Health Committees as Vehicles for Community Participation: A National Colloquium on Health Committees in South Africa

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Report of a National Colloquium on Health Committees in South Africa

LEARNING NETWORK

Summary

Health Committees are structures mandated by the Health Act and can serve as key vehicles for community participation in health, acting as the interface between the Health Services and communities. However, there is little clarity on the roles and functions of health committees and on how best they should be institutionalised in the health system in South Africa.

As part of a project of the Learning Network for Health and Human Rights, a civil society partnership working with higher education institutions to identify best practice for realising the right to health, a national colloquium on Health Committees was convened on September 29th 2014. The colloquium, attended by over 100 participants, from a diverse range of backgrounds, including many health committee members, researchers, health activists, government officials and NGO members, provided an opportunity to share research findings and experience from the project and other partners working on community participation in health. The Colloquium was funded by the European Mission to South Africa.

The colloquium programme included inputs from key government officials, NGOs, legal experts and researchers working with health committees, and from health committee members from around the country. Extensive group work also generated important guidance for taking the issue of community participation through health committees forward.

Some of the key learnings from the meeting were (i) participation is a constitutional imperative and health committees provide the opportunity to realise the vision of participation contained in various policy documents; (ii) a clear commitment was expressed from government to supporting the integration of health committees in the health system; (iii) the importance of capacity building for health committees and for providers and managers in building community participation was highlighted; (iv) the key role health committees can play in monitoring of service delivery – rather than providing a service, health committees are primarily about governance and oversight. The governance role is reflected in most policies and guidelines but often is not the practice; (v) the importance of building partnerships between providers and health committees was evident; (vi) health committees often taking on broader social development roles because of the challenges of poverty in the communities in which they operate; (vii) the value of health committees' oversight and support role is amplified when there is tiered participation upward from facilities – through sub-districts, districts and higher levels; (viii) through their actions, health committees can protect the rights of the most marginal in society, thereby enhancing equity in the health system; (ix) although 7 out of 9 provinces have some form of policies in place pertaining to health committees, it is unclear how well these policies are implemented. Existing research suggests many obstacles exist to implementation and South Africa has a record of having excellent policies but weak implementation.

Some of the challenges related to the lack of clarity on roles and functions of health committees, unclear processes to ensure representivity and legitimacy of committees and absent support for their functioning. Moreover, lack of recognition and absent or

insufficient funds to cover costs is extremely demotivating to health committees. The Colloquium agreed that oversight and governance roles were the primary job of a health committee, along with advocacy, social mobilisation and representation of community needs. Different approaches to ensuring broad community representation were proposed, almost all of which emphasised the process of democratic constitution of health committees, extensive community outreach, enabling voice particularly for vulnerable groups and involving local ward councillors whilst avoiding co-option of health committees to party political agendas.

The Colloquium closed with a number of resolutions, urging the adoption of provincial legislation to recognize the roles and functions of health committees as critically important vehicles for community participation in health, with the involvement of health committees in finalising this legislation, and calling for high level political support for health committees. Other resolutions address questions of resources and training, the linking of facility-based health committees to structures at sub-district, district and higher levels and the integration of requirements for functional health committees in department of health quality management programmes such as the Ideal Clinic programme and the work of the Office of Standards Compliance.

The meeting resolved to pursue the establishment of a national network on health committees to take forward the resolutions and some of the outstanding work required. As framed by one delegate, health committees have been on the policy agenda since 1995 and the National Health Act first provided for recognising health committees when adopted in 2003. The consensus at the meeting was that “19 years is way too long.” The meeting closed with some international reflections on community participation in other countries, confirming the role of health committees as vehicles of democratic governance, and framing the process, including the deliberations of the colloquium, as part of a commitment to deepening democracy in health.

Contents

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The meeting was hosted by the Learning Network for Health and Human Rights, which is a collaboration of 5 civil society organisations (The Women's Circle, Ikamva Labantu, Epilepsy South Africa, The Women on Farms Project and the Cape Metro Health Forum) as well as 4 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 researchers from Maastricht University in the Netherlands and Cardiff University in the UK) 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 participatory action research, training and advocacy are linked to empower organisations and their members to assert rights for health. The Vision of the Learning Network is 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. (seewww.salearningnetwork.weebly.com). The grant which funded this work was provided by the European Union to the University of Cape Town.

Background

South Africa's National Health Act provides for community participation structures linked to health facilities at all levels. The Act stipulates that each clinic (or group of clinics) should have a health committee, composed by the facility manager, ward councillor and community members, with the idea that these committee act as vehicles for community participation in health. However, research has shown that lack of clarity on role and function is one of the main barriers for creating effective and sustainable health committees and so presents a major challenge to community participation in health. Furthermore, confusion about role and lack of a clear mandate impacts on the role that health committees currently play. Research has also shown that lack of support undermines meaningful participation and that health committees in many cases function sub-optimally in parts of South Africa. If South Africa is to realise its vision of a District Health System based on the Primary Health Care approach, particularly given its commitment to advancing universal access to health care through a National Health Insurance, addressing this policy gap around community participation is a key development challenge for the health sector.

Over the past few years, the Learning Network for Health and Human Rights (LN), a civil society-university partnership[1] has been working on strengthening community voice through health committees. In 2012, it received funding from the European Union Mission to South Africa as part of the EU's strengthening of Primary Health Care Progamme to undertake a project focused on "Health care users' experience as a focus for unlocking opportunities to access quality health services." A central component of this project has been a set of activities to strengthen the capacity and mandate of health committees to act as vehicles for realising the right to health.

As part of this work, the LN convened a National Colloquium on Health Committees at the Belmont Square Conference Centre in Rondebosch on the 29th of November, 2014.The purpose of the colloquium was

1. To better understand the roles and functions of the health committees in a re-engineered primary health care system;
2. To understand the best institutional and legal framework to maximise the contribution of the health committees to a responsive health system.

The colloquium was attended by more than 100 participants, including health committee members from many provinces, health officials, NGOs involved in working with health committees, and health and legal researchers.

[1] The Learning Network is a participatory action research collective of 5 civil society organisations (The Women's Circle, IkamvaLabantu, Epilepsy South Africa, The Women on Farms Project and the Cape Metro Health Forum) as well as 4 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, Maastricht University, in the Netherlands, and Warwick University in the UK) 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 are linked to empower organisations and their members to assert rights for health. The Vision of the Learning Network is 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

Introduction and Overview of the Colloquium

Participants were welcomed by Leslie London from UCT's School of Public Health and Family Medicine who outlined the purpose of the colloquium and its programme and drew the attention of the participants to a preceding meeting held on the 27th and 28th September in which participants from Africa had held a consultative meeting on health committees and highlighted the importance of health committees as vehicles for democratic governance in health systems. Flora Bertizzolo, the EU's health attaché to South Africa, then gave a brief input, explaining the importance that the EU attaches to its work in South Africa, which it views as a strategic partner. One of three key areas for the EU's work in health is a focus on health as a human right, under which the EU has funded projects to strengthen the demand for quality health care. She thanked the organisers and wished the meeting well on its deliberations.

The programme that followed (See Appendix 1) included a presentation from the Deputy Director General for Primary Health Care in the Department of Health, Ms Jeanette Hunter, and a number of presentations: (a) from NGOs working with health committees; (b) from health committees presenting their experiences; (c) a rapid appraisal of provincial policies on health committees; (d) a reflection on constitutional imperatives informing policy on participation in health; and (e) a case study from the Eastern Cape on participation. These presentations and the questions they generated informed groups discussions that addressed three key questions: (a) what are the roles and functions of health committees; (b) how do we ensure broad community representation within health committees; and (c) how should health committees be institutionalised in policy, practice and legislation? This report summarises the presentations and discussions over the course of the Colloquium.

Health committees are often referred to by different descriptions, such as health facility committees, clinic committees and health committees. In this report, the term health committee is used to refer to any of these structures and applies to committees linked to a primary care facility or group of facility with the intention of fostering community participation in health.

Opening address: Health Committees and Community Participation in National Policy Development (Jeanette Hunter, DDG, National Department of Health)

Jeanette Hunter, the Deputy Director General for Primary Health Care in the National Department of Health (NDoH), delivered the keynote address on the National Department of Health's Perspective on Community Participation in Health and the Role of Health Committees.

She confirmed the Department's view that participation by communities in health was an important policy objective for the Department, reflected in the National Health Act (NHA), which stipulates that each clinic or group of clinics should have a health committee. However, she indicated that one the Health Department's major challenges with regards to health committees is that they have no overview of which committees are functional. She referred to the provisions of the NHA, which require that provincial legislation should stipulate roles and functions, and acknowledged that there is still lack of clarity about health committee roles and functions. However, this is not unique to clinic committees but is also a challenge for other structures such as hospital boards.

Ms Jeanette Hunter, DDG PHC. Photo: Damaris Kiewiets

The National Health Department is in the process of updating guidelines for clinic committees. Hunter indicated that a guideline was preferable to a national policy since the Act was clear about the need for a committee.

The composition of health committees is also clearly determined in the NHA (community members, facility manager and ward councillor)."As head of a health facility, I would make sure that senior clinic staff members were included," said Hunter. Furthermore, she stressed the importance of local government councillors being represented on the clinic committees. "By virtue of being led by the councillors', clinic committees will have a direct means of communicating to MECs, the Minister of Health and other relevant political leaders."She framed the committees' roles as follows:

- These committees are people's representatives;
- They must serve on behalf of the catchment area (of the clinic) to address the needs of the local communities;
- They need to have a relationship with the clinic management;
- They should hold conversations with the district and with the province.

Hunter then went on to present the Department's project on The Ideal Clinic, which is part of the presidential programme Operation Phakisa. The project is seen as a way of developing well-functioning clinics. The National Department of Health has developed a set of criteria for an ideal clinic and these are consistent with the elements of the National Core Standards of the newly formed Office of Health Standards Compliance. Having a functional health committee is one of the elements of the Ideal Clinic so this offers an opportunity to enhance establishment and functionality of health committees.

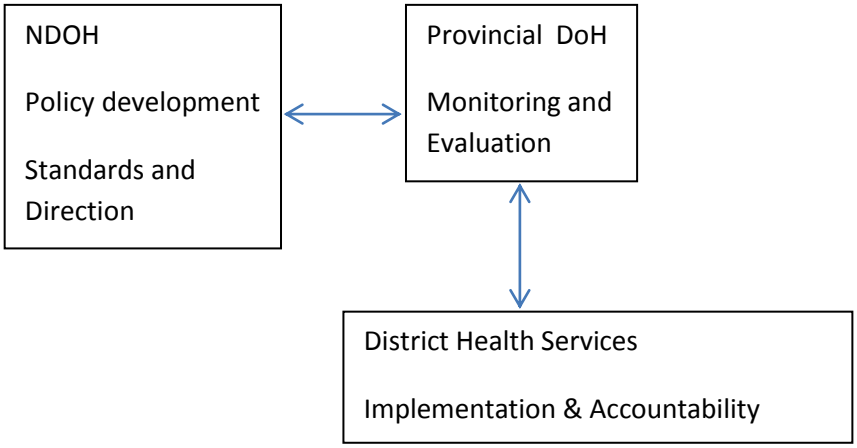
It was therefore essential that health committees know the requirements of the Ideal Clinic, said Hunter. She suggested that a pocket guide, similar to Section 27's pocket guide on the National Health Act, should be developed for easy reference to the criteria for the ideal clinic. Ms Hunter emphasized the important role health committees can play in ensuring that criteria are met for clinics to become Ideal Clinics.

The need for training was also emphasized by Hunter. She argued that there is a need to develop a manual for both hospital boards and health committees to enable them to work with the concept of an Ideal Clinic. Also required is joint training and orientation of health committees with health professionals to address issues of health, health promotion, disease prevention, and service provision.

The presentation was followed by questions and discussion. One question addressed the issue of the need for some conformity amongst provinces with regards to health committees. Referring to the

concurrent institutional arrangement between the national government and provincial governments, Ms Hunter explained that the NDoH does not have authority to tell provinces what they must do. She argued that the concurrent institutional arrangements are a good model. “It provides for a decentralised approach with districts having good decision making authority,” said Hunter.

She used the following diagram to illustrate the point about concurrent powers.



She argued that attention should focus on implementation rather than on developing new policies: “We have brilliant policies. The gap is in their implementation. We need simplistic guidelines, in which every job will be detailed with regard to the steps required for implementation,” said Hunter.

The keynote address was followed by a session where NGOs and universities working with health committees presented their work.

Strengthening the Monitoring Role of Community Health Committees: Lessons from a Community Scorecard Pilot Project (Brittany Bunce, Black Sash)

Brittany Bunce from Black Sash presented a project on Strengthening the Monitoring Role of Health Committees. This project forms part of a larger project on Reducing Child and Maternal Deaths (RMCH). Bunce was the project manager on the project, which was piloted in Port St. John in the Eastern Cape and in uMgungundlovu in KwaZulu-Natal.

The project’s aim was to improve maternal and child health services through introducing community monitoring. A scorecard was developed with the local community and another with health care providers but the emphasis of the work was to develop, through shared discussion, a ‘joint scorecard.’ The presentation illustrated how the community score card allowed for broad participation of the community, promoted dialogue and improved relationship between service users and providers. It also facilitated common understanding of issues and solutions.

The scorecard developed by Black Sash was based on a scorecard first developed and used by Care Malawi, but Black Sash’ scorecard reduced the number of steps. It also changed complex terms such as ‘indicators’ with simpler terms like ‘what we want to see’. Finally, the tool was modified to ensure

that demand side barriers as well as supply side barriers to accessing maternal and child health services were addressed.

She presented baseline research, which outlined factors that hindered the effective functioning of the committees and listed a number of lessons learnt from the project:

- Health committees are good at mobilisation and interacting with communities;
- Community monitoring provides the opportunity to bringing people together;
- The project was able to include decision makers into the process;
- Community monitoring requires a paradigm shift towards taking up responsibility and not sharing the blame for poor services. It requires an active citizenship;
- Very little can be achieved through being conflictual. Health committees were required to understand the conditions of health workers. Developing the scorecard had improved relationships between health workers and community;
- Policies need to be enforceable;
- Committees would benefit from training.

Mentoring Health Committees in the Eastern Cape: Health Committees in Action (Zingisa Sofayiya, the Learning Network)

Zingisa Sofayiya from the Learning Network on Health and Human Rights spoke about her experiences with mentoring health committees in the Eastern Cape. She described her work as a mentor in the Nelson Mandela Bay Health District, working with committees, journeying alongside them and supporting them so that the committees run effectively. She explained that health committees need support to unleash their potential and to be agents of change. The process started with selection often health committees from three sub-districts. The primary mentoring role to date has been to improve their understanding and implementation of their roles as health committees.

The Eastern Cape Policy on health committees is very clear in describing four distinct roles: oversight, social mobilisation, advocacy and fundraising. Oversight requires that the committees understand Primary Health Care, the objectives of the clinic, targets and indicators and the complaints process. Social mobilisation requires that the committees mobilise in the local communities. The committees have been working on developing social maps, addressing the social determinants of health, and mobilising people in the community around these issues - especially dumping sites and sanitation issues as many communities still have bucket system sanitation.

The committees have been engaged in the door-to-door campaigns (alongside the R-PHC programme), clean-up drives, educating communities on health rights, advocacy particularly around security issues at the health facility and establishing food gardens. A major challenge has been finding a venue in which to conduct the mentoring programme. They often move from one venue to the next during the mentoring.

In closing, she played a DVD made of an interview with one of the committees that she mentored. In the DVD, health committee members from Ikamvelihle Primary Health Care Centre talk about the benefits of the mentoring programme and how it has helped them to feel comfortable in their role.

Western Cape Heath Committee Training (Fundiswa Kibido, the Learning Network)

Fundiswa Kibido, a trainer with the Learning Network in the Western Cape, started her presentation on training of health committee members in the Western Cape by explaining that the following areas are covered in the training: health systems, meaningful participation, community participation, power and democracy, legislative framework, and the complaints process. Kibido explained that training focused on health committees' roles as it had been found that committee members were often working as volunteers at the health facility rather than being involved in governance structures.

The training of health committee members in the Western Cape consists of a three-day training programme and subsequent establishment of Learning Circles, where further capacity building takes place, often addressing issues that emerge in the training such as social rights. The approach to training and capacity building is to empower health committee members. Kibido stressed the importance of addressing power dynamics within communities, between health committee members, ward councillors and health facilities.

Kibido highlighted the following outcomes of the training programme:

- A database of health committee members has been compiled;
- A three day training programme for health committee members has been conducted for 355 health committee members;
- Nine topics have been identified for the Learning Circles;
- A mentoring and capacity development programme for identified health committee members has started (within the Learning Circle programme).

Results indicate that the training has helped to revive health committees, as they now know and understand their roles better. She suggested that the next step should be training health professionals to better understand community participation and the role of health committees, a project that the Learning Network is currently undertaking. Furthermore, she emphasized the need to develop a broader community development strategy to address the severe social dysfunction that committee members face daily. She ended her presentation by saying that although the work was challenging, it was also immensely rewarding.

The presentations from organisations working with health committees were followed by a plenary discussion. The first comment focused on the DVD from the Eastern Cape, which the member of the audience found showed lack of respect for health committee members from health professionals as they were constantly interrupted, since the DVD showed how health professionals walked in and out of the room whilst the DVD was being made.

Another comment suggested that the issue of sustainability due to lack of funding for health committees should be addressed by including health committees in the health facility's budget.

Other participants commented on the need to ensure that health committees are equipped to understand the National Health Insurance.

The session that followed focused on the experiences of health committees.

Health Committee experiences from Nelson Mandela Bay Metro (Abraham Isaacs, Nelson Mandela Bay Health Forum)

Abraham Isaacs, chairperson of Nelson Mandela Bay Health Forum, opened the session by telling the audience that health committee members from Nelson Mandela Bay were coming to Cape Town on an exchange visit. They intended to share experiences with health committees in Cape Town and learn from each other. "We are hoping to find out about good practice and to return home to implement good practice," said Isaacs.

He then gave an overview of health committees in the Nelson Mandela Bay district, explaining that all 50 clinics in the district have a health committee. These were established in 2010 in accordance with the Eastern Cape Policy, which was developed in 2009. At the time of establishment, health committee member were trained in a three-day training programme. In addition to health committees, three sub-district health forums have been established and a few weeks ago a district forum was established with the district manager.

Isaacs also outlined some of the challenges for health committees. The major challenge is the limited resources for health committees, resulting in health committees not having money for transport and stationary. However, Isaacs promised the audience that health committees will continue despite the challenges they face.

"Despite these challenges, we are not giving up. We know we have an important role to play for our communities, representing their interests at the clinics. We will not be crying about the lack of resources, we will push on until we get the resources," he said. Isaacs ended his presentation by thanking the Learning Network in the Eastern Cape for the support they have provided.

Health Committee Experiences from the Cape Town Metro (Nozibele NowhiMndayi, Gugulethu Health Committee)

Nowhi Mndayi described how health committees in her area are formed to improve accountability. She explained that health committee members represent organisations in the communities. She explained how their health committee is comprised. Health committee members are expected to have a letter from their organisation that gives them the mandate to represent the organisation in the committee. Committee members are required to report back to their organisation. "This is what we call accountability," she explained.

The role of health committees was "… to ensure that the community receives good health care. We can talk about the needs of the community all day, but we have to make a difference. We check on the services. We notice that people are queuing for the health services from 04h00. This is not right. It is not healthy and it is not safe," commented Mndayi.

The Gugulethu health committee member argued that health committees should monitor health services, even though some health professionals may feel threatened by their presence. She also stressed the importance of facility managers supporting the health committees.

In further elaborating on the role of health committees, Mndayi insisted that health committees should not clean the clinics or act as security guards. “That is not our role or responsibility. I’m sorry, but we are not cleaners or securities. That is the role of government and we are there to see that government does its job properly,” she said.

Similarly to the Nelson Mandela Bay district, health committees in Cape Town are also organised into sub-district health forums and have an umbrella body called the Cape Metro Health Forum. Mndayi acknowledged the support from the Learning Network and said the support had helped empower committees and give them dignity.

NGO Experiences with Rural Health Committees (Sharon Messina, the Women on Farms’ Project)

Sharon Messina, health teams officer at the Women on Farms’ Project based in Stellenbosch, spoke about her organisation’s involvement with health committees and the Learning Network. She said that Women on Farms have established two new health committees in the rural farming areas of Rawsonville and Wellington and received support from the Learning Network in the process.

She reflected on the difficulties women working on farms face when seeking health care. “The farms and farming areas are sorely under-resourced. Women who attend clinics from the farms are often neglected. When you’re from a farm, you are often attended to last. Farm workers are often treated poorly by health professionals, who assume that because they are from the farms they cannot understand or feel injustice. Health professionals underestimate the knowledge of women on farms. There are many health and human rights violations that are happening in the clinics related to the farm workers and particularly to women. We need to make sure that these violations stop,” said Messina.

Reflecting on how to improve the health services, Messina stressed the importance of continued monitoring of health service. “The bad attitude of clinic staff is sad to see. Whenever we hear this, we follow up and report these incidents to the health services. After our reporting, it seems that things improve, but we need to continuously monitor,” she argued.

The need to address social determinants of health was highlighted as important. Furthermore, Messina pointed out that in many rural areas health committee members are often selected by the facility manager and she said that this needs to be changed.

The plenary that followed addressed a number of issues. One participant suggested an investigation into how community participation is organised in Brazil as South Africa is modelling its health reform on that country. An important aspect of the Brazilian system is, according to the participant, that local councillors interrogate the Health Department about its budget. “We see none of this here. Should we not be pushing more for this? We are looking to build a participatory democracy, more needs to be done to make this happen.” Another question dealt with the role of local government councillors and their absence from health committees despite being prescribed as members by the

National Health Act. Health committee members explained a local solution to this problem in Gugulethu and Khayelitsha, where health committee members attend their ward committee meetings in order to get the local government councillors involved in health and health committees. The way in which the Women on Farms Project works was used to illustrate the importance of visibility. They work with the media and organise marches to highlight the plight of female farm-workers. It was suggested that health committees should become more visible and market themselves better for instance through using the radio and local media.

The Constitutional Framework for Participation (Ashraf Mahomed, human rights lawyer)

Human Rights lawyer and former Head of the South African Human Rights Commission in the Western Cape, Ashraf Mahomed provided input on the constitutional and legal framework for participation.

He began his presentation by saying that access to health care is fundamental to our democracy. "We live in a constitutional democracy. Our Constitution was adopted on the 10th of December 1996 and provides an enabling framework with enabling provisions."

Mahomed outlined some essential elements of our constitutional democracy. These include:

- The supremacy of the Constitution;
- Sovereignty – power to govern is vested in the state;
- People's participation is fundamental to democracy;
- It is a secular state – i.e. no official religion;
- Rule of Law – the state must act in act in accordance with the law;
- Accountability – i.e. government must explain laws and actions;
- Separation of powers.

The Constitution applies to all spheres of government (local, provincial, national). "It is the world's friendliest constitution" claimed Mahomed. Mahomed contended that active and informed community participation is essential to our democracy. He stressed the importance of the right to participation and government's obligation to make is possible for people to participate in decision making. In other words, there is a legislative requirement for participation. "Related acts and policies provide that government must make it easy for people to participate. The Alma Ata Declaration on Primary Health Care makes it clear that active meaningful community participation is essential," stated Mahomed.

He then outlined some of the policies that are in place to facilitate participation in health such as the White Paper on the Transformation of the Health System, the Western Cape Health Facilities' Boards Act, the National Health Act's section on health committees and the section in Local Government Municipal Systems Act's on community participation. He went on to discuss aspects of community participation in a Constitutional Democracy, arguing that "democracy does not end with elections". He said that government needed input from people to make decisions and that citizens should be able to interact with government on decisions that affect them. A human rights framework is used to define government's obligations.

Mahomed expanded on a human rights framework for participation, saying that the importance of community participation is that it makes government open, transparent and accountable and forces it to act on its promises. Therefore, citizens have a right to set the agenda for discussion, prioritisation and implementation. They also have a right to have a say in the overall health strategy, to participate in decision-making and be properly informed.

Moving on to health committees, he argued that there was consensus that health committees should be involved in governance, oversight and strengthening community participation.

He ended his presentation by asking three key questions for health committees.

- What are the key community participation interventions around access to primary health care?
- What are the key challenges and obstacles in the participation process in your community?
- How do you think participation should work in your community?

A Rapid Appraisal on Provincial Policies on Health Committees (Hanne Jensen Haricharan, the Learning Network)

Hanne Jensen Haricharan from the Learning Network presented a rapid appraisal of provincial health committees in South Africa. She started by presenting background research conducted amongst health committees in Cape Town. This research identified four key challenges for health committees.

- They have limited reach with only 55 % of clinics having health committees;
- Sustainability and functionality of health committees are often compromised;
- It is questionable how representative committees are as the process of forming health committees is unclear;
- Health committees play a limited role with limited decision-making and power.

The research identified lack of clarity on roles and functions of committees as a major reason for health committees' limited role and linked this to a policy vacuum in the Western Cape, where a policy drafted in 2008 was never implemented. Haricharan said that her research had showed the impact of a policy vacuum amongst health committees in Cape Town, but that there had been limited knowledge of policies in other provinces. The rapid appraisal attempted to get an overview of provincial policies.

The rapid appraisal found that at least seven out of nine provinces had policies, draft policies or legislation pertaining to health committees. The Western Cape was the exception, though a process to provide a legislative framework for health committees in the Western Cape Facility Boards Act had recently been initiated. Furthermore, it is unclear whether there is a policy in Limpopo.

The policy appraisal found that there was consensus on health committees playing a role in governance, accountability and networking/stakeholder management. Other roles, which were only stipulated in some policies, included advocacy, fundraising and social mobilisation. Her presentation highlighted that, although there was consensus around health committees playing a governance

role, research showed that there often is a discrepancy between policies and practices as many health committees' main function is to support the clinic with day-to-day operational tasks.

She explained that there were at least two ways of forming health committees, by election or by appointment by the health MEC. Only one provincial policy stipulated that health committees should be elected, one was not clear, and, in the remaining provinces, health committee members are nominated by the MEC. She argued that it was worth debating whether community participation structure should be formed by appointment by provincial ministers. She suggested that the nomination process that leads to appointment should be scrutinized and that the implications of a top-down approach to community participation needs to be understood.

Composition of health committees was also explained. While most provinces followed the composition suggested in the National Health Act (community members, facility manager and local government councillor), two provinces had what she called a 'sector approach' to composition of health committees. In those provinces health committees would have representative from certain sectors such as disability, traditional leaders, business, youth, women and religious communities. While there were pros and cons of both approaches, Haricharan suggested that it was important to interrogate why certain sectors should be represented while others – such as refugees and the sexual minorities – were not included.

The appraisal of policies showed that there was limited financial and other support for health committees. Only the Eastern Cape policy stipulated that health committee members should be trained.

The presentation was concluded by posing some issues for consideration.

- Clarity on role and function;
- Should health committees be elected or appointed?
- How should health committees be composed, according to the National Health Act or should they have 'sector' representative;
- How should health committees be capacitated (financial support, other support, training)?
- How should health committees link to other community participation structures?
- How can community participation structures have influence on the broader health system e.g. at policy level?

Review of the Eastern Cape Policy on Health Committees (Therese Boulle, Learning Network)

Therese Boulle from the Learning Network presented her work on a review of the Eastern Cape Policy on health committees. She said that the formulation of the policy started in 2006 when representatives from the Provincial Strategic Planning Department approached a broad group of stakeholders working on health committees in the Nelson Mandela Bay[2] to start the process of compiling a policy for health committees. About 30 people gathered to give input. Amongst these were health committee members, officials and NGOs. Three years later, in 2009, the policy was completed, launched and promulgated.

[2] These included the Municipal Health Directorate; Department of Health, health committee members and Community Development Unit at Nelson Mandela Bay Metropolitan University.

The promulgation happened with much pride as the Eastern Cape was one of the first provinces to have a policy on health committees. The policy is a substantial and comprehensive document of 28 pages, concurring largely with the 1997 White Paper on the Transformation of the Health System in South Africa. She argued that one of the strengths of the policy is that it sets out clearly how to establish health committees, and who takes responsibility for various aspects of their establishment.

The policy is also fairly prescriptive as to how communities should be represented on the committees. A list of sectors that should ideally be presented includes traditional health practitioners, religious sector, women's organisations, youth structures and disabled people. In the process of establishing committees, representation was broadened as it was decided to create committees that were inclusive rather than exclusive. Furthermore, the policy provides for a committee of 15 people for three years, including the ex-officio positions of the facility manager, organised labour and the ward councillor.

In the policy, the roles for the committees were spelled out and fairly well described. As examples of this she mentioned accountability, which is interpreted as an oversight role, with the additional roles of social mobilisation, advocacy and fundraising. However, she argued that this level of detail might be too prescriptive in its description of roles. "I think this is a limitation of the policy because it is too prescriptive, and not sufficiently broad to include the ethos and spirit of community participation."

The policy also stipulated that training of health committees should take place and a three day training programme was designed and implemented for all health committees.

In addition, roles are also spelled out for facility managers, sub-district and district management as well as organised labour. However, there is no specific allocation for stewardship of the committees, and this is a limitation, argued Boulle.

Amongst other things, the policy also provides for sub-district and district health forums. "We regard these as essential and invaluable for sustainability as committees come together and draw strength from one another; share problems which are often mutual; boosts the power and authority of the committees, and hold the services to account," reflected Boulle.

In conclusion, Boulle described the Eastern Cape Policy as not a bad first attempt. "There are things we need to improve. We will be working with the committees to address improvements of the policy."

Group Discussions

Participants split into groups twice during the day to discuss roles and function of health; how to ensure broad community representation; and the best institutional arrangement for health committees. In plenary, groups presented the main points of their discussion:

Roles and functions of health committees:

The roles and functions identified in group discussion broadly confirmed what was presented in the inputs from health committees and NGO's working with health committees and were consistent with the various policy documents presented. They include oversight and governance roles, advocacy, social mobilisation and representation of community needs.

For governance to be effective, there had to be meaningful input, which means that the form this takes may differ across different districts. Advocacy envisaged for health committees included health promotion activities but also keeping communities informed, human rights education, involvement in the complaints mechanism and articulation of community needs. Maintaining a link between the community and the services was important.

In terms of oversight, there were various suggestions made, including involvement in management of services, monitoring and evaluation, overseeing complaints resolution and involvement in human resources processes. However, other than agreement about the need to be involved in oversight, what this comprised exactly was not consistent across the groups.

In terms of social mobilisation, the elements for health committees were to encourage community participation, raise awareness, network and develop inter-sectoral collaboration.

Fund-raising was seen as important for addressing community needs and for community upliftment, but must take place in a manner consistent with the legal and policy framework.

Lastly, all groups confirmed the importance of health committees playing a role in establishing accountability in the health system.

How to ensure broad community representation

There were three groups grappling with the representivity of health committees. A strong sentiment was expressed that committees must be democratically elected. Even if the MEC is required to sign off on confirming health committee membership, this should not interfere with the process of first identifying health committee members through democratic processes.

Whilst democratic election was one principle, another was to ensure broad and inclusive representation so that all voices are heard. Particular emphasis was placed on participation by vulnerable groups and efforts should be made to include vulnerable groups and support their participation in health committees. This meant that there needed to be some way to make the election process one which addressed different sectors or groups. Suggestions were made as to which sectors or groups might be earmarked in constituting a health committee but no definitive list could be reached. Health committees also needed to be culturally sensitive in the way they worked.

Another key element to representivity was the importance of ensuring that health committees represent the needs of the local community. Holding consultative meetings may be one way in which committee members stay in touch with the broader community and provide a voice for the community. This should be part of how committees operate and should also therefore be supported by the health system if it wants representive committees. Thus, while health committee may also report to the health department on their performance, their main form of accountability should be to the community and they should advocate for the

community in relation to the services. Political support for health committees was critically important to ensure they are recognised, get the resources required to hold community meetings and serve as genuine vehicles for community voice.

Ward councillors are meant to be part of health committees but often do not participate. Poor councillor representation could be taken up with South Africa Local Government Association (SALGA). However, there is also the problem of councillors dominating or manipulating committees for narrow political gain. One suggestion was made that councillors serving on the committee should not hold office to try to mitigate this risk.

Part of the representive role of health committees would also involve the health system visibly recognising health committees as important (for example, in providing venues and refreshments for meetings). The lack of resources, support and financial means are demotivating to health committees and undermine their ability to represent communities. Improved communication with communities through, for example, notice boards and use of community radio, may help to better link health committees with their communities.

There are also other participation structures in communities from which we could draw lessons – for example, School Governing Bodies and police forums and health committees. Good practice in those forums might be helpful for health committees. Health committees should also develop relationships with other health cadres.

Optimal institutional arrangement for health committees

The groups discussed what would comprise the best way to formalise (institutionalise) health committees.

Firstly, there should be a national civil society campaign to strategize and advocate for institutionalisation and ensure harmonization across the country. Mobilisation and awareness-raising in communities on community issues and health rights will enhance community buy-in and contribute to community participation in decision-making processes, which is part of promoting

active citizenship. A situational analysis to establish what exists and what needs to be done to formalise health committees would be helpful.

There was a strong preference for institutionalisation through provincial legislation rather than relying only on policy. Nonetheless, a national framework (policy) was useful to guide provincial legislation. How to form a committee, as well as its composition, roles and responsibilities (particularly the need to report back to, and hear from the community) need to be clarified in such a policy, as well as stipulating the need for representivity from all sectors of society and protection of the autonomy of health committees from party political influence. A code of conduct for health committee members would be helpful to avoid some of these pitfalls. A policy would also be the basis for guiding committees in developing their constitutions. How committees are able to effect redress of violations should also be written into policies and legislation. Institutionalisation will also be achieved by adopting policies and procedures in other parts of the health system that mandate community involvement in all planning processes, so giving health committees a recognised and visible role in planning.

Given these roles, it was critically important to make sure there are sufficient budgets to support the work of health committees (reimbursements) and that provinces provide support (space and communications). Equally, training and development of health committees are vital but have to compete with other government priorities of government. While there are many NGOs currently involved with health committee capacity building, it is ultimately government's responsibility to ensure training of health committees. Training of health professionals and local government councillors was also necessary for the successful institutionalisation of health committees.

From the point of view of managing the health system, human resource policies and procedures also need to support the institutionalisation of community participation through health committees. For example, district and sub-district managers should account for their performance in supporting health committees, meaning that community participation should appear as a Key Performance Area in the assessments of relevant health staff (managers and some providers). This could be extended to the idea of holding local government councillors accountable through local ward-based structures.

The levels at which health committees operate should include sub-district, district, provincial and national forums in a tiered system. This should be captured in law and policy. Visibility of health committees (for example, putting up notices on community notice boards, addressing community on community radio) would also strengthen the institutionalisation of committees. The fundraising role of health committees was discussed, not as a way to allow government to avoid covering the core costs of health committees, but should be considered for activities that were 'additional' to the core mission of health committees (for example, specific health promotion activities). We should not have a situation where health committees and communities are expected to pay for the costs of participation.

Resolutions:

Based on these discussions, the National Colloquium adopted the following set of resolutions:

1. Given the long delay in enacting the provisions of section 42 of the National Health Act, we call on Provinces to pass legislation as a matter of urgency to recognize the roles and functions of Health committees as critically important vehicles for community participation in health.
2. We call on the Minister of Health to table the status of health committees at the National Health Council to give direction and create an enabling environment for the adoption of provincial legislation on health committees.
3. Civil Society demands that government should provide the necessary resources (human resource support, training, reimbursement of costs and physical infrastructure as needed) for health committees to function optimally because it is obliged to do so by The National Health Act (NHA).
4. In developing regulations on health committees there must be participation by health committees and communities in the process.
5. There should be a tiered structure for community participation from facility to national level allowing for 2-way communication.
6. The Department of Health, when finalizing criteria for defining a functional health committee as part of evaluating health facility performance in the Ideal Clinic programme and in the work of the Office of Standards Compliance, must include participation by ward councillors and facility managers in their health committees.

The meeting resolved to pursue the establishment of a National Network on Health Committees to take forward the resolutions and some of the outstanding work required. The areas in which more work was identified as needed included:

a) The extent of roles and responsibilities and particularly that of ward councillors in the health committees;
b) How best to support health committees taking on fundraising roles in ways that supplement but do not substitute for core government support;
c) Inter-sectoral interventions needed to address health that require cooperation of other government department;
d) Political buy-in from elected leaders at local, provincial and national level;
e) Participation as a Human Rights issue;
f) Monitoring and Evaluation systems for health committees to help confirm what is a functional health committee;
g) Legal action to ensure health committees are appropriately recognized;
h) Mass mobilization in alliance with other civil society organisations in health.

Health committees have been on the policy agenda since 1995 and the National Health Act first provided for recognising health committees when adopted in 2003. The consensus at the meeting was that “19 years is way too long.” We need to see urgent progress on implementing health committees. A press release after the meeting, capturing these sentiments, is contained in Appendix 3.

Concluding comments: The Role of Health Committees in Advancing Democratic Governance.

Walter Flores, Director of Centre for the Study of Equity and Governance in Health Systems in Guatemala, concluded the day by reflecting on the discussions during the colloquium. His talk focused on health committees as democratic structures. He defined health committees as a voluntary community-based group engaged with local healthcare services and health authorities. He suggested that there are three different paths health committees can take. These often represent a trajectory toward a deepening of democracy, but health committees in one country may be on different paths and health committees may alternate between these different paths. The paths he describe were:

- Concern with epidemics;
- Decentralisation;
- Democratisation.

Walter Flores argued that we should aim for the third path, the democratisation model, where communities have ownership of the facilities and are part of decision-making processes. This path is linked to constitutional reforms and laws for citizen engagement and representation in public spaces.

The presentation suggested that the main difference in the three paths of health committees is the level of participation health committees have in decision-making, whether they are self-appointed, appointed by authorities or elected by communities and the degree of autonomy they have.

Walter Flores then asked the question: How do we advance the democratisation of health committees? He raised the following points.

- Laws and regulations must change to be inclusive of people's power. In Brazil, communities are required to be part of the budget approval process;
- Civil society needs to pressure government to develop progressive and inclusive laws that promote participation;
- Mass campaigns need to inform citizenry on the legal provisions – either with government or NGOs;
- Legitimate channels of engagement need to be established. Community needs to know what is happening. A complaints box (used in many health committees)is not a sufficient mechanism for engagement;
- Capacity building on a large scale is needed – sometimes this is with the support of government and other times mass alliances with civil society coordinate this support;
- Committees need to develop skills and knowledge so as to engage public institutions to hold them accountable.

Importantly, collective consciousness needs to shift so that people understand that it is a civil duty to participate and that participation includes the right to participate in key decision making.

The National Colloquium was closed by Zandile Xate, a health committee member from Eastern Cape, who delivered the vote of thanks and expressed gratitude for the opportunity to engage and debate.

Evaluation

In their evaluations of the meeting, participants expressed satisfaction with the colloquium. Participants indicated that the colloquium met both its objectives and their own expectations. Many participants valued the opportunity to share experiences across provinces highly. The opportunity to discuss roles and functions of health committee was also commented on by many participants. They highlighted the importance of having a forum where health committee members were given 'voice' and valued engagement between various stakeholders: health committee members, health officials, CSO's and academics. Many participants suggested that similar forums should take place annually and that networking between stakeholders must continue.

Conclusion

The Colloquium was a first step in a process of reaching national consensus on community participation structures in South Africa. Despite the existing situation, where there are many gaps in the policy context and a great deal of uncertainty about roles and functions, the Colloquium did generate consensus on some issues – that health committees are governance structures that hold the health system accountable; that health committees require support (training, recognition, reimbursement) and that such support is a government responsibility; and that health committees can be key structures for democratic governance, consistent with our Constitutional imperatives supporting democratic citizenship. As a first step, it laid the basis for further work going forward and the expectation of future networking and meetings to take the process forward.

Appendix 1: Programme for National Colloquium on Health Committees, 29th September 2014

A National Colloquium on Health Committees

Background and Programme

The National Health Act stipulates that each clinic should have a health committee, composed by the facility manager, ward councillor and community members. However, the Act leaves it to provincial legislation to stipulate role and function of these committees. Currently, six provinces have legislation, draft legislation or guidelines pertaining to health committees. The National Department of Health have written a Draft Policy on Health Governance Structures including Health Committees. However, despite these uneven policies, we know that there is little clarity on the role of health committees across the country.

Research has shown that lack of clarity on role and function is one of the main barriers for creating effective and sustainable committees. Furthermore, confusion about role and lack of a clear mandate impacts on the role that health committees currently play. Research also shows that lack of support undermines meaningful participation and that health committees in many cases function sub-optimally.

Over the past few years, the Learning Network for Health and Human Rights, a civil society-university partnership has been working on strengthening community voice through training Health Committees. In 2012, it received funding from the European Union Mission to South Africa as part of the EU's strengthening of Primary Health Care Programme to undertake a project focused on "Health care users' experience as a focus for unlocking opportunities to access quality health services." A central component of this project has been a set of activities to strengthen the capacity and mandate of Health Committees to act as vehicles for realising the right to health.

This Colloquium is one of the activities of that project, and therefore takes place in the context of work to strengthen Health Committees by the LN and other Civil Society Organisations. It is aimed at stakeholders involved with health committees, including managers, providers, policy-makers, civil society organisations, researchers and health committees themselves from around the country.

Date: 29 September 2014

Venue: Belmont Square Conference Centre, Rondebosch

Time: 9h00-17h00

Objectives:

1. To better understand the roles and functions of health committees in a re-engineered Primary Health Care system.
2. To understand the best institutional and legal framework to maximise the contribution of health committees to a responsive health system.

Participants: Approximately 100 participants from the services, health committees, civil society, research institutions and policy makers.

Draft Programme

Time	Topic	Presenter
8.30-9:00	Arrival, tea/coffee	
9-9:15:	Opening, introduction: Purpose of the national colloquium. Comments from the EU	Professor Leslie London, UCT. Flora Bertizzolo, Health Attaché, EU
9:15-10:00	Keynote address: National policy developmenton community participation and health committees	Deputy Director General Jeannette Hunter, National Department of Health
10:00-10:45	Presentations from NGOs working with health committees: Black Sash: Monitoring Reducing Maternal and Child Death through strengthening Primary Health Care Programme (RMCH): Working with health committees to reduce maternal and child deaths. Learning Network, Eastern Cape: Mentoring health committees Learning Network, Western Cape: Western Cape Health Committee Training	Brittany Bunce, Black Sash, Susan Wilkinson, RMCH, Zingi Sofayiya, Learning Network, Eastern Cape, Fundiswa Kibido and Anita Marshall,Learning Network Western Cape
10:45-11:15	Tea	
11:15-12:00	Health committee experiences Input from CBO working with health committees	Abraham Isaacs, chairperson, Nelson Mandela Bay District Health Forum Mozibele Nowhi Mdayi, Gugulethu Health Committee Sharon Messina, Women on Farms Project
12:00-13:00	Group discussions: role and function of health committees Ensuring broad community representation	
13:00-14:00	Lunch	
14:00-14:30	Constitutional framework for participation Rapid appraisal of on provincial policies on health committees	Ashraf Mohamed, human rights lawyer Hanne Jensen Haricharan,

	Eastern Cape Policy Review	Learning Network Therese Boulle, Learning Network
14:30-15:15	Group discussion: policy and institutionalisation	
15:15:16:00	Feedback from both group discussions	
16:00-16:20	Tea	
16:20-16:40	Way forward/resolutions	
16:40-16:50	Summary and input	Walter Flores, Center for the Study of Equity & Governance in Health Systems,Guatemala
16:50-17:00	Closing and thanks	Zandile Xate, Health Committee member, Nelson Mandela Bay

Appendix 2: Participants in the National Colloquium on Health Committees, Sept 29th 2014

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Appendix 3: Press Release – National Colloquium on Health Committees

Health committees as vehicles for community participation: Release from a National Colloquium on Health Committees, 29th September 2014

A national colloquium was held in Cape Town on 29th September to consider the role of health committees as vehicles for community participation in strengthening the health system in South Africa. In total, over 100 participants from all over the country considered inputs from a diverse range of speakers, including members of health committees in the W and E Cape, NGOs involved in working with health committees, and health and legal researchers. The keynote address was given by Ms Jeanette Hunter, DDG for Primary Health Care in the National Department of Health who sketched the National Department of Health's perspective on community participation and the role of clinic committees. Participating in the debates were health officials, NGO workers, researchers, health committee members and delegates from other African countries attending the Global Health Systems Research conference. The meeting, funded by the European Union Mission to South Africa, came up with the following resolutions:

7. Given the long delay in enacting the provisions of section 42 of the National Health Act, we call on Provinces to pass legislation as a matter of urgency to recognize the roles and functions of health committees as critically important vehicles for community participation in health.
8. We call on the Minister of Health to table the status of health committees at the National Health Council to give direction and create an enabling environment for the adoption of provincial legislation on health committees.
9. Civil Society demands that government should provide the necessary resources (human resource support, training, reimbursement of costs and physical infrastructure as needed) for health committees to function optimally because it is obliged to do so by The National Health Act (NHA).
10. In developing regulations on health committees there must be participation by health committees and communities in the process.
11. There should be a tiered structure for community participation from facility to national level allowing for 2-way communication.
12. The Department of Health, when finalizing criteria for defining a functional health committee as part of evaluating health facility performance in the Ideal Clinic programme and in the work of the Office of Standards Compliance, must include participation by ward councilors and facility managers in their health committees.

The meeting resolved to pursue the establishment of a National Network on Health Committees to take forward the resolutions and some of the outstanding work required. The areas in which more work was identified as needed included:

i) The extent of roles and responsibilities and particularly that of ward councilors in the health committees;
j) How best to support health committees taking on fundraising roles;
k) Inter-sectoral interventions needed to address health that require cooperation of other government department;
l) Political buy-in from elected leaders at local, provincial and national level;

m) Participation as a Human Rights issue;
n) Monitoring and Evaluation systems for health committees to help confirm what is a functional health committee;
o) Legal action to ensure health committees are appropriately recognized
p) Mass mobilization in alliance with other civil society organisations in health.

The National Health Act first provided for recognising health committees when adopted in 2003. The consensus at the meeting was that "19 years is way too long." We need to see urgent progress on health committees.

Participants at a National Colloquium on Health Committees hosted by the Learning Network for Health and Human Rights, 29th 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 Anita Marshall at anita.marshall@uct.ac.za.