

Strengthening health centre committees as a vehicle for social participation in health in east and southern Africa

Regional Meeting Report



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**Regional Network on Equity in Health in East
and Southern Africa (EQUINET)
Training and Research Support Centre
with Community Working Group on Health
and MEDICO International**



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30 January - 1 February 2014**

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1. Background

Social participation in health systems has been a consistent element of post-independence health policies in east and Southern African (ESA) countries and central to primary health care (PHC). The Regional Network for Equity in Health in east and southern Africa (EQUINET) 2007 Regional Equity analysis highlighted that social participation and power are key for equitable health systems, and for reclaiming and using resources for health. However EQUINET's 2012 Regional Equity Watch showed that despite this policy commitment and the inclusion of the right to health in some constitutions of ESA countries, there are still many gaps in meaningful levels of social participation in health systems.

EQUINET has explored many dimensions of participation and social power in health since 1998. Health Centre Committees (HCCs) (known by a range of names in different countries) are one way of facilitating social participation and shared decision making in health systems. EQUINET Equity Watch reports at regional and national level (at www.equinet africa.org) have presented a range of evidence that HCCs can contribute to the quality and coverage of and equity in access to health care and improved health outcomes. However they have also highlighted that there are few specific policies or guidelines for HCCs in relation to their role, functioning, authorities and resources, variable levels of representativeness of social groups in HCCs and of communication between HCCs and communities, and limited monitoring of their functioning and impact.

Work was done in EQUINET in the 2000s on the impact of HCCs in several ESA countries, in 2009 onwards in the learning network on health rights on HCCs as a vehicle for claiming health rights, and in the pra4equity network on participatory processes within HCCs to strengthen communication between frontline services and communities. Building on this regional work and on progress in strengthening HCCs in some ESA countries, the EQUINET steering committee proposed to strengthen regional exchange, evidence and policy input on the functioning of HCCs and their contribution to equity in health. Through Training and Research Support Centre (TARSC) as cluster lead for the equity watch work and Community Working Group on Health (CWGH) as cluster lead for the work on social empowerment in health systems, and in co-operation with Medico International, EQUINET thus convened this Regional meeting on Health Centre Committees in East and Southern Africa to:

- i. Provide a forum for exchange of experience and learning between partners doing work on training and strengthening HCCs in countries in the ESA region;
- ii. Exchange and review information on the legal frameworks, capacities, training materials, and monitoring systems used in capacity building of HCCs, identify and discuss ways of advancing and documenting good practice in these aspects of HCCs; and
- iii. Develop a shared monitoring framework for assessment of the capacity, functioning and impact of HCCs, to apply to settings where HCCs are operating, and to discuss options for on-going exchange and documentation on the learning across settings.

The meeting gathered 20 delegates representing seven countries from east and southern Africa (See delegate list in Appendix 1), all of whom are involved in training and strengthening HCCs. The meeting was supported financially by Medico International, TARSC and delegate contributions to travel and accommodation. The meeting process was participatory (See programme in Appendix 2). Prior to the meeting a background review of published literature on HCCs in ESA countries was prepared and circulated (Machingura F and Loewenson R, (2013), 'Health centre committees as a vehicle for social participation in health systems in east and southern Africa: Background report for the Regional meeting on health centre committees, EQUINET: Harare). This report is separately available, although elements presented at the meeting are captured in this report. This report documents the inputs, exchanges and learning at the meeting, the resolutions for strengthening HCCs in ESA countries, the recommendations for monitoring and exchange of HCC work and the proposals for follow up at regional level.

2. Opening

Rene Loewenson from TARSC/EQUINET and Itai Rusike from CWGH welcomed delegates to the meeting, noting that both organisations had been working jointly for quite some time on the area of strengthening HCCs. Rene noted that EQUINET works from local to regional level in ESA countries, and engages globally from self-determined perspectives derived within the region ('bottom up'). EQUINET's work covers many aspects of equity and social justice in health, from wider social and economic determinants, such as food and nutrition, to health system issues, such as fair health financing or HCCs, as well as how these issues are engaged on globally, such as to secure medicine production and access in trade systems. EQUINET has five clusters of work and the work on HCCs falls under the social empowerment cluster, led by CWGH, and links with the Equity Watch cluster led by TARSC and the learning network on health rights led by CEHURD Uganda. EQUINET supports capacities for building equitable health systems, such as participatory approaches to building people-centred health systems. It engages in policy forums such as Southern African Development Community (SADC) and the East Central and Southern African (ECSA) Health Community, and with other networks that also seek social justice in health, including the regional trade union networks (SATUCC), the Peoples Health Movement and COPASAH.

Itai explained the history of HCCs in Zimbabwe, noting that CWGH and TARSC have been trying for some time to make community participation a central part of the health system in Zimbabwe. The two organisations have done this through occupying spaces of debate, working with communities and engaging with the Ministry of Health and Child Care (MoHCC) to develop and promote the adoption of training and guidelines for HCCs. He pointed out that the recently enacted constitution now includes the right to health which gives greater leeway to push for legal recognition of HCCs. He noted that the Advisory Board of Public Health has discussed the development of a statutory instrument on HCCs and that MoHCC have worked on this for submission to parliament.

Sabine Eckart from Medico International Germany echoed Rene and Itai's welcome. She explained that Medico has been championing the right to health for over 40 years, working with a range of partners. She highlighted Medico's role in supporting HCCs in Zimbabwe, while also recognising the importance of keeping a regional lens on the work to ensure greater impact. She welcomed EQUINET's agenda of 'Reclaiming the resources for health' as one that Medico shares. Country participants introduced themselves, highlighting their wide range of experiences. Delegates from Open Society Foundation and Health Partners International were also welcomed.

Dr Portia Manangazira, Principal Director Epidemiology and disease control in the MoHCC Zimbabwe gave opening remarks on behalf of the Principal Director for Policy Planning, Monitoring and Evaluation (Dr. Dhlakama). She pointed out that the public health sector was the largest in the country but was constrained in meeting its mandate to ensure the health needs of the population, acknowledging challenges to be addressed such as the still unacceptably high rate of maternal mortality in Zimbabwe. She welcomed EQUINET's work on health equity and the focus of this meeting on HCCs, as HCCs provide a mechanism for communities to participate in revitalising PHC and for strengthening and monitoring service delivery. Dr Managazira noted that 80% of health centres in the country have a constituted HCC, but many only exist on paper. She informed delegates that the MoHCC therefore looks forward to



Dr Portia Manangazira,

reviewing the report and recommendations from the meeting and the regional exchange, as it will also further stimulate the work being done in Zimbabwe.

2. HCCs presence and status in the region

Following the introductory session, delegates moved into a participatory exercise to map and discuss the presence, status and strengths of HCCs in the region. The actual names given to these mechanisms in different ESA countries varied, as shown in Table 1. Delegates agreed to use the term HCC in the meeting for ease of communication and the same is used in this report.

Table 1: Terms used for HCCs in ESA countries

Country	Terms used for HCCs
Angola	No term found
Botswana	No term found
DRC	Health Centre Management Committees (HCMCs)
Kenya	Health Facility Committees (HFC), Community Health Committees (CHCs),
Lesotho	<i>Health Centre Advisory Committees (HCACs)</i>
Madagascar	Village Health Committees (VHCs)
Malawi	<i>Health Centre Advisory Committees (HCACs)</i>
Mauritius	Area Health Committees (AHCs)
Mozambique	Community Health Committees (CHCs)
Namibia	Clinic Health Committees/Councils (CHCs)
South Africa	Community Health Committees (CHCs)
Swaziland	Local Health Committees (LHCs)
Tanzania	Health Facility Governing Committees (HFGCs)
Uganda	Health Unit Management Committees (HUMCs)
Zambia	Neighbourhood Health Committees (NHCs)
Zimbabwe	Health Centre Committees (HCCs)

Source: Machingura and Loewenson (2013)

Using a map of the region, each country group was given a set of coloured stickers (green = yes, yellow = somewhat, red = no) and were asked to put the appropriate sticker on their country in answer to the following questions:

- Do HCCs exist in your country?
- Are they recognized in law?
- Are they active and functional?
- Do they involve and empower all in the community?
- Do they have influence on the functioning of the health system at local level?

During the subsequent discussions, delegates observed that overall, while HCCs exist in theory in most countries, there is a problem in moving this to practice. They are not well recognised, often are not active or influential, with little community involvement. There were few green stickers and more red than green!

Delegates indicated that HCCs exist in all countries, but were not recognised in law or were not active:

- In *DRC* they are present in policy, but not recognized in the law, and with little evidence of them being active, empowering of communities or influential. Amuda Baba from the DRC pointed out that approximately 60 - 70% of HCCs in the DRC are linked to the churches, which have their own set of criteria for selecting HCC members and activities.

- In *Malawi, Kenya and Zambia* HCCs are not recognised in law but in health strategies. They have variable levels of functioning, community involvement and influence, including in different areas.
- In *South Africa*, HCCs exist and are recognised in the National Health Act, but the Provincial Minister of Health in many of the provinces around the country appoints HCC members, which is seen to limit effective community empowerment.
- In *Uganda*, HCCs are recognised in the national health policy as mechanisms for improved management under Ministry of Health (Health Unit Management Committees), so half of the HCC members are civil servants and the other half are appointed by the political leadership. This top-down approach to deciding who should be represented on an HCC was observed to not encourage community participation or a sense of ownership.
- Delegates noticed that *Zimbabwe* seemed to have more green dots! There are a number of reasons raised for this, including: an active civil society that works closely with the Ministry of Health and plays an important role in advocating for the existence and functioning of HCCs; clear terms of references for HCC membership which ensures that they are independent of political ambitions and measures giving space for community roles, such as preventing political leaders or nurse-in-charges from being the chairperson of an HCC.



Mapping HCCs in the region

The exercise confirmed the motivations that led to the workshop – all countries support the existence of HCCs but there are gaps in putting this support into practice. Issues of impact need to be addressed. Delegates felt that this gap minimises opportunities for people’s health, since functioning HCCs provide opportunities for social participation in decisions and for information flows that contribute to improved health.

4. The legal status of HCCs in the region

Fortunate Machingura (TARSC Consultant) gave a brief presentation of the findings of the background report on the legal provisions for HCCs in the region. Despite the policy commitment to community participation, only three out of 16 ESA countries (that is, South Africa, Zambia and Tanzania) have laws or constitutions on HCCs. Zimbabwe is currently negotiating a new legal instrument. The other 13 countries do not have legally binding guidelines on the composition, role, functioning, authority, resourcing or training of HCCs. In Uganda, Ministry of Health provides for HCCs under their legal mandate and set their operation as a Ministry of Health guideline. Fortunate noted that not having a specific enabling law or statute may lead to HCCs not being recognised by health managers and workers, or by the communities they serve, and can make it difficult to hold them accountable for managing resources or decisions made.

Even where guidelines do provide for HCCs they can vary in detail. For Zambia, the establishment, composition, functions and monitoring mechanisms are very explicit. In South Africa, on the other hand, the provisions are vague and left for the provincial authorities to decide. In other countries, guidelines or strategies broadly provide for participation mechanisms without detail. Fortunate concluded by asking delegates to reflect on the following, to be discussed over the next few days:

- Do legal frameworks make HCCs accountable to the health services or the community? With what implications?
- When the watcher becomes part of the system, who will watch the watcher?

Moses Lungu, of the Lusaka District Health Management team (LDHMT) presented Zambia's experiences with HCCs, and particularly their changing legal status and how this was addressed. Later in the meeting a DVD was shown on Zambia's experiences with using participatory approaches and health literacy to strengthen NHC work.

Box 1: The changing legal status of Zambia's neighbourhood health committees

Presented by: Moses Lungu, Lusaka District Health Management Committee (LDHMT)



NHC meeting, Lusaka Zambia © LDHMT

In 1991, when the new Movement for Multi Democracy (MMD) government came into power, the health system and health had declined and staff morale was low. Government committed to building a health system that guaranteed “*equity of access to cost effective quality health care as close to the family as possible.*” The 1995 National Health Services Act set in law District Health Boards and Neighbourhood Health Committees (NHCs), as well as the Central Board of Health at national level. NHCs were established and became the vital link between the community and the health institutions.

Over the next 10 years the number of NHCs in the country grew. They also faced a series of challenges related to the voluntary nature of the work of NHC members, their lack of planning skills, ethical conduct and political interference. In 2006, subsequent reforms in the health system led to the abolition of the Central Board of Health. The National Health Services Act was repealed, and the structures under it were dissolved, except for the NHCs. Hence while NHCs continued to exist their legal mandate was removed.

Despite the change in their legal status, the MoH continued to recognise the role NHCs play in PHC and maintained their role through policy guidelines. This was especially successful in Lusaka where an NHC Working Group was formed which set up Operational Guidelines for NHCs. This group has also held annual general meetings every year since 2006 to review NHC experiences and activities, and has set a constitution for NHCs (that was circulated to delegates). Currently a new National Health Services Act is being drafted. There is advocacy for NHCs' legal status to be reinstated in this law.

This case study led into an interesting discussion among delegates on the benefits and challenges of making HCCs legally binding. Even if there is a legal framework, there is no guarantee that communities will know about or understand it (as is the case in South Africa), and laws or guidelines still need to be enforced. At the same time HCCs need to have a legal status to receive and account for public funds, and should have a constitution to manage funds from any quarters. The law may be important, but legal provisions need to arise from and be upheld by the actions of communities.

Rene and Moses facilitated the next activity. Delegates divided into 2 groups, one group to discuss ‘What do we have in current law?’ and the other ‘What do we want to see in law?’ Each group wrote their key areas on cards, divided into the 3 levels – constitution, acts and regulations/guidelines. The cards were laid onto the ground at the different levels and discussed further in



terms of the correspondence or gap between what was perceived as needing to be in the law at different levels and what was actually there in reality. Table 2 below summarises the outcomes of the group discussions:

Table 2: Group discussion on legal status of HCCs

	In relation to HCCs, what do we	
	Want to see in the law	Have in current law
In the Constitution	Right to health Right to public access to information Right to public participation Freedom of speech Freedom of association	Countries with newer constitutions (Zimbabwe, S Africa, Kenya) include right to health services, information, speech and association.
In Acts and statutes	Public Health Acts to include: i. participation and public official duty to support participation ii. access to public health information; iii. private sector duty to make information public to service users iv. Powers and duties of HCCs, clearly outlined;	South Africa includes HCCs in the National Health Act. Clauses on participation and information present but general
In Guidelines	Clear specification of i. Composition, roles, capacities; ii. Resources and funding iii. Feedback mechanisms to community; iv. Reporting and links to other levels of the system and local government	Many countries have guidelines, such as in Uganda; Zambia uses a constitution of the NHC. Guidelines, often written by the Ministry of Health, generally cover i. Composition, roles ii. Reporting

Generally HCCs are better provided for in guidelines than in binding laws, and guidelines are reasonably clear on their composition and duties and reporting. They are less clear across ESA countries on their funding and obligations on social accountability. In the discussion it was agreed that constitutions need to include the right to health, health services, participation and other rights in Table 2 as the basis for HCCs to be driven by and accountable to society, and not as a top down management structure. This means that these rights need to be included in constitutions in countries not yet including them, including processes underway such as in Zambia and Tanzania, and that those working on HCCs need to be part of the engagement on rights to health.

It was noted that many Public / National Health Acts are outdated or being updated raising the opportunity to strengthen provisions for HCCs and for participation and information more generally. It was agreed that these national Health Acts need to be aligned to the rights in the constitution; and to be more explicit about the legal position of HCCs. They also need to be clear about the authority of HCCs. Delegates observed that detail on HCC functioning could come in regulations or guidelines to give flexibility for updating, but at minimum the structures and their powers and duties need to be included in the enabling law.

Finally the issue of representation was raised, for HCCs to have a means to network and raise local issues at other (higher) levels of the system. Sabine gave the example of Mali, where a national association of HCCs meets annually. In Zimbabwe the CWGH provides an opportunity for national networking. Delegates reiterated that the law should consolidate the social involvement, communication and networking needed to make the HCCs effective, so that their legal status needed to be put in the context of the wider public rights to information, speech and association, as in constitutional provisions. The law or guidelines would remain on paper unless processes for social information and activism and for capacitating systems bring them into reality.

5. Composition and role of HCCs

5.1 Overview from the background paper

Drawing on findings from the background paper, Rene gave a brief summary on the **composition** of HCCs in the region, noting that

- An HCC generally has a membership of 10 – 15 people, and usually is a mix of community and health service representatives. Some countries have been more specific about who should be on the HCC – number of women, which vulnerable groups, which staff from the health service. In some cases, the community is displaced by political leadership (councillors, MPs) and in one instance (Kenya) the HCC is only made up of community reps.
- It is not always clear whether the members are appointed or elected, in each case how this is done, and implications for the functioning and representativeness of the HCC.
- Representation of all groups is a complex issue, especially because of the diverse interests and needs in a community.
- Issues of gender balance, and how far HCCs are occupied by people with influence and/or capacities also comes into play here.
- Composition can also impact on the power imbalances in a committee related to how it functions internally, as well as its relations with health workers, the community, technocrats and other sectors (such as agriculture or education).

She observed that there are two types of **roles** for HCCs that position them between communities and health services. In relation to the community, they have a role in

- health action; health promotion, prevention and disease control in the community;
- advocacy and community voice;
- information and health literacy and
- ensuring services are accountable to the public.

In relation to health services, they have a role in

- communication between services and the public, and disseminating service information to the public
- local resource generation eg building toilets, fences;
- supporting community health workers (CHWs); and
- advocacy on local service needs to higher levels.

In some countries HCCs co-manage service delivery, resources, commodity supplies and in some instances hiring and firing health personnel.

She raised a question as to whether their role is primarily to service the community or the health service. In South Africa this is reflected at policy level. On the one hand, the South African National Health Act (2003) provides for the establishment of Health Committees (HCs, but often called Clinic Committees) with a clinic or health centre bias. At the same time, the government has produced a white paper on transforming the health sector in which it talks about community health committees where the focus is on giving community a greater voice. Generally, the desk review suggested a bias towards a service role, with varied interaction with the community. Members' understanding of their roles is sometimes weak, with little or no training; clinic staff do not have the commitment, time or capacities for HCC roles; and often there is no policy on how long an HCC member can stay on the committee, how often it should meet, and who is attending.

Therese Boule, Hanne Haricharan (UCT) and Brittany Bunce (Black Sash) presented the experiences on South Africa on the formation, composition, roles and relationships, policy and practice of health committees in South Africa (See Box 2). Their input included a short film that gave direct voice to different people working with HCCs in South Africa.

Box 2: Formation, roles and relationships of health committees in South Africa

Presented by: Therese Boulle, Hanne Haricharan (UCT) and Brittany Bunce (Black Sash)

National law has created the basis for Health committees (HCs) in South Africa but there have been varied experiences at provincial level in defining the composition, roles and functions of HCs. The composition and roles of the HCs were guided by provincial legislation. In the Eastern Cape, the Learning Network at UCT has spearheaded work to understand and support the role of HCs. Also, social mobilisation teams have been established in all 48 HCs in the Nelson Mandela Bay Health District area with the task of 'igniting enthusiasm and excitement for health committees'. Community meetings were held, with the municipality opting for a consensual and inclusive process for nominating committee members.

Over the last 3 years it became clear that the facility manager plays a key role in the functioning of the HC, especially in building trust between committee and health facility staff. The HCs have also learnt that it is important to gain the support of the local councillor since s/he has the authority to call meetings. The team continues to work on improving relations with the district management.

In the Western Cape, Black Sash has recently started work in strengthening HCCs as part of a programme to reduce maternal and child mortality. They have conducted a baseline in two districts to assess the functionality of HCCs. The baseline found that roles and responsibilities are not well understood in these two areas. HCC members were taking roles as volunteers - in security or as queue monitors for example - rather than monitoring and oversight roles. There is a general lack of engagement between HCs and the wider community.

Overall, the South African experience indicates the importance of ensuring that the HC has a clear mandate from the community, as well as access to higher levels of the health system.



Therese Boulle presenting on the South Africa HCC roles

5.2 HCC roles

Delegates agreed that it was important to first discuss roles, before making any recommendations on composition, as composition should follow roles. Therese asked delegates whether the primary purpose of HCCs was to

- i. provide a forum for community representation and voice? or
- ii. to create and strengthen links between the community and the health service? or
- iii. to oversee the role of the health system?

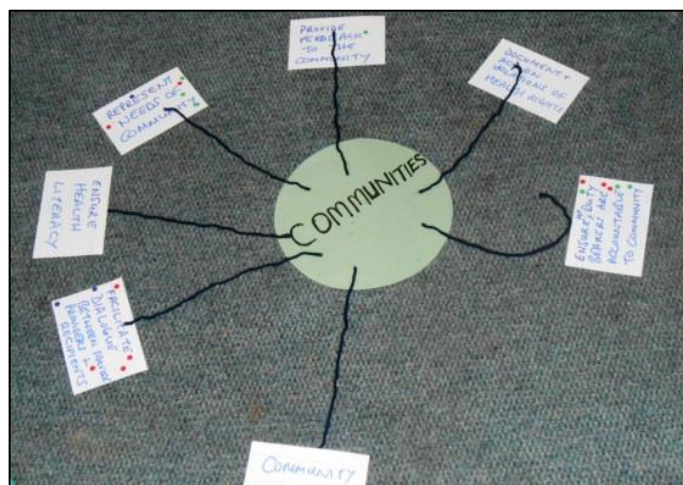
These three roles are not mutually exclusive, but the discussion raised some interesting responses. Delegates saw HCCs as a form of participatory democracy, as part of people's right to participate in decisions that affect their lives. In this case, HCCs are part of a much larger struggle. This is not only about health service delivery, but also the wider social determinants of health. When there are limited other organised community-level mechanisms dealing with these determinants, such as environment, HCCs may go beyond their core business to represent these issues as well. This was noted to happen in some areas of Zimbabwe. Lot Nyirenda from Malawi also expressed concern that participation in HCCs can become 'commodified,' where the role of HCC members is based

less on community interests or needs than on what is paid for, such as by non-state organisations coming in with plans and financial resources. These differing HCC roles reflect the wider tensions that exist in whether we have largely medical care systems with some outreach or PHC-oriented health systems that engage other sectors on social determinants of health. These different approaches affect the role of the clinic and, by extension, the roles of HCCs.

Therese and Rene facilitated a participatory exercise in which delegates in three groups identified the roles of HCCs in relation to

1. health services
2. communities
3. other actors

In each group delegates produced a spider diagram with each leg of the spider representing a particular role (see photo). The three spider diagrams were brought together so they could be viewed jointly and the roles reviewed by all delegates together, including those roles that were linked.



The spider diagram on HCC roles in relation to the community

The roles identified in each major relationship are shown in Table 3a below:

Table 3a: Group discussion on HCC roles

Roles in relation to...	HCC Role
Communities	Ensuring that health facility duty bearers are accountable to communities
	Representing the needs of the community
	Facilitating dialogue between service providers and recipients
	Providing feedback on services to the community
	Mobilising communities on health actions
	Widening health literacy in the community
Health services	Raising the needs and concerns of community
	Budgeting and planning services
	Overseeing service delivery
	Communicating and providing information on service delivery
	Raising advocacy at higher levels
Other actors	Interacting with local government to improve services
	Building partnerships with education, private sector, faith based orgs
	Networking for resource mobilization
	Monitoring activities of other sectors
	Influencing policy and practice of other sectors at local, national level
	Engaging the local government and central government systems

This indicated that community roles were often to strengthen the orientation of services to communities, more than direct health work in communities. For health services, the roles related in part to bringing community needs to services, but also to be part of the management of services. Finally HCC roles in relation to other actors largely link to building supportive roles around health services, but also ensuring other sectors also promote health.

Each delegate was then given 3 stickers to put on those roles they saw as most important for HCCs. The colour indicates whether they initially related to community, health services or other actors.

Table 3b: Delegate prioritisation of HCC roles

HCC Role	No. of 'votes'
Ensuring that health facility duty bearers are accountable to communities	8
Representing the needs of the community	6
Facilitating dialogue between service providers and recipients	6
Raising the needs and concerns of community	5
Budgeting and planning services	5
Interacting with local government to improve services	5
Overseeing service delivery	4
Build partnerships (education, private sector, faith)	4
Communicating and providing information on service delivery	2
Providing feedback on services to the community	1
Mobilising communities on health actions	1
Raising advocacy at higher levels	1
Networking for resource mobilization	1
Monitoring	1
Widening health literacy in the community	0
Influence policy and practice (local and national)	0
Access vertical levels of the governance system	0

Delegates admitted that they found it hard to prioritise only 3 roles, but they also recognised that it was an important exercise in moving away from long bureaucratic lists of what HCCs should be doing to identifying key roles and the synergies between them. When looking at the roles that had the most number of dots, delegates noticed that this synergy did come through – with community as the central focus. As shown in table 3b, this was largely focused on ensuring that services are 'people centred' in being responsive to community needs, accountable to communities in their performance and communicating with communities on what they do. Interestingly, delegates did not prioritise as strongly roles for HCCs inside the communities, such as in mobilising health actions or resources inside the community or improving health literacy. It would be interesting to do the same exercise at local level to see how the HCCs themselves, health workers and communities view the roles!

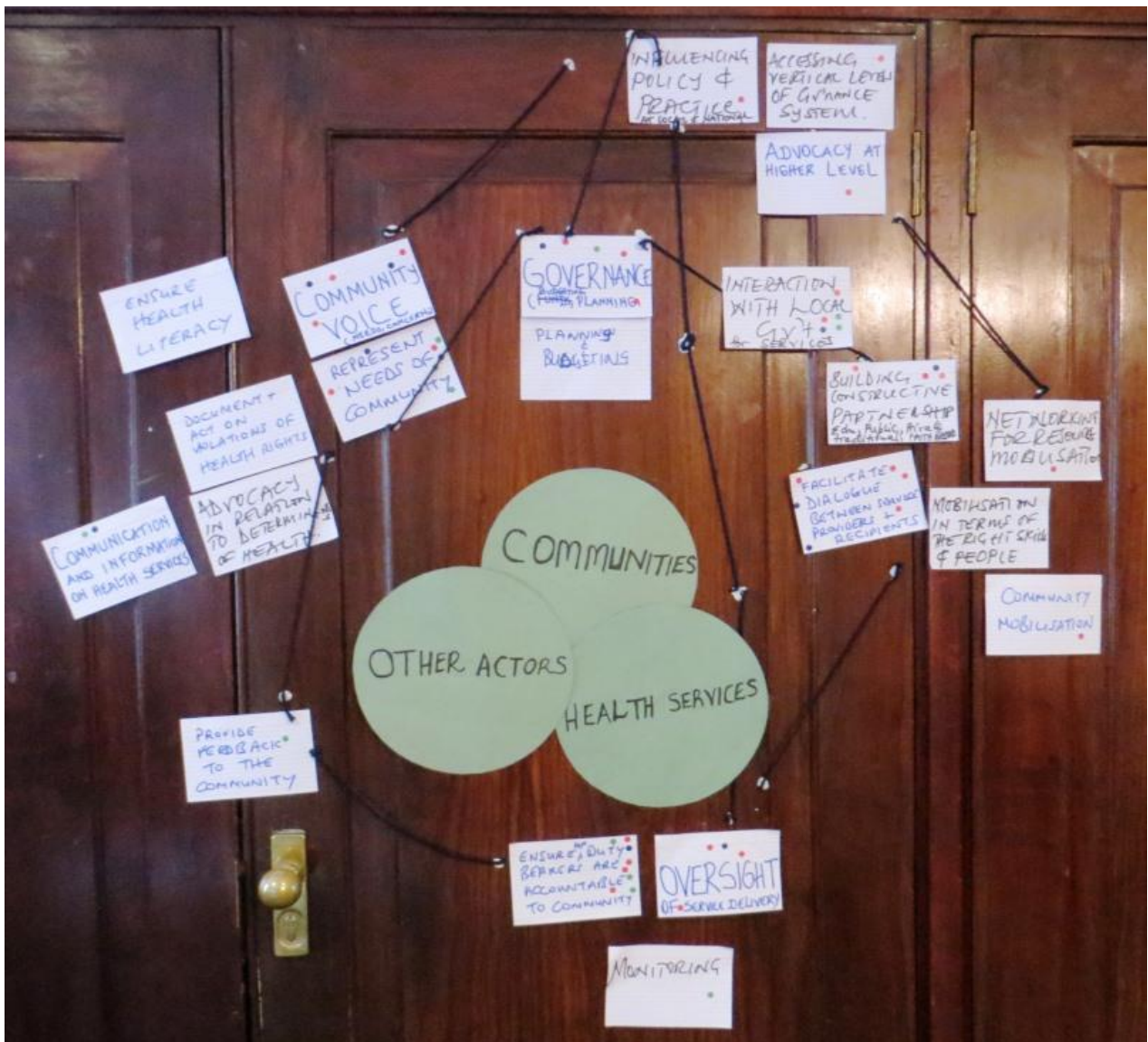


Exploring the role of HCCS – Making the spider diagrams

Rene and Therese facilitated a discussion that allowed delegates to think about the roles of an HCC in a more systemic way, linking roles in relation to processes in health systems. The photo of the combined diagram on the following page highlights this.

1. The process starts with building an informed community – in ensuring the health literacy of the community, in sharing information on health systems and the key health risks and violations of health rights
→
2. This informs and builds strength of the HCCs in their key role in representing community voice on needs and priorities in the interaction with health services (and with other actors) →
3. HCCs brings this community experience, and the problems and solutions to ‘the table’ in the health system, so community representatives and health sector personnel can jointly design and implement the plans and budgets for the health system at primary care and community level;
→
4. This joint role in governance gives the HCC the information, authority and motivation to go back to communities to facilitate dialogue and consultation on plans (and to revisit plans if needed); to mobilize social action and input, to engage with local authorities and build constructive partnerships and facilitate dialogue with different actors to ensure that problems identified are addressed, and the services and health actions implemented
→
5. This raises the oversight role of the HCC, in making sure that the agreed plans have been implemented, in monitoring and ensuring that the duty bearers are capacitated, supported and resourced to deliver on plans and that they do so in a manner that is responsive to the community
→
6. With feedback to the community on this, and documentation and reporting to those involved and to the system at higher levels
→
7. To support strategic review and reflection with communities and health workers to make improvements, and engagement and advocacy on improvements, including with other sectors, or at higher levels of the health system
→
8. For the cycle to begin again....

While policy parameters and guidance at higher levels may inform this interaction, the organisation of roles respects and reinforces the importance of social experience, input and communication as a driver of subsequent HCC roles, in representation, decision-making, planning, budgeting, engaging other sectors and oversight. It also raises the issue that emphasising one specific role, without addressing the prior or subsequent roles, may make an individual role ad hoc and less effective. Delegates commented that there are weaknesses or bottlenecks in implementing this more systemic understanding of the HCC roles in the region. This makes HCCs more reactive than proactive in their functioning, such as in following signals from funders or higher authorities, and may also limit their ability to meaningfully involve communities, to manage political lobbies or to address power imbalances between communities and other actors in the health system. It was noted that these roles would be revisited later in the meeting for the discussion on capacities and monitoring.



Roles of the HCC as process in the health system

5.3 Composition of HCCs

Leading on from the previous discussions, the question then arose: who needs to be in the HCC to deliver on these roles?

Delegates stood round a table with 10 empty chairs that they were asked to fill with who should be included in the HCC, given the roles identified in the prior activities. For each type of person identified (nurse in charge, youth etc) a delegate would wear a label for that category and fill a chair. Once the chairs were all filled then other types would argue why they should be included and who they should replace, given the roles of HCCs. (The number of chairs were defined by the average size of HCCs in the region). The activity led to active debate, especially around whether specific vulnerable social groups were adequately represented by those at the table. In the time available for the activity, delegates concluded that HCCs needed to include representatives of: women, youth, people living with disabilities, the clergy, civil society (specific type depending on the community); a traditional leader/ chief; the nurse-in-charge; a community health worker; and a member of local government.

On reflection against the roles identified earlier, delegates observed that in putting the ‘usual categories’ of representatives there may be limited representation of some vulnerable groups, and that while those involved may help to raise community needs, they may not be able to tackle budget and funding issues, where there can be shortfalls and power imbalances in the discussions. As one of the delegates said in her fictitious role as nurse-in-charge: *“My role is to present the budget and, if possible, to confuse the HCC through using lots of technical language!”*



Filling the table with who should be in the health centre committees- ‘clergy’ defending their seat against the claims from a group that has no seat at the table

6. Building capacities of HCCs

6.1 Overview from the desk review

Fortunate presented evidence from the background document highlighting that training materials exist in a number of countries in the region, but that there is scant information on the functioning, frequency and quality of training. The structure and organisation of materials also differs across the region. Some have detail defining the structure of the health system and the entry points for HCCs, such as in the Zimbabwe, South Africa, Kenya and Tanzania material. Some are more technical than others. The South Africa and Zimbabwe training manuals use participatory mechanisms for HCC members to use when facilitating health activities at community level. HCC materials are also used with other materials to support training.

As part of the presentation, Fortunate raised a number of key questions related to HCC training and capacities which she recommended delegates reflect on during their group discussions later on in this session. In relation to capacity building, she asked:

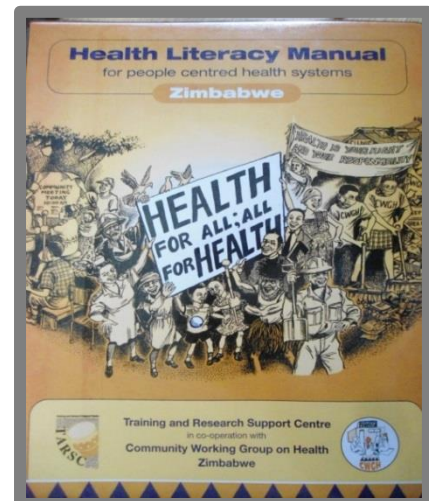
- What capacities are most important for HCCs to effectively give voice to communities?
- What approaches, resources and processes will build and reinforce these capacities?
- Who needs this capacity building? With what complementary support to communities, health workers and HCCs?

In relation to training processes and materials, she asked:

- What approaches and content are used in materials, with what strengths and challenges?
- How can the training materials be linked to action and to communities?
- How often should training take place?
- Who facilitates the training and mentors HCC members? What capacities are needed for this?
- What resources, institutional backing and other support are needed for building HCC capacities?

Edgar Mutasa, CWGH presented the experiences of strengthening HCC capacities in Zimbabwe (See Box 3 below).

In the follow up discussion, delegates noted that it was important to undertake a skills audit in their countries to identify what skills are available for the full functioning of their HCCs. They also recognised that capacity building has to go beyond simply training HCC members, to including the wider community.



Box 3: Strengthening HCC capacities in Zimbabwe

Presented by: Edgar Mutasa, CWGH

After a brief background history of the development of HCCs in Zimbabwe, Edgar Mutasa looked at how HCC capacities have been strengthened through the work of the Community Working Group on Health (CWGH) and other partners, including TARSC and the Ministry of Health and Child Care. He pointed out that one of the strengths of the training programme is that the HCCs have had access to a number of capacity building processes, rather than one single process. These include the Health Literacy programme, the development and use of the HCC Training manual for dedicated training, and participation in the annually held week-long Winter School in Public Health programme run by TARSC and University of Zimbabwe.

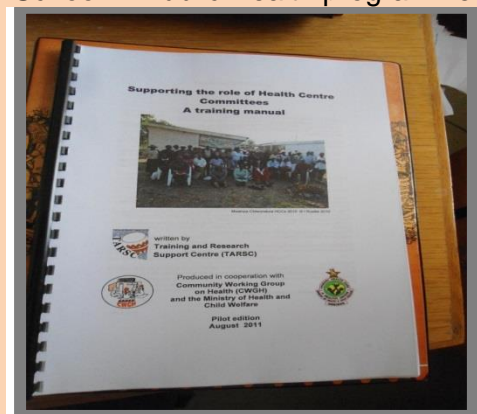
The HCC Training Manual includes the following sections:

- Module 1: health systems in Zimbabwe
- Module 2: health centre committees
- Module 3: working with communities
- Module 4: working with health workers
- Module 5: health planning
- Module 6: health budgets
- Module 7: building alliances and sources of support

The training is conducted at least once a year for each HCC. Refresher training is provided upon request.

The Health Literacy manual aims to strengthen the capacity of facilitators and organisers in CSOs and other institutions – including HCCs - working at community, district and national level. It provides both information on health and health systems, as well as a range of participatory methods to support community awareness, knowledge and action.

Both manuals use participatory methods to raise community voice and build skills and knowledge on the evidence and experience generated within communities. This allows for a sense of community ownership and the development of 'home-grown' solutions to community problems. CWGH has also noticed that these trainings have a ripple effect for new HCC members. Exchange visits between strong and weaker HCCs are also an effective way of improving capacities.



Zimbabwe's HCC training manual

6.2 Identifying capacities and gaps

Rene facilitated an activity to identify the gaps in capacities in HCCs. The key roles of HCCs identified in Section 5 were put on cards and delegates using 4 beans each identified those areas where strong capacities already exist to fulfil these roles. The outcome is shown in Table 4, with comments, including on processes supporting capacities in countries.

Table 4: Delegate identification of capacity gaps

HCC role	HCC capacity*	Comment
Health literacy & information sharing	Medium	In Zim, Uganda, Zambia, need to expand
Organising information on community health needs and rights violations	None	No tools or capacities to do this.
Representing community needs	High	Need tools for community needs assessment
Co-decision in planning and budgeting	Medium	Some skills in Zambia and Uganda. Need training to manage budget discussions and tracking
Engaging on plans and issues with local government	Medium	Skills gap in engaging technical, political actors with community information.
Networking with other sectors and actors on health systems and actions	High	Networking and social skills higher. May need stronger capacities to push content.
Mobilising people for health action	High	Good social skills
Mobilizing skills and resources	Low	Especially to mobilise external resources.
Monitoring service activities, resources	None	Limited capacities and tools
Oversight for service accountability	Low	Some capacity building underway but difficult to be do if earlier roles not capacitated
Minute taking	High	Most HCCs know how to do this.
Documenting and reporting	None	Weak skills for this
Feedback to communities, review	None	Social skills but need facilitation skills
Taking up issues at higher level	Low	Need national level institutions

* based on numbers of seeds applied where 6+ = high; 3-5 = medium; 1-2 = low and 0= none

Note: shaded areas are where HCC capacities are weakest

The table shows the overall capacity shortfall in the region and specific gaps which need to be addressed. Not surprisingly, capacities are higher in social areas and lower in technical areas, but skills gaps are most significant in organising information to and from communities, which limits the effective use of social capacities, such as in relation to organising community information on needs and rights violations, or giving feedback to communities. Further a capacity block in one area, such as in monitoring services, can limit abilities to effectively deliver on others, such as service oversight or community feedback. Gaps in areas such as planning and budgeting, and especially the latter, can make it difficult to overcome power imbalances in the relationships between themselves and health authorities, and their ability to influence decisions.

This points to the importance of seeing these skills as part of a spectrum of abilities. If communities are disempowered upstream – when it comes to identifying and articulating their health needs, getting involved in planning and budgeting, etc - then they will not have built sufficient collective knowledge and influence to be able to monitor services, ensure accountability or take issues up to a higher level.



Reviewing areas of HCC capacities

At this juncture, delegates were asked to stand next to one card where they thought that, as an organisation, they had the strongest ability and resources for building HCC capacities (a human bar chart!). Interestingly, the groups' greatest strength lay in networking – not a capacity gap for HCCs - , with their capacity-building skills weak in most other areas. This showed the need for organisations supporting HCCs to also build and diversify their skills base to be able to train HCCs more effectively.

6.3 Who is building these capacities and how?

Fortunate facilitated a participatory method called the Margolis Wheel, where delegates pair in a circular format which allows for people to keep changing partners, to discuss the following two questions:

1. who are we training? who is doing the training?
2. how are we doing the training?

This method generated a lot of information. On the first question – who are we training and who is doing it? - the discussions showed that training was happening both within the HCCs but also more widely in the communities. Community health workers, councillors and district administrators, politicians, religious leaders, as well as HCC members were identified as some of the recipients of the training. Non government organisations (NGOs) and government trainers were doing the training, and international organisations providing funding.



Who are we training? Using the Margolis Wheel

The second question highlighted some of the ways in which training was taking place and the successes and challenges related to the training process. Training methods were diverse. Some used participatory approaches at community level, others brought two or three HCC representatives from a number of HCCs in a district together to train at district level. Some of the key successes included: a broad approach to training which included many stakeholders; training needs identified by community members and health personnel; linking training with follow up activities; and the use of participatory approaches in training.

Delegates also faced many challenges. Those most often mentioned were problems with follow up; irregular training; a lack of resources and trainers; no clear guidelines on how and what to train; difficulties in scaling up training to a large number of HCCs; and the problem of the content of the training being determined by external funders.

6.4 Summary discussion

In the summary discussion on training activities and materials for HCCs a number of recommendations were made to be taken forward in the future:

1. *Share information:* At the most basic, it will be important to collect all the information/training materials already in circulation in the region and to put this information on the web for easy access, including the report prepared for this meeting and the 64 documents used in it. EQUINET has a searchable bibliography section on their website (www.equinet africa.org) and will add the training materials, training reports and other documents which reflect good practice into the database to make them more widely available both to this group but also to the wider health community. EQUINET will also include all delegates on the pra4equity mailing list and delegates should also share urls of where their own materials can be accessed.

2. *Documentation*: Linked to this is the need to improve our documentation of experiences in training/ capacity building of HCCs for wider dissemination.
3. *Collaboration/ policy framing*: both within and between countries so that a more comprehensive approach to training and interacting with authorities can be developed. This can be linked to wider collaboration on HCCs.
4. *HCC exchanges*: include possibilities for peer-to-peer learning through organising field visits to HCCs both in and between countries
5. *Internal capacity training*: follow up on further capacity building for institutions working with HCCs for institutions to provide relevant and needed HCC training.
6. *Monitoring*: develop monitoring mechanisms and tools for assessing the success of HCC training programmes.

7. Monitoring and information exchange

Both the background desk review and meeting discussions highlighted a major gap throughout the region in terms of monitoring the functioning and impact of HCCs, and in exchange of information on HCCs. It was also recognised that monitoring and documenting HCC practice and impact is important for securing greater policy attention and management support. During different stages of the meeting, delegates divided up into groups to discuss issues related to monitoring and information exchange in relation to:

- Group 1: Legal/policy provisions, power, authority, accountability
- Group 2: HCC composition
- Group 3: HCC roles and relations
- Group 4: Capacities, health literacy and training
- Group 5: Performance and functionality
- Group 6: Impact on social power in health, on health and health systems



Group discussions on monitoring

For each discussion, delegates focused on the following 3 questions:

1. What do we need to monitor and document to assess progress?
2. Who does this?
3. What information do we exchange to support work within and between countries?

Table 5 overleaf briefly outlines the main points arising from the group discussions in relation to these questions.

Table 5: Key points from group discussions on monitoring

Area	What to monitor/ document?	Who does this?	What information to exchange?
Laws and policies	Existence of key provisions in constitution and specific acts; Are laws accessible, easy to understand; used for resource allocation and expenditures	CSOs, government bodies, researchers (to define baseline)	HCC minutes; constitutional provisions; experiences on strategies for negotiating and enforcing laws; Share info also at district and community level
HCC Composition	Who is in the HCC vs needed skills; Tenure; Election process; Social groups represented; balance between community and other reps; Criteria to be a member	Community (for accountability); health authorities; CSOs	Experiences on how HCCs are composed
HCC roles and relations	Which roles are functioning and effective; What the enabling factors are; What impact each role is having	HCCs; communities; Ministry of Health officials. Use existing community meetings	Case studies – both positive and challenging experiences; tools used for monitoring roles
Capacities	Legal provisions; budget; guidelines for training; frequency and quality of training; impact of training	HCC, CSOs and government all have a role	Training manuals and reports; participatory tools for training; follow up reports; strategic reflections on capacities
Performance and function	No. and attendance at HCC meetings; Meeting records; Action plans; Performance vs country guidelines.	CSOs, local authorities, MOH at district level	Within countries: monitoring tools participatory tools (to measure quality of HCC meetings, not just frequency); experiences
Impact on social power, health, health systems	<i>Social power:</i> participation levels; HCC issues taken up by local gov or health system; community resources raised <i>Health systems:</i> disease prevalence; health perceptions, knowledge of health issues; health promotion/prevention	HCCs provided with skills and tools to monitor; Report back to communities in community meetings; meetings; Supported by community leadership, CSOs; DHOs	Documenting stories: reports, monitoring tools, training materials, useful indicators, videos, etc; peer review and exchange visits; need control studies to illustrate impact. Monitor not only the HCC but the health system as a whole.

Using the detail of these group discussions a draft monitoring framework was compiled and presented in the last session by Fortunate, with input from Brittany and Lot, using the group input.

Various ways of exchanging regionally were also discussed, presented in Section 8.

7.1 Monitoring framework

The areas below were proposed as an early draft of a framework for gathering and sharing information on HCCs that can be further developed and refined in follow up work after the meeting. Some information would be obtained less frequently (such as the legal status), while others may be shared more regularly, such as annually.

Legal status:

1. Are there laws providing for the rights to health; to public participation; to information; to association (differentiate if Constitution, Act, statutory instrument, Policy or Guidelines)?
2. Are HCCs provided for in a specific Act/ regulation/ guideline (specify)? Does it provide for
 - a. composition?
 - b. roles and responsibilities?
 - c. method of election of HCC members?
 - d. Is it understood and easy to translate into action?
 - e. Is it available?

Composition:

1. Which social groups in the community are represented in the HCC? Which are not?
2. Which capacities relevant to HCC roles are represented in the HCC? Which are not?

Roles and relations:

1. Which HCC roles are being implemented? Which HCC roles are not? (*Use list developed in the meeting*)
2. What specific HCC roles/actions/links have had an impact on health and health systems in the past year? How?

Capacities:

1. Training:
 - a. Has there been any training for HCCs ever? in the past year?
 - b. Are there guidelines for HCC training? How did communities participate in the formulation of these guidelines?
 - c. When was the induction training done for the current HCCs?
 - d. How often have the HCCs had refresher training?
 - e. When was the training last done?
 - f. What gaps are there in coverage or content of training?
 - g. Does government have TOTs and follow up mechanisms?
 - h. What evaluation is done of training content, approaches? How satisfied are HCCs?
2. Quality and depth of training: In the last training (specify timing):
 - a. Who was trained? *List*
 - b. Who were the trainers?
 - c. What training approaches were used?
 - d. What new/ old training materials were used?
 - e. What new topics were introduced?
 - f. What activities were implemented after the training?
 - g. What report(s) were produced? Who received them?
3. Alliances and support for training:
 - a. Is there a budget for HCCs capacity building?
 - b. Which partners (state and non-state) supported the last HCC training?

Performance:

In the past year:

- a. How many HCC meetings were held?
- b. Did the HCCs have a say in plans?
- c. Did the HCCs have a say in budgets?
- d. Have the HCCs tracked budgets?
- e. Have HCCs received and used funds earmarked for community level?
- f. Have HCCs held meetings with communities for information sharing/ health literacy?
- g. Have HCCs reviewed their work with communities?
- h. Have HCCs met nationally to exchange and review?

For the last HCC meeting: (specify when held)

- i. How many members attended? Which members?
- j. Were minutes produced?
- k. What action points came from the meeting?
- l. What report back meetings were held with communities?

Impact

1. On Social power and participation:
 - a. Number of community members involved in activities of HCC
 - b. Representation of vulnerable groups on HCCs

- c. Participation of vulnerable groups in activities related to HCCs
 - d. Number of issues raised by HCCs taken up/addressed by local government or health system
 - e. Number of issues raised by HCCs escalated to higher levels of governance system through tiered representation
 - f. Mobilization of community resources for health (time, material, human, financial etc.)
 - g. Number and quality of networks between different stakeholders
2. In the health system- Changes in:
- a. Perception of quality/ access/ availability of services by health service users
 - b. Uptake in catchment population for specific promotive, preventive and curative health services
 - c. Coverage of specific promotive, preventive and curative health services
 - d. Perceived satisfaction with relationship by catchment population of specific promotive, preventive and curative health services
 - e. Support for CHWs
 - f. Number of skilled health workers at facilities
 - g. Rates of staff turnover
 - h. Support of HCCs by health system e.g. transport, communication, essential office supplies, refreshments for meetings
 - a. Prevalence of common diseases in catchment population
 - b. Self-perception of health in different social groups in communities
 - c. Knowledge of health issues in different social groups in communities

8. Regional networking and advocacy

Itai facilitated discussion on regional networking, starting with presentation of two case studies, presented by Prima Kazoora, HEPS Uganda for Uganda and Ireen Otieno, National Taxpayers Association for Kenya (See Boxes 4 and 5). Even though Uganda and Kenya are neighbouring countries, they each have their different contexts and different areas of practice.

Box 4: Working with HUMCs in a devolved system in Uganda - who champions them at national level?

Presented by: Prima Kazoora, HEPS Uganda

There is no law for Health Unit Management Committees (HUMCs) in Uganda, but there are operational guidelines for the establishment and scale-up of Village Health Teams. Nevertheless, as Prima explained, HUMCs do exist. Members of the HUMCs are nominated by representatives higher up in the health system –so HUMCs at Health Facility II and III are nominated by the sub-county health committee, the District Council approves nominations for Health Facility IV, etc.

The function and roles of HUMCs are defined. They consist of monitoring the general administration of the HC



Participants at the HUMC training 2013 Mbarara district © HEPS

including procurement, storage and use of HC goods and services. They supervise the management of finances disbursed from higher levels of the health system, and foster communication with the public.

Prima noted that, while there is increased accountability to the community in some districts and HUMCs have played a role in resolving conflicts at HCs, HUMCs face a number of challenges:

- Not all HUMCs are functional across the 112 districts;
- There has been political interference in the selection of the HUMC members affecting their performance;
- Most HUMCs do not know their roles and responsibilities
- Reporting structures are not clear. Some HUMCs report to local councils, others to Ministry of Health
- HUMCs lack independent budgets to carry out activities.

All of this means that it is not clear who is ultimately responsible, at what level, for the functioning of the HUMCs.

While the Uganda case study is an interesting example of how HCCs function at various levels of the system, the Kenya country example looks at how HCCs – known as Health Facility Committees – get involved in budgets and tracking resources at the facility level.

Box 5: The role of health facility committees in ensuring and tracking resources for community priorities

Presented by: Ireen Otieno, National Taxpayers Association

Health Facility Committees (HFCs) first came into existence in Kenya in the 1980s when the government singled out the district as the most basic and effective unit for planning, development and delivery of public services. However, due to removal of user fees and an overall lack of resources, HFCs had almost become redundant until their revival in 1998. At this stage, the government introduced the Health Sector Services Fund (HSSF) which aimed to generate and provide sufficient resources for basic operational costs in districts, maintenance of the facility and equipment, as well as outreach and community based services. The HFC (composed of community members and health facility reps) was set up to manage these funds with the overall role to oversee the general operation and management of the health facility and act as a link between the health facility and community.

HFCs in Kenya play a key role in the financial management of the health facility. Members get involved in record keeping, defining health centre activities, priorities and targets, and in developing Annual and quarterly plans. They also have the authority to hire and fire health centre personnel.

Ireen noted that this has both great possibilities and risks for community participation, depending on the skills and motivation of HFC members, and their level of engagement with the wider community. As Ireen pointed out - *“the HFC should not forget their critical role of being the convenor of the community and not a representation of the entire community.”*

This calls for clear mechanisms to ensure and track resources to avoid abuse of funds. This is best undertaken by the community itself to ensure actual beneficiaries benefit from the allocations.



Resource tracking in Kenya © NTA

The examples gave delegates the opportunity to reflect on the learning from the meeting in relation to advancing the status and performance of HCCs in the region. Drawing also on the monitoring discussions, various forms and means of exchange were proposed on between countries, including:

- A link on the EQUINET website for HCC work in the region providing easy access to documents, reports, HCC materials, videos, pictures, etc
- Email list sharing of experiences, monitoring tools, training materials

Within countries it was also proposed to improve exchange across sites by

- HCC exchange visits between wards and between districts
- HCC 'Whatsapp' SMS lists to disseminate information on HCC actions to maximise impact
- Sharing participatory approaches used and experiences on both successes and challenges
- Institutionalising selected indicators on HCCs (from list in Section 7.2) in the routine health information system

9. Resolutions and proposed follow up work

This last session pulled together the various recommendations arising from the meeting.

One team (Rene, Edgar and Paula) worked on the policy resolutions) that were presented and adopted, presented in Section 9.1 below. It was proposed that EQUINET take these forward to the ECSA Health Community and other regional bodies. At the same time, delegates agreed that it is important to discuss these resolutions at national level, to get further input and endorsement before any regional submission.



Meeting discussions

A second team worked on the monitoring framework, as already reported in Section 7.

Finally, a third team (Itai, Therese and Amuda) prepared draft recommendations on the way forward for discussion in this session, and summarised in 9.2 below.

Rene indicated that after the meeting TARSC would finalise the background report (Fortunate and Rene) with the review feedback received, the meeting report would be finalised by Barbs and Rene and circulated to delegates for input, and a summary brief prepared by Rene and reviewed by all, drawing on the background report and meeting report, that would be used for follow up engagement. It was also agreed that the report of the meeting would be drawn on to prepare an oped for the EQUINET newsletter on the roles and proposals for strengthening HCCs in the region, and that all materials would be circulated on the pra4equity mailing list and other relevant mailing lists.

9.1 Resolutions on the role and functioning of HCCs in ESA countries

Delegates at the Regional Network for Equity in Health in east and southern Africa (EQUINET) Regional meeting on Health Centre Committees in East and Southern Africa held in Harare Zimbabwe 30 January- 1 February 2014 exchanged experience and learning on training and strengthening health centre committees (HCCs) in countries in the ESA region, known by various names in these countries but recognised as an important mechanism for social participation in health systems and for improving health equity outcomes. Guided by a common vision of building people centred health systems, as a group of health practitioners from seven ESA countries working with HCCs, the meeting adopted resolutions to raise the profile of and to support work to build vibrant and effective HCCs throughout the region.

Noting

- The policy commitment to community participation in health and to ensuring mechanisms for this at all levels of the health system, including within primary health care (PHC);
- The positive role that social participation plays in health and in health system coverage, performance and accountability;
- Increasing inclusion of the right to health and health care within constitutions of the countries in the region; and
- The variable levels of implementation of these policies and rights in relation to the mechanisms for social participation within and across countries in the east and southern Africa (ESA) region;

Understanding that

- Community participation involves a range of levels, from sharing of information through to joint decision making and action in health systems;
- Participation demands a health literate society;
- Mechanisms for joint decision making and exchange between communities and services exist in policy at primary care level in ESA countries;
- Such health centre committees (HCCs) primarily draw their legitimacy and mandate from communities; and that
- Social participation demands investment at the primary care and community level in health;

We urge national authorities and all organisations working in health to

1. Include the right to health, to health care, and to public participation and information in all constitutions of the region;
2. Reform national public health law to include provisions for participation and public information; and to provide for the recognition, roles and duties of mechanisms for this (HCCs) at the primary care level of the health system
3. Establish by regulation and guidelines and disseminate clear information on the roles, composition, powers, duties, capacities of and resources for HCCs, including to
 - Facilitate health literacy and public health information;
 - Identify and represent community needs;
 - Ensure community voice in health systems, with attention to disadvantaged groups;
 - Prioritise, plan and budget services with health personnel;
 - Engage with stakeholders and communities on resourcing and implementing health plans;
 - Monitor health expenditures, services and actions and their impact;
 - Ensure accountability of services to the community;
 - Provide feedback to, and review progress with communities, and
 - Report and engage on the progress, challenges and needs of community and primary care levels at higher levels.

4. Clarify and protect the non-partisan role of HCCs, including in relation to other mechanisms and within local government;
5. Provide guidance for HCC composition, with flexibility to reflect diverse settings within countries;
6. Ensure that HCC members representing communities are democratically elected by those communities and represent the diversity of community groups;
7. Ensure nation-wide comprehensive health literacy programmes in communities;
8. Ensure that HCCs have knowledge and capacities to implement their roles through induction and on-going capacity building, mentoring and information;
9. Establish standards and guidance on the core content of and processes for comprehensive HCC training;
10. Provide resources within health budgets for capacity building and functioning of HCCs;
11. Set up tools and guidance on monitoring and accountability of the functioning, performance and impact of HCCs and health services; and
12. Set up a national working group to co-ordinate the strengthening and support of HCCs in relation to all areas above and to co-ordinate the activities of national state and non-state actors and international partners on HCCs.

We commit as organisations working with HCCs to

1. Promote comprehensive PHC approaches in working with HCCs;
2. Strengthen the effectiveness of HCCs in informing communities, supporting health literacy, gathering information on community views and needs and giving feedback to communities;
3. Share information on the constitutional provisions, laws, statutes and guidelines, particularly in the ESA region, to strengthen legal provisions on public rights and participation in health and the role of HCCs;
4. Develop, share and disseminate tools, training resources and our own skills to support the functioning of HCCs;
5. Develop, use and disseminate tools for monitoring health and services and for monitoring the functioning, performance and impact of HCCs;
6. Network HCCs within countries to document and exchange experiences and capacities and to raise community evidence, knowledge and voice and social accountability at national level; and
7. Network regionally to exchange and document experience, promising practice and resources for HCC roles and capacities.

9.2 Proposals for follow up work

Delegates discussed and agreed on recommendations to deepen and strengthen practice and learning on HCCs, within countries and as a region. Delegates thus proposed follow up work to:

1. Develop a network of practitioners working with HCCs to document, share and make their work more visible, within the context of shared values and principles, within local contexts. This will include amongst others examples of good practice, case studies, reports and training materials. It was agreed that this be done within EQUINET with the cluster lead at CWGH co-ordinating and a working group for this area with leads and representatives from each country to support communication and outreach, and to take up regional dimensions of the actions below, while noting that country level actions are the responsibility of actors within countries.

2. Make a concerted effort to document and report on work being done, with time included in working schedules and budgets to reflect on and document work, and to include a peer review process for partners to provide comments, feedback and suggestions on documents to promote a culture of learning, documenting and sharing practice.
3. Improve the legal standing and tenure of HCCs in countries by seeking all opportunities to ensure their inclusion in law, and their specific roles, powers, duties and operational guidance policies, regulations and guidelines, together with the responsibilities of respective state health institutions, and to make these provisions accessible to HCCs and local communities.
4. Build social activism within the HCCs and local communities by putting communities at the centre of work and by ensuring that there is a constant flow of information and feedback contributing to a dynamic dialogue between communities and health services
5. Support a more holistic approach to the roles of HCCs and an understanding that different roles are related and mutually reinforcing. This recognises that follow up work with HCCs will review current policies, guidelines and training to strengthen and build coherence around the different and connected roles and capacities of HCCs identified in the meeting, so that they reflect community needs, contribute to decision making, engagement and oversight on health sector planning, budgeting and services, and provide continuous feedback mechanisms to the health system and communities in a process that is reflective, so that the health committee remains dynamic and open to transformation.
6. Build and encourage a vigilance in the HCCs around the composition and representation of the health committees so that they remain alive to the needs of the communities living in and around the catchment areas of the health facilities. This includes follow up work to actively identify the concerns and needs of marginalised groups in communities and to build their capacity to be able to participate in the committees in a meaningful way.
7. Identify and strengthen the diverse range of capacity needs of the committees, communities and the health system; including identifying the gaps in capacities against those needed for the roles of HCCs; and developing strategies and implementation plans to fill these gaps. To support this follow up work was proposed to
 - a. Tap the learning of experienced committee members to mentor and advise new committee members after their tenure is complete.
 - b. Clarify the resources to be provided for HCCs to function effectively (transport, access to essential office supplies, refreshments for meetings), while avoiding payment approaches that commodify community participation.
 - c. Engage health authorities to take up this responsibility to support and resource the HCCs, to avoid HCCs becoming reliant on project funding.
 - d. Set up exchange visits between HCCs within countries, and through the regional network across countries.
8. Further develop the monitoring framework regionally, with a few indicators that are institutionalised in the health information system, and a monitoring system with a wider set of parameters for information sharing at country level and across countries.
9. Engage with other sectors to enhance multi-sectoral collaboration in a holistic and comprehensive model of PHC that addresses the broader social determinants of health.
10. Ensure that the work of the committees is noted at every sphere of government through forums that bring HCCs together at sub-district, district , provincial and national level.
11. Evaluate and review work within countries and regionally, to promote learning and to continually improve practice, with progress review regionally within 12 -18 months.

Delegates raised in the discussion the need to draw on experience from other countries globally, especially in terms of how HCCs have been recognised and institutionalised. It was also raised that it is important to link this work with other processes within EQUINET - such as work on health literacy, health financing and budget tracking, retention of health workers, and community monitoring – since these issues are all linked- and with other networks in the region.

Discussions following agreement of this document highlighted the immediate next steps as:

- adding all delegates to the PRA4equity mailing list
- updating and finalise the background document for wider distribution
- finalising the meeting report
- Making the hardcopy meeting reports and background document available to the participating organisation leadership and to health authorities, and providing feedback on the engagement on these documents to the regional working group.
- Putting the background document and meeting report in the EQUINET website, and using the url link to the EQUINET website for the report, circulating information on it in the EQUINET and other newsletters and on the pra4equity and other mailing lists
- Including an oped in the EQUINET newsletter
- Writing a concept note on the follow up work to engage interested participants and partners, integrate in existing work processes and develop more detailed plans and budgets to mobilise resources for new follow up work.

Delegates proposed follow up after the meeting through EQUINET, through its cluster leads at CWGH and TARSC, with a concept note on follow up work led by CWGH, working with specific organisations in the group taking leadership in specific areas of strengths. It was proposed to have dialogue on partnerships, starting with Medico, AMHI-OSF and HPI who participated in the meeting.

10. Closing

Rene and Itai gave thanks to all those involved in the work on organising and preparing the inputs and documents for and from the meeting and to delegates for their contribution. They thanked MoHCC Zimbabwe for their policy support and Medico and others contributing resources and wished all safe travels home. In place of the usual formal concluding remarks, delegates sat in a circle and, with a ball of string, created a 'connecting web' in which each person threw the ball of string to another member in the circle, saying why they wanted to remain in touch with them.



Our 'connecting web'

With much humour and affection, delegates expressed their gratitude for what they'd learnt from each other and pledged to remain in touch. By the end of the activity there was lots of string left, so we threw the ball out of the circle to represent our pledge to involve others in our collective commitment to strengthening the role of HCCs in the region as a vehicle for social participation.

Acronyms

CHW	Community Health Worker
CSO	Civil society organisation
CWGH	Community Working Group on Health
DHO	District Health Officer
EQUINET	Regional Network for Equity in Health in east and southern Africa
ESA	East and southern Africa
HC	Health Committee, South Africa
HCC	Health Centre Committee
HFC	Health Facility Committee, Kenya
HSSF	Health Sector Services Fund
HUMC	Health Unit Management Committee, Uganda
LC	Local Committee
MOH	Ministry of Health
NHC	Neighbourhood Health Committee, Zambia
PHC	Primary health care
PRA	Participatory reflection and action
TARSC	Training and Research Support Centre
TOT	Training of trainers



Appendix One: List of Participants

#	NAME	INSTITUTION	EMAIL	Address	Phone and Fax number
1	Rene Loewenson	TARSC ZIMBABWE	rene@tarsc.org	47 Van Praagh Ave Milton Park Harare	Tel: 04-708835; Fax: 04-737220
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20	Vinay Viswanatha	AMHI Public Health Program Open Society Foundations USA	Vinay.viswanatha@opensocietyfoundations.org	224 West 57 th Street New York, New York 10019	+12125476939
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Appendix Two: Meeting Programme

DAY ONE – Thursday January 30 2014

TIME	CONTENT	SESSION PROCESS	FACILITATION
Welcome, objectives and overview			
8.30 - 9.00	Registration	Participant registration. administration	Mevice TARSC
9.00 - 9.45	Welcome, Introductions Objectives and overview	Welcome remarks Delegate introductions – including institutional info and work on HCCs Introductory remarks Introduction Medico Objectives of the meeting and overview and adoption of the programme	EQUINET: Rene Loewenson TARSC, Itai Rusike CWGH P Manangazira for D Dhlakama, Director Policy and Planning, MoHCC S Eckart, Medico Rene
HCCs in the region			
9.45 – 10.45	Mapping of HCCs presence, status in the region	Participatory exercise to map and discuss presence, status and strength of HCCs in the region, and build a common language and shared understanding of HCCs <i>Do they exist? Are they recognized in law? Are they active and functional? Do they involve and empower all in the community? Do they have influence on the functioning of the health system at local level?</i> Discussion	Rene
10.45 – 11.00	Tea		
Laws governing HCCs in the region			
11.00 – 11.45	Laws governing HCCs	Presentation of the findings of the background report on laws Discussant: <i>Country example Zambia's experience with laws, policies, guidelines and constitutions on HCCs</i> Discussion	Fortunate Machingura Moses Lungu, Zambia
11.45 – 12.45	Legal frameworks governing HCCs: Gaps, good practice and follows up	<i>What legal framework and provisions for HCCs?</i> Gp 1: What do we want to see in law? Gp 2: What do we have in current law? Discussion: <i>What good practice examples are there?</i> <i>What gaps are there?</i> <i>Where do rights need to be advanced?</i> <i>What strategies for advancing the legal status?</i>	Rene and Moses
12.45 – 2.00	LUNCH		
Composition and roles of HCCs			
14.00 – 2.45	Composition and role of HCCs in the health system	Presentation of the findings of the background report on composition, roles and relationships with the health system Discussant: <i>Country example South Africa: Experiences in forming HCCs, and engaging communities and health services</i> Discussion	Rene Therese Boule, South Africa
2.45 – 3.45	Composition and role of HCCs in the health system	<i>What do HCCs do?</i> Participatory activity Gp1: In relation to health services Gp 2: In relation to communities Gp 3: In relation to other actors (political, others) Discussion:	Therese and Rene

TIME	CONTENT	SESSION PROCESS	FACILITATION
		<i>How do roles compare with current practice? What challenges are there? What needs to happen to address the gaps?</i> Who needs to be in the HCC to deliver on these roles? Participatory activity	
15.45-16.00	TEA		
Discussion 1 on monitoring and information exchange			
16.00 – 17.00	Monitoring and information exchange on HCCs	Group discussions. Given the discussions of the day and only in relation to Gp 1: Legal / policy provisions, power, authority, accountability Gp2: HCC Composition Gp 3: HCC Roles and relations 1. What do we need to monitor and document to assess progress in the status and roles of HCCs? 2. Who does this? 3. What information do we exchange to support work on the status and roles of HCCs – within countries; between countries	Delegates
17.00	End of Day One		

DAY TWO – Friday January 31 2014

TIME	CONTENT	SESSION PROCESS	Facilitation
Discussion 1 on monitoring and information exchange			
8.45 – 9.45	Monitoring and information exchange on HCCs	Plenary report back and discussion of the working group reports. Gp 1: Legal / policy provisions, power, authority, accountability Gp2: HCC Composition Gp 3: HCC Roles and relations	Itai
Capacities and Training of HCCs			
9.45 – 10.30	Capacities and training of HCCs	Presentation of the findings of the background report on capacities and training Discussant: Country example Zimbabwe: <i>What capacities are being developed and how? What has been learned about doing this in the process?</i> Discussion	Fortunate Edgar Mutasa Zimbabwe
10.30 - 11.00	TEA		
11.00 - 11.45	Capacities of HCCs	What capacities do HCCs need and have? Participatory activity Discussion <i>What capacities are there? Where are the shortfalls? In what ways can these shortfalls be addressed? What should we do to take this forward?</i>	Rene
11.45 - 13.00	Training and training materials for HCCs	What capacity building for HCCs? Participatory activity 1. <i>Who are we training? Who is doing the training?</i> 2. <i>What capacities are we training them in?</i> 3. <i>How are we doing the training?</i> 4. <i>What training resources and materials are we using?</i> Shared discussion	Fortunate and Rene
13.00	LUNCH		
14.00 – 15.15	Training and training	Summary discussion on training activities and materials for HCCs	Fortunate and Rene

TIME	CONTENT	SESSION PROCESS	Facilitation
	materials for HCCs	<i>What training is needed given the awareness and capacities to be built? How? What materials are needed? What good practice examples can we use? What should we do to take this forward?</i>	
Discussion 2 on monitoring and information exchange			
15.15 – 15.30	Monitoring and information exchange on HCCs	Introduction to Group discussions – to be held on day 3. Given the discussions of the day and only in relation to Gp 1: Capacities, health literacy and training Gp2: Performance Gp 3: Impact on social power in health, on health and health systems 1. What do we need to monitor and document to assess progress in the area of your group? 2. Who does this? 3. What information do we exchange to support work in your group area– within countries; between countries	Delegates
15.30	TEA and end of formal proceedings on day 2		
15.30 –	Informal country exchanges		Delegates
End of Day Two			

DAY THREE– Saturday February 1 2014

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
Discussion 2 on monitoring and information exchange			
9.00 – 10.00	Monitoring and information exchange on HCCs	Group discussions as introduced on Gp 1: Capacities and training Gp2: Performance Gp 3: Impact on social power, health, & health systems	Delegates
10.00 - 10.30	TEA		
10.30 – 11.15	Monitoring and information exchange	Plenary report back and discussion of the working group reports.	Facilitator: Lot Nyirenda Malawi
11.15 - 12.00	Regional networking, advocacy	Reflections on the learning from the meeting for advancing the status and performance of HCCs in different contexts: <i>i. Uganda: Working with HUMCs in a devolved system- who champions HCCs at national level?</i> <i>ii. Kenya: How do HCCs ensure and track resource allocation for their roles and for the priorities of their communities.</i> Discussion on issues arising Discussion on regional networking, exchange	Itai and Therese Prima Kazoora Uganda Ireen Otieno, Kenya
12.00 - 13.00	Recommendations, Resolutions and next steps	Summary of the Recommendations of the meeting. Review of the monitoring framework Review and adoption of the EQUINET Harare Resolutions on strengthening HCCs in east and southern Africa Summary and closing discussion of future work	Delegates, Itai Delegates, Fortunate Delegates, Rene
13.00	Closing	Closing remarks by hosts and delegates	All