CIVIL SOCIETY PROMOTION OF EQUITY AND
THE SOCIAL DETERMINANTS OF HEALTH
THROUGH INVOLVEMENT IN THE
GOVERNANCE OF HEALTH SYSTEMS: THE CASE
OF THE COMMUNITY WORKING GROUP ON
HEALTH IN ZIMBABWE.

A case study commissioned by the Health Systems Knowledge
Network

Itai Rusike
Community Working Group on Health (CWGH)

March 2007
Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.
Acknowledgments

This paper was reviewed by at least one reviewer from within the Health Systems Knowledge Network and one external reviewer. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

This work was carried out with the aid of a grant from the International Development Research Centre, Ottawa, Canada, and undertaken as work for the Health Systems Knowledge Network established as part of the WHO Commission on the Social Determinants of Health. The views presented in this paper are those of the authors and do not necessarily represent the decisions, policy or views of IRDC, WHO, Commissioners, the Health Systems Knowledge Network or the reviewers.
1. Introduction and background

In organising People’s Power for Health, the CWGH is an active member of EQUINET and has been actively participating in other regional initiatives including the Health Civil Society in East and Southern Africa Network (HCS) and during the Southern Africa Social Forum held in Harare in 2004 it hosted the HCS. Our resolutions were adopted by the Southern Africa Social Forum. Zimbabwe’s health sector is severity compromised. The CWGH seeks to ensure that the sector is rebuilt from bottom up, not the top down, and that the lowest income communities are the first to see improvements, and not the last.

Following a landmark six-week strike action in 1997 by health professionals against low salaries, poor working conditions and a decline in the quality of health services in the country, The public wanted to see raised salaries and improved working conditions. These could well benefit doctors and nurses, prompting them to resume their duties and probably save some lives, but could not, for instance, make health fees affordable to the poor, avail drugs and facilities in public health centers, increase poor rural people’s access to health service or result in more serious efforts to fight HIV and AIDS to represent the interests the most affected parties – ordinary people. Doctors and nurses easily organized themselves for a strike that could benefit them because they had a union, but communities did not.

The founders of the CWGH felt that the strike was legitimate but insufficient to redress the overall deterioration of Zimbabwe’s public health delivery system and that public health concerns remained at the periphery because there was no institution to voice the concerns. It was this situation, which motivated several
national civic organizations; coordinated by the Zimbabwe Congress of Trade Unions (ZCTU) to come together in 1997 to review the current state of affairs in the health sector and look at ways in which communities could achieve greater control over their own health. In early 1998, a network of membership based civic organisations was formed in Zimbabwe that focused on advocacy, action and networking around health issues, called the Community Working Group on Health (CWGH). The first step was to ask communities and civic organisations what their perceptions are toward their health. The survey brought up concerns about the inadequacy of public health services in terms 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.

Stakeholders who formed the CWGH realised that priority health programmes varied widely across different areas and decided to take CWGH down to different districts for locals to drive its programmes and set its agenda. The CWGH members also invited the associations of health professionals and representatives of government, churches, the private sector, Non Governmental Organisations and traditional health providers in a meeting in order to identify conflict or consensus over community views and strategies on health. From there District Committees were set up and tasked to identify their main health-related problems and develop solutions for them. To date, the CWGH has established local CWGH committees at district level in 25 districts in Zimbabwe. The committees coordinate local activities, including education and health action and link the community with all service providers.

2. Political and Legislative limitations

Zimbabwe’s current unstable political environment has seen the government becoming highly suspicious of NGOs, accusing them of
supporting its political opponents. This has not significantly affected the work of the CWGH at the grassroots where local authorities and the police are informed of all its activities. Instead we have taken advantage of the structures that the Ministry of Health and Child Welfare came up with in early 1980s that communities can operate within by revitalising some of them and these include: the Village Health Worker, Village Aids Action Committee, Ward Aids Action Committee, and District Aids Action Committee. CWGH has also lobbied with the National Aids Council on a number of activities. The Health Centre Committees whose role is to identify the health problems of the community. And these comprise of people from different fields i.e. business people, church representatives, youth reps, health professionals (Environmental Health Technicians & a Community Nurse), and members of the local authority like councillors. It was resolved at the 2004 CWGH national meeting that the CWGH cooperate with Training and Research Support Centre (TARSC) through the Community Monitoring Programme (CMP) to outline and measure the costs of a ‘health basket’ to make visible the costs of maintaining health for different Zimbabwean households. The ‘health basket assessment’ seeks through pilot sites in different areas and communities in Zimbabwe to identify the changing costs of those inputs considered by communities and public health personnel as essential for health.

It is at the national level where political suspicion has been most strongly felt, as the CWGH has had to approach its advocacy and lobbying mission with caution. The government has introduced draconian pieces of legislation which restricts the operation of the civil society in Zimbabwe. The Public Order and Security Act (POSA), which only legitimizes public gatherings commissioned by the police remains a continuous threat to planned meetings in communities. The Access to Information and Protection of Privacy Act (AIPPA) militates against the CWGH’s bid to express its independent position in response to specific public health policies.
Despite all these challenges, the network of civic groups in the CWGH has grown more focused and informed in their health actions, more deeply rooted in the community and is now an important national voice on health. It is a vocal advocate for equity, primary health care and public participation in health. These are all national policy goals, but have become sidelined by the market-driven economic reforms of 1990’s. The CWGH is a pressure point for public policy to reflect on health rights and social values widely held by all Zimbabweans

3. Meaningful advocacy and lobbying campaigns
The CWGH has effectively exploited its networks of professionals, practitioners and the general citizenry to campaign for health policies that have a human face. Of major significance has been its perpetual cry for an increased health budget and in particular lobbying for the allocation of 15% of the government vote to health as per the Abuja Declaration and this has been done through its annual position paper presented to the Ministry of Health, Parliamentary Portfolio Committee on Health and the Ministry of Finance with input from the district structures. By use of our Gender desk that ensures gender budgeting, our position paper takes into consideration the gender issues. This has borne some fruits, although below the CWGH’s expectations, as finance ministers in the previous two years have acknowledged in their presentations that health services were poorly resourced and mildly increased the health budget. At the local level, district health committees and health centre committees have campaigned most significantly. In addition to challenging authorities at public health centres over poor patient care facilities or practices, they monitored the administration of the AIDS Levy closely, ensuring that deserving cases benefited. Albeit in selected areas, they have monitored the transparency of processes of distribution of food
relief. Although their influence on the outcomes of the process is minimal owing to corruption at some distribution points, at least they drew public attention to it. In Mutare for example, Catholic Development Committee (CADEC) and the district health committee members took stock of homes where terminally ill patients and orphans lived and submitted the list of the names to authorities responsible for distributing food, urging them to consider these first especially female headed homes. This also lessens the stress on women and girls in the community them being the ones that take care of the sick.

4. The Health Centre Committees

In 2001, the CWGH initiated a process of setting up or revitalising Health Centre Committees to strengthen the capacities to demand resources for these levels of the health system (CWGH 1998d). The HCCs mainly comprises of people from different fields i.e. business people, church representatives, youth reps, health professionals (Environmental Health Technicians & Nurse), and members of the local authority like councillors who come together to help their community taking into consideration the gender composition in terms of organisations represented. HCC assist communities in identifying their priority health problems, plan how to raise their own resources, organise and manage community contributions and use available resources for community health activities. The HCCs are linked to the clinic and cover the catchments area of a clinic.

To date the CWGH covers 25 districts, and in about half of these has set up health centre committees, and supported these with training and capacity inputs to identify priority community needs and actions, plan the resource inputs to meet these needs and make organised demands on district health budget and on the Health Services Fund. The committee is trained in order to disaggregate expenditure according to its differential impact on women and men.
girls and boys, taking into consideration gender relations. The Health Services Fund is sector wide fund comprising retained fees and donor funds, allocated to the district and to be spent on a 60:40 ratio at district hospital level and below.

The research carried out by TARSC and CWGH on the impact of HCCs showed that there is strong evidence of positive health outcomes associated with HCCs. The evidence supported by the mechanisms of community resource mobilisation, information outreach and social actions around health indicate that HCCs play a positive role within health systems. They provide evidence of roles for community participation beyond dialogue and consultation. They are however constrained by weaknesses in their own capacity and functioning, particularly in terms of knowledge of the health system, capacities for communication and information links with communities, and the basic resource for their functioning.

More deeply they are constrained by the resource limitations within their communities and in the primary care level of the health system they operate in, particularly where there are falling resources allocated to district outreach, to primary health care and to quality of care at clinic level. The ambivalence around their recognition and functioning and the lack of resources directed at their activities appears to be part of the general under-resourcing of the primary care level of the system. Effective demand of or organised voice at community level is not easily sustained, and may be defensively responded to in such a situation. (R Loewenson, I Rusike, M Zulu TARSC/CWGH 2004)

5. The community level

At the level of communities CWGH has set up district health committees and health centre committees to plan area-specific health programmes and implement them respectively. District
Health Committees identify problems affecting their areas, ranking them by order of their severity to develop and prioritize suitable intervention programmes. They submit budgets for their programmes to the secretariat for approval and administer the funds on its behalf.

The Ministry of Health in the early 1980s set up structures through which communities could operate. The CWGH lobbied for the return of the Village Health Worker (VHW) who works as a focal person for the village and also addresses health needs of the village e.g. in the distribution of condoms and family planning pills, helping in the building of blair toilets. With the feminization of poverty, by bringing back the VHW we reach out those female headed homes and the fact that 70% of rural population is women; CWGH gets to the intended beneficiary. In this era of the HIV/AIDS pandemic, the National AIDS Council (NAC) has formed structures from the village level to the national level. In the villages, Village AIDS Action Committee (VAAC) addresses AIDS related issues in the village and gives information to the Ward AIDS Action Committee (WAAC). The WAAC then works in close contact with the District AIDS Action Committee (DAAC) in addressing HIV/AIDS issues in the district. CWGH, in its HIV/AIDS programme, has been working in close contact with these structures and has proved to be a reliable and trusted partner in its operating districts. CWGH in collaboration with NAC trained Home Based Care which mainly involved women capacity building them in Chipinge. Two CWGH members were nominated into the National AIDS Council Board. With a board member of the CWGH having chaired the Public Health Advisory Board from 1999-2002

6. The Health Budget

Since 1998, the CWGH working with the Parliamentary Portfolio Committee on Health compiles a position paper on the health
budget with input from its district structure and presents this paper to the Ministry of Finance and Ministry of health as a way of community participation in the budget process. The CWGH has taken advantage of the good co-operation with parliamentarians through the portfolio committee on health and has lobbied the committee to influence the direction of health policies. By coming up with sex disaggregated data, CWGH position paper is a gender sensitive paper and when considered in budgeting the grass roots benefit, for example by advocate for minimum charges for maternity fees in public hospitals and village clinics and allocating more funds on prevention than on cure.

CWGH is perfectly placed to address most health challenges facing Zimbabwe today. Most of these emanate from the countries deteriorating economy, which has seen the government failing to finance most of its financial obligations. In the face of acute shortages of basic medication, deteriorating patient care facilities in public health centers and a mass exodus of health personnel, CWGH has become increasingly necessary to lobby the government to increase its budget allocation to the health sector and improve its service provision policies.

The government has, however, kept its health budget low, opting instead to increase health fees and tighten the conditions of treatment for patients in its health centers, for example women admitted at Harare Central Hospital after delivering their babies were there were officially considered visitors and their babies patients, and despite paying high fees at public health institutions, patients continue to be referred to pharmacies to buy medication were it is expensive. To this CWGH has carried civic education on health activities to empower communities with knowledge about their rights.

As has become a tradition, the CWGH compiles annual position papers on the health budget and jointly organise pre-budget and post-budget meetings with the parliamentary portfolio committee on health bringing in the Ministry of Health, Ministry of Finance, National AIDS Council and other stakeholders to discuss the health budget and our input is greatly valued by the stakeholders.
7. The Health Basket

Discussion at community level carried out by civic groups have identified that people view health as central to protecting our humanity, dignity, sovereignty and progress. At a time when people’s health is negatively affected by HIV/AIDS, rising costs of basic goods, food insecurity and unemployment, provision of accessible, affordable quality health services and public health programmes are very important to promote health, prevent ill health and treat illness. At the CWGH national Meeting held on July 2 2002 the reports from the districts provided evidence of severe shortfall in people’s goals of adequate food, water and sanitation, shelter and transport. The Quarterly Civic Monitoring Programme report of March 2004 presented at the district CWGH meeting further verified this position. Families especially female headed were reported to have stopped using basic commodities like toothpaste, sanitary pads and soap because they had become unaffordable to rural and urban households, food production and household costs to have risen sharply, and health care services to have risen in cost.

It was resolved at the CWGH eleventh national meeting that the CWGH cooperate with the Community Monitoring Programme (CMP) and Training and Research Support Centre (TARSC) to outline and measure the costs of a ‘health basket’. This would aim to make visible the costs of maintaining health for different Zimbabwean households. It would be accompanied by assessment of what is ‘driving’ the rising costs of medical care for households reported in the CMP quarterly reports. The programme was used to build research skills in the district personnel in the CWGH and the different communities have used the reports to engage authorities in the different communities.

Conclusion

The story of the CWGH is one of increasing and widening confidence within civil society of the right to act and the issues to act on. This has begun to generate some tangible health gains for communities in situation of general
decline in health. The CWGH builds on the lessons learned from the exceptional health gains based on primary health care and community mobilization in Zimbabwe in the 1980’s. Given the withdrawal of those gains in the 1990,s it adds the new understanding that these gains are not a privilege but a right, one that demands active community organising, advocacy and control within health systems. The real challenge for the CWGH is to ensure that real improvements in the public health are irreversibly sustained by an informed public that protects its rights to health.

**List of Acronyms**

- TARSC  Training and Research Support Center
- CWGH  Community Working Group on Health
- MoHCW  Ministry of Health and Child Welfare
- ARVs  Anti-Retroviral
- IMF  International Monetary Fund
- HCCs  Health Centre Committees
- WAACS  Ward Aids Action Committees
- DAACS  District Aids Action Committees
- VAACS  Village Aids Action Committees
- VHW  Village Health Worker
- NAC  National Aids Council
- PVO  Private Voluntary Ac
- POSA  Public Order Security Act
- AIPPA  Access to Information and Protection of Privacy Act
- CMP  Community Monitoring Programme

**Bibliography / References**


3) Evaluation of Civic Health Education Programme TARSC 2005


6) Briefing Document On CWGH, 1999

7) Evaluation of SAIH-Supported Projects in Zimbabwe, 2005

8) The costs of Health, Community Monitoring Programme TARSC Monograph 1 2005