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COMMUNITY PARTICIPATION IN HEALTH SYSTEM GOVERNANCE

Experience with the Health Unit Management Committee approach in Kiboga and Kyankwanzi districts

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This paper is built on an action research project titled, *Health System Governance: Community Participation as a Key Strategy for Realizing the Right to Health,* **implemented by CEHURD in partnership with Learning Network for Health and Human Rights of the School of Public Health and Family Medicine at the University of Cape Town (UCT), South Africa, and with financial support from International Development Research Center (IDRC).**

Moses Mulumba, Richard Hasunira and Juliana Nantaba compiled this paper. David Kabanda and James Kibirige participated in the implementation of the project.

COVER PHOTO BY RICHARD HASUNIRA: Members of Health Unit Management Committees contribute to a discussion during a human rights training session organized by CEHURD at Kyankwanzi District Headquarters, 25 November 2013

EXECUTIVE SUMMARY

Introduction

Uganda's National Health Policy (2010-14) asserts that Health Unit Management Committees (HUMCs) – together with Village Health Teams (VHTs) – have helped to increase participation of beneficiaries in planning and monitoring of community health programs (Ministry of Health, 2009).

This paper explores the experiences and perceptions of community stakeholders with regard to HUMCs as an institutional structure for their participation in health governance. In particular, the paper describes the situation of community participation through HUMCs, the mandate and status of HUMCs, as well as community and stakeholder perspectives on, and commitment to participation or facilitating community participation in health governance through HUMCs.

Methods

This work has used participatory action research methods to engage grassroots communities, community health workers, members of HUMCs, health workers, health facility in-charges, program managers, as well as leaders at the community and local government levels in the districts of Kiboga and Kyankwanzi districts in central Uganda. The program of work has involved training and capacity-building; building networks; sharing of experiences; and testing local systems for participation. It has also involved student internships, regional meetings to share experiences and best practices in community participation in health system governance.

Findings

Local and district leaders as well as program managers were overall supportive of community participation in health governance and were generally satisfied with HUMCs as one of the strategies to ensure this is achieved. But HUMCs and VHTs are not sufficiently facilitated to play their representation roles.

Selection of the membership of HUMCs, including the chairperson, by the local government – rather than directly by the members of the community – detaches this key participation structure from the community it represents.

Ministry of Health guidelines explicitly state that the HUMC's mandate is to monitor and govern the health facility on behalf of the respective local government. This makes the committee members answerable to the appointing local government, and not to the community that the HUMC members supposedly represent. HUMC members participating in a focused group discussion (FGD) were divided on whether they worked for the community who they were selected to represent or the appointing authority, but were unanimous in acknowledging the obligation to report regularly to the latter.

Results from this work point to a potential conflict of interest, as most members of HUMCs, which is an oversight structure, also double as VHTs, who from theory and practice are community health workers and part of the health system. In addition, the influential position of the secretary is reserved for the health center in-charge, who is a service provider.

Another major issue is in relation to the functionality and capacity of HUMCs, particularly at lower health facilities. While the health structure prescribes the different levels of care that should serve the different layers of administrative/ geographical area, in practice, this is not the case. In Kiboga and Kyankwanzi districts, HUMCs at some health facilities were not meeting regularly as required by Ministry of Health guidelines.

Knowledge of HUMCs as a strategy for community involvement in health system governance was generally low among ordinary grassroots people and other community stakeholders reached by this work. Community members were largely not aware of who seats on the HUMC of their local facility, and did not feel that such individuals, where they existed, represented them or their interests. This work found some HUMC members who were not aware of the procedure of their selection and had never received any form of training or orientation.

Grassroots community members did feel that they had the power to engage their leaders and representatives effectively to determine how the health system serves them. HUMC members engaged by this process reported minimal feedback from communities served by the health facilities they oversee, yet health workers reported being harassed by local politicians on a full range of issues.

Emerging issues

Local and district leaders as well as program managers were overall supportive of community participation in health governance and were generally satisfied with the strategies being used to ensure this is achieved. There is need to build on this support to address the existing gaps in actual realization of meaningful community participation in health governance by providing resources; considering community views; and ensuring functionality of the community participation structures.

Results from this work call for interventions to strengthen community awareness of the right to health, health literacy and orientation and training of community stakeholders as well as HUMC members and health workers on the role of HUMCs.

These results call for interventions to strengthen community-level accountability systems by empowering community stakeholders to claim their right to participation in the governance of the health system and demanding accountability from members of HUMCs and other representation structures. Oversight and service provisions roles are theoretically different and need to be separated in the HUMC model. Assigning service providers (health facility in-charges) or community health workers (VHTs) oversight roles by making them members of HUMCs creates a potential conflict of interest.

Commitment to community participation in health governance needs to be matched by allocation of resources to facilitate HUMCs and other structures created for the purpose. Service coverage needs to expand to create opportunities for the population to participate in heaklth syste givernance.

Conclusion

The HUMC strategy to community participation in health system governance has created a potential conflict of interest by allowing health providers to be part of service monitoring structures. There is need for interventions to build capacities of HUMC members, local leaders, health workers and communities in order to identify and exploit opportunities for using HUMCs to realize the right of communities as beneficiaries of public health care to participate in the governance of the health system and realizing the right to health.

INTRODUCTION

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INTRODUCTION

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This paper discusses the observations and experiences of CEHURD (Center for Health, Human Rights and Development; www.cehurd.org) with the implementation of a community action-research project to identify opportunities for best practice in utilizing community participation as a vehicle for realizing the right to health. The three-year project started February 2012 and is being implemented in Kiboga and Kyankwanzi districts in central Uganda in partnership with Learning Network for Health and Human Rights of the School of Public Health and Family Medicine at the University of Cape Town (UCT), South Africa, with support from International Development Research Center (IDRC).

The Health System Governance and Community Participation Project builds on CEHURD's previous work around the right to health implemented within the Network on Equity in Health in Eastern and Southern Africa (EQUINET), for which CEHURD is the coordination point for the country networking cluster. This includes work on community expectations on access to essential medicines and community consultations on the formulation of new goals and governance for global health conducted in Buikwe district in central Uganda. It also includes research commissioned by EQUINET in 2010 that assessed the regional situation with regard to constitutional commitments to the right to health (Mulumba et al., 2010), as well as CEHURD's maternal health litigation work (Mugala, 2012).

This paper explores the experiences and perceptions of community stakeholders with regard to Health Unit Management Committees (HUMCs) as an institutional structure for their participation in health governance. In particular, the paper describes the situation of community participation through HUMCs, the mandate and status of HUMCs, as well as community and stakeholder perspectives on, and commitment to participation or facilitating community participation in health governance through HUMCs.

METHODS

SUMMARY

This work has used participatory action research methods to engage grassroots communities, community health workers, members of HUMCs, health workers, health facility in-charges, program managers, as well as leaders at the community and local government levels in the districts of Kiboga and Kyankwanzi districts. The program of work has involved training and capacity-building; building networks; sharing of experiences; and testing local systems for participation as a key strategy for realizing the right to health. The project team met and received briefings from local and district leaders, health workers and program managers.

METHODS

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This work is part of a broader project that has been implemented since February 2012, targeting community members and stakeholders, health committees, civil society, health officials, local leaders and program managers. Kyankwanzi and Kiboga districts are both rural districts, neighboring each other in the central region.

Kiboga and Kyankwanzi districts border each other in rural central Uganda, about 150km west of Kampala (Kyankwanzi Local Government, n.d.). Kiboga district was formed in 1991. In 2010, the district was split into two, the western part being set up as a separate district of Kyankwanzi. The district is sub-divided into one town council (Kiboga Town) and six subcounties of Kibiga, Lwamata, Bukomero, Muwanga, Kapeke and Dwaniro. Kyankwanzi, on the other hand, is also subdivided into one town council (Kyankwanzi Town) and six subcounties of Mulagi, Ntwetwe, Gayaza, Wattuba, Butemba and Nsambya.

The 2002 national census estimated the population of Kiboga district at about 108,900, while current estimates put the population at 140,100. The population of Kyankwanzi district is estimated at 184,279 (Kyankwanzi Local Government, n.d.). Kiboga district is served by 19 public health facilities: One hospital, one Health Center IV, five Health Center IIIs, and 12 Heath Center IIs. Kyankwanzi on the other hand does not have a hospital, but has one Health Center IV, five Health Centre IIIs and 22 Health Centre IIs.

Both districts are in a locality with relatively higher levels of poverty than the national average, and the district local government of Kyankwanzi has stated that poverty is the main underlying cause of poor health in the district (Kyankwanzi Local Government, n.d.). In 2009, Kyankwanzi, by then still a subcounty of Kiboga district, was recorded as the poorest administrative area in Central Uganda, with 38% of the population living on less than one dollar a day. Other challenges are related to high levels of illiteracy, especially among women; high prevalence of preventable diseases; emergence of diseases of lifestyles; inadequate distribution and provision of health services and other social services, including safe water supply and sanitation facilities.

In 2012, CEHURD twined with Learning Network for Health and Human Rights of the School of Public Health and Family Medicine at the University of Cape Town (UCT), South Africa to implement a three year project *"Health System Governance: Community Participation as a Key Strategy for Realizing the Right to Health".* This project commenced in February 2012, and is supported financially by International Development Research Center (IDRC).

This work has used participatory action research methods to engage grassroots communities, community health workers, members of HUMCs, health workers, health facility in-charges, program managers, as well as leaders at the community and local government levels in the districts of Kiboga and Kyankwanzi districts. Through a series of review and reflection by the research team and the target populations, a spiral process of co-learning has been facilitated via periodic review of, and reflection on, research results and new research questions, anticipation needed advocacy and training interventions.

The program of work has involved training and capacity-building; building networks; sharing of experiences; and testing local systems for participation as a key strategy for realizing the right to health. It has also involved student internships, regional meetings to share experiences and best practices in community participation across the region, and exchange visits between project teams in Uganda and South Africa.

The project team met and received briefings from local and district leaders, health workers and program managers. In Kiboga, the project team met the political and technical leadership, led by the district chairperson. The team also visited Kiboga Hospital and held a meeting with the Medical Superintendent and his team. In Kyankwanzi, the delegation held a meeting with the district leadership, led by the chief administrative officer and the district health officer. The team also toured Ntwetwe Health Center IV and held a meeting with the facility in-charge and his team. The briefings focused on their respective roles, the opportunities for community participation and the existing barriers.

COMMUNITY PARTICIPATION AND THE RIGHT TO HEALTH

SUMMARY

Community participation means that the community is no longer a passive recipient of health care, but an active participant in the creation of a health care system that serves their specific needs.

THOMAS & LONDON, 2006

COMMUNITY PARTICIPATION AND THE RIGHT TO HEALTH

Community participation is not only a human right in itself, but is also increasingly being recognized as essential for realizing the right to health (Potts, 2008). It means that the community is no longer a passive recipient of health care, but an active participant in the creation of a health care system that serves their specific needs (Thomas & London, 2006). If appropriately designed and empowered, participation through health committees can enable communities have a positive impact on access and quality of services (McCoy et al., 2012).

The Alma-Ata Declaration on Primary Health Care (1978) states that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care." The Declaration recognizes that with active public participation, individuals become part of a collective effort to assess health needs, collaborate with others, and evaluate the reform of health care programs.

Hence, development of appropriate institutions and mechanisms for structured community participation in the health system has the potential to increase awareness of community-specific health issues, disseminate knowledge and health education, and increase accountability for health (Yamin, 2009).

At an individual level, participation leads to an increased sense of partnership with, and communication between community members and the health system, with the relationship being based on transparency and mutual respect and trust. Individuals, who will be more inclined to learn about health issues specific to their community, and their lifestyle choices and overall wellbeing will be influenced by what they learn (Meier et al., 2012).

At the community level, participation contributes to the system's effectiveness and sustainability by providing feedback and securing involvement in collective decision making(Brownlea, 1987). Collective deliberation improves both community development and health system governance, resulting in more reasoned, informed, and public-oriented decisions (Gruskin et al., 2012). Through such meaningful engagement, community members can exert influence on policymakers to allocate and utilize funds equitably and efficiently (Meier et al., 2012). As a result of this participatory orientation, the health system becomes more tailored to the specific community's health needs and thus more likely to improve health for all.

POLICY FRAMEWORK FOR COMMUNITY PARTICIPATION IN HEALTH

The Local Government Act (1997) decentralized governance to the district level. Hence, primary health care, provided by village health teams (VHTs)/Health Center I-Health Center IV, is managed by district local governments in addition to general hospitals. However, the subcounty local government supervises VHTs/Health Center I-Health Center III. Regional referral hospitals (RRHs) and national referral hospitals (NRHs) are under the direct oversight of Ministry of Health.

The Uganda government recognizes the importance of community involvement in the successful fulfillment of the right to health. The National Development Plan (NDP), the overall Government development strategy, sets and prioritizes the empowerment of individuals and communities for a more active role in health development and the implementation of the Uganda National Minimum Health Care Package (UNMHCP). Under the NDP, government commits to encourage and support communities to participate in decision-making and planning for health services provision, through village health teams (VHTs) and health unit management committees (HUMC).

The National Health Policy (2010-14) envisages two strategies for achieving community participation in health governance: expanding and exploring ways of sustaining the VHTs as well as building capacity to ensure effective HUMCs (Ministry of Health, 2009). VHTs are community health workers and under Uganda's health structure, constitute the first level of care, Health Center I, at the community level. In this regard, the question then is whether VHTs, who are technically health workers, are a community participation mechanism.

McCoy and colleagues (2012) frame seven roles for health facility committees: 1) Governance, 2) Co-management; 3) Resource generation; 4) Community outreach; 5) Advocacy; 6) Health intelligence; and 7) Social leveler. Besides community outreach, the rest of these roles are clearly distinct from those assigned to VHTs by Ministry of Health (2010) under the Village Health Team Strategy and Operational Guidelines.

The guidelines specify that VHTs function as the most decentralized element to a primary care system, by delivering first level care at household level; and that they constitute the lowest health delivery structure and serves as a Health Centre I (HC I). The guidelines further specify that VHT members work together as a team to promote healthy practices at the community level, such as the use of pit latrines, washing hands, sleeping under mosquito nets, instilling health seeking behavior among the community.

In addition, VHTs advocate for increased community uptake of prevention interventions such as immunization, essential nutrition actions, sexual and reproductive health and rights and others. In addition, VHTs provide integrated community case management (ICCM) where they treat children for common childhood killers such as malaria, diarrhea and pneumonia; follow-up mothers during pregnancy and after birth; support people who have been discharged from health facilities and those on long term treatment. All these, and other roles VHTs play in Uganda's health system, clearly orient them toward health work and away from community representation.

On the other hand, HUMCs are more reflective of community participation in governance, as they link the community, local government and point of care. Members of HUMCs are nominated from among the community where the health facility is located by the subcounty or district executive committee and confirmed by the respective local council (quasi legislature). The same authorities also select the chairperson. The health unit in-charge is the secretary to the HUMC.

The 2003 Guidelines on Health Unit Management Committees prescribes five key functions of HUMCs:

1) **To monitor the general administration of the health center on behalf of the local council and Ministry of Local Government;**

2) **To manage health unit/health sub-district finances by approving, overseeing and supervising budgets, work plans and procurements; and ensuring observation of financial regulations and accountability;**

3) **To advise upon, regulate, monitor the collection, allocation and use of finances from other sources;**

4) **To monitor the procurement, storage and utilization of goods and services; and**

5) **To foster improved communication with the public thereby encouraging community participation in health activities within and outside the unit.**

THE CONCEPT OF HEALTH SYSTEMSANDGOVERNANCE

SUMMARY

Community participation means that the community is no longer a passive recipient of health care, but an active participant in the creation of a health care system that serves their specific needs.

THOMAS & LONDON, 2006

THE CONCEPT OF HEALTH SYSTEMS AND GOVERNANCE

Governance is one of the six core components or building blocks that World Health Organization (WHO) uses to describe health systems. The other components are: service delivery, health workforce, health information systems, access to essential medicines and financing (WHO, 2010). The health system consists of all organizations, people and actions whose primary interest is to promote, restore or maintain health. To have a strong Health system, there must be strengthening of the building blocks by addressing key constraints in each of building blocks (WHO, 2010). Strengthening health system governance involves establishing strategic policy frameworks and combined with effective oversight, coalition-building, appropriate regulations and incentives, and, transparent and effective accountability mechanisms (WHO, n.d.).

Governance therefore provides the overall policy and regulation of the health system. This is a cross-cutting component that influences all the other five components, and ultimately the soundness or effectiveness of the health system.

United Nations Development Program (UNDP) developed five principles of good governance: legitimacy and voice, direction, performance, accountability, and fairness. Legitimacy and voice entails participation and consensus orientation; direction entails having a strategic vision; performance points to responsiveness, effectiveness and efficiency; accountability involves holding all players accountable and calls for transparency; while fairness deals with equity and inclusiveness, and rule of law (WHO, 2008). It is against these principles that a governance system will be measured as either facilitating or frustrating the strengthening of a health system.

STATUS OF THE RIGHT TO HEALTH IN UGANDA

SUMMARY

The 1995 Constitution does not explicitly provide for the right to health in the Bill of Rights (Chapter Four). However, in its National Objectives and Directive Principles of State Policy (NODPSP), which are supposed to "guide all organs and agencies of the State, all citizens, organizations and other bodies and persons in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions", the Constitution provides that the state shall endeavor to fulfill the fundamental rights of all Ugandans, and in particular ensure that they enjoy, among others, access to health services (NODPSP XIV).

CONSTITUTION OF UGANDA, 1995

STATUS OF THE RIGHT TO HEALTH IN UGANDA

Uganda is a signatory to various regional and international human rights treaties that commit it to respect, protect and fulfill the right to health, described in the International Covenant on Economic, Social and Cultural Rights *(*ICESCR), to which Uganda is party, as the right to "the highest attainable standard of physical and mental health".

The 1995 Constitution does not explicitly provide for the right to health in the Bill of Rights (Chapter Four). However, in its National Objectives and Directive Principles of State Policy (NODPSP), which are supposed to "guide all organs and agencies of the State, all citizens, organizations and other bodies and persons in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions", the Constitution provides that the state shall endeavor to fulfill the fundamental rights of all Ugandans, and in particular ensure that they enjoy, among others, access to health services (NODPSP XIV). NODPSP XX obliges the state to "take all practical measures to ensure the provision of basic medical services to the population".

Like all other states, Uganda owes all of its inhabitant's basic essential health goods and services under its obligations under the ICESCR and other international human rights frameworks, as well as under the Constitution (Gostin et al., 2010). The National Health Policy (2010-14) lists a basic set of services under the Uganda National Minimum Health Care Package (UNMHCP) that the state commits to deliver – free-of-charge – to all people of Uganda.

The package includes four clusters of interventions: 1) Health promotion, disease prevention and community health initiatives, including epidemic and disaster preparedness and response; 2) Maternal and child health; 3) Prevention, management and control of communicable diseases and; iv) Prevention, management and control of non-communicable diseases. The UNMHCP is delivered under the primary health care (PHC) structure, consisting of village health teams (VHTs) as well as health center levels I-IV, managed by district local governments.

In spite of the obligations and commitments in the national and international frameworks, incidences of health rights violations have been confirmed by the Uganda Human Rights Commission (UHRC) which noted that health consumers' rights are being violated but the violations are not properly addressed (WHO, 2010). Some of the factors cited for these violations include the limited appreciation of rights relating to health and the absence of clearly defined and pre-existent remedial structures in the country to address the violations.

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SITUATIONOFCOMMUNITYPARTICIPATION THROUGH HEALTH UNIT MANAGEMENT COMMITTEES

HUMCs are the key link mechanism of the health system to the grassroots community. It links the community, the local government and the health facility. HUMCs are established at facilities at the different levels of care, except at Health Center I, which is constituted by VHTs.

HUMCs consist of representatives of the community within which the health facility is located. Ministry of Health guidelines require that the committee is chaired by "a prominent educated public figure of high integrity and not holding any political position" and constituted by one "educated representative" of each of the major administrative units within the area served by the facility. The education sector is represented by one individual from among teachers from the educational institutions. The health workers of the facility are represented by one health worker and the facility in-charge, who serves the secretary to the committee. The lowest local government unit (Local Council I) is represented by its chairperson. The relevant local government is represented by the secretary for health.

One major issue is the very status of this institution as a community representation structure. Besides the automatic members (LC I chairperson, facility in-charge, and secretary for health), the rest of the membership, including the Committee chairperson, are nominated by the relevant local government executive (Chairperson) and confirmed by the respective local council. Hence, Local Council III select members as well as the chairpersons of Health Center II and Health Center III HUMCs, while the District Local Government selects HUMCs of Health Center IVs and General Hospitals. In a way, however, this arrangement, in which HUMC members are not directly elected by ordinary community members, but by the respective local government, is a weakness as it detaches the committee from the community it purports to represent.

Indeed, Ministry of Health guidelines explicitly state that the HUMC's mandate is to monitor and govern the health facility on behalf of the local government (and not of the community). Responding to the question on whom they worked for, HUMC members participating in a focused group discussion (FGD) were unanimous in saying they represent the community and not the local government. But they were divided on who they work for; some said they worked for the community from which they were selected, while others said they worked for their appointing authority.

"I'm working for the one who appointed me and that's the council." — **HUMC FGD participant**

Ministry of Health HUMC Guidelines make it clear that the oversight roles are performed "on behalf of the local government", and hence HUMC members are answerable to the local government, which is the appointing authority, and not to the community that the HUMC member supposedly represents. In addition, the HUMC is obligated to report to the appointing local council on a regular basis, while their reporting to the community is not written down as an obligation. Although some HUMC members insisted that they represent the specific category of people from whom they were appointed, their appointment by politicians has the effect of detaching this crucial institution from the common person in the community.

The second issue is about the potential conflict of interest. It was observed that most members of HUMCs, save for the automatic members – health in-charge, LC I chairperson and health secretary – also double as VHTs, who from theory and practice are part of the health system. According to the national guidelines on HUMCs, the HUMCs are charged with monitoring the general administration of the health facility, the facility's (and in case of HC IVs, health sub-district) finances, including approving budgets and monitoring procurement and expenditure.

RASHID, HUMC FGD PARTICIPANT

"I first became a VHT then I was elected as a member about one year ago. I started in 2009 as a VHT while serving home packs to the children from 2-5years. In 2012, around March, I was appointed as a member of the HUMC. I remember I was appointed not elected."

This oversight role potentially conflicts with the responsibility of providing services, which some of the HUMC members are involved in by virtue of their double status as VHTs, and also by the fact that the influential position of the secretary, who this work found has the biggest influence on whether and when the HUMC sits, is reserved for the health center in-charge, who is a service provider. In order to maintain check and balances, it will be important to separate these roles by ensuring that none of the HUMC members is a service provider at the same time. In addition, the influential position of secretary on an oversight structure is reserved for the in-charge of the health facility.

Responses from respondents in this work also indicate that the tenure of HUMCs is not clear. Some participants suggested that it is supposed to be two years, while others said it is five (changing with each general election that brings in new local governments). In the case of Mulagi HC III, the HUMC was reconstituted following a training of the HUMC by World Vision, resulting in the chairperson stepping down after realizing he was not competent to chair the HUMC.

One female participant disagreed with the procedure for selecting HUMCs, saying it should by geographical location, not by professions. Another participant complained that the members are not selected in a transparent manner, and that politicians do not consider competency because they seek to reward their campaign agents.

Participants at a human rights training did not have clear knowledge of the procedure for electing and replacing HUMC members. In one testimony, a participant said that when Nalinya Health Center III opened, the LC III chairperson asked for names, 15 candidates were reportedly provided at a community meeting held at the health center. The 15 reportedly selected six people who eventually got to become members of the HUMC alongside the health center in-charge. In another account, it was reported that the LC III executive committee nominates 5-6 members and the council confirms them. These then become HUMC members together with the In-charge and the LC I chairperson.

And in a third suggestion, one member of HUMC said she became an automatic member because she was the secretary for women affairs at the parish where the facility is located. HUMC members present were not aware of the procedure for electing and replacing HUMC members, saying they simply got letters informing them of their membership from the subcounty. This suggests that in future it may be important for nominees to be interviewed by the councils before being confirmed as HUMC members.

Another issue is in relation to the functionality of HUMCs, particularly at lower health facilities. The Annual Health Sector Performance Report for 2009/10 reports that all HUMCs at Regional Referral Hospitals are functional, but that functionality and guidelines for establishment of HUMCs at general hospitals and lower level units "need to be reviewed". The report also shows that the training and orientating of HUMC members has been slow, with an initial national training team of 20 trainers being established that year. The report adds that the next step of training regional training teams to subsequently train district level trainers and members of Hospital Boards was planned for 2010/11. Before receiving training and orientation, it is possible that the effectiveness of HUMCs as an oversight and planning structure is limited.

HUMC members participating in the human rights training sessions reported that the HUMCs of Mulagi HC III and Gayaza HC III in Kyankwanzi were meeting quarterly as required by Ministry of Health guidelines. In Kikolimbo HC II, it was reported that the HUMC had met twice the course of 2013, and on both occasions, it was a handover ceremony to new facility management.

COMMUNITYPERSPECTIVES ON PARTICIPATION

SUMMARY

Many community members at the grassroots level do not appreciate the need to claim their right to health and demand to participate in health governance. In addition to lack of information, some community members feel that they cannot make substantial contribution because they are not aware of their right to health.

COMMUNITY PERSPECTIVES ON PARTICIPATION THROUGH HEALTH UNIT MANAGEMENT COMMITTEES

Community knowledge of HUMCs as a strategy for their involvement in health governance was generally low among ordinary people. Knowledge of this structure and how they are elected was relatively better among local leaders, particularly at the level of Local Council III and above. Grassroots community people were not aware who represented them at the HUMC of the health facility nearest to them. Hence, ordinary community members participating the participatory reflection and action (PRA) sessions did not feel that HUMC and its members were their representatives at health centers or that they represented their interests.

Many community members at the grassroots level do not appreciate the need to claim their right to health and demand to participate in health governance. As a result they are indifferent and therefore do not respond even when called upon to take part in community meetings, which are convened by village (Local Council I) chairpersons, who are automatic members to HUMCs of health facilities within their village, that present them with opportunities to demand accountability from their leaders.

In addition to lack of information, some community members feel that they cannot make substantial contribution because they are not aware of their right to health. During the presentation, one of the participants mentioned that when one lacks knowledge on the issues to be discussed in a village meeting, they will not have the confidence to participate during the meetings. Hence, there is a critical need to empower communities on the right to health and the opportunities to claim it through participation in health governance.

"When I had just become a member of the council, I took time once and moved around the village to invite community members for a budget conference. Some of the community members asked me whether they were going to be paid for attending. When the day came, very few people showed up and most of them were community leaders."

LOCAL COUNCIL MEMBER

The health system is structured in such a way that each village or 25-30 households are served by a Village Health Team of five members; a parish by a Health Center II; a subcounty by a Health Center III; a county by a Health Center IV, and a district by a General Hospital. In practice, however, not every administrative/geographical unit is served in accordance with this guideline.

Respondents in Kiboga district informed the project team that not all parishes have a health center II at the moment. The Medical Superintendent of Kiboga Hospital said resource constraints have prompted a slow-down in the establishment of health center IIs and a shift in emphasis to ensuring functionality of existing health center IIs. Respondents in Buikwe district also reported under-coverage of health facilities.

BUIKWE DISTCIT HIV FOCAL PERSON

"We have limited health facilities, that is, Ssi subcounty has like three health facilities, that is, Kavule, Ssenyi and Ssi health centers, and yet it is a big subcounty leading to under service. Ideally, if we had a health facility at parish level it would be better in increasing access but even some big parishes have no facilities. Kawolo has also few health facilities, which are: Busabaga, Nagembe, and Mpogwe."

Respondents in Buikwe blamed inconsistencies in government policy. At one point government was reported to have stopped opening up health center IIs and for the last five years none was opened in the district. The recruitment of health workers has been on and off. This implies that people within the unserved villages and parishes do not have an opportunity to be members or to e represented on HUMCs.

The creation of a new district of Kyankwanzi, which was split from Kiboga may have also come with its own challenges due to transition challenges. The newly created district does not have a general hospital, and has only one health center IV, Ntwetwe HC IV. By the time of this work, plans were underway to convert Ntwetwe HC IV into a general hospital, which will them leave the new district without a health center IV. These changes are coming with challenges to the community participation set up both in the new and the old districts.

Local and district leaders as well as program managers were overall supportive of community participation in health governance and were generally satisfied with HUMCs as one of the strategies to ensure this is achieved.

The gap in this commitment however, is in the practice, in terms of providing resources, considering community views, and ensuring functionality of the community participation structures. It was reported that the budgets for health facilities are too small to support the HUMC quarterly meetings, given that at each sitting members are supposed to get some transport allowance. Health workers in the meeting said that the Ushs 400,000 they receive quarterly usually comes when health centers are in debt.

The observation so far is that commitment to community participation in health governance remains largely verbal or on paper. It is important that local leaders become more proactive in supporting community participation, through harnessing local and community resources to support HUMCs. There is need to build the capacity of local leaders to understand their duty in promoting, protecting and fulfilling the right to health, including ensuring meaningful participation of healthcare consumers and other community stakeholders in health governance.

HUMC members participating in this work reported that patients are not reporting their complaints to the members of HUMCs, but instead report to politicians and other government authorities who end up harassing health workers. One problem is that HUMC members are not known by all the people in the community and even the few who know them do not know their mandate. This may be due to the fact that HUMC members are elected by the subcounty and district councils, rather than directly by community members. Even then however, a male meeting participant who is a member of Mulagi LC III also reported not to know the HUMC members of Mulagi HC III.

On how awareness about HUMCs could be raised, the respondents suggested the following: LC I chairpersons are automatic members of HUMCs in their areas of jurisdiction, hence they should use the village meetings that they convene to communicate issues relating to the HUMCs that they are part of; the list of HUMCs should pinned up on notice boards of health centers; HUMC members should be introduced to religious leaders, who should then help to communicate to their congregations; and the non-performing members should recalled. It was noted that the LC III chairperson has powers to recall members of HUMCs. The chairperson can easily find out if a particular member is not attending meetings by reviewing HUMC meeting minutes and attendance lists.

CONCLUSION

SUMMARY

The HUMC mechanism has gaps in terms of capacities of the members who do not fully understand their roles and need to be engaged to identify and exploit opportunities for improving their work. Community response to claim the spaces for participation in health governance is poor. The observation so far is that commitment to community participation in health governance among local government leaders remains largely verbal or on paper.

CONCLUSIONS

HUMCs are considered the key link mechanism of the health system to the grassroots community, but their effectiveness is compromised by lack of training and orientation, the lack of a direct link with the community, conflict of interest, and limited community awareness of its mandate. In concept and in practice, the HUMC strategy has gaps in terms of capacities of the members who do not fully understand their roles and need to be engaged to identify and exploit opportunities for improving their work.

Community response to claim the spaces for participation in health governance is poor. There is a high level of apathy among community members, who have lost hope and confidence in the ability of their leaders to address their priority concerns. There is a general lack of interest in the activities of grassroots leaders because local council I have overstayed their mandate, planning processes are non-responsive, and locals do not a see a need to participate in village meetings. Many community members at the grassroots level have lost hope and do not see the need to claim their right to health and demand to participate in health governance. This implies a critical need to restore hope among community members through empowerment and to work with local leaders and health providers to rebuilt public confidence in the health system.

Community knowledge of HUMCs as a strategy for their involvement in health governance was generally low among ordinary people. Knowledge of this structure and how they are elected needs to be improved among community members. There is need to empower communities and sensitize them on the value of claiming their rights by demanding for accountability from leaders, including pushing for, and attending, community meetings with leaders and other duty bearers.

Local and district leaders as well as program managers were overall supportive of community participation in health governance and were generally satisfied with the strategies being used to ensure this is achieved. There is need to build on this support to address the existing gaps in actual realization of meaningful community participation in health governance by providing resources, considering community views, and ensuring functionality of the community participation structures.

The observation so far is that commitment to community participation in health governance among local government leaders remains largely verbal or on paper. Facilitation for HUMCs is insufficient, while parts of the population are not served by health facilities – and hence have no opportunity to participate in health governance. It is important that local leaders go beyond tokenism and become more proactive in supporting community participation, through harnessing local and community resources to support HUMCs.

Respondents at facility level reported that health workers had not received any form of training in human rights, and thus, were not aware of the importance of community participation in health and what role they could play in fostering it. The next phase of work needs to build the capacity of health workers in human rights, including the importance of community participation in health governance.

REFERENCES

Brownlea, A. (1987). Participation: Myths, realities and prognosis. *Soc Sci Med*, *25*(6), 605-614. Retrieved from http://http://www.sciencedirect.com/science/article/pii/0277953687900852

Gostin, L. O., Ooms, G., Heywood, M., Heffeld, J., Mogedal, S., Rottingen, J. A., . . . Friedman, E. A. (2010). *The joint action and learning initiative on national and global responsibilities for health* (World Health Report 2010, Background Paper, No 53). Retrieved from World Health Organization website: http://www.who.int/entity/healthsystems/topics/financing/healthreport/JALI_No53.pdf

Green, A. (2012, June 20). *Activists to Pursue Maternal Health Case Against Government | CEHURD*. Retrieved from http://www.cehurd.org/2012/06/activists-to-pursue-maternal-health-case-against-government/

Gruskin, S., Ahmed, A., Bogecho, D., Ferguson, L., Hanefeld, J., MacCarthy, S., . . . Raad, Z. (2012). Human rights in health systems frameworks: What is there, what is missing and why does it matter? *Glob Publ Health*, *9*(3), 337-351.

McCoy, D. C., & Hall, J. A. (2012). A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Policy and Planning*, *27*(6), 449-466. Retrieved from http://heapol.oxfordjournals.org/content/27/6/449

Meier, B. M., Pardue, C., & London, L. (2012). Implementing community participation through legislative reform: a study of the policy framework for community participation in the Western Cape province of South Africa. *BMC International Health and Human Rights*, *12*(15). Retrieved from http://www.biomedcentral.com/1472-698X/12/15

Ministry of Health (n.d.). *Basic information about Village Health Teams: Improving health at the household level*.

Ministry of Health (2009). *National Health Policy: Reducing poverty through promoting people?s health* (May 2009 Version). Retrieved from http://www.health.go.ug/National_Health.pdf

Ministry of Health (2010). *Village Health Team Strategy and Operational Guidelines*. Retrieved from Malaria Consortium website: http://www.malariaconsortium.org/inscale/downloads/uganda/VHT-strategy-and-operational-guidelines.pdf

Mugala, J. (2012, June 7). *Centre for Health Human Rights & Development & 3 Ors v Attorney General | Uganda Legal Information Institute*. Retrieved from http://www.ulii.org/ug/judgment/constitutional-court/2012/4

Mulumba, M., Kabanda, D., & Nassuna, V. (2010). *Constitutional provisions for the right to health in east and southern Africa* (EQUINET Discussion Paper 81). Retrieved from Regional Network for Equity in Health in East and Southern africa (EQUINET) website: http://www.cehurd.org/wp-content/uploads/2011/01/Report-on-the-Right-to-Health-in-ESA-Country-Constitution.pdf

Padarath, A., & Friedman, I. (2008). *The Status of Clinic Committees in Primary Level Public Health Sector Facilities in South Africa | Health Systems Trust*. Retrieved from Health Systems Trust website: http://www.hst.org.za/publications/status-clinic-committees-primary-level-public-health-sector-facilities-south-africa

Potts, H. (2008). *Participation and the right to the highest attainable standard of health* (ISBN 978-1-874635-40-6). Retrieved from Human Rights Centre, University of Essex website: http://www.essex.ac.uk/hrc/research/projects/rth/docs/Participation.pdf

Thomas, J., & London, L. (2006). *Towards Establishing a Learning Network to Advance Health Equity Through Human Rights Strategies*. Durban: University of Kwazulu-Natal.

UHRC (2010). *13th Annual Report 2010 to the Parliament of the Republic of Uganda*. Retrieved from Uganda Human Rights Commission website: http://www.internal-displacement.org/8025708F004CE90B/(httpDocuments)/A6006A1C50F8021EC12579FA003E915D/$file/UHRC+Annual+Report+2010.pdf

World Health Organization (2008). *Health system governance for improving health system performance: Report of a WHO global consultation 7-9 November 2007 Cairo, Egypt* (WHO-EM/PHP/043/E). Retrieved from http://gis.emro.who.int/HealthSystemObservatory/PDF/Publications/Reports%20of%20Workshops%20and%20Meetings/PHP043healthsystemgovernancefinal.pdf

World Health Organization (2010). *WHO | Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. Retrieved from http://www.who.int/healthinfo/systems/monitoring/en/index.html

World Health Organization (n.d.). *WHO | Governance*. Retrieved January 27, 2014, from http://www.who.int/healthsystems/topics/stewardship/en/

Yamin, A. E. (2009). Suffering and powerlessness: The significance of promoting participation in rights-based approaches to health. *Health and Human Rights*, *11*(1), 5-22. Retrieved from http://www.hhrjournal.org/2013/08/29/suffering-and-powerlessness-the-significance-of-promoting-participation-in-rights-based-approaches-to-health/

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