HEALTH COMMITTEES, PARTICIPATION AND ACCOUNTABILITY – STRATEGIES FOR STRENGTHENING THE HEALTH SYSTEM

Health and Human Rights Programme, School of Public Health and Family Medicine; and Division of Nursing, University of Cape Town
Learning Network for Health and Human Rights
Cape Metro Healthcare Forum

Funded: European Union, IDRC, South African National Research Foundation

October 2016

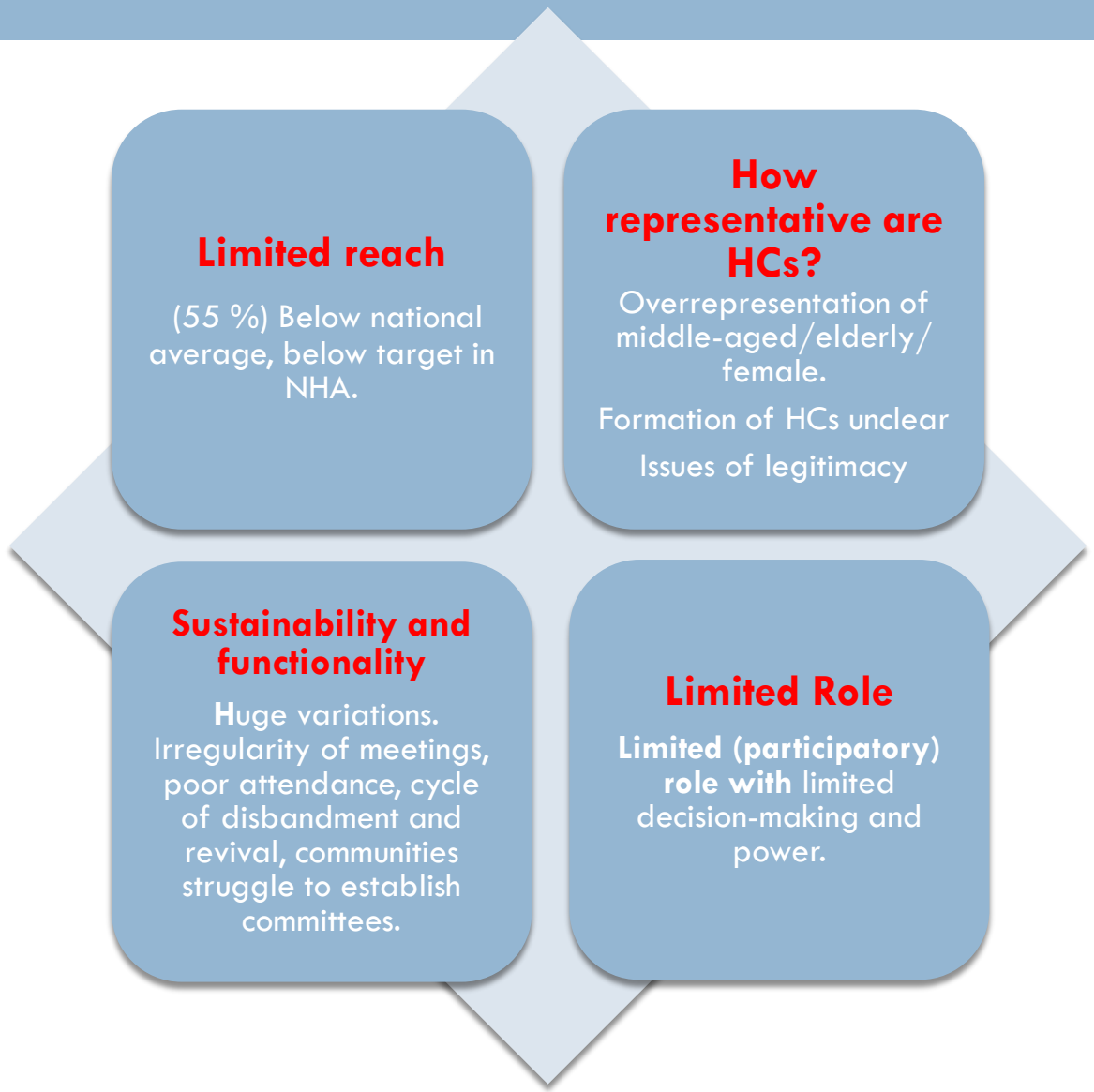
Background: Community Participation in Health

- **Alma-Ata:** "People have the right and duty to participate individually and collectively in the planning and implementation of their health care …"
- **Benefits** of Community Participation well researched
- **White Paper** on Transformation of the Health System (1997): Participation in *planning and provision* of health services. Ensure *accountability*.
- **National Health Act** (2003) :

  a) Each clinic should have a health committee composed of: Facility manager, ward councillor, community members.

  b) **Provincial legislation** to stipulate roles and functions.

Preliminary findings: Health Committees in Cape Town

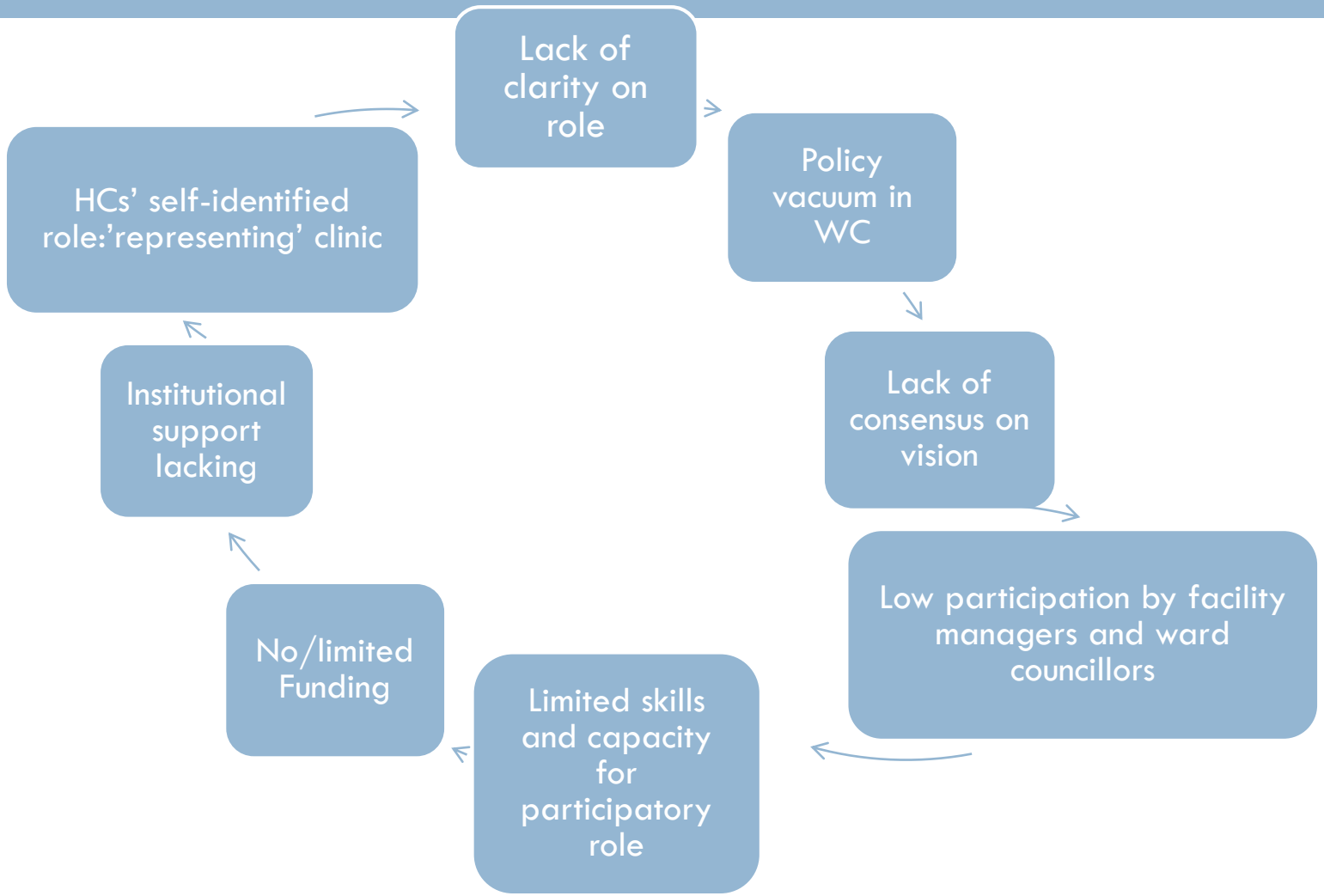


Challenges for community participation

- Previous research in LN:
  - Critical role of agency for realising rights
  - Problems in meaningful community participation (Glattstein-Young, 2011; Pardue et al, 2012; Haricharan, 2012)
- Two roles:
  - Governance/accountability
  - Service support, extension of services
  - HCs mainly assist clinic rather than governance/accountability (Haricharan, 2012)

- Policy vaccuum:
  - NHA establishes H Committees at every facility/grouped facilities; mandates composition but silent on role
  - Roles and functions left to provincial legislation
  - Draft WC policy on H Committees never adopted

Factors impacting on HCs



Responding to the quadruple BoD

- 2012 EU support to SA govt: → Strengthen PHC
- ***Health care users' experience as a focus for unlocking opportunities to access quality health services***

Two principles:

- Community, civil society agency critical to change conditions of vulnerability that give rise to ill-health, social exclusion, inequity
- Actions to support PHC need to be underpinned by clear commitments to the right to health

Objectives

1. **Strengthen capacity, mandate and authority of Health Committees in Western and Eastern Cape;**
2. Enhance CSO capacity to advocate for health rights;
3. Enhance the capacity of health care providers to engage meaningfully with needs of vulnerable patients and communities;
4. Evaluate patient-oriented quality assessment tools

Strengthening Health Committees

	Packages:
1	Rapid national appraisal policies and practices
2	Policy dialogue to establish HC roles
3	Implementation review E Cape
4	Capacity building HCs: training, materials W Cape
5	Capacity building HCs: training, revision materials E Cape
6	Model complaints process at facility as learning opportunity
7	Mentoring HCs, sub-district forum E Cape
8	Sharing best practice: HC exchanges, Learning Circles
9	Model establishment new HC; develop guidance
10	National Colloquium – aim for consensus

Interventions

W Cape

- 3-day training addressing leadership, roles
- Mentorship through Learning Circles
- Exchanges of HC members W and E Cape
- Policy dialogue with health authorities, DHCouncil
- Model Complaints Process
- Pilot to develop guideline for establishment of HC
- Advocacy around legislation

E Cape

- Short training compared to intensive mentoring NMBM

Both sites: Training with health facility staff; Materials development: Manuals, LN modules, DVD

Research Programme

Report here on three of a number of areas of research

1. Policy mapping of Health Committees in the Health System in SA (slides 11 to 26)
2. Strengthening capacity and roles of Health Committees (slides 27 to 36)
3. Strengthening capacity of providers to engage Health Committees (slides 37 to)
4. Parallel stream of work in Uganda

Policies on Health Committees

- Starting Point is **National Health Act** (2003) :

  a) Each clinic should have a health committee composed of: Facility manager, ward councillor, community members.

  b) **Provincial legislation** to stipulate roles and functions.

- National Health has developed a Guideline
- What have the provinces done?

Overview of provincial policies

Province	Policy/guidelines exist	Form	Year
Eastern Cape	Yes	Policy	2009
KwaZulu-Natal	Yes	Section in Provincial Health Act	2009
Free State	Yes	Section in Provincial Health Act	2009
Mpumalanga	Yes	Guidelines	2009
Gauteng	Yes	Draft guidelines	2009
Limpopo	?	Told about policy, but not seen it	2009
Northern Cape	Yes	Policy	2013
NorthWest	Yes	Guideline for Health Governance Structures	2014
Western Cape	Yes	Draft Bill on Health Facility Boards and Clinic Committees.	2015

Policies: Roles of health committees

Role	Explanation	Which provinces?
GOVERNANCE	Policy, strategy, planning, identify health needs and priorities, advice	All
GOVERNANCE, ACCOUNTABILIY and OVERSIGHT	Monitoring, complaints management	Most
NETWORKING/STAKEHOLDER MANAGEMENT	Strengthen ties with communities, liaise with stakeholders	Most
ADVOCACY	'Represent facility', advocate for using services	Eastern Cape, Mpumalanga
FUNDRAISING	Raise funds for facility, Health Committee, PHC activities	Mpumalanga, Gauteng, Eastern Cape, Western Cape
SOCIAL MOBILISATION	Getting community involved in health	Eastern Cape
SUPPORT FOR FACILITY		Gauteng

Policies: National Draft Policy

National Draft Policy on Health Governance Structures (2013). Powers and functions:

a) Assist … with *policy and strategy*

b) *advisory* and technical support

c) *Oversight*

d) Financial and expenditure review

e) Staffing and personnel issues

f) Community participation

Policies: Role of HCs, cont.

- Trend towards seeing HC's as governance structures. In line with National Draft Policy.
- Western Cape:
- Limited accountability function.
- Weaker roles and powers than WC Hospital Boards and 2008 draft.
- WC MEC can authorise HCs to perform additional duties or revoke duties.

Policies: Formation of health committees

Formation process	Provinces
Appointed by MEC	Free state, Mpumalanga, Kwazulu-Natal, Northern Cape, Western Cape
Elected	Eastern Cape
Unclear	Gauteng (elected/appointment)

Policies: Formation, continued

- Should community participation structures be appointed by MEC – top-down approach?
- How does the nomination process happen? Who nominates? What role does facility managers play in nomination process? Implications?
- National Colloquium consensus: HCs democratically elected.
- But still:
  - Who is eligible for election?
  - Who elects – community structures or individuals?

Policies: Composition health committees

Composed as outlined in NHA	Composed of 'sector' representatives
Mpumalanga, Gauteng, KwaZulu-Natal, Northern Cape, Western Cape (nominated by a body representing community interests)	**Free State**: disability, business, traditional health practitioners, health experts. **Eastern Cape**: traditional healers, organised labour, community based organisation, religious community, women's group, youth, NGO, disabled.

Policies: Composition continued

- Critical issues:
  - Which approach ensures broad and inclusive representivity?
  - Which sectors should be represented and why?
  - Sectors not represented: health workers, other 'marginalised' groups such as refugees, LGBT.
  - Does sector representation make HCs more accountable?

Policies: Financial support

No support	Reimbursement for expenses	Allowances and Fees
Free State, Eastern Cape, North West,	KwaZulu-Natal Western Cape (travel _ Department may compensate)	Mpumalanga: MEC to determine fees and allowances. Gauteng: fees, allowances for travel and incidental expenses. Northern Cape: Facility Manager to avail resources.

Policies: Support for Health Committees

Type of Support	Province
• No Support	KwaZulu-Natal, Free State, North West
• Secretariat support	Mpumalanga, Gauteng, Eastern Cape, Western Cape.
• Administrative Support	Western Cape, Northern Cape
• Financial accounting support	Western Cape
• Office + equipment	Gauteng
• Venue	Eastern Cape, Western Cape
• Logistical support	Eastern Cape

Policies: Training and Capacity Building

- Easter Cape: training and induction.
- Western Cape/North West: induction of new members.
- Other provinces: no provisions for capacity building.
- Not clear who should be responsible for training/induction

Policies: Linkages to other structures

- Western Cape: MEC can take measure to ensure collaborative working relationships between boards, committees and District Health Council
  No provision for structures at sub-district level
- Eastern Cape: Sub-district health fora and District Health Forum.
- North West: tiered reporting lines between various levels of governance structures.
- Other provinces: no linkages.

Policies: Role of Facility Manager

- Role of facility manager (beyond admin support): stipulated in Eastern Cape, Western Cape:
- Western Cape:
  - Take measures to assist the committee in performing its role.
  - Forge strong co-operative relationships with HC
- Eastern Cape:
  - Support, facilitate participation in planning of health days.
  - Guide and inform committees about regulatory framework ….. In order for committee to exercise its oversight responsibilities

Policies: Critical Issues

- Clarity needed on role and function.
- Formation of Health Committees: Elected or appointed?
  - If not elected, how can they be legitimate?
- Composition of Health Committees: 'sector approach' or NHA-approach.
- Minimal capacitation for participation (limited support, training, financial support).
- Limited linkages to other community participation structures.
- No upstream influence.

Policies: A framework for HCs?

- Legislation rather than policy.
- Governance structures: bringing community voice into planning and strategy and ensuring accountability.
- Democratically elected structures with broad, inclusive and diverse representation.
- Linked to tiered structures for community participation where committees elect representatives to higher structures.
- Capacitated to participate meaningfully.
- Resources and financial support provided for functional and sustainable participation.
- Facility managers' enabling role and participation should be addressed.

Health Committee training WC

- From March 2014 to June 2015, training for:
  - W Cape 355 HC members; 7 out of 8 sub-districts; 43 HCs; 7 Learning Circles involving 75 HC members
  - E Cape 202 HC members from 4 sub-districts received 1-day training; 9 HCs intensive mentoring.

Two WC sources data for evaluating:

- Immediate post-training evaluations for n=298
- Interviews Sept 2015 with n=58 both quant/qual

Findings: Skills

- Confident in HC role 92%
- New skills learnt for HC role 92%
- New knowledge of HCs 90%
- New knowledge of Health System 78%
- New knowledge of Community Leadership 89%
- Capable to run a HC 86%
- Confident to be a Community Leader 81%
- Improved ability to carry out HC role 83%

Confidence and Skills

- "… the confidence that came with time… in time we understood why things were happening; decision were taken because we had the knowledge, we could draw up a petition and tell them this, that and the other. And they couldn't tell us "no but you're wrong' because we got the information beforehand."
- " … I think this has made a huge impact on the committee, I've seen transformation on leadership. I've seen the committees engage at a completely different level. I've seen growth in the leadership in the different communities, as well as in the different sub-district. I've seen people taking responsibility."

Findings: HC functioning

- Health Committee functioning well: 90%
- Health Committee meets regularly: 83%
- Members retained in past year: 90%
- Involved in complaints management 81%
- Involved in M&E 79%
- Involved in Health Campaigns 78%

Findings: Relationship to stakeholders

Relationship to facility manager:

- Facility manager reports regularly to HC: 76%
- Good or excellent support from manager: 66%

Relationship to community:

- Annual community meeting: 66%
- Regular community meetings: 52%
- Community is aware of HC work: 62%

Managers: a more equal relationship?

- "I know that I 'm not their slave. If the clinic is dirty it's not my role, it's not my duty to go and clean the clinic. There are supposed to be staff employed to do the cleaning, so I can say "Look, there's a shortage of cleaners here; because the place is constantly dirty…' But that does not mean Health Committee members must no go and assist in cleaning the clinic."
- "…what has changed is the fact that we do understand more, what they experience and why. The decisions that they implement are not theirs, so we've come to that understanding and I do feel that they now realize that we are not actually the enemy on the other side, that we are there to assist them…"

Community relationships

- “since the Learning Circles, after the meetings we’ve had since our regular executive meetings, they are now more vocal: they will tell you more what’s going on: they will notice things more and they will come and tell you at meetings: this is what is happening…”
- “… I think because it’s something that has happened in some communities: but not in most of the communities. And so the committees have a responsibility to ensure that it happens and in some of the committees it happens bimonthly; and in some committees it happens monthly; and in some committees are now adopting it to do it on a quarterly basis, where they have a big public meeting.”

Findings: Understanding HC roles

- Oversight is NB for HC 60%
- Represent Community Views to services 90%
- HCs can influence health service's plans 90%
- HC should influence budgets 44%

"*You know, I always thought that the Health Committees' role was to run campaigns; and, you know, do education and awareness. But that was just one aspect of, of what a Health Committees' role should be. And the training also focused on how we as Health committees must be involved in looking at the type of services that are delivered at the clinic…*".

Ongoing challenges

"The same old problems persist, and that makes it very frustrating for just about anybody who is involved in health committee work….. there is no legislation, there not being resources you know of funds just operating cost for health committee member. So, you know, to travel from home to a meeting and then there's admin costs; and the cost of the work that they are doing in the clinic, so they are completely un-funded. So that's the frustration…"

Discussion – how have things changed?

- Improved functionality of HCs;
- Participation of facility managers;
- Enhanced confidence; improved understanding of role and of health system constraints, skills built;
- Stronger engagement with community.

→ Mainly linked to improved understanding of Role and Function of HC???

- Systems: Patient complaints; setting up HCs; mentorship

Health Worker Interventions - Training

After Health Committee training, their functioning is still challenged by:

- Lack of Health Care Providers' (HCPs) responsiveness towards HCs:
  - Misunderstandings about HC roles and responsibilities
  - Lack of engagement of facility manager with HC

- Implementation of a Training Programme May 2015; Primarily targeting HC providers and managers

Research Objective

This study evaluates HCPs' immediate responsiveness towards HCs as a result of an interactive, rights-based training on "Community Engagement for Quality Care".

More specifically, the extent and nature of changes in:

- Understandings of HCs and their role
- Intentions to change practices towards HC functioning

Methods

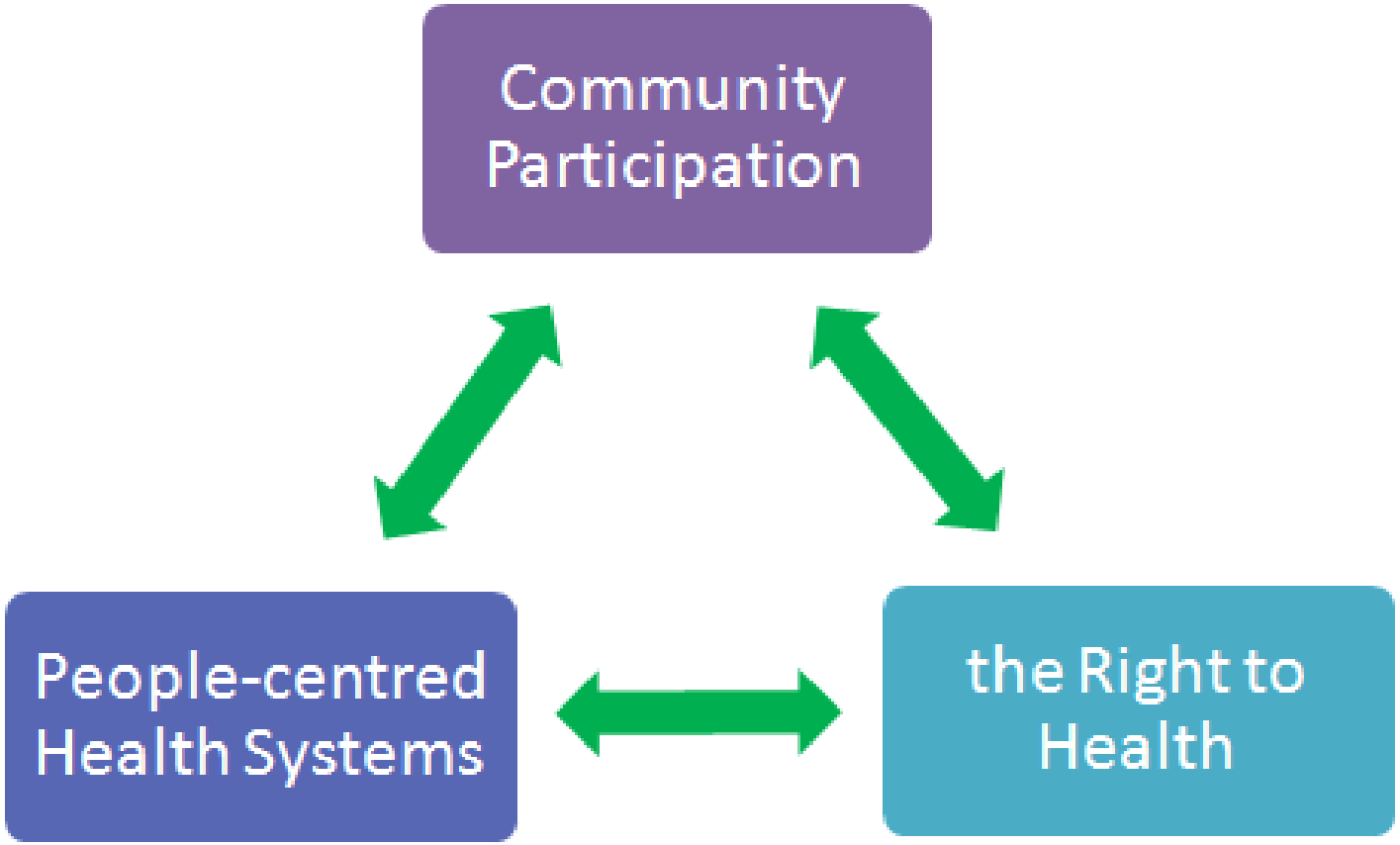
Qualitative realist evaluation, including:

- 34 training participants (HCPs: 9 (5 senior professional) nurses, 15 facility managers, 2 health promotion officers and 3 environmental health practitioners)
- all Cape Metropole health sub-districts

Adopting the following methods:

- Observations of two training sessions with different groups.
- Pre- and post-training questionnaires (n=31 and n=29)
- Semi-structured interviews of 10 participants, 3-4 months after training

Conceptual Framework



Findings – Understandings

HCs were understood to be:

- a key body of communication between the community and the HCPs
- able to assist with and improve health care in terms of:
  - needs-responsiveness
  - quality
  - accessibility

"The closure of [...] clinic is a classic example of what happens in the absence of a Health Committee. The community had no input in the closure of [said facility]. Should the clinic have had a functioning health committee, a collective grievance could have been lodged against the City of Cape Town Health Directorate."

Clinic Manager # 5

Findings – Intentions to engage

- HCPs expressed intentions to engage differently:
  - Active engagement with the HC
    - Consult HC in improving health talks (nurses)
    - Active participation in HC meetings more regularly (clinic managers)
    - Improve relationships with other HC stakeholders, such as ward councillor, environmental health practitioner (clinic managers)
    - Encourage active co-operation between HC members and HCPs (e.g. health promotional officer)
  - Ensure clear roles and responsibilities are set for all members and stakeholders involved
- No intentions when:
  - HC is functioning well
  - Professional position is perceived a barrier to engage with HCs

Findings - Action

Reported short-term changes in practices after training:

- Contact ward councillor

Perceived limitations to changing practices:

- Superiors impeding HCPs' ability to:
  - attend trainings
  - implement their gained responsiveness

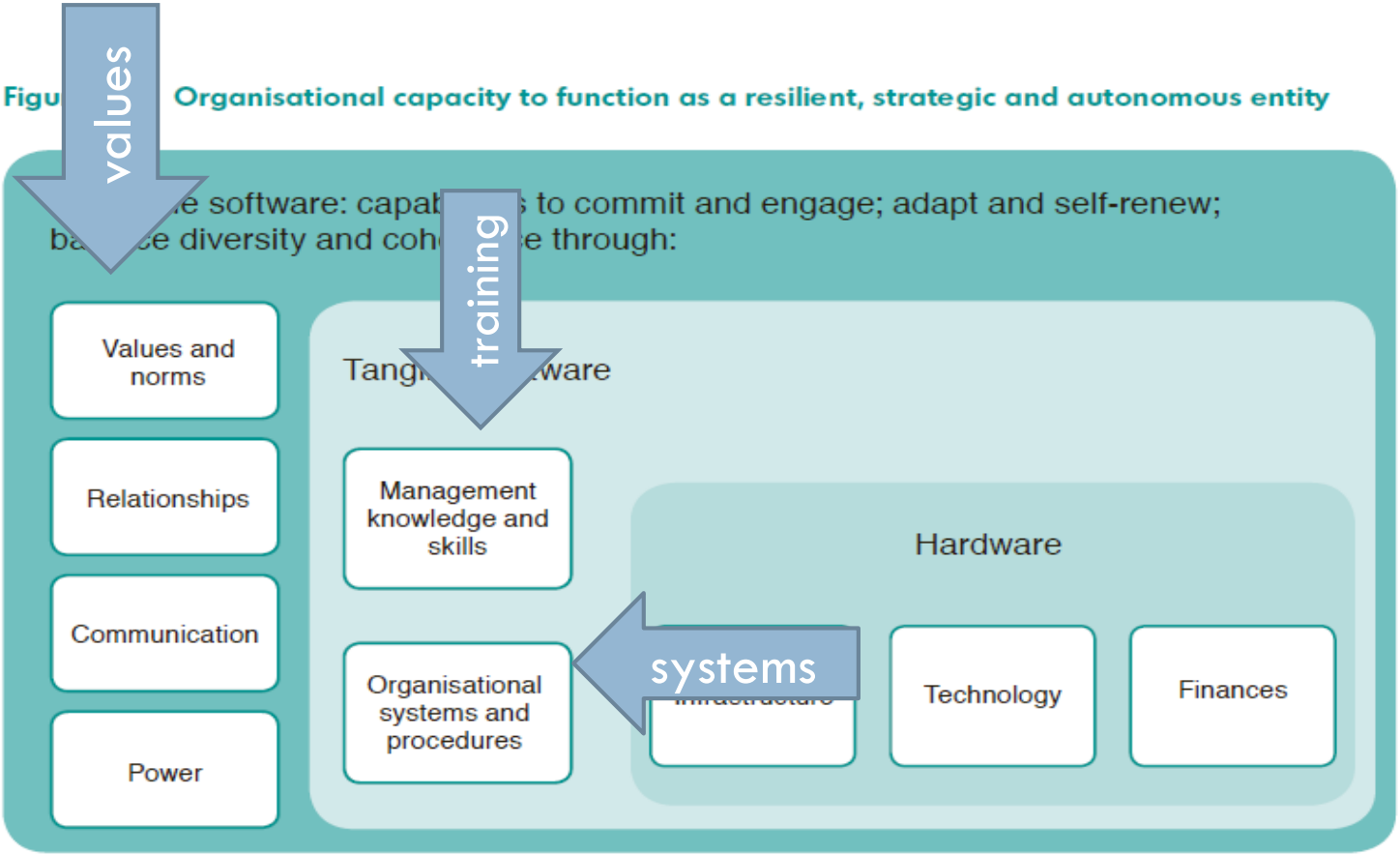
However, there is a:

- Willingness to receive more training
- Perceived importance of training other stakeholders, such as superiors and second-in-charge.

Conclusion

- Training played a role in increasing HCPs' responsiveness towards HCs' roles and functions.
- HCPs' increased responsiveness to HCs potentially promotes community members' active participation in tackling discrepancies between the services provided and the community's needs.
- However, this training must be ongoing and sustained in order to achieve impact on the strengthening of people-centeredness and responsiveness of health systems.

Discussion – Hardware and Software: Tangible and Intangible



Source: Elloker S, Olckers P, Gilson L, Lehmann U. Crises, Routines and Innovations: The complexities and possibilities of sub-district management. In (Eds) South African Health Review 2012/13. Chapter 13, pp 161-173. Durban: Health Systems Trust.

Conclusion

Critical gaps & opportunities:

- Trust and shared values
- Rights-based approach to health
- What is understood by governance remains disputed

- Not only hardware (laws, systems) and tangible software (training, skills) important
- Intangible software – relationships and values – are as important

- **Resources: www.salearningnetwork.weebly.com**