Health Centre Committees as a vehicle for social participation in health systems in east and southern Africa

**Training and Research Support Centre (TARSC)
with Community Working Group on Health
and MEDICO International**

**Regional Network for Equity in Health
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Executive summary

Health Centre Committees (HCCs) have provided one vehicle for social participation and accountability in health systems in east and southern Africa (ESA). Recognising this contribution and building on prior work on HCCs, EQUINET held a regional meeting involving those working with HCCs in ESA countries to exchange experiences and information on the laws, roles, capacities, training and monitoring systems that are being applied to HCCs in the ESA region. The meeting gathered 20 delegates representing seven countries from the region, all involved in training and strengthening HCCs. An interim desk review of existing published literature on HCCs was prepared for the meeting. The desk review covered all 16 ESA countries covered by EQUINET, that is Angola, Botswana, Democratic Republic of Congo (DRC), Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Delegates validated and added to the evidence presented. This discussion paper combines the evidence from the desk review and the further evidence that was presented at the regional meeting. It covers the legal frameworks, roles, composition, capacities and monitoring of HCCs in ESA countries.

The policies of ESA countries include support for participation, particularly as a part of their primary health care (PHC) approach. However, despite the almost universal policy commitment to community participation and reference to HCCs in many strategic plans, few specific policies or guidelines elaborate the role, functioning, authorities and resourcing of HCCs. Most ESA countries do not have laws that explicitly provide for these aspects of HCC functioning. Without an enabling law, HCCs may not be recognised by health managers and workers or by the communities they serve.

This report highlights that in practice HCCs are a heterogeneous set of entities, with composition, roles and functions varying across ESA countries. While their diverse composition brings different skills and interests to HCCs, they also vary in how far they represent community interests, depending in part on whether their members are elected by communities or appointed by health authorities. An inherent tension exists between how far HCCs are occupied by influential people within the community and representatives of more disadvantaged groups. While the latter bring experience and voice of those with higher health needs to planning, the former may have greater leverage in addressing the power imbalances in the interaction between communities and heath personnel.

HCC roles are often listed in guidance documents. This report proposes that rather than a disconnected list, HCC roles should be clearly located within health system processes, starting with their engagement with the community. Building an informed community strengthens HCCs in bringing community voice on needs and priorities into the decision making for and functioning of health services. HCCs bring social knowledge, experience, views on health problems and solutions within communities to jointly design and implement the plans and budgets for the health system at primary care and community levels. This joint role in governance gives the HCC the information, authority and motivation to: facilitate dialogue and consultation with communities on plans; mobilise social action; build constructive partnerships and facilitate dialogue with different actors to ensure that problems are addressed; and implement services and health actions. This raises the oversight role of the HCCs. They monitor and ensure that plans have been implemented in a manner responsive to the community, give feedback to the community and discuss with communities and health workers how to make improvements, in a cycle that again identifies new needs to feed into planning.

Effective implementation of these roles has been documented to show a positive impact on advancing the right to health, to improve the performance of PHC systems, the satisfaction

and retention of health personnel at primary care level and the satisfaction of communities with their services. HCCs support communication and the resolution of conflict between communities and health services and play a role in mobilising local resources for health activities and services, such as for land to cater for accommodation of nurses working at health facilities.

In many countries, however, the roles are less well defined, undermining their legitimacy and functioning. This can combine with resource constraints, overworked and under-resourced primary care services and health workers and lack of bottom up functioning of or devolved authority in health systems and lack of interest from managers, health workers and community members to weaken their role and impact. Training materials exist in a number of countries, but their content and the frequency of training varies from country to country.

The report raises a number of areas that may need more systematic attention if HCCs are to achieve their intended roles.

Responding to the potentials and challenges in HCC functioning, and the opportunities for positive impact on health, delegates to the EQUINET regional meeting made proposals for improved functioning of HCCs, shown in *Box 2* in Section 8.

The report notes that if the intention is to build PHC-oriented, people-centred health systems then HCCs need skills for activism and transformation to help build social participation and power. If they are to have a positive impact they need tools for strategic review, reflection and learning from practice and from the changes they make. To have a positive impact, HCCs need a range of tools for gathering community needs, tracking budgets, for strategic review, reflection and learning from practice, and for monitoring and review of health action and the performance of health systems. Some institutions within the region working with HCCs may form a community of practice to develop and exchange information, resources and learning on developing the tools, capacities and measures that support HCCs in people-centred health systems.

1. Background

For many decades, community participation in health systems in ESA countries has been a consistent element of health policies to support primary health care (PHC). The adoption of PHC in all countries in the region means that public participation is central to the design and implementation of health systems. In the Alma Ata declaration, community participation implies that individuals, families and communities enjoy health as a right and a responsibility, locating participation in functions of systems in planning, service delivery, budget and other processes (WHO 1978). However, the Regional Network for Equity in Heath in East and Southern Africa (EQUINET) found in its regional equity analyses in 2007 and 2012 that although ESA countries have implemented various measures in the past three decades to mobilise communities for health, it is often to support implementation of programmes funded and designed at higher levels of the health system (EQUINET SC, 2007; EQUINET, 2012). Significant power imbalances exist within health services, including between health workers and communities, between different levels of the system and between national and international actors. These power imbalances can leave the most vulnerable social groups relatively powerless (McCoy et al., 2011; Baez and Baron, 2006).

Work in 20 sites in nine countries in the pra4equity learning network in EQUINET in 2007-2009 showed that frontline health systems are able to respond to community priorities, but do not always do so, do not link well across sectors and narrowly perceive community roles. Health services were found to have high legitimacy, but weak capabilities for social roles. Their ability to foster participation was limited by inadequate resources, an organisational culture of top-down planning and limited reward for health workers' social roles, even though social barriers to health service uptake led to resource inefficiencies and poor adherence to treatment (TARSC, 2009). However, the work also showed that these issues are amenable to change. Communication gaps between communities and health workers were closed by changes in work organisation and services and by involving client networks. Increased awareness within communities was found to support early detection of and response to problems and uptake of services. When joint mechanisms such as HCCs were functional, co-operation and trust between communities and health systems increased. Shared diagnosis of problems and planning of actions improved co-operation and co-ordination across agencies, actors and sectors, improving resource inflows for promotion, prevention and care and uptake of and adherence to services (TARSC, 2009).

One way that systems facilitate such social participation is through committees and boards at neighbourhood, primary care level and in hospitals. Health Centre Committees (HCCs) involve representatives of communities and primary-care level health workers in planning, implementing and monitoring health services and activities. Known by different names in different countries, they are emerging as a common mechanism at community and primary-care level for communities to ensure that health systems access and use resources to address community needs, are responsive and accountable to communities, and create opportunities for social participation and co-determination in health systems, with positive impact on health outcomes (McCoy et al., 2011; EQUINET, 2012).

Recognising this contribution of HCCs in health systems and building on prior work, EQUINET held a regional meeting to exchange experiences in Health Centre Committees in east and southern Africa (ESA), convened by Training and Research Support Centre (TARSC) in association with Community Working Group on Health (CWGH) and Medico International. The meeting provided a forum for people doing work on training and strengthening HCCs to exchange and review information on the laws, roles, capacities, training and monitoring systems applied to HCCs in the ESA region. The meeting gathered 20 delegates representing seven countries from east and southern Africa, all involved in training and strengthening HCCs. The ESA countries included were Democratic Republic of

Congo, Malawi, Kenya, South Africa, Zambia and Zimbabwe. The full meeting report is separately available (TARSC et al., 2014). An interim desk review of existing literature was prepared for the meeting covering all 16 countries in east and southern Africa, that is Angola, Botswana, Democratic Republic of Congo (DRC), Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe (Machingura and Loewenson, 2013). This discussion paper combines the evidence from the desk review validated at the meeting and further evidence from the knowledge and experience of the delegates presented at the meeting on the legal frameworks, roles, composition, capacities and monitoring of HCCs in ESA countries.

2. Methods

The desk review was implemented between September and November 2013, covering a descriptive summary of evidence on:

i. legal frameworks
ii. composition, roles, function of HCCs
iii. capacities, training materials and activities
iv. monitoring systems used for reporting and internal review
v. experiences of functioning, and
vi. impact on health systems, health and participation of HCCs

for the 16 ESA countries covered by EQUINET, that is Angola, Botswana, DRC, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia,Zimbabwe.

Evidence was sourced from an internet search of published literature on Google, Google scholar, Pubmed, Medline, Sage publications, popline, in web libraries-IDS Sussex participation online library; University of Manchester; EQUINET and TARSC and online journals and law libraries. The search covered papers post 2000 and the search terms included: east Africa OR southern Africa OR the name of one of the 16 individual countries (indicated above) AND participation; mechanisms; OR health centre committees; OR health facility committees OR *committees and the same terms subsequently used with law OR training OR monitoring OR evaluation OR impact. Further reports were sourced from members of the pra4equity network in EQUINET and civil society organisations working with HCCs; from EQUINET Equity Watch reports for Kenya, Uganda, Tanzania, Mozambique, Zambia and Zimbabwe; and from the 2012 Regional Equity Watch. The 107 documents sourced were reviewed and 64 documents included that had information on HCCs or closely related structures like village health teams or ward health committees.

The search and review faced several limitations. Much information on HCCs is in grey literature that is not available online, although efforts were made to overcome this through accessing information from country-level contacts in the pra4equity network in EQUINET. HCCs are referred to by a number of different names and not all may have been captured by the search, although the generic term ‘committee’ was used. The reports often presented information on what should be happening in HCCs or what is happening in particular sites or districts of a country that may not be representative of the country as a whole, given the variability in functioning of HCCs within countries.

The regional meeting provided an opportunity to validate and strengthen the information from the seven countries participating. The meeting used a participatory process to review evidence, draw experience from countries, review and subject the evidence to the collective validation of the delegate group and reflect on the learning from the evidence. The meeting reviewed evidence and experience on the legal frameworks, roles, composition, capacities and monitoring of HCCs in ESA countries. The learning from the organisations participating are included as experiential knowledge in this report, as are the recommendations made on key areas for strengthening HCCs in ESA countries.

3. Health Centre Committees in the ESA region

Health Centre Committees (HCCs) are termed by different names in ESA countries (see *Table 1*). HCCs are joint community health-service structures at the primary-care level of the health system, covering the catchment area of that primary-level facility (usually termed a clinic or health centre). They provide for participation in the functioning of the health centre and PHC activities, to involve communities in planning and implementing health services and health actions and to promote public accountability in health (Boulle et al., 2008; TARSC, 2010; Machingura et al., 2011; LDHMB, 2012).

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	Health Centre Advisory Committees (HCACs)
Madagascar	Village Health Committees (VHCs)
Malawi	Health Centre Advisory Committees (HCACs); Health Centre Management Committees (HCMC)
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)

Sources: MoH and Aga Khan Health Services 2005; Bredenkamp and Mullen 2013; Ministry of Health and Social Services Namibia 2009; Paradith 2009; Makaula et al. 2012.

HCCs were reported to be present in more than 30% of all health districts in Zimbabwe, South Africa and Tanzania (Loewenson et al., 2004; Padarath and Friedman, 2008; Ifakara, 2011). Most HCCs were reported to have met at least once a year (Goodman, 2011; Ndavi et al., 2009; Nduati, 2010; Haricharan, 2011; Nantaba, 2013). Some HCCs were reported to be meeting at least four times annually in parts of South Africa, Tanzania, Zambia and Zimbabwe (Ifakara, 2011; Machingura et al., 2011; Ngulube et al., 2004; Haricharan, 2011; Padarath and Friedman, 2008). It would appear that while HCCs exist in policy in almost all countries in the region, their presence, activity and functionality varies widely within and across ESA countries (TARSC et al., 2014). The next sections discuss this in further detail.

4. Laws and policies establishing HCCs

HCCs may require a continuum of legal provisions to function effectively as a vehicle for community voice. HCCs would be strengthened by constitutional provisions that guarantee public rights to health services, to access information, to public participation and to freedom of speech and association. Public or national health acts would desirably need to include more specific provisions on how participation is organised in health systems, including the role, duties and powers of the mechanisms provided. Regulations or guidelines would need to provide more detailed guidance on the composition, roles, capacities, resources, reporting of HCCs and their obligations to the community (TARSC et al., 2014).

Despite the almost universal policy commitment to community participation and reference to HCCs in many strategic plans, there was limited evidence of the inclusion of HCCs in national laws or of regulations outlining their role, functioning, authority and resources. In Kenya, South Africa, Zimbabwe and Mozambique, the constitutions establish rights to health services and to public participation in health (Mulumba et al., 2010), but in general old public health laws in ESA countries do not adequately translate these constitutional rights into formal mechanisms (TARSC et al., 2014).

The review of published literature highlighted examples of legal provisions covering HCCs in:

i. South Africa, where the National Health Act 61 2003, Chapter 6 on Health establishments, section 42, subsection 1, 2 and 3, state that provincial law provide for district health councils, and establish and describe the functions of clinic and community health centre committees as including representatives of the communities served by the clinic or hospital, although without clarifying their functions (Padarath, 2009; Department of Health South Africa, 2013);
ii. Tanzania, where HCCs operate under the Local Government Urban Authorities Act 1982 and the Local Government District Authorities Act (Macha et al., 2011; Kamuzora and Gilson, 2007; Tidemand et al., 2008), and historically in
iii. Zambia, where Neighbourhood Health Committees (NHC) were established through the National Health Service Act of 1995, 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 as the link between the community and the health institutions. The National Health Service Act 2005 dissolved the Central Board of Health (CBOH), although NHCs continued to exist despite their legal mandate being repealed (GoZ, 1996; Ngulube et al., 2004; TARSC, UNZA, 2011).

Kenya and Malawi provide for HCCs in national health strategies, such as the Ministry of Health Strategic Plan 2011-2016 (Malawi Ministry of Health, 2011). In Kenya, the government officially established Heath Facility Committees (HFC) in 1998 (Opwora et al., 2009) and policies have recently been developed for Community Health Committees (CHCs) to support PHC (Ministry of Public Health and Sanitation, 2012). The Zimbabwe National Health Strategy 2009-2013 proposed investment in HCCs (Zimbabwe MoHCW, 2009) and the Tanzania Health Sector Strategic Plan (2003-2008) proposed introduction of Health Facility Governing Committees (HFGCs) in all health facilities. In Uganda and Zimbabwe operational guidelines in the ministries of health outline the composition, roles and responsibilities of HCCs (COWI, EPOS, 2007; Ministry of Health Uganda, 2009, 2010, 2012; Loewenson, 2000; Zimbabwe MoHCW, 2009). We were not able to obtain information on Angola, Botswana, Lesotho, Mauritius, Madagascar, Namibia and Swaziland.

Delegates to the regional meeting noted that HCCs need to have a legal status and constitution to receive and account for public funds, whether from the state or external funders (TARSC et al., 2014). This may be necessary under laws setting out how public finances are accounted. Vague mandates were also reported to lead to poor recognition in the functioning by national-level structures and key stakeholders, undermining legitimacy of HCCs (COHRED, 1997). At the same time, experience in Zambia highlights that even where there is no law, HCCs may still be sustained or become stronger, as long as they receive policy support from the Ministry of Health and functional support from local government level and communities. In Zambia, after the repeal of the enabling 1995 law in 2005, neighbourhood NHCs continued to exist and the Ministry of Health continued to recognise and maintain their role in PHC. In Lusaka, an NHC Working Group was formed. The group set up Operational Guidelines for NHCs, held annual general meetings to review NHC experiences and activities, and set a constitution for NHCs (Lungu, 2014, in TARSC et al., 2014). Equally, even if there *is* a legal framework, there is no guarantee that

communities will know about or understand it, or that the law will be enforced. The law may be important, but may remain on paper unless upheld by community actions.

5. The role and function of HCCs

HCCs are mechanisms that involve both communities and health services. In general, in relation to the community, they have roles in health action; health promotion, prevention and disease control in the community; advocacy and community voice; information and health literacy and in ensuring that 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; in local resource generation such as building toilets, fences; supporting community health workers (CHWs); and advocacy on local service needs to higher levels. In some countries, such as Uganda, HCCs co-manage service delivery, resources, commodity supplies and in some instances hiring and firing of health personnel (see *Table 2* and TARSC et al., 2014).

Table 2: Roles of HCCs in ESA countries documented in the literature

Country	HCC Roles
Kenya	Community Health Committees provide leadership and governance oversight in implementation of health and related matters in community health services at level and the operations and management of the health facility. They plan, co-ordinate and mobilise the community to participate, along with themselves, in community dialogue and health action, advise the community on the promotion of health services, represent and articulate community interests in health in local development forums; facilitate feedback to the community on the operations and management of the health facility and implement community decisions pertaining to their own health. In relation to resources, they facilitate resource mobilisation for implementing the community work plan and ensure accountability and transparency; manage the people and resources for health in the community and mobilise community resources towards the development of health services within the area. CHCs facilitate negotiations and resolve stakeholder conflict at level; lead in advocacy, communication and social mobilisation and monitor, evaluate and report on the community work plan.
Malawi	Health Centre Management Committees are a conduit for grievances in relation to health service performance, while Health Centre Action Committees mobilise communities to participate in development projects at the health centre such as helping to build shelters for pregnant mothers awaiting delivery.
Namibia	Community-based health committees identify and co-ordinate the health needs in their communities; facilitate the selection of, guide, support and motivate community health workers (CHWs); support and assist CHW and primary-care level activities and support service delivery; and organise health activities at community level. They mobilise resources and may provide incentives for community health committee practitioners.
South Africa	HCCs in South Africa have strongly defined oversight roles. They oversee adherence and provision of the primary health-care package, including the general norms and standards of the health facility, and monitor and report the extent the health facility is meeting and achieving the health indicators and targets set for primary health care, including adherence of health facilities to opening and closing times. They also monitor the effectiveness of communication with communities and the extent to which management of the health facility addresses and resolves complaints submitted by communities. They have no role in the appointment of staff in a health facility but oversee that management meets the objectives of the facility and implements committee decisions. To achieve this they can facilitate access to facility information, can recommend studies to be done on facility performance; and provide reports on the facility performance to the District Portfolio Council for Health. Aside from these monitoring roles, they have roles in advocacy, social mobilisation and fundraising and training.
Tanzania	Health facility committees oversee and give community feedback on the operations, management and quality of services in the health facility. They develop plans and

Country	HCC Roles
	budgets for the facility, mobilise community contributions to the community health fund (CHF) and ensure the availability of personnel, medicines and equipment in services.
Uganda	The Health Unit Management Committees support community outreach work, including patient follow-up at the grassroots level, mobilise people to use services and support facility communication with the public. They monitor the health centre budget expenditure and performance, the procurement, storage, and utilisation of all HC II goods and services in line with local government regulations; evaluate tenders; recommend procurements and oversee facility administration.
Zambia	NHCs have a number of community roles: they disseminate information to communities on prevention and promotion; coordinate and supervise community health activities and initiate and participate in health-related issues at household and community levels. To support this they identify, facilitate and co-ordinate training needs for the community; identify health problems in the community in conjunction with others, bring them to the attention of the health centre and develop action plans to address community health needs. They also have oversight roles, in monitoring and evaluating health-related activities, conducting household registration once a year and seeking information each month on the existence of infectious and other diseases of relevance/concern and hold services accountable on resources used.
Zimbabwe	HCCs facilitate people to identify their priority health problems, actions and plan how to raise resources, organise and manage community contributions for community health activities. They use information from the health information system and from communities in planning and evaluating their work and health interventions and seek mechanisms for training to do this. They function as a channel for information flow from the community to the district health team and back to the community; including in the link with different health providers on issues of patient care and service performance. They keep communities informed on health budget issues, particularly as relating to local resource mobilisation; and work with the rural district council (RDC) to motivate and implement public health standards, such as for water supply and sanitation.

Note: No information found for Angola, Botswana, DRC, Lesotho, Madagascar, Mauritius, Mozambique or Swaziland.
Sources: Jepsson and Okuonzi, 2000; TARSC, 2010; Kenya MoH, 2006; Poku, 2008; Loewenson, 2004; Mubyazi et al., 2007b; COHRED, 1997; Padarath and Friedman, 2008; Ifakara, 2011; United Rep of Tanzania, 2008; Orkman and Svenson, 2009; Ndavi et al., 2009; Macha et al., 2011; Ngulube et al., 2004; Loewenson et al., 2000; Nelson Mandela Metropolitan University, 2010; MoHSS Namibia nd; AKHS undated; LDHMB, 2012; REACH Trust, 2014; Ministry of Health Uganda, 2003.

In some countries the roles of the HCCs are aligned with other roles of actors in the system, as for example shown for Kenya in *Table 3*overleaf.

In South Africa, those working with HCCs have observed that the facility manager plays a key role in the functioning of the committees, especially in building trust between committee and health facility staff. HCCs are also important in gaining the support of the local councillor since s/he has the authority to call meetings (Boulle et al., 2014, in TARSC et al., 2014).

While *Table 2* highlights a range of roles, the evidence suggests that the roles have a stronger bias towards service functions in some countries (such as Tanzania) and more focus on community roles in others (such as Zimbabwe). This raises a question on the *primary* role of HCCs. Is it to service the community or the health service? This question is also relevant to their role in supporting health equity. They have been documented to play a role in mitigating social stratification by raising needs of and empowering more disadvantaged and marginalised sections of the community and by highlighting the processes or factors leading to such disadvantage (McCoy et al., 2011).

Table 3: Key roles and functions of health committee and related cadres in Kenya

Community Health Workers (CHW): roles	Community Health Extension Workers: roles	Community Health Committee (CHC): roles
• Community health promotion • Treat common ailments and minor injuries, with support of the CHEW • Stock the CHW kit with supplies from user funds • Refer cases to nearest facilities • Promote care-seeking and compliance with treatment • Visit homes to determine health status; dialogue on health action • Promote home care with CHEWs and facility support • Answer questions and give advice • Be an example and model of good health behaviour • Motivate community members on health-promoting practices • Organise village health activities • Maintain village registers and records of health events.	• Oversee CHW selection • Organise and facilitate CHW training • Monitor management of the CHWs' kits • Collate CHW information for feedback and dialogue in community • Compile reports from CHWs to send to facility management committees • Receive feedback from facilities and share information with CHCs and CHWs for planning • Follow up and monitor actions emerging from dialogue and planning sessions to ensure implementation.	• Oversee implementation of community health services • Mobilise resources to implement community work plans; ensure accountability • Manage people and funds in the community • Plan, co-ordinate and mobilise community participation in dialogue and health action • Facilitate negotiations and conflict resolution among stakeholders at facilities • Lead in advocacy, social mobilisation, communication • Monitor and evaluate the community work plan and work of the CHWs • Prepare quarterly reports on events in the community

Source: Adapted from Kenya MoH, 2006.

In the EQUINET regional meeting on HCCs the issue was addressed by thinking about the roles of an HCC in a more systemic way, linking the roles to processes in the community and in health systems (TARSC et al., 2014). Figure 1 overleaf shows in a photo the meeting proposal for the roles and their linkages, summarised below:

1. The work of the HCC starts with **building an informed community** – in ensuring the health literacy of the community, in reviewing with community members their experiences and views on improving health, including for different social groups within communities, in sharing information on the key health risks and violations of health rights and on the actions to be taken to address these, including by health services;
   →
2. This informs and builds strength of the HCCs in their key role in **representing community voice** on needs, actions and priorities to improve heallth 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 that community representatives and health sector personnel can **jointly design and implement the plans and budgets** for the health system at primary care and community levels.
   →
4. This joint role in governance gives the HCC the information, legitimacy and motivation to **go back to communities to facilitate dialogue and consultation on plans** (and to revisit plans if needed based on feedback and information from health and other services); to mobilise social action and input, to engage with local authorities and to build constructive partnerships and facilitate dialogue with different actors to ensure that problems identified are addressed, and that services and health actions are implemented.
   →
5. This raises the oversight role of the HCC, in **making sure that the agreed plans have been implemented**, in monitoring and advocating that the duty bearers are

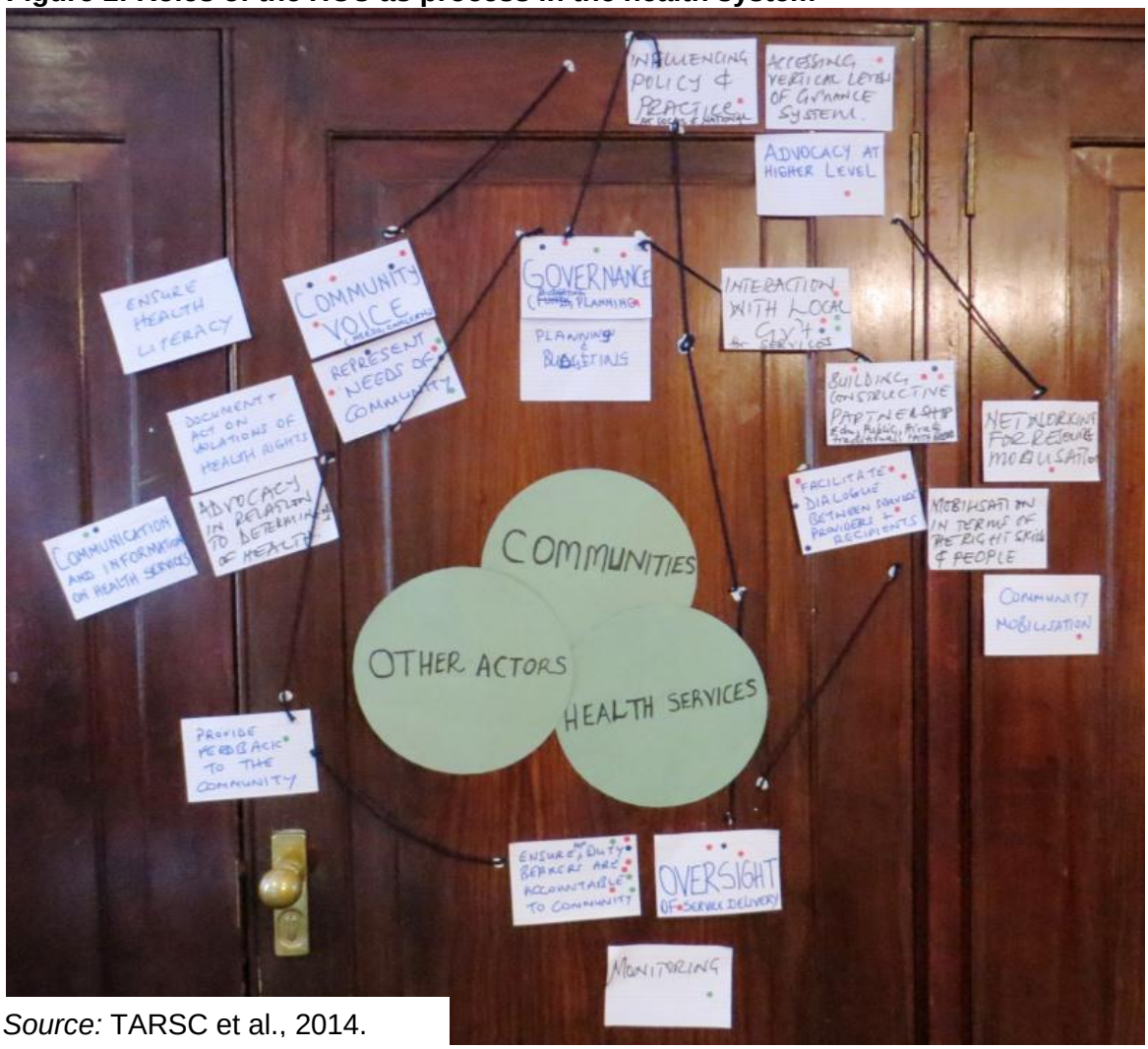
capacitated, supported and resourced to deliver on plans and that they do so in a manner that is responsive to the community.
→

6. With feedback to the community on the implementation of plans, **reporting to health authorities and communities** and to the health system at higher levels.
→

7. To support **strategic review and reflection with communities and health workers** on the actions taken, to make improvements in PHC and primary care services, and to engage and advocate on these improvements, including with other sectors, or at higher levels of the health system .
→

8. For the cycle to begin again….

Figure 1: Roles of the HCC as process in the health system



Source: TARSC et al., 2014.

This understanding of HCC roles implies that social experience, input and communication are primary drivers of subsequent HCC roles, informing representation and decision making in planning and budgeting, the engagement with other sectors and the oversight and review of the performance of local services in improving health. The HCC provides a means to support population health and, in this, to address factors leading to poorer health in some groups, particularly when services are less effective in reaching such groups. A more systemic understanding of HCC roles also highlights that the roles are linked. Emphasising one specific role, without addressing the prior or subsequent roles, may make

an individual role ad hoc and less effective. When there are weaknesses or bottlenecks in implementing a systemic sequence of roles, HCCs can become more reactive than proactive in their functioning. For example if they have limited ability to meaningfully engage and involve communities, it can make them reactive to technical or political lobbies. This may limit their ability to address power imbalances between communities and other actors in the health system or to effectively involve communities within key processes in health systems.

Such limitations were noted in the literature, and HCCs were reported to face challenges in implementing these roles. These challenges were identified as:

- Lack of clear and agreed definition of roles and responsibilities;
- Problems with selection of HCC members, including inadequate representation of the wider community;
- Limited access to the community and to call for meetings;
- Lack of interest from the community affecting legitimacy, representation and sustainability;
- Risk of 'provider' bias and lack of community ownership, particularly as most HCC meetings take place at health facilities;
- Lack of appreciation of or capacities for their roles amongst HCC members;
- Irregular meetings, poor attendance at meetings, and difficulties in retaining members;
- Lack of incentives for their work and resources for their roles;
- HCCs undertaking clinic responsibilities and unpaid clinic roles. and in so doing undermining their ability to effectively oversee the performance of services;
- Overworked health staff at clinic level lacking time, oversight roles in their portfolios and capacities to provide support to HCCs;
- Lack of commitment from health care workers to HCC meetings;
- Lack of 'bottom up' budgeting and implementation of initiatives; and
- Limited or lack of co-operation with local government officials and facility managers (Boulle, 2007; Goodman et al., 2011; Machingura, 2010; Ngulube et al., 2004; Ndavi, 2009; Haricharan, 2011; Padarath, 2009; Ifakara, 2011; Opwora et al., 2009).

These shortfalls and the proposals for addressing them are further discussed in the next sections in relation to capacities in Section 6 and in relation to proposed improvements in HCC functioning in Section 8.

6. The composition of and capacities in HCCs

6.1 Composition

The composition, roles and functions of HCCs vary across ESA countries. As shown in *Table 4*, they have common features, in all having:

- community and health worker members;
- between 10 and 15 members;
- a chairperson, a vice chairperson, a secretary and a treasurer; and
- an effort to include women.

The composition of the HCCs can affect their ability to deliver on the roles discussed in Section 5, bringing different skills and interests to the committee. The literature identifies various concerns as to whether or how HCCs represent or bring voice from various social groups in the community. The literature also questions the representativeness of HCCs in relation to the diverse groups and interests in communities (Jeppsson and Okuonzi, 2000; Howard et al., 2002) such as whether they involve *both* influential people and disadvantaged people (Ngulube et al., 2004; Jeppsson and Okuonzi, 2000).

Table 4: Composition of HCCs in ESA countries

Country	# members	Composition
Kenya	11-13	At least one-third of the committee is drawn from women's groups or organisations, and others from community-level faith groups, youth groups and or from people living with disabilities. The election/ appointment process is not documented. Community health action group (CHAG) members are community resource persons supporting health.
Malawi	10	Elected by people from surrounding villages and holding office for five years. The male:female ratios vary. Membership includes retired civil servants and pensioners with capacity to conduct HCC activities. Health workers are not expected to be members of the HCMC but of the HCAC, but some HMCS health workers.
South Africa	15	Include a chairperson, vice chairperson, secretary, deputy secretary, treasurer, and committee members elected by the community that communicate with the head of the health facility.
Uganda	9	Health Unit Management Committees for levels two and three health centres are nominated by the sub-county health committee and appointed by the local council. The HUMC for a level four health centre is nominated by the district health committee and appointed by the district council. It Includes public figures 'with high integrity', the medical officer in charge (who acts as secretary); the head of the nursing division; community representatives; staff representative and the assistant chief administrative or assistant town clerk in a municipality. The HCII HUMC includes 'a respectable person, the medical person in charge of the Health Unit, two public figures able to write and read, a staff representative of the health unit, and a teacher from a nearby school. A parish chief where the centre is located and a local council chairperson may be co-opted whenever necessary.
Zambia	10	Includes a chairperson, vice chairperson, secretary, vice secretary, treasurer, vice treasurer, publicity, vice publicity and two committee members. Members are elected by the community.
Zimbabwe	11-15	Includes representatives of the community nominated / elected by their institutions and associations: youth, women, civil society, of faith-based groups, of specific interest groups representing vulnerable communities; public and private health services, and other sectors: schools, agriculture, labour, housing, women's affairs and police. The councillor and other political leadership are ex-officio members of the committee.

Note: No information found for Angola, Botswana, DRC, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, Swaziland and Tanzania.
Sources: Jepsson and Okuonzi, 2000; TARSC, 2010; Ministry of Health, 2006; Malawi Ministry of Health, 2011; REACH Trust, 2014; Poku, 2008; NTA, nd; Loewenson, 2004; Mubyazi et al, 2007; COHRED 1997; Paradath and Friedman, 2008; Orkman and Svenson, 2009; Ndavi et al., 2009; Macha et al., 2011; Ngulube et al, 2004; Kenya Ministry of Public Health and Sanitation, 2013; Goodman et al., 2011; Haricharan, 2011; Campbell et al., 2007; Boulle, 2007; PHM, 2012; South Africa Department of Health, 2013; Zimbabwe PHC Taskforce, 2010; Ministry of Health Uganda, 2003.

Influential members can bring negotiating power for the community to the HCCs. However, this raises a question of whether they adequately represent the interests of more disadvantaged communities (TARSC et al., 2014). The representation of the latter may not be achieved within broad categories such as 'women' and 'youth' and may need special attention. Additional delegates working with HCCs in the regional meeting noted that while

community members may be confident to raise community needs, they may not have the same confidence in handling budget and funding issues, leading to power imbalances in budget and planning discussions (McCoy et al., 2011).

Another concern raised in the literature and reiterated at the EQUINET regional meeting is whether communities elect members in HCCs, as was reported to be the case in Zimbabwe, South Africa, Uganda, Kenya, Tanzania and Zambia, or whether higher level authorities appoint them (Molyneux et al., 2012). Sometimes the system does both: The Ministry of Health in Namibia (2009) reports that members of the committee are invited through community structures to volunteer themselves. From the volunteer pool, those considered capable by the community structures are interviewed, competed and appointed as relevant.

6.2 Capacities and training

Capacity shortfalls can be addressed through training and mentoring activities. *Table 5* shows capacity shortfalls identified by ESA country delegates in the EQUINET regional meeting. *Table 5* suggests that social capacities are generally judged to be stronger than technical capacities. However, gaps in communication or information skills limit the effective use of social capacities in representing community needs in HCC processes. A capacity block in one area can limit abilities to deliver effectively on other functions, such as when a capacity gap in monitoring services limits ability to provide service oversight or community feedback. Gaps in areas such as planning and budgeting, noted earlier, can make it difficult to overcome power imbalances in the relationships between members and health authorities, and affect how far HCC members can influence decisions.

Table 5: Regional meeting delegate identification of HCC capacity gaps

HCC role	HCC capacity gap (*)	Comment
Health literacy and information sharing	Medium	Need to expand within and across countries
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 but 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

* As collectively rated by delegates in the EQUINET regional meeting using a ranking and scoring method. Shaded areas are where HCC capacities are weakest

Source: TARSC et al., 2014.

As in the case of their roles, the skills needed by HCCs should be seen as a connected spectrum of abilities. If communities are disempowered in early roles, such as identifying and articulating their health needs, or in planning and budgeting, 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, undermining these later capabilities. Literacy was reported to affect the confidence of HCC members in their roles (Glattsein-Young, 2010). Low or less meaningful levels of participation were reported to lead HCC members to feel demoralised (Uzochukwu et al., 2011; McCoy et al., 2011).

Training methods used to build HCC capacities are diverse. Some use participatory approaches in training within the community, while others bring two or three HCC representatives from a number of HCCs in a district together to train at district level. The training has been noted to be irregular; with a reported lack of resources and trainers; guidelines in only a few countries on how and what to train; difficulties in scaling up training to a large number of HCCs; and with the content of the training often determined by external funders (TARSC et al., 2014).

Some countries have specific training materials for HCCs:

i. Kenya has training materials for community health committees, including a Curriculum for Community Health Committees, a trainers' manual and handbook for community health committees and community health volunteers' (CHVs) Basic Modules. In the training for community health action group (CHAG), members and health managers are tasked to work with and guide CHAGs to offer services to communities, linking them to care and referral (MoPHS Kenya, 2012).
ii. In South Africa, the Nelson Mandela Metropolitan University (2010) developed a training manual for community health committees that supports committees to understand and implement their roles.
iii. Tanzania's Ministry of Health developed a District Health Management Training Manual 2001; a Community Health Action Group Training Manual, and a Trainers' Manual for Community Health Committees (MoHTz, 2011; Mubyazi, 2007a).
iv. Zambia developed a Guideline for Activities of the Neighbourhood Health Committees (NHC) Lusaka District' (LDHMB, 2012).
v. Zimbabwe has a number of training materials for HCCs. These include a HCC training manual, health worker guidance and training materials and a community Health Literacy Manual (Machingura, 2010).

The contents and structure of Kenya's and Zimbabwe's HCC training manuals are shown, for example, in *Box 1*.

Box 1: HCC Training materials

In Zimbabwe
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

Training is conducted at least once every year for each HCC. Refresher training can be provided upon request. The manual uses participatory methods as its approach to raise community voice and build skills and knowledge on the evidence and experience generated within communities (TARSC, CWGH, MoHCW, 2011).

In Kenya

Kenya's Handbook for community health committees and community health volunteers (CHVs) Basic Modules Manual Facilitators Guide was developed with the following modules:

- Module 1: Applying the practice of leadership in the community health context
- Module 2: Governance in the context of community health services
- Module 3: The role of CHCs in effective communication, advocacy, networking & social mobilisation in the community unit
- Module 4: Personnel management issues
- Module 5: Resource mobilisation/financial management
- Module 6: Community health information system
- Module 7: Monitoring and evaluation and the way forward

Source: MoPHS Kenya, 2012, 2013.

It is not only their competencies that affect the performance of HCCs. The absence of guidelines and clear direction, noted earlier, and the lack of resources for HCC functioning and reliance on voluntarism can undermine the conduct of committees and lead to ad hoc support from health facility personnel (Ngulube et al., 2004; Padareth, 2009). Other factors affecting HCC performance include the distance to the clinic, access to transport for outreach; the strength of investment in PHC; and the ability of the clinic to address demand for services, such as in relation to the adequacy of staff or medicines at the facility (Loewenson et al., 2004; Mubyazi et al., 2007a and 2007b; Katabarwa et al., 2005).

7. Monitoring the performance and impact of HCCs

HCCs are reported to have had various areas of positive impact in health and health care, including:

- advancing the right to health, to implement provisions in constitutions, e.g. Haricharan (2011) in South Africa;
- improving the performance of PHC systems, the satisfaction and retention of health personnel at primary care level and the satisfaction of communities with their services in Loewenson et al. (2004) in Zimbabwe, Ifakara (2011) in Tanzania and Katabarwa et al. (2005) in Kenya;
- supporting communication and the resolution of conflict between communities and health services in Ifakara Health Institute (2011) in Tanzania and REACH Trust (2014) in Malawi;
- mobilising resources for health activities and services, including for land to cater for accommodation of nurses working at health facilities in Ifakara (2011) in Tanzania and COWI, EPOS (2007) in Uganda;, and
- Managing funds disbursed from national level, such as the Health Transition Fund resources disbursed through results-based financing in CWGH (2014) in Zimbabwe.

These impacts are generally measured through surveys and there is limited evidence of routine monitoring of the process or impact of HCCs, or of HCCs themselves monitoring service performance. In Zambia, for example, the NHC constitution provides for monitoring of budget expenditures (Ngulube et al., 2004). It would thus appear that there is a gap in monitoring the functioning and impact of HCCs, a gap that may be important to secure greater policy attention and management support for HCCs.

In the EQUINET regional meeting, delegates identified some key areas that would be important to include in a monitoring system, including:

i. On laws and policies – the existence of key provisions in the constitution and specific acts, and whether the laws are accessible, enforced and used for resource allocation;

ii. On the HCC composition and capacities – in terms of the election process; the social groups represented and not; and the type, frequency of and support for training;
iii. On the HCC roles and relations – including the roles, the meetings held; the key areas of functioning (in community, representatives, budget and planning and engagement with communities and services) and the resources applied to support these functions;
iv. In relation to social power – in terms of levels and forms of social participation of different social groups; the quality of local networks and level of co-determination;
v. Health outcomes, including in terms of disease prevalence; health perceptions, knowledge of health issues; and coverage, quality and responsiveness of health services (TARSC et al., 2014).

8. Discussion

This report highlights that HCCs are recognised in health policy to have a role in PHC and community participation in health in ESA countries. There is evidence of the positive impact of HCCs on the performance and outcomes of PHC systems. In practice, however, HCCs are found to be a heterogeneous set of entities, with composition, roles and functions that vary across ESA countries. While a range of skills and interests are present in HCCs, they may not be representative of communities and particularly of groups with higher health needs. Their representativeness may depend on whether their members are elected or appointed, but even elected committees may not necessarily involve the more disadvantaged groups. Further, while inclusion of groups with high health needs brings their voice to health planning, inclusion of those in the community with greater wealth or community power may be seen by communities to give greater leverage in addressing the power imbalances in the interaction between communities and heath personnel.

HCC roles are often listed in guidance documents. This report proposes that rather than in a disconnected list HCC roles be located within health system processes, starting with their engagement with the community. The work of the HCC starts with building an informed community that collectively identifies its needs and priorities, giving strength to the HCC in their key role in representing community voice on needs and priorities in the interaction with health services. HCCs bring this community experience and community evidence on problems and solutions to jointly design and implement the plans and budgets for the health system at primary care and community levels. This joint role in governance gives the HCC the information, legitimacy and motivation to go back to communities to facilitate dialogue and consultation on plans; to mobilise social action, build constructive partnerships and facilitate dialogue with different actors to ensure that problems identified are addressed, and the services and health actions implemented. This raises the oversight role of the HCC, in monitoring and making sure that the agreed plans have been implementedin a manner that is responsive to the community, with feedback to the community. The work feeds into strategic review and reflection with communities and health workers to make improvements, in a cycle that again identifies new needs to feed into planning.

These roles are documented to have positive impact on advancing the right to health, in improving the performance of PHC systems, the satisfaction and retention of health personnel at primary care level and the satisfaction of communities with their services; in supporting communication and the resolution of conflict between communities and health workers and in mobilising resources for health activities and services.

In many countries, however, the roles are less well defined, undermining their legitimacy and functioning. This can combine with resource constraints, including overworked and

under-resourced primary care services and health workers; with a lack of bottom-up functioning of or devolved authority in health systems and lack of interest from managers, health workers and community members, all combining to weaken the role and impact of HCCs. Training materials exist in a number of countries but their content and the frequency of training varies from country to country. To have a positive impact, HCCs need a range of tools for gathering community needs, tracking budgets, for strategic review, reflection and learning from practice, and for monitoring and review of health action and the performance of health systems.

The report thus raises a number of areas that may need more systematic attention if HCCs are to achieve their intended roles. Responding to the potentials and challenges in HCC functioning, and the opportunities for positive impact on health, delegates to the EQUINET regional meeting made proposals for the actions needed to improve the functioning of HCCs. These proposals are shown in *Box 2*.

Box 2: Resolutions on the role and functioning of HCCs in ESA countries

Delegates to the Regional Network for Equity in Health in east and southern Africa (EQUINET) Regional meeting on Health Centre Committees (HCCs) held in Harare Zimbabwe 30 January-1 February 2014 exchanged experiences and learning on training and strengthening health centre committees (HCCs) in the ESA region. HCCs are known by various names in these countries, but are recognised as a potentially 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, the delegate practitioners from seven ESA countries 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 to 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 ESA region;

Understanding that

- Community participation involves a range of levels, from sharing information to joint decision making and action in health systems;
- Participation demands health literacy within 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 levels in health.

We urge national authorities and all organisations working in health to

1. Include rights 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, including for 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;
- Facilitate community identification of health needs and priorities and bring this evidence to health services;
- Ensure community voice in health systems, with attention to disadvantaged groups;
- Prioritise, plan and budget services with health personnel;
- Engage 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 flexible guidance for HCC composition 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 nationwide comprehensive health literacy programmes in communities.
8. Ensure that HCCs have knowledge and capacities to implement their roles through induction and ongoing 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.
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.

The proposals for action highlight the range of ways in which the roles, capacities and functioning of HCCs can be strengthened, so that they in turn make their contribution to translating constitutional rights and /or policy commitments to social participation in health

into practice. The paper scopes the ways HCCs can contribute health and health systems, but also points to a need for a more systematic and sustained investment in the guidance, capacities and tools needed to support these roles. With the numerous institutions in the region working with HCCs, there is scope for stronger networking to build a community of practice to support work underway, to share resources and tools and review experience. Such a community of practice could also play an important role in monitoring, reviewing and exchanging on the impact such investments in HCCs are having on health systems and health outcomes, including addressing the power imbalances and determinants that lead to inequities in health.

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Abbreviations

AHC	Area Health Committee
AKHS	Aga Khan Health Services
CBOH	Central Board of Health
CEHURD	Center for Health, Human Rights and Development
CHAG	Community Health Action Group
CHC	Community Health Committee
CHEW	Community Health Extension Workers
CHF	Community Health Fund
CHMT	Council Health Management Team
CHVs	Community health volunteers
CHW	Community Health Worker
CU	Community Units
CWGH	Community Working Group on Health
DRC	Democratic Republic of Congo
EQUINET	Regional Network for Equity in Health in East and Southern Africa
ESA	Eastern and Southern Africa
GoZ	Government of Zimbabwe
HC	Health Centre
HCC	Health Centre Committee
HCAC	Health Centre Advisory Committee
HCMC	Health Centre Management Committee
HFC	Health Facility Committee
HFGC	Health Facility Governing Committee
HUMC	Health Unit Management Committee
LDHMB	Lusaka District Health Management Team
LHC	Local Health Committee
MoHCW	Ministry of Health and Child Welfare
MoHT	Ministry of Health Tanzania
MoPHS	Ministry of Public Health and Sanitation
NHC	Neighbourhood Health Committee
PHC	Primary Health Care
PHM	Peoples Health Movement
PMO	Provincial Medical Office
RDC	Rural District Council
TARSC	Training and Research Support Centre
UNICEF	United Nations Children's Emergency Fund
VHC	Village Health Committees
VHT	Village Health Technician
WHO	World Health Organisation

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care-oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair financing of health systems
- Valuing and retaining health workers
- Organising participatory, people-centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions: TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; Health Economics Unit, Cape Town, South Africa; MHEN Malawi; HEPS and CEHURD Uganda; University of Limpopo, South Africa; University of Namibia; University of Western Cape, South Africa; SEATINI, Zimbabwe; REACH Trust Malawi; Ministry of Health Mozambique; Ifakara Health Institute, Tanzania; Kenya Health Equity Network; and SEAPACOH

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