Evaluation of a project to strengthen health committees in the Cape Town Metropole

Hanne Jensen Haricharan, School of Public Health and Family Medicine, University of Cape Town

Introduction

The Learning Network for Health and Human Rights in collaboration with the Cape Metro Health Forum conducted a programme with health committees in the Cape Town Metropole and Nelson Mandela Bay Metropole from Nov 2013 till August 2015. The programme was part of an EU-funded project titled "Health care users experiences as a focus for unlocking opportunity to access quality health services". The specific objective for work with health committees was to: "Improve the capacity, authority and mandate of health committees". This should be measured according to improved functioning of health committees.

The work with health committees in Cape Town consisted of the following work packages.

1. A rapid appraisal of provincial policies on health committees.
2. Community dialogues
3. Training of health committees
4. Learning circle and exchange programmes.
5. Complaints process
6. Establishment of new health committees
7. National colloquium
8. Health worker training

This evaluation concerns the overall impact of the project in the Cape Town Metropole. A similar report has been conducted for health committees in the Nelson Mandela Bay Metropole. In addition, there are separate evaluations of the following: training (post-graduate student, report from trainers), health worker training (post-graduate student), exchange visits, complaints process, establishment of new committees and an evaluation of the national colloquium.

Methods

A mixed method approach was employed, using both quantitative methods (surveys) and qualitative (in-depth interviews and observations). This approach enabled us to triangulate data.

The evaluation is based on the following data:

1. A survey with all participants (298) that took part in the training programme was done immediately after the training. The questionnaire was self-administered, but conducted in the presence of the projects' trainers, enabling participants to ask questions when needed.
2. A survey with 58 health committee members (almost 20 percent of all health committee members participating in the project) on completion of the entire project. The questionnaire was self-administered, but conducted in the presence of the researcher, enabling clarification of questions when needed.
3. In-depth interviews with 10 stakeholders – 5 health committee members, 3 member of the Cape Town Metropole and 2 facility managers (pending). The interviews were tape recorded and transcribed subsequently.
4. Field notes were taken during survey collection and interviews. The process of recruiting participants was also documented.

All research instruments were translated into Afrikaans and isiXhosa, enabling participants to choose their preferred language. Written informed consent was taken.

Sampling

All participants were part of the survey conducted after training. Participants for the end-of-project survey were selected to ensure an even spread across the eight health sub-districts in the Cape Metropole. Participants who had been actively involved in project activities were selected for the in-depth interviews as it was deemed they would be able to give an optimal assessment of strength of weaknesses of the project and elaborate on quantitative findings. In addition, selection aimed at getting representatives from all eight sub-districts.

Data-analysis

The post-training survey done immediately after training was purely quantitative and was analysed through simple descriptive analysis. The post-project evaluation questionnaire contained mostly quantitative questions, which were analysed doing a simple descriptive analysis. The qualitative questions were coded where possible and in addition analysed through thematic inductive analysis. The in-depth interviews were analysed through inductive thematic analysis.

Assessment of bias

The evaluation is based on surveys with all trained health committee members, a survey with a cross-section of health committee members and interviews with purposively selected individuals. While the survey with trained health committee members is 100 percent representative for committees that were involved with the project, the evaluation survey is based on health committees' willingness to participate. Consequently, there is a risk of bias in that only health committees that were well-functioning accepted participation in the evaluation. Indeed, it is important to note that we found evidence of health committees that had folded during the project time. For instance, most health committees in a particular sub-district were unavailable for meetings and research. Generally, there were huge variations between the eight sub-districts with some sub-districts having many functional health committees, others not.

While it is important to consider potential bias, it is worth mentioning that the results of this evaluation will be compared to data from previous research which has similar risk of bias (in including only participants who are willing to participate and form reasonably functioning health committees).

Results

Demographic Profile

Health committee members were asked both about their education level, employment status, monthly income, gender and age. The results confirmed that health committee members are mostly unemployed (52%). Only 29 % are either employed or self-employed, while 11 percent stated that they were pensioners. The data on the demographic profile is from the training evaluation.

Table 1: Employment status

Category	Number	Percentage
Unemployed	155	52.01%
Employed	67	22.48%
Pension	33	11.07%
Self-employed	21	7.05%
Unemployed but not looking	16	5.37%
Spoilt	6	2.01%
TOTAL	298	100%

A question about monthly income revealed that half of HC members have no income, while 22 % get a pension or a social grant. See Table 2 below for detail.

Table 2: Monthly Income

Category	Number	Percentage
None	150	50.34%
Pension/Social Grant	65	21.81%
Less than R4 000	63	21.14%
Between R4 000 and R10 000	11	3.69%
More than R10 000	3	1.01%
Spoilt	6	2.01%
TOTAL	298	100%

In terms of health committee members' educational level, only 23 % have passed matric and 8 % have a post-matric qualification. For more details, on educational level see table 3.

Table 3: Educational level

Category	Number	Percentage
Between Grade 7 & Grade 12	142	47.65%
Passed Matric	70	23.49%
Below Grade 7	43	14.43%
Post-Matric Qualification	25	8.39%
No Matric but Diploma	7	2.35%
No Answer	5	1.68%
Spoilt	6	2.01%
TOTAL	298	100%

Functioning of health committees

Both quantitative and qualitative data showed that health committees had a relatively high level of functioning in the sense that they held regular meetings and were able to retain members. The data in this section come from the post-project evaluation survey. The evaluation showed that most health committee members assessed their committee to be well-functioning. Table 4 indicates perceived functionality of Health Committees.

Table 4: Functionality of Health Committee

Our health committee is well-functioning	Numbers	Percentage
Agree	52	89.66%
Disagree	2	3.45%

Don’t know	4	6.89%

To a question of whether their committee had met in this past month, 84 % affirmed this, with 14 % answering negative. The remaining participants did not answer the question. This information was confirmed by a question to which health committee members were asked whether the agreed with the statement: “The health committee meets regularly to discuss issues affecting the health of the community.” Table 5 indicates regularity of meetings.

Table 5: Regularity of Health Committee meetings

Health committee meets regularly	Numbers	Percentage
Agree	48	82.76 %
Disagree	5	8.62 %
Don’t know	5	8.62 %

The membership of health committees varied between five and 14 members, with the average number of members being eight. Interestingly, health committees seem not to have problems with retaining members. Thus, 90 % of the surveyed health committee members answered that they had retained their members over the past year. Table 6 indicate this.

Table 6: Health committee retaining member in past year

Has your committee maintained its members over the past year	Numbers	Percentage
Yes	52	89.65 %
No	2	3.45 %
No Answer	4	6.9 %

Facility manager participation

Another indication of functionality is the participation of facility managers. A question about facility manager’s attendance at the last health committee meeting showed that 79 percent of facility managers had attended the meeting, with 16 percent not participating. Five percent of the respondents did not answer this question. Furthermore, when facility managers did not attend meetings, a representative of staff did in 41 percent of cases.

This was confirmed by a question where health committee members were asked if they agreed with the following statement: **“**The health committee includes members of the clinic staff.” For more detail, see table 7.

Table 7: Health committees including clinic staff as members

The health committee includes members of the clinic staff	Numbers	Percentage
Agree	36	62.07 %
Disagree	17	29.31 %
Don't know	5	8.62 %

The difference between the two questions may be due to the continued uncertainty about whether facility managers or his/her representative are part of the health committee or just attend meetings.

A question also probed whether facility managers delivered a formal report at the health committee meeting. 76 percent confirmed this, with 22 % indicating that no formal report was given.

Table 8: Formal report given by facility manager at HC meeting

Formal report given at HC Meeting	Numbers	Percentage
Yes	44	75.86 %
No	13	22.42 %
Don't know	1	1.72 %

Asked to rate the support health committees received from their facility manager, a bit more than half ranked this to be excellent, while 1/5 ranked it to be poor. The answers show that support varied hugely. See table 9 for details on perceived support from facility manager.

Table 9: Perceived support by facility manager

Level of support	Numbers	Percentage
Poor support	12	20.69 %
Little support	0	0 %
Average support	5	8,62 %
Good support	5	8,62 %
Excellent support	33	56.90 %
No answer	3	5.17 %

Local government councillor participation

The participation of the local government councillor (ward councillor) was also measured. 31 percent indicated that the ward councillor or a representative for him/her attended the last meeting. Details are in table 10.

Table 10: Ward councillor participation

Ward councillor participation	Numbers	Percentage
Yes	18	31.04 %
No	39	67.24 %
No answer	1	1.72 %

Further, majority of health committee members (76 %) confirmed that they invited their ward councillor, while 21 percent did not. 3 percent did not answer that particular question.

Relationship with community

The survey also probed health committees' relationship with the community by asking whether the health committee had held a community meeting in the past year and how often meetings took place. The answers showed that the majority on health committees did engage in meetings with the community. Table 11 indicates level of engagement between health committee and community.

Table 11: Number of health committees with annual community meeting

Meetings with community	Numbers	Percentage
Yes	38	65.52 %
No	16	27.59 %
No answer	4	6.89 %

Frequency of community meetings ranged between yearly and monthly.

The relationship between health committee and community was further probed through a question, asking participants whether the agreed or disagreed with the following statement: **"**The actions of the health committee in this area are known and appreciated by the local community." Table 12 indicates that 62 % of health committee members perceived the local community to know about the committee.

Table 12: HC is known and appreciated by the local community/HCs visibility

The actions of the hc is known and appreciated by the local community	Numbers	Percentage
Agree	36	62.07 %
Disagree	1	1.72 %
Don't Know	21	36.21 %

A similar question probed the following statement: "Community members of the health committee discuss issues regularly with the local community." Table 13 shows that just over half agreed with the statement, indicating that the relationship between health committee and community is perhaps not as strong as it could be.

Table 13: Engagement with community

Community and HC discuss issues regularly	Numbers	Percentage
Yes	30	51.72 %
No	15	25.86 %
Don't know	13	22.42 %

Improved skill and capacity

The post-training evaluation (on which this section is based) focused on participants' assessment of their skills and capacity to perform certain functions. In addition, it assessed their confidence in performing specific roles and tasks. Overall, the results showed high levels of skills-improvement, capacity and confidence levels. Table 14 shows the how the rated the usefulness of the training.

Table 14: Usefulness of training workshops

Category	Number	Percentage
Very Useful	278	93.29 %
Useful	10	3.36 %
No Answer	4	1.34 %
Spoilt	6	2.01 %
TOTAL	298	100 %

Table 15 shows confidence level of health committee members in fulfilling their role after the training. It is worth noting that 92 % felt very confident.

Table 15: Confidence in being able to fulfil role as a HC Member

Category	Number	Percentage
Very confident after the workshop	273	91.61%
More confident, but not sufficiently	15	5.03%
No Answer	4	1.34%
Spoilt	6	2.01%
TOTAL	298	100%

A question asking whether HC members had acquired skills that were useful for them as health committee members, showed a similar pattern with the majority saying that they gained useful skills. Table 16 has more details.

Table 16: New skills and competencies gained that are useful for a CHC Member

Category	Number	Percentage
Yes	273	91.61%
Some not enough	16	5.37%
Had skills already	3	1.01%
Spoilt	6	2.01%
TOTAL	298	100%

A question probing general improvement in knowledge showed similar levels of improvement. Table 17 provides more detail on the question.

Table 17: Improved knowledge amongst HC members post training

Category	Number	Percentage
Yes	272	91.28%
Not enough	18	6.04%
No	2	0.67%
Spoilt	6	2.01%
TOTAL	298	100%

A particular aim of the training was to improve understanding of role and function of HCs. Again, the majority of participants indicated that they understood the roles of HC members after the training. Table 18 displays HC members' understanding of HC role.

Table 18: After the training, I understand the role of CHC members

Category	Number	Percentage
Yes	270	90.60%
Improved but not 100% clear	18	6.04%
Understood role before training	3	1.01%
No	1	0.34%
Spoilt	6	2.01%
TOTAL	298	100%

Another area, which training focused on was providing health committee members with an understanding of health systems. Fewer, but still a large majority, of HC members' understanding of Health Systems improved. Almost 1/5 of participants felt they needed more knowledge. Table 19 shows further details.

Table 19: After the training I have a better understanding of the Health System

Category	Number	Percentage
Yes	233	78.19%

Improved but more knowledge needed	55	18.46%
No	4	1%
Spoilt	6	2.01%
TOTAL	298	100%

Human rights and health was yet another focus of the training, for which the evaluations show substantial improvement. Table 20 provides details.

Table 20: Improved knowledge of Human Rights

Category	Number	Percentage
Yes	252	84.56%
More but not enough	27	9.06%
Knew about HR before training	11	3.69%
No	2	0.67%
Spoilt	6	2.01%
TOTAL	298	100%

The last question about knowledge gain related to leadership. Consistent with the other answers the vast majority felt that their knowledge had improved. Table 21 indicates the extent of improvement.

Table 21: Improved knowledge of community leadership

Category	Number	Percentage
Yes	264	88.59%
More but not 100%	16	5.37%
Knew before the training	11	3.69%
No	1	0.34%
Spoilt	6	2.01%
TOTAL	298	100%

Table 22 reflects answers to a question where participants were asked to mention the most important skill that they had acquired through the training. Notably, leadership skills stand out as the most important skills gained from the training. The question asked participants to choose ONE important skill they thought they got on this course.

Table 22: Most important skill acquired through LN training

Category	Number	Percentage
Leadership skills	100	33.56%
No answer	45	15.10%
Communication	35	11.74%
Confidence	34	11.41%

Role of CHC	16	5.37%
Conflict Management	16	5.37%
Rights	15	5.03%
Health	13	4.36%
Teamwork	11	3.69%
Knowledge	7	2.35%
Spoilt	6	2.01%
TOTAL	298	100%

In a similar way, a question asked about the most important understanding gained from the LN training. Here function of health committees top the list.

Table 23: Most important understanding gained from LN training

Category	Number	Percentage
Function of CHC	73	24.50%
No Answer	55	18.46%
Social Skills	52	17.45%
Rights	35	11.74%
Function of Health System	23	7.72%
Knowledge	20	6.71%
Community development	17	5.70%
Leadership	17	5.70%
Spoilt	6	2.01%
TOTAL	298	100%

Confidence in filling out role as HC member

The post-training questionnaire also probed how confident health committee members felt in carrying out the roles envisioned and described in the training, which was based on National Guideline in the absence of a provincial policy on health committees. Overall, confidence levels are high and at a similar level as the improvement in skills. Table 18 shows that 86 percent are confident, though 11 percent do not possess enough confidence to run a committee though their confidence has improved.

Table 24: Feeling capable of running an effective Health Committee

Category	Number	Percentage
Yes	255	85.57%
Increased but not enough to run a committee	34	11.41%
No	2	0.67%
Capable before workshop	1	0.34%
Spoilt	6	2.01%

TOTAL	298	100%

Participants showed high confidence levels in their ability to promote human rights (82 %). Despite this, it is worth noting that promoting human rights received the highest percentage of people not sufficiently confident in their ability as shown in table 25 below:

Table 25: Confidence in promoting the Right to Health

Category	Number	Percentage
Yes	245	82.21%
More but not 100% confident	44	14.77%
No	3	1.01%
Spoilt	6	2.01%
TOTAL	298	100%

While the majority of participants (82 %) also felt confident in being community leaders, 14 % felt more confident, but not sufficiently so. Table 26 shows confidence levels in being a community leader.

Table 26: Confidence in being a Community Leader

Category	Number	Percentage
Yes	243	81.54%
Better but would like to be more	41	13.76%
Confident before training	6	2.01%
No	2	0.67%

The results from the overall evaluation, assessing skills and ability as HC members mirror those of the post-training evaluation. Thus, 90 % of Health Committee members said they had sufficient skills to function effectively as a health committee member. Details are in table 27.

Table 27: HC member confidence in having sufficient skills to function well as HC member

Have sufficient skills to function as HC member	Numbers	Percentage
Yes	52	89.65 %
No	2	3.45 %
No answer	4	6.90 %

A similar pattern can be observed to a question about whether the Learning Network programme had improved their skills. 83% agreed with this statement. For more detail see table 28.

Table 28: LN programme improved ability to carry out HC role

LN programme improved ability	Numbers	Percentage
Yes	48	82.76 %
No	3	5.17 %
No answer	7	12.07 %

Role of health committee in complaints management and monitoring

The evaluation questionnaire probed how frequent health committees engaged in complaint management and monitoring. The results showed that many health committees were engaged in those activities as table 29 and 30 indicate.

Table 29: Health committees engaging in complaint management

Health committee members engaged in complaint management	**Numbers**	**Percentage**
Yes	47	81.04 %
No	8	13.79 %
No answer	3	5.17 %

Table 30: Health committees involved in monitoring or evaluation service delivery

Health committee member involved in monitoring or evaluation	**Numbers**	**Percentage**
Yes	45	77.59 %
No	9	15.52 %
No answer	4	6.89 %

A question asking about whether health committee members felt that their committees were effective in their oversight role, showed high confidence levels in this role. Table 31 provides the details.

Table 31: Perceived effectiveness in oversight role

HC perceived to be effective in oversight role	**Numbers**	**Percentages**
Yes	48	82.76 %
No	4	6,89 %
No answer	6	10.35 %

Further, an important role for many health committees continues to be participating in health campaigns, as indicated by table 32.

Table 32: HC members involved in health campaigns

HC members involvement	Numbers	Percentage
Yes	45	77.59 %
No	10	17.24 %
No answer	3	5.17 %

Understanding of role of health committees

I number of statements probed how health committee members understood the role and function of the health committees. It is clear from the answer below, that HC members perceived oversight to be a relatively important role.

Table 33: Understanding of oversight role

Oversight is an important role for the health committee	Numbers	Percentage
Agree	35	60.35 %
Disagree	15	25.86 %
Don't know	8	14.79 %

However, health committee members perceived it to be far more important that they bring community views to the clinic, as indicated in table 28.

Table 34: Understanding of role in bringing community voice to clinic

The health committee is important to bring community views to the staff at the clinic	Numbers	Percentage
Agree	52	89.66 %
Disagree	2	3.45 %
Don't know	4	6.89 %

Equally important was health committees' involvement in health plans, as indicated in table 29

Table 35: Understanding of HCs involvement in health plans

The health committee can influence health plans in our area	Numbers	Percentage
Agree	52	89.66 %

Disagree	2	3.45 %
Don't know	4	6.89 %

A minority believes that health committees should be involved in budgeting. This is reflected in table 36.

Table 36: Understanding of health committees' involvement in budgets

The health committee should influence the way health budgets are spent	Numbers	Percentage
Agree	26	44.83 %
Disagree	25	43.10 %
Don't know	7	12.07 %

Motivation

Both the post-training evaluation and the post-project overall evaluation contained questions to assess health committee members' motivation and decision to remain in the health committee. The answers show high levels of commitment from health committee members. The statement below from the overall evaluation shows that most health committee members find enjoyment in being a health committee member.

Table 37: Enjoyment in being a HC member

Have you enjoyed being a HC member	Numbers	Percentage
Yes	56	96.56 %
No	1	1.72 %
No answer	1	1.72 %

The post-training questionnaire also probed motivation and likelihood that health committee members will remain in the health committee. Table 38 shows that developing communities, helping people and improving health services are the most frequent reasons for being a health committee member. More detail on motivation to be involved in HC can be found in table 38.

Table 38: Motivation to get involved in HC

Category	Number	Percentage
Community Development	79	26.51%
Helping people	47	15.77%
No answer	41	13.76%

Improve services in clinic	39	13.09%
Personal experience	16	5.37%
Get more knowledge	14	4.70%
Inspired by other CHC members	6	2.01%
Get involved in the community	5	1.685
Wasn't a question in the questionnaire	45	15.10%
Spoilt	6	2.01%
TOTAL	298	100%

In table 39, data on the likelihood that HC members will remain in the HC is depicted. 75 % indicate that they are either very likely or like to continue being part of an HC.

Table 39: Likelihood that HC member will remain part of HC in a year's time

Category	Number	Percentage
Very likely	182	61.07%
Likely	44	14.77%
No	8	2.68%
Don't know	6	2.01%
Spoilt	6	2.01%
Wasn't a question in the questionnaire	52	17.45%
TOTAL	298	100%

A variety of a factors seemed to impact on the decision to continue in the Health Committee, as reflected in table 40.

Table 40: Factors influencing decision to continue being HC

Category	Number	Percentage
No answer	55	18.46%
Community development	49	16.44%
Help people	38	12.75%
Improving health	35	11.74%
Get more knowledge	28	9.40%
Get support from the community/clinic	22	7.38%
Support within HC	8	2.68%
Be employed	5	1.68%
Spoilt	6	2.01%
Wasn't a question in the questionnaire	52	17.45%
TOTAL	298	100%

A question assessed whether HC member feel they are being acknowledged for their contribution. A small majority (60%) said yes, while 14 % did not feel acknowledged. See Table 41 for more details.

Table 41: Is there sufficient acknowledgement for HC Work?

Category	Number	Percentage
Yes	180	60.40%
No	41	13.76%
Don't know	15	5.03%
No Answer	4	1.34%
Spoilt	6	2.01%
Wasn't a question in the questionnaire	52	17.45%
TOTAL	298	100%

Results qualitative data

Improved knowledge and skills

The qualitative data confirmed that health committee members felt that there knowledge had improved in a number of areas and was a key outcome of the project. Several areas were mentioned such as human rights. Clarity on role of function was emphasised by all respondents. The quote below illustrates this.

> *It gave clarity on what the role of the Health Committee should be in relation to the health facility. 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. (CJ)*

One respondent argued that providing clarity on roles and functions had been one of the highlights of the project: "I think it is the, it's an issue of us understanding firstly our role as clinic committee. Now we have an understanding as to what is it that clinic committees must do; and secondly the issue of how to resolves issues when there are challenges". (ts)

Yet another committee member pointed to information about National Core Standards as important for her.

> *A lot of the committee members myself included was very pleasantly surprised to know that there are a set of standards (referring to the national core standards) whereby you can evaluate the level of services at the clinic like stuff like cleanliness; and attitude of staff, availability of medicines. So when a client come to you, and they for instant say that there was no medicine available for the child, now I can relate to the training …. That one of the core standards it that there must be medicine available (…)we were given tools whereby somewhere within Government there is something in writing that gives you the right to call*

the clinic; or the clinic manager, or clinic staff to order – something that we were actually never aware of. (CJ)

Importantly, the new knowledge made health committee members feel empowered – as expressed by one member, who explained how the health committee initiated a petition, which they took to the provincial Health Department: "so (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."

Amongst the skills that were most frequently mentioned, were leadership skills, which many respondents argued had improved their own skills and those of other. This perception confirms the quantitative data.

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…. Member of CMHF exco.

Increased confidence and changing relationship with facility managers

A major theme that emerged from the qualitative analysis was that the new knowledge and new skills had let to a new level of confidence. This confirms the quantitative data. However, the qualitative data illustrates how this newly gained confidence is changing the power dynamics between health committees and facility managers and the way health committees operate. One member indicated that before they would not have the confidence to approach the manager, but this has changed. Another interviewee highlighted that fact that 'she is no longer their slave':

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.

The new confidence resulted in a different relationship and engagement with facility managers. There were numerous statements regarding improved relationship between facility managers and health committees, based on mutual understanding and developing trust.

At the beginning it seems as if you're on two different camps so you engage with them; but you are very cautious. You don't divulge too much …. I think 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, to communicate their… whatever they have to do to the community and why it's being done…. So things have changed and I think it's because of the knowledge that we now have (gf)

The health committee member quoted above also explained that the relationship between the health committee and the facility managers has changed because both parties have more clarity on the role of health committees. This has led to less tension and a new form of engagement. In fact, it has led to the health committee and the facility manager working together to solve problems at the clinic. In this case, the health committee organised a community petition and approached the provincial Health Department with five requests. Two of the requests resulted in positive change in that the department improved security at the clinic and assigned more staff to the clinic. Facility manager and health committee seem to have found a new strategy in addressing problems with service delivery, as indicated in the quote below:

> *I can tell you now the managers would come to me and tell me, 'we're experiencing this problem; unfortunately it's out of our hands, you as a Health Committee must now assist us and engage with us with the Health Department." But what we do is, we do it from our plot, not including – we don't tell the Health Department they brought this to our attention….. (gj)*

Relationships are not always going well, but there is evidence, that increasingly health committees and facility managers are beginning to work together, to forge partnerships. One HC member recalls how some facility managers are reluctant, 'but somewhere, somehow we are getting there'. She highlights that the training has created a framework, which enable health committees and facility managers to find some common ground.

> *It (the relationship) hasn't always been good, but after the training it changed, because of we shared the manual that we received from Learning Network to say "Look, this is what we are expecting. This is how we are going to do things in the clinic.' So those proposals were good; it created an opportunity for us to plan jointly the programme of action and say: if we are having monthly meetings what are we discussing in our first meeting; what is it that the facility manager is going to report about. (ts)*

The chairperson of the CMHF assessed that about 60 % of committees have experienced that their relationship with their facility manager has improved.

> *I would say out of the 80 %, out of the 90 % that has been trained it has happened: it's happened in at least 60 % of the clinic committees where health committees have been trained. I've also seen that if there's public engagements; that the facility managers are present … and if it's not the facility manager that there is a representative that is being sent from that facility. And that is something that has not happened in the past. (df)*

Some concrete results of a better co-operation with facility managers were noted in facility managers reporting to committees and providing support. This is also reflected in the quantitative data.

Voice and assertiveness

Not all facility managers attend meetings and resistance was still experienced by some of the respondents. Yet, it was also clear that health committees would continue to push for the attendance of their manager and make several attempts at improving engagement and attempt to hold the facility manager accountable, something that can be understood as health committee members becoming more assertive. One health committee member for instance would request an explanation when a facility manager was absent from a meeting. In a similar ways one committee would continue to approach the local government councillor to attend meetings.

A newfound assertiveness is also reflected in committee member who are increasingly clear about their role and what they will do at the clinic. In one committee, committee members used to do menial work such as cleaning etc. with the blessing of the health committee chair. That is not happening anymore. "I think the facility manager know that she mustn't even try to ask us those kinds of things; unless people think that they want to do it. I can't stop somebody, I can say that "if you want to you can go, but it is not your duty to do it." (cj)

Another example of assertiveness is health committee members who request reports from facility manager or want information on the clinic's budget as indicated in the following: "I asked her look, where is the clinics' budget? They don't want to give that information; but it is your right to ask if the clinic has the budget."

Several respondents highlighted that the project had given people a stronger voice to health committees. In particular, it was argued that less vocal and confident health committee members became more vocal and confident, as illustrated be a member who said that the training had 'truly empowered health committees':

> *They feel empowered and I can tell you, 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. (gj)*

> *Because you know your, your rights now: you know what you are allowed, and now you will engage the managers regarding those things.*

The CMHF chair-person reflected on how health committees have begun to not accept status quo, but asking question and demanding answers.

> *Building the capacity of health committee (has been important); and the health committees understanding their role. I think (the programme) has brought about a huge change and a shift of where they have been in just…. Accepting things as it is. Now they are not just accepting things. They want to know why the service is not delivered, and if the services are not delivered what are the reasons. So there has been a complete shift of reasoning in that regard.*

Taking on new roles

Health committees are increasingly taking on new roles. One of the areas which quantitative data indicated health committees were becoming involved in was complaints management and monitoring and evaluation of service delivery. Several respondents indicated that their involvement in complaints management was of newer date. Two respondents indicated that the health committee would hold the key to the complaint box indicating that no complaints box could be opened without the presence of the health committee. In other cases, there is still reluctance from facility managers to involve the health committee. However, there are also examples of health committee that have addressed for instance abuse of patients through their involvement in the complaint management. This led to the dismissal of a student nurse, who physically abused women in labour (ts)

> *You know, with all this information, I'm getting you know your mind opens up. So we can now ask the facility manager "listen we can make a formal request: involve us if it's a , if it's a serious complaint. And a certain procedure needs to be followed.* (cj)

Fewer respondents argued that they were part of monitoring and evaluating service delivery, but at least one committee member said that the committee would show up at the clinic and monitor service delivery, including waiting times and staff attitudes. Another example highlights the potential role of health committees in monitoring. In this case, the health committee identified theft from the clinic and initiated and implemented a monitoring project.

Realising Rights

Acting to improve patients' rights and human rights has become core to many health committees and it is evident that they increasingly talk about rights.

> *So our clinic committees are aware about the patients' rights: and we also encourage our patients as well to understand, and know their rights too (ts)*

> *At the health centre the committee wasn't really involved in insuring that patients – the waiting time was reduced, that the medication is on time, that there is a pharmacist. And in these three years that was one of the aims of the committee… they wanted to create a facility that is user friendly for all people accessing the facility. And so at that facility the psychiatric patients were treated completely different to all the other patients: because you know that they will get high and they will possibly cause some havoc at the facility. And then they addressed the matter; because every person that accesses the facility has an equal right to access of services. It doesn't matter when you come, or how you come into the facility. And so with the management of that facility they now have a service that is user friendly for everyone, the waiting time is reduced; the attitude of staff towards the community has change. And also that between the facility manager and the committee there's a much better understanding of the services that is needed for the community. (df)*

One committee took up the issue of HIV-positive patients folders being in plastic folders, which are different from other patients, and thus makes them easily identifiable. As of yet no solution has been found to the problem, but the health committee vows to continue fighting for the rights of patients.

Engaging with higher levels of health system

As already mentioned, there are health committees that have begun to engage not only at facility level, but also at a higher level by taking issues to the department. Some committees, especially those with well-functioning health forums, which operate at a sub-district level, work closely with health sub-district managers. They take issues identified in the sub-district health forums to the managers. In addition, health committees in one sub-district have approach the CEO of the local district hospital as they do not have any connection with the hospital's board and feel that there is a need for community participation structures to be involved in the hospital.

Another example of health committees engaging successfully with departments via the sub-district health forums is rendered by a Cape Metro Health Forum exco-member. When services were closed in one clinic, the committee took the matter to the sub-district level and when that did not yield any result, it was taken to the department.

> *And the end result is the fact that this facility has been upgraded…. Extra doctors have been given…. Extra pharmacist has been given, and…. There's a better understanding and working relation with the local committee.*

Improved relationship with the community

Several health committee members argued that their relationship with the community has improved though the evidence was not as strong as that of the facility managers. In the community where the health committee successfully petitioned the Health Department, community members are according to the respondents aware of the health committee and will approach them if they have complaints. The Health Committee also make use of a Facebook page, and the health committees' names and contact details are put up in the facility to increase its visibility. The health committee member describes the relationship as positive, but also argues that it could be stronger. "Whenever they come to us with their concerns, that tells me there is a relationship – I would love it to be stronger though".

An exco-member of the CMHF assesses committees' relationship with communities as a 'work in progress'.

> *We have achieved it (improved relationship with communities) in some communities but not in all the communities, and I think that is work in progress. 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. (df)

One health committee stressed the importance of communities not just engaging with the health committees around complaints, but also engage positively with suggestions.

Constraining environment remains

While the qualitative data showed improvements in skills and confidence levels of health committees and a shift in how they approach their role and work with facility managers, the interviews also made it clear that there are still many constraints facing health committees. These are not new. Few mentioned legislation. The issue of funding and resources were mentioned by several as seriously impeding health committees' functioning. It was argued that this made it difficult to retain members, and that health committees' sustainability depends on creating an enabling environment.

One member of the CMHF exco argued that while she felt that there was a new energy amongst health committee members, she detected frustration from many health committee members, who she said felt that they were now 'equipped', trained and ready to action, but did not have the resources to act.

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; because now I know what to do, I know how to perhaps contribute to a solution. I have been trained on how to engage with different stakeholder. But I still can't do anything without resources. (aj)

Many respondents also argued that there is need for continued capacity-building and support. On-going mentoring was highlighted by several, while others said that there needs to be training that assists committees' in putting their new knowledge into effective plans. One respondent explained that health committees need to be able to ask somebody for assistance.

With all this knowledge that I've gained…. So how do I put that knowledge into practice? So we get trained, we get trained: but we don't get mentored along the way (…) some form of mentoring must follow the individual: or must follow the committee. (cj)

The same Health Committee member strongly urged the Learning Network to continue their work with health committees and warned that people will otherwise feel 'abandoned.' She is particularly concerned that the Learning Circles seem not to continue as originally planned.

People again feel abandoned – (it) started out as a very good initiative because I can tell you …. Unless there was a death in somebody's family; then they didn't come on a Saturday (for training). That was how committed people were to do the training. (cj)

Networking and national engagement

An unexpected outcome of the programme has been plans to initiate a national network have been forged. Health committee members the benefits have realised the benefit of networking and having co-ordinating and over-arching structures at various levels. Exhange programmes, national colloquium and community dialogues have provided health committees with platforms where they have exchanged ideas.

We could share ideas, we could learn from each other, and I think one of the big ones was the fact that out of this, the voice of health committees has been strengthened and also how they have started working together with each other in the different districts, sub-districts, but also together as a collective at the Metro level.

The engagement has also ignited discussion on how to created co-ordinating and representative bodies that can strengthen the community voice at higher levels. In particular one respondent talked about a cohesive structure functioning at various levels and coordinating health committee.

We have… through your process we've become aware: before we were just, you know, moving, moving not having any plans of where do we want to see ourselves moving, you know. Having a provincial structure, and a national structure that speaks on our behalf. But after your intervention the training; we've started having visions on how we see ourselves being coordinated as clinic committees. (ts)

Reviving the current umbrella body in Cape Town, the Cape Metro Health Forum, is for some members an important part of creating this structure. First step is suggested to be an AGM that elects leaders representative of clinic committees.

Discussion

A report from 2012 assessed the status of health committees in Cape Town. Research conducted with the committees in 2010-11 showed that health committees faced several challenged. They had limited reach, they were often 'unsustainable' with infrequent meetings, there was issues around their legitimacy and the played a limited role. Several factors were identified as impacting on this situation: lack of clarity on role of health committees, lack of a provincial policy, facility manager attendance, ward councillor attendance, capacity of health committee members (add more). This discussion will compare the results of this evaluation with the 2012-report.

The past research was able to identify health committees at 62 (check this number) clinics. The current project trained health committees from (check with Fundiswa). Thus the number of health committees in the Cape Town Metropole remains constant though some committees have folded and others been created. Sustaining committees and ensuring that there is a health committee linked to all clinics as stipulated in the National Health Act remains a challenge. It is important to note that possible 'selection bias' may eschew the results of this evaluation and the comparison with the 2012-research in that committees that were willing to participate and were available were included in the evaluation. In the 2012, all committees – irrespective of how they functioned – were approached and some committees participated despite being barely functional (e.g. not having had meetings for some time)..

This evaluation show that amongst committee that were part of the evaluation, functionality improved. Thus, 90 % of the health committees members surveyed indicated that they had a well-functioning committee and 82 % indicated that their committee met regularly. 90 % of committees had retained their memberships over the past year. While there is no quantitative data from the 2012 survey, qualitative data showed that many committees struggled with having regular meeting and poor functioning was observed. In addition, many committees struggled to retain members (add data).

Whether the improvement in health committee functioning is a general improvement or a result of bias is a question that needs to be considered. In approaching health committees for the evaluation, it became clear that some health committees continue to struggle. Thus there seem to be four 'weak' sub-districts with few well-functioning committees, and four strong sub-districts with many well-functioning committees. The health committee members participating in interviews all came from 'strong' sub-districts. The survey had participation from 6 out of the seven sub-districts, which participated in the programme.

Facility manager attendance and participation

One of the most significant results of the evaluation is the attendance and participation of facility manger and the improved relationship between health committees and facility managers. The 2012 research found that only 44 % of facility manager attended the meeting observed compared to 79 % of HC members indicating that their facility manager attended their last meeting. Similarly, qualitative data from the 2012 research indicated that many health committees had a strained relationship with the facility manager. The relationship with the facility manager amongst health committee members interviewed for this evaluation varied, but the majority told of good relationships with facility manager and facility managers that participation in meetings and worked with the health committee. The importance of facility managers' participation has been highlighted in much research and

this evaluation confirms that health committees thrive when the relationship with the facility manager is one of engagement.

Ward-councillor attendance

Surprisingly, this evaluation showed a marked increase in ward councillors' attendance, up from 4 percent in the 2014 survey to 31 % in this survey. The impact of ward councillor attendance was not explored further.

Relationship with community

Health Committees' relationship with the communities they represent was identified as problematic in the 2012-research, but there are strong indications of an improved relationship. Thus 65 % of health committees indicated that they held meetings with the committee at least on an annual basis, while 62 % said that the community knew and appreciated the health committee. Qualitative data also indicated improved relationship, though several respondents indicated that it could be improved further. Visibility of health committee which was raised as problematic the 2012 report was also raised by respondents in the evaluation.

HC members' capacity, knowledge and skills

A major finding from this evaluation was improvement in HC members' knowledge, skills and capacity. While heath committee members in the 2012-research also chowed confidence in their ability to carry out their role (need to find %), the important difference is in the kind of tasks they felt comfortable in carrying out (check report). This differs from the kind of task that they indicated they were able to fulfil now with the majority (80-90 %) saying that their knowledge about health system, human rights and leadership had improved. And with similar high number indicating that they felt confident about their leadership skills and their ability to advocate for human rights.

The most significant finding is perhaps around clarity on role and function of health committee. In the 2012 percent, clarity of role of health committees was the most frequently mentioned problem for health committees. Thus 80 % (check) of health committees mentioned 'clarity of role and function' when they were asked what would enable their health committee to function better. In this evaluation 90 % indicated that they understood the role and function of health committees. Further, many argued that clarity on role of function was an important factor in the improved relationship between committee and facility managers.

Voice and assertiveness

The qualitative data highlights that health committee members had become more assertive and that particularly 'weaker' members had more voice. This contrasts – to some extent- with the 2012-report, where many health committee members felt uncomfortable speaking

up. For instance one chair person in the 2012-report asked her committee members to participate more in meeting rather than 'feeling small' and refraining from voicing their opinion. More assertive members engaged differently with facilities by requesting information, insisting on being part of complaints management and insisting on playing a different role compared to the 2012-report, where the majority of health committee members were happy to carry out tasks given to them by the facility manager and 'assist the staff wherever we can.'

Changing roles: monitoring and complaint management

The 2012 survey contained a detailed analysis of the role of health committee, which indicated that majority of health committees (70%) acted as a voluntary workforce assisting the clinic with tasks such as cleaning, filing and security. There was minimal involvement in tasks understood as relating to oversight – governance and accountability with…. Involved in complaint management and ….. involved in monitoring and evaluation (check numbers).

The current evaluation shows that this has changed with 81 percent of health committees being involved in complaint management and 77 % being involved in monitoring and evaluation. The qualitative data confirmed that health committee members no longer sees their role as 'sweeping the clinic' and resist when facility managers expect them to do be a voluntary workforce.

This changed is mirrored by health committees current understanding of their role as structures that are engaged with oversight (60 %) and bringing community needs to the clinic (89 %). This is in contrast with the 2012 survey, in which most committee members (70 %) saw themselves as 'assisting the clinic'.

Engaging at higher level

The qualitative data in this evaluation also showed that some health committees have begun to engage at different levels in the health system, taking issues to sub-district levels or directly to the Provincial Health Department rather than only operating at facility level. Thus, some health committees seem to be expanding their sphere of engagement.

Clearer vision

Some health committee members also indicated that stronger collaboration between committees and structures that could represent health committees and community voice at higher levels were needed. They advocated for provincial and national forums.

Challenges remain

While great strides have been made, the qualitative research indicates that there are still huge challenges. While the uncertain policy context did not emerge strongly, it is an

unresolved undercurrent. The LN programme with health committees was in the absence of a Western Cape provincial policy of health committees, designed around a national policy framework, which provided a context within which health committees' role was understood. This may explain why heath committee members did not express the same level as frustration about the lack of policy context as they did in the 2012-report. However, roles of health committees vary greatly between the national guidelines and the newly published Western Cape draft policy and it is unclear how a new provincial policy will impact on health committees.

Limitations

There are at least two limitations. A relative small number of surveyed health committee members (20%) for the post-project evaluation. The findings may have been stronger if all health committee members had been surveyed. However, all health committee members participating in the training filled out a post-training questionnaire. Many findings were consistent with those of the post-project evaluation. Further, qualitative data also confirmed many quantitative findings. There may be some bias as it is possible that only relatively well-functioning health committees agreed to participate. However, a similar bias can be said to have existed in the 2012 survey.

Conclusion

This evaluation showed that much can be achieved through a capacitation programme of health committees and through creating a place for constructive dialog and networking. Health committee members' knowledge, skills, capacity increased and their voice became stronger and more assertive. Their understanding and practice of their role also changed, and with increasing clarity on role and function, their relationship with facility managers improved, in some cases resulting in a successful partnership. Health committees increasingly seem to expand their sphere of influence and have begun to nurture a vision that health committees being organised with coordinating and representative structures at both at district level, provincial level and national level to improve community voice in health to higher levels.

However, several challenges remain. Firstly, it remains unclear how many clinics have well-functioning committees. While the evaluation show evidence of many well-functioning clinics, the process also indicated that there are sub-districts, which do not have many well-functioning committees, some committees have folded, and there are still many clinics which do not have health committees. The policy context is still an uncertain factor in the future of health committees. As several health committee members indicated, health committees remain severely constrained by limited resources and funding. Thus, for progress to be sustained, issues such as policy, resources and funding need to be addressed.

As many health committee members have indicated it is also imperative that some form of support system be put in place to support the activities and the role of health committees. This should not only be in the form of on-going training, but also in the form of an office/person that could mentor and provide support for health committees.

Recommendations:

1. The Western Cape Province should finalise legislation on health committees that takes the view of these committees into account (refer to elsewhere). Such a policy should ensure proper capacity building for health committees and ensure funding and resourcing for committees.
2. An on-going capacity building programme and a mentoring/support programme should be implemented to sustain health committees.
3. Funding and resource needs to be provided for health committees.
4. A tiered structure should be created to coordinate health committees and take community views to higher levels in the health system.
5. A programme should be established to ensure health committees are established at all facilities/communities.