Strengthening Health Centre Committees as a Vehicle for Social Participation in Health Systems in East and Southern Africa

'Are Health Centre Committees a vehicle for social participation in health?' Regional review meeting report

Community Working Group on Health (CWGH)
with
Training and Research Support Centre (TARSC)
University of Cape Town (UCT) and
Lusaka District Health Office (LDHO)

in the
Regional Network for Equity in Health in East and Southern Africa (EQUINET)

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Contents

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Cover photo by Caiphas Chimhete: 'Group pose by participants at the regional HCC exchange visit held at Mwanza clinic in Goromonzi district, Zimbabwe'
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1. Background

Social participation in health has remained a central pillar to primary health care (PHC) in east and southern Africa (ESA). Numerous studies, policy briefs and discussion papers led and coordinated by the Regional Network for Equity in Health in east and southern Africa (EQUINET) have shown the importance of social participation in strengthening health systems. The adoption of primary health care (PHC) in all east and southern African countries means that public participation is central to the design and implementation of health systems.

One mechanism for this is through Health Centre Committees (HCCs) that involve representatives of communities and primary-care level health workers in planning, implementing and monitoring health services and activities (See TARSC, CWGH (2014) Health Centre Committees as a vehicle for social participation in health systems in east and southern Africa; Policy brief 37 EQUINET, Harare, at www.equinetafrica.org/sites/default/files/uploads/documents/EQ_Polbrief_37_HCC_2014.pdf. EQUINET has continued to explore ways of strengthening and improving the functionality of HCCs through regional sharing and networking of the various partners working with HCCs.

EQUINET held a regional meeting themed, 'HCCs as a vehicle for social participation in East and Southern Africa' from the 30th of January to the 1st of February 2014 in Harare, Zimbabwe. Among the outcomes of the meeting included to

i. Improve the legal standing and tenure of HCCs in countries by seeking all opportunities to ensure their inclusion in law,
ii. 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,
iii. 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 and
iv. Build social activism within the HCCs and local communities by putting communities at the center 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.

EQUINET through the Community Working Group on Health (CWGH) as the cluster lead for the work on social empowerment in health, in partnership with Training and Research Support Centre (TARSC), University of Cape Town (UCT) and Lusaka District Health Office (LDHO), with support from Open Society Initiative for Eastern Africa (OSIEA) have embarked on a regional programme, 'HCCs as a vehicle for social participation in health systems in East and Southern Africa' to address some of the outcomes mentioned above. This report documents the proceedings during the Regional HCC exchange visit held at Mwanza clinic, Goromonzi district on the 20th of June 2017 and the review meeting held in Harare on the 21st of June 2017. A total of 50 and 30 delegates respectively, participated with regional representation from Malawi, Zambia, South Africa and Uganda.

The objectives of the meeting included:

i. To discuss experiences with laws, policies, guidelines and constitutions on HCCs
ii. To share experiences in using Photovoice to enhance the role of HCCs
iii. To discuss current training materials and programmes for HCCs in the region
iv. To discuss strengthening of internal capacities of institutions working with HCCs through information exchange and skills inputs

The meeting included presentations, panel and plenary discussions focusing on the different areas of work designated to each of the partner organisations working in the programme.

The review meeting was preceded by the regional HCC exchange visit whose aim was to share HCC experiences through sharing of ideas and allowing for practical peer to peer exchange among HCCs and partners.

1.1 Regional HCC Exchange Visit

As part of the 'Health Centre Committees (HCCs) as a vehicle for social participation in health in East and Southern Africa' CWGH in the Regional Network for Equity in Health in East and Southern Africa facilitated a regional HCC exchange visit. The visit was done at Mwanza clinic in Goromonzi district, Mashonaland East province with the aim of the exchange visit was to share HCC experiences regarding roles and responsibilities, laws, policies and guidelines on a regional level. The exchange visit was attended by over 50 participants including partners and HCC representatives from Zambia (Lusaka District Health Office), Malawi (Global Hope Mobilization), Uganda (Centre for Health Human Rights and Development) and South Africa (University of Cape Town). Local visiting HCC representatives came from Masvingo, Kariba and Arcturus. District authorities were also part of the visit with representatives from the District Administrator's office, Rural District Concil, District Health Executive and local leaders (chief, headman and village heads).

As the host, Mwanza HCC shared their experiences and lessons learnt including challenges and successes in executing their duties and responsibilities. An opportunity was also given to regional partners and in-country HCC members to also share their experiences regarding HCC work.

District Medical Officer, Dr. Gwinji giving a brief overview of the health system in Goromonzi district

The District Medical Officer, Dr. Gwinji highlighted that Goromonzi has 292 000 inhabitants spread out across 35 administrative wards. He said that the district comprises of 3 hospitals namely, Makumbe District Hospital, Chikwaka Rural Hospital, Ruwa Rehabilitation Centre and approximately 29 clinics which are spread across the district. Ownership of these facilities is divided among rural district council, Ministry of Health and Child Care, church related and the prison services. In addition, he explained the role played by the DHE that is developing and implementing the district health plans as well as supporting the HCCs at community level. He acknowledged the important role that HCCs play in leading community health actions and ensuring that community needs are addressed by health centers.

The HCC Chairperson for Mwanza Clinic, Ms Nhapi gave an overview of the work being done by her HCC. She began by emphasizing the importance of documentation of all activities undertaken by the HCC. As part of documentation, the HCC minute book was up to date with all meetings clearly recorded. She acknowledged the importance of documentation saying as an HCC they had managed to continue the work of the previous HCC through using the previous minutes. Ms Nhapi said the major role of the HCC as the connection between the community and the health facility means that it is important to have feedback mechanisms that enable the HCCs to facilitate feedback between the health system and the community. She also highlighted that the HCCs planned and prioritized health actions within the community. She said the HCC is managing the Results Based Financing (RBF) Disbursements for the development of the clinic. She said currently the HCC is collecting information from communities through various sources such as suggestion boxes, community score cards, health literacy facilitators and HCC feedback forms. All of which are then used to compile a report for use in engaging authorities.

The HCC is also working with Health Literacy Facilitators (HLFs) whose role is to educate their communities on different health issues including rights so that the communities are more empowered on issues of health. HLFs use the Patient's Charter to raise awareness on the rights of patients and this has since become an important tool of empowering communities. These two cadres have managed to improve the health situation in their area. Mr. Munyongani the vice chairperson of the HCC narrated the story of significant change by chronicling the construction of the waiting mothers home were the HCC had to engage with the MP, Chief and the community to enable the process to be accomplished. This was an initiative that the HCC undertook after community consultations showed that women were having difficulties in travelling long distances to deliver at the facility, a situation that was leading to home deliveries and maternal deaths.

Mwanza HCC chairperson Ms. Nhapi explaining the documentation process of the HCC.

This prompted the HCC to consider and action the construction of a waiting mothers' home to enable expecting mothers to overcome this challenge. He explained how the HCC mobilized the resources necessary for the construction whereby the community molded bricks, provided food for laborers, sand for the foundation and other locally available material. The HCC used their skills acquired from training in building alliances as they managed to negotiate for free labor from the Zimbabwe National Army (ZNA).

Key discussions explored during the visit include;

Sustainability
The question of sustainability came up during discussions regarding the issue of donor funding of the different project being done by HCCs. Mwanza HCC explained that their mandate is not donor driven but instead based on volunteerism by community people in ensuring that there is communication and feedback between the community and the facility.
Political interference
Regarding political interference, Mwanza HCC emphasized that it remains a non-partisan committee hence HCC members are not nominated on political lines but rather on ability to represent the community, the HCC also works closely with their leaders such as Chiefs, Councilor and the Member of Parliament. The councilor remains as an ex-officio member.
Composition of the HCC
Mwanza HCC noted that composition of its HCC considered age and gender by ensuring that there is a balance of gender as shown with the current chairperson and there is also youth representation in the committee.
Government support
Mwanza HCC acknowledged that there is still need for more support for HCCs from government that goes beyond just policy statements to actual recognition in law and sustainable capacity building.

The visit was concluded by a site tour of the clinic including the waiting mothers' home to the visitors.

Participants being shown the Waiting Mothers Home built with support from the Community Working Group on Health

2. Opening

Mr. J. Ngirazi the Executive Chairperson of CWGH chaired the morning session by welcoming delegates and led the introductions of delegates.

Itai Rusike giving the opening remarks

In his opening remarks Mr. Itai Rusike, Executive Director of CWGH, chronicled the work of CWGH together with TARSC in advancing the importance and work of Health Centre Committees in Zimbabwe. Particularly CWGH and TARSC, through the Public Health Taskforce, developed HCC guidelines which were then adopted by the Ministry of Health and Child Care for use. This was followed by the development of the HCC training manual which was peer reviewed and adopted by the Ministry of Health and Child Care. It is through such efforts that the role and importance of HCCs in health governance has increased and today HCCs are now managing critical funds such as the Health Development Fund which is one of the largest health funds in Zimbabwe. CWGH and other partners have also been instrumental in the review of the Public Health Act established in 1924 and now out of date. The Public Health Act Amendment Bill is now waiting to be tabled in parliament for debate and adoption. The revised act will see HCCs being legally recognized thus increasing the importance of their mandate in executing their roles.

He also outlined the budget advocacy work that CWGH has done and continues to do with CSOs in Zimbabwe towards advocating for increased funding by government towards health. He cited the pre and post budget analyses produced and presented at meetings with parliamentarians done before and after the budget announcement as ways of incorporating community views in national budgeting processes. Through joint efforts in advocating for the right to health in the constitution, Zimbabwe managed to include the right to health in its constitution in 2013, however the country still has a lot to do in order to realize this right. Overall, CWGH is a strong advocate for community participation in health and strongly believes in the principles of the Alma Ata principles which push for people centered health systems. He encouraged CSOs to always document and share work being done in order to have accurate representation of their work.

3. Presentations, Panel and Plenary Discussions

3.1 Legal frameworks governing HCCs: Gaps, good practice and follow-ups

Idah Zulu, from the Lusaka District Health Office, gave a presentation on the 'Legal frameworks governing HCCs in Zambia'. She mentioned that Zambia's health reform in the 1990s was precipitated by a rapid deterioration in health care services and infrastructure and a demoralization of health staff during the 1980s structural adjustment led reforms. In 1991, government committed to building a health care system that provided "equity of access to cost effective quality health care as close to the family as possible," and made a commitment to participation of stakeholders, including local communities, in health service planning and delivery. Neighbourhood health committees (NHC) were set up in 1994 to support government efforts, in recognition that most diseases can be dealt with when the community collaborates with the health facility. The composition of HCCs was based on community selection of people from zones of a health centre to create a NHC from which a chairperson is elected to become leader for the zone. Each NHC chairperson becomes a member of a health centre committee (HCC) at the health facility. The HCC also involves health staff (community coordinators). The nurse in charge at the health centre is the secretary to the HCC and a chairperson is selected from amongst the NHC chairpersons.

Idah noted that the Constitution of Zambia provides for the right to life but not explicitly the right to health or health care; however, the National Health Services Act 1995 provided for NHCs and the principle of participation in law.

In 2006, as part of wider reforms, the 1995 National Health Services Act was repealed, removing the legal mandate of NHCs. The NHCs continue to function drawing their mandate from respective national health strategic plans and from guidance in the annual planning and budgeting handbooks. However, Idah was of the opinion that the new Health Services Act in Zambia should bring back the legal mandates of the HCCs and NHCs, with clear guidelines for HCC functionality. In advancing the legalisation of HCCs, LDHO has held country consultations from community to national level with various key structures including NHCs, HCCs, provincial medical officers, district medical officers and CSOs in collecting inputs that should be considered in reviewing the Health Services Act in order to have the inclusion of HCCs.

Idah Zulu giving her presentation

Idah's presentation led to an interesting discussion among delegates. People agreed that in Africa gains tend to be lost after every national election when there is a change of government, hence the need to devise a means of ensuring continuity of good policies and laws. The repealing of the law in Zambia raised a number of questions related to the role/s communities can play in ensuring their rights are not overturned. This includes strengthening relations with the relevant line ministries and members of parliament. Delegates agreed that interventions at community level continue to change lives of communities for the better but more needs to be done to ensure national level accountability. Hence the need to have a well-defined strategy for resolving issues using a 'bottom up approach' through clear lines of accountability.

The meeting reaffirmed the importance of including the right to health in our constitutions and, based on this constitutional right, in moving from policy to law. This was especially important in relation to the composition and roles of HCCs. Delegates stated clearly that they want a stand-alone law for HCCs.

The power dynamics behind the Ministries of Health was also questioned , especially in relation to their weak influence in ensuring health is prioritised and reflected in the national budget. The influence of the private sector in health was also discussed with delegates agreeing that this ever growing influence was not good as it would result in less access to healthcare as health would become privatised.

3.2 Capacity building of HCCs

Prof. Leslie London from the University of Cape Town gave a presentation on findings from the regional audit of HCC training. The main objective of this work was to map activities and approaches that provide capacity building for structuring community participation in different countries in the region. Thirteen organisations from seven countries - namely Ethiopia, Kenya, South Africa, Tanzania, Uganda, Zimbabwe and Zambia - responded to a questionnaire. The audit covered a number of aspects of training, including content of training, facilitators, sustainability, approaches and methods.

The audit noted that content of HCC training commonly covered issues related to governance, accountability, monitoring, problem solving, the national health system, planning process in the health system, social mobilisation, with less on conflict management, fundraising, intersectoral work, home-based care, political economy of health and vulnerable groups. Leslie highlighted that manuals and materials developed in most cases are not readily available for sharing on the web, hence the need to have a clearing house. Training varies with some training being done by project staff that have knowledge in PAR in collaboration with Ministry of Health staff.

Leslie went on to mention that most training is dependent on donor funding with very few respondents citing government support. One of the respondents was quoted as saying "… Not mainstreamed, usually conducted as project based, therefore not sustainable …" Most common methods of training is done through peer training and learning and refreshers with less of training of trainers with a variation in training days of between 1 – 5 days but most commonly 2-4 days. Duration is also dependent on the availability of funds thus if funds are available the training is longer. The training largely draws from participant experiences in plenary and group work. Some of the training manuals use participatory approaches such as social mapping, Margolis wheel, spider diagram and spiral models).

Respondents cited some successes as resulting in empowered communities that are able to solve health issues using their knowledge and experience. The HCCs trained have managed to implement skills such as communication skills, health planning with the involvement of the community, improved interaction between health workers and community, increased utilization of services at the health center and increased resource mobilization. In the instances where HCC training is complemented by health literacy and human rights empowerment of communities, effectiveness of HCCs has increased as these communities have shared information on key health risks and violations of health rights.

Despite such successes, there are still quite a number of challenges faced such as the inability to reach all HCC members for training and the requisite follow-up monitoring of these HCCs to check on execution of their duties and responsibilities. High turnover of HCC members with volunteers losing interest because of no incentives has often led to an increase in the need to re-train. Government failure to recognize and

support HCCs has led to high donor dependence on funds to conduct training. In his conclusion, Leslie noted that availability of materials needs to be improved and 'novel' methods of training such as theatre and photovoice need to be explored further.

In the plenary discussions following Leslie's presentation, delegates recommended the following:

- Government/policy support at higher levels is important to ensure training and follow up is consistent and sustainable, especially since most training is donor funded. It is of concern that the number of training days and the content of training is often compromised due to lack of funding and/or unclear policies in relation to HCCs
- Training needs to be diverse, adapted to local conditions. The context of the training influences the content of the materials. Using cultural references can deepen the quality of the training
- Sharing training materials and experiences is important
- Training can drive policy; we can't wait for those at the top to implement, we need to 'rabble-rouse' from below.
- The success of HCCs depends on a strong grassroots base, as shown in countries like Brazil
- There needs to be some discussion on when to do HCC training, especially important for new HCC members
- Organizations involved in HCC training need to be wary of new programmes that may undermine the role of HCCs. CWGH noted that the introduction of Results Based Financing has confused the role of HCCs. This has happened because most of the HCCs in Zimbabwe were formed in order to manage RBF funds and not necessarily to carry out their roles and responsibilities. HCCs that were formed because of RBF only received training in handling finances and carrying out standard operating procedures for using RBF funds.

3.3 Photovoice as a tool to strengthen HCC roles

Barbara Kaim presenting on the photovoice programme

Barbara Kaim from the Training and Research Support Centre (TARSC) gave a presentation on 'Using Photovoice to strengthen HCC roles in ESA' She defined photovoice as being a participatory action research (PAR) strategy that puts the camera into the hands of people of all ages and status, and usually those who are disempowered. She explained that both the process of taking photographs and the way they are used can deepen people's understanding of their situation, promote dialogue between themselves and with others, and motivate action. She pointed out that photovoice is based on the belief that communities have a wealth of knowledge and experience to draw on and that the photovoice process is a creative, catalytic way of generating that knowledge. It can shift the power dynamics between the researcher and the researched and it attempts to counter the danger of 'the single story.'

Under the current project, eight HCCs in three countries are using photovoice to explore whether this approach can be used as a tool to support the negotiating power of HCCs, especially in terms of planning and budgeting. The focus is specifically on exploring how people's lives are impacted by poor access to water, sanitation, housing, etc - ie the social determinants of health (SDH) - and whether the use of photographic images can support HCC demands for action to be taken to resolve these problems. Since the start of the programme, TARSC has facilitated a training of trainers in Harare (Sept 2015), followed by an in-country training of HCC members (early 2016) and then 2-3 cycles of HCC photographers taking photos, with regular reviews. This will result in the development of a communication tool for policy engagement and finally a synthesis report documenting learning & recommendations.

Participating HCC representatives from South Africa, Zambia and Zimbabwe presented some of the photographs they have taken and used to engage their communities and authorities. The images powerfully showed that access to water, poor waste disposal and inadequate housing are impacting on the health of communities in all eight sites as shown in the photos below.

Waste dirties our environment
Photo by LDHO Zambia HCC photographer

Clean water from a burst water pipe, now polluted. Masvingo.
Photo by Entrance Takaidza, HCC photographer,

Doctor Behind Bars: Crime is a huge problem in our townships. Photo by Nceba Magoxo, HCC photographer, South Africa

Soaring through the air: We make a plan with what we have.
Photo by Mfundo Chimarilo, HCC photographer, South Africa

Following the photo displays, representatives from South Africa (Nceba Magoxo), Zambia (Idah Zulu and Manzunzo Daka) and Zimbabwe (Mavhuto Katimbe and Prosper Muzambi) participated in a panel discussion hosted by Barbara Kaim. They explored together questions such as how they have used the images to date, whether they see Photovoice as an empowering process, and whether it has improved engagement with community members and authorities. They also discussed their overall successes and challenges.

The panel discussion was rich with stories and insights. In summary, panelists have used, and continue to use, photos generated from the Photovoice programme in a variety of ways – sending pictures showing

burst water pipes and uncollected garbage to a WhatsApp group that includes decision makers (Rujeko HCC), producing a booklet for dissemination, distributing photos during meetings with authorities. Panelists agreed that the process has not always been easy, but has been rewarding, especially in improving HCC member relations with community members and with local authorities.

There were a number of examples (from Rujeko, Arcturus, Lusaka) where photos helped move local authorities to take action in dealing with, for example, burst water pipes or uncollected garbage and some evidence that HCCs are being given greater access to clinic and/or council meetings. The group was unanimous that photovoice can be an empowering process. It gives the HCC an effective tool to use when negotiating with authorities - the photos provide concrete evidence to back up their concerns with regard to specific health hazards in their community.

The panelists also noted that photographs need to be shared both upstream, with local authorities and decision makers, and downstream, with community members, for greatest impact. Community discussion, using photos as a trigger, is important in deepening their understanding of root causes and in empowering them to take action and to act as a pressure group in ensuring local authorities meet their obligations. Photovoice is working most effectively in communities who were involved in the Health Literacy programme, reinforcing the belief that an organized, health literate community that already has experience in engaging with authorities is important.

There are other challenges. Taking photographs in politically sensitive areas can back fire, as happened in South Africa where police told the photographers to delete all the photos they had taken. Unequal power dynamics between unresponsive authorities and community can hinder HCC members' abilities to have input into budget and decision making processes. Poverty is a further constraint.
In looking ahead, panelists said that they want to consolidate what they are already doing in their respective areas, and document the process and learning. In the long term, all 3 countries said that they were keen to expand the number of HCCs using Photovoice, integrating it into existing activities.

3.4 Strengthening of internal capacities of institutions working with HCCs

Edgar Mutasa presented on the networking experiences of CWGH with other civil society organizations in working with HCCs. He began his presentation by outlining the history of work done by CWGH regarding advocating for the recognition of HCCs and capacitating them on their roles and responsibilities. Over the years CWGH has become synonymous with community participation especially through HCCs. He emphasized that in addition to the HCC and HLF training manuals, CWGH has also made use of HCC exchange visits and community feedback mechanisms as key activities for strengthening the role of HCCs.

CWGH embarked on capacitating HCCs with community feedback mechanisms with Save the Children in all the provinces across Zimbabwe. This partnership titled, 'Strengthening Community Participation in Health' saw HCCs being capacitated on how to collect, collate and report data for engagement with authorities. The focus was on Maternal, Newborn and Child Health (MNCH) with some key indicators such as availability of medicines, staff attitudes, timely referrals and health rights knowledge among communities. Collection of information was done through suggestion boxes, community score cards, health literacy facilitators and HCC feedback forms. Information from these sources would then be synthesized into a report and used to engage the relevant authorities regarding all the issues raised.

Key achievements from these mechanisms include HCCs creating and strengthening platforms for communities to dialogue with Health Service Providers and their representatives demanding accountability. Also HCCs have managed to facilitate improvements in working relationships between communities and health personnel (nurses). HCCs have improved their skills and attitude towards their work through receiving community feedback on their performance. Authorities from the Ministry of Health and Rural District Councils are continuing to critically review health practices and strategies at primary and secondary levels of care through the use of evidence generated by HCCs.

There is need to further explore the impact of community feedback mechanisms as has been implemented during the 'Strengthening Community Participation in Health' project. CWGH has also done collaborative work in building the capacity of HCCs; Training of Health Literacy Facilitators (HLFs) in farm worker communities with General Agricultural Plantation Workers Union (GAPWUZ), Training of HCCs with Family AIDS Caring Trust (FACT) and training of HCCs on Palliative care with Island Hospice and Healthcare.

3.5 HCC Experiences from Uganda and Malawi

Nakibuuka Musisi from the Centre for Health Human Rights and Development (CEHURD) in Uganda gave a brief overview of the work of Health Unit Management Committees (equivalent of HCCs). She said, although Uganda has guidelines that state the roles and responsibilities of HUMCs, their functionality is affected by quite a number of challenges. There seems to be a disconnect between the guidelines and the governance structure which may be due to the fact that there is no requisite legislation to enforce the functionality of HUMCs. Policies are not law in the country. Among the communities there is limited knowledge on the roles of HUMCs as a strategy for their involvement, thus leaving a gap for communities to hold legislators accountable.

Nakibuuka Nor Musisi stressing a point during deliberations

Caleb Thole from the Global Hope Mobilization (GLOHOMO) in Malawi said Health Centre Advisory Committees have been in existence for quite some time but lack the backing of the law. However GLOHOMO and other CSOs are trying to advocate for an increased governance role of these committees so they can demand greater accountability, leading to improvements in quality services.

4. Conclusions and Closing Plenary

The closing session was chaired by Tafadzwanashe Nkrumah. It was agreed during the closing plenary that HCCs continue to be a strong mechanisms for social participation as evidenced by the work they are doing throughout the East and Southern African region.

Are HCCs a vehicle for social participation in health?

- HCCs continue to mobilize resources for the development of Clinics
- HCCs have managed to facilitate improvements in working relationships between communities and health personnel
- HCCs have managed to dialogue with, and demand accountability from service providers
- HCCs get feedback from the community regarding resources and services (such as quality including availability of staff, availability of medicines, staff attitudes etc) being offered and they also send information to communities from the clinic thereby contributing to improved health.
- HCCs have created an opportunity for women to be involved in decision making structures
- HCCs continue to facilitate sharing of cultural practices
- HCCs have managed to strengthen governance for health by creating synergies for supporting the health system from sector ministries, departments and organisations i.e. ministries in charge of roads, communication, energy and water etc
- HCCs continue to stand as a governance structure with representativeness of all social groups in the community drawing its mandate from the communities they represent.

Emmanuel Kamonyo presenting on the support and work of OSIEA

Emmanuel Kamonyo, representing Open Society Initiative for Eastern Africa (OSIEA), commended the work done so far under the programme saying one of OSIEA's focus was on social accountability. He highlighted that funding had come to the consortium to encourage cross-learning of social participation between East and Southern Africa. He said OSIEA has since changed focus from social accountability to governance for health which is in line with their new strategic direction.

Going forward, Tafadzwanashe said the processes in this project would contribute towards promoting and realizing shared values of equity and social justice in health. Using a country experience approach, there will be guidelines regarding training material focusing on topical issues especially the contentious headings which include elections, representativeness, key roles and responsibilities of HCCs.

The aim is to post the training tools on a website and have a user friendly narrative that will help visitors navigate – this will be an online resource. The guides will extend to development of laws for HCCs and using photovoice to enhance the roles of HCCs.

Expected outcomes of the programme;

- Information exchange, dialogue in the network and skills inputs towards the strengthening of HCCs and internal capacities of institutions working with HCCs.
- Documented learning experience on improved legal standing and tenure of HCCs in countries: This will be a result of established policy and guidelines: Increased information sharing 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; To be achieved through information exchange on existing policies in the region.
- Production of HCC training resources including tools for use as reference and guides in the ESA region; UCT and partners will draft a training guide for use in the region.
- Documented learning experience of photovoice enhancing a tool to support the negotiating power of HCCs, especially in terms of planning and budgeting.

In closing, Idah Zulu gave the vote of thanks, expressing gratitude towards OSIEA, who has given financial support for the programme and especially the review meeting. She encouraged everyone to continue with the hard work and unity of purpose in ensuring that equity and justice in health is realized urgently.

Appendix 1: Meeting Programme

TIME	CONTENT	SESSION PROCESS	FACILITATION
08.30 – 09.00	Registration	Participant registration	CWGH secretariat
Welcome, Objectives and Overview		**Session Chair: Mr. J. Ngirazi**	
09.00 – 09.10 09.10 – 09.30	Introductions Institutions in the partnership	• Delegates • LDHO, TARSC, UCT and CWGH • OSIEA	 Representatives of organizations
09.30 – 09.35	Opening Remarks	Welcome Remarks	Mr. Rusike – Executive Director, **CWGH**
09.35 – 09.40	Objectives	Objectives of the meeting	Mr. Tafadzwanashe Nkrumah - **CWGH**
09.40 – 10.00	Policy/legal recognition and guidelines for HCCs in Zimbabwe.	**Health Centre Committees**: National Policy and Guidelines	Mr. S. Banda – Director **Department of Policy and Planning, Ministry of Health and Child Care**
10.00 – 10.20	Legal frameworks governing HCCs: Gaps, good practice and follow-ups	Zambia's experience with laws, policies, guidelines and constitutions on HCCs. Does Zambia have the right to health in the constitution? What has been the collective influence and advocacy from stakeholders towards ensuring the inclusion of the right to health in the constitution? How far have countries gone in implementing the right to health? Is there HCC recognition in the acts and statutes? What is the current functionality of existing guidelines in countries?	Ms. Idah Zulu - **Lusaka District Health Office (LDHO)**
10.20 – 10.40	**Plenary Discussion**		
10.45 – 11.15	**TEA**		
Sharing experiences in HCC work		**Session Chair: Tafadzwanashe Nkrumah**	
11.15 – 11.45	Capacity building of HCCs	What are the current training materials and programmes for HCCs in the region – What were the results of the HCC audit using the mapping tool?, Presentation of draft guidelines for capacity building of HCCs? – focusing on the topical issues i.e. working with communities, working with health workers, building alliances for health, planning and budgeting.	Prof Leslie London **University of Cape town (UCT)**
11.45 – 12.15	**Plenary Discussion**		
12.15 – 13.15	**LUNCH**		
13.15 – 15.00	Photovoice	Share experiences in using photovoice to enhance the role of HCCs: Country experiences i.e. Zambia, Zimbabwe and South Africa,	Barbra Kaim **Training and Research Support Centre (TARSC)**

		How has been the experience of HCCs in using photovoice? i. Acceptance by authorities and the community ii. Examples of change that has happened to date iii. Challenges in implementation	
15.00 – 15.15	**Plenary Discussion**		
15.15 – 15.35	**HCC Experiences from Uganda and Malawi**	Regional experiences from Uganda and Malawi on the work of Health Centre Committees.	Ms. Nakibuuka Nor Mususi –**Center for Health, Human Rights and Development (CEHURD)** Mr. Caleb Thole **– Global Hope mobilization (GLOHOMO)**
15.35 – 15.45	**TEA**		
15.45 – 16.00	Strengthening of internal capacities of institutions working with HCCs through information exchange and skills inputs	The Zimbabwean context: How many collaborative efforts have been achieved among stakeholders in building the capacities of HCCs. What forms of Mechanisms have been established for sharing and addressing community health problems by, and among HCCs	Mr. Mutasa – **Program Officer CWGH**
16.00 – 16.30	**Plenary Discussion**		
16.30 – 16.45	Follow up work – phase 2 Way forward	Opportunities for further collaboration and support for the regional work on HCCs.	Emmanuel Kamonyo – **Open Society Initiative for Eastern Africa (OSIEA)** Mr. T. Nkrumah – **Program Officer CWGH**
16.45 – 17.00	Vote of Thanks		Ms. Idah Zulu - **Lusaka District Health Office (LDHO)**

Appendix 2: Participant list

Name	Sex	Organization and Contact Details
Eunice Chidawa	F	CWGH Secretariat
Raymond Yekeye	M	CWGH Secretariat
Prosper Muzambi	M	HCC Rujeko Masvingo
Idah Zulu	F	LDHO
Samson Coffee	M	CWGH Kariba
Dana Mwachande	M	HCC Acturus Mine clinic
Entrance Takaidza	F	CWGH Masvingo
Barbara Kaim	F	TARSC
Emmanuel Kamonyo	M	OSIEA Nairobi, Kenya
Itai Rusike	M	CWGH Secretariat
Katimbe Mavhuto	F	CWGH Acturus
Tafadzwanashe Nkurumah	M	CWGH Secretariat
Manzunzo Daka	M	LDHO – NHC
Caiphas Chimhete	M	CWGH Secretariat
Mutasa Edgar	M	CWGH Secrtariat
Faith Kowo	F	CWGH Secretariat
Caleb Thole	M	Global Hope Mobilisation Malawi
Penelope Mandeya	F	CWGH Secretariat
Tanayaradzwa Munouya	F	CWGH Secretariat
Nakibuuka Noor	F	CEHURD
Nyaradzo Mashayamombe	F	Tag A Life International
Nceba Magoxo	M	University of Cape Town