The Role of Health Committees in Equitable, People-centred Health Systems in the Southern and East African Region

University of Cape Town
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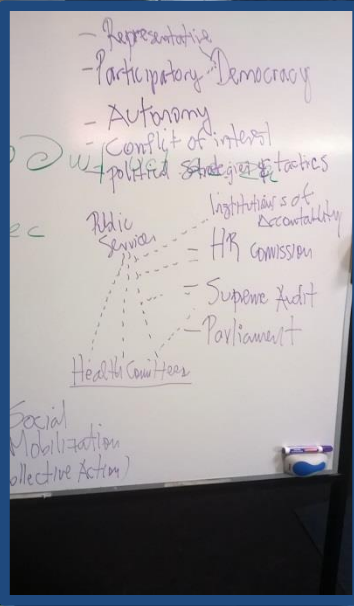

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Summary

A two-day consultation on health committees as vehicles for community participation was held in Cape Town on September 27th and 28th 2014 prior to the 3rd Global Health Systems Research Conference. The meeting, funded by the International Development Research Council (IDRC Canada), had 38 participants from 12 countries of which nine were African countries. The meeting build on previous regional networking to share experiences of health committees as vehicles for community participation from countries across the globe. The discussion focused particularly on health committees in the African region, but benefited from considerations of experiences from other countries of the South (Guatemala and India). The discussions also reaffirmed the importance of health committees for Health System responsiveness and highlighted the importance of health committees as autonomous structures able to enhance democratic governance of health systems through monitoring and evaluation of health service performance and holding the state accountable. This applies irrespective of how services are delivered. To achieve this, it is critically important for health committees to be capacitated to fulfil this role through appropriate training, health systems design and sustainable support. Government should recognize the importance of health committees for their health systems, and invest appropriate human and financial resources to ensure functional health committees. Such investments are part of state obligations with respect to realising the Right to Health. Further, strategies must be developed to obtain buy-in of health workers, managers and policy-makers in supporting meaningful participation by health committees.

The meeting committed to strengthening regional networks between countries of the South for advancing health committees as vehicles for community participation. Governments must recognise and incorporate health committees into their health systems in ways that maintain their roles as autonomous agents for democratic governance. Furthermore, the WHO should provide guidance on inclusion of health committees in Health Systems Governance. Current discussions on updating the WHO Building Blocks approach could benefit from recognising the role of collective community action through health committees.

Background

The Learning Network for Health and Human Rights, in conjunction with CEHURD (Centre for Human Rights and Development) and the Regional Network on Equity in Health in Southern Africa (EQUINET) hosted a 2-day regional consultation on the Role of Health Committees in Equitable, People-centred Health Systems in the Southern and East African region. The regional consultation, funded by a grant from the International Development Research Council (IDRC), took place from 27 - 28 September 2014 at the University of Cape Town, South Africa and preceded the 3rd Global Symposium on Health Systems Research held in the same city from 30th September.

The aim of the meeting was to share experiences of community participation in health systems governance through health committees in South and East Africa (see Appendix 1 for the invitation notice). The focus of the consultation was on health committees as a strategy for realising the right to health and strengthening health systems in different contexts. The consultation built on previous meetings by the different partners in Kampala and Kiboga (Uganda) and Harare (Zimbabwe) over the previous four years[1]. The consultation included a diverse range of participants, including civil society organisations, researchers and health committee members with participants from a wide range of countries – mainly South and East Africa – but also from Tunisia, the United Kingdom and the United States of America. Participants were drawn from those previously attending regional meetings as well as attendees of the Global Health Systems Research meeting in Cape Town which followed the consultation (see Appendix 2 for list of participants). A limited amount of funding was available to support some participants from the Southern and East African region.

The consultation was organized around an opening address, a panel presenting experiences in the region, an input from India about health committees in India and extensive sets of group discussion (see Appendix 3 for the programme)[2].

1. Walter Flores: The Role of Health Committees in Advancing Democratic Governance

The meeting was opened by Walter Flores from the Centre for the Study of Equity and Governance in Health Systems (Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud- CEGSS) in Guatemala. CEGSS is a civil society organisation that undertakes research, advocacy and capacity building around social participation, public health policies and the right to health in Guatemala, mainly in municipalities with large percentages of indigenous populations. This work has led CEGSS to work with the Ministry of Health at the national level, providing technical assistance in the design and implementation of institutionalized community monitoring. CEGSS is one of a number of civil society organisations (CSOs) supporting communities in Guatemala to engage with state entities to ensure the fulfilment of their health rights.

Flores defined health committees as voluntary community-based groups engaged with local health services and authorities and outlined three paths that define their formation and function:

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[1] Reports can be downloaded from www.salearningnetwork.weebly.com
[2] Presentations can be downloaded from wwwsalearningnetwork.weebly.com

a. Aiding in the delivery of services to deal with epidemics through a more horizontal organisation (rather than the classical highly vertical health structures). This is a common civic task that is both legitimate and useful;
b. Decentralisation has led to the transfer of responsibilities to local governments (as part of a wider reform strategy of reducing the size of the state and public funding);
c. Democratisation has mandated constitutional reforms that establish laws and norms for engagement of citizen representation in public spaces to control public services. This involves participating, as autonomous citizens, in the planning, monitoring and evaluation of public services as a right. This is a right that is recognised in right to health conventions and the legal framework of many countries.

These definitions differ in several respects, such as the level of participation in decision-making, the formation and composition of these structures, roles and responsibilities as well as the level of autonomy. Health committees exist at different levels of organisation and there is variability in the level of participation in decision-making, whether members are appointed or elected, in legislation stating their specific roles and responsibilities as well as the degree of autonomy to generate their own activities and processes. For example, in the first model, there is no decision-making by communities and they are appointed by authorities. In the third model, health committees are elected by communities and have a lot of autonomy to define their activities. This results in differences in the legislation and laws that state the roles and responsibilities of health committees. Flores further noted that all these roles may exist in the same country, they may overlap and there are different and sometimes conflicting views of the role of communities and the types of health committees that exist. For example, in Guatemala, health committees are part of aiding in the delivery of services and are organised and controlled by municipal authorities, while citizens' health councils (part of democratisation) are autonomous from authorities, with community elected representatives. These variations create confusion amongst communities regarding their role and also create tensions with service providers, who question the accountability role played by health committees and ask questions about the utilisation of resources. Sometimes the authorities are unaware of legislation relating to social participation because it is not promoted.

Flores emphasised that the democratic model was preferable as this model can advance social participation and the right to health. Here communities play a role in governance of health services in order to improve the responsiveness of health services to community needs by demanding accountability and appropriate use of public resources. In this sense, health committees are vehicles to strengthen democratic governance; to support rights with an emphasis on equity and participation in decision-making and including marginalised populations.

Legal Frameworks and Health Rights

The discussion, which followed Flores' presentation, highlighted that while a legal framework is important, it is insufficient to ensure democratic governance in health. Firstly, there needs to be active facilitation and support of structures to function (handholding), otherwise these structures risk being captured by elites, controlled by political decision-makers and conflicting interests. Challenges often

stem from poor implementation. Secondly, different stakeholders are required in health committees to represent different expertise. Thirdly, it is critical to create awareness in communities regarding how they can engage with service providers so that health committees are able to adopt autonomous decision-making.

Thus, while it is better to have a legal framework, on its own, this does not ensure meaningful participation. For example, authorities might say they support community structures, but don't want to give away power in practice (which is what is required in community governance). As a result, there is a lot of resistance that requires communities to fight for these spaces and dismantle barriers. Rights cannot be taken for granted, but needs to be fought for.

Community participation through health councils in Guatemala

In Guatemala, there are several Constitutional provisions, which allow for communities to engage with authorities and state institutions - Parliament, National Ombudsman, etc.. Despite this seemingly progressive environment, many of these provisions are not implemented and many barriers continue to limit citizens' participation in practice. Community decisions have control over a very small proportion of the national budget and are heavily influenced by the individual interests of politicians, resulting in conflicts of interests (with community needs) and corruption.

These barriers have two consequences: Either people lose interest and trust in the system, thus withdrawing their involvement. Alternatively, people fight for these spaces. The latter has been the predominant strategy in Guatemala in the last 10 years. This has involved working with health councils (or health committees), using right to health and health literacy frameworks as well as other frameworks and processes that require communities to measure their level of organisation and the role they are playing in communities. Capacity building is another important component, involving rights literacy and entitlements. The next step is then to assist communities to develop tools (in-depth interviews and surveys) which they use to collect data, which they then analyse and use to engage with authorities about gaps in service delivery.

Community accountability creates tension with authorities (who are often not aware of the legislation) as communities start asking authorities questions about public services that authorities are not comfortable with. However, accountability is not the only objective of health committees. Working together with local authorities to address issues at a higher level and demand the mobilisation of more resources to municipalities is also an important strategy. This requires different strategies for social mobilisation in order to open up spaces for community engagement. For example, communities can approach Parliament (especially parliamentarians from the opposition parties) to open up spaces and make presentations or they can hold press conferences to pressure authorities to take heed of community priorities.

In engaging with authorities, particularly at higher level, communities may be asked to produce hard evidence to support their concerns. Two ways were outlined in which communities are able to do this, whilst overcoming the barrier of long distances. One method involves community members being taught to make video recordings and take photos as evidence. Another is the development of monitoring tools

through SMSes that are reported to a central geo-referenced map, which is communicated with authorities. Transport and lunch stipends are provided when health committee members leave their local areas to attend meetings and other engagements. This is important to ensure that communities represent their own interests and are not represented by NGOs. Flores pointed out the importance of capacitating health committees to be able to engage with Parliament and judiciary system. Local issues are often linked to broader problems higher up in the health system, thus a requiring a broad strategy that addresses issues at all levels.

Successes and Challenges

Initially, lack of understanding of the importance of community participation led to authorities resist and reject the idea of participatory decision-making. Also, informing communities about how resources are being misused results in demands for improvements in service delivery. Often this has resulted in adversarial and confrontational relationships. However, a good working relationship has now been created between communities and authorities in Guatemala (as channels of engagement have been opened up) and authorities and communities representatives are jointly monitoring the use of resources and the performance of health care services. This has resulted in authorities joining communities in demanding a better allocation of resources (medicines, emergency transport, etc.) from higher levels. However, there is a constant power struggle because some authorities and health providers remain negative about an autonomous engagement of communities in the health services.

Some issues such as maltreatment of patients, opening hours, informed consent, culturally sensitive services, can be addressed at the local level. However, issues that are more structural, such as the lack of medicines, equipment, supplies, lack of personnel and infrastructure, need to be addressed at higher levels. Health committees tend to be located at the municipal level and this limits their ability to deal with higher-end issues. There is a need for continued strengthening of the knowledge and skills of communities to equip them to engage with the state institutions as well as other human rights bodies / organisations in order to demand democratic governance structures. Thus health committees have an important role to play in the creation of democratic (participatory) governance spaces.

2. Panel Discussions

The meeting proceeded with three panel presentations to reflect on the experiences of community participation in the region. Firstly, Veronicah Masanja, a health provider and health committee member working with the Centre for Health Human Rights and Development (CEHURD[3]) spoke about the challenges facing community participation in Uganda. Then, Tatenda Mutasa spoke to capacity building with health committees based on Zimbabwe's experience. Lastly, Professor Leslie London elaborated on the policy challenges facing work in South Africa.

2.1 Veronicah Masanja: The Politics of Community Participation in Uganda

[3] CEHURD (Centre for Health Human Rights and Development) is a civil society organisation based in Uganda. It is a non-profit organisation that undertakes research and advocacy aimed at the enforcement of human rights and the right to health in Eastern Africa. CEHURD was formed to contribute towards ensuring that laws and policies are used as principal tools for the promotion and protection of health and human rights.

Veronicah Masanja spoke of her experience as a member of a health committee in her locality where she is part of CEHURDs work on strengthening community participation in Uganda.

She explained that health committees are supposed to monitor services in facilities (such as drugs supplies and distribution) and act as a link between the community, health care providers and local government. They are also supposed to be involved in planning, budgeting and monitoring action plans. Health committee members are supposed to be selected by sub-county boards, and approved by the local councils. Health committees are not involved in the selection process.

However, there are many problems in practice. Few health committees are involved in planning, budgeting and monitoring action plans and the appointment of committees lacks democratic practices. There is limited participation from committee members or the community. Often, local councils have not approved the committees. Moreover, according to the guidelines, members are not supposed to hold political positions, but the guidelines are not followed and people are selected according to individual interests (rather than what the community wants). She noted that although she is a health provider, she holds the position of secretary in her health committee even though the formal policy is that providers can only be an ex officio member. This is a conflict of interest as health providers will not hold themselves to account as is expected of health committees.

Also, many committee members are civil servants and they form cliques when voting takes place. Thus, health committees are driven by government interests and communities are not well represented. Moreover, political leaders who serve on the committee focus on prioritising electoral politics and the need to secure more votes. This highlights the problem of members not balancing various interests (political interests, health committee interests and health provider interests), but rather putting their own interests first.

Furthermore, the criterion for selection to a committee is not known and members don't know about selection until they are told that they are now part of a committee. Health committees are not recognised by higher bodies other than the people who select them. Indeed, the mandate of health committees is not known by most and health committee members are not known to the community. Hence, they tend to represent the government and not the community they are supposed to serve.

Civil society organisations are now getting involved in training health committees on their roles and how to carry out these. As health committees are unclear about their role, they are also unclear of their monitoring function. So the question is what health committees can do to redirect resources towards their interests? Civil society is helping in advocacy activities to protect peoples' rights, but these programmes need to go beyond awareness-raising. Another problem is a lack of funding. Neither health committees nor facilities have budget earmarked to support the work of health committees and the funds of health facilities are limited. Funds to reimburse people for costs incurred are therefore limited and often do not cover costs. This results in absenteeism and fewer meetings as it becomes a challenge for people to attend meetings.

In short, although guidelines exist, they are poorly implemented and there is poor support provided. These obstacles result in poor attendance. Furthermore, health committees have to operate with conflicts of interests and particular agendas of individuals selected for political reasons.

2.2 Tatenda Mutasa: Capacity Building - Zimbabwe's Experience

Tatenda Mutasa from the Community Working Group on Health (CWGH[4]) spoke on Zimbabwe's experience with a focus on capacity building for health committees.

In Zimbabwe, health committees are perceived as mechanisms for community involvement in health service planning at the local level. Mutasa outlined the role of health committees as identifying priority health problems with communities, planning how to raise their own resources, organising and managing community input and advocating for the availability of resources for community health activities and inputs. Health committees discuss community health issues with health workers at health committee meetings and report on community grievances about the quality of health services to health authorities. In Zimbabwe, health committees are supported by the National Health Strategy 2009 – 2015, which involves a commitment to reinvigorate primary health care and to support community participation in health.

CWGH has undertaken training on health literacy, which refers to people's ability to obtain, interpret, and understand basic health information and health services - and to use such information and services in ways that promotes their health. This programme places people at the centre of health care and builds core public health skills and creates a forum for dialogue, learning, sharing of information and experience as well as critical analysis in health. The aim is to build knowledge and perspectives, shape effective strategies, and strengthen the community voice at all levels, while also building strategic alliances to influence policy and practice towards health equity and social justice. This is premised on building skills and knowledge to raise the community voice and translate knowledge into action. Training on the roles and responsibilities of health committees has also been undertaken to build capacity and technical support to engage health providers and communities in the east and southern Africa region.

CWGH has also developed advocacy on the right to health, including motivating for the inclusion of the Right to Health, now enshrined in the new Zimbabwean Constitution. Other training provided by CWGH through on-going support and training programmes include Financial Management and Results based financing (RBF), monitoring tools (in consultation with communities through health committees), to ensure community ownership and involvement in accountability and community scorecards. The latter were developed jointly with communities to systematically monitor performance management in order to hold authorities accountable for health service provision.

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[4] The Community Working Group on Health (CWGH) is a civil society organization in Zimbabwe that has implemented several programmes aimed at improving accountability in health, by providing technical leadership in strengthening health committees. This includes the development of guidelines to inform on the functioning of health committees, including formation (where members are elected and not appointed), composition as well as roles and responsibilities

Health committee training also includes the capacitation of health providers (to be responsive to health committees). MOU's (Memoranda of Understanding) with various government ministries and parliamentary bodies, who also make presentations on materials and work done, has resulted in a relationship of mutual respect with the authorities.

2.3 Leslie London – Health Committees: Vehicles for Realising the Right to Health in South Africa?

Leslie London presented on the experience of the Learning Network for Health and Human Rights[5] working with health committees with a focus on policy challenges for community participation.

The history of community participation structures in health in South Africa can be traced back to the 1980s when there was strong engagement in the health sector by the anti-apartheid movement, principally under the National Progressive Health Care Network (NPPHCN). In the 1990s, the Cape Metro Health Forum was established as a structure for inclusion of communities into public governance structures in health and in 1997, the White Paper on Transforming the Health Services was issued, outlining a strong role for community oversight in the new health system. In 2003, the National Health Act was adopted and, and in 2013, a national draft guideline on health governance structures was proposed by the Department of Health.

The White Paper on Transforming the Health Services aimed to promote active public participation in health after South Africa's democratisation in 1994. This paper saw health committees as a mechanism to improve public accountability and facilitate dialogue. Health Committees should enable the public to participate in the planning and provision of health services, establish communication between health services and communities as well as ensure accountability (monitor progress made towards decisions on actions to be taken). It is clear from this background that health committees were intended to function as governance structures that hold the services accountable.

In contrast, the National Health Act of 2003 said very little about health committees (describing only the need to establish committees linked to facilities or groups of facilities, and an outline of their minimum composition, Section 42). It left definition of health committees' roles and powers to Provincial legislation. Moreover, unlike the intent of the White Paper, the NHA provided no articulation with other governance structures (e.g. District Health Councils). This has resulted in a policy hiatus. In the Western Cape, for example, a draft policy for health committees was produced in 2008, with a strong governance role, but it was never adopted and was abandoned in 2012 at the same time as financial support for health committees (to cover transport, venues, reimbursements) was withdrawn. The process of

[5] The Learning Network is a participatory action research collective of five civil society organisations (The Women's Circle, Ikamva Labantu, Epilepsy South Africa, The Women on Farms Project and the Cape Metro Health Forum) and three higher education institutions (University of Cape Town – the Health and Human Rights Programme in the School of Public Health and Family Medicine, University of the Western Cape, and Maastricht University, in the Netherlands) that collaborate to explore how collective action and reflection can identify best practice with regard to using human rights to advance health issues. This is accomplished through a programme, in which research, training and advocacy empower organisations and their members to assert rights for health. The vision of the Learning Network is thus one of empowered communities able to enjoy healthy lives, which will achieved through building best practice in realising the right to health through action and reflection. The current work of the Learning Network has a strong focus on public participation governance structures in health.

establishing health committees as formal structures was subordinated to the District Health Council and linked to amendments to the provincial Health Facilities Boards Act. As a result, the process of advancing a policy on health committees was suspended in the province.

An overview of health committees in South Africa conducted by the Health Systems Trust suggests that roughly half of primary care facilities have health committees, with less than half of these committees reporting local councillor participation. Research suggests that some of the challenges that are faced by health committees include fluctuating members as well as meeting frequency (this influences sustainability and functionality). Also, health communities often have weak links with their communities and members are made up mostly of older, female members. Facility managers also play a key role in the effectiveness of health committees, especially if committees have limited powers. Where there is no community mandate and where there is no policy framework, health committees are dependent on facility managers, who then become the gate-keeper.

Further obstacles for health committees are the lack of funding and the poverty context of communities, since in the absence of funding, the poorest communities have to cover the costs of their participation, which leads to disengagement. Also, the roles played by health committees have been limited mainly to some problem-solving, volunteering their services to facilities (including the provision of cleaning and security services) and health education. Furthermore, there are many gaps in the roles and responsibilities of health committees in policy documents and this requires much attention. Health committees are often not sure of their roles and end up doing volunteer work to assist facilities, rarely functioning as oversight bodies. Research shows, however, that the more empowering the participation, the more likely committees are to impact on the right to health. This impact is mostly seen in improving acceptability and accessibility, which leads to improved availability and quality of services.

However, meaningful participation is relatively limited in the Western Cape: most health committees appear to be rarely involved in tasks described in the provincial draft policy; the majority of members do not understand the draft policy (or are not aware of it); and members lack the skills to implement the policy. This leads to health committees functioning as an extension of health services, with little focus on governance or the oversight role.

Seven out of nine provinces in South Africa have policies that speak (at least on paper) to health committees as being part of health governance (with tasks including oversight, networking, dealing with patient complaints, representing communities and advocating on their behalf as well as other roles, including raising funds). There is diversity in these provincial policies regarding the membership of health committee (who should be involved from what sectors), whether members should be elected or appointed, which forms of financial and human resource support they can expect, if and how they are linked to other governance structures, etc. Also, policies are silent on capacity building activities and there is limited provision for upstream influence in the health system and limited engagement on addressing social determinants of health. It is also unclear whether these committees should get involved in advocacy activities for the clinic or for their communities.

Health committees' capacity to play a role in governance has been undermined because of lack of clarity on what is meant by governance. It is also unclear how to ensure representivity since most provincial policies leaves it to the MEC (Member of the Executive Council) to appoint health committees. Furthermore, there are no capacity building activities in place and there is also a failure to link these structures to higher level policy influence. Finally, lack of stewardship for health committees was mentioned as a barrier for implementation of policies.

The National Draft Policy on Health Governance Structures (2013) provides guidelines that indicate a strong governance function for health committees aimed at empowering communities to be involved in the provision and oversight of health services. The roles stipulated in this document include involvement in supporting management (setting policies and draw up plans to ensure equity in access); involvement in technical support (such as monitoring); oversight (access to information and reporting); financial oversight and human resources (assisting in appointments, setting financial policy); community participation (regular reports back, take up patient grievances); advocacy and fundraising.

The challenges facing health committees as genuine vehicles for community participation in South Africa include a failure to translate the promise of the Constitution into reality, the lack of financial and human resource support to implement policies, the absence of stewardship in the services for community participation, the absence of capacity building, the failure of leadership initiatives to enable managers to be more receptive to criticism as is required in oversight, confusion about the roles of community health workers and health committees and the limitations imposed by material deprivation in communities on ordinary people's capacity to participate in committee structures.

These are multiple challenges. Rather than walking away, communities can use the spaces available and claim those spaces that are not available. Pressure to change policy must come from communities and infiltrate upward through the system.

2.4 General Discussion

During a general discussion several points were made:

a. The impact of electoral politics was noted across many contexts. Preoccupation with elections can undermine health committee autonomy. Thus there is a need for mechanisms to support community participation that avoid or at least manage these tendencies.
b. The experiences highlighted how spaces can change. Much of the current work on health committees is trying to navigate invited spaces, which are sometimes closed down. Then, the challenge becomes one of turning them into spaces of meaningful participation.
c. What also emerged in the discussion is that it is not necessary for a legal framework to be very detailed to be effective. Rather, the Guatemalan experience suggests that it needs to embed the core principles of social participation and allow communities the space to organize for

democratic governance. Whatever legislation is available must lead to a handover of power - even a small paragraph with clear mechanisms of engagement can lead to many programmes that further open up spaces for community participation. An example might also be the South African legislation which, at national level, provides framework legislation and leaves provinces to decide the detail. Whether such details will include measures that devolve power remains to be seen.

d. Across all country contexts, a lack of resources to lower-level governance structures was noted. Without resourcing participation, government is relying on volunteerism for the purpose of achieving its own objectives. Bringing community members on board as partners, especially those with little say in society, requires them to be empowered to participate meaningfully, including upskilling to exercise power. Oversight should go beyond merely criticizing health services to identifying system challenges and advocating for system solutions. A more critical analysis of what has worked and what hasn't worked is needed. We should lobby for community accountability, including representation to the World Health Assembly and other international platforms.
e. Even as we reach consensus on the oversight roles of health committees (for example, "hand in and nose out"; - that is, doing the monitoring and not doing the work), there will be a need to monitor whether committees are actually doing what is intended and what differences they have made. There needs to be clarity on the roles of health committees, otherwise there will be a disjuncture between the roles that are fulfilled by communities and recommended roles.

3 Group discussions: what has worked and not worked and lessons learnt

Delegates were split into groups to discuss what has worked and not worked in their contexts as well as to outline the lessons learnt from these processes. Feedback from different groups (not representing any consensus overall) is listed below.

3.1 What has Worked	What has NOT Worked
● Existence of structures and guidelines, ● Inclusivity, ● Meeting consistency, ● Voluntary services, ● Gender balance, ● Multi-purpose structures (same committee involved in education, road sector and security), ● CSO (civil society organisations) support, ● Movement from decentralisation to democratisation of health committees, ● Using existing structures like committees instead of creating new ones, ● Accountability and timely action by health committees, ● Training, ● Working with facility staff – contribution of health care providers, ● Local solutions, ● Participatory processes, ● Women's participation, ● No compromise on democratic principles, ● Legislation (policy and guidelines)– initiates dialogue, ● Existing legislation is broad, but has gaps – no need to pass new legislation, but to focus on implementing existing legislation, ●Constitution, from which policies are derived, protects participation.	●Health committees given roles they cannot handle, ●No training/capacity building (on roles, etc.), resulting in conflicts. Training is needed on roles (including monitoring), systems building, government obligations and patient rights charters, health literacy, training for health providers and other duty bearers (no current knowledge of participation), ●Lack of clarity on functions (seen as health workers), ●Lack of support and recognition, ●No cooperation from middle level managers, ●Narrow focus on health care (capacity to address the social determinants of health), ●Not enough capacity to address the structural issues, ●Paradigm shift (health committee involvement in planning), ●Negative attitudes, ●Lack of resources (therefore no incentive to perform functions), ●Not involving health providers in health rights training, ●Not distinguishing roles of community health workers and health committees, ●Lack of transparency among CSOs (need to honest with communities), Some issues are not taken up by health committees, ●Disconnect in what the health committee recommends and what the Health Department can do, ●Expanding participation and representivity to also include marginalised groups, ●Low hanging responsibilities (only limited to community level initiatives), ●3 Fs: Functions, functionaries (staff – accountability) and funds (committees are still not involved in budgeting – counties make decisions). True devolution requires transfer of all Fs to the community, ●Accountability upwards to bodies who appoint health committees and members, ●Separating management and governance, ●Sectoral representation – marginalised / vulnerable

	populations are often not represented, ●No national forum, ●Participation only for a subsidy, ●Links or partnerships with NGOs, ●Lack of political will (or too much interference), ●Communities are not aware of existence of health committees, ●Health committees are not part of health sector planning, ●Tensions of federalism between different provinces / counties, ●No governance of the private health sector who are mostly profit-driven.

3.2 Lessons Learnt

a. Overall, it was clear that community engagement is critically important, but has many problems in practice. Policies may exist but are often not followed (e.g. in committee selection and decision-making).
b. Lack of clarity on the roles of health committees, CSOs and government is a major obstacle and should be addressed. It is not the primary objective of health committees to improve health (which is government's obligation), but to improve participation, through which health may be enhanced. Governance should be the core function of health committees; this also implies that sometimes it is necessary for people with technical expertise to join social spaces so as to strengthen health committees' capacities.
c. Accountability is central to this role. Health committees should hold service providers and services accountable but also must themselves be accountability to their community (giving feedback and taking up their needs).
d. The scope of health committee work can and should be broad: Firstly, there should be links between different levels of government so that health committees can influence at local and national level. Rather than restricting advocacy and planning to only local level, voices from communities need to be expressed in advocacy and planning at all levels, including national and global. A human rights framework may help to facilitate such higher level engagement. Secondly, there is a need to move beyond health care to address social determinants of health and the right to health. Lastly, we need to recognize that as the issues get more complex and time-consuming, participation becomes more difficult and there is a threat that participation may decline.
e. Community participation processes and structures should allow for broad and diverse representation and recognize diverse opinions within the committee. A code of conduct may be helpful for allowing everyone's voices to be heard, and to deal with conflicts of interest on the committee.

   When forming health committees, it was unclear whether election was always preferred over selection. We need to understand the context for participation - structures are dynamic and should be allowed to evolve with time and over different contexts.

f. The need for adequate resources is evident. Training and on-going support are essential on health committee roles and the right to health. This means investing in systems of sustainable capacity building. Also, funding to cover costs is necessary. This will be particularly so when committees are performing well in terms of seeking community inputs through community meetings, as they should. In a resource-poor setting, there is a need for a multi-sectoral structure that cuts across different sectors in a collaborative networking manner.
g. There is a need to bring health committees together to network and share experiences and for knowledge-networking fora to support health committee work. Collective advocacy by health committees can also strengthen claims to proper financing of participation and appropriate legislation. Advocacy can successfully make use of media. Through networking, we can enable translation of lessons into practice.
h. There are other stakeholders to whom participation and accountability should apply – the private sector and NGO's themselves. For example, Ministries of Health should be supported to create spaces for community participation in governance of the private sector, and monitoring of NGOs by communities should form part of this work. Universities and researchers also need to be accountable in their work with health committees.
i. There needs to be a Monitoring and Evaluation system to document the impact, influence and role of health committees. How does one measure success? A human rights framework may be one way to develop such tools.
j. Lastly, the objective of accountability is not just individual health care providers but the health system. Health professionals need to be provided with the skills to support community participation and therefore also need training.

4. Experiences from other contexts – Prasanna Saligram: Communitisation in India

Prasanna Saligram from the Public Health Foundation of India (PHFI[6]); shared the experience in India of community participation. Amendments in the Constitution provided for the devolution of powers (functions, functionaries and funds) to LSGs ("Local Self-Governments"). Health was one of a number of sectors identified for these reforms. This brought in certain mechanisms like "Village Assemblies", which envisaged local community participation. The LSGs also have standing committees which look into specific social sectors (like health and education). Different states have different approaches and there has been much experimentation (by civil society formations) to create community health workers' cadre and local health committees.

In 2005, the concept of "communitisation" brought to the fore community participation. Some of the mechanisms include ASHA (Accredited Social Health Activist-similar to the community health worker), VHSC (Village Health and Sanitation Committees) –who control the Untied Funds for local action, Hospital Management Committees, Community Planning and Monitoring – Community Action for

[6]Public Health Foundation of India (PHFI) is a public-private initiative in India that consults collaboratively with multiple constituencies and groups. PHFI is a response to the limited institutional capacity to strengthen training, research and policy development in public health.

Health. All the committees were part of LSGs and had representation from LSGs, ASHA workers, health department workers and civil society members. Communities were thus empowered to do planning and monitoring of the health services. These opened up new avenues for governance and the Untied Funds was a step towards autonomy for community governance structures.

Some lessons were presented from the Indian experience:

Generally, true communitisation did not happen as planned, with the exception of one state. There was a focus on low hanging fruits, which addressed local service delivery issues, but not the systemic issues. The Untied Fund was used mainly for ‘hardware’ (rather than software), meeting immediate concerns rather than long term sustainability. The system also had the potential to become too radical in that, during the constant battle for participation, there was a backlash when the boundaries for citizen power were pushed. The result was that most programmes did not go beyond the pilot phase. There was resistance to expand participation (include more civil society members into the committees). Buy-in from the department / local staff was a very important determinant of the programme’s success. Notably, no mechanisms were established to channel local level plans to state level planning and the idea to establish an overarching federation of committees did not happen. The committees therefore tended to remain very locally bound.

The experience was similar to Guatemala’s in that lots of handholding was needed to make health committees work (need specific facilitation mechanisms). There was also a multiplicity of health committees with different names in different states (creating complexities). Not all committees were able to incorporate in their work the Social Determinants of Health, which are often at the forefront of community needs, but which are often beyond the purview of the Health Department, and not part of their strategy.

5. Key Issues to emerge

The discussions from the first day were summarized overnight and presented to the meeting as the basis for ongoing group work on Day 2. These issues included health service issues, the design of Community Participation, issues related to Monitoring and Accountability, Capacity Building / Training for health committees, government obligations and accountability, including roles of health committees, civil society and government. The discussion that ensued highlighted a number of key issues.

5.1 Health Service issues:

The meeting grappled with the question of how one gets health workers to buy in to community participation involving health committees. How do we work with health workers, managers and policy-makers whose attitudes might be hostile to meaningful community participation? This will be an ongoing challenge.

Action steps identified in this regard were:

1. Awareness raising and education is needed for health providers on the objectives of community participation (aimed at improving their attitude and rendering them more responsive). This might

take the form of training workshops for health providers on community participation and accountability (integrating into values and mechanisms);

2. NGOs and health professionals should be involved in the development and production of materials;
3. Health and human rights approaches needs to be included in the academic curricula of health professionals (and in-service training);
4. Understanding the health care providers' views, their environment, their needs and the demands they face from higher structures (in order to improve retention) will help community structures to support health care providers to challenge management to better address community needs;
5. Greater representation of health care providers on policy body committees may also enable more flexibility in local responsiveness to communities.

5.2 The design of community participation

Here the issues were related to how we plan for the integration of participation in health systems.

a. How should health committees be constituted so as to best represent and act for communities rather than the health services or local political leaders? If and once elected, how should they continue to engage communities? How do they take up issues of vulnerable/marginalised groups? How are the constituted as genuinely democratic spaces? Leadership and communication by health committees is critical.
b. How should community participation be structured so that health committees are able to translate action/inputs/feedback from local, to regional, to national (and international) level? There was discussion about having tiered representation. The democratic nature of this representation relies on all lower level HCs being functional.
c. Health committees should facilitate community input into service planning and policy. How best can they do so? This is part of strengthening the role of health committees in governance.
d. Sustainability of health committees emerged as a common thread in the discussion.

    - Legislation has a role in institutionalising HCs but should leave an appropriate balance of flexibility, autonomy and legal status (recognition). The law should only create the space, institutionalising the right to participate, but not define the detail, and rather allow that to emerge organically.
    - Volunteerism does not preclude reimbursement, since funding is part of ensuring democratic processes and obligations. However, it was not clear whether funding should come directly from government or from other local development sources.
    - Different strategies are needed to maintain spaces for democratic engagement. These strategies are not just about funding. Nonetheless, it is important to ensure the existence of a legal mandate.
    - Part of ensuring ongoing sustainability is ensuring ongoing review of legislation and policies.

e. Health committees need to be integrated in a health system that is responsive. We should take a long-term view of health committees in relation to Health System conceptualisation. For

example, the current discussion about revisiting the WHO framework for health systems (building blocks), in which governance is one of the essential building blocks, should take account of different models and changing roles of health committees. This highlights the important contribution that HSR can play in evaluating and strengthening the role of health committees in health systems.

In terms of *constituting health committees*, there was agreement that elected representation was ideal but could be reached by different means. There would need to be consultation processes with the community, invitations to NGOs to send representatives, community information and sensitisation activities so as to achieve diverse representation based on community needs. The aim would be to draw on leadership from all levels of society, with gender balance (and encouraging women's leadership) and priority representation for vulnerable groups. One also needed to be conscious of dual loyalties of representatives, avoiding representation of political parties and including health care providers and local councillors as ex-officio rather than elected and/or office-bearing members.

We grappled with the issue of how *health committees could engage beyond the local to interact with national / regional authorities*. If health committees are in continuous engagement with health facilities, then health care providers can act as a link to the local government level, and councillors can use their status to influence budgets and policy issues. Where health committees have established sound systems for community dialogue and feedback, there can be a system of community representation at all levels and potentially a coordinating body that makes representation to all levels (local, county, national, etc.) to which other stakeholders in health could be invited.

We explored in some depth *what kind of role(s) health committees should be playing*. A human rights approach was thought to be potentially helpful in thinking through these roles. Health committees would, for example, address community needs, be involved in decision-making as community agents (the voice of the community) and have their capacity built to be active and informed agents. A human rights framework supports realizing the right to health through participation and lends itself to advocacy to meet health needs using the framework of AAAQ (Availability, Accessibility, Acceptability and Quality). A rights framework also introduces the idea that responsibility is coupled with rights. International human rights instruments and the General Comment 14 thus may provide useful guidelines to strengthen health committees as participative governance structures in health systems.

Action steps included those identified above and should be geared to community mobilisation to secure services to meet community health needs and improve service delivery.

5.3 Monitoring and Accountability

In our discussions, we separated the issues of Monitoring and Accountability, conceiving of the former as being about understanding what makes health committees functional, while the latter related to how health committees can hold services accountable.

The discussion on what constitutes functionality included a set of formal indicators: e.g. has a constitution / guiding document which provides for inclusive representation from the community; follows procedures (such as member selection) in line with the constitution; meets regularly (with attendance consistent with the quorum) and has minutes to document meetings; holds regular meetings with the community; and reports to the Department of Health and to community meetings. Additionally, there were other aspects of performance which would require more qualitative assessment, such as transparency and accountability in managing funds to ensure they are used for their intended purpose; ability to address issues higher up in the health system if problem is not resolved at lower levels; ability to bring about dialogue between health services and the community; ability to exercise independence from political parties; ability to monitor adherence to health service commitments and to be involved in the complaints process (take up user complaints and input to compliments). Lastly, there were also wider considerations in judging functionality of a health committee. For example, strong health committees would be able to address both hardware (facilities, equipment, etc.) and software issues (attitudes); be able to network, inter-sectorally in the community and to engage with other organisations and NGO groups in the community.

Action steps identified included the following:

1. We should develop a common approach to M&E of health committees in the region (developed and shared through a network);
2. We should aim to generate documented context-specific evidence that is produced in an inclusive way;
3. We should ensure capacity is built for monitoring with a common understanding of accountability as part of a strategy to avoid a backlash as well as assuring legal protection;
4. Capacity building activities should harmonise with the work of other oversight agencies;
5. We should develop codes of conduct that enhance credibility provide clear standards and avoid conflict of interest;
6. Election of health committee members (with particular skills set) should ensure inclusion of those from diverse vulnerable groups;
7. Creation of community awareness and communication with the community will help to hold health committees accountable to communities, thereby enhancing their functionality. This means health committees will have multiple levels of reporting – to communities and to health services;
8. Constitutions should define clear roles and functions, and ensure that health care providers and officials have appropriate ex-officio status (separate from sub-committee) – i.e. cannot hold office or vote.

The other half of M&E dealt with accountability – of the services to the communities they serve – and what role health committees can and should play. Here, the discussion was about holding services to account and how health committees should be involved in community-based monitoring of the health system (social / political accountability). This is linked to community awareness of health committee role (including vulnerable groups) and is critically dependent on the autonomy and composition of health committees (which are often dominated by health providers or government officials and which therefore limits the committees' ability to exercise oversight). Here again, a human rights approach is

useful because it clearly identifies duty bearers and stakeholders, and allows for involvement of other oversight agencies. Here, the key outcome is to enable health committees to be involved in bringing evidence to policy-makers attention. The flow of information is in both directions - how does the health committee get information and how can they present evidence to those who make decisions?

Action steps identified included the following:

1. We must facilitate grassroots policy participation to ensure equitable distribution of resources. It is community action for change that will make the difference. Strategies could include:
    a. mobilizing communities to engage parliament (e.g. parliamentary committees on health);
    b. on-going capacity building (highlighting an important role for universities and researchers) as well as strengthening support and supervision;
    c. advocacy for funding for operations and activities of health committees;
    d. engagement in planning and review meetings; and
    e. strengthening communication and feedback mechanisms.
2. Additionally, intervening with health workers was identified as important so reviewing health care provider training curricula to ensure graduates are more likely to adopt and support participatory approaches.
3. Lastly, there were a set of networking actions. Firstly, it was important to build knowledge networks in the region related to health committees, expanding the scope of health committees into sub-national (districts and counties) and national levels through mobilisation and pooling resources, and establishing global linkages (for example, knowledge of international treaties and sharing of information and experiences).

Capacity building was therefore a common thread to all the work above identified as important to advance health committees as vehicles for Realising the Right to Health and strengthening health systems.

6. Way Forward

The final session of the regional consultation addressed the way forward. Two sets of actions were identified - both immediate actions and longer term plans to take this work forward and expand its reach and effect. This is captured below.

Action	By Whom?
Immediate actions:	
1. Sharing of reports and experiences – delegates to share with each other	LN, Moses to invite participants to join EQUINET list
2. Send Links to existing Community of Practice networks, legal empowerment	Walter
3. Declaration from this meeting	All of us
4. Position paper on health committees as part of democratic governance; include mapping of the practice Generating evidence for policy and practice and advocacy	Walter to lead; all of us to contribute, Bennet, Stephen
5. Approach the Association of Schools of Public Health in Africa (ASPHA); national Public Health Associations to take up research to support	Leslie
6. Leverage Social Responsibility / Social engagement / service learning commitments of Universities	All of us
7. EQUINET to steward this work going forward, in partnership with others	Itai, Moses, All of us
Longer term plans:	
8. Website for exchange; list serve, email dissemination; problem solving; advice	EQUINET
9. Develop a curriculum/'syllabus' for democratic health committee capacity building;	Anita + Fundiswa to lead
10. Lobby WHO to adopt policy position on HC as vehicles for democratic governance a) Use global meetings to raise this as key policy issue at conferences b) Use existing policy positions to build the case (Ouagadougou Declaration) c) Push WHO so that our experience is the basis for participation policy - ? south to lead its development c) Capacity Development for Health Professionals to work with HCs; right to health, etc. d) Contribute to WHO's process for mainstreaming human rights into WHO by inserting participation e) Advocacy with Health Professional Training Institutions and Regulatory bodies – Right to health and Community Participation	EQUINET to lead Daniel; Stephen; Leslie; Vincent; Ben
11. Lobby UN system to ensure that when state report on the Right to Health they	Damaris +

	should report on participation in health; involve HCs in reporting on Right to Health	
12.	Networking Schedule piggy back onto existing meetings planned; be opportunistic raise additional resources for ongoing meetings/Networking	Itai/ EQUINET
13.	Develop and share training materials; adapt materials to local context	Led by Itai/ EQUINET
14.	Piggy back onto existing fundraising opportunities	
15.	Future meetings – field visits to see work on the ground e.g. piggy back onto COPASAH	
16.	Organise Training to use social participation tools under COPASAH in region Community of Practice on Accountability and Social Action in Health www.copasah.net	Walter
17.	Use Social Media for our future meetings	All of us; Damaris to lead
18.	Discussion document on participation in the Right to Health – to relate to the General Comments 14 limited attention to participation; basis for lobbying and advocacy	Moses, Hanne
19.	Opportunities for health committees to meet, exchange experiences, build practice	
20.	South-south collaboration – South to North teaching!	All of us
21.	Materials development and Information Dissemination for local use	All of us
22.	Account to this group next time we meet what we have done since last meeting	All of us
23.	A UN Convention on Participation? Democratic governance. (long-term and thinking big…)	

The meeting also concluded by adopting two statements – one expressing solidarity with the people of West Africa fighting Ebola and highlighting the importance of community participation in effective responses to Ebola (Appendix 4) – and the second affirming the importance of health committees as key to strengthening health systems in the region (Appendix 5).

6. Evaluation

Of those who completed the evaluation (22 of 38 participants), all felt that the meeting achieved its objectives and their expectations were met. People cited that they liked the smooth logistics, the diversity of the participants and sharing of different experiences, the Latin American experience, the focus on empowerment and the orientation towards Africa.

People also felt that some things could have been done better and these should be considered for future meetings, including holding a cultural event, details circulated beforehand, adequate time to drill down on specific issues (such as the human rights approach), wider stakeholder involvement including more health committees, government officials and other stakeholders (e.g. NGOS) as well as more

research-based evidence / benchmarks for the functionality of health committees. Other future actions for considerations also include reporting on implementation activities, creating a repository for materials reporting back on our networking activities, expanding discussion to Hospital Boards, ensuring wider participation (more countries and people), including participation from the poorest, field visits to health committees to share experiences as well as longer meetings, comprising of more days.

7. Conclusion

The meeting, held over two days, with 38 participants from 12 countries of which nine were African countries, was able to build on previous regional networking and share experiences of health committees as vehicles for community participation from countries across the globe. The discussions reaffirmed the importance of health committees for health system responsiveness and highlighted the importance of health committees as autonomous structures able to enhance democratic governance of health systems through monitoring and evaluation of health service performance and holding the state accountable. This applies irrespective of how services are delivered. To achieve this, it is critically important for health committees to be capacitated to fulfil this role through appropriate training, health systems design and sustainable support. Government should recognize the importance of health committees for their health systems, and invest appropriate human and financial resources to ensure functional health committees. Such investments are part of state obligations with respect to realising the Right to Health. Further, strategies must be developed to obtain buy-in of health workers, managers, policy-makers and community gatekeepers in supporting meaningful participation by health committees.

The meeting committed to strengthening regional learning networks between countries of the south for advancing health committees as vehicles for community participation. Governments must recognise and incorporate health committees into their health systems in ways that maintain their roles as autonomous agents for democratic governance and the WHO should provide guidance on inclusion of health committees in Health Systems Governance. Discussions on updating the WHO Building Blocks approach could benefit from recognising the role of collective community action through health committees when inserting notions of public and patient engagement.

Appendix 1: Notice of the Regional Meeting on health committees

Regional Consultation on Health Committees: Vehicles for realising the right to health and strengthening health systems

The Learning Network for Health and Human Rights, in conjunction with the Network on Equity in Health in East and Southern Africa (EQUINET) will be holding a 2-day regional consultation on the Role of Health Committees in Equitable, People-centred Health Systems in the Southern and East African region just prior to the Third Global Symposium on Health Systems Research.

The regional consultation, funded by a grant from the International Development Research Council, will take place in Cape Town on Saturday 27 and Sunday 28 September 2014 at the University of Cape Town.

The meeting has been called to share experiences, from the southern and east Africa region, of community participation in health systems governance through health committees. The focus of the consultation is on health committees as a strategy for realising the right to health and strengthening health systems. The consultation will build on previous meetings by the different partners in Kampala, Kiboga and Harare over the past four years. Target participants are those who have experience of working with health committees and community participation structures. We hope to have a diverse range of participants, including civil society organizations, researchers, service providers, managers and health committee members.

There is no registration cost for this meeting but only a limited number of places are available. If you would like to take part, please send an expression of interest as soon as possible, outlining your motivation for participation, to Kanya Mdaka at kanya.mdaka@uct.ac.za and to kanya.mdaka@gmail.com.

A limited amount of funding is available for travel costs. If you wish to apply for travel support, please indicate in your email (i) a motivation why you need travel support; (ii) what organisation you work for and what your involvement is in health committees; (iii) whether you will need a visa to attend.

Appendix 2: Participants at the Regional Meeting on health committees (September 28th 2014)

REGIONAL CONSULTATION ON HEALTH COMMITTEES: CAPE TOWN, SEPTEMBER 2014				
No	**Participant**	**Country**	**Organisation**	**Email**
1	Aaron Mulaki	Kenya	Health Policy Programme	amulaki@nb.rti.org
2	Anita Marshall	South Africa	Learning Network for Health and Human Rights (LN)	anita.marshall@uct.ac.za
3	Belgacim Sabri	Tunisia	Tunisian Association Defending the Right to Health	sabrib2@yahoo.com
4	Belinda Jackson	South Africa	United Nations Association of South Africa (UNASA)	
5	Benjaim Meier	United States	University of North Carolina	meierb@email.unc.edu
6	Bennet Asia	South Africa	National Department of Health	asiabe@health.gov.za
7	Damaris Kiewiets	South Africa	Cape Metro Health Forum (CMHF)	damaris.fritz90@gmail.com
8	Daniel Iga Mwesigwa	Uganda	Heartsounds Uganda	daniel.igamwesigwa2003@gmail.com
9	Edgar Mutasa	Zimbabwe	Community Working Group on Health (CWGH)	edgar@cwgh.co.zw
10	Edwin Mbugua Maina	Kenya	Concern Worldwide	edwin.maina@concern.net
11	Francis Serunjogi	Uganda	Centre for Human Rights and Development (CEHURD)	serunjogi.francis@live.com
12	Fundiswa Kibido	South Africa	Learning Network for Health and Human Rights (LN)	fundiswa.kibido@uct.ac.za
13	Hanne Haricharan	South Africa	Learning Network/UCT	hanne.haricharan@uct.ac.za
14	Isgaak Kamaar	South Africa	Cape Metro Health Forum (CMHF)	isgaakkamaar@gmail.com
15	Itai Rusike	Zimbabwe	Community Working Group on Health (CWGH)	itai@cwgh.co.zw
16	Joe Varghese	India	Public Health Foundation of India	vakkan2000@gmail.com
17	Juliana Nantaba	Uganda	Centre for Human Rights and Development (CEHURD)	jnantaba@gmail.com
18	Kanya Mdaka	South Africa	Learning Network for Health and Human Rights	kanya.mdaka@uct.ac.za
19	Leslie London	South Africa	University of Cape Town (UCT)	leslie.london@uct.ac.za
20	Lot Nyirenda	Malawi	Reach Trust	nyirendalot@yahoo.co.uk
21	Lulama Sigasana	South Africa	Ikamva Labantu	Lulama@ikamva.co.za
22	Maria Stuttaford	United Kingdom	Warwick University	Maria.C.Stuttaford@warwick.ac.uk
23	Moses Lungu	Zambia	Lusaka District Health Management Team (LDHMT)	moseslungu@yahoo.com
24	Moses Mulumba	Uganda	Centre for Human Rights and Development (CEHURD)	mulumbam@gmail.com
25	Mzanywa Ndibongo	South Africa	Cape Metro Health Forum (CMHF)	mzanywa_ndibongo@hotmail.com
26	Nicole Fick	South Africa	Learning Network for Health and Human Rights (LN)	nicole.fick@uct.ac.za

27	Prasanna Saligam	India	Public Health Foundation of India	psaligram@iiphg.org
28	Prima Kazoora	Uganda	Coalition for Health Promotion and Social Development (HEPS Uganda)	pkazoora@heps.or.ug
29	Richard Hasunira	Uganda	Centre for Human Rights and Development (CEHURD)	richardhasunira@gmail.com
30	Robinah Alambuya	Uganda	Pan African Network of People with Psychosocial Disabilities	robinahalambuya@yahoo.com
31	Severina Lemachokoti	Kenya	Naretu Girls and Women Empowerment Programme	severinalem@gmail.com
32	Stephen Olus Okeyo	Kenya	Great Lakes University of Kisumu	olusokeyo@yahoo.co.uk
33	Tamara Sam	South Africa	Cape Metro Health Forum (CMHF)	mamcirhasam@hotmail.com
34	Vandie Veronicah Masanja	Uganda	Centre for Human Rights and Development (CEHURD)	vandielo@gmail.com
35	Vincent Mubangizi	Uganda	Mbarara University of Science and Technology	vmubangizi@must.ac.ug
36	Walter Flores	Guatemala	Centre for the Study of Equity and Governance in Health Systems	waltergflores@gmail.com
38	Wondwosen Gebeyaw	Ethiopia	Ministry of Health / Health Financing and Governance Project	kggwonds@gmail.com

Appendix 3: Programme for Regional Meeting on health committees
September 27 and 28 2013.

Regional Meeting on Health Committees

A regional consultation for East and Southern Africa is planned for the 27th and 28th September 2014 with aim of sharing experiences and identifying good practice with respect to Health Committees in the region and to establish stronger networking around health committees.

TITLE: The role of Health Committees in Equitable, People-centred Health Systems in the Southern and East African region

Saturday 27th

8.00 – 9.00	Registration	Coffee and registration
9.00 – 9.15	Opening	
9.15 – 10.00	Plenary 1	Opening Address and Discussion: The role of health committees in advancing democratic governance Walter Flores, Guatemala
10.00 – 10.30	Tea	
10.30 – 12.30	Plenary 2	Panel discussion: Experiences from the region: Uganda, Zimbabwe, South Africa
12.30 – 13.30	Lunch	
13.30 – 15.00	Group discussions	
15.00 - 15.30	Tea	
15.30 – 16.30	Plenary 3	Feedback from groups
16.30 – 17.15	Plenary	Experiences from other contexts: India, US and Phillipines
17h30+	Reception	

Sunday 28th

9.00 – 9.30	Plenary 4	Reflection on Day 1; identification of areas for focus
9.30 – 11.00	Group discussions	
11.00 – 11.30	Tea	
11.30 – 13.00	Group discussions	
13.00 – 14.00	Lunch	
14.00 – 15.30	Plenary 4	Feedback from groups and plenary discussion
15.30 - 16.00	Tea	

16.00 – 17.00	Plenary 5	Way forward and concrete plans of action Vote of thanks

Date: 27th and 28th September 2014

Venue: Frances Ames Room, Barnard Fuller Building, University of Cape Town Health Sciences Faculty, Anzio Rd, Observatory Cape Town

For more information contact Mr Kanya Mdaka at kanya.mdaka@uct.ac.za

Appendix 4:

Statement of Support for People Impacted by Ebola Virus Disease

We extend our condolences to the families of the more than 3,000 people affected by Ebola, including the more than 210 health care workers. As an international meeting of people working in the area of health and human rights, and gathered over the past two days to consult on the work of health committees, we wish to express solidarity with those working and living in areas affected by Ebola. We acknowledge the dedication of governments, health care workers, civil society organisations and concerned individuals struggling to prevent the spread of Ebola, treat those with Ebola, support their family and friends and contain the spread of the disease. We acknowledge the sacrifices being made and unfaltering service in extremely challenging conditions with limited resources. Recognising the importance of community participation is vital in dealing with epidemics. We call on governments to recognise the rights of communities to participate in the response of health crises such as Ebola. We also call on governments and global organisations to recognise and facilitate community participation through relevant policy and legislation and resource community participation in health systems. The current epidemic is not one only of African governments and requires a global response.

Participants at the Regional Meeting on Health Committees co-hosted by the Learning Network for Health and Human Rights, the Centre for Health, Human Right and Development (CEHURD) and the Network on Equity in Health in East and Southern Africa (EQUINET), 27-28 September 2014, Cape Town.

For further details, contact Professor Leslie London, School of Public Health and Family Medicine, University of Cape Town, 0791896368; email leslie.london@uct.ac.za or Moses Mulumba (CEHURD) mulumbam@gmail.com;

Appendix 5:

Health committees as vehicles for community participation: Release from a Regional Consultation 27th and 28th September 2014

This regional meeting held in Cape Town, South Africa, of 38 participants from 9 countries, having considered experiences of health committees as vehicles for Community Participation from countries across the globe, reaffirms the importance of health committees for Health System responsiveness.
We highlight the importance of

• Health committees being autonomous structures able to enhance democratic governance of health systems through monitoring and evaluation of health service performance and holding the state accountable, irrespective of how services are delivered;

• Health committees being capacitated to fulfil this role through appropriate training, health systems design and sustainable support;

• Governments recognising the critical importance of health committees for their health systems, and invest appropriate human and financial resources to ensure functional health committees;

• Investments in health committees which should be seen as part of state obligations with respect to realising the Right to Health;

• Strategies to obtain buy-in of health workers, managers, policy-makers and community gatekeepers in supporting meaningful participation by health committees

This meeting commits to strengthen regional learning networks between countries of the south for advancing health committees as vehicles for community participation.
We call on

• Governments to recognise and incorporate health committees into their health systems in ways that maintain their roles as autonomous agents for democratic governance;

• WHO to provide guidance on inclusion of health committees in Health Systems Governance;

• Discussions on updating the WHO Building Blocks approach to recognise the role of collective community action through health committees when inserting notions of public and patient engagement.

Participants at the Regional Meeting on Health Committees co-hosted by the Learning Network for Health and Human Rights, the Centre for Health, Human Right and Development (CEHURD) and the Network on Equity in Health in East and Southern Africa (EQUINET), 27-28 September 2014, Cape Town.

For further details, contact Professor Leslie London, School of Public Health and Family Medicine, University of Cape Town, 0791896368; email leslie.london@uct.ac.za or Moses Mulumba (CEHURD) mulumbam@gmail.com.