communities as health change agents at local levels, as their conceptualisation as mere beneficiaries continues to prevail. In this light, the thesis makes a contribution to existing literature on community participation in the Zimbabwean health system by focusing on mechanisms that exist for community participation in the health system and on how rural communities have organised themselves to occupy these and other spaces (not necessarily defined by health policy) in order to be responsible and take ownership for their own health in line with what is expected by the primary health care approach.

There is presently limited comprehensive and robust analysis of community participation in the health system in Zimbabwe to determine its advantages and weaknesses in attaining the goals of the primary health care approach. This study aims to bridge this gap by critically analysing community participation at primary care level. While there have been numerous government and donor led assessments as well as non-government organisations supporting the strengthening of the health system, there has not been rigorous analysis on the nature of and extent of community participation required for the strengthening of the health system. The significance of my thesis then is that is seeks to critically assess community participation in light of the present health policy as applied at the primary level from the lens of communities both as end user clients and representatives of the health system at primary level. The research also seeks to provide insight into the process of participation at primary level by wider social groups representing communities to determine the nature and extent of community involvement in the health system. Programmatically, the analysis provides

valuable information for communities and policy makers to inform sustainable interventions for the health sector in the long run for Mwanza ward in Goromonzi, Zimbabwe.

The main goal of the study is to critically analyse the role of community participation in the health system in Goromonzi district, Zimbabwe. Following the main goal, secondary goals include:

a) To identify legislative, regulatory and normative mechanisms that enable community participation in the health system in Zimbabwe.
b) To assess how community members view their role in the health system at local level.
c) To examine whether community participation can be linked to improved health outcomes at the local level

1.3.2 Research design

This section elaborates on the research design underpinning my study. It covers the research plan, the 'target' population, the sampling procedure, the selection of the study area, instruments for data collection, and finally the analysis of information gathered. I also later discuss the challenges faced during the data collection period that potentially could have compromised the validity of the study.

In order to conduct the field study, the Community Working Group on Health (CWGH) facilitated my entry into Goromonzi district. The network also set up introductory meetings for the study with Goromonzi Rural District Council Social Services Department, the Ministry of Health and Child Care Executive in the district and the traditional leadership in Mwanza (the ward of specific focus). A working relationship between the CWGH and I existed before the inception of this study. In the period from 2010 to 2012 I participated in as well as facilitated CWGH participatory action research projects in a number of provinces in Zimbabwe. The selection of Goromonzi district was informed by consultation with the CWGH. This is owing to their vast experience and expertise in community mobilisation for health research and health policy advocacy. Goromonzi is one of the districts in which the CWGH has been implementing its projects since 1999. It has set up 12 functional health centre committees in rural Goromonzi (CWGH, 2015).

Goromonzi District, as the empirical site for the thesis, is one of nine districts in Mashonaland East Province. Goromonzi covers an area totalling 2,459 square kilometres or 254,072 hectares. It is a district located 32 kilometres southeast of the country's capital of Harare. In 2002, Mashonaland East Province had a population of 1,127,413 with Goromonzi district having the highest population in the province (13,68%) (Mashonaland East Provincial Census 2012). A more recent census conducted in 2012 pegs Goromonzi population at 224,987 persons of whom 113,661 (50,5%) are female (CSO, 2012). Of this population, 96,16% reside in rural areas with the remainder (3, 84%) residing in urban areas. Originally, Goromonzi had 21 rural wards but due to delineations prior to the 2008 Presidential elections, the wards increased to 26. The field work was carried out in Mwanza ward which is ward 12 in Chief Chikwaka's communal area. Mwanza ward is the home of the oldest functional Health Centre Committee first set up in 2001.

The research for my thesis was qualitative in nature (Maanen, 1979; Adams, 1985; Patton, 1990; Blaike, 2004; Neuman, 2006; Terre Blanche and Durrheim, 2006). Four qualitative research techniques were employed which are: focus group discussions with Mwanza HCC, and the District Health Executive; semi-structured in-depth interviews with community members; in-depth interviews with key informants and simple observation of community health literacy meetings. To assist me I had a research team comprising of three people (two research assistants and one data analyst) in addition to myself. The research took seven months including planning, implementation, and data collection and analysis (from May 2015 to November 2015).

Sampling of community respondents involved snowball methods. The focus was on community members (male and female of legal consenting age in Zimbabwe, which is 18) who accessed health services on research days as well as attended health literacy meetings at specified times during the field work. Thus, respondents were selected from the available population at the clinic at the given time. Having conducted an interview, a number of respondents recommended others. Semi-structured in-depth interviews were conducted with non-randomly selected community members. A total of 33 community members were interviewed. The questions for this group of respondents was open ended which focused on the existence of the HCC, structures for participation at the village and ward levels and what the community's role was in health in general. Due to the informality and conversation-style

of the interviews, the interview guide used was flexible (see Appendix 3 for the main questions).

While the focus of the study was community members, it was crucial to gather evidence from the district health executive, rural district council social services officer and CWGH secretariat as well as the health workers at Mwanza rural health centre. For this group of respondents, a combination of semi-structured interviews and key informant interviews were conducted (see Appendix 1 for list of key informants and interview guidelines). Questions were more technical for this group and were structured on the history of health policy and strategy in Zimbabwe and the value community participation adds to the health sector. Two focus group discussions were also held, one with Mwanza HCC and the other with the District Health Executive team in Goromonzi. The discussions were important because they provided direct evidence about the similarities and differences in the participants' opinions, experiences and attitudes towards community participation in health.

Direct observation was extensively used throughout the field study. The greatest advantage that this provided was the opportunity to reflect and verify information gathered from other methods used in the study. This included a chance to observe health workers interacting with community members during health literacy campaigns for maternal and child health. I also attended and observed a community meeting where Mwanza HCC facilitated a community health needs identification and prioritisation agenda. The last meeting to note was when Mwanza HCC met with the health workers at Mwanza clinic in a monthly progress meeting.

In addition to the above research techniques, I also made extensive use of primary documentation about health in Zimbabwe from the Ministry of Health and other ministries in the Government of Zimbabwe, such as the Ministry of Finance and the Ministry of Local Government Rural and Urban Development. International and local civic actors have also conducted research on the health sector and health indicators in Zimbabwe, and I consulted their works as well. These include the World Health Organisation (WHO), United Nations Children Education Fund (UNICEF), United Nations Development Programme (UNDP), Community Working Group on Health (CWGH), Women's Action Group (WAG) and Training and Research Support Centre (TARSC).

To analyse data gathered from the various methods employed, standard thematic identification, coding and analysis was used. This mode of analysis provided a more inductive form of interpretation and analysis which allowed space for the evidence (primarily the voices of community members in and outside the HCC) to express their subjective experiences of participation in health. This facilitated room for themes to emerge from these shared experiences rather than being pre-determined by the researcher (Denzin and Lincoln, 2009; Silverman, 2013).

Before data collection was undertaken with Mwanza HCC and community members, the Ministry of Health District Executive and the other key informants, all necessary ethical considerations were taken into account. It should be noted that the identity of all community members including HCC members has been altered for anonymity purposes. It was assured that information gathered was to be solely used by the researcher for academic purposes.

1.3.3 Fieldwork Challenges

The political context in Zimbabwe particularly Mashonaland East is known to be very volatile and this has made state structures wary of 'outsiders' and research in general. This made obtaining permission from the district authorities especially the Rural District Council very difficult. Permission from the Ministry of Health was made easier by an existing Memorandum of Understanding between the CWGH and the Ministry. However, permission was only granted after two separate protocol visits to the council with the support of CWGH and the District Nursing Officer in Goromonzi. For the study to be accepted, a letter underwritten by the CWGH to the Council was submitted. It specified the objectives of the study.

The atmosphere at the first of the community meetings I observed was tense in that the CWGH had not obtained police clearance from the Zimbabwe Republic Police to mobilise the community through the HCC for a community meeting. However, the situation was rectified by the Headman in Mwanza who indicated that it was the HCC that had called for the meeting and not the civic organisation. Civic organisations are still labelled as regime change agents in the district even though it was not 'election season'.

Using the English language to communicate in the initial stage of interviews was a major challenge. In most instances, responses given were not relevant to the question asked. To adapt, the researcher inquired, before each subsequent interview, the respondent's preferred language of communication. Most of these were conducted in *Shona*, a few in English with one in *isiNdebele*.

Lastly, there were frequent requests for 'allowances' after community meetings as well as after certain key informant interviews from community members and health workers. One interviewee, after being told that there was no compensation for participation, retorted that information was not for free and that the researcher should be more like other civic organisations operational in the district. This example points out that research is a social process and how it is conducted invariably impacts evidence gathered and documented. My analysis was sensitive to this to prevent the misrepresentation and distortion of information gathered.

1.4 Thesis outline

The following chapter (Chapter 2) provides a conceptual framing for the thesis by discussing participation and community participation in development and specifically in health. The emphasis is on unpacking the concept of community participation and how this has been integrated into health. Chapter 3 provides an analysis of the political and socio-economic developments in Zimbabwe in the three decades that have passed since independence. It provides a contextual frame within which the health system has had to evolve. Chapter 4 is a general overview of health in Zimbabwe with Chapter 5 providing an in depth analysis of the mechanisms that exist for community participation in health in Zimbabwe. Here there is some comparative discussion on the platforms created for community participation through the local government framework and the health system itself.

An overview of the research site (Goromonzi) follows in Chapter 6. The chapter provides a brief historical background of the district as well as offers insight into the socio-economic and political profiles of the district. Perspectives on community participation gathered from the District Health Executive in Goromonzi are also included in this chapter. Chapter 7 follows with a case study on Mwanza Clinic Health Centre Committee based largely on my original field research. Chapter 6 and 7 provide evidence on the perceived value of

community participation in the health sector and also highlight in what other forms, besides that which is legislated for, is participation taking place in the community. The final chapter (Chapter 8) draws together the conceptual framing and the empirical evidence in making final comments on the nature and form in which community participation exists in the Zimbabwean health system.

Chapter 2: Community participation

2.1 Introduction

Participation of communities in the form of both formalised and informal groups is widely argued to be an important factor in the development process. Participatory approaches have been used for many years in the health sector mainly for needs assessment and implementation. Approaches that primarily saw communities as passive recipients of health care services have given way to those which seek to make more of the potential that more active community participation might offer for enhanced accountability and improved responsiveness of services. Rapid and participatory appraisal methods have been means through which health service users have been consulted on the appropriateness of services and the evaluation of interventions. This has been to enhance health policy effectiveness. From this angle, community is regarded as a user and recipient of a service. With the growing trend for community participation, the role of communities has evolved to now include resource inputs such as time, labour and finances which have implications for the locus of control over decision making (Cornwall, 2010). According to Gaventa and Robinson (1998), rather than passive recipients, communities have in many contexts including Zimbabwe become active makers and shapers of services, exercising their preferences. In health, community participation is arguably linked to improved health outcomes and is regarded as a crucial factor in health systems strengthening.

This chapter unpacks and examines the concept of participation from a theoretical perspective and the types of participation communities exhibit in the development process. The focus of the chapter is a discussion on community participation as envisioned by the Primary Health Care approach. How community participation has been integrated and applied in the Zimbabwean health system will be discussed in-depth in a later chapter.

2.2 Understanding participation

Historically, the theoretical foundations of the concept of participation can be traced back to the work of Aristotle (Puri 2004). He defined a citizen as someone who is entitled to participate in decision making processes for the sustenance of the state. Rousseau's ideal of

active citizenry reflects the concept of participation as an end in itself. Over time, the concept of participation has acquired varied meanings (Frediani, 2010). According to Agarwal and Gibson (2001), at the one end of the spectrum, participation could mean just a nominal membership in a group and at the other end it could imply having an effective voice in the decision making process. In contemporary times, the ideas of Benjamin Barber (1984) and Jayaprakash Narayan (1974) define participation as an essential part of a community's vision of ethical life propounded by a system of participatory democracy as an alternative to parliamentary democracy (Puri, 2004).

The social capability approach makes a useful distinction between efficiency based participation and agency based participation. Efficiency based participation understands participation as an instrumental means to a predefined end that varies from institutional efficiency to state defined public interests. This form of participation forms the backbone of the social capital theory popularised by Robert Putnam (1993), with Putnam (1993) stating that there are two prerequisites for effective 'good government'. The first one is an active citizenry that engages with the state on public affairs. The second is a civic culture in which citizens are bound together by horizontal relations of authority and dependency whose norms and values are informed by solidarity and public spiritedness. This relates to the concept of social capital which over time has heavily influenced development interventions by states mobilising pre-existing local networks for varied policy goals using a top down approach. Agency based participation concerns itself with the role of human agency in policy and political changes. It is more concerned with people's involvement and inclusion, as an end-in-itself, in development processes. According to Puri (2004), agency based participation places emphasis on empowerment of those who are affected by policies and political changes, along with an equitable distribution of costs and benefits among them. Participation in this case becomes a goal in itself.

For the purposes of this study, the social capability approach will be regarded as an open framework guiding people centred development. The study employs a combination of both efficiency and agency based participation with an emphasis on the latter. From a policy makers' perspective, the efficiency approach focuses on conditions necessary for creating strong, responsive, effective and representative institutions (Puri, 2004). The agency approach emphasises deepening democratic processes through equitable inclusion and recognition of marginalised groups in society in the decision making process capitalising on

human agency. This approach sees participation as empowerment and equity with its foundations heavily rooted in Amartya Sen's work on entitlements and capabilities. For Sen, development should be focused on a combination of 'functionings and capabilities' enhancing quality of life through empowerment, equity and human agency. As Sen (1993:270) argues: "Functionings represent parts of the state of a person – in particular the various things that he or she manages to do or be in leading a life" (Sen, 1993:270). The capability of persons reflects the alternative choices and options availed to them in deciding the kind of life to lead. Capabilities are a derivative of functionings (Sen, 1993:278) Functionings thus refers to achievements whilst capabilities refer to the set of opportunities presented to a person in life. The advantage of the capability approach is that it evaluates a person's life "in terms of his or her actual ability to achieve various valuable functionings as a part of living" (Sen, 1993:271).

Alkire (2003:5) further elaborates, stating that functioning is an umbrella term for the resources, activities and attitudes people spontaneously recognize to be important such as knowledge. Capabilities, however, are the freedoms that people have to achieve the lifestyle that they have reason to value (Frediani, 2010:176), as well as the opportunities presented to a person for this purpose. Freedom of choice is an essential component in a person realising their capability in order to achieve or to function in society. Freedom is understood as a concept that contributes to converting capabilities into functions and this conversion is fuelled by human agency. Sen's capability approach includes aspects of both agency and efficiency but highlights human agency as the main objective in development. According to Sen (2005), development should focus on the expansion of capabilities for their 'intrinsic value'. I agree to a certain extent with this view as people should not be viewed by policy makers instrumentally as the means for producing an end but rather as an 'end' in themselves. To achieve development as a broad goal this 'people centred approach' places human agency at the centre in contributing to changing policy, social commitment and norms that require collective action (Puri, 2004).

The capability approach acknowledges structural, local and personal factors that may impact on a person's achievements as well as opportunity-sets in life. Individual factors are associated with one's individual capacities which could include literacy levels and physical conditions. Local factors are associated with facilities and collective norms whilst structural factors include market mechanisms and the political structure. A combination of these factors

affects people's freedoms. The interaction of these diverse factors at the collective level may affect the range of options available in a community and subsequently what they can achieve in terms of quality of life, as the opportunity-set will be altered. Development for people would work in such a way that these factors are effectively managed to enable an individual or community to be able to exercise their full capability.

Power relations also have a critical role to play in agency based participation. The concept of agency is directly related to relations of power (Frediani, 2010:180). Eyben (2004) identifies five perceptions of power which are: power to, power over, power with, power as knowledge and power structure, and these vary with the differing of contexts. In light of the capability approach, 'power to' shapes people's ability to act and even to identify the things that they value, which is referred to as 'adaptive preference' by Sen (1999). This concept, according to Frediani (2010:180), has a direct link to the idea of 'false consciousness' which impedes people from knowing their real interests. He thus notes: "The Freirean pedagogical tradition has argued that people need access to knowledge to develop a critical consciousness and overcome processes associated with power and domination" (Frediani, 2010:180). Hence a power analysis to unpack relations of power is critical in understanding how participation happens in a given context.

The idea of participation whether it is efficiency based or agency based privileges the idea of community and the local which allows room though for an assumption that community is to be viewed as an undifferentiated cohesive whole. Communities however like any other human collective are a space for internal differentiation, contestation and power differentials (Puri 2004). Within a community there can be hierarchical and exclusive formations which influence how participation happens. But proponents of the social capability approach argue that the approach places emphasis on empowerment, equity and voice which allows for it to cater for difference within a group (Ribot, 1995). Sen provides an example when discussing poverty and entitlements stating that "a person is exposed to poverty when the exchange entitlement set that s/he has is not sufficient for meeting the basic necessities of his/her life. These entitlements are in turn determined by his/her particular place especially class in society" (Dreze and Sen, 1995:10-11) However, the approach has come to acknowledge the limitations presented by the issues of difference and power that shape community life (Puri, 2004). Inequalities, social hierarchies and discrimination are in fact characteristics of everyday life and these have a bearing on participation in development processes.

Communities are made up of households and individuals. The study focuses on the community as unit of analysis. Whilst Sen's (1993) capability approach may seem preoccupied and centred on the individual, individual agency is the foundation for collective agency that impacts on social functioning or actively playing a role in society. Arguments for participation both from an efficiency base and from an agency base do not fully capture the dynamics of community participation. This is so because factors such as tension, conflict and power within a community have an effect on how participation is expressed. These factors create a space in which power differentials dominate and socio-economic disparities reign which in turn could mean the exclusion of those who do not have power within society.

2.3 Community participation in development

Traditionally participation has been viewed as active, passive or interactive (Mikkelsen, 1995). Active participation is open in nature. Community members are able to take part actively in all stages of decision making within the policy process. Project decision making, management and monitoring and evaluation are done by the community. Interactive participation is when community members in the 'target' area partake in the planning process and conduct joint analysis of the situation. There is room but less so than active participation for the community to interact with the development process from the inception phase until its end. Passive participation is when either the community maintains a distance and does not intervene in the process or when the development intervention side-lines it. Participation in a passive form describes a situation where people are told what is going to happen or has already happened, with no ability to change it (Mikkelsen, 1995). This type of participation typifies the top-down approach whereby people are only informed for legitimacy purposes. Ownership over the project locally is impossible as community members have not been meaningfully included from the beginning.

When there are external influences on a community to come together to form groups or committees this is known as functional participation. Functional participation relates to the active and interactive participation in that the external force acts as a catalyst for participation. The main purpose of these groups would be to take forward predetermined goals set by the community as a whole and take control of local decisions at practical and structural levels in governance. According to Mikkelsen (1995), participation in this regard can be considered a right and not just a mechanical process. It can be argued that this type of

participation if optimised has a number of advantages that ultimately result in sustainability and ownership. The main advantages of the people centred approach, which relates to the capability argument of having people participate as an end in itself in development especially at community level, are that there are elements of empowerment, capacity building and self-reliance fostered through an intervention. Empowerment, according to Davids, Theron, Maphunye, and Kealeboga, (2009), centres on individuals developing a critical understanding of their circumstances and social reality. Capacity building as likened to Freire's concept of concientisation can be described as a mechanism to enable local people to determine their own values and priorities and act on their own decisions.

According to Mikkelsen (1995:47), participation involves a process of local communities becoming aware so as to be able to respond, interpret and interact with the development process which is usually led by the state. Roodt (2001:472) concurs with this notion stating that "[i]t is a process whereby poor and oppressed people become politically and socially aware that their living conditions are not 'natural' but the result of the exploitative policies implemented by the state and an elite minority". What is central to this concept is that awareness is achieved through active participation in educational/political/social organisations in conjunction with fellow citizens and which will enable oppressed people to actively change their lot in life. Therefore, the full potential of individuals is realised after they have been made aware of their opportunity-set; then, depending on their human agency and freedom of choice, they act in order to achieve valued goals for their well-being (Frediani 2010).

Davids et al (2009:63) term people-centred development as "a process by which the members of the society increase their personal and institutional capacities to mobilize and manage resources to produce sustainable and justly distributed improvements in their quality of life consistent with their own aspirations". The community development process is a cycle wherein active participation should take place at every stage of the development initiative in order for developmental interventions to be effective. Roodt (2001:470) describes community participation in development as a conscious process wherein small, geographical contiguous communities are assisted by more developed communities to achieve improved standards of social and economic life. This is done primarily through their own local efforts and through local community participation at all stages of goal selection, mobilization of resources, and execution of projects, thus enabling these communities to become increasingly self-reliant. In

the context of this research, the concept community participation in development denotes a conscious process, in which a group of individuals with a common interest come together with or without the help of outsiders to make positive change in their lives. In addition, it does not require outside help as a prerequisite for change for the better in people's lives.

Mansuri and Rao (2003:16) assert that community participation in development will lead to "development that is more responsive to the needs of the poor, more responsive to the government and better delivery of public goods and services". Community organising is crucial and involves mobilising the 'target' community and identifying problems. Through mobilising and raising awareness, interventions that may lead to sustainable development are identified jointly between the state and the public. Community planning is a process through which the community identifies its future vision. The visioning process establishes a desired end state for the community and a vision for the future towards which they strive (Green, 2007). After developing a joint vision and plan, implementation is the stage when the actual necessary action and procedures are undertaken in order to meet the goals and objectives of the development project. According to Green (2007) the process of monitoring is essential whilst the development intervention is underway. Monitoring and evaluation are vital in community development because the community is able to identify whether they are taking the necessary steps towards fulfilment of their desired goals and objectives.

Involvement of community members can also result in better maintained community assets as they are more informed and involved in the process. In this sense, the role of participation is a channel for communication and accessing information. When the community participates, it provides information about its preferences and gains information that may influence its optimal choice. Both types of information are likely to lead to increased welfare for the community and better development outcomes (Mansuri and Rao, 2003). Khwaja (2004) argues based on the economic model of property rights that participation in communities also adds more value than just the sharing of information in that it is a means of exerting influence or bargaining power. The greater a community participates in an activity, the more likely it is to have a say in this activity. The process of participation underscores that, while an agent may be able to share information perfectly, it may have little incentive to either provide or gain the requisite information unless it has the ability to influence the decision and moreover knows that it has this ability. The basic property rights model suggests that ownership over a decision should be given to the agent whose effort or investment matters significantly in the

decision. By giving the agent, whose investment matters more for the decision, greater influence in the decision, it is assured that this agent has high incentives to make the investment leading to greater benefit for all (Khwaja, 2004). In the context of this research, the term participation is regarded as the ability of the community to identify their challenges and needs and then take charge of their situation by interacting and contributing actively in the development initiative/s. Change agents are only there as catalysts, and the community members are at the centre of the development process.

To provide a critical perspective on participation, Khwaja (2004) argues that community participation may not always be desirable in terms of project sustainability. According to his research, "while increased community participation is beneficial in decisions that require relatively more local inputs/knowledge, it is detrimental to project success in decisions requiring investments that the community is at a disadvantage of providing" (Khwaja, 2004:428). Participation may be used as a form of manipulation. Khwaja (2004) raises a concern that, in light of the importance of community driven development and decentralisation of public services, there may currently be too great a reliance on participation as a cure for all. For example, if participation in a project is dependent upon material incentives for a community (such as provision of labour in return for food parcels), then the will to participate ceases when incentives are no longer offered. This affects sustainability of the developmental intervention. Participation in this sense is regarded as a scapegoat to blame the failure of certain projects on the community. Communities themselves have limitations as they are not entirely cohesive and the burden in terms of resources (financial and non-financial) may be overwhelming. More often than not culture and the way of life in a particular context including the power structures are overlooked by policy makers especially when considering the decentralisation of public services. The interaction of factors such as class, gender and existing knowledge within a community influences the way in which a community responds and interprets a developmental intervention. A balance is necessary in policy that acknowledges and utilises the benefits of community participation whilst managing the limitations.

2.4 The primary health care approach and community participation

Adopted in 1978 by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) through the Alma Ata Declaration (1978), the Primary Health

Care (PHC) approach tries to ensure that essential health care be made universally accessible to the poor in communities by means acceptable to them, through their full participation and at a cost that the community and the state can afford (Rifkin, 1986). The approach means that community participation would be integral to the functioning of the health system through both the delivery of services and decisions about health and health services. According to Wayland and Crowder (2002), participation is essential to PHC because individual and community action is seen as being more important than medical technology for improving health among the poor.

Early public health literature on the PHC approach and community participation suggested three approaches (Jewkes and Murcott, 1996; Morgan, 2001) – the medical approach, the health services approach and the community development approach – in which health programmes were to be modelled on. The approaches reviewed in the 1980s by Susan Rifkin describe how health policy planners develop community participation in health programmes based on the way in which health policy makers define health and on how they think the community should respond to their definition. The medical approach defines health as the absence of disease, with community participation as activities undertaken by groups of people following directions of medical professionals in order to reduce individual illness and improve the general environment. This approach augurs well with passive participation where patients are inactive recipients of health services. The health services approach defines health as the physical, mental and social wellbeing of the individual whilst defining community participation as the mobilisation of community people to take an active part in the delivery of health services. This approach supports interactive participation where there is some room for participation in service delivery. The community development approach defines health as a human condition which is a result of social, economic and political development, and community participation as community members being actively involved in decisions about how to improve that condition (Rifkin, 1986; Wayland, 2002). This last approach supports active participation where communities are fully involved in all stages of service delivery.

Acknowledging that the meaning of community participation has varied over the years, the first two approaches are critically different to the third one with regard to community participation. The first two focus on health services as the most important factor in health improvements with health professionals at the helm of decision making. The community development approach in health regards people's perception of health and their motivation to

change health care as critical factors in shaping health policy and subsequent programmes: "It stresses the importance of community people learning how to decide the ways in which change can best be achieved" (Rifkin, 1986:241). Over the years the medical and health services approaches have come to be known as the 'top down' approach to health with the 'bottom up' approach to health being the community development approach.

According to community development proponents, as early as the 1950s and 1960s there are helpful lessons that should be considered in community participation in health in order to avoid the same pitfalls that community development faced (Forster, 1982; Rifkin, 1986). There are three lessons which are centred on the issue of power. The first is that communities are not homogenous and do not always have the will to cooperate for the common good. The greatest example is that, in poverty, individual concerns often override community goals. Only when extreme scarcity of resources is removed and people are economically better off can co-operation take place (Rifkin, 1986; Jewkes and Murcott, 1996). The second is that community leaders do not always act in the best interests of the rest of the community. People who have been identified by the community as having influence often use new opportunities to enrich themselves. In relating this to the capability approach, power structures and how power itself is exerted within a community affects (either positively or in the case of the example, negatively) how one may exercise their human agency for desired change Thus a pro-poor programme can end up promoting those who are already better off. The last lesson is that government planners and community members do not always share the same objectives. According to Wayland and Crowder (2002:234), government staff want local resource mobilisation to free capital for other national priorities whereas community members want to instil confidence and foster self-reliance. This conflict of interest often creates difficulties for community development programmes which when using the efficiency approach to participation, constitutes bad capital.

2.5 Conclusion

In conclusion, a community is often regarded as a homogeneous entity in which all members live in the same way and have the same interests and aspirations. However, in reality, a community is a group with differing interests categorised by class, sex and power. These social dynamics affect the way in which a community participates in development. Furthermore, these dynamics also affect how an individual participates within the community

and how the community as whole relates to development processes. Taking the community development approach in health, participation can be viewed as a means of improving access and the utilisation of health services. From a curative perspective, prevention from disease is also enhanced. According to De Vos, De Ceukelaire, Malaise, Perez, Lefevre and Van der Stuyft (2009) participation using the community development lens can also be perceived as an end in itself, building networks, developing capacity and empowering people to understand and influence the decisions that affect their lives. This view is critical in light of the primary health care approach. However, as discussed earlier, the relation between power and human agency is an important dimension of how a society and an individual conceives and expresses participation. The following chapter sheds light on the contextual nuances that frame health in Zimbabwe.

Chapter 3: The Political Economy of Zimbabwe

3.1 Introduction

In order to properly understand the primary health care system in the Zimbabwean context, a historical analysis of political and economic developments subsequent to independence is necessary. Once heralded as the bread basket of southern Africa, Zimbabwe later experienced a crisis which involved an "interruption in the reproduction of economic, cultural, social and political life" (Johnson et al 2000). This happened despite the government's continuous proclamation of being a sovereign people centred nation. An analysis of the political and economic developments and trends visible particularly in the early years of independence is important as these trends shaped and influenced later processes, with some of the impact still evident to this day. This chapter offers a brief summary of pre independent Zimbabwe and explores in more detail the three decades that have passed after independence through a political and economic lens. The discussion will also provide introspection on three main cross cutting themes that make the context complex and dynamic. In order of presentation, these are land and race, labour and state centralism.

3.2 The Zimbabwean pre- independence era

The political economy of colonial Zimbabwe was peculiar in that the initial speculative incursion by mining capital gave way for the establishment of white 'self-government' known as Southern Rhodesia in 1923. The aim of this political dispensation was to deepen white agrarian capital in the home market (Moyo and Yeros, 2005). Racial, territorial and legal segregation was also established by the white political leadership. Through this, the mode of rule was a combination of direct and indirect forms which suppressed the majority black population.

Inter capitalist conflict between the white industrial bourgeoisie and white agrarian bourgeoisie emerged over time as the former challenged the latter's vision of a 'white settler home market'. According to Moyo and Yeros (2005), this sowed the seeds of black capitalism through the creation of a small agrarian capitalist class outside the communal areas in what was known as 'Native Purchase Areas'. This was however insignificant as there was no support from the white colonial government and this impeded blacks from expanding or

even competing in the markets. Labour in this era was confined to unwaged female labour in the communal areas and low wages in industry and commercial farming which led to "a workforce in motion straddling communal lands, white farms, mines and industrial workplaces" (Moyo and Yeros, 2005:167). Under such conditions, trade unionism became a struggle as it was difficult for the African (or black) workforce to organise and mobilise which was an advantage to the white-settler state.

The liberation struggle was driven by political, economic, social and cultural demands with land redistribution being one of the key demands. There were three main pieces of legislation that were put in place to guide the process of land acquisition under colonialism. The Land Apportionment Act of 1930 formalised the separation of land between blacks and whites. This Act excluded Africans from that half of the country that contained the best farming land, despite the fact that Africans constituted over 95% of the population. The Land Husbandry Act of 1951 was passed with the intention to firstly "reorganize the communal areas along capitalist lines. Secondly the Act sought to enlarge the sphere of influence of white-settler capital beyond southern Rhodesia to colonial Malawi and Zambia thereby establishing the Central African Federation" (Moyo and Yeros, 2005:169). The Land Tenure Act of 1969 was enacted as an adjustment to the 1930 Act. This new act facilitated further the racial division of land, resulting in the movement of more indigenous African people out of white areas (Moyo, 1986). The motive was to divide land more equally between minority whites and majority blacks, but with the white minority still owning vast tracts of land at the expense of the dispossessed African population crowded into infertile reserves (Moyo and Yeros, 2005). These pieces of legislation resulted in a dual system of land ownership involving the mass expropriation of prime agricultural land by the colonial settlers and the subsequent marginalization of black people into reserves, later called tribal trust lands and now known as communal areas. Many communities resisted and were most often confronted with brute force. The forced removals and land dispossession eventually sowed the seeds for the nationalist struggle (Chitsike, 2003).

The inability of the black labour movement to mobilise was due to the white capitalist system "which made unionism an onerous struggle" (Moyo and Yeros, 2005:168). This discontent in labour also contributed to existing tensions around land. Colonial Zimbabwe's nationalism, though about land, must also be seen as a 'human rights movement' and a movement for democracy and the restoration of dignity (Bhebe and Ranger, 2001). In the mid-1970s,

unresolved internal and external constraints within the white-settler state affected the economic and political situation, "for the state never broadened the home market beyond the settler element… [I]nstead it reinforced functional dualism in its segregationist form and relied on the super-exploitation of black labour for rapid capital accumulation" (Moyo and Yeros, 2005:167). The remaining years before Zimbabwe's independence were characterised by guerrilla warfare and the quest for an inclusive non-racial democracy. This coupled with other global and internal economic factors forced the colonial state to focus on a negotiated transition to post-colonialism. This resulted in the Lancaster House Agreement of 1979 between the Patriotic Front (PF) nationalist coalition and the British government.

3.3 1980s: Placing the people first

Independence in 1980 provided the new government in Zimbabwe an opportunity to fulfil the vision of 'national reconciliation' by facilitating equity in the distribution of wealth and income in the new republic. The Growth and Equity Strategy was developed to allow the new government to embark on redressing conditions for the majority that had been neglected during the colonial period. The key objectives of the Growth and Equity Strategy were broadly to see the establishment of "a socialist society; rapid economic growth; economic restructuring, balanced development and equitable distribution of income and productive resources; development of human resources; worker participation; development of economic infrastructure and social services and fiscal and monetary reform" (Raftopoulos, 2001:220). The long term economic policy looked to merge a continuity of production structures with policies to improve the conditions of the majority of the population who had previously been disadvantaged. In retrospect, the 1980s in Zimbabwe seemed to signify the birth of an era of general prosperity and a more equitable socio-economic dispensation as the new leaders systematically dismantled the racist social and political structures inherited from colonialism publicly proclaiming 'education, housing and health for all by the year 2000'. They spoke a language of socialist transformation that resonated very well with the majority of the Zimbabwean people (GoZ, 1981; Raftopoulos and Mlambo, 2009).

The signs for Zimbabwe's growth and development at the onset of independence from 1980 were encouraging. According to Hammar and Raftopoulos (2003), the nationalist government was focused on reconstruction, reconciliation and redistribution under a socialist banner. An impressive expansion in social services took place during much of the 1980s. The state, in

order to work towards fulfilling its promises, stretched its resources to achieve rapid delivery of benefits to a highly expectant population. At this time Zimbabwe was highly favoured by the international community with incessant outpourings of donor assistance giving rise to yet another postcolonial developmentalist state (Raftopoulos, 2001).

Zigora et al (1996) agree with most scholars in stating that it is undisputed that, for most of the 1980s, the Zimbabwean government made impressive achievements in the provision of essential social services such as health care and education, with the country serving as an example of how to balance development with a commitment to advancing the well-being of the majority. Major social programmes led to important improvements across social indicators and a sharp decline in disparities (Mlambo 1997; Jenkins and Knight 2002; Bond and Manyanya 2003; UNDP Human Development Report, 2010). There was also an expansion of credit, marketing and extension services to small scale farmers resulting in increases in their national share of sales of crops such as maize and cotton (Hammar and Raftopoulos 2003).

Progress in the first ten years of independence for the health sector included the provision of hospitals and clinics, the training of health professionals and the development of a highly effective primary health care system. Praise hailed from the World Bank for improved indicators (better than the averages in sub-Saharan Africa) on the number of children immunized, the increase in life expectancy from 55 to 59 years and the reduction of maternal mortality to 90 per 1000 deliveries and infant mortality declining from 82 to 72 per 1000 births (World Bank, 1992:10). This had mixed effects, improving services on the one hand if somewhat unevenly, but increasing the disciplinary reach of the state on the other. By the end of the1980s the growing intolerance of the state became more evident in its rampant actions on consolidation of power. It was clear that the government was moving towards a one-party state. In addition, the rapid growth of the public sector created a black bureaucratic middle-class that progressively strained the fiscus, while laying the foundations for a future alliance with the political elite, so entrenching a process of accumulation from above (Sachikonye 2002). There was little display from the ruling elite towards entrenching accountability structures, and this laid roots for elite accumulation and corruption.

3.4 1990s: Economic Liberalisation and Political Challenges

Macro and fiscal constraints in the late 1980s began to reverse the developmental gains that had been made in the first decade of independence. It became apparent that the government's impressive policies, thrust as they were on the expanding of social expenditure against a shrinking economic base, were not realistic. By 1990, according to Hammar and Raftopoulos (2005), facing economic decline and under pressure from emerging global neo-liberal hegemony after the collapse of Soviet socialism, the government designed a World Bank-style Economic Structural Adjustment Programme (ESAP) in 1991. It was officially cast as 'a home grown' reform and, initially, ESAP had been more about expansion than contraction. But, over time, it took its toll on the Zimbabwean economy and people.

The structural adjustment programme was disastrous to the welfare of the poor. Immediate and sustained negative effects from ESAP included unprecedented increases in interest rates and inflation, a 65 per cent fall in the stock market, deindustrialisation precipitating a 40 per cent decline in manufacturing and causing companies to close, massive jobs cuts and a substantial decline in real wages and overall standards of living (Raftopoulos 2001). A poverty assessment conducted by government in the mid-1990s noted the increasing poverty levels and concluded that 61 per cent of the population lived in households with income per person below a level sufficient to meet basic needs, with 45 percent living below the Food Poverty Line (FPL) (UNICEF 2011:21). It should be noted that coupled with the increasing poverty levels, this period also saw rapid growth in the spread of the HIV and AIDS with a prevalence rate of 25 per cent (ZHSA 2010)

The escalating economic crisis during this period created an environment conducive for political strife within and outside the ruling party. Within the ruling party a lack of accountability amongst party cadres predictably caused internal fissures. This mistrust within led to some cadres running as independents in elections held in the years that followed. Those in leadership faced political pressure as industry experienced growing public discontent through labour strikes. The inability of the state to maintain high levels of social expenditure, a noticeable economic contraction and increasing levels of concern about corruption and the democratic credentials of the state, all contributed to open criticism of the ruling party (Raftopoulos and Phimister, 2004).

Growing public protests, increasing poverty levels, a looming pandemic in the form of HIV and AIDS, dissatisfied civil servants and corruption allegations against the head of the ruling party, all affected the credibility of the ruling party and the state. Saunders (2000) asserts that the regime's response to this was to become increasingly authoritarian and coercive under the rubric of 'good governance'. Major decisions taken in this period include the 1997 awarding to the Zimbabwe National Liberation War Veterans Association (ZNLWVA) of one off cash payments and ongoing pensions monthly, as well as a significant percentage of newly acquired land for resettlement. In 1998, Zimbabwe joined the war in the Democratic Republic of Congo termed as an act of solidarity in defence of sovereignty and regional security (Raftopoulos, 2001). Such commitments placed political strain and an unsustainable burden on an unstable economy affecting the provision and delivery of public services including the social sectors. With regards to the health sector, the austerity measures under neoliberal adjustment promoted the rapid liberalisation of health service allowing for private capital's involvement to increase (Sachikonye 2002). This largely made public health inaccessible to the poor on the basis of affordability. Zigora et al (1996) argue that the 1990s saw a widening of the gap in access to health services between the well-to-do and the poor majority. This is evidence of a shift in policy by the government where earlier it was people oriented and egalitarian, but in the 1990s the policy approach became more market driven focusing on decentralisation through privatisation.

3.5 Crisis and recovery in Zimbabwe: 2000- 2014

3.5.1 2000- 2008: The years of political and economic crisis

The anticipated positive effects of the reforms were not realized (Bijlmakers, Basset and Sanders 1998). Between 1997 and 2008 (dubbed 'the crisis period'), Zimbabwe underwent unprecedented economic decline. According to the Ministry of Finance (2009), the economy had shrunk by more than half. Such an economic contraction is not even experienced by countries ravaged by war. Average inflation, which stood below 20% in the mid-1990s, reached 55.8% by 2000 (IMF 2009). The staggering fall of the national Gross Domestic Product (GDP) was a result of a self-induced economic depression which crippled the economy through massive unemployment, capital flight and the collapse of service delivery.

The economic meltdown was exacerbated by activities in the political realm including land occupations promulgated by ruling party supporters and the fast track land reform programme

(Sachikonye, 2002; Nyazema, 2010; Mlambo, 2013). By the end of 2003, inflation had reached 365%. According to the IMF (2009), it was then in free fall with month on month inflation exceeding a million percent thereby rendering a new meaning to the term hyperinflation. In August of 2008, the central bank redenominated the Zimbabwean dollar, slashing zeros from the notes by December of the same year; the highest national currency unit was a Z$10-trillion note which was worth a loaf of bread. Although the government made efforts to stop the recording and publicising of this historic economic information, the IMF in 2009 calculated that inflation peaked at 500 billion per cent in September of 2008 (IMF 2009). This period saw agriculture, mining and manufacturing suffering major setbacks due to escalating external debt (Raftopoulos and Phimister 2007; Vasudevan, 2008). Capacity utilization slumped to 2% to 10% suggesting a major deindustrialization that translated into company closures, layoffs and retrenchments. Formal unemployment ballooned to 85% (Ministry of Finance, 2009).

According to the IMF (2009), fiscal policy lay in the hands of the Reserve Bank of Zimbabwe although their mandate lay solely with handling monetary policy. The central bank became the de facto government, funding the security apparatus, non-performing state-owned enterprises, farm equipment and inputs as well as government operations. The country's economic collapse reflected in government revenue which tumbled from US$1 billion in 2005 to US$134 million or 3 per cent in GDP terms in 2008 (MOF, 2009). The state virtually went into retreat with shutdowns imminent for public service. Table 3.1 below displays selected social indicators for Zimbabwe. These indicators reflect the outcome of economic and political decisions that had been taken in earlier years.

Table 3. 1: Select Social Indicators for Zimbabwe

Indicator	1990	2000	2006
Human Development Index (rank)	121	128	151
Human Poverty Index (rank among 108 poor countries)	…	60	91
Adult literacy	67	89	89
Infant mortality rate (per 1000)	61	73	81
Under five years of age mortality rate (per 1000)	87	117	132
Maternal mortality rate (per 100 000 births)	330	700	880
Life expectancy (years)	60	43	41
Population using clean water (percentage)	78	85	81

Source: MOF (2009).

These indicators show the disastrous impact of the economic crisis on Zimbabweans. They represent a bleak situation that fully captures the failure of state functionality and its inability to feed its own population. Evidence that directly reflects the public health situation is that the average life expectancy declined from 60 to 41 years between 1990 and 2006, maternal mortality increased from 330 per 100,000 live births in 1990 to 880 per 100.000 live births in 2006 (USAID, 2010:8). The impact is far much greater on those who did not manage to access health care on the basis of affordability, as the 1990s had seen the extensive privatisation of the sector as well as the introduction of user fees at government institutions (Zigora et al, 1996). According to the Ministry of Finance (2009), statistics released during late 2008 showed that 4,000 Zimbabweans were dying each week mainly from malnutrition, tuberculosis, AIDS and road traffic accidents. The clearest evidence of the economic downfall was the cholera outbreak in 2008 which quickly became a pandemic. The outbreak was a result of poor sanitation and contaminated drinking water due to the inability of the state through a parastatal to provide purified water and maintain sanitation facilities. Over 140,000 people were hit by the outbreak with more than 4,000 having died in the period 2008-09 (UNAIDS, 2010).

Politically, ZANU-PF experienced its first defeat through a 'no' vote in the constitutional referendum of 2000. This loss is significant as it was a clear indication of negative public

opinion towards ZANU-PF post-independence. The need to consolidate the position of the state saw the use of violence to curb opposition and to maintain pole position in the country's 2002 and 2008 presidential elections. By 2008, the country's economy had clearly collapsed and the state had failed to defend the basic welfare of its citizens. A serious paradox is that during this period of total lack of control, government authorities were in total control of security and political infrastructure.

3.5.2 Zimbabwe post-2008: Recovery?

The Global Political Agreement (GPA), signed in September 2008, is said to be one of the most outstanding and momentous occasions in the history of Zimbabwe outside of the Unity accord of 1987 and the Constitutional Referendum in 2000. The GPA impacted the social, political and economic fortunes of literally almost everybody in the country as it resulted in the Government of National Unity (GNU) in February 2009. The GNU came into effect after ZANU-PF failed to concede defeat to the Movement for Democratic Change-Tsvangirai (MDC-T) led by Morgan Tsvangirai in harmonised elections held in 2008, leading to a rerun. In this regard:

> The period leading up to the runoff election saw politically-motivated violence on a scale hitherto unknown in the country in terms of all possible parameters – geographical spread, the number and frequency of incidents, the viciousness and cruelty of the acts, the calibre of the perpetrators, the logistical sophistication of the operations and the impunity exhibited to name but a few (OSSREA Zimbabwe, 2013:7).

The scale and magnitude of the events and precariousness of the situation forced the MDC-T to drop out of the runoff election leaving the ruling party ZANU-PF to run uncontested. External pressure from the region forced the ruling party government to negotiate with the lead opposition to form a framework for addressing the economic situation and charting a better course for the future of the country, including the writing of a new constitution.

The era of the GNU opened the space for more meaningful participation on the part of other political parties in Zimbabwe. On the social and economic fronts, the GPA held the hope for a better future for millions of Zimbabweans in all corners of the country regardless of social status, political affiliation or any other categorisation (Biti, 2014). Public finance reforms created room for the Ministry of Finance to retain control in public finance which had somewhat been lost in the preceding years to the Reserve Bank. The reforms were meant to

boost investor confidence and revive the Zimbabwean economy which had now adopted a multi-currency system. The initial years of the GNU saw the economy exhibit growth due to a mining boom; however internal squabbles and sabotage amongst the three ruling political parties (including another faction of the MDC) saw the national envelope shrink and growth stagnate (Biti, 2014).

Regarding the social sector, the GNU inherited government institutions that had deep rooted factors and weaknesses that undermined service delivery. These systemic weaknesses paved the way for increased informality and warped service delivery whose overall effect has been the creation of eyesores and public health threats in open spaces (Chitsike, 2013). For the health sector especially, there was marked improvement in the system. However, research by Mlambo (2013) concluded that these improvements were not to the levels expected by the stakeholders due to the continued financial challenges that faced the government. To address these challenges, a recommendation was made to the government to facilitate the increased participation of non-governmental organisations (NGOs) and the private sector in the health delivery system so as to work progressively towards national health goals.

The GNU resulted in the stabilisation of an out-of-control situation. One of its by-products was the new Zimbabwe Constitution in 2013. Research by OSSREA (2013) argues that the parties to the GPA, rather than the ordinary people of Zimbabwe, were in control of the constitution making process. The authors conclude that the document that emerged from the constitution making process is a product of negotiations among the most influential political elements and not a people-driven constitution. The Constitution of 2013 made way for elections in July of the same year in which ZANU-PF regained full control of the government by an overwhelming margin of 61% (OSSREA 2013). Serious political and economic crisis conditions continue until 2015 and these have had an impact on the effective delivery of primary health care in Zimbabwe.

3.6 A discussion of select themes in Zimbabwe's socio economic and political history

The following three sections provide an overview of three main themes of land and race, labour and state centralism. These three factors have played an undoubtable role in framing the Zimbabwe situation politically, socially and economically.

3.6.1 Land and Race

In unpacking the Zimbabwean situation, land and race are cross cutting themes that have an undeniable prominence in the current state of the nation politically, economically and socially. According to Muzondidya (2010), ZANU-PF's authoritarian-based prolonged stay in power cannot be understood without interrogating the failure of both its internal and external opponents to deal effectively with the question of race, particularly unresolved legacies of racial polarisation and inequalities. There were after independence unresolved racial inequalities in the economy, especially in land ownership and utilisation.

In the years before independence, blacks settled in communal areas with poor soils and low rainfall and hence they could hardly make a living off the land. The Second *Chimurenga* (armed struggle stemming from the 1970s) was a national uprising that saw the involvement of peasant communities in the villages of communal areas, with the war culminating in the Lancaster House Conference in 1979 which resulted in the independence of Zimbabwe in April 1980. Colonial land policies and practices were the main causes of the liberation struggle. During the struggle, land equality and equity were central issues in the liberation war discourse. Thus, at independence, the new government was forced to consider redistributing land as a way of transferring land from the minority white commercial farmers to the majority black Zimbabwean population.

In the early 1980s the Zimbabwean government made significant strides in redistributing land to the black majority population. The approach to address the land issue during this period which went on until 1997 was based on a slow and cautious market-based strategy. Sam Moyo (1986:13) describes that the approach involved the state purchasing land for redistribution following willing-buyer-willing-seller procedures. With the active involvement of many state ministries, namely Agriculture, Local Government, Health, Transport, Education, Construction and Social Welfare, land was acquired for black people from white commercial farmers under this "willing-buyer willing-seller" scheme (Moyo and Yeros 2007:104). The private sector led the land identification process with central government being a reactive buyer choosing land offered. Beneficiaries of the state-bought land were selected mainly by officials at district level under the watchful eye of central government.

The land question seemingly took precedence in state policies and the government established the Intensive Resettlement Programme (IRP) to address three main concerns: unequal and inequitable land distribution, insecurity of tenure, and unsustainable and sub-optimal land use (GoZ, 1998). The rationale was to primarily resettle people displaced by the war, the landless, the poor, the unemployed and the destitute. The initiatives were consistent with the new government's socialist oriented development programme that emphasised equity and social justice, and ensuring the relocation of the indigenous population onto more productive lands (GoZ, 2000). However, the process stalled in the mid-1980s and it was only in the 1990s that the government sought to reaccelerate the land reform and resettlement programmes owing to economic and socio-political pressure. Here there is an evident use of the land and race issues for political mobilisation and scapegoating in the mounting economic pressures of the 1990s.

Throughout the 1980s (Stoneman, 1981) and into the early 1990s, white farmers had been reluctant to relinquish their colonially inherited control over land and water resources. More broadly, there had been little structural change in the Zimbabwean economy which had remained in foreign hands, especially British and South African multinational corporations. This continued foreign ownership meant that, to a large extent, locals were excluded from the productive sectors of the economy. Many whites in this period focused on maintaining their privileged economic status (Moyo and Yeros 2007). According to Hammar and Raftopoulos (2003) many white Zimbabweans had been influenced by settler culture and had made no effort to reform their political attitudes towards their black compatriots in order to contribute to nation building. This was most evident in the social sectors of health and education and places of social contact where little integration had taken place.

Though there is evidence as highlighted above that the land policy of the 1980s and early 1990s period was slow and eventually stalled, research by Kinsey (1999) indicates that there were some positive outcomes for blacks resettled during this period. In this respect, Raftopoulos (2001) states that the newly-settled were provided with facilities that included potable water supplies, dip tanks for livestock, clinics, schools, improved sanitation, housing loans, roads and marketing depots. These outcomes are to a large extent positive and may be termed sustainable because of positive behavioural change on the resettled farms including reduced alcoholism, reduced rates of suicide and decreased domestic violence due to the provision of livelihoods.

From the year 2000, land clearly became the key weapon for redressing the racial prejudices and inequalities. This was through rectifying the racially-based land injustices of the past through land redistribution in the form of the Fast Track Land Reform Programme (FTLRP). In the year 2000, the government of Zimbabwe launched the large-scale FTLRP as part of its ongoing Land Reform and Resettlement Programme (LRRP), the second phase of which began in 1997. The FTLRP emerged as a direct result of the land occupation movement that began in February 2000. The motive behind the FTLRP, as propagated by the ruling party, was to address the racially-skewed land distribution pattern inherited at independence in 1980. Prior to 2000, land redistribution had occurred on an insignificant scale such that, by the late 1990s, Zimbabwe still retained a colonial dualistic agrarian structure.

From the late 1990s, ZANU-PF consciously redirected in a gradual manner popular anger rising towards the government by focusing on the unresolved questions of belonging, citizenship and economic rights and appealing to a notion of exclusive Black Nationalism (Muzondidya, 2011). The debate was shifted in this time period into a more 'native–settler question' in order to reconnect with the public who were increasingly showing signs of discontent as a result of the negative consequences of the structural adjustment programmes. Land was consciously portrayed in this light in order to appeal to the older generation, those that had experienced colonialism. For the large proportion of the Zimbabwean population, overpopulated in the communal areas and living adjacent to commercial farms owned by whites, the ZANU-PF rhetoric about the 'return of the land to its rightful owners' had and still has a popular resonance (Moyo, 2009; Muzondidya, 2011). The politics of nativism for ZANU-PF from the late 1990s to the present day has rhetorically been designed to conceal the party's own policy shortcomings, authoritarianism and elite accumulation (Raftopoulos, 2006; Hammar, 2009; Muzondidya, 2011).

By projecting the land issue as a decolonisation matter, the Zimbabwean government has over the last few decades been able to retain political legitimacy. For Makumbe (2009), ZANU-PF has skilfully utilised the emotive issue of race to mobilise support internally, regionally and internationally, while both the opposition and the external critics of the ruling party underestimated the power of race in building support for ZANU-PF and in polarising political opinion on Zimbabwe. However opportunistic this is, it has not managed to resolve once-and-for-all the legacies of racism and racial inequalities in the economy and in land ownership.

Mlambo (2005) argues that what has helped to make race a powerful strategy to mobilise in post-2000 Zimbabwe are the concerns about the legacies of colonialism and racialism in the region as well as 'Third World' grievances about the continued dominance and marginalisation of the South under globalisation. This regional and global socio-economic context provided ZANU-PF space and room to navigate and turn race into a powerful mobilisation tool in the face of mounting pressure. Race continues to matter to most Zimbabweans as it still remains embedded in the social, economic and political structures of the country. This may partly explain why ZANU-PF has remained in power even after an economic meltdown and collapse of health and education as integral elements of the social sector.

3.6.2 Labour

Government in 1980 made several policy decisions for the protection of workers' income and employment. These were firstly in response to the pre-colonial era which suppressed the African workers. Secondly the policies responded to a spate of public sector strikes in 1980-82 which resulted in the formation of the Zimbabwe Congress of Trade Unions (ZCTU). The main pieces of legislation passed to uphold policy commitments to workers were the Employment Act, Minimum Wages Legislation Act and the Labour Relations Act. It should be noted that although this legislation was for the safeguarding of worker rights and conditions, there was excessive room for state control within the labour legislative framework from the onset. As Sachikonye (1986) notes, the persistent presence of the state represented by the minister in the legislation indicated the new government's concern with consolidating power in the early years.

To further entrench its power, the state dominated in the functioning of the ZCTU. As Raftopoulos and Sachikonye (2001) highlight, for much of the 1980s, workers were regularly reminded about their subordinate role to the party. When strikes took place, workers were scolded and chastised for their ingratitude to the liberation struggle, as led by the nationalist movement, and its values. In addition, war veterans were active in mobilising support for the ruling party at the workplace. This placed pressure on employers to employ war veterans who would then be involved in workers' committees. This as a strategy insured constant presence in the workplace and kept a pulse beat on attitudes in the national workforce. This also facilitated an easier way to mobilise as well as influence workers.

The labour movement in Zimbabwe only became prominent in light of the mounting social and economic problems from the late 1980s into the 1990s and onwards (Raftopoulos and Sachikonye, 2001), with the rise of labour as an important theme in relation to the ESAP. Prior to this adjustment programme, labour was weak and considered a subordinate extension of the ruling party. Owing to economic challenges brought on by ESAP, retrenchments and job cuts became the order of the day. Employment growth decreased from 2.5 per cent during 1985-90 to 1.5 per cent in the years 1996-99 (Raftopoulos and Sachikonye, 2001). The effects of this were that both living and working conditions for workers and their families became the opposite of what had been promised at the dawn of independence.

The decline of incomes for workers led to dissatisfaction being expressed through strike action. There were increasing numbers of workers participating and recurring strike action over unresolved grievances at national level, including growing militancy in public sector strikes (Saunders 1995). Such public displays of dissatisfaction from ZCTU-affiliated unions were sure to cause discomfort for the state. In fact, the national public sector strike in 1996 and the mass stay away of 1998 definitely shook the confidence of the state. The former strengthened the links between ZCTU and public sector unions and the latter established the potential effectiveness of labour as a social movement for change. These events signalled the growing need for change within the country which was a cause for concern for the ruling party.

As the majority of Zimbabweans further bore the brunt of escalating economic woes, the labour movement took advantage of this and linked the economic crisis to problems in national governance. Through this process, the ZCTU developed a strong alliance with a wide range of civic groups around issues of democratisation and human rights as these had been neglected by the ruling party. Within the context of the reinvigoration of labour and its increasing involvement in human rights and democracy issues, Zimbabwe's most prominent urban-based opposition protest movements in the late 1990s emerged, along with the formation of the Movement for Democratic Change (MDC) in 1999 (Muzondidya, 2010). Raftopoulos (2001) interestingly points out that, in a space of two decades, the labour movement had moved from a weak and divided organisation, under the shadow of a dominant nationalist party, to the facilitator of a broad opposition alliance that was challenging state power.

With the inception of the MDC, the labour movement became increasingly caught in a highly polarised situation, and was placed in-between an intangible political tug of war. As a pawn in the political game, labour was subordinated to political forces with for example the ZANU-PF government seeking to subvert labour's power through authoritarianism. As well, the incorporation of labour movement leaders into MDC structures weakened the labour movement and also compromised its position and mandate for the ordinary worker. Because of this, the labour movement cause is often mistakenly tied to the MDC cause. True to authoritarian form, state repression included violent crackdowns on labour activities and frequent harassment and intimidation of labour leaders, with structural changes in the labour force resulting in a massive decrease in the number of people in formal employment (Raftopoulos, 2007). Numbers were further decreased due to skills flight into the regional and international realms which heavily affected the social sectors of health and education. All these factors constrained the organising force and power to mobilise for genuine labour issues and concerns.

Post-2000, deep divides along political lines further weakened the labour movement and yet the socio-economic climate continued to decline at alarming rates. The main labour group (ZCTU) attempted to mobilise civil servants for various protests which were not successful. Leadership struggles and polarisation led to workers themselves losing confidence in the mobilising power of the labour movement. This was evidenced for example in 2004 when a nation-wide job stay away was called for by the ZCTU in protest to support corruption and mismanagement allegations against the National Social Security Authority (NSSA). Workers ignored the call (Muzondidya, 2011). This particular example illustrates disengagement and loss of identification between the labour movement and the worker. Politics and power overrode welfare concerns of the ordinary worker. The labour movement leadership failed to harness and direct the anger of the people over growing discontent about salaries and deteriorating socio-economic conditions to force a change in government. The close ties of the labour movement with the MDC elicited a harsh and hostile response from ZANU-PF in government, which further weakened this platform for worker participation in the safeguarding and promoting of workplace rights.

3.6.3 State Centralism

In the early years of post-independence, the ruling party (ZANU PF) committed itself to furthering the aspirations of nation building. Within the first five years of independence the

government worked to Africanise the state (Raftopoulosm1986). In consolidating its presence, the new government focused on the land issue, deracialising social services and allowing for the organisation of the black labour workforce into trade unions. It worked to transform and democratise the structure of governance in both urban and rural areas through decentralisation of power and resources to local government (Muzondidya, 2011). However, the foundations for this process were not as strong as assumed. Various scholars are in agreement that post-independence Zimbabwean politics have pointed to the continuity of authoritarian governance, from the colonial period, with reference to the ruling party in government. Makumbe (1998) in fact argues that decentralisation was primarily aimed at establishing a one-party state.

A culture of political intolerance was adopted by the ruling party and this affected its performance in practicing the democratic ideals it espoused as it entered power. Sithole (1988) states that the government "skilfully articulated populist policies on land, indigenisation of the economy, employment and workers' rights and initially delivered on some of its social and economic promise at the same time using violence and coercion as integral elements of ruling power retention in electoral policies" (Sithole, 1988:84). The government allowed for the multi-party system to be functional although with limited space to campaign, and it did not create an environment or set conditions for elections to be free and fair (Makumbe and Sithole, 1997). Over the years, and still evident today, state resources and institutions such as the army, police, intelligence services and state media are used to ensure electoral hegemony (Moyo 1992; Makumbe, 1998; Murithi and Mawadza, 2011). This also has had significant impact on social order and the performance of the economy.

After independence, in broadening democratic participation, various local government reforms were introduced with the intension to involve the public in decision-making at the local level. The Prime Minister's *Directive on Decentralisation* of 1984 provided the basis for a hierarchy of representative bodies at village, ward, district and provincial levels offering opportunities to widen and deepen democracy through creating mechanisms for participation (Mutizwa-Mangiza, 1990; Zigora et al. 1996). According to Makumbe (1996), these platforms were for identifying viable strategies to ensure effective rural governance, active community participation and sustainable local development. In essence the local government decentralisation process was not successful because of the excessive involvement of the ruling party in the process. The establishment of Provincial Governors was geared towards

expanding the political base and ensuring the perpetuation of dominance of ZANU-PF as the only political force in the country (Makumbe 1998). The Village Development Committees (VIDCOs) and Ward Development Committees (WADCOs) were meant to spearhead development at the local level as well as democracy, but they were not allowed to evolve into inclusive structures of governance due to the overbearing nature of the ruling party.

These platforms for local participation for development remained local ZANU-PF party committees and cells carried over from the liberation war (Hammar, 2005:19). This characteristic is still evident today as, at this level of government, partisanship and authoritarian practices pervade both popular participation and democratic developmentalism (Muzondidya, 2011). Muzondidya (2011) therefore places ZANU-PF's political legacy as preserved through a culture of decentralised despotism in rural Zimbabwe, and it has resulted in rural areas being partially insulated from alternative political influences. Rural spaces have been literally cordoned off from opposition party influences. This is partly due to ZANU-PF's dominance and control of both state administrative structures and rural populations.

Socially, ZANU-PFs continued dominance throughout the last three decades has not allowed democracy coupled with development to grow. One example that stands out as an excessive use of force and violence to maintain power and curb dissent was the *Gukurahundi* massacres in Matabeleland Province. The immediate causes of the outbreak of violence between the 'dissidents' and government forces was a 'distrust within, and then repression by, the newly formed Zimbabwe National Army' (Alexander and Mc Gregor 2001:181). The military played a central role in this dramatic show of force. Opposition was stifled when the violence and killing in this period ended in 1987 after the signing of the Unity Agreement between ZANU-PF and Patriotic Front-Zimbabwe African Peoples Union (PF-ZAPU). This agreement ushered in more powers to the executive through a constitutional amendment (Constitution of Zimbabwe Amendment Act Number 7). This action significantly weakened and marginalised the legislature. This method of political subordination was also used over the years to control women's groups, labour, students and other civil forces whenever they expressed dissent or organised protests (Sachikonye, 1986; Raftopoulos, 2004:4-5). The response of the state towards *Gukurahundi* has marked the post-colonial history of Zimbabwe in ways that have yet to be confronted, resulting in a lasting division based on 'tribalism' and pointing to selective citizenship.

From the pre independence era into the current decade, the political-military nexus has always been strong in Zimbabwe. The dominance of the security sector in the country has resulted in the militarisation of many aspects of national policy and largely affecting implementation in addressing socio-economic issues. The military admittedly has never been directly involved in the day to day running of the country (Muzondidya, 2011). However, its top leadership continues to be consulted in important decision making processes of both the ruling party and government. This goes beyond the apolitical mandate in governance for the military and security forces as set by the supreme law of the land. The military has been used to safeguard support for the ruling party and to thwart any signs of dissent from the root through various methods of force, coercion, violence and assassination. In return, the elites in the security forces have been huge beneficiaries of the land redistribution programmes and lucrative mining contracts in the DRC as well as nationally in the Marange mining areas in Manicaland Province (Murithi and Mawadza, 2011; United Nations, 2014).

In recent years, the weakness of state legitimacy has manifested itself in ZANU-PF through attacks from within. The land occupations from 2000 onwards, the economy spiralling out of control, a growing lack of accountability and adherence to the rule of law and the extensive use of force and violence on opposition, are just some factors that have contributed to cracks within the ruling party. This is most evident at local level. There have been instances where in rural districts, teachers, health workers and local government officials have been relieved of their duties owing to partisan politics. This attack on the local state has created long standing grievances around the lack of financial capacity, maladministration and corruption of local authorities. The result has been that the ruling party has gained greater control at district and provincial levels with the Provincial Administrators and District Administrators more subject to party structures (McGregor, 2002).

3.7 Conclusion

The political and economic trends developed and nurtured in the early years of independence had important implications for the environment in which democracy was to be practiced. These trends also fostered a hostile environment for civic participation as there was no room for the growth of alternative political movements. Room for civic participation in local government decision making processes was also limited. It was these hegemonic tendencies throughout the decades coupled with economic challenges that affected the standard of living

for all Zimbabweans negatively. Serious fractures in the ZANU-PF notion of national unity influenced decision making that in hindsight can be termed mediocre in nature. The concerted effort to maintain power by the ruling party over the years has undermined institutional structures especially at local level, where the people live their lives. At this level of government, there are serious problems, including capacity gaps in public sector professionals, thus weakening public service. Problems in health care delivery are in fact part of broader fiscal and administrative incapacities characterising the contemporary Zimbabwean state, and they can only be fully understood in relation to the broader political economy of the country since independence.

Chapter 4: Health in Zimbabwe

4.1 Introduction

Functional health systems normally have excellent primary health care as a firm foundation. Currently, the Zimbabwean health system is recovering from a decade of economic decline, which adversely affected health service delivery and reduced post-independence achievements in health (Osika, Altman, Ekbladh, Katz, Nguyen, Rosenfeld, Williamson, and Tapera, 2010). The chapter focuses on the history of the health system and health service delivery in Zimbabwe between 1980 and 2009 with the hope of determining how the hopes set at independence in 1980 turned into despair as the health system crumbled. The period from 2009 to 2013 will be touched on briefly to highlight attempts at resuscitating the health sector in the period of the Government of National Unity (GNU). From 2009, the intolerant authoritarian nationalism that informed government policies and actions is a stark paradox to the earlier promises of the liberation struggle. Challenges for participation in the health system will be covered through the exploration of the following themes which are, in order of presentation, health financing, human resources for health and accountability in health.

4.2 Health pre-1980

Zimbabwe's impressive achievements in providing health services for the majority of the population in the first decade after independence has to be seen within the context of the situation inherited from colonial rule (Mlambo, 2013). In colonial Zimbabwe there were major disparities in health services, with these services being unquestionably highly skewed in favour of the dominant white ruling elite. Blacks under colonial rule were greatly disadvantaged by their lack of access to economic and other opportunities to function and flourish as human beings. Prior to 1980, access to health facilities for example was marked mainly by race rather than by class (Matshalaga, 2000). The black population, 80 per cent of whom resided in rural areas, lacked physical health facilities such as clinics and hospitals while the urban white population and small urban black population were better served with health facilities (Zerai, 1993).

Saunders and Davies (1988) note that it was by political design that the white minority population enjoyed better health standards than the majority black population. In the 1970s government spending per black patient was half the spending for a white patient with a total of 389 doctors serving in urban areas as compared to only 11 doctors in rural areas (CWGH 1998). There was gross inequality in the provision of health services with 44 per cent of publicly funded services provided for central hospitals serving 15 per cent of the population (mainly white) while only 24 per cent went to primary and secondary level rural health services for the majority of the population (Saunders and Davies, 1988). Only a third of the health ministry's budget pre 1980 went to curative services with a large proportion of the allocation being given to a major hospital way out of reach of the rural majority population (Zigora et al., 1996).

Two thirds of the health budget went to preventative services but these were not targeted to the majority population in rural areas. The greatest burden of disease and illness fell on the most vulnerable groups of the population including infants, children under five and women of child bearing age. Most of these diseases were of a preventative nature such as nutritional deficiencies and communicable diseases (Mlambo, 1997). Mortality rates varied substantially by geographical location, race and class; for example, in 1980, there was a 1:3 ratio in infant mortality for whites against one of 5:10 for urban blacks and rural blacks (Matshalaga, 2000). The government of Rhodesia ran a discriminatory health system in geographical, financial and social terms, with the white minority monopolizing the economic resources for its own preventive measures. The result of this was that health care was not accessible to the majority of the black population.

4.3 People at the centre: health in the 1980s

At independence, the new government declared that health would be accessible to all with a set timeline for the year 2000. The state recognised the presence of multiple and uncoordinated providers of health care and a misdistribution of personnel between urban and rural areas and between races and social classes. This threatened the establishment of a national unified health service, so various measures were proposed in the Transitional National Development Plan (TNDP 1983). For Sanders (1995), the measures included the abolition of racially discriminatory laws; a restriction on the expansion of private facilities; post-training bonding of health workers to the public services; the barring of immigrants from

private practice; incorporation of the traditional health sector; rationalisation of therapeutic procedures through the establishment of an essential-drugs list and the establishment of a universally applied national health insurance scheme. These broad measures introduced were to improve the quality of life for the ordinary Zimbabwean.

Post-independence health policy, as expressed in Planning for Equity in Health (Ministry of Health, 1984) reflected the broader national objectives outlined in the Transitional National Development Plan, to establish a society "founded on socialist, democratic and egalitarian principles" and to end "imperialist exploitation through more equitable Zimbabwean ownership of the means of production". The priority task in 1980 was stated to be the restoration and rehabilitation of the war torn infrastructure. With the expressed recognition that the causes of ill-health lay in the conditions of people's lives, and in the context of an urban, racially and curatively biased health care system, the government in 1980 guaranteed to transform health care so that all citizens would have access to a comprehensive integrated National Health Service. Health policy during this era placed great emphasis on preventative approaches to public health through the establishment of infrastructure for good sanitation, safe water and health service delivery facilities. Family planning and child immunization were prevalent along with health education for villages and the training of health workers. Free health care was provided to those who earned less than 150 Zimbabwean dollars (Munyuki and Jasi, 2009).

Under the government's Planning for Equity in Health Policy initiative, the 1980s witnessed a very rapid growth of the public health sector. As Loewenson and Chisvo (1994) note, the investments made in health in 1980 produced significant reductions in morbity and mortality, reduced health differentials between urban and rural communities and improved access to preventative and curative health services. New hospitals and clinics were established to cover all provinces of the country whilst existing structures were upgraded. The target was that by 2000, 456 health centres, 612 rural hospitals and 25 district hospitals along with 10 provincial hospitals be fully functional to serve at least 85 per cent of the population. The estimated distance between a patient and a clinic was to be 8 kilometres to facilitate easy access to service delivery. In the period of the 1980s, the Zimbabwe government health policy therefore emphasized equity with clear commitments to addressing the racial divide in health service delivery through the redistribution of resources and being responsive to people's needs by incorporating community participation.

4.4 Health and structural adjustment: 1990-2008

Under ESAP, government priorities in health provision shifted from being people oriented to being more market driven through privatization. Thus, while the earlier policy approach emphasized the need to redirect resources to the most needy in society, thereby putting an end to the inherited colonial rural-urban racial bias by giving the poor majority greater accessibility and placing greater emphasis on preventative rather than curative approaches, policy in this period did the exact opposite. The Minister of Health at the time, Dr Stamps commented as follows on the impact of the ESAP on health:

> The structural adjustment policies have had a bad effect on our health care system. In the rush to make our economy more efficient and market oriented, we are losing the gains made in health since independence. I do not pretend to have the answers to economic problems but I don't claim to be an economist. What I do know, is that due to higher charges for health services, we have seen an unacceptable rise in maternal death in childbirth and a dramatic rise in death from preventative diseases from diarrhoea (Meldrum 1993 in Matshalaga, 2000:780).

The major components of the adjustment programmes focused on stabilizing the economy through the adoption of restrictive fiscal and monetary policies and, as an afterthought, a poverty alleviation component intended to cushion "vulnerable" groups such as those who had been retrenched and poor families and children, against the adverse effects of these reform measures (Gaidzanwa, 1999). However, the anticipated positive effects of the reforms were not realized as the economic situation was exacerbated by an unprecedented drought (1992-1993), and the HIV epidemic reached its peak with a prevalence rate of close to 30% (Bijlmakers, Basset and Sanders, 1998). During this period, expenditure on health on the country's rural clinics dwindled. These clinics, which served approximately 80 per cent of the population, received a reduced allocation after each passing year (Saunders, 1996). As a result, the health sector stagnated while there was a significant increase in private sector health which provided services that were largely unaffordable for the majority. Munyuki and Jasi (2009) state that the rapid liberalization of the health sector in the 1990s opened the door so private capital could increase its share of the domestic market at a time of government cuts in public expenditure and the imposition of fee payments for medical services. These changes initiated a process of decline in the public health sector that was eventually to result in the reversal of the gains of the 1980s.

Coupled with very poor economic performance, the combined effects of the HIV and AIDS pandemic and natural disasters such as drought created an environment in which poverty levels doubled, dubbing the period from 1997-2008 'the crisis period' – this included the onset of land reform and the decline in industrial and agricultural performance with various economic reforms failing to reverse economic decline (Nyazema, 2010). With the collapse of the economy and public finance, ordinary citizens were left to fend for themselves against mounting difficulties in order to meet their basic needs (UNICEF, 2011). At the height of this crisis, and to illustrate the deterioration of the social sectors, was the cholera outbreak of 2008-2009 with 98,531 cases and 4,282 deaths recorded by the Central Statistical Office (2009). This was the worst outbreak in Zimbabwean history and underscored the extent of the deterioration in basic water, sanitation and health services, weakening the health system drastically (USCDC, 2009).

4.5 The revitalisation of health in Zimbabwe: 2008-2013

The consummation of the Government of National Unity together with the stabilization of the economy in 2009 created an environment that allowed the health sector to move from emergency planning to medium to long term planning. The National Health Strategy (NHS) for 2009-2013 was the successor to the National Health Strategy of Zimbabwe for 1997-2007. In 2009, the health sector was indicated as a key priority for the inclusive government through economic policies for recovery, notably the Short Term Emergency Plan (STERP) and the Mid-Term Plan for 2010 to 2015.

The gradual decline in the economy had affected the health system in Zimbabwe which saw a systematic decrease in key areas of maternal and child health, and communicable diseases such as cholera and typhoid. Both of these indicators had become foreign to Zimbabwe since they had been from independence the core performing elements of the primary health care system (ZHSIC 2012). The revitalisation of the health system from 2009 validates the historical focus of the state (through the health ministry) on primary health care with a strong focus on community based approaches complemented by robust referral systems and facilities. The NHS (2009-2013) states that the core objectives of the health system in Zimbabwe is

> To keep as many people as possible in good health in the community through health protection, health promotion and disease prevention strategies; to provide appropriate

> quality services for those needing care in the community (primary care) and to provide high quality hospital services at the appropriate level for those few requiring that form of treatment and care (Zimbabwe MoHCW and NAC 2009a:11).

The strategy also recognises that "community participation enhances quality health care, and ideas for the health system can be influenced by the service users" (Zimbabwe MoHCW and NAC 2009a:11). As well, it underscores the importance of a broader focus in developing and implementing successful health services, as it states that "good health and quality of life do not derive only from the health sector, but are influenced by a myriad of other factors which are outside its direct influence. All sectors of the economy impact on the health and quality of life of all citizens through their direct influence on the social determinants of health" (MoHCW 2009:22).

An ongoing focus on the primary health care approach is still envisioned by the government of Zimbabwe with a commitment to resource the community and primary care levels of the health system as espoused in its current strategic direction. The primary level consists of a network of community health workers and health centres. According to the Ministry of Health and Child Welfare (MOHCW) (now Ministry of Health and Child Care or MOHCC), the community level of health services includes all actions that families and communities can take to maintain and improve their health and nutritional status (MOHCW, 2013). The primary level of the health system is made up of community/village health workers, with clinics taking the form of Health Centres. It is clear that the principles of primary health care contained in the Alma Ata Declaration of 1978 remain relevant to health care and health service delivery in Zimbabwe and inform health policy in the present day.

4.6 Human Resources in health

Human resources for health have been a health policy priority for the government of Zimbabwe since 1980. The primary health care approach allowed the government to work towards achieving equity which later informed the National Health Strategic Plan (1997-2007) and the Zimbabwe National Health Strategy (2009-2013) with the identification of human resources for health as the key to realising this goal. The health sector has developed and adopted several policies, strategic plans and guidelines to ensure standardised care and treatment, as well as to guide implementation of health service delivery by the public and private sectors.

In 2007 the state through the health ministry employed 65% of national health workers through owning and managing 70% of the national stock of health facilities and through grant support to 75% of private not-for-profit facilities ran by missions and local authorities (ZMNHR, 2007:6). In terms of public expenditure on the human resources component of health service, the 1980s saw increased spending but – in the light of structural adjustment – this gradually decreased to 47% by 1999. In 2004/2005 public expenditure on health drastically lowered to 34% of recurrent and capital expenditure (MOF, 2009), with this decline being animated by the economic decline Zimbabwe experienced during the 1990s. At the same time, the health system showed significant signs of strain in meeting increasing demand. Besides economic policy and management demise, the failure of the health system from the late 1990s to 2009 can also be attributed to the devastating effects of brain drain.

The worsening economic environment was discomforting to the average health worker which was evident in the significant rise of labour protests and worker unrest. The most significant show of labour dissatisfaction occurred in late 1996. A widespread strike of junior doctors and nurses crippled central and urban public health services for many weeks. In the same year, the ruling party (ZANU-PF) congress together with the national labour centre ZCTU called for a commission of inquiry into the health sector. It was at this stage that civic interest groups, communities and other stakeholders expressed discontent in declining quality of care, imposed fee charges, inadequate drug supplies, long waiting times, negative attitudes of health staff, transport problems to and between health services, and falling real pay of health workers (CWGH, 1997; Mutizwa-Mangiza, 1997). The social sectors (and specifically the health sector) were the most affected by wage declines with workers fleeing the National Health Service and in most instances the country in search of wages that would sustain a better standard and quality of life. At the height of the economic depression, the MOHCW reported the loss of over 3,500 health staff, which at the time left more than 60 percent of physician positions vacant across the country (WHO, 2009).

The brain drain in the health sector has not been extensively documented although there is some literature, such as Gupta and Dal Poz (2009), Nyazema (2010) and Mlambo (2013), which examines the environment in which it is occurring. In 2010, the Ministry of Health acknowledged that Zimbabwe, once renowned in the sub-Saharan region for providing high quality, accessible and affordable health care services to its populace, was now facing a challenge in attracting and retaining qualified health personnel. And “without a well-trained

and motivated health workforce it will be difficult to provide health care services to the standards required' (Chihaka and Dhlakama, 2009:4). A guiding policy (Human Resources for Health Strategic Plan, 2010-2014) for human resources for health was introduced in 2009 to highlight the government's intention to strengthen this core determinant for health service delivery in revitalising the health system.

Nurses and midwives represent the majority of primary health care workers in Zimbabwe and they greatly outnumber physicians (ZDHS, 2013). Research done by Nyazema (2010) shows that nurses and midwives make up 46% and 19% of the national health workforce respectively, with 7% as physicians (but with most critical physician positions vacant). In 2013, the Ministry of Health in Zimbabwe was using the staff establishment set by the government in 1980. This means that, even if all the established positions for nurses, doctors and midwives were filled in Zimbabwe, health worker density would be 1.65 per 1,000 people. As Mlambo (2013) indicate, this is short of the WHO recommended 2.28 per 1000 people.

The inability of health policy to respond to and cater for human resources for health as a prerequisite to health for all from independence all through to today has resulted in persistent violation of the notion of health for all premised in the primary health care approach. The economic situation of course has intensified the failings of health policy with dual employment becoming a common feature in public health service (Gupta and Dal Poz, 2009). Dual employment, which is an overlap between public and private medical practice, reflects the health system's inability to sufficiently compensate its trained workforce resulting in health workers sacrificing their duty in public service for greater financial incentives in the private sector. Although in 2010 nearly two-thirds of Zimbabwe's population live in rural communities, there is a clear urban bias in the distribution of health workers in the public service (Nyazema, 2010). Rural areas are the most affected by vacant posts in the health system; however, both urban and rural areas still suffer from significant service delays as health worker supply continues to fall short of service demand (Mlambo, 2013).

4.7 Health Financing

Financing for health in Zimbabwe is broadly divided into public and private health financing. Public funding is done through the national budget allocation while private health financing

comes from private health insurance funds, out of pocket spending from the public and donor health funding among others. Government of Zimbabwe spending increased steadily in the first decade of independence which saw the state improving access to the previously disadvantaged majority population.

The burden of financing health services was shifted considerably during the ESAP period from the state towards individuals (Nyazema, 2010). User fees introduced in the 1990s had a serious negative impact on the utilization of health services. Zigora et al (1996) noted a sharp drop in health service usage following the introduction of user fees. And UNICEF records that there was a whooping decline in health services by 30 per cent, and fewer people were visiting clinics and hospitals because they could not afford hospital fees (Mlambo, 2013). The 1990s saw the widening of the gap in access to health services between the well-to-do and the poor majority leaving the poor to resort to traditional healers whose charges were affordable (Mudyarabikwa and Madhina, 2000). By effectively transferring the burden of funding health services from the government coffers to individuals and households, the government's policies made it difficult for poor people to access health services previously available to them in the first decade of independence.

With the economic crisis reaching its height in 2008, the health sector experienced an ongoing fall in public health financing until the formation of the GNU. Market forces previously introduced in the 1990s played a crucial role in continuing to limit access to care for the majority owing to cost. The continuing poor performance of the economy from the early 2000s led to a reduction in public health expenditure and increasing private health expenditure (Munyuki and Shorai, 2009). The bulk of private health expenditure in this period was borne by the public. In this regard, Makuto and James (2008) note that the contribution of household and individual expenditure on health was found to be 48.5 per cent (household) and 50 per cent (individual) respectively of total private health spending. This means that the public now heavily relied on the private sector for health services. The period also created an environment for unethical behaviour by some health professionals. An example of such behaviour is the referral of patients by a doctor from a public facility to his or her private practice for treatment where charges are much higher.

After economic stabilisation in 2009, there was a rebound in terms of public health financing from the budget with the Zimbabwean government's increased commitment to providing

public health services. However, public health care expenditure remains far below 15% of Gross Domestic Product (GDP) (HSA 2010). The public health services have remained a small part of Zimbabwe's economy constituting less than 1% of GDP (ZHSA 2012). Furthermore, the priority in terms of allocation of government funds to the four levels (primary, secondary, tertiary and quaternary) of health care is given to tertiary level (that is, to central hospitals). This is however inconsistent with the PHC approach to which the state subscribes and which advocates for the provision of basic services at primary level.

Funding patterns for district services since 2009 have remained underfunded despite the government's commitment to increase health care utilisation at the primary level. A health services assessment in 2012 established that, in 2011, the average funding at district level was US$50,641 while at provincial and central levels the allocations were US$362,254 and US$4,137,683 respectively (ZHSA, 2012). The inadequate funding of the health sector especially at primary level affects provision of adequate and standardised health services. This affects human resources, sufficient drugs and most importantly the quality of service and care provided at health facilities. Most rural clinics are less operational due to the inadequate supply of basic drugs (MoHCW, 2010). Given that people in rural areas depend on public provision of health care services, inadequate health care services at health centres may influence negatively the sheer seeking of health care services. Further, the user fees policy of the 1990s era continues to be applied despite various policy commitments to provide free services for particular social groups such as the elderly and children under 5, as well as for maternity services. Justifications from the government on maintaining the user fee policy has been that it is pertinent to the mobilisation of resources due to government's inconsistent and inadequate funding to the health sector.

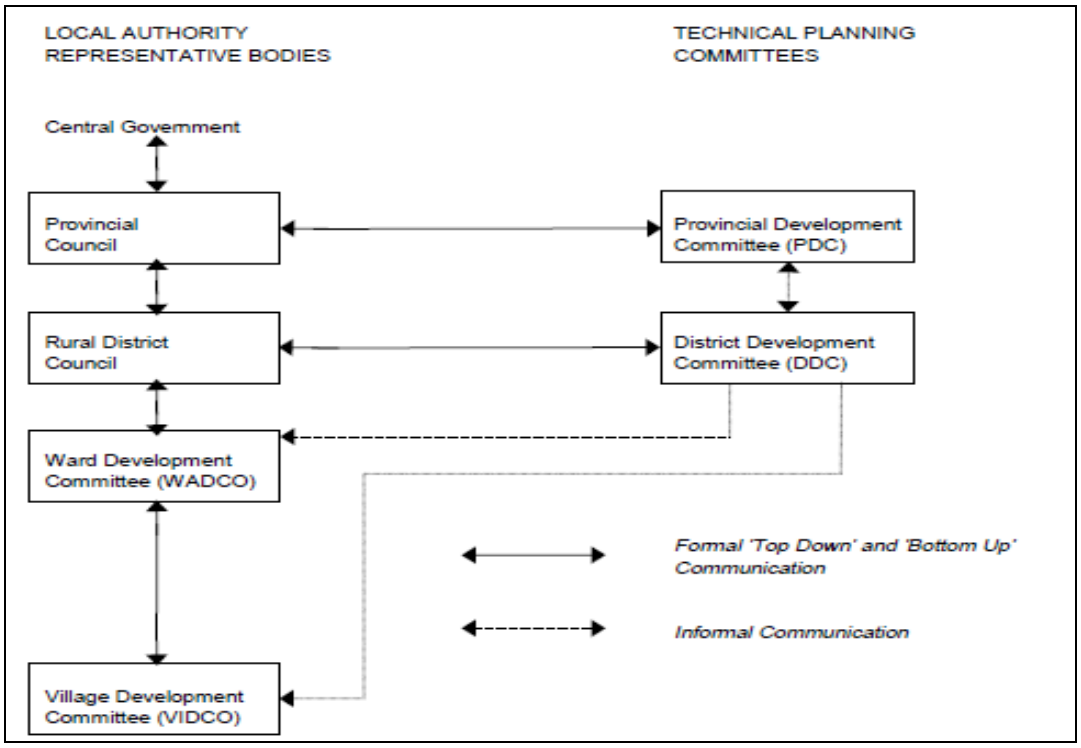
The districts' health facilities receive funds from the Ministry of Health and Child Welfare (MoHCW) through the Health Service Fund (HSF) to supplement their revenue which has been financed by foreign donors for the last three years (Nyazema, 2010; Mlambo, 2013). However, due to insufficient resources from the government budget, health facilities have been found to be more dependent on user fees revenue to support their budgets (NHS 2009-2013) which still leaves the burden placed on the public. Research by Zigora et al (1996) and Loewenson (2008) notes that communities have often criticised the lack of consultation in deciding on cost recovery policies and levels. Local authorities also report frustrations from the public with regard to financing for local level development projects as the same

communities are already overburdened financially in support of public services (Chatiza, 2012). Health financing is a clear example highlighting the failure of the government to protect its citizens. A policy is a commitment which can only be turned into a reality once resources have been allocated and spent. In this case, government health policy has failed to guard the citizen from increasing out-of-pocket costs.

4.8 Accountability in the health system

Independence for Zimbabwe was a pivotal moment for transformation. Pre 1980 state structures were formed in such a way as to be accountable only to white minority interests. 1980 offered an opportunity for both widening and deepening participation in the governance of many spheres of public activity including health (Loewenson, 1998). The Prime Minister's Directive on Decentralisation (1984) established organisational structures for wider participation of the public at the local level. These institutional reforms abolished racial segregation laws whilst introducing the universal franchise in all areas of local government. Stewart, Kulgman and Helmsing (1994) argue that these reforms were to facilitate participation in development planning by providing a hierarchy of representative bodies at village, ward, district and provincial level as illustrated in Figure 4.1. This shows the tiers in which local government planning happens. The village, ward, district and provincial committees selected representatives who then interacted with central government administrators to prepare local development plans which would then feed into the national level process.

Figure 4. 1: Hierarchy of Local Government in Zimbabwe



Source: Loewenson et al (1999: 16).

Mutizwa-Mangiza (1997) argues that these structures had various positive effects. They enhanced co-ordination between ministries at local level and allowed for the public to participate in local level development planning. The structures basically created a channel for central government to convey information on public investment programmes and communicate government policy priorities. Loewenson (2000) likewise notes that the platforms for participation set up by government created channels for political interest groups to participate in developmental self-help projects for income generation processes. But Stewart et al (1994) highlight that the model for participation opted for by the government of Zimbabwe had weaknesses that undermine effective participation. There was weak consultation in the nomination process for representatives on the various bodies at all levels (village, ward, district and provincial) which had a negative impact on special interest groups such as women and youth. The allocation of functions between different levels of government were not well defined from the onset between local and central government which also made local government dependent on the central level grants, with the central government directing the grants for specified purposes. This meant that the local levels had very limited room to raise funds for their own context specific issues and were confined to beer sales and rates on property.

De Visser et al (2012) claim that local government in Zimbabwe is only but a mirror image of central government as provincial governors and district administrators were appointed by the Ministry of Local Government and the Cabinet, making them accountable to them and not the local communities in which they serve. Plans produced at district or provincial level had little or no influence in national planning as the Executive and sectoral ministries led the budget and planning process as determined by the government's policy priorities and these did not necessarily reflect the needs of the people. The weaknesses in the system resulted in elected officials at local government level merely rubber stamping central level plans for their areas of regulation with low levels of beneficiary (or local) participation (Makumbe, 1996). In a review of decentralisation of local government for wider participation in Zimbabwe, Chatiza (2012) notes three major factors which weakened effective participation in local government development, namely, "the dominance of decision making structures by central officials, the tendency of a small elite to represent local interests with limited popular participation and the ever present dominance of the ruling party in state affairs" (Chatiza, 2012:16).

The health system was layered onto this framework for local government which meant that participation in health policy would follow the overall government hierarchy. Zimbabwe operates a four-tier health delivery system consisting of primary, secondary, tertiary and central levels of health care which are meant to function as a referral chain (NHS 2009-2013). The MoHCW is in charge of the health care system for policy planning, administration, allocation of funds and coordinating responses to national health issues (ZHSA, 2010). Although the delivery system is dominated by the public sector, health care services are provided by both public and private players. Government operated hospitals and clinics are complemented by those run by private companies and church based organisations (NHS 2009-2013). From 1980, the health system was envisaged as integrally linked to other development programmes, such as the organisation of rural infrastructure, education, housing and food production. The adoption of the Primary Health Care (PHC) approach by the Government of Zimbabwe demanded the direction of new resources towards previously deprived (i.e. pre independence) areas and most importantly stressed the conscious and active participation of communities in transforming their own health (Sanders 1998).

The premise of the PHC approach is a sense of ownership over health services by communities which make democratisation a central feature. Woelk (1994) argues that popular democratic control is a crucial ingredient for the success of primary health care initiatives and

is the most distinguishing feature of the approach. The principle of mutual respect and dialogue is assumed to be integral in the relationship between the state as the service deliverer and the public as the service recipient. Health policy planners as early on as independence envisioned a mutual relationship between the health service and the community in which both were set to benefit (Sanders and Davies 1988). In this respect, Woelk (1994) notes that the PHC approach in Zimbabwe "emphasised three basic ideas: improvement in health status as interlinked to improvement in socio-economic conditions; that mass participation was the key to over-turning these conditions; and that the health care system had to be made to be responsive to the "mass needs of the people" at the primary level" (Woelk, 1994:1028) These ideas were to ensure fair distribution of and access to health resources, as well as the democratization and facilitation of community participation in the health system (Mlambo, 2013).

Health policy since 1980 strongly endorsed community participation as being a component within a system where in fact decision making was generally centralised and dominated by administrative inputs (Loewenson, 1988). Mutizwa-Mangiza (1990) and Loewenson (1998) thus emphasise that the health sector expressed its policy through the mobilisation of communities for PHC programmes and activities which included community contributions to health infrastructure, establishment and community support of village health workers, and organising communities around drought relief and child nutrition initiatives. True to form, though, these programmes had a strong state presence with community participation being merely compliance with state led initiatives as the state provided technical and financial support.

In terms of structure, the health sector had health executives that participated within the local government framework at village, ward, district and provincial level. Specific health committees were also set up in some districts and were linked to health centres and district hospitals. The main strategy for engaging communities was through the work of community health workers (CHW) at village and ward level. Community health worker is the broad term for volunteers in the health system at the primary care level such as village health workers, family planning distributors and home based care givers. According to Loewenson (1988), the CHW concept has its roots in Zimbabwe from the time of the liberation struggle. The term CHW became universal when independence had been attained. The Ministry of Health adopted the term VHW in order to specify the sphere of operation for the volunteers. In

1980, the VHW was initially viewed as a cadre elected by and accountable to the community, but trained and supported by the state through the health ministry (Sanders 1996). The role of the VHW was to mobilise communities for health activities and social awareness on health programmes. The health worker (qualified health personnel) was to be responsive to the local situation by supporting the role and health promotion work of the VHWs in the community. The government provided VHWs with bicycles for transportation and monthly allowances together with basic drug packs which consisted of mainly antimalarials and analgesics (MOHCW, 2007).

It is agreed that communities are not homogeneous in nature, with groupings of people tending to be divided into conflicting classes and interest groups. In this regard, state centralism had a role to play in the politicisation of the village health worker programme from its onset. ZANU-PF ran training programmes early in 1980 where communities had to identify individuals to be trained by the party on "nutrition, child care, hygiene, sanitation and a little home treatment" (Mlambo, 1997:16). One of the main challenges faced by the VHW programme was that, owing to the fact that in communities where most people are poor and often illiterate, the tendency is for the better-off and better-educated to dominate (Sanders and Davies, 1988). This had negative implications for both the selection and control of the community based health worker. Also related to selection, Sanders (1996) notes that in some areas at ward level there was real popular involvement in the selection of VHWs, but in many other wards effective popular participation did not take place owing to the size of the ward. This meant that in many areas selection was done by the District Council and, in some cases, it was acknowledged that there was some nepotism, with councillors choosing their wives and friends.

These were the beginnings of bureaucratisation and undermining of popular initiatives. Further, the payment of these VHWs (Z$33 per month) was made by District Councils from a grant received from central government. Responsibility over the VHW was taken over by the central state through local government at district level. Over time, the VHW was no longer directly answerable to the poor people of the community and could not be recalled by them. Inevitably, VHWs viewed themselves as accountable to their District Councils rather than the villagers they served. The financial support by the state also reinforced a perception of the VHW as the least important arm of the health system. The VHW scheme inevitably failed in the late 1980s due to a number of challenges, some of which are highlighted above. The first

decade of independence thus saw the nature of the VHW substantially transform. The accountable and community selected cadre had been made into a low level civil servant loyal to the government. Owing to the change in the nature of VHWs, the involvement of the grassroots levels in district health policy strategy, planning and monitoring became remote from the late 1980s into late 2007.

Largely criticised as a top down policy, and inadequately reinforcing the role of community participation in the health system, the VHW programme was mainly an outreach arrangement dependent on volunteers to bridge the gap between the health centre and the community. At primary level, physical accessibility to health care is a critical issue and hence outreach is a way of extending basic health services beyond physical health infrastructure. The heavy use of outreach service by the health system implies inadequate capital investment to improve accessibility to services. In light of the challenges faced by the health system with regard to engaging communities, communities have played complementary roles in support of the health system. With resources for health dwindling on the side of the state post-independence, the participation gap has continued to widen. Communities have had to take on a larger burden of looking after those ill, in providing home based care, and in paying for health care including in some instances where health policy states that the service is free but service providers charge regardless.

Two examples that illustrate the nature in which participation outside of that which is prescribed by health policy took place in Zimbabwe are when the health sector in the mid-1990s faced problems of HIV and AIDS (with increasing drug resistance in communicable diseases such TB) and the cholera outbreak of 2008-2009. In both cases, organised groups of community members with assistance from civic actors and health activists devised strategies that took into account people's health needs for action. Communities took on the role of health education (previously the role of the VHW) and of home based care together with resource contributions for the maintenance of health facilities and, in some instances, purchased medicines for clinics at ward level (Loewenson, 2000; CWGH, 2012). The willingness of communities to mobilise social contributions for health, particularly if more meaningful forms of participation existed, shows great potential for an effective PHC system. The challenges of the local government framework highlighted earlier are also prominent in the health system as it is recognized that there are low levels of beneficiary participation,

local elite participation, and poor engagement with civil society which has limited community participation.

In revitalising the health system post the economic collapse of 2008, the VHW scheme was resuscitated in the health sector. Although primary health care goals had not been achieved in the post-independence period, the health ministry in the present day continues to view the principles of universal access, equity, affordability, community participation, empowerment and inter-sectoral collaboration as the foundation of successful health service delivery (MOHCW, 2013). The above principles are developmental in character as, at the primary level according to the PHC approach, there should be a conscious acceptance by the community of the responsibility for its own health. The current strategic direction (NHS 2009-2013) of the ministry has been focused on strengthening the role of community participation in the health system through the village worker as they are often the link between communities especially in relation to rural and local health services. The inclusion of community in the health system is an attempt at strengthening the public accountability relationship between the state and the citizen. Recent literature on accountability in the health system (Loewenson, 2009; Mlambo, 2013) and community involvement in health in Zimbabwe (Loewenson et al, 2013) suggests that community participation improves transparency in health service delivery. In this context, this thesis examines the nature of community participation within the health system and the availability of spaces for accountability to be exacted.

4.9 Conclusion

The Zimbabwe case for health illustrates how a liberation movement in southern Africa literally won the fight against colonialism but then proceeded to inherit the ills of its predecessor and lost the post liberation struggle for the betterment of lives and the protection of health as a human right. The political and economic situation in Zimbabwe affected the country's attempts to operationalise the primary health care approach in health. Structurally, and as the intention, the system has set up a referral chain in terms of health care. However, (from the literature reviewed), the system in practice utilises a 'top down approach' to health policy in which community participation takes place through the mobilisation of communities for health services. Communities are confined to respond to state health interventions without being consulted on the appropriateness of the intervention. This is evidenced by the fact that

the community health worker programme literally disappeared due to the lack of government funding. There are some indicators that the intention of the current government is now to transition towards a 'bottom up approach' to health where communities are at the centre of the system. The following chapter provides a detailed and critical discussion on the existing spaces that have been created in the health system to facilitate this envisioned transition.

Chapter 5: Mechanisms for Community Participation in Zimbabwe

5.1 Introduction

Primary Health Care (PHC) was adopted in Zimbabwe in 1980 to deliver health care to the majority of the rural population to increase community access to health services (Loewenson, 2009; ZDHS, 2010). Zimbabwe's health services are divided into four levels of care: primary, secondary, tertiary, and quaternary. The primary level consists of rural clinics and rural hospitals as the main health facilities that provide health care services. This level provides health care services for both preventive and curative needs. There are also government, private sector, mission and municipal clinics at this level. The secondary level of care in the health system consists of district hospitals. The tertiary level consists of provincial hospitals, and at quaternary level, are central hospitals. The system is organised in such a way that rural health centres refer patients to district hospitals, which in turn refer them to provincial hospitals. The provincial hospitals then refer patients to central hospitals. The study focuses on the primary level of care. To understand how community participation happens in the health system at this level, the chapter will outline the history of participation in local government in Zimbabwe and then how the concept has been mainstreamed into the health sector. The focus of the chapter will be on the structures for participation in the health system as stipulated by the legislative and regulatory framework.

5.2 Local Government structures for participation in Zimbabwe

5.2.1 Pre-Independence

Eighty years of colonial capitalism in Zimbabwe resulted in an economy at independence in 1980 characterised by the concentration of ownership of land, mineral and other wealth in the hands of a small, local and largely foreign capitalist class (Loewenson, 1984). The policy of racial segregation dominated economic and social policies and was enforced by such legislation as the Land Apportionment Act of 1930 (Mutizwa-Mangiza, 1985). In the colonial era, services, legislative and executive structures were oriented towards preserving the interests of capitalists whilst they primitively accumulated in an environment that had low wage structures hardly enough for family subsistence and limited expenditure on the social services for the majority (Loewenson, 1986).

In pre-independence Zimbabwe, there were three main local authorities; these were the local municipality, the district councils and the African councils. Rural councils formed in the 1960s serviced only white areas with a fair degree of autonomy, while the Native (later termed African) Councils which covered the reserves were subject to central control (Stewart et al., 1994:3). The Native (African) Councils were under the supervision of a centrally appointed Native (District) Commissioner. These councils also included chiefs who were paid and appointed officials of the government, and were supposed to represent African opinion. The European settlers controlled the system of government at national level. Africans in both urban and rural areas were disenfranchised and excluded from participation in local government. Agere (1996:23) notes that the local government system and structures were dualistic, with one for whites and another for blacks, and this disadvantaged the black majority. By the time of independence, the councils were barely functioning and, in those areas where the war had been fought, chiefs had been forced to withdraw from their often ambivalent cooperation with the colonial state or face violent attack (Alexander, 2006:107).

The attainment of independence made local government reform a vital necessity. Among the underlying objectives of local government reform were: to create a modern unified state linked from village to national level; to replace customary authority with democratic institutions; to create an entirely new basis for rural authority; and to institutionalise development (Alexander, 2006:107-111). These reforms were expected to lead to the redefinition of identity outside the narrow customary or tribal limits to create identification defined holistically by being citizens of one nation.

5.2.2 Post-Independence

The dawn of independence saw the country being demarcated into three main tiers of governance. These are central, provincial and district. The Ministry of Local Government, Rural and Urban Development (MLGRUD) and the Ministry of Community Development and Cooperatives (MCDC) were introduced as part of local government reforms, and the Ministry of Lands and Agriculture formally introduced provincial and district structures (Stewart et al, 1994). The national level constitutes the central government and state, which is subdivided into many ministries. The central government does medium- to long-term planning by outlining the national plan. This is where broad goals like land reform, poverty alleviation and social sector development are formulated (Plan Africa, 2000).

The second tier is the provincial level. The country is subdivided into 8 administrative provinces and 2 metropolitan cities (Harare and Bulawayo) with provincial status. Zimbabwe's provincial tier of government is headed by a Resident Minister (Provincial Governor) who is a presidential appointee. The institution of Governor was created under the Provincial Councils and Administration Act (1985) to perform co-coordinative, consultative and political functions, seen as essential for the speedy and co-ordinated development of districts and provinces. Forty-eight Governors chair provincial councils. The membership of a provincial council is drawn from district councils, parliamentarians and party leaders within a province. The Provincial Development Committee (PDC) (chaired by a Provincial Administrator) is the technical arm of the Provincial Council, and is made up of heads of government departments (Chatiza, 2012).

The district level forms the third tier of governance. The district level constitutes the traditional leadership, elected councillors, government and political leadership. According to Mbereko (2010), the communal areas in Zimbabwe are characterised by multiple structures: government, political and traditional. Resource management at this tier of governance falls under government departments, rural councils and traditional leadership. The Goromonzi Rural Council (GRC) was established in 1980. In 1990, the Ruwa Local Board joined with the Goromonzi Rural Council under amalgamation and it became the Goromonzi Rural District Council (GRDC).

An important piece of the Zimbabwean regulatory framework that created space for participation at the local government level is the Prime Minister's Directive (1984-1985). It provided for the creation of a hierarchy of representative bodies at village, ward and district levels. These structures were formed as part of the decentralization programme. The local development committees, namely, the Village and Ward Development Committees (VIDCOs and WADCOs), which are also composed of elected members, were charged with the responsibility of defining local development needs (Mutizwa-Mangiza 1990). These development committees were described as "democratic institutions of popular participation to promote the advancement of development objectives set by government, the community and the people" (Alexander, 2006:108).

A WADCO normally consists of two representatives from each VIDCO. These usually include the secretary and the Chairman of the VIDCO. The functions of VIDCOs and

WADCOs are similar but differ in the degree of responsibility or area of jurisdiction, with the WADCO being responsible for a larger area than the VIDCO. The WADCO was expected to formulate a Ward Development Plan which took into consideration the needs of all the villagers in a ward. According to the Traditional Leaders Act (1998), the WADCO would be in charge of reviewing and integrating Village Development Plans under the direction of the Ward Assembly. A ward assembly consists of all headmen, village heads and the councillor of the ward. Members of the ward assembly also elect a headman from among themselves to be the Chair of the Ward Assembly. Their duties include the supervision of village assemblies and the review of development plans. These characteristics are uniform to all rural districts in Zimbabwe (De Visser et al, 2012).

At the sub-district level, the VIDCO is supposed to be the basic unit of organization for development in communal areas in Zimbabwe (Makumbe, 1996:45). The history of VIDCOs shows that local governance structures have undergone three stages in terms of legislation. The first was in the period after 1984 when the VIDCO structure was defined by the Prime Ministers Directive. The second shift came in 1988 when VIDCOS were defined through the Rural District Councils Act. The third was in 1998 when VIDCOs began to be guided by the Traditional Leaders Act. The VIDCOs functions include enabling the villagers to identify and articulate the villagers' needs, and the coordination and forwarding of the villagers' needs and proposals to the WADCO. Their duties also included the allocation of land to new settlers. They were supposed to be a link between the people and the WADCO. In the present day, VIDCOs are expected to cooperate with government extension workers, and operate market stalls, income generating activities, health posts, adult literacy classes and craft and technology industries.

With regard to composition, the VIDCO specifies the inclusion of a youth representative and women's representative over and above the representation of other groups in the village such as businesses in both formal and informal trading. Makumbe (1996:45) notes that the inclusion of representatives from the youth and women is primarily intended to cater for the ruling party's youth and women's league which acted as the party's 'ears' and 'eyes' at the grassroots level. The creation of WADCO and VIDCO structures was expected to lead to the 'empowerment' of women and other marginalised members of the community in rural areas.

The Traditional Leaders Act of 1998 had a significant impact on community participation in local governance. In the 1980s, the Zimbabwean government lacked a clear policy that defined the relationship between the traditional leadership and the newly appointed VIDCO/WADCO structures and the government officials from the MLGRUD, especially over land. This resulted in conflict between the traditional and bureaucratic authorities. The Rural District Council (RDC) was recognized as the land distributing authority responsible for land redistribution under the Communal Land Act. Stewart (1998:27) notes that the traditional leadership did not accept the new dispensation and some kraal heads, headmen and chiefs still exercised their traditional right to allocate land without consulting the WADCO/ VIDCO or the RDC.

In 1998, the Government of Zimbabwe sought to resolve the conflict by reinstating the traditional leaders' power through the Traditional Leaders Act of 1998. This Act had a significant impact on the manner of participation in politics and how development was to be undertaken at the local level. The Act restored the powers of village heads and the headmen, at the expense of the elected structures that were to increase the voice of the public. The village assembly (made of traditional leaders) was given the power to consider and resolve all issues relating to land, water and other natural resources within the area and make a development plan for the village. It had the power to elect and supervise the VIDCO. The village assembly would be chaired by the village head. The restoration of the traditional leaders' powers was accepted as new law with resignation by villagers. The move can be construed to as a means to protect the ruling party at the local government level laying a firm foundation for state control of all platforms for community input and involvement. The law was retrogressive for participation as the platforms were now more open to political manipulation (Makumbe, 2009).

The consolidation of village and ward input into the planning process was to be done by the District Development Committee. This committee in local government comprises of technocrats that make up the fabric of the government at local level. They are responsible for consolidating village and ward level plans for development covering all sectors including health into the district plan. The district plan was meant to be administered through the District Development Fund (DDF). The fund was an institution created by central government to assist in the provision of infrastructure and is one of the main sources of public finance for the development of rural areas, especially the communal lands. However,

though the DDF "scored some resounding successes in the 1980s, it has since suffered from goal displacement and has become a vehicle for massive mismanagement of resources and corruption by both the local and national political elite" (Chatiza, 2012:106) According to De Visser et al (2012), village and ward committees were created with good intentions. But, with the deterioration of the economy along with the social sectors which are the pillars for a populist-nationalist government, they have become prone to political elite capture thereby snuffing out the voice of the ordinary Zimbabwean.

5.3 Structures for participation in health in Zimbabwe

5.3.1 Community participation in health: the last three decades

In the first decade of independence, the health sector was a priority area for the Zimbabwean government in that it was one of the main areas where redress had to occur in favour of the previously racially segregated and economically disadvantaged majority. Adopted in 1980, PHC laid the foundation and set standards to which health policy in Zimbabwe was to be implemented and some significant advances were made in the realm of health. However, serious problems remained and even intensified. For example, life expectancy drastically fell in the 1990s due to the AIDS pandemic.

Overall, the economic and political environment became increasingly volatile from the mid-1990s. Coupled with the onset of the fast track land reform and its wider implications for the political economy of the country, the health status of the nation became vulnerable. The crumbling of the economy by 2008 affected the public health sector the most, and made health a hazard for the vast majority of Zimbabweans who use government services, faith based services and traditional health care, with about a tenth of the population only using the private for profit health sector. The Ministry of Health and Child Care reported in 2013 that the top ten causes of death in the country were HIV and AIDS, influenza and pneumonia, tuberculosis, stroke, coronary heart disease, malaria, diarrhoeal diseases, low birth weight, birth trauma and maternal conditions (MOHCC, 2013).

Going back to the 1980s, the local government reforms served to decentralise government. Along with this, the health sector decentralised to the primary level through the village health worker programme. Frankel et al (1992) provide a comprehensive analysis of the positive and

negative features of village health worker programmes: VHW programmes have arisen from and reinforced more equitable distribution of health resources, enhanced positive relations between communities and health workers, have generated support groups within communities, enhanced appropriate referral patterns, and provided community based information within the health system. VHW programmes have also, however, lacked adequate resources and supplies to sustain them as well as adequate technical support and supervision from the health system. With regard to accountability, VHW faced problems in having to be answerable to the health system through health staff and additionally to the community which nominated them. VHWs also have been exposed to personal danger in environments where the state or other powerful interest groups have been threatened by their roles, have worked for long hours at personal cost, and have faced hostility from formal health workers threatened by their non-professional status (Frankel et al 1992). Overall, the VHW programme in Zimbabwe suffered in the wake of the growing economic and political problems in the period 1998-2008 as the government was unable to sustain the programme.

Along with the community health workers, the health sector had at each local government level (village, ward, district and province) health advisory committees. These committees were meant to participate in the local government development committees representing the health system. Specific health advisory boards were also set up at district hospitals and provincial hospitals in the first decade of independence. According to the Loewenson (1994), the committees' initiatives were along self-reliant means such as the development of water supplies and sanitation. These interventions though seemingly increased the distance between the community and the health system as health programmes were more centrally designed.

The 1990s saw the government of Zimbabwe usher in a structural adjustment programme that led to the liberalisation of the health sector. Together with the combined effects of AIDS, drought, poor economic performance and high levels of poverty, the health gains made in the first decade of independence were stagnated. This situation saw the disintegration of the health advisory boards and the village health worker programmes as health financing was rapidly decreasing. In 1997 the Ministry of Health published its first draft of a National Health Strategy (MoHCW, 1997). This signalled the start of a serious re-assessment of the health sector for Zimbabwe as the system seemed to be failing to meet the needs of the populace. Discontent from the health civil service coupled with a decentralisation policy that

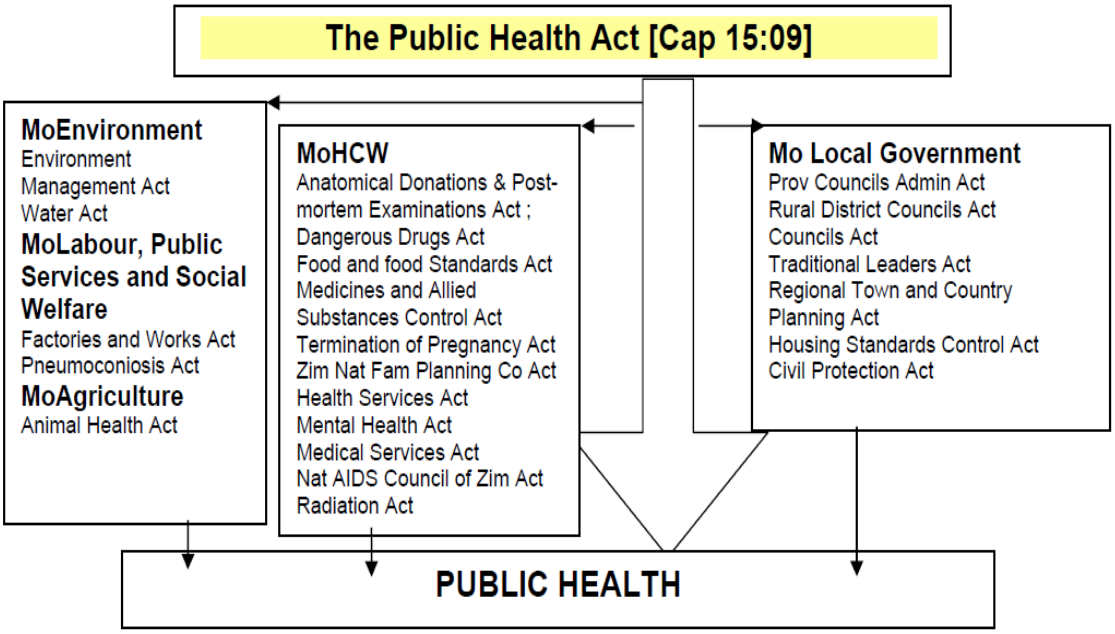
was failing to be operationalised due to the dominance of the central level left room for citizens to organise themselves for their own health.

In the period 2000-2008, the economic and political situation contributed to the collapse of the health system especially the community thrust of the programme. As Mlambo (2013) highlights, "the downward economic spiral that followed after 2000, as the Western world either boycotted Zimbabwe or imposed sanctions on its leadership and select businesses saw the country's GDP plummet drastically between 2000 and 2008, while the inflation rate rose to unprecedented heights in modern history" (Mlambo, 2013:367). These severe political and economic conditions had an impact on public funding for the effective delivery of primary health care in Zimbabwe. With the collapse of the economy and public finance, ordinary citizens were left to fend for themselves against mounting difficulties in order to meet their basic needs (UNICEF, 2011). Community participation played an integral role in response to the cholera outbreak in 2008. Organised groups in communities mobilised local communities and conducted health education and taught health and hygiene practices in support of formal health workers (CWGH 2008, 2009).

5.3.2 Legislation and regulations governing the health sector in Zimbabwe

The Public Health Act of 1924 (last amended in 1970) is the principal law regulating public health in Zimbabwe. It is administered on behalf of the government by the Ministry of Health and Child Care. In Figure 5.1, other health legislation which supports and complements the Public Health Act is shown (TARSC, 2011).

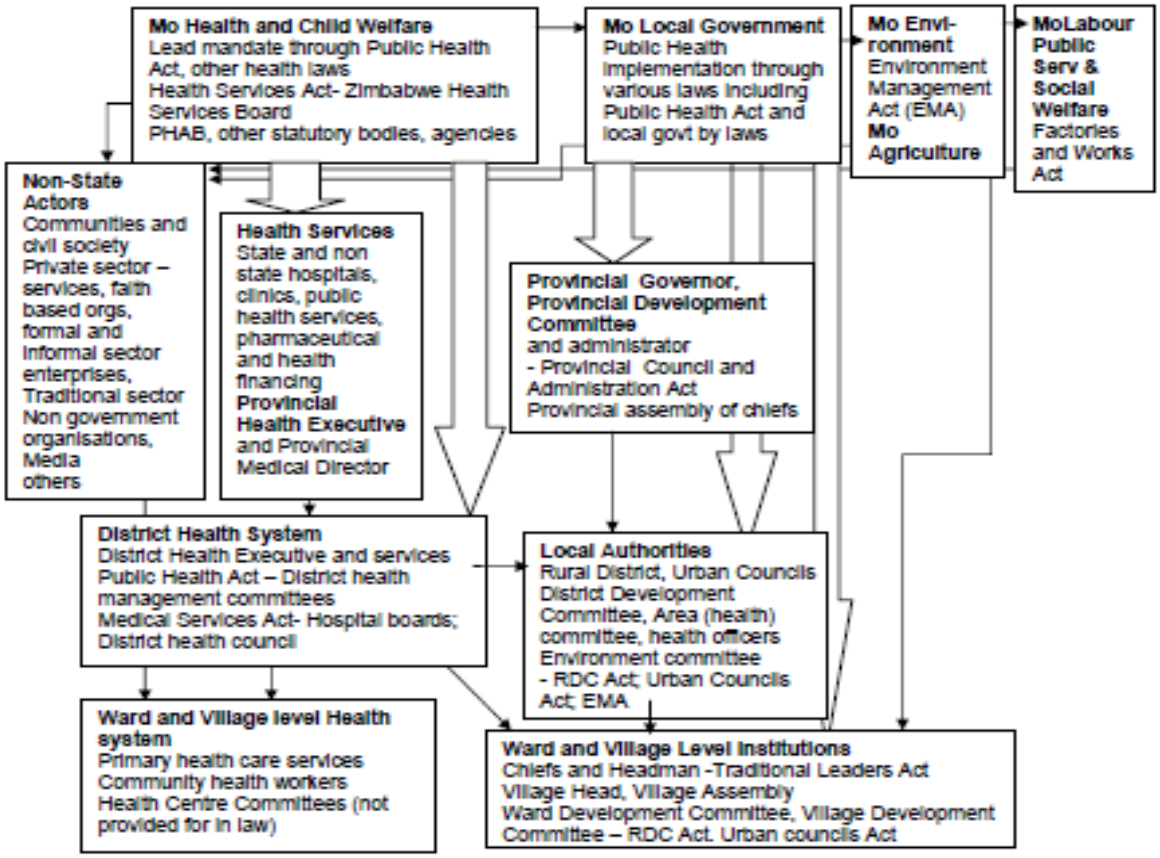
Figure 5. 1: Public health legislation in Zimbabwe



Source: TARSC (2011: 6).

The Public Health Act is implemented in urban and rural areas through District Medical Officers (DMO). In the 1980s, the Ministry of Health set up the District Health Executive (DHE) under the chairmanship of the DMO to run and manage services at district level in rural areas (TARSC, 2011). In urban areas, the DHE and DMO are under the urban council but, in rural areas, the DHE is not a structure under local government but one under the central Ministry of Health. At provincial level, the Provincial Health Executive was established under the chairmanship of the Provincial Medical Director (PMD). While not the principal administrator of the Public Health Act, the Ministry of Local Government is tasked with the implementation of the Act the district level, assisted by medical officers of health, health inspectors and health advisory committees (TARSC, 2011). The Traditional Leaders Act [Chapter 29:17] of 1998 provides for the role of chiefs and headmen in health matters, including notifying of outbreaks of epidemics, promoting good standards of health and enforcing environmental conservation and planning laws (TARSC, 2011). The diagram below outlines the public health system as set out in law.

Figure 5. 2: The public health system in Zimbabwe



Source: TARSC (2011:19).

The legislative framework for health in Zimbabwe as stated earlier provides for community health councils at district level and hospital advisory boards at hospital level and these include community representatives in advising on client care and health management issues. These structures for community participation were weak and had no policy or resource allocation authority. From the viewpoint of Loewenson (2000), "these structures played a positive role but did not make services planned and financed at central level more responsive to user demands or inputs, particularly given weak district discretion on areas of spending or retention of revenue and lack of meaningful authority in planning" (Loewenson, 2000:17). It is because of this that these structures disappeared during the troubled economic times the country went through from the mid-1990s. This offered up the opportunity and indeed the necessity for the general public to take up spaces in the health system as services were failing against a growing disease backdrop. In the midst of the turmoil, civil society stepped in to rescue the existence of these platforms in the health system.

One such civic actor is the Community Working Group on Health (CWGH) formed in 1997. Founder organisations include the Association of Mine Workers in Zimbabwe (AMWZ), Women and Aids Support Network (WASN), Womens Action Group (WAG), Training and Research Support Centre (TARSC), Zimbabwe Farmers Union (ZFU), and the Zimbabwe Congress of Trade Unions (ZCTU) (CWGH, 1998:3) It is a network of civic groups that recognised the need to give and add voice to the health interests of rural peasants, formal and informal sector workers and unemployed people. The group came together to share experiences and information on health, to analyse the health situation and to put forward strategies based on the identified problems (CWGH, 1997; Loewenson 1999, 2010). It identified the existence of public discontent with the manner in which community participation was being expressed in Zimbabwe and the need to strengthen the mechanisms for participation, transparency, consultation and accountability within the health sector from local to national level. The CWGH network thus works to promote and strengthen informed participation in local health planning. The experience of the network in community mobilisation has spanned nearly the last two decades in Zimbabwe. And it has sought to revitalize the community health structures known as Health Centre Committees for participation especially at the primary level in line with the PHC approach for equitable health service delivery.

Post 2008, the National Health Strategy (2009-2015) makes a commitment to ensure that communities are empowered to participate actively in the management of their local health services in line with the PHC approach (EQUINET 2015). The predecessor to this current strategy (from 2009 to 2013) emphasised the establishment of and, in some areas, the revitalisation of Health Centre Committees (HCC) as the vehicle through which communities participate in health policy. HCCs were originally proposed by the MoHCW in the 1980s to assist communities in identifying their priority health problems, plan how to raise their own resources, organize and manage community contributions, and tap available resources for community development as health advisory committees. This 'new' community health structure "is a joint community-health service structure linked to the clinic and covering the catchment area of a clinic usually a ward or more" (CWGH 1998, 2005, 2011, 2015). However, it is important to highlight that these HCCs are not regulated by law although the Ministry of Health has consistently included the structure in its strategy. This may be attributed to the fact that the Public Health Act has not been reviewed since its last amendment in 1970. This raises a serious problem as health is an ever changing concept

which does not remain stagnant over time. It is also critical to note that there is discord between the principal piece of health legislation and current health policy in terms of recognising and acknowledging the existence of a community structure as part of the health system.

HCCs represent a mechanism through which communities at the primary level interact with national health strategy. In terms of composition, the HCCs involve the Ward Councillor, the Nurse in Charge at a clinic, the Environmental Health Technician (EHT), village health workers, health literacy facilitators, home based care givers, and local civil society or community based organisations representing women, youth, the disabled, children and people living and/or affected by HIV and AIDS. They also include the headmaster or school teacher responsible for health, a church leader, a traditional leader, and traditional and faith healers and other health providers. Besides the health workers, the traditional leader and local elected government representative (ward councillor), the local community in the ward is responsible for electing the rest of the HCC members as they are accountable to them (CWGH and MOHCW, 2011). The Ward Councillor, traditional leader and none of the health workers are allowed to be Chairperson of the committee, and the Chairperson in fact has to be a representative from the community. Formal health workers at the primary care level who are eligible for co-option into the HCC include the nurse, nurse aid, EHT, general hand and nurse in charge, The Primary Care Nurse (PCN) or Nurse in Charge (NIC) at the clinic is always a member of the HCC and provides secretariat services in the committee. Thus the HCC has a direct link with the nurse in charge.

In 2011, the Ministry of Health together with the Community Working Group on Health developed guidelines to set out the function and role of the HCC in the community in relation to both the health system as well as the local government framework. Although these guidelines are not regulated as law in Zimbabwe, they were adopted by the Ministry of Health to the extent that the HCC structure was added to the health system framework formally in 2011 (National Health Strategy 2009-2013). The roles and responsibilities of the HCC, according to the guidelines, are shown in Box 5.1.

Box 5. 1: Roles and Responsibilities of an HCC

- ✓ Bring community priorities into health plans
- ✓ Ensure that health resources, budgets and fees for service are used in a transparent way
- ✓ Organize community actions for health
- ✓ Promote dialogue with health services on the quality of care issues
- ✓ Make claims on district level funds like the Health Services Fund
- ✓ Advocate for essential resources for their services from the Rural District Council and MOHCW
- ✓ Organise community inputs to health services
- ✓ Monitor quality of care and take up community grievances

Source: CWGH and MOHCW (2011:23).

In summary, Health Centre Committees are structures through which the health system is meant to engage with patients to elicit information on how best to address the most pressing health needs at the local level. Ideally, in line with the PHC approach, this information flow between the patient and service provider strengthens vertical accountability within the health system thus making it 'people-centred'.

Table 5. 1: Legislation and policy supporting community health structures

Piece of legislation/ Policy provision	Description
The Health Services Act (2005)	**Provides** for the establishment and the operations of both public and private hospitals and Medical Aid Societies. The Act provides for the establishment of the Health Service Board, Community Health Councils and Hospital Management Boards at Central and Provincial Hospitals.
District Councils Act 1980 (as amended in 1982)	**Revived** local government structures and how they interact with communities. The councils are the principal planning and development agencies within their authority zones. They ensure that central level policies are implemented at district level.
Public Health Act: Chapter 15:09	**Provides** for the duties, roles and organization of public health system in Zimbabwe, including mechanisms through local government to address public health issues.
Prime Minister's Directive on Decentralization (1984 and 1985),	**Provided** the basis for the devolution of authority to subnational level (the district). It also provided a hierarchy of representative bodies at the village, ward, district and provincial levels. It outlines the roles of the Village Development Committees (VIDCOs) at village level; Ward Development Committees (WADCOs), which cover about six villages and consist of VIDCO representatives. They oversee and prioritize local needs and forward these to the District Council; District Development Committees (DDC) responsible for planning and co-ordination committees at district level.
Provincial Councils and Administration Act 1985	**Clarifies the roles of** Provincial Councils. Provincial councils oversee District Councils in implementation and monitoring through the Provincial Development Committee (PDC). The PDC is responsible for formulating plans for provincial coordinated development. The committee produces long and short plans that reflect District Development Plans, provincial plans of Ministries.
National Health Policy 1980; 1997-2007; 2009-2013; 2009-2015	The health sector activities have been guided by policy documents, such as Planning for Equity in Health of the early 1980s, the National Health Strategy, "Working for Quality and Equity in Health" (1997-2007) and the National Health Strategy, "Equity and Quality in Health, a people's right" 2009-2013. The strategy for 2009-2013 was extended to 2015 and it commits towards the establishment of health centre committees within the health system. The strategy identifies that, communities, through health centre committees or community health councils will be actively involved in the identification of health needs, setting priorities and managing and mobilizing local resources for health.

Source: CWGH, TARSC and MOHCW (2011:28).

The lack of a clear statutory instrument in this instance has not hampered community input into the health system. This is so because there are different laws and policies within the Zimbabwean legal framework which acknowledge the work and contributions of organised

community groups to the health system. The above table (Table 5.1) highlights the various laws and policies that support the existence of a community mechanism in the health system.

5.3.3 Synergies within the health and local government framework for community participation

In the first and second decade after independence, community participation was often interpreted as community mobilisation for health programmes led by the state. In the third decade, communities were pushed to respond and address health issues within their reach. This response was self-initiated and prompted by the economic situation. However, the ways in which the health system (or framework) as well as the local government framework interpreted community participation has been expressed through the limited spaces for participation in centrally defined programmes that exhibited weak technical capacity and allowed for political elite capture. As discussed earlier, there was no clear strategy in the allocation of roles in the local government framework between traditional leadership and local authorities. However, there are clear synergies between the health system and the local government framework in terms of legislated spaces where communities can engage with governance and development issues. The laws outlined above provide for different local government and Ministry of Health structures to feed into each other. In Table 5.2, the areas of convergence between the local government framework and health system for community participation are outlined.

Weaknesses in the local government legislative framework in Zimbabwe have negatively affected the health sector in terms of not providing clear and adequate mechanisms for participation. Most communities at local level have reported poor communication on or even an inadequate understanding of the content or implications of decentralisation (CWGH, 1997; CWGH 2002). Further, central government appointed health advisory boards which have been observed to have little accountability to the public. Mlambo (2013) notes that health boards appointed by central government through the Ministry of Health were delegated few responsibilities in practice, particularly over revenue raising and retention, financial controls and staffing, which weakened their ability to make significant impacts on hospital performance. This brings to question their value to the health system in terms of community participation. It is clear from this that it is naïve to assume that quality, equity and participation are inevitable outcomes of decentralisation.

Table 5. 2: Mechanisms for community participation in health

Level of Government structure	Health system structure	Mechanism for community participation
Village Development committee	Village health worker, home based care giver, health literacy facilitator	Health Centre Committee
Ward Development committee	Health facility Primary care clinic	Health Centre Committee
Rural / Urban Council	District health District Hospital	District Hospital Management Board
Provincial Council	Provincial health team Provincial Hospital	Provincial hospital management board
Central government	Ministry of Health and Child Care Zimbabwe Health Services Board	Public Health Advisory Board, National Task forces; Interagency committees on health

Source: CWGH, TARSC and MOHCW (2011:46).

The implementation of PHC in Zimbabwe has been constrained by the tendencies of bureaucratization and centralization with communities confined to endorsing plans from the central level. Mutizwa-Mangiza (2009) argues that increasing community involvement opens up the space for positive transformations in service provision such as ensuring more appropriate health service delivery and enhancing the quality of care. However, if the community is not capacitated to exercise this right and responsibility afforded by participation spaces in the health system, then it will not be effective. As Cornwall (2010) claims, effective engagement requires not only institutional changes, and most particularly changes in procedures for decision-making and control over resources, but also a focus on enhancing the capabilities of communities to exercise their new rights and responsibilities in health.

There are further criticisms that the decentralisation of participation weakens the ability to challenge national institutions and policies and may thus strengthen central control (Puri 2004). The experiences of decentralisation in Zimbabwe's health system provide a strong indication of the need to back participation in the management of services with participation in setting and monitoring policies on the allocation of resources, on service standards and on how management authority is distributed at different levels of health services. Fieldwork by Mutizwa-Mangiza (2009) and Loewenson (2010) supports the notion that decentralisation of the health system in Zimbabwe, amongst other reforms, poses a challenge to – and an

opportunity for – participatory structures at local level to move beyond roles of defining needs and disseminating information to making health policy and standard setting more accountable to public interests and ensuring the execution of policies by management structures.

The success of the health system, including community participation in Zimbabwe is highly dependent on the state's capacity to manage and direct the efforts of various health services providers through policy, legislation and incentive structures. Without this clarity and effective management, there can be a duplication of effort and lack of accountability. As Loewenson (2010) points out, "the absence of credible public policies, weak involvement of civil groups, or poor satisfaction of their interests can lead to ad hoc arrangements such as local interventions by voluntary and non-government organisations seeking redress for health related grievances outside the health strategy" (Loewenson, 2010:26). The potential of community participation for and in the health system in Zimbabwe has been documented over the years by the CWGH. The network has noted (CWGH, 2010, 2013) the will and ability of communities to mobilise social contributions to health, particularly if more meaningful forms of participation could be developed to unleash and organise such potential.

The negative features of the decentralised character of the health system weakened the possibilities for building a more 'bottom up' self-sustaining approach for having public input into framing national health policy. The pillars of a successful primary health care programme are building capacity within and empowering communities to engender participation in initiatives planned for their well-being. Adequate information and knowledge about health conditions and services add value to communities in fully exercising their freedoms, as people need to make informed decisions. In this regard, Ratna and Rifkin (2007:519) emphasise that capacity building enables "local people to obtain and act upon new skills and/or knowledge to improve their health", that this is central to any empowering process. In a similar vein, White and Harris (2001:129) note that "it is vital to provide a person with clear and sufficient information to enable them to solve their own problems, which offers them a sense of security in relation to future occurrences." But capacity and empowering dimensions seem in large part absent from the public health sector in Zimbabwe. The CWGH network puts it as follows: "[C]ommunities continue to express dissatisfaction both with how policy decisions are made and with how health services are managed at a time when they are being called upon to make greater contribution to and more discriminating use

of those services" (CWGH, 2013:13). This is an indication that the health system in Zimbabwe needs to respond more effectively in order to tap into the potential that community participation may hold in light of the country's fragile economic and political state. Participation in health needs to move from mobilisation for (and compliance with) centrally defined programmes to mechanisms through which communities can shape their health systems and make services more responsive to their interests.

5.4 Conclusion

This chapter has covered the legislated spaces available to communities to occupy and interact with health and local government. Legislation is very important to institutionalise community participation as it secures and regulates the space for participation. According to De Vos et al (2009), legislation encouraging and ensuring participation in the long term leads to the institutionalisation of certain norms which make participatory decision making a given. However, if the legislation is weak, as seen with the local government framework, this has a negative impact on participation. At the same time, community participation is a dynamic process which undergoes constant change as seen in the case of health in Zimbabwe. The last two chapters have outlined the structure of the health system. To use an analogy of the human body, they are a skeletal frame. The next two chapters involve putting the flesh onto the skeletal frame. They discuss empirically, amongst other points, how the spaces for participation in the health system have been interpreted and subsequently occupied by Mwanza community members in Goromonzi District.

Chapter 6: Goromonzi District and the District Health Executive

6. 1 Introduction

This chapter has two main themes. The first two sections (sections 6.2 and 6.3) discuss Goromonzi District as this is the district in which the case study site is situated. Overall, these sections provide a brief situational analysis and a historical overview of the district, as well as a social, economic and political profile of the district along with the health situation in Goromonzi. The historical discussion on Goromonzi relies extensively on other recent theses that have been situated in Goromonzi but, unlike this thesis, focused on land reform and various themes such as gender in Zimbabwe (Marongwe 2008; Murisa 2010; Chakona, 2012). The second theme (in section 6.4) discusses empirical evidence gathered from the Ministry of Health's Goromonzi District Health Executive. It covers the perspective of the executive on community participation and whether it recognises added value from the presence of the HCC and community at local level in the health system in light of national health policy. The Mwanza Clinic Health Centre Committee and the thoughts of community members around health and participation in Goromonzi are covered in the following chapter.

6.2 A brief background to Goromonzi District

6.2.1 Situational analysis of Goromonzi District

Goromonzi is located in Mashonaland East Province in the eastern part of Zimbabwe and covers an area of approximately 3,500 square miles (9,100 km2). The district's geographical location within the province is bordered by Marondera to the east, Harare to the west, Manyame to the south, and Murehwa and Domboshava to the north. The district is largely rural and is located approximately 32 kilometres south east of Harare which is the capital city of Zimbabwe (see Figure 6.1).

According to the Mashonaland East Provincial Census in 2002, Mashonaland East Province had a population of 1,127,413 with Goromonzi district having the highest population of all districts in the province (13.68% of the province's population). The 2002 Census also provided gender disaggregated information for Goromonzi in percentage terms, with 49.7% of the population as males and 50.3% as females. Ten years later, the 2012 National Census

pegged Goromonzi's population at 224,987 persons of whom 113,661 (50.5%) are female. In a decade, there had been an increase of 154,262 persons in Goromonzi (Central Statistical Office 2012). These figures were derived from 58,013 households, with an average household size of 3.9 persons, which is also the average household size for Mashonaland East Province as a whole. Of this population, 96.16% reside in rural areas with the remainder (3, 84%) residing in urban areas. Originally Goromonzi had 21 rural wards but, due to delineations prior to the 2008 presidential elections, the wards increased to 26. In this process, some urban and rural wards were combined together in order to dilute the public vote as urban voters were speculated to be biased towards opposition parties (Murisa, 2010). Nine additional wards form what is known as Ruwa Urban (which is currently governed by a Local Government Board) and neighbours Goromonzi. Due to its proximity to the capital (Harare), urban development does impact the district to a certain extent as it is part of Harare's broader development plan known as the Harare Combination Master Plan.

Figure 6. 1: Location of Goromonzi District in Mashonaland East Province in Zimbabwe

Source: Chakona (2010:62)

6.2.2 Historical context of Goromonzi District

In the colonial period, Goromonzi was known as Salisbury District. Its colonial name was derived from the fact that it was located near and around the capital of Rhodesia. The roots of the settler economy were based in large scale commercial farming. With high agricultural potential, the district had 'been nearly all pegged as farms as early as 1897' (Palmer, 1977:265). It had a total of 9 Native reserves at the point of its creation, namely, Chikwaka, Musana, Chinamhora, Jeta, Kunzwi, Musungu, Nalire, Seki and Gwebi. In 1941, Salisbury District had 4 Native Purchase Areas, namely, Muda, Marirangwe, Shangure and No. 4, with European land (in the form of commercial farming) occupying more than two-thirds of the district (Marongwe, 2008). In the years that followed, the district was split into several districts, one being Goromonzi. The three main chieftainships existing in Goromonzi are Chinamhora, Rusike and Chikwaka, with the largest area of control falling under the latter. Most of what constitutes Harare today originally belonged to Chief Chinamhora in the pre-colonial period. The research site, which is in Ward 12 in Chikwaka communal area (and specifically Mwanza Clinic) falls under Chief Chikwaka.

The district is predominately Shona. In terms of totems, Chief Chikwaka is of the Nzou-Samanyanga clan (Marongwe, 2008). Goromonzi is predominantly inhabited by the *Vashawasha* people. The *Vashawasha* people are believed to have originated from Ethiopia, making them part of the Bantu tribes. Characterised by the use of the *Zezuru* dialect in Shona, they settled in the Chishawasha area which, in the Zezuru language, means 'country of the *Vashawasha* people' (Vambe, 1972). Their settlement in the district resulted in the displacement of the Rozvi-Shonas who migrated elsewhere, while those who remained behind were absorbed by the *Vashawasha* society. In the times that followed, the *Vashawasha* were themselves displaced and further split into several groups as they are believed to have been the first casualties of the Pioneer Column (Marongwe, 2008). This displacement can be attributed to their close proximity to the emerging capital where white supremacy reigned. Father Hartmann, a Jesuit Priest who had acted as a Chaplain to the Roman Catholic members of the Pioneer Column, was the recipient of the fertile land Chishawasha on which he proceeded to establish a mission station called St Ignatius of Loyola Mission. Following colonial settlement, the *Vashawasha* people had white neighbours who then introduced trespass laws, which became the main basis for protecting white freehold property in rural areas (Marongwe, 2008). Before, communities were free to walk to

and from surrounding places that included Goromonzi, Makumbe, Murehwa and beyond, without hindrance. The restrictions also facilitated an air of mistrust that characterised the relationship between the indigenous people and the white colonialists. This longstanding conflict contributed to tensions when the land ownership question increasingly gained momentum in the 1990s. White farmers who were known for mistreating their labourers or had conflict-ridden relationships with their communal neighbours had their farms targeted during the fast track land occupation in 2000.

6.3 Socio-economic and political profile of Goromonzi district

The rural economy of Zimbabwe is strongly influenced by its ecology, land tenure and use, population density and land distribution (Plan Africa, 2000). As stated earlier, communal lands during the colonial period were known as Native reserves or tribal trust lands which were set aside for indigenous (or black) people. Goromonzi district is well-known for agriculture specifically horticulture, green house farming, mining, tourism and urban development (http://www.masheast.org/services-view/goromonzi-district/). The mining sector is dominated by a gold mine owned by London and Rhodesian Mining and Land Company (LONRHO) in Arcturus (Arcturus and Gladstone mines). In terms of economic activity as well as formal employment, the mining sector is a major player in the district. Although these particular mines are estimated by Goromonzi Rural District Council (GRDC) to produce 50kgs of gold per month, their input in terms of infrastructural and financial development in the district has been minimal (GRDC, 2000). Marongwe (2008:176) argues that this is because 'mining settlements are associated with the development of illegal settlements that surround them'.

Subsistence farming dominates rural communities in Zimbabwe and the district is no different. Subsistence farming in the communal areas has been based on an average plot size of 3-4 acres per household or about 1.5 hectares (GRDC 2000). Up to the year 2000 there were no irrigation schemes in the communal lands, so residents depended on rain-fed agriculture. With the absence of irrigation schemes in customary areas, all the main dams in the area were privately owned by large scale commercial farmers (Chakona, 2012). Agriculture and tourism were the most affected in Goromonzi because of fast track reform. From independence until 1999, the economy and a significant percentage of all formal employment in Goromonzi were based on commercial farms that grew flowers and gourmet

vegetables in greenhouses for export to Europe. The commercial farms are no longer operational due to the redistribution of land under the fast track programme. This land reform from 2000 coupled with the declining performance of the national economy, undercut local sources of employment and also disrupted the agricultural activities of communal farmers. The renewed ZANU-PF led dispensation from 2009 which came after the socio-economic collapse of Zimbabwe in 2008 has not led to a significant recovery. Rural District Councils have the power over land allocations in the communal areas, while traditional leaders also play a vital role on this matter. In customary areas, small-scale commercial vegetable farming is still common amongst the farmers in Goromonzi to an extent that these farmers regularly supply the main vegetable market in Harare (Mbare Musika). These gardens are recognised as a valuable resource, which have played an important role in smallholder household food security in Zimbabwe, especially in seasons of low rainfall when crop production on sandy soil is poor (GRDC 2010).

There has been a considerable improvement of social services and basic infrastructure in communal areas since 1980, in line with the Zimbabwean government's policy to redress the racial imbalances inherited from the colonial era. This included a specific effort to develop district centres and growth points in communal areas to ensure greater access to markets and employment for the majority of the rural poor. According to the Government of Zimbabwe, "[i]nvestment in growth points will be given preferential treatment as part of national strategy for the urbanisation and industrialisation of rural areas" (cited in Mbiba, 2001:434). The Chikwaka community in Goromonzi is serviced by Juru Growth Point, which is approximately 10 kilometres north east from Mwanza clinic (the research area of focus). Services found at Juru Growth Point include multiple grocery and clothing shops, a petrol station, butcheries, vegetable market, grinding mills, a clinic known as Kowoyo, a police station and a lodge four kilometres away from the centre.

An Afrobarometer survey done in Mashonaland East district in 2010 shows that the inhabitants in Goromonzi district place economic issues (and specifically the absence of employment) as very high in their priorities of what needs attention by the government (post the economic collapse of 2008-2009). The survey also offers useful insights into the living conditions in Goromonzi. In this regard, only 53% of the respondents had access to portable water, and none of the respondents had access to a toilet "in the house" (Afrobarometer Mashonaland East 2010). An overwhelming 82% owned a radio but only 38% owned a

television, while none of the respondents owned a motor vehicle or motor bike. In terms of education, there are ten schools in the Goromonzi area: five primary and five secondary schools serve 6,729 students, ages 5 to 22. There are more than fifty students in each class with only one teacher, and textbooks, workbooks and other learning materials are noticeably absent and the school libraries are sparse. The cost of school fees, uniforms and textbooks are out of reach for many families, so it is unusual for a child to attend school without interruption or to complete all of his or her schooling (http://www.masheast.org/services-view/goromonzi-district/).

According to district profiles compiled in the last five years, as provided by Goromonzi Rural District Council (GRDC 2010, 2012, 2013), the degree of poverty in the rural communities in Goromonzi can be seen in the following: there are poor housing standards for the majority of residents, children dropping out of school on a regular basis, and a massive reliance on handouts from NGOs and politically-inclined 'well-wishers' (or politicians seeking to buy votes). In addition, socio-economic hardships result in poorer households often having to sell their livestock under distress in order to survive. But are there a select few communal area households with working capital, livestock and agricultural machinery, the capacity to eat healthy foods, and well-educated members who have moved out the district in search of work elsewhere. But when using official poverty measurements, even these households cannot be considered as well-off by international standards. In reports from recent years, the Community Working Group on Health (CWGH) notes that the Chikwaka village community uses social status to consider who should benefit from various income-generating projects initiated by either government departments or non-governmental organisations (CWGH 2011, 2013).

The main organisations in development at the district level include the state, formal political parties, non-governmental organisations and the church. These organisations provide varying opportunities for community members to participate in development in different forms but invariably at the grassroots where they are located. In terms of politics, Goromonzi since independence has been under the control of the ruling party ZANU-PF. This has greatly influenced the shape and form of participation in the district over the more than three decades of independence. In formal politics, the political elite in Goromonzi (Mwanza ward specifically) are mostly relatives of the male traditional leadership and politicians in power at national level and this has influenced the selection of community health cadres that represent

the health system in the community. In order to better understand the political dynamics in the district and how these have affected community participation in health, the thesis pays particular attention to the legislative and regulatory framework for local governance as well as the platforms in the local government framework and health system for participation in the district.

6.3.1 Health in Goromonzi

The health patterns in any society reflect the social relations and organisation of production within that society (Loewenson 1986). As indicated above, economic activity in the district is largely characterised by mining, commercial and subsistence farming. In terms of the workforce in Goromonzi, it largely consists of mineworkers, farm labourers and peri-urban workers (GRDC 2010). Like elsewhere in the country, the health delivery system in the district over the last two decades experienced a gradual deterioration as a result of multiple factors. According to GRDC (2010), these factors include amongst others 'sanctions from the Western countries', inflation and brain drain as well as a national decline in industrial and agricultural productivity.

The Zimbabwe Demographic Health Survey for 2010-11 offers general information on Goromonzi district health indicators and factors affecting the community health status. There are 25 health institutions in the district including the district hospital Makumbe. A majority of rural health care facilities belong to the Rural District Council and a mere six are government owned. The government through the Ministry of Health and Child Care has overall responsibility for health service delivery and therefore provides services in all the clinics. The health status of children under five in the district is the poorest compared to that of the same age grouping in comparison to other districts in Mashonaland East Province (ZDHS, 2011) in terms of nutrition. Poor health status is ordinarily associated with unfavourable factors including overcrowding, poor housing, poor access to water and insanitary conditions.

The study is focused on Mwanza clinic in Mwanza ward under Chief Chikwaka in Goromonzi. With regard to community health workers, Mwanza ward has six village health workers, 1 Health Centre Committee composed of 14 people, 8 health literacy facilitators and approximately 30 home based care givers. The current staff establishment at the clinic stands at 1 Registered General Nurse and Midwife (RGN), 1 State Registered Nurse (SRN), 1

Primary Care Nurse (PCN), 1 nurse aide and 1 cleaner, making a total of 5 staff members. The required staff establishment is 8. The clinic is at a level higher than a rural health centre in that it offers maternity and all HIV and AIDS services but it is still regarded as a primary health care facility.

The Mwanza clinic services a catchment area of approximately 14,984 villagers (MoHCC Goromonzi, 2015). Services offered include immunisation, male circumcision (an outreach site), cervical cancer screening (also as an outreach site), and treatment of communicable diseases (TB, HIV, malaria and Diarrhoea) and non-communicable diseases such as diabetes and hypertension. The District Hospital (Makumbe Mission) is approximately 100 kilometres away from those it is meant to serve (primarily the Chikwaka-Mwanza, Gutu-Gosha, Rusike areas). Patients in these areas have to pass through the capital city of Harare first before they get a bus to Makumbe mission. In observing a community meeting during the course of the fieldwork, I noted that the journey is approximately 5 hours which amounts to half a day. In most cases, it is unavoidable for patients to organise separate accommodation arrangements en route to the district hospital to enable them to access service on the next day. Thus there is a huge expectation and burden on patients in that they are forced to incur out of pocket costs which essentially become a barrier to accessing the health service.

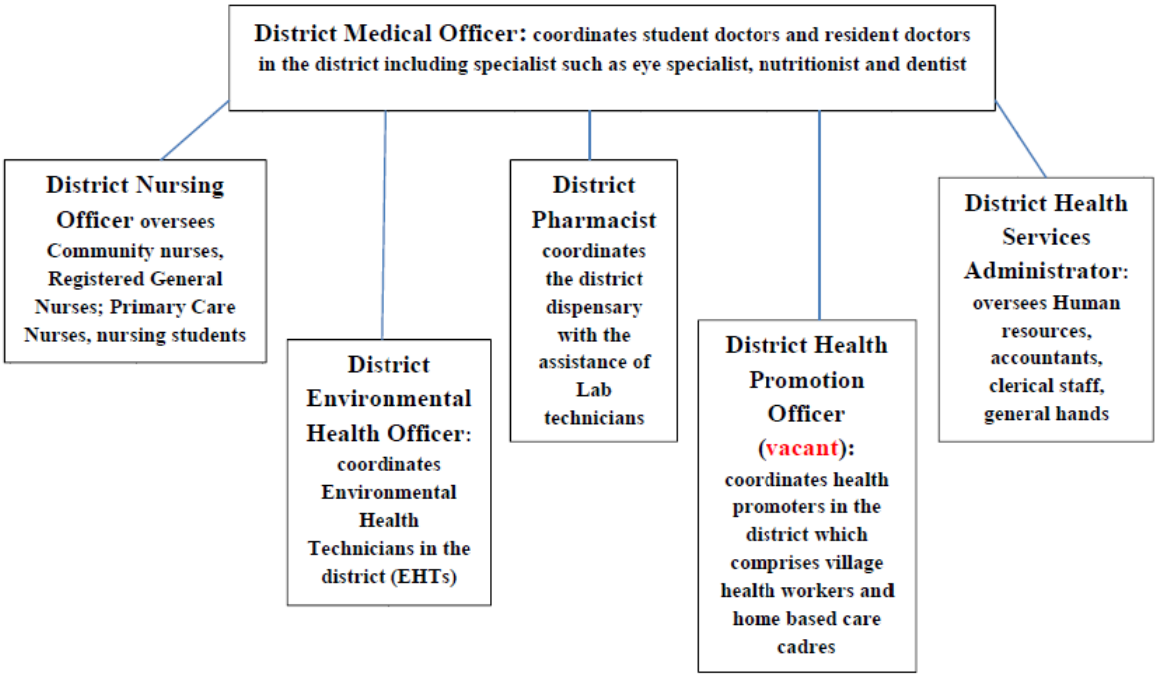
6.4 District Health worker perspectives on community participation in health in Goromonzi

6.4.1 Goromonzi District Health system

The health workers at the district hospital operate as a health care team each with a specific responsibility of overseeing and coordinating their various specialised units in the health system. The health management team at the district level is known as the District Health Executive (DHE). The DHE in Goromonzi is located at Makumbe Mission which is a government run district hospital. The DHE at Makumbe Mission is composed of the District Medical Officer (DMO) at the helm and is supported by the District Nursing Officer (DNO), District Health Promotion Officer (DHPO), District Environmental Health Officer (DEHO), District Pharmacist (DP) and District Health Services Administrator (DHSA). In Figure 6.2, I present the organogram of the District Health team in the district of Goromonzi, which also highlights vacant positions at management level.

The district health care team is not only responsible for health service delivery. Overall, the role of the team's health workers at local level is to provide comprehensive health services including prevention, promotion and public health. The District Health Executive is responsible for the management of the daily operations of the district health activities including district hospital management. The District Medical Officer, in an interview, noted that the district hospital management team is composed of the hospital superintendent, hospital administrator, matron, pharmacist and accountant who, together, coordinate and run the institution as an entity. It is separate from the DHE.

Figure 6.2: Goromonzi District Health Executive



Source: DHE Focus Group Discussion September, 2015.

The District Health Executive oversees all health service providers (including mission, private, council and government health facilities) in the district as it represents the Ministry of Health at district level. As the District Medical Officer (DMO) notes with respect to the DHE:

> *We are the ones who are consulted by the Rural District Council on health matters. We work with the Social Services Department and Goromonzi Rural District Council. Additionally, we also have multiple strategies to reach out to the traditional medicine*

sector. A majority of the elder generation prefer traditional medicines as it provides treatment for a variety of illnesses (Dr Karise DMO Goromonzi, August 2015).

In this regard, the DHE is the highest level of institutional management for health in the district. The district tier in the health system is responsible for developing a plan of work and the costs of service provision to feed into the higher tiers of the health system as well as being aligned to national health policies and priorities.

It is clear that the overarching goal of the Zimbabwean national health policy is to improve the overall well-being of all people with health risks by having in place a health system that is responsive to Goromonzi district's needs. In this respect, there are three policy documents that have guided Zimbabwe's health system historically, with the most recent being implemented at district level by the DHE, as articulated by the District Health Services Administrator in a focus group discussion (FGD):

"Planning for Equity in Health," which dates back to the early 1980s; the National Health Strategy, "Working for Quality and Equity in Health, 1997-2007"; and its successor document adopted in 2009, the National Health Strategy, "Equity and Quality in Health: A People's Right (2009-2013). This policy is the one we are still implementing as it was extended until 2015 (FGD, DHSA Mr Nyoni Goromonzi, September 2015).

In line with health strategy, Zimbabwe's health delivery services are decentralised with health care services provided from quaternary level down to primary level. A distinction made and marked as important by the DNO (Sr Masango) is that the public health system is centralised for policy and administrative guidance. The central administration is responsible for providing decision-making for the health system, determining funding allocation, coordinating responses to national health issues (such as the recent cholera outbreak in 2008), and approving the hiring of staff at the district and provincial levels. The central office of Ministry of Health then is basically the backbone in the system's functioning. In elaborating upon the various arms of the health system, the DNO highlighted the importance of the health system:

Those outside of the system often reduce it to mean health care services, but health systems promote overall health and well-being in communities, protect people from sickness, generate public trust and attempt by all means possible to reduce the

barriers that people face in using services (DNO, Sr Masango Goromonzi, September 2015).

In the FGD, members of the District Health Executive expressed consensus that, for Zimbabwe at least, the primary health strategy is the most equitable and appropriate way to address basic health needs, to address the underlying social, economic and political causes of poor health, to provide accessible essential health services and to involve the participation of communities. Some of the activities outlined by the DHE members, and which are implemented to operationalise the strategy, are also found in the district's strategic plan:

- Preventive health education that focuses on disease control and management;
- Promotion of food supply, proper nutrition and a healthy lifestyle;
- Adequate supply of safe water and basic sanitation;
- Maternal and child health care, including family planning;
- Expanded immunization for the under 5s against the major infectious diseases;
- Provision of essential drugs as per the essential drug list of Zimbabwe 2015

(Ministry of Health Goromonzi District Strategic Plan 2013-2015).

The DHE argued that the comprehensive PHC offered in Zimbabwe strives to be particularly suited to addressing the current health needs and challenges facing the nation. As the DMO noted:

> *Although we are heavily resource constrained, with the impressive aid assistance of various international and domestic development partners we aim to address the priority problems causing ill health, bringing resources for actual health service delivery to the individuals and families that most need them* (DMO Karise Goromonzi, September 2015).

The DNO stated that the main aim for the national health strategy at the moment is to integrate the new Zimbabwe Constitution of 2013 into health issues. The new Constitution has provision for the right to health care in the Bill of Rights. Previously, the right to health was not contained in the Constitution in Zimbabwe. The DNO notes that the Ministry is working towards progressive realisation of this right for every Zimbabwean citizen within the maximum available resources in a sustainable manner. She highlighted that, to fully operationalise the PHC strategy and realise the outcomes it promises, the health system requires and indeed has already adopted a multi-sectoral approach at varying levels to promote health in Zimbabwe in general including in Goromonzi. But the District Nursing

Officer lamented on the fragile state of the system in that it is heavily reliant on donor support for basic items such as medicines. The main funders are USAID, UK Department for International Development, European Union, and United Nations now through the Health Transition Fund (HTF).

In describing the state of the health system in the phase of the current national health strategy, DHSA Mr Nyoni highlighted various areas of concern. The first is health financing. He claimed that the health system has been deeply affected by the country's unstable political, social and economic situation. For example, the high levels of inflation between 2005 and 2008 caused dramatic reductions in the value of funds allocated to health facilities and health offices. Because of this, the ability to purchase equipment or provide services was severely eroded at district level in Goromonzi. In particular, the scarcity of health financing in the district has made the absence of drugs and medicine a regular feature in district clinics in recent years. The DHSA highlights that the deteriorating economic situation in Zimbabwe has led to the central pharmaceutical company (National Pharmaceutical Company of Zimbabwe, or NatPharm) being unable to manage properly the country's health commodities:

> *This has resulted in stock-outs of essential drugs, vaccines and medical supplies, and a reliance on donor-supported vertical programmes for various health commodities, particularly reproductive health products, malaria, and HIV/AIDS treatment and prevention goods* (DHSA Nyoni Goromonzi, September 2015).

The second concern raised by the DHSA was human resources. As a very critical element in health service delivery, the economic pressure hit hard human resources arrangements in the system:

> *Human resources where I supervise, before the economic issues, there already were poor conditions of service by this I mean low salaries, poor infrastructure and lack of equipment* (DHSA Nyoni Goromonzi, September 2015).

But, the post-economic crisis from the year 2000 only made a bad situation worse, coupled with the HIV and AIDS risks for health staff and increasing health service demands from the public:

> *We are still groping in the dark and only starting to find our feet back to be honest. Currently, we still have all these funders supporting even the most basic of items such as salaries as our own government has failed to raise the money* (DHSA Nyoni Goromonzi, September 2015).

It was a shared sentiment in the DHE focus group that, as the lead health grouping in the district, the DHE remains committed to implementing health programmes and disease prevention activities that aim to bolster Zimbabwe's health system so that there is no further regression.

Under human resources, another weakness noted by the DHE in national health strategy is that health as a sector is becoming increasingly reactive by focusing resources on the curative side. The sector in the first decade of independence focused resources on the preventative side investing heavily in health promotion and education and only as much as possible on the curative side. This was the community participation arm of the system. In Goromonzi, evidence of this shift is the fact that the post of District Health Promotion Officer has been vacant for the last 12 years. It was said to be very difficult because those working under this promotion function have suffered:

> *The village health workers have been left neglected especially because of this lack of focused managerial staff* (DEHO Madziva Goromonzi, September 2015).

The manifestation of this gap has seen villagers only mobilised to participate in campaigns against particular health problems that have funding at a particular time, or that emerge suddenly. Examples cited of this were:

> *Cholera is a good example because of the 2008 economic situation. As a country, we were all on our knees. Good hygiene practices were not being followed in a situation where water was scarce. HIV/AIDS and Maternal and Child health indicators also nose-dived during this period.* (DEHO Madziva Goromonzi, September 2015).

In earlier times, the village health worker was responsible for health education which included teaching mothers in their homes how to maintain healthy environments that prevent diseases, and preparing salt and sugar solution at the first sign of diarrhoea or dehydration. The gradual decrease in public health expenditure by the government of Zimbabwe has had a huge impact on community participation in health especially in the period 1998-2008. According to Mr Nyoni the DHSA for Goromonzi, the decrease in funding to health affects community health workers the most. Commended for their high commitment in communities, village health workers have gone since 1999 without their state legislated stipend currently pegged at USD14,00 per quarter:

> *If it has been paid out in this district, it has largely been on an ad hoc basis purely funded by an external donor such as UNICEF* (DHSA Nyoni Goromonzi DHE, September 2015).

The inconsistency of donor funding has also affected the payment of allowances to village workers. As a result, the poor appreciation from the government of these volunteers in the health system has affected their performance. In this context, the DHE admitted that the return of communicable diseases that had been eradicated in the early years of independence (such as cholera) is a sign of the complete failure of the community health worker project due to a continued state of de-motivation.

Another particular area highlighted by the DHSA, and again related to human resources, was health governance. With regards to health administration in the district, the resource constraints (particularly transport and human resources) have limited the levels of supervision in the health system which has made monitoring and verification very difficult. He went on to add:

> *But we must also mention that even though we still have human resource constraints, there have been some efforts in this area. We are training our junior workforce through the existing senior workforce on a peer to peer model* (DHSA Nyoni Goromonzi, September 2015).

In this respect, the DHE has developed strategies that seek to attract and retain medical staff and this is mainly financed by development partners and is intended to create supportive working environments that enhance performance.

A further matter raised by the DHE was the need to enhance the health service experienced by patients and to ensure feedback on this. The Ministry's strategic plan for five years would be relevant to this but it needs to be complemented by the Patients' Charter. The Patients' Charter, originally developed in 1996, has recently been revised and the new version is supposed to be posted up at the entrance of each government health facility. The Charter provides a basic framework for how clients should be treated throughout the health system, and defines the responsibilities of clients as patients within the health system.

6.4.2 Perceptions on the role and value of community participation in health in Goromonzi

It was shared knowledge in the District Health Executive that initially the health system incorporated the notion of community participation through community health workers. The use of village health workers (VHWs) in community mobilisation and service delivery in

interventions such as immunisation programmes, health education and environmental conservation was the vehicle to link the community with the health system. According to the DEHO, in the first two decades of independence, community participation was expressed through the community health workers as outreach workers:

> *They provided health education which harped on the preventative side* (DEHO Madziva Goromonzi, September 2015).

The DMO also noted that the earlier approach by the Ministry of Health to community participation highlighted an ever increasing gap between health providers and village-community levels in Zimbabwe. He added that the current strategy views community members through health centre committees as contributors in health policy formulation and implementation. They are seen as stakeholders in problem solving in the context in which challenges faced by the system have to be understood by the whole community. From the perspective of the DMO (Dr Karise), the current primary health care strategy creates room for the community especially at the planning phase in policy:

> *When communities participate in health sector planning, it opens up the space to influence decision making or rather provides a forward looking frame for future programming in the sector. As for us health workers, we are trained to work as a team and are available and able to respond to the health needs of the community. Within the system, the referral chain complements and supports this.* (DMO Karise Goromonzi, August 2015).

As noted in earlier chapters, the resuscitation of the health sector post the 2008 economic meltdown emphasised a firmer more grounded approach to incorporating community participation in health. A key recommendation raised in the Zimbabwe Demographic Health Survey on community participation reads as follows:

> The revitalization of health committees provides an outstanding opportunity for Zimbabwe to strengthen community participation in the health sector. Therefore, the MOHCW should develop written guidelines to codify the roles and responsibilities of the committees, and establish an understanding on the role of committees to support, advocate, and assist health care facilities. Health workers are also a key part of this process: they must also gain further understanding and training on how to better include the community in guiding health service delivery. Measuring the impact of these committees is key to understanding the types of roles they play in communities. (ZDHS, 2010:18).

The DMO and DHSA both made reference to the above recommendation from the ZDHS (2010) in that it was these findings that informed the concerted efforts by the Ministry of Health to integrate communities into health sector planning and decision making. They stated that communities found alternative ways beyond those of community health workers to interact with the health system. For instance, human resources and financing gaps have opened opportunities for communities to provide direct support to their local health facilities. Taking the Mwanza community for example, its members have shown a strong history of community involvement in supporting their rural health facility even during the toughest of times. The community members through their HCC have an interest in having their health issues addressed as they take part in identifying the most pressing ones. This was noted from reports submitted by the Environmental Health Technician (EHT) stationed at Mwanza clinic who reports that the community is motivated to support the system in addressing its shortfalls. Examples that were cited off hand included the regular fundraising initiatives by community members for upgrading health services at Mwanza clinic, as well as actually taking care of the clinic themselves in terms of cleaning and security. The District Environmental Health Officer (DEHO) noted:

> *I am not sure if this is common in other districts but in ours we are encouraging them* [Mwanza HCC] *to cross pollinate other wards because of the good work they are doing. The community in that ward is always ready to work with the health staff. Here we acknowledge our community participation platforms under the health system because they add value to our work* (DEHO Madziva Goromonzi, September 2015).

This sentiment was shared by all the members of the DHE at Makumbe Mission in Goromonzi.

In terms of representation, the DHE confirmed that community participation in health has been strengthened through health centre committees at clinic level. The DHE acknowledges that the HCC as a structure has to work hand in hand with local government community structures for improved coordination. According to the DHE, in line with the current strategy, health centre committees should be at any given time able to provide sound feedback and advice to service providers (be it private or government), and without fear that the committee will be co-opted for other purposes or bypassed in any way. The DHE added that additional structures for including citizens in health services decisions are the Ward and Village Development Committees, which are supposed to have a role in managing and overseeing health facilities from a local government lens. They admitted that that they rarely interact

with VIDCO and WADCO structures. But rather they work with the Social Services Department at the Rural District Council who ideally collates health information from the various development committees in the district.

At district level, both the DHE and the Social Services Officer in the Goromonzi Rural District Council recognised that there are some areas within the district where health centre committees do not function satisfactorily, especially in community health priority setting processes and representing the community at higher health authority levels. The two areas of concern mentioned are firstly, that there are some clinics within the district that still have not organised themselves and set up a health centre committee. This is despite numerous attempts by the DHE with the assistance of Mwanza HCC leadership. Secondly some HCCs exist without being endorsed by the rest of the community including traditional leadership. This makes such groupings illegitimate in light of the process of establishing a HCC as per the MOHCW and CWGH 2011 Guidelines. These concerns have been brought to the fore by the Results Based Financing (RBF) model introduced through the Health Transition Fund in 2011. Broadly, through this model of donor health financing, health centres in select areas in Zimbabwe are provided funds for clinic maintenance and other related issues on the basis of the number of births registered at that facility. The more pregnant women who deliver at a health centre, the more money that is paid out by the RBF fund administrator. This money is managed by the Health Centre Committee (HCC) at the facility and not by the district level health administration team. The HCC in Mwanza only started receiving this fund at the start of 2015.

The District Medical Officer, in a key informant interview, indicated that the Ministry of Health and Child Care in its current national strategy emphasises the importance of community participation as value addition but it suffocates the health worker with excessive work. The nurse in charge at a clinic is responsible to work hand in hand with community health workers in the villages and wards covered by the clinic's catchment area. It is also envisaged that the nurse in charge at a rural health centre is supposed to work hand in hand with community leaders (especially village heads and the ward councillors) to make sure that information is shared through established structures and mechanisms that are governed by the local government framework. However, this is a huge expectation from the health system on the nurse as the position has many other duties which are of top priority such as service delivery itself. As the DMO emphasises as an example:

> *You may find that the nurse is actually only in contact with the traditional leadership in the area when they pay a visit at the clinic due to ill health* (DMO Karise Goromonzi, August 2015).

An interview with the head nurse (DNO) in Goromonzi shed light on the experience of nurses in the district. And the claims of the DNO were corroborated by the Nurse in Charge (NIC) at Mwanza clinic. In the nursing profession, a key quality that is essential in delivering health service is patience. The workload of nurses at rural health centres was said to be overwhelming. The DNO stated that there were rural health centres being staffed by one or two primary care nurses whereas the national establishment requires that these centres have 2 registered nurses and 3 primary care nurses as a minimum for nursing staff.

As indicated earlier, Mwanza clinic has a current staff establishment of five: the Nurse in Charge, a Registered General Nurse and Midwife (RGN), 1 State Registered Nurse (SRN), 1 Primary Care Nurse (PCN), 1 Nurse aide and 1 cleaner. The required staff establishment is 8. Mwanza clinic is ranked higher than a rural health centre because it offers obstetrics care as well as all services associated with Anti-Retroviral Therapy (ART), as at the beginning of 2014. The clinic is, however, still referred to as a primary health care centre at the rural level despite having the additional services. The facility still receives the same financial input from the central level as that of a rural health facility, which is much less than what is required to service a catchment area of approximately 14,984 villagers. The number of villagers was in fact said by Nurse Ruzvidzo (the nurse in charge at the clinic) to be less than the actual number served as the clinic also services patients from wards outside of the ward periphery. He expressed his frustration as follows:

> *We are short staffed making us overworked. I am doing the work of nurses which I am not remunerated for because the government does not have money. At the end of the day, we have to keep going because the people need the medicine (which we sometimes do not have) and care* (NIC Ruzvidzo Mwanza clinic Ward 12 Goromonzi, August 2015).

It was noted that HCCs have shown, to a large extent, a lack of capacity to weigh the health needs of communities in the district and to prioritise in such a way that health needs are addressed in a comprehensive and sustainable manner. An example cited by the District Health Administrator at Makumbe mission was that HCCs in the district are expending

capital investment in improving health infrastructure but they are procuring sub-standard materials which do not last long:

> *The HCC has monopolised community participation in that I am not even sure that community members are consulted by this select group of people and whether they provide feedback on what is happening with RBF money. The HCC is becoming more powerful because of these financial resources and if the nation is not careful, ordinary community members will not see it fit to participate* (DHSA Nyoni Goromonzi, September 2015).

Table 6. 1: Roles of HCCs as perceived by HCCs and health workers

Activities	HCC views	Health workers (DHE) and local authority views
Roles	Key informants in identifying health needs of the community and finding ways of dealing with them. Educating on community health issues. Encouraging people to use health services. Notifying communities on health campaigns and doing them.	Role in the community appreciated. Some members of the DHE stated that they did not fully accept the work of the HCC as it has not formally been legislated for.
Reporting of issues by the HCC agenda	HCC decisions and feedback is reported to the clinic, local authority, ward committee, community.	HCC is seen as a source of information for health services on community issues and events so to the district health team they convey information from the community to the DHE
Issues that HCCs have decision making authority in	Fundraising Sanitation Clinic security Facility maintenance Facility cleanliness RBF funds	If it were not for the RBF it would only be issues on security and sanitation.
Communication and time taken for response to decisions on issue to be made	DHE takes a long time to respond to requests from the community through the HCC. Protocol viewed as a hindrance and sometimes hinders progress and discourages the HCC.	Generally, report good communication and, when meetings are called, health staff always attends.

Similar to the DHSA's above sentiments, the DNO argued that in some instances the community does not see any sense in participating in various developmental projects intended to improve their own life. She states that this may emanate from the feeling that, increasingly,

they are not involved from the beginning in such projects. Community participation will not yield progressive results, according to the DNO, if communities are not confident of what the returns are especially if they have bad experiences from previous contributions. The donor syndrome also cripples community participation because villagers believe that 'donors grant money for anything and everything under the sun'. Mwanza ward is a different case however in the eyes of the DNO as, at ward level, there has been a consistent effort by the HCC to sustain its presence and credibility in the community.

For community participation to yield the results envisioned in the Zimbabwe national health policy, there has to be significant unity of purpose between the HCC and the health staff within the system. In this respect, Table 6.1 is very instructive in comparing the perceptions of the health workers including the Social Services Officer from the Ministry of Local Government and those of the HCC members, when considering the role of the HCC and its health activities. The views expressed by the HCC on their role in the community are elaborated on in the following chapter (chapter 7).

From this table, the first inconsistency on the role of the HCC in the health system is that some DHE members state that they are illegitimate as they are operating outside the confines of the Public Health Act (1928). Others within the DHE acknowledge the role of the HCC because national health strategy alludes to their involvement in health. On the part of the health authorities, the HCC is seen as communication facilitator to convey and extract information to and from the community. The HCCs and officials agree that HCC jurisdiction relates to issues of clinic security and dealing with sanitation. This is in contradiction to earlier notions by the DMO that health strategy has opened up space for communities to input in decision making around health plans and budgets. Another important point to note from the table is that while the health authorities note that there is good communication between themselves and the HCC, the HCC states the opposite. The HCC notes bureaucracy within the system over the time taken to take decisions around issues which with the HCC deals. For them, this is de-motivating.

6.5 Conclusion

This chapter provided an introduction to Goromonzi district in which my case study of Mwanza Clinic Health Centre Committee is situated. It provided a brief summary of the

social, economic and political landscape of Goromonzi district, as well as the perspectives of the District Health Executive and health workers more broadly on community participation as stated by the current national health strategy. The purpose of the next chapter is to focus more specifically on Mwanza ward's HCC with particular emphasis on the perceived value of community participation (from the viewpoint of the HCC) and lastly the views of community members serviced by Mwanza clinic in Goromonzi Ward 12.

Chapter 7: Community participation in health: Case study of Mwanza Rural Health Centre, Goromonzi

7.1 Introduction

Since the adoption of the Alma Ata Declaration by global health organisations, community participation has been hailed as the panacea for health programmes. The declaration made in 1978 emphasised community involvement in health service affairs as an essential component of the primary health care approach towards better health for all (Mubyazi et al 2007). It envisioned an environment where there is an increased amount of sharing and learning from experience both positive and negative in pursuit of realising 'Health for All'. For Zimbabwe, the adoption of the primary health care approach in 1980 set the parameters then and in the present day to which national health policy is guided. The PHC approach in Zimbabwe also focuses on transforming health systems into a people-centred health system using a bottom up approach to policy decision making and implementation.

This chapter discusses more specifically my research findings about the level and form in which community participation happens in the health system in Mwanza ward in Goromonzi. The findings are presented in terms of three main themes. The first theme covers Mwanza clinic's Health Centre Committee, its composition and function, how the HCC fits into the health system and if (from the HCC's perspective) it contributes to community participation goals in national health strategy. The challenges the HCC faces as well as their expectations are also covered. The second section (and theme) discusses information gathered from community members whom are not affiliated to the health system, either through the HCC or as a Community Health Worker, in order to assess how they view their role in the health system at primary care level. The third section is a brief analysis of the findings from all three stakeholders that is, the DHE, the HCC and the community. In the end, my field work at Mwanza clinic sought to critically analyse the nature, form and shape of community participation in the health system.

7.2 Mwanza Health Centre Committee

Mwanza Health Centre Committee was formed in 2001. According to the HCC Chairperson Mrs A. Togarepi, the group has been existence since 1995 but it was formalised in 2000 through the efforts of the Community Working Group on Health. Mrs Togarepi has been the HCC chairperson for Mwanza since 2000. She spoke about the formation of the HCC as led by the CWGH in her ward in the following way:

> *When the CWGH Chikwaka chapter was formed they came to our clinic and called for a community meeting where they told us about health literacy and the importance of the community being mobilised to be organised for our own health* (Mwanza HCC Chair A. Togarepi, Chikwaka in Goromonzi, September, 2015).

Important stakeholders that had to be notified so as to be present for the community meeting were the village heads and the Nurse in Charge:

> *Our Sabhuku* (Headman) *and sadunhus from each village in Mwanza* (i.e. village heads) *were there and they agreed for the HCC to be formed to work with the clinic staff* (Mwanza HCC Chair A. Togarepi, Chikwaka in Goromonzi, September, 2015).

Before the formation of the HCC, the HCC chair indicated that she and a number of other women in the ward would occasionally meet to discuss the welfare of those infected and affected by HIV/AIDS. She stated that:

> *The number of those sick was growing because these people could not afford to go to the clinic or Makumbe mission because of user fees* (Mwanza HCC Chair A. Togarepi, Chikwaka in Goromonzi, September, 2015).

These community women were volunteer home based care givers with NGOs in the area (namely Island Hospice and Womens Action Group) which were addressing HIV/AIDS issues. The HCC Chairperson also highlighted that those with children in the villages in Mwanza preferred to give birth at home with the assistance of a traditional birth attendant. This was a matter of concern as traditional birth attendants do not have what health practioners refer to as emergency obstetrics care which is critical in child bearing. This mode of delivery, according to the interviewee, increased the chances of death of both the mother and child.

Interviews were conducted with the secretariat of the CWGH about the formation of HCCs in general. The CWGH is a network of membership based civic organisations formed in 1997,

after much discontent with the health system about the absence of community participation. A survey of membership views as well as constituent organisation discussion in the CWGH consistently noted the dissatisfaction of communities with what was being termed 'participation' in the health sector. To a large extent, this was perceived to mean, in practice, as merely compliance with state defined programmes, with civil society actors being excluded. None of the civic organisations in CWGH were represented on existing so-called community health structures, nor did they know what took place in them. This issue relates to a lack of coordination between the government and civic actors on community participation. This confirmed a view expressed during meetings of civic representatives and health officials that there is a persistent gap in structured communication with communities and that this acts as an impediment for health promotion (CWGH 1998, MoHCW 1997).

The drive by CWGH from early 1998 was to strengthen mechanisms for participation, transparency, consultation and accountability within the health sector from local to national level. Ultimately, the existence of CWGH in Zimbabwe is to ensure the operationalisation of the primary health care approach in Zimbabwe. Based on the initiative of CWGH, there existed a programme of work that enhanced information sharing and social networking on health issues at local level in the Chikwaka area in Goromonzi. The group facilitated district level meetings between health care providers and civic organisations in the area to promote and exchange dialogue at local level on promotion, prevention and management of health problems, and to strengthen informed participation in local health planning. It also set up local CWGH forums, carried out health education and advocated for primary health care policies.

In an interview, the CWGH Executive Director (Mr Itai Rusike) provided statistical information that prompted and supported the civil society intervention in the health system. Joint research in 2007 with the Training and Report Support Centre (TARSC) assessed the health system and subsequent health service delivery, in which it was discovered that government was allocating inadequate human, financial, drug and other resources to health centres and preventative levels of the health system. For the research team, this was evidenced by the poor allocation of nursing staff relative to workloads (more specifically, 3% of nurses for about 40–70% of outpatients at health centre level). This means that the number of patients severely outnumbered available nursing staff at clinic level:

> *However unacceptable this is, it is disappointing to note especially after the 2008-2009 period that the situation has worsened in most rural areas. The declining budget allocation to preventive and outreach services (from 15% in 1985 to less than 10% by 2001 and now in 2015 it is 9%) and the significant shortfall in drug availability at clinic relative to district hospital level (65% vital drug availability at clinics relative to 83% at district hospitals in a 2007 survey). All this evidence just points to how starved the health system was and still is in some instances at the very point of interface with the community which clearly undermines policy commitments to equity in health and towards meaningful participation in health systems* (CWGH Director Itai Rusike, October, 2015)

According to the CWGH secretariat, a process of setting up or revitalising HCCs to strengthen the capacities to demand resources for lower levels of the health system began in 2001 (CWGH 1998). The CWGH indicated that there are various protocols that have to be observed before actually setting up a HCC at a health facility. These include the identification of gatekeepers in the target area. The Ministry of Health at the district level (that is, the DHE) also identifies the areas that need a HCC or where a HCC requires strengthening. An introductory meeting is then held with the gatekeepers who also include the Councillor representing local government. As the CWGH engagement officer for Mashonaland East Province indicates:

> *After being given permission to work with the communities by the traditional leadership in the area as well Council with an MOU* [Memorandum of Understanding], *the Nurse in charge at the clinic then calls for a community meeting. Village Health workers are notified of the meeting and then they make this notice at their village and ward level development committee and assembly meetings. The councillor and Sabhuku are also notified. All these people are supposed to attend the meeting. This is the process we follow in all the areas we work with* (CWGH Mashonaland East Provincial Engagement Officer E. Mutasa, October, 2015).

The background that informed the placement and subsequent formation of the HCC at Mwanza Clinic was that the Ministry of Health District Health Executive recorded increasing delays in the uptake of services by the Mwanza and surrounding wards in the period 1995-1998. For example, the long delay in seeking sexually transmitted infection (STI) treatments was an important factor in the inadequate control of STIs in Zimbabwe, and this indicator

was evident in Goromonzi district. Longer for women than for men, these delays relate less to service availability than to social factors influencing health seeking behaviour and quality of care (MOHCW and NAC, 1998). Delays in seeking health care was in fact found to be the most common avoidable factor in maternal deaths in Goromonzi (as well as the rest of Zimbabwe), due to limited knowledge in communities of signs of puerperal sepsis and other risk factors in pregnancy and delivery, as well as insufficient transport to health services. User fees and doubling of medical costs with poorly functioning public exemption systems and negative attitudes in public health service providers further undermined contact with health services (CWGH, 1997). The public exemption system is the offering of certain health services for free for specific groups in the population. This is regulated by health policy as well as the Patients' Charter. For example, the elderly (over sixty-five years of age) do not have to pay user fees at government and council health facilities. The negative attitudes of health workers additionally undermined the complementary roles of the health sector and the community roles in disease management and control at a time when the political economy was beginning to spiral out of control. For the CWGH Director, the revitalisation or setting up of HCCs at clinics is of paramount importance as it serves the purposes of closing the gap between the health system and the rural community. This is so because the primary user of public services in health is the rural constituency.

The first meeting for the Chikwaka community in Mwanza ward took place on the 14th of June 2001.

> *At the meeting, we had the 'who is who' of the community. The business people came in their numbers, the Ministry of Health was represented by the nurses at the clinic as well the District Nursing Officer (DNO) from the district level and of course local government through the Social Services Officer and the ward Councillor. The community together with their leadership came in their numbers. What was impressive was that they all came because health mattered to them and they wanted to hear what we had to say about the seemingly deteriorating situation* (CWGH Director Itai Rusike, October, 2015).

It is important to note that the CWGH Director emphasised strongly that the role of the CWGH as a network is that of a catalyst in communities so that the latter has one voice and a unified point of reference when it comes to health issues in their constituency.

7.2.1 Composition of Mwanza HCC

A focus group discussion with Mwanza HCC shed light on how the group was constituted as well as the logic behind its specific composition. The current HCC was elected by the community in 2012. The HCC stated that, between the years 2001 and 2012, community meetings to reconstitute the HCC had been held twice. At both these times, the Chairperson has remained the same as well as the Vice Secretary. The Ministry of Health and CWGH HCC guidelines of 2011 indicate that the HCC is to be composed of the Ward Councillor as a political representative, the Nurse in Charge at the health facility, the environmental technician, village health workers and other community health cadres, and local health oriented community based organisations representing all social groups in the community. This includes women, youth, the disabled, informal traders, farmers, business owners and people living with HIV/AIDS. The table below (Table 7. 1) outlines the members in the HCC at Mwanza and which group they represent.

Table 7. 1: Composition of Mwanza HCC

Mwanza Clinic Health Centre Committee			
Name		**Organisation/ Group**	**Position in the HCC**
1.	Mrs Togarepi	Village Health Worker/ women's representative	Chairperson
2.	Mr Mupa	Farmer (Zimbabwe small scale organic farmers forum- ZIMSOFF)	Vice Chairperson
3.	Mr Ruzvidzo	Nurse In Charge (Ministry of Health)	Secretary
4.	Mr Taderera	EHT Ministry of Health	Vice secretary
5.	Mrs Chasi	Home based care giver/ people living with HIV/AIDS	Treasurer
6.	Mr Duri	Informal trader/ business	Committee member
7.	Mrs Madziro	Teacher (Ministry of Education)	Committee member
8.	Mr Hove	Zimbabwe Republic Police (ZRP)	Committee member
9.	Mrs Ngoni	Church representative/ child care worker- department of Social Welfare government of Zimbabwe	Committee member
10.	Mr Mubaira	Traditional leadership (village head)	Committee member
11.	Mr Nhimbe	Local Government: Ward Councillor	Committee member
12.	Ms Tariro	Youth representative	Committee member
13.	Mrs Madyira	Orphans and vulnerable children representative	Committee member
14.	Mr Nkomo	Disabled person's representative	Committee member

Of the 14 members, 6 are women. The HCC guidelines (MOHCW and CWGH 2011) indicate that the local government representative as well as the traditional leadership representative can only serve the community in this committee as ordinary committee members. They cannot be voted into key decision making positions in the committee such as Chairperson. This is to safeguard the space as a purely community driven platform that cannot be polarised. The position of secretary is also reserved for the Ministry of Health through the Nurse in Charge. This is purely for record keeping reasons as well as for health information

gathering and dissemination purposes. The chairperson of the committee has to be a representative drawn from the social and vulnerable groups in the community.

7.2.2 Functions and value of HCC in Mwanza: Committee Perspective

The following section discusses the functions of an HCC. The discussion also provides insight on what (from Mwanza HCC's perspective) differentiates the HCC from local government participation structures (VIDCO and WADCO) in the district. The section ends with evidence of HCC impact in Mwanza.

7.2.2.1 Role of HCC in Mwanza

The Mwanza HCC was very vocal when it came to outlining its role in the community. Certainly the group had a strong perception of its roles in relation to making improvements at the clinic, but less so in relation to its role in primary health care and community health. From and FGD with HCC, I gathered that there are two main functions of an HCC. These are health education and communication. The foremost important role of the HCC is organising community health actions through health literacy education. As the HCC vice chairperson said:

> *The power of the fish is in the water. We as the community are the key to development* (Mr Mupa Vice Chairperson Mwanza HCC, September, 2015).

This statement in principle means that the source of development lies with community involvement in decision making:

> *To participate you need to know what to say* (Mr Mupa Vice Chairperson Mwanza HCC, September, 2015).

In other words, if community members are not enlightened on health matters then their input will be off track and will not contribute significantly to any development process. The vice chairperson of Mwanza HCC also offered an interesting perspective on participation in Zimbabwe in general. He stated that the low levels and poor quality of participation are reminiscent of the colonial era:

> *Unfortunately, people still find it difficult to speak out. It is still a long way to go even though we are independent. We, as the HCC, our job is to make sure that whenever we get the chance, we contribute through the district health staff and to a small extent our councillor* (Mr Mupa Vice Chairperson Mwanza HCC, September, 2015).

Health literacy, from the perspective of the HCC, is when the HCC conducts community sensitisations on various health themes as a way of promoting preventative care. As an official of the CWGH put it:

> *Health literacy is the ability to obtain, understand and interpret health information and services in ways that enable people to use such information and services to improve their own health* (CWGH Mashonaland East Provincial Engagement Officer E. Mutasa, October, 2015).

The health literacy approach to educating communities on their health rights and responsibilities emphasises the need for action which is based on local health needs and priorities. Community-based action on social determinants of health such as water and the environment contribute to reducing health inequities in communities. I had an opportunity to witness the Mwanza HCC in action at Mwanza clinic during a community awareness programme for maternal and child care. The meeting was on health literacy for maternal and neonatal care. This meeting was in line with the national accelerated response to decrease the maternal mortality rate. In Zimbabwe, many women give birth at home without skilled care and with high maternal and neonatal mortality. Maternal mortality levels were in 2007 at an unacceptably high level of 725 deaths per 100,000 births (Munjanja 2007). In 2012, the figure had increased to 925 deaths per 100, 000 births. At the meeting, the total number of people present was 180 with most being women. The key speakers at the meeting were the District Nursing officer, the Nurse in Charge and the HCC Chairperson. The platform allowed me to get a 'hands on feel' of what the HCC described as health literacy. Community members were encouraged to attend antenatal care classes and register their births at the clinic as this significantly reduces the risk of death from complications as compared to delivering at home with an unskilled person.

The HCC members saw their second function as being a communication vehicle between health services and communities. In terms of communication, there is evidence to support the fact that communities raise complaints about quality of care and access issues to the HCC. Mwanza HCC has over the years monitored service quality at the clinic and has used information gathered to inform community and health worker feedback meetings. It is at these platforms that the HCC is informed of the challenges that affect health staff and subsequently has a negative impact on staff performance. The HCC highlighted that whenever community members do not receive quality service at the clinic, do not get the proper medication to treat their condition or, most commonly, they are made to wait in a line

for up to 9 hours, they look to committee members to complain. After a complaint is received, the committee investigates the matter by establishing whether the scenario has happened to anyone else in the ward. After this, a meeting between the HCC and clinic staff is scheduled:

> *I remember at one meeting, the clinic staff shared with us that it is not easy to work in a rural area where there is no electricity and poor piped water supply. Also there are not enough nurses at the clinic and that you find one person doing the work of 2 or 3 people.* (Mrs Ngoni Mwanza HCC Committee member, September, 2015)

The HCC members claimed as well that it is through these meetings with clinic staff that 'they get to hear the other side of the story'. Examples cited of poor service conditions of staff include the delay in the payment of salaries by the government which in turn affects staff attitudes and subsequent treatment of patients. It is difficult to attract and retain staff in rural areas as they are less developed (for example, no electricity) than their urban counterparts. A shortage of staff translates into existing staff being overworked and some tasks are simply not done or postponed in a way that negatively affects service delivery:

> *So in the instance where there is a shortage of medication it may be because they are late in ordering stocks from the dispensary at the District hospital* (Mrs Ngoni Mwanza HCC Committee member, September, 2015)

HCCs play a role in communication to communities and in social mobilisation around health campaigns. Here the role of the HCC in Mwanza is important when it comes to disease prevention control and management:

> *As for me, my village did not have a village health worker. The one's that used to come were from other villages. But since the HCC, my villagers come for meetings called by the HCC because one of us is there and is the chair person. We relate better to her because we know she knows what exactly our problems are* (Mr Mubaira Sadunhu (village head) Mwanza HCC Committee member, September, 2015).

This role of the HCC thus seems recognised and is utilised both by the community and the health system in terms of communication. The HCC was more confident of its chances of succeeding in areas relating to communication and information than in accessing or mobilising resources or making a real difference to health services in a sustainable manner. Although the Mwanza HCC has managed to mobilise resources for the construction of a waiting mother's shelter (WMS) and minor renovations at the clinic, its members felt that this was largely through networking efforts of the CWGH secretariat.

7.2.2.2 HCC relations with Local Government community structures

The general perception by HCC members of the HCC's relation to local government is that the health system is separate from that of local government. This means that the HCC feeds into the Ministry of Health. The VIDCO and WADCO structures feed into the Ministry of Local Government. HCCs are platforms for local communities, in which a primary health care facility exists, to participate (in addition to the village and ward level development committees) under the local government framework. The HCC though was unclear on what the responsibility of Local Government was in health service delivery, particularly in relation to the responsibility of the rural district council. At local level, priority development needs including health are identified by community members through village (VIDCO) and ward (WADCO) structures (UCA 2002; RDCA 2008). The Council and district level government departments (which include the DHE) then set priorities for the Council budget. The HCC expressed that they are not involved in this process as an HCC. Because of this, the HCC highlighted that they (as community representatives) needed education on key areas of health systems, on their role and on issues such as developing plans and budgets for health in the district.

Further, they claim that the HCC is apolitical and has no direct relation to party structures, and that the HCC is a different group as compared to the VIDCO and WADCO. Members of the HCC argued that the main difference between the HCC and the VIDCO and WADCO structures was that they 'do not talk about ZANU PF' and 'hand out farm inputs' as is done by the development committees in local government. Mutizwa-Mangiza (1990) argues that the village and ward development committees were created purely because of the political interest of the ruling party as a consolidation strategy after independence: "They [ZANU PF] created channels for participation by political interest groups in self-help projects such as in rural water supply and sanitation, village grazing and land reorganisation schemes and appear to have facilitated some diversification of sources of local revenue" (Mutizwa-Mangiza 1990: 23). The HCC Chair provided an experience she went through during the 2008 election period to illustrate the polarised nature of the VIDCO/WADCO. She was approached at a ward meeting and was told to voice her support for the ruling political party and the running candidate for the party at that time. She states that she vehemently refused and was then subjected to victimisation and harassment in the ward for a certain period of time:

> *Now, it is all forgotten. I chose to keep my identity in the community as a Village Health Worker, and as the HCC chair. Imagine if I had given in, we would have lost the community's trust especially in the taking up of health concerns in the district and also the community would have stopped paying the USD1,00 for the WMS* (Mwanza HCC Chair A. Togarepi, Chikwaka in Goromonzi, September, 2015).

From the focus group discussion with the HCC, it became clear that the HCC saw the local council as separate from the health system in terms of service delivery. Local Government structures receive financial input from the Rural District Council through the Ward Development Fund administered by the Ward Councillor (UCA 2002, RDCA 2008). This fund is from the District Development Fund. In terms of sources of financial input to the HCC, the community, the Ministry of Health and the local council were identified in order of importance. The community contributes to the HCC purse (at a rate of USD 1,00 per household per month) through their villages and this money is used to do minor maintenance jobs at the clinic (as the government and council have been failing to do this since the mid-2000s). The HCC Treasurer noted that:

> *Since 2012, we as the HCC have been spearheading the construction of a waiting mother's shelter here at Mwanza. Our villagers have to travel more than 90km to just get a place to give birth. This is not right! Children and mothers are dying from something which God created. Now it is like a curse to be pregnant because of these challenges. However, through the additional assistance of the CWGH network, their donors and the Zimbabwe National Army which we approached for labour, we are now building it for our women* (Mrs Chasi, Mwanza HCC Treasurer, September, 2015).

In responding to why it is important to have a HCC (in addition to VIDCO and WADCOs) in a community, the Mwanza HCC Secretary indicated that after independence the health sector had, at each local government level (village/ward, district and province), health executives who participated in the local government development committees (VIDCO and WADCO). These health executives formed sub committees within the ward and village development committees. The Nurse in Charge was very articulate in his description of these sector specific sub committees as had been envisioned in the health system in the earlier years of independence. He referred to Ministry of Health guidelines issued in 2004 which state that the Ward Health Committee provides leadership and support to communities to ensure that

their needs are reflected in the overall District Health plan compiled by the Ward Development Committee. Its mandate was to do the following:

- identify health problems in the area and suggest possible solutions;
- use information from communities to plan, monitor and coordinate health programmes;
- assist with relevant stakeholders and authorities to solve complaints from communities;
- encourage the community to participate in Ward Health programmes;
- act as a channel of information flow between the community and the RDC/DHE;
- raise and source community funds for agreed health programmes including funding for drugs and ensure the security of health resources;
- Support local community based workers.

He shared though that in reality, this overall mandate was not properly pursued and realised as the created structures were taken over by political interests. The user fee policy also reduced the uptake of health services by the communities. Another issue highlighted by the Nurse in Charge was that the centralisation of government activities meant that financial resources were slow in reaching the district level due to government bureaucracy and that, when the money then reached the intended communities, local authorities tended to use the money for purposes other than health.

The CWGH secretariat shed light on the weaknesses of the streamlining of health structures with that of local government. The CWGH claims that, with reference to the local government framework, even today the roles and functions at the different levels of government are neither well defined nor agreed upon between central and local government. This semi-confused state has cascaded into the relation between local government and the traditional leadership. The powers of local authorities and those of traditional leaders are not clearly set out. Accountability is then difficult to exact as responsibilities are not spelt out. This is evidenced through the land issue where the distinction between customary and state land is somewhat confused. This then affects land use as customary land falls under the jurisdiction of traditional leadership and this prevents local authorities from developing the land.

The CWGH secretariat believes that decisions at the community level under the local government framework are largely dominated by the technocrats in local government, both because of their significant numbers on local planning structures and their position as central government employees. An important factor that shapes the environment in which the health community structures had to operate is the power dynamic as played out by the state:

> *You see, the dominance of the state at this level of government has somewhat blurred the lines when it comes to the separation of the state and the ruling party* (CWGH Mashonaland East Provincial Engagement Officer E. Mutasa, October, 2015).

The opinion of the CWGH engagement officer was that the strategy by the ruling party has been to neutralise the threat of provincial (often ethnically-based) and political power blocs. This has however weakened the transfer of decision making to the local level thus not fully operationalising the decentralisation model. It is because of this that the local structure's full potential was never actually explored:

> *It was because of this that even today you see the foreign donors bypass this bureaucracy and go straight to community based organisations, village level committees and even sectoral ministries at the local level and fund them directly* (CWGH Mashonaland East Provincial Engagement Officer E. Mutasa, October, 2015).

Another reason provided for the failure of the decentralisation model as proposed by the local government framework is that the district and provincial health boards were not obligated to report to the Rural District Council and so this meant that sometimes there was duplication of government efforts. The programmes that were implemented in the health sector were administered from the central government level such that communities were left to merely contribute to infrastructure projects and to participate in health education. In this way, health policy was definitely centrally defined and controlled with the community just responding:

> *Their compliance was only what was needed to see the programmes run. But you see when the economy started to crumble in the late 90s then going into the 2000 decade, my friend, communities were abandoned by the so called government. There were no medicines in the clinics, there were no nurses and doctors did not exist at the clinic level* (CWGH Mashonaland East Provincial Engagement Officer E. Mutasa, October, 2015).

Mr Mutasa also provided experiences from his work during 2008 where he remembers an encounter in Mashonaland East Province where the clinics he visited were being manned by national service cadets some of whom did not even know anything about health.

7.2.2.3 Impact of HCC in Mwanza

The 2008 economic situation resulted in proper hygiene and health practices being eroded. At Mwanza clinic, the records show that 36 people died in the second half of 2008 from cholera and dysentery. In the opinion of the CWGH engagement officer, this is the foremost factor that led to the cholera outbreak in 2008:

> *We suffered my friend, there was no food and there was no water. Our hygiene practices had deteriorated in the villages because all that support from the government through the feeding and health education programmes was no longer there. People died* (CWGH Mashonaland East Provincial Engagement Officer E. Mutasa, October, 2015).

According to the CWGH, the HCC in the affected communities was very instrumental in restoring some semblance of health services in Mwanza. Mwanza HCC through their ties with the CWGH network sourced rehydration packs and sanitary and hygiene packs to kick start health education on healthy environments at the household level. Mr Mutasa indicated that the HCC members were the ones who moved door to door in the ward to educate the women in the villages:

> *So you see, even when the state let the community down, the community found ways of picking itself up. This is not only a case of Mwanza, we can even talk of Chipinge, of Bulawayo, of Gokwe even Uzumba Maramba Pfungwe. There are HCCs there that did the same thing* (CWGH Mashonaland East Provincial Engagement Officer E. Mutasa, October, 2015).

It is from this positive experience that the CWGH states that they continue to push health authorities in the country to firstly acknowledge and to secondly further integrate and pronounce the role of community participation in health systems in Zimbabwe.

The health worker in the HCC as well as the CWGH secretariat were particularly conversant and knowledgeable in highlighting the weaknesses in the previous set up (with the village and ward health committees) and thereby to bring out the importance of the HCC as a structure for effective community participation in health. The other HCC members were either quiet or

indicated in the focus group discussion that what they were hearing was new information to them. From the focus group discussion with Mwanza HCC, the following were given as the added value of having a HCC in addition to the platforms for participation in the local government framework:

- ✓ The HCC is solely situated in the health system at the primary care level. It is accountable to the community it serves and is a bridge between the health system and the community.

  If it were not for us, the HCC in this area, drugs would still be running short due to theft until today. We are the ones who initiated to use some of the money from user fees and also collected village contributions to put burglar bars as well as hire a night watchman for the clinic. (Mr Hove ZRP, Mwanza HCC, Goromonzi October, 2015).

- ✓ The HCC election process is solely owned by community members in that they nominate committee members in a community health meeting where the roles and responsibilities are discussed beforehand, which thereby manages expectations. The political leadership is given a backseat in this structure. This is different from the village and ward health committees which were selected by political and traditional leaders and these structures have been highly criticised for more closely reflecting nominees from higher levels of the party hierarchy than direct community interests.

- ✓ The HCC collects information to inform health policy:

  When we gather people for a community meeting to identify the most pressing priority needs, the ranking and scoring participatory method allows for the community to prioritise needs that are most pressing across the sexes and age groups without focusing on the men or women or even the youth. What comes out is our common problem which needs to be addressed. We have hope that the government will use the information we bring out because it is coming from us the people of Mwanza who are facing Mwanza specific health problems (Ms Tariro Youth Representative Mwanza HCC, Goromonzi, October, 2015).

- ✓ The HCC allows for joint problem solving:

  The HCC is important in our community because it allows us, the community and health workers, to find solutions to health issues as well as fix our clinic to be better (Mr Nkomo Disabled person representative Mwanza HCC, Chikwaka, Goromonzi, October, 2015).

- ✓ The HCC is a neutral space in the community:

> *The beauty of the HCC is that it brings people in the community together. Those belonging to politics leave it aside; those from business, leave it side because when it comes to health it is everyone's matter. It does not matter if you are rich or poor, sickness affects all of us. We are all the same and we all have different parts to play together with the government to keep and maintain good health in our community* (Mr Nhimbe Ward councillor Mwanza HCC Chikwaka, Goromonzi October, 2015).

The information contained in the following table (Table 7.2) was compiled after a HCC feedback meeting held at Mwanza clinic in October 2015. I observed this meeting as means of obtaining first-hand information on what the perceived benefits are when a community has a functioning and active health centre committee. In the meeting, the HCC through its Chairperson provided feedback to community members present on work carried out by Mwanza HCC which included assisting other communities in the Chikwaka, Juru and Gora areas to set up HCCs at their respective clinics in the period of 2014-2015. The Mwanza HCC also assisted resettlement communities around John Reimer clinic to form a HCC. This community is unique in that the land which it occupies was allocated to these farmers in the period of the fast track land reform of 2000-2002. Some of the community members around John Reimer were also victims of 'Operation Murambatsvina-Operation Restore Order' (2005-2006) carried out by the City of Harare and the Ministry of Local Government to rid the capital city of illegal structures and squatters. Mwanza HCC was instrumental in setting up an HCC at the John Reimer clinic as those communities do not fall under the traditional set up of having a village or ward and so had no platforms for participation in their social development as they are on farms.

Table 7. 2: Impact of Mwanza HCC

Mwanza HCC area of success in the period 2014-2015	Resources used for health in the community	Health service delivery improvements	Challenges that still remain
Staff toilet completed for the clinic to motivate staff at Mwanza. 5 Health education and community campaigns held together with village health workers. 3 health commemorations held in the ward. Involved in feeding orphans and vulnerable children. Contributed with money to take lab samples to the district hospital for 10 patients. Bought 2 benches for the clinic. Waiting Mother's shelter is now in Phase 3 where roofing is completed. Continued to employ security guard at clinic. Cleaning of the clinic. Bought cables for the generator donated by the Member of Parliament.	Collected USD1,00 per household in the villages in Mwanza Collected every two months From User fees, council takes 60% and the clinic remains with 40% which we used for clinic maintenance	Improved health staff living conditions through construction of staff toilets. Staff members are friendly and now open clinic from 7am until 8pm every day except for Sunday where they do not open. After 3 years, the WMS will be open beginning 2016 and this will result in more mothers delivering at the clinic. Security at the clinic.	Waiting time at the clinic still long because of the staff shortage. Community still has to pay for lab samples for some patients because the clinic will have no fuel to take them to the district laboratory at Makumbe Mission. Water still a challenge at the clinic because donated tank is leaking.

A recent boost to Mwanza HCC finances has been the Health Transition Fund (HTF). One of the main objectives of the HTF is to provide core funding for community participation in health at the primary level. The HTF does this through the RBF model where an HCC is paid out a certain amount of money based on the amount of live births recorded at the clinic.

According to Mwanza HCC, the fund has started being operational at its clinic in 2015 having being introduced in 2013. The money is for clinic infrastructural development and maintenance especially aligned to maternal and child health services. The money received is managed by the HCC with the DMO, HCC Chair and Treasurer as signatories. The HCC has sole responsibility of planning for the RBF resources with the clinic staff and with the community. After spending, the receipts are submitted to the District Health Services Department for record keeping by the HCC Treasurer.

> *We have used all the RBF money received in January, March and July 2015 to move the WMS from slab level to finish the roof. Now we are going to start buying furniture for our maternity waiting home* (Mrs Chasi Treasurer, Mwanza HCC October, 2015).

Below (in Box 7.1 and Box 7.2) are two brief cases that have been documented by the CWGH on the work (and impact of the work) of the HCC in the Chikwaka area at Mwanza clinic.

Box 7. 1: Blair Toilet for Staff through Fundraising by Mwanza HCC

In Goromonzi district the HCC of Mwanza clinic in 2010-12 engaged in fundraising with the community to improve staff working conditions at the clinic. The HCC members initiated the idea of improved sanitation at the clinic for the staff at a community meeting 3 years before it was completed in 2012 when the nurses at the clinic complained that their toilets were unhealthy for them and their families.

It was at this meeting that they decided to fundraise for a toilet on their own. Efforts to have the Ministry of Health to address this problem were fruitless in that the District Health Executive of Goromonzi communicated that there were no funds for such projects as available resources were already committed. They discussed the idea in the HCC and then with the community and agreed on a maximum fee that would be paid by all members of the community and all users of the clinic per two months. In 2010 this fee was US$0, 50 and it was increased to US$1, 00 in 2011. For transparency, the community elected treasurer from the HCC was the fund signatory with the Chairperson. The HCC used its bank account at Metropolitan Bank, Murehwa to place their funds. The total raised was US$ 800, 00 and it was all used for the staff toilet.

Picture 1: Mwanza Clinic Blair toilet (2012)

Source: CWGH Annual Narrative Report, 2013:14.

Box 7. 2: Construction of a waiting mothers' shelter in Chikwaka, Mwanza Clinic

Villagers in Chikwaka community faced by a 2012 poor agriculture harvest and economic hardships of the past decade are still struggling to pull resources together to build a maternity waiting home at Mwanza rural health centre. The waiting mother's home is set to accommodate three (3) nursery beds and eleven 11 adult beds for expecting mothers including those that would have given birth. The home will alleviate the plight of expecting mothers, who travel long distances to access maternal services. The nearest referral hospital, Makumbe is 105km away. Transport to Makumbe is very unreliable and costly. Reports are that some women are dying and, others are giving birth on the roadside because they are travelling long distances. The picture below shows Phase 1 construction of Chikwaka-Mwanza Waiting Mothers' shelter at the beginning of the year 2012 with support from the Zimbabwe National Army as contractors and Ministry of Public Works providing the Expertise and supervisory services for free.

On phase 1 of the project Community contributed a once off payment of US$1 per household since 2011 towards security of the building material provided by an external donor and food for the youths supporting the contractors. The total amounts collected in 2011 and 2012 are (US$1,427.00) and (US$638.00) respectively. Many households could not afford to pay a dollar in 2012 due to poor harvests since they relied on seasonal farming. However, the general community also provided free labor towards attaining locally available resources such as bricks, river sand, pit sand and ¾ quarry stones.

Picture 1: Chikwaka-Mwanza WMS construction; Phase 1

Source: CWGH Annual Narrative Report 2013:16**.**

7.2.3 Mwanza HCC Challenges and Expectations

The focus group discussion with the HCC facilitated a platform in which the HCC could share their concerns in terms of their role and what is expected of them as per the Ministry of Health guidelines contained in the HCC Manual developed in collaboration with the CWGH in 2011.

The lack of feedback from health authorities at the district level was cited as the most discouraging factor in the HCC carrying out its mandate. The HCC invests time in inviting

villagers in the ward to attend and contribute in community meetings. The meetings are for community members to identify and prioritise what the most pressing health needs are for the community, as articulated by the Youth representative on the HCC*:*

> *Our responsibility as the HCC according to the guidelines is to do exactly this* [to identify and prioritise] *so that this is carried forward to the district plan of the DHE. Our input we understand is that we represent the community voices. The biggest problem has been that when we input into the clinic plan so that this can be passed on, there is no feedback from the DHE to say that this is what we have taken and this is what we have not* (Ms Tariro Youth Mwanza HCC Goromonzi, October, 2015).

Feedback from the DHE completes the cycle for the HCC in that it will have responses to community queries that were raised in earlier meetings to report back on. The HCC noted that this was an expectation held by the community of the HCC:

> *It seems like we keep saying the same things for example, more nurses, more medicines, more equipment but the situation does not seem to change. So sometimes we feel like we are not being heard. They do not come back to us; they just take our information (*Ms Tariro Youth Mwanza HCC Goromonzi, October, 2015).

The HCC were wary that, if the lack of feedback from the DHE persisted, it would lose credibility and trust from the community.

All members of the HCC acknowledge and welcome the relief brought on by the RBF fund. It was noted though that the delay in the disbursement of these funds slowed down a number of projects in the community:

> *People in our villages are already overburdened; they do not have money for contributions. When we sensitised them on the RBF we said it was what our government is doing for us to make us survive and for us to have health. It was welcomed by all but it was delayed. Not even one person explained to us why it was so delayed* (Mrs Madyira OVC representative Mwanza HCC, Goromonzi, October, 2015).

Associated with this concern, the committee felt that it had information gaps on how health services are actually delivered and how this is linked to its input into health planning.

The HCC therefore highlighted that there was no clarity on what happened subsequent to its input being provided. The HCC members felt that education on the functioning of the health system from central level to clinic level was needed to close this gap. It was also raised that

there was need for more education on budgeting so that they could educate communities. It was agreed that transparency on issues to do with health plans and budgets at district level would help the HCC review with communities their needs and options so as to align these with what is available in the district budget. This kind of information from the DHE was important in that it would make facilitating community planning easier and would tap into community resource mobilisation to assist in closing the gaps that are within the reach of the community itself. Increased information on how the health system works was said to be critical for the HCC to continue supporting the work of community health workers in the villages:

> *If we know what happens when and why we will raise awareness on it and also make sure communities know more about public health. We will also know and work with the RDC and the community to raise awareness on, motivate and support the implementation of public health standards, such as water safety and sanitation and food safety to avoid diseases* (Mr Duri, Informal trader Mwanza HCC, Goromonzi, October, 2015).

The HCC further expressed that the lack of a clear concrete clause in the public health act to legitimise the structure undermined their functioning. This is seen as a gap that is mostly responsible for not being taken seriously by the DHE or even the RDC because of the lack of legitimacy. The lack of recognition in formal legislation makes the HCC a structure that is convenient to have but not actually important. This gap, as communicated by the HCC, allows the DHE and the council to 'keep ignoring' the HCC as they are not compelled to work with the structure:

> *We have to beg for feedback, we have to beg for a space to address the community at the Councillor's meeting even though he is one of us. He never comes to our meetings. He only comes when the CWGH is there because there will be food and a little allowance for transport* (Mrs Madziro Teacher, Committee member Mwanza HCC, Goromonzi October, 2015).

Coupled with this comment, most of the HCC members cited that some community members are jealous of the positions occupied by HCC members because they think that that there is an allowance from the CWGH. Committee members insisted though that the work they do is purely out of passion and on a voluntary basis. It was noted that some villagers stopped attending community meetings led by the HCC all together as they felt that it was a waste of time attending if they too were not compensated monetarily.

In terms of expectations, HCC's views centred on the building of more capacity to better interact with the rest of the community.

> *I hope that the CWGH continues to encourage us and also teach us on the New Zimbabwe Constitution so that we know and understand our right to health. We will be in a better position to teach other* (Mr Nkomo Disabled persons' representative Mwanza HCC, Goromonzi, October, 2015).

The CWGH's support in terms of technical capacity to build skills as well as its networking capacity to draw donors to the ward was highlighted as crucial to keep the HCC growing. The HCC stressed that within the ward there are some hard to reach areas and that, in the coming year, the committee expects to have strategies to address this challenge. The HCC expects to continue to encourage villagers in Mwanza ward to increasingly participate in agreed upon Ward health programmes. The HCC also looks to continue facilitating entry for health oriented organisations in the ward so that health interventions reach and involve all social groups that need them. The HCC believed that its coordination role in the years of its existence in the ward has helped improve the health situation in the local community and that this must continue so as to react in time if there are any disease outbreaks by supporting the health team in managing these outbreaks through its extended reach in the community. Additionally, HCC members indicated that there will be more effort placed in monitoring the health authorities to see whether their input is actually used to inform the district health plan and budget, so that their current perceived exclusion is rectified. To allow for this, there is an expectation placed on the DHE to improve communication and be transparent about the health programme especially when it came to their ward. The last expectation raised was that the government needed to put more effort in taking the burden off the people in making health accessible and affordable to the poor. HCC members want to see the government take over health infrastructure development and maintenance instead on leaving it to the community to mobilise itself to take on resource-heavy projects when it is the government's responsibility.

7.3 Community members' views on their role in the Health System

Community member insights are important for this study in order to obtain an 'outsider' perspective on how the community surrounding Mwanza clinic interacts with the health system. I refer to 'outsider' in that these community members are not members of the HCC. This section discusses three main themes. The first is awareness of the HCC as a structure

and its relation to local government structures. The second is knowledge of HCC roles and responsibilities as well as the activities they conduct. The last is insight on what community members perceive as their role in health.

7.3.1 Recognition of existence of Health Centre Committee

Whilst the district health executive and local government social services department reported that village health committees and health management committees existed in accordance with health guidelines and local government decentralised structures, there is low recognition amongst villagers of the HCC and how it functions. This was gathered from randomly selected respondents sampled at Mwanza clinic. These respondents were not part of a health committee at village or ward level. In total 33 patients were interviewed of which 23 were female. Table 7.3 below contains information on the sample of respondents and whether they knew of the HCC in Mwanza.

Table 7. 3: Sample characteristics: Existence of HCC

Sex	Recognition of existence of HCC	
	Yes	No
Male	7	3
Female	13	10
Total	20	13

13 people (3 men and 10 women) were not aware of the HCC. The term 'health centre committee' seemed to be less clear among these respondents as if it was something they never knew before. A possible explanation for the high figure for females could be that a majority of village women do not create time to attend community meetings as they are occupied with running the home, farming and raising children. Attendance at community meetings only takes place when they are compulsory and villagers have been summoned by the village head and/or the ward councillor. It should be noted that the majority of patients that visited the clinic on research days were women and children.

These community members (10 women and 3 men) had never heard of the HCC or rather the name of the committee. This is in contrast to knowledge about local government, as a

common thread amongst these respondents was clear understanding on the existence of local government platforms for participation. The term's VIDCO and WADCO were more recognised than the HCC. They noted that there were meetings called for by either the Village head or Councillor which all villagers attended. The meetings were held, for instance, about questions around land and agriculture, information on funerals and children sent away from school due to fee payments not being made. The sharing of this information is for the village to know of those who are in need and also hear notices from the village heath worker one respondent said.

> *At the ward assembly, Councillor Nhimbe is the one who talks to us. He talks about council and also about the farming inputs that we get from him and the MP. We also talk about farming land and village expansion at this meeting. This is where we talk about our land needs but it is up to the traditional leadership to decide whether one gets or not* (Community member (male) interview 16, Chikwaka Goromonzi, October, 2015).

A number of responses within this group of respondents (the 10 women and 3 men) who did not know of the HCC provided more or less the same narration on what happens at village and ward level meetings, but what is peculiar is that some of them lacked clarity on whether these platforms were political or government. The peculiarity is in that these respondents referred to the WADCO as a ruling party structure. To them, the government is the ruling party. This is significant to my study in that the HCC Guidelines (CWGH and MOHCW 2011) state that an elected representative cannot be a leader in the HCC. It confirms the view that community development processes are prone to being misinterpreted as political initiatives if led by an elected politician. A community member noted:

> *Whenever we meet as a ward we would have been brought together by the ward Councillor. We talk about development and how we are progressing as we plan at the beginning of the year as a party. All the things we do should be in line with the party plan* (Community member 22 (male) Chikwaka, Goromonzi October, 2015).

No further questions on political party affiliation were asked for fear of deviating from the subject of focus and raising sensitive political issues. Within this very same group (13 who did not know of the HCC), from various villages within Mwanza ward, it can be assumed that they were not aware of the duties and mandates of HCCs as they had stated earlier that they did not know of one existing in their ward. For them, health issues are raised by the village health worker at village and ward meetings. The village worker is a volunteer health

promotion cadre in the health sector. The VHW programme began after independence in Zimbabwe and this could be the reason why this group of respondents was more familiar with the VHW than the HCC.

All 33 respondents expressed knowledge over community health workers and named them as '*mbuya hutano'* (i.e. village health worker). The village health worker is popularly known for education on clean environments in the home, collecting and disposing of refuse in an environment friendly manner, keeping safe water and cooking food well:

> *They follow up on us and also do home visits when one is not well. They call us for health campaigns. They used to do this each month in my village but now it is here and there* (Community member 1 (female) Chikwaka, Goromonzi October, 2015).

They confirmed that they knew that each village had at least one village health worker. Other community health workers known by all the community respondents were the home based care givers and health literacy facilitators. It is important to note that even though the government VHW programme was severely affected by the economic situation in the period 2000-2008, community members still remember the cadre. Through the HCC, the VHW now has a support structure in terms of other volunteer community members to widen health programme reach, mobilise the community and consistently teach health literacy in the ward.

Most of the respondents (20) felt that traditional leaders and the ward councillor only participated in health campaigns in the form of public gatherings but did not actually follow up to find out whether health services were actually being delivered to all in a fair manner. The traditional and local government leaders were said to only attend to guard against any hate speech against the authorities or the ruling party. These leaders were contrasted to the HCC chairperson who was said to be very good with patient follow up in the villages. This can be attributed to the fact that the HCC chair is a village health worker.

The respondents that knew of the HCC (20) in one way or another reported that HCC members were chosen by nomination and voting at community meetings through a voting system involving community members. One community member highlighted that HCC members were selected from the different social groups they were actively representing and the community voted them into positions. Overall, 60% of the 20 expressed that some HCC members were chosen because of their role in health services and status in the community, such as councillors, traditional leaders and health personnel. To test their familiarity with the

HCC, interviewees were asked whether they knew the names of the people on the HCC. Over half of the 20 respondents who were familiar with the HCC structure were able to do so (14), indicating that generally those who knew about the HCC also knew who was on it. This indicates that there is a certain level of contact between the HCC and the community. However, if this is contrasted to the catchment area that the clinic serves, the sample size limits the generalisability of this particular finding.

From the various interviewees who were aware of the HCC and had some inclination of the kind of work they carried out, claims around the committee's composition were raised more fully and clearly by a few. These community members noted that the HCC reflected a range of social groupings in the community: men, women, farmers, youth, widowed, church, teacher, elderly and the disabled. One of the respondents, a widow, thus said that the HCC was a representative structure in their community because it included orphans, disabled people, the elderly, youth and widowed women. The HCC, for some, was seen as a structure for those who could not afford private health care. Those who use the government clinic the most are those who have no other alternative. In addition, the widow stated that as vulnerable groups they are regularly overlooked in local government structures (at the village and ward level) and have difficulty in attending community meetings:

> *But because we have someone there in the committee* [HCC] *who is facing the same challenges that we face, we know that they will stand up for us and also share the information with us when they can* (Community member 33 (female- widow) Chikwaka, Goromonzi October, 2015).

7.3.2 Knowledge of the HCC and its work

A total of 20 interview respondents expressed that they knew of a health centre committee that was elected to work with the clinic. These very same respondents concurred that the primary role of the HCC was to address community health problems, give advice to communities on health issues, provide health information and take up issues with health services. As one female said:

> *As for myself, if you are referring to those people who call us to the clinic and tell us about health, I know of them* (Community member interview 1 (female), Chikwaka Goromonzi, October 2015).

These respondents, in some way, expressed being satisfied with the performance of their representatives in the health centre committee, some of whom are community leaders such the Ward Councillor and Village Head and sometimes the Headman:

> *I know of the HCC through my village head. He is always talking about it and he encourages us to attend the meetings they call in our villages* (Community member interview 7 (female), Chikwaka Goromonzi, October, 2015).

This satisfaction was based on the fact that most could remember a couple of times in which the committee members visited their villages to sensitise them on health matters such as malaria prevention, cholera prevention, HIV/AIDS, environmental issues such as waste management, and participation in clinic and ward health activities. This group of respondents (13 women and 7 men) expressed that the HCC usually conducted meetings which ended in the committee encouraging villagers to contribute financially to clinic activities:

> *When we usually meet with them, they will be encouraging us to contribute to the clinic. We contribute only when we can. The nice thing is that they do not force us but they just remind us that everyone will need the clinic one day and so we must take care of it all the time so that when you need it, it is in the best condition possible to help you* (Community member interview 10 (female), Chikwaka Goromonzi, October, 2015).

An example given by one woman was when each household in the village in the period 2008-2009 was asked to contribute a bucket of maize which was being collected to provide food for health staff at the clinic.

> *I remember in those years when we had no food, we collected the little that we could even the bulgur wheat from the church and shared with the nurses at the clinic. It is because they also did not have. Also they allowed us to pay user fees with maize if we did not have money.* (Community member interview 6 (female), Chikwaka Goromonzi, October, 2015).

They thus see the HCC as health promoters and advisors, as bridges to ensuring that health interventions address community health problems, and as a problem solver for community issues with the clinic. It is apparent in some of these responses that the extent to which inputs from the community are taken to the clinic by the HCC was not clear. But there is an acknowledgement that to a large extent the HCC is making a direct improvement to the health facility itself:

Right now I know that the HCC called donors to come and build a mother's shelter. We are also contributing to the project but it is good to know that they are getting us to do something about helping mothers and babies (Community member 17 (female) Chikwaka, Goromonzi October, 2015).

There are also examples from the responses pointing to nurses' attitude to patients gradually undergoing a shift in a positive direction. It was said that the nurses were often very rude towards patients and that this made the clinic an unwelcoming place. The clinic only opened on weekdays and was not open during the weekend. This was an inconvenience:

As you know sickness has no appointment so you need service at any time (Community member 30 (female) Chikwaka, Goromonzi October, 2015).

It was stated that, since the work and intervention of the HCC, Mwanza clinic now opens on Saturdays.

The most articulate story provided from the group was from a young woman who shared how the HCC approach to health education had an impact on her life. She spoke about how she had lost her sister and her unborn child due to complications in a home delivery. She stated that, at the time of the tragedy, not many people knew that that the nurses at the clinic could deliver babies. The assumption was that these services could be performed only at the district hospital. The distance to Makumbe Mission was said to be the main barrier besides cost in accessing services at Makumbe:

It comes to a little more than 100km. Even those who can afford the service take long to get there (Community member 17 (female) Chikwaka, Goromonzi October, 2015).

The distance has also been the reason why HIV positive villagers have defaulted on their antiretroviral treatment regimen as the mission is too far. It was claimed that some patients seek health care services from neighbouring districts such as Murehwa District and visit the Musani Mission Hospital because, even though the distances are far, they are much the same as Makumbe. The traditional method of asking for assistance from '*mbuya nyamukuta'* (i.e. a traditional birth attendant) was the norm in their village. Payment for this service was said to be 3 chickens if it is a girl and a goat and a cock if it is a boy:

For me my first 2 children were delivered at home by that 'mbuya'. For my sister when the baby would not come out, they made my sister confess to sleeping with another man because that is why the baby will not come out. It is known that if you are unfaithful to your husband, if you are pregnant, the baby will not come out until you shout out everything and ask for forgiveness from the ancestors. If they accept

> *then the baby will come out. I wish I had known about the maternity side of our health as women. I would have saved my sister. It is the HCC because of their community awareness campaigns that I now know that no one else has to die from giving birth in my family or in my village* (Community member 17 (female) Chikwaka, Goromonzi October, 2015).

From those villagers who were more familiar with the HCC structure (20 people) as well as the health system to a certain extent, it was largely felt that, in terms of accountability loops, the HCC reported to the health staff in the clinic and at the district level. The reporting by the HCC to the community seemed to be restricted to when the CWGH initiates a meeting. When the CWGH secretariat is in the ward, the HCC provides feedback to the community. It is interesting that communities do not know that the HCC is accountable to the community first and foremost. To them, the HCC reports to the clinic staff, the CWGH and the district offices. A matter of concern arising from the sample group (13 women and 7 men) is thus that feedback from the HCC is provided when an external visitor in the community is present (for example, the CWGH) such that, when a visitor is not there, communication with the community may be lacking. A majority of these community members (11 in 20) expressed that the HCC is helpful in addressing health issues. These 11 respondents interact with the HCC frequently and have had issues they have raised addressed. The 9 other respondents noted that it was difficult to say whether the HCC solves community health problems. This does seem to reiterate that there is need for a 'two-way street' between HCCs and communities. It is clear from the responses that those who know, interact with, take issues to and get feedback from the HCC see the value of the HCC hence they are motivated to continue to participate.

Table 7. 4: Roles and functioning of HCC as reported by community members

Characteristics of HCC	**Mwanza HCC**
Composition (who are they?)	EHT, nurse, headman, councillor, village health worker, traditional healers, teachers, business people
Accountability (who do the HCC answer to?)	CWGH Clinic District health team
Role in community (what do they do?)	Arranges meetings with community to identify and discuss health issues; Organises awareness campaigns on mothers and babies; Sanitation; Visits the sick in the community; Works and helps with clinic in articulating community problems; Collects money for security, toilets and mothers shelter.
Main issues of discussion during community meetings at clinic in 2015	Health issues: HIV/AIDS, Maternal Health; how to look after the sick & orphans; maintenance of clinic; Security issues; Construction of toilets; Sanitation; Accommodation for staff and their welfare; Food aid; mothers shelter; waste management vegetable gardens as income generating projects

7.3.3 Perceived role of the community in Health

In terms of understanding what the role of the community is in the health system, a number of respondents had contributions to make on this matter. The main perception from the sample was that the community do have a role to play. For most (26 respondents of the total sample), decision making on how the district developed lay in the hands of the council and the traditional leaders. In terms of the health programmes specifically, this was seen as largely placed under the leadership of the health workers at district level and council:

> *As for me health plans and decisions are made by the councillor and the nurses at the clinic. My job is to visit the clinic when I am sick, be attended to and get medicine. I also attend their health meetings when they call for them* (Community member 9 (male) Chikwaka, Goromonzi October, 2015).

Contrary to this perception, some respondents highlighted that there are practical activities that individuals in a village do to contribute to health in their community and also promote good health practice. They stated that it can happen at many levels. For instance, at individual

level, a person can make sure to wash their hands after using the toilet or even wash food before cooking and also use mosquito nets to prevent malaria:

> *As a village we can promote each other to dig a deep hole and use it as a waste pit far from the huts so that there are fewer flies and we can plant nutrition gardens to promote healthy eating* (Community member 19 (male) Chikwaka, Goromonzi October, 2015).

But there is a lack of clarity amongst villagers on their roles in the health system. All the respondents expressed that their main role was to contribute funds to the clinic. From the more conversant in the sample, the following list of sources of community revenue for health services was compiled:

- Village funds from the traditional heads,
- Revenue collection by the council,
- User fees,
- Community share ownership funds,
- Local commodity sales and some cost-sharing.

The general notion was that, through the HCC, community members can mobilise their own resources to carry out health initiatives within their own control and reach. To complement the (above identified) revenue streams are the labour, time and other inputs people in the community provide, particularly when villagers are directly involved in health activities.

7.4 Bringing it all together: Mwanza Case study

The role of community members in the health system has definitely gone beyond what it was in the 1980s in that the mechanisms to participate have been widened to include all social groups and also the creation of a separate structure for health instead of having a subcommittee attached to the local government development committee. These are positive steps towards strengthening community participation in the health system. However, if community members are not aware of why they should participate and how it affects them if they participate or do not participate, the platforms for participation are prone to manipulation.

I observed from all three stakeholders (DHE, HCC and Community members) interviewed that there are indeed spaces for community participation in local decision making processes. The spaces I refer to are the HCC, the VIDCO and the WADCO. Only the VIDCO and

WADCO structures are legislated for in Local Government and they exist to facilitate multi sectoral development at the local level. The health sector has the HCC as a parallel structure to local government community structures to capture community voice for national health policy. The expectation is that the HCC works in unity with existing development committees. From the fieldwork findings, this has not fared well. From the interviews, politics and a lack of coordination towards working with villagers and local authorities in health and local government have been the main barriers.

There is a limited understanding of the health system in the community in Mwanza as well as in the HCC. Questions to the community that were meant to elicit information on the health system were not asked in most instances as the majority of respondents placed the decision making process in the council and the health workers. Within the HCC, the HCC secretary who is a health worker by profession and (to a small extent) the HCC Chairperson (a VHW) were the only conversant people when it came to the health system. If community members including their representatives are not aware of the basic structure of the health system, how and when decisions are made, and by whom then this limits the extent to which they can interact with the health system.

The HCC was identified as the structure through which the health system strengthens community participation in fulfilment of national health policy by the DHE. The lack of feedback and bureaucracy in the DHE were raised by the HCC as the main constraints in them performing their role and function. The HCC is a community representative structure. Failure to complete communication and feedback loops impedes active participation. The HCC as community representative has to be recognised as a stakeholder in health not only on paper but in day to day implementation as well. In this way a culture of participation is nurtured in the community.

The HCC is perceived to be a valuable stakeholder from all the interviewed groups. In terms of composition, the HCC is fairly representative in taking into account all social groups (which is a good attempt at being inclusive). From the community side, the HCC is valuable to only those who know of it as a health participatory structure. It is valued for the many roles it plays in health literacy and improving health service delivery. The community members who did not know of the HCC indicated that they were more aware of the village health worker for health promotion purposes. In terms of structures for participation, they all

referred with ease to the VIDCO and WADCO. Observations on the necessity of the HCC as a representative of the community indicate that there is strength to a large extent in having an organised group to lead consultation in the community. However, the weakness is that over time, the structure should be wary of distancing itself from the community and becoming entrenched in 'a life of its own' and thereby losing focus. Each social group has its own priorities and the structure has to be flexible enough to absorb these differences and deal with them satisfactorily.

There seems to be evidence to support the fact that government is 'passing the buck' in terms of service delivery. Communities still find themselves bearing indirect out of pocket costs to contribute to health other than through medicines and user fees. These costs are what the HCC collects to pay for security, buy cleaning substances for the clinic and pay for the transportation of patient samples for lab testing. But it is the role of the government to provide adequate up to standard health services progressively to the maximum of available resources according to Zimbabwe's supreme legislation (Constitution of Zimbabwe, 2013: 34)

7.5 Conclusion

Mwanza HCC has been in existence for the last fourteen years. The chapter first of all discussed how the HCC came into existence and its understanding of the importance and value of having the committee in place. In this same thread, some success stories were shared as well as key challenges that affect the operation of the HCC. Lastly, to end the chapter, I provided an overview of the thought and input of community members on health within the ward and their opinions on their role within the health system itself. To conclude the study, a thematic analysis of the findings of the thesis is provided in the following concluding chapter.

Chapter 8: Conclusion

8.1 Introduction

This thesis broadly contributes to health literature in Zimbabwe by providing insights on how community participation is happening at the clinic level. This critical introspection on participation contributes to existing studies on the primary health care approach in Zimbabwe by specifically offering perspectives on how participation in health policy has been interpreted by multiple stakeholders, namely, the district health management team (DHE), community members and a HCC. These 3 stakeholders are integral to the health system. This critical analysis adds to a growing body of work on how the Zimbabwean government is seeking to operationalise the PHC approach since 1980. In this concluding chapter the summary of the findings focuses on the specific thesis objectives. The implications in relation to community participation in health will also be discussed. Recommendations and limitations arising from the thesis will be outlined and lastly a conclusion of the study will be presented.

In unpacking the primary health care approach, it is clear that it depends on a high level of community participation. The main assumption informing the approach is that, when affected communities participate in health, they increasingly gain ownership from their involvement. This kind of participation most importantly frames health service delivery and customises it to suit the needs of those consulted in what is termed a 'bottom up approach' to health policy. This thesis sought to, as its main objective, to critically analyse the role of community participation in the health system in Goromonzi district, Zimbabwe using Mwanza clinic health centre committee as a unit of study. Following the main goal, the secondary objectives of the study were:

a) To identify legislative, regulatory and normative mechanisms that enable community participation in the health system in Zimbabwe.
b) To assess how community members view their role in the health system at clinic level.
c) To examine whether community participation can be linked to improved health outcomes at the local level.

The study of the Mwanza Health Centre Committee as the focus of the research was complemented by a focus on the District Health Executive in Goromonzi and community members not affiliated to the structure formally other than being a resident and within the catchment areas of Mwanza ward's clinic. I examine the three secondary goals in turn and – in doing so – I address the overall objective as well.

8.2 Summary and analysis of findings

8.2.1 Analysis of mechanisms for community participation in health (legislation and regulations)

The thesis employed a desktop analysis of health legislation and regulations that inform national health policy in Zimbabwe. It sought to identify the various spaces that have been created within the health system and local government framework for communities to participate in health policy formulation, implementation and monitoring. A number of pieces of legislation in Zimbabwe on health do highlight channels through which community voice is to be heard in the various stages in national health policy formation and implementation. However, there is no set regulation within the current health legislation that allows for the existence of HCCs in their current form. One key informant from the district health executive felt that, if there was no legal provision that set out and governed HCC operations, it places HCCs in a difficult position. The legislation should be put in place as this will be the means by which HCCs would be empowered to operate and through which they could receive an allocation from the national budget for their activities and not rely on donor funds and community contributions. What exist are mere guidelines prepared by the Community Working Group on Health and these were subsequently adopted by the Ministry of Health in 2011. The adoption of these guidelines by the government through the Ministry was brought on by the weak nature of the health system due to the economic collapse in Zimbabwe. It was more of a survival decision and not so much a 'we have thought this through and this is the clearest and best way forward'. The implications of this were highlighted by the HCC itself in a focus group discussion.

The lack of transparency on planning and budget information as well as the inconsistent character in which feedback takes place points to the fact that the health system itself has not fully integrated community participation. The guidelines and the situation that HCCs are now

the custodians of the health transition fund aid through the results based financing model indicates that there is acknowledgement and recognition of the existence of the HCC as a vehicle through which communities can participate in health. In my opinion, although the health system has undergone various 'facelifts' in three and half decades of independence, there are still remnants of the past present within its operations. The form in which community participation takes place may have shifted from the individual to include that of the group but the following still remain:

- A top down approach is still being employed in health policy formulation as the HCC is not completely involved in health planning. Its role has been confined to identifying and consolidating the most pressing needs of the community of which most have not been addressed. The bottom is still implementing what the top decides.
- There has been a shift in the control over resources especially when the RBF funds are concerned. The only concern that arises in this scenario is when donor assistance to the health sector has come to an end. There are no signs especially from what was gathered in interviews with the DHE in Goromonzi that point to the government of Zimbabwe being able to sustain this approach as health allocation through the national fiscus is decreasing. This model of health financing, though a huge relief to the strained health sector, is not sustainable in the long run.
- The lack of clarity between the role of the HCC and the village and ward development committees when it comes to health has bred uncertainty with community members. The status of the HCC once legalised may provide some clarity and address any 'ownership' concerns. There is also evidence of weak links with local government on health from the thesis findings.

8.2.2 Assessment of key stakeholder perceptions on community participation in health

According to the World Health Organisation (WHO)

> Community participation has several advantages which include increased self-reliance, self-awareness and self-confidence in self-examination of problems and in seeking solutions for the identified issues. Community participation promotes equity through sharing responsibility, solidarity and serving those in greatest need. Behavioural changes in target populations are promoted and uptake and support of health services is facilitated. Culturally more appropriate services are created as communities contribute their unique knowledge (WHO 2008: 36).

The creation of a HCC within the Mwanza community was to close the gap that existed between the health system and the community, and facilitate community participation in health in order to achieve that which is highlighted by the WHO.

There has to be an appreciation that community participation happens at various levels as highlighted by the evidence provided in the empirical previous chapters. The definition above provided by WHO regarding community participation suggests levels of community participation in terms of groups at individual level, group level and community level. The thesis explored all three levels. These levels are important for health policy and must be taken into account by Zimbabwe health technocrats. In reviewing the changes that the health system has had to undergo in the last three and a half decades, it is important to note that the health policy has shifted away from a focus mainly on the participation of individuals and viewing health and health interventions from a microscopic perspective through its community health worker programme. The shift in the last five to ten years has been to include the group dimension for harnessing community input in the functioning of the health system through the revitalisation and establishment of HCCs. It is necessary to take note of the levels at which people are participating in terms of the HCC as well as the local government platforms, but it is also crucial to examine the forms in terms of involvement in different activities. Rifkin (1990:12) came up with five forms of participation following an analysis of l00 case studies on community participation in health programmes (Oakley, l989:10; Rifkin, 1990:12). Rifkin (1990:12) states that people can be involved in participation in the following ways:

(1) Receiving benefits, services and information from experts,

(2) Participation in programme activities, for example distribution of contraceptives or contributing money to the health programmes,

(3) Participation in implementing health programmes such as choosing clinic sites or organising child welfare and nutrition clinics,

(4) Participating in monitoring and evaluation of programmes and

(5) Participating in decision-making and planning.

When using the Rifkin model to assess the forms in which the Mwanza community operates through the HCC, the thesis findings point to the community fully operating in terms of the first four forms in the model. With respect to the first form, Mwanza HCC receives health literacy training from civic groups within and outside of Goromonzi which it then uses to

inform its community meetings and health promotion activities. Health promotion, health education and community mobilisation done by the HCC to complement that of the community health workers in the ward satisfies forms two and three in the above model. The HCC satisfies form four in following up health interventions initiated by council and the Ministry of Health in its ward.

The challenge is in relation to the fifth form, where the HCC itself highlighted a lack of transparency and accountability in planning and budgeting by the DHE coupled with a lack of capacity in terms of knowledge to engage with the system at that level. In my opinion this form of engagement is the core to community being involved in the framing of future health policy. Even though the HCC facilitates platforms for the community to identify its most pressing health issues, the lack of feedback makes it difficult to assess whether the input has been taken on board or disregarded. The DHE should be in a position to explain and justify decisions taken in coming up with the district plan and budget. It is the role of the government to justify why the chosen course of action is the best option given the array of health issues and the limited nature of resources. Supplying this kind of information would go a long way in addressing some of the challenges raised by the HCC. However, the concept of community participation is a complex one especially when it comes to planning and budgeting. Its complexity lies not only in its many definitions but also in the fact that it has to be acceptable to the community, the service providers and the government.

The Mwanza HCC case study highlights the complex nature of the concept of community participation in that in some instances there were nuances where I felt inclined to believe that there seemed to be government complacency and resignation to leave it all to the community. Due to the economic situation in Zimbabwe, communities have had to step in where the government has failed as evidenced by the Mwanza case. However, there is a danger in that community participation may be seen as a way of releasing the responsible ministry of its duties. This is not a sustainable model as the community is already overburdened. This may become a deterrent to communities and they may resort fully to relying on traditional medicine affecting future health outcomes. It may also result in the promotion of local elites and the community may be seen as a threat to political authorities when community members become more demanding. This is evidenced by some of the community perceptions that expressed dissatisfaction with the HCC in that community members felt that HCC members were benefitting financially. Threats from the political realm in the district are very real as

seen with the capture of the village and ward development committees in the local government framework. For the health centre committee in Mwanza, the integrity and objective disposition of the committee members is what has seemed to withstand political interference. This can be attributed to the fact that the country is right in the middle of the electoral cycle. The situation may change when it becomes election season in which political efforts are heightened especially at community level.

Although great efforts are being made to involve community members in the health system through national health policy by the government centrally and the district level in health, there seems to be limited community participation from the perspectives shared by both the DHE and some community members. Mwanza HCC admitted that there are hard to reach areas within its own clinic's catchment area which automatically implies that there are some villages which have not been or are rarely in contact with the HCC. Also within the sample of community members, although the sample was small as compared to the catchment area size of the clinic, 13 of the total of 33 members expressed a lack of knowledge of the HCC and its role. If this is the mechanism to which national health policy is relying on to bridge the gap between itself and the community, then more has to be done. It can be observed that some of the community members in the sample are actively interacting with the HCCs, while others are not. For those interacting there is some indication that the HCC members are assisting, while those who do not interact or take issues to the HCC do not obtain responses or results from the HCC. This does seem to indicate that there is a 'two-way street' between the HCC and the community. Those who know, interact with, take issues to and get feedback from the HCC have their views about the HCC reinforced and see the value of the HCC. Those who do not make contact with the HCC get more isolated and do not see the value of the HCC. Also linked to this is the notion that the closest villages to the clinic will be kept informed and educated on best health practices. The more distant the village the less informed it will be. There is a risk in this that the HCC narrows its links with a smaller and more active share of the community, who may not be the most vulnerable. In terms of areas for improvement for the HCC, communication was cited the most. This, when taken together with the HCC's challenges, is not entirely within the HCC's control. Poor communication can be linked to the lack of feedback from the DHE to the HCC on community input and contributions.

From the observation of a community sensitisation meeting in Mwanza ward, there seemed to be a high level of health knowledge amongst the community members present at the meeting.

This can be attributed partly to the number of community campaigns and health promotion activities that have taken place in the life span of the HCC in the ward. All three sets of interviewees (DHE, community members and Mwanza HCC) acknowledged though a limited knowledge and appreciation of the health system itself. Without information on how the systems functions, it is hard to have informed active participation as each stakeholder's role will not be clear. This lack of clarity may negatively influence health practices in the ward if not addressed.

It is clear from the evidence that the work of Mwanza HCC is highly dependent on an informed community. This is seen through the emphasis on health literacy as the cornerstone of community awareness, with meetings often taking the form of reviewing experiences and views on improving health with different social groups in the ward sharing information on the key health risks and actions that make health rights realisable. A missing link in the relationship between the HCC, the government and the wider community is the lack of information on the clinic and district budget. This affects monitoring health service. The HCC as community representatives said that this was due to having poor knowledge of health resources such as the health services fund as well as required staffing levels and budget processes. The HCC noted that the CWGH has committed to increase capacity building efforts to address this gap. The health staff from Mwanza clinic noted that while HCC members made input about for example the renovations and infrastructure maintenance needed to improve the local health centre, the health facility itself was not involved in coming up with a budget as this was done only by the health authorities at the district level, who sometimes did not take account of the priorities set at clinic level.

The HCC with a majority of the community members thus identified the major gaps as resources, communications and skills with some calling for training and improved communication. In general, there seemed to be no concerns raised on the representation of vulnerable groups in the committee. There thus appeared to be no gaps in Mwanza HCC's representation of extremely vulnerable groups except for those more distant from the health centre. A concern was however highlighted by the district health executive through the district administrator that the HCC should be wary about distancing itself from the community. He warned that without regular communication, the HCC would lose touch with the social groups that it represents in the HCC and become detached from the community. The HCC in turn noted that "members of the district health executive should be included in

HCC trainings to raise their awareness on HCC roles and operations so that the relationship is strengthened within the health system itself" (Mwanza HCC FGD, Goromonzi, October 2015). The above comment was raised because the HCC generally felt it was held back by lack of knowledge on the managerial roles of key health personnel like the DNO and DMO and lack of direct contact with health authorities besides the Nurse in Charge. The HCC identified a need for direct meeting with the district health authorities.

Mwanza HCC was stated by key informants at district level and by some members from the community sample as being a voice of the community. The HCC is regarded as a link between health services and the community. It is perceived to have political backing because of the presence of key political leaders such as the councillor and the traditional leader. Some health informants identified the councillor as a key figure in influencing the performance of the HCC as councillors had the authority and links to impact on issues. However, members of the HCC highlighted the low level of commitment of the ward councillor in Mwanza and hence weakened links with the RDC.

In terms of identifying factors that enhance community participation with reference to the current character and form it happens in Mwanza ward in Goromonzi, it should be highlighted that political interests have to be objectively balanced although health itself is political in nature. Neutrality has to be maintained as political dynamics may have a destabilising effect on participation. The government has to be committed to an extent that there is acknowledgement and recognition of HCC functions such that an environment in which organised community groups can realise full potential and flourish in an integrated health system is created. The government can demonstrate this commitment through the enactment of adequate legislation for HCCs. The local level leadership (such as the traditional and elected leadership) has to buy into the concept of the HCC in a community by being members of the HCC and actively participating in committee roles and activities. For example, the councillor is a member of the HCC as the councillor represents local government on the HCC structure. The role of the councillor is to be a communication conduit between the HCC (and the health system) and the RDC in local government. If the councillor is not committed there can be a duplication of government efforts in the ward due to a lack of synergy in communication channels. For example, local government through district development funds may allocate funds for health facility maintenance and the DHE may also plan to do the same in the district health budget. The HCC is the platform at which

such irregularities may be avoided or joint interventions identified for effective use of public resources.

From the thesis findings it can also be deduced that, for individuals to participate in the HCC and health activities in their community, there has to be some form of health education that nurtures this behaviour over time. When people are informed, they can then participate and cooperate in health programmes. It is further evident in the case of Mwanza that the communities share the burden of ensuring health care by providing material, financial and human resources which in many ways fosters a sense of ownership and leads to a sense of control over their self-initiated projects.

8.2.3 Community participation and improved health outcomes

The thesis found that, in order to offer concrete evidence on whether community participation in Mwanza ward can be linked to improved health outcomes, a more in-depth approach that would employ qualitative and quantitative methods to collecting and analysing information is required. To offer conclusive evidence, the thesis would have needed to investigate and identify the underlying intermediate and immediate causes of health needs in Mwanza ward. This information would form part of a baseline on what the health situation was before the HCC's formation and subsequent intervention. A comparative analysis of the before and after scenario would be one way of offering concrete evidence on community participation and its link to improved health outcomes overtime.

From a superficial level, the study did highlight some factors that may influence health outcomes. Examples of these observations include:

- Mwanza HCC was able to educate its surrounding villages on the importance of health and health services. This is evidenced by the kind of discussion that I observed in the field during a community meeting. A more informed individual on health risks can be assumed to then have the capacity to decide to act and behave in a health conscious manner. This is supported by a story provided by a community member on health education on maternal health and the advantages of birthing at a health facility.
- The identification of health issues and prioritising them (according to the most pressing objectively) points to a rise in the level and sophisticated nature through which the Mwanza community now approaches its health matters. This may influence

long term health outcomes in that, if the health system is responsive, it will accordingly address the most pressing needs of the most affected in a targeted manner thereby allowing for progressive steps in having a people centred health system as propagated by the primary health care approach.

- Through its composition, the inclusion of all social and vulnerable groups in the community including the traditional and local government leadership in the committee creates a platform that allows for a systematic way in which various stakeholders can approach health issues relying on each other's strengths.

8.3 Limitation of the study

In pursuing this thesis, including the fieldwork underpinning it, some issues posed limitations to generalising the thesis conclusions. First all, the small sample size of 33 community members was not representative of the entire catchment area of Mwanza clinic in Goromonzi. Secondly, the sample was conveniently selected from those community members that attended the organised community meeting and those who visited Mwanza clinic on specific research days; it is therefore possible that some clients with different characteristics were excluded.

Despite the limitations, the thesis findings assisted in understanding the nature and form in which community participation in health is happening in Zimbabwe. The study highlighted participation in an organised manner through the health centre committee. It also highlighted some of its short comings in relation to national health policy expectations.

The health professionals in the district, where this study was conducted, could actually use these findings to step up the levels of community participation. More emphasis is needed on raising awareness about health policy formulation and implementation as well as the structures and processes that exist in decision making within the health system. The awareness would hone in on how health service decisions are made, by whom and when they are made. This kind of information empowers community members and HCCs to identify the correct decision makers for the resolving of health issues. The HCC and community can also be able to identify the most strategic points within the health system for the addressing of community health needs.

8.4 Recommendations

Within the overall context of reinvestment in primary health care in light of the past experiences in the last three decades, the HCC is still to a large extent the most viable way in which the Zimbabwean health sector can fully realise the promise of the primary health care approach. The HCC provides a mechanism for organising community health literacy, health promotion and social networking on health. The benefits of this are that the community builds itself through the continued interaction and discussion on health issues. There is need for this discussion to be deepened to include the health system and how it functions in responding to the needs of those it serves. In general, the HCC in Mwanza would have to improve on the following to better perform its function:

- Clear delineation between all platforms that exist in the community having clarity and a common understanding of each of their roles and function in the ward. Serious consideration must be given to the education of the community on issues such as the decentralisation process and awareness of the structures and programmes in order for people to appreciate and participate meaningfully in health issues.
- Obtain a greater understanding of health planning and budget processes as well as the functioning of the health system. The objective would be to share this information with the community.
- Improve feedback with the wider community so as to maintain credibility and momentum in the ward and the district to a large extent.
- The health system is in the hands of the central planners at national level. Introducing programmes without involving community members in the decision making process and without stimulating their own initiatives might produce major problems. One such problem relates to the lack of sustainability and that there will most likely be neither community ownership nor commitment. The Mwanza case study, specifically with reference to the waiting mother's shelter, is a good example to bring out this point. Resources from external resources are being targeted to respond to what the community has indicated as the most pressing need at that time instead of designing programmes and initiating health infrastructural projects that will not be appreciated by the community.

In order to strengthen the way in which the health system may further integrate community participation and harness it to strengthen the system itself, there needs to be recognition of the

differentials in power and how these influence participation, positively or negatively. This is most pertinent as primary health care is targeted at the most vulnerable in a society. There is also need for a concerted effort to support and facilitate the sharing of community experiences and use this as hard evidence collated with public health information to identify and plan interventions accordingly with those affected. Lastly integration of bottom up planning involving community priorities within health planning, with an influence on the allocation and use of local resources and resources from the state and other sources, should be transparent, and done in a manner that seeks to build an integrated health development plan that is multi-sectoral in nature.

8.5 Conclusion

In making a final comment on community participation in Mwanza ward in Goromonzi, the most critical notion is that there are many factors that capture and define community participation in health and this has an impact on how it then plays itself out in the system. The thesis attempted to unpack and understand community participation through the HCC as a way of understanding how it happens in the ward. A majority of the respondents in the study view community participation as being important. There were also differing levels to which community members including the HCC participated and interacted with the health system in light of the contextual factors that shape Zimbabwe. The indicators identified – as influencing community participation – were leadership, resource mobilisation, skills and knowledge, communication, legitimacy and organisation within the structure. It is hoped that further studies on primary health care in Zimbabwe will be able to build on the analysis of community participation pursued in this thesis.

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Appendices

Appendix 1: Interview Schedules

a) District Health Executive and Local Government Social Services Officer

1. What in your opinion is the role of the community in the health system?

2. How have community views/input/feedback being incorporated into the health system at district level?

3. What is the national health policy stance on the role of the community in the health system?

4. What has been the impact of having health centre committees in the district?

5. What are the current challenges facing the health system in Goromonzi district?

6. What in your views are the benefits and/disadvantages of community involvement in the health system?

7. How would you describe the state of the health system now as compared to the last two decades?

b) Mwanza Clinic Nurse in Charge/ Nurse

1. What in your opinion is the role of the community in the health system?

2. How have community views/input/feedback being incorporated into the health system at district level?

3. What has been the impact of having Mwanza health centre committee at the clinic?

4. What is the working relationship like between the HCC and VIDCO and WADCO structures in Mwanza?

5. What are the current health challenges in Mwanza ward?

6. What in your views are the benefits and/disadvantages of community involvement in the health system?

c) CWGH Secretariat

1. How would you describe the state of the health system over the last three decades in Zimbabwe?

2. What has been your role in influencing the current national health policy stance on the role of the community in the health system?

3. What in your views are the benefits and/disadvantages of community involvement in the health system?

4. What impact has Mwanza HCC made in Goromonzi?

5. What are the current challenges facing community participation in health in Zimbabwe?

d) Key Informant Interview Schedule

Key Informant	**Organisation and Position**	**Date and Place of Interview**
Dr. Karise	District Medical officer	August 2015
Sister Masango	District Nursing Officer	September 2015
Mr Nyoni	District Health Services Administrator	September 2015
Ms Madziva	District Environmental Health Officer	September 2015
Mr Ruzvidzo	Nurse In Charge Mwanza clinic	August 2015
Mr I Rusike	Executive Director (CWGH)	May 2015/ October 2015
Mr E Mutasa	Mashonaland East Provincial Engagement Officer (CWGH)	October 2015
Ms F Kowo	Program Assistant (CWGH)	October 2015
Ms A Togarepi	Mwanza HCC Chairperson	September 2015
Mr Mubaira	Village head (Mwanza)	September 2015
Cllr Nhimbe	Ward Councillor (Mwanza)	September 2015

Appendix 2: Guidelines for Focus Group Discussions

a) FGD Questions for Health Centre Committee

1. What is your role in the community?

2. What have been the effects of having a health centre committee here in Mwanza (negative and positive)?

3. What is the difference between the HCC and the WADCO?

5. How would you compare the standard of health well-being in your community from independence until now?

b) FGD Questions for District Health Executive

1. What is the value of community involvement in the health system?

2. What has been the DHE's experience in integrating community participation in all processes of the health system at the local level?

3. What is your role in relation to the health system and to local government?

4. How would you compare the standard of health well-being in the district from independence until now?

Appendix 3: Guidelines for Semi structured interviews

a) Community members

1. Do you feel you have a say in the health system? Please explain why.

2. How useful is the health centre committee in your community?

3. Do you know how health services are delivered in your community?

4. How do you address any issues concerning health in your community?

5. Can you suggest any ways of addressing the health challenges you have identified in (4)?

6. Do you participate in any health related activities in your ward? Please explain.

7. Are you satisfied with the level of participation in health in your community?

8. What are your views on the quality of health service delivery over the last 10 years?