Extending Participation: Challenges of Health Committees as Meaningful Structures for Community Participation

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A study of health committees in the Cape Town Metropole

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Acronyms and Abbreviations

AGM .....Annual General Meeting

CMHC.....Cape Metro Health Forum

CSO.....Civil Society Organisation

DoH.....Department of Health

DOT.....Direct observation treatment

HC-member.....Health Committee member

HIV.....Human Immunodeficiency Virus

ICESCR.....International Covenant on the Economic, Social and Cultural Rights

NGO.....Non Governmental Organisation

NHA.....National Health Act

NRF.....The National Research Foundation

PHC.....Primary Health Care

Sanpad.....South Africa-Netherlands Research Programmes on Alternatives in Development

TB.....Tuberculosis

UN.....United Nations

WHO.....World Health Organisation

Executive Summary

"When we as health committee members want to express our opinion as to what is needed in our communities, listen, please listen." Health committee member

"It is the state's obligation to guarantee the realisation of the right to health and develop the institutional mechanisms to ensure that participation takes place." Helen Potts, Participation and the Right to the Highest Attainable Standard of Health (2009: 4)

Community participation in health has been a tenet of the primary health care approach since the Alma Ata declaration (1978). In South Africa, community participation in planning and provision of health care services has been outlined in The White Paper on Transformation of the Health System (Department of Health, 1997) and is seen as part of a wider reform of the health system. Community participation has been formalised in The National Health Act 61 of 2003 (Department of Health, 2004) with provisions for the establishment of health committees, hospital boards and district health councils. Health committees are intended to serve as a link between the health services and the communities they serve. With regard to health committees, the Act stipulates that each clinic/community health centre or a cluster of these should have a health committee. The Act stipulates that health committees should be constituted by one or more local government councillor(s), the head(s) of the health facility/facilities, and one or more members of the community in the area served by the health facility/facilities. The Act furthermore requires that the provincial governments must develop legislation that stipulates the functioning of health committees in the provinces. According to Padarath and Friedman (2008), provincial legislation is in varying stages of development. In the Western Cape, a Draft Policy Framework for Community Participation/Governance Structures for Health is yet to be implemented.

Research has shown that health committees have the potential to impact positively on health and health care services and on the right to health (Loewenson et al 2004, Glattstein-Young 2010). Despite the importance of community participation, studies indicate that health committees in South Africa are not functioning optimally (Boulle et al 2008, Padarath and Friedman 2008).

This study, conducted in partnership with the Cape Metro Health Forum (CMHF), aimed to obtain an overview of how health committees in the Cape Town Metro function, and to identify factors that

impact on their functioning. Furthermore, it aimed to draw up recommendations on how to strengthen health committees and community participation, with a focus on identifying capacity and training needs. The study used multiple methods, including surveys, focus groups, participant observations and in-depth interviews.

The study identified four key challenges for health committees as structures for community participation:

Reach: Firstly, the study identified that health committees existed in approximately 55 percent of the municipal and provincial clinics and health care centres. In other words, health committees have yet to be set-up at almost half of the clinics. The study also found that many communities struggled to establish health committees; and many committees struggle to survive.

Sustainability and functionality: Secondly, the study found that sustainability and functionality of health committees was a major challenge. There were huge variations in the functionality of committees. By and large, health committees struggled with sustainability. This manifested in irregular meetings, many meetings cancelled, poor attendance at meetings, and difficulties in retaining members. Many health committees are 'fluid' entities, which sometimes become non-functional or have periods where they do not operate. Others have to be revived several times.

Representivity and legitimacy: Thirdly, committees struggle to become representative structures for community participation. Many health committees listed their relationship with the wider community as a challenge, arguing that the wider community was often unaware of the health committee. In some cases health committees were not seen as legitimate and representative structures. The majority of health committee members were over 45 years old and women.

Role: Finally, health committees played a limited participatory role and struggled to see their mandate clearly. Health committees were most frequently involved in tasks where they assisted or supported the clinic in the capacity of being 'auxiliary' health or social workers or raising health awareness. In other words: they often acted as 'extra staff' for understaffed and overworked services. They rarely provided an oversight function, and their involvement in providing governance was limited. Their activities were mostly directed at patients, rather than at the health system. However, there are signs of an emerging vision of health committees taking on a more meaningful understanding of community participation.

Factors affecting sustainable and meaningful community participation: A number of factors impacted on the current challenges to health committees.

- **Lack of clarity of the mandate, role and function** of health committees emerged as a key theme. With the Draft Policy not passed into legislation, health committees exist in a policy vacuum. The Draft Policy does not function as guidelines for health committees as very few health committees had any knowledge of the Draft Policy; and the vast majority did not understand the role and mandate described in the Draft Policy.
- L**imited skills and capacity** also undermined the functioning of health committees and a strong call for capacity building and skills development of health committees emerged from participants in this study.
- **Limited co-operation with ward councillors:** ward councillors were reported to participate regularly in four percent of the health committees.
- **Limited co-operation with facility managers:** facility managers participated in 44 percent of health committees. This limited health committees' sphere of influence. There was often limited power-sharing and co-operation with the health facilities and committees.
- **Commitment from members** was also identified as an issue. Uncertainty about role and function, a lack of a clear purpose, as well as practical barriers to the efficient running of health committees contributed to this.
- **Perceived lack of recognition and political will** to implement community participation was a cause of frustration and disillusionment, sometimes resulting in disengagement and lack of commitment.
- **Lack of basic material resources and funding.** Sustainability of health committees was affected by a **lack of basic material resources** such as access to office space and equipment, and lack of funding or access to funding to cover the 'cost of participation', administrative cost for the committee and for projects.
- **Lack of institutional support** from health facilities or the health system undermined effective, meaningful and sustainable community participation.
- **Lack of interest from communities** made it difficult to recruit members and create sustainable and representative committees.

The study found that health committees contribute to realising the right to health, but their contribution is mainly through supporting and assisting the health services, rather than through participation. It

suggests that a 'participatory' aspect should be strengthened through developing a shared vision for community participation. Legislation that stipulate health committees' mandate is urgently needed for health committees to become functional and meaningful community structures. Furthermore, a supportive context and support to building institutional capacity is needed both to ensure that participation becomes 'meaningful', to ensure that health committees become legitimate and representative community structures that are functional and sustainable.

Recommendations:

This study recommends that health committees, health authorities, as well as partners such as the Learning Network, pay urgent attention to realising meaningful community participation in health. While this study does provide a number of recommendations, any step forward should be done in partnership with community structures and health services.

The following recommendations are made:

(a) Develop a shared vision for community participation.
(b) Implement legislation for community participation
(c) Establish clarity on how health committees fit into the broader health governance system.
(d) Ensure that sufficient funding reaches health committees.
(e) Develop a capacity building programme.
(f) Strengthen internal capacity amongst community structures.
(g) Strengthen relationship between health committee, facility managers and ward councillors.
(h) Strengthen relationship between community and health committee.

1. Introduction

"A health committee is good because it really helps the community to know about their rights and about their health." Health committee member

This research is part of the research conducted by the Learning Network on advancing health as a human right. The Learning Network was initiated in 2007 as a network consisting of six civil society organisations (CSOs) and academics from four universities. The Learning Network is founded on a vision of health as a human right and civil society agency as essential to realising the right to health. The network was formed to advance an understanding of how human rights can best be realised and to explore the role of civil society organisations in realising this right. One of the objectives of the Learning Network is to advance the right to health through strengthening community participation. The Cape Metro Health Forum (CMHF), which joined the network in 2008, argued at a plenary in the latter part of 2008 that the limited capacity and skills of health committee members impacts negatively on the functioning of health committees. It was decided that the Learning Network should explore this issue further through an 'audit' of health committees in the Cape Metropole. One of the academic partners, the Health and Human Rights Division at the University of Cape Town's School of Public Health, undertook to conduct the audit. The research was carried out between October 2009 and January 2011.

2. Background

The three-tiered system of community participation structures in health

Health Services in the Cape Town Metropole are run by two authorities, viz. the provincial Health Department, which is responsible for day-hospitals and some community health care centre and clinics; and the City Health Department, which is responsible for a number of clinics.

Currently, in the Greater Cape Town Metropole, community participation at clinics and community health centres is a three-tiered system. Health Committees (sometimes called clinic committees) constitute the first layer. The second layer consists of eight sub-districts health fora (fora and forums are

used interchangeably in this report) with representative from all health committees in that sub-district. The last layer consists of the Cape Metro Health Forum (also called the Cape Metropolitan Health Forum), an umbrella body for all health committees, represented by members of the eight sub-district health fora. At present, all these bodies are voluntary structures with no formal status.

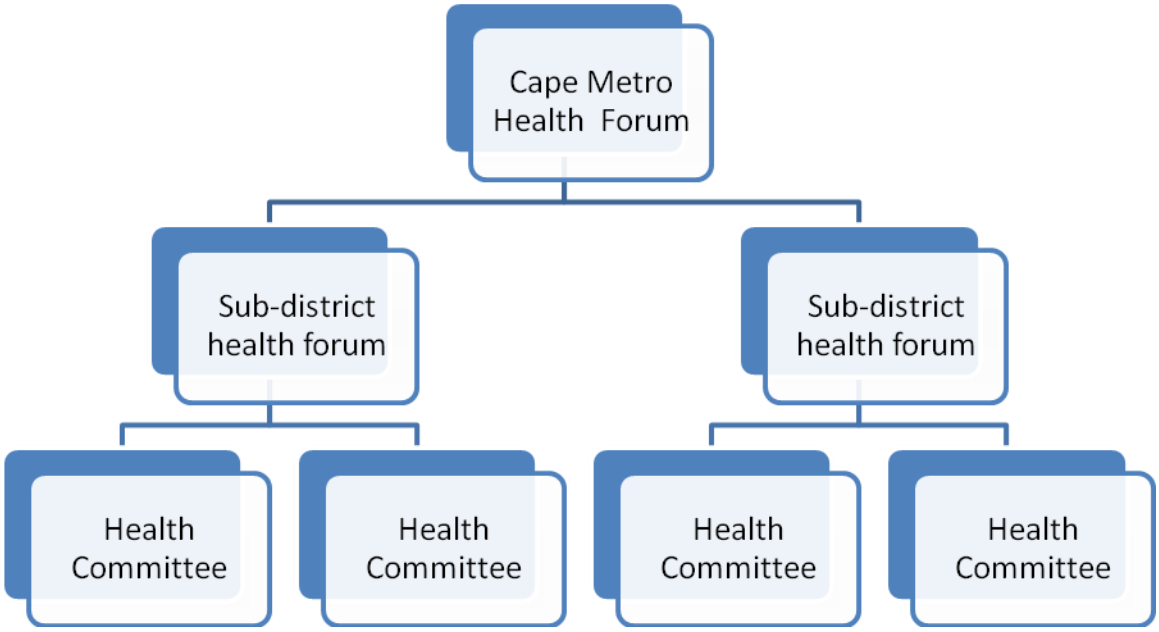

Figure 1 Three-tiered system of community participation structures

However, in some places this structure is supplemented by other committees. In addition or instead of health committees, some areas have health forums. These generally cover a broader geographical area and more clinics, sometimes including a day-hospital. In the Khayelitsha sub-district, a parallel structure exists alongside health committees, called ward health committees. These deal with health issues in particular wards (electoral geographical areas). Thus, in Khayelitsha there is a clear division between health clinic committees, which deals with issues relating to particular facilities, and ward health committees.

Legislative framework for health committees

Section 42 of The National Health Act of 2003 (no. 61 of 2003) provides the regulatory framework for health committees in South Africa. It states that a health committee must be established for a clinic, a group of clinics, a community health centre or a group of clinics and/or community health centres. The

act furthermore states that the committee must include the head of the facility, one or more local councillor(s), and one or more members of the community that is served by the facility. The National Health Act stipulates that the functioning of health committees must be prescribed in provincial legislation. In the Western Cape, as in other provinces, legislation on health committees still has to be implemented. However, in the Western Cape, a Draft Policy Framework for Community Participation/Governance Structures for Health (henceforth the Draft Policy) has been written (see appendix 1). This Draft Policy outlines all the structures of community participation in health and formulates its strategic objective as establishing "effective community participation structures in all districts in the Western Cape." This includes the establishment of functional health committees (also called clinic/community health centre committees) for all clinics and community health centres. A set of guiding principles set out a framework for community participation structures:

(a) PHC principles as articulated in the Alma Ata Declaration and the NHA of 2003;
(b) Strengthen governance of service delivery structures and facilities through effective participation;
(c) A focus on working in partnership with other stakeholders to improve the quality of care at all levels of the health system;
(d) Involving communities in health service delivery and health promotion activities;
(e) Establish mechanisms to improve public accountability and promote dialogue and feedback between the public and all relevant stakeholders;
(f) Building a responsive organization within legal and political frameworks guided by the constitution and various pieces of legislation;
(g) Involve communities in various aspects of the planning and provision of health services; and,
(h) Encourage communities to take greater responsibility to their own health promotion and care.

The Draft Policy stipulates that the clinic and community health centre committees must carry out the following tasks:

(a) Provide governance as it relates to service provision within the facility/facilities;
(b) Take steps to ensure that the needs, concerns and complaints of patients and the community are properly addressed by the management of the facility/facilities;
(c) Foster community support for the initiatives and the programmes of the facility/facilities;
(d) Monitor the performance, effectiveness and efficiency of the facility/facilities.

The Draft Policy states that health committees must meet monthly and establish rules for its proceedings. In addition, the Draft Policy states that the "facility management will provide appropriate support for the optimal functioning of the committee."

The sub-district health forums are envisioned as structures that assist in co-ordinating, as well as monitoring and evaluating the effectiveness of clinic/CHC committees. The Metro Health Care Forum assists in co-ordinating the effectiveness of sub-district health forums, and monitor and evaluate their effectiveness.

The adoption of a policy on health committees has been held back by the long adoption of the Western Cape District Health Councils Act. However, this Act was passed into law in December 2010, hopefully paving the way for legislation on community health committees to be implemented.

However, the District Health Councils Act is silent on community participation and health committees, raising questions about how health committees fit into the broader health governance system. Previously, health committees have been conceived as being linked to the District Health Council.

At present, the South African health system is facing major changes with the planned introduction of a National Health Insurance, which will focus mainly on community outreach services and entail a re-engineering of primary health care. It is unclear how this will impact on community participation. The Green Paper, published in August 2011, mentions community participation only in relation to the re-engineering of primary health care and the introduction of municipal ward-based Primary Health Care Agents. These teams of primary health care agents will be headed by a health professional and be allocated a certain number of families. The Green Paper states that: "The teams will collectively facilitate community involvement and participation in identifying health problems and behaviours that place individuals at risk of disease or injury: vulnerable individuals and groups; and implementing appropriate interventions from the service package to address the behaviours or health problems."

In the Western Cape, a strategic planning framework is under way. A discussion document called "2020 The Future of health care in Western Cape" reaffirms a commitment to community participation, stating that broader public participation and local community involvement is an integral part of the principles of the primary health care approach. The document addresses the issue of community involvement in governance by talking about participation by the public and local communities which could include an "*active involvement in the decision-making and governance of health services"* as well as involvement in campaigns around healthy lifestyles. Furthermore, the document suggests a review of

the provincial Facility Boards Act to provide more systematically for clinic committees and health forums.

3. Literature review

Community participation as part of primary health approach

Community participation is part of a wider health system reform in post-apartheid South Africa. This reform aims to move away from a centralised, mainly curative health system to the establishment of a district health system, based on a primary health care approach, which not only provides health care services, but also addresses the underlying socio-economic determinants of health. The Alma Ata declaration, adopted in 1978, is the key document outlining the primary health care approach. It defines primary health care as follows:

> Essential health care, based on practical, scientifically sound and socially accepted methods and technology made universally accessible to individuals and families in their community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination (WHO, 1978: 45).

As is evident in this quote, participation is viewed as an important, integral, part of a primary health care approach. This notion can also be found in the White Paper on Transformation of the Health System (Department of Health, 1997), which argues that active participation is essential to achieve the goal of implementing a primary health care approach.

> It is essential to obtain the active participation and involvement of all sectors of South African society in health and health-related activities. All sections of the community, all members of households and families and all individuals should be actively involved, in order to achieve the health consciousness and commitment necessary for the attainment of goals set at the various levels. The people of South Africa have to realise that, without their active participation and involvement, little progress can be made in improving their health status. (White Paper on Transformation of the Health System, 1997: 5-6)

Importantly, the White Paper argues that participation entails that communities are involved in "various aspects of the *planning and provision* of health services" (my italics). It also emphasizes the importance of establishing mechanisms to improve accountability as well as promote dialogue and feedback between the public and health providers.

Other literature, such as Baez and Barron (2006), comment on community participation as essential to the implementation of a district health system because it ensures that the health needs of communities are adequately met by the health system.

Benefits of community participation

A number of studies in southern Africa document the benefits of community participation. In a recent study, Glattstein-Young (2010) concluded that some health committees in the greater Cape Town area were able to advance the right to health and improve service delivery. The thesis suggested that the benefits of community participation were greater for 'stronger' health committees, but even in resource-poor settings with minimal support, community participation had a positive impact on the right to health. One example of this was a health committee that was successfully involved in ensuring that a day clinic changed into a 24-hour-facility. Loewenson et al (2004) found, in a study in Zimbabwe, that the community health committees improved both health outcomes and health services. Thus, clinics with health committees generally had more staff, expanded programmes, and better drug availability. Loewenson et al also found that health committees were instrumental in finding successful solutions to problems. Baez and Barron (2006) noted that community involvement in Malawi had resulted in a more responsive health service.

Along the same lines, Oakley (1989) argued that community participation is instrumental in creating a more responsive health service, which is appropriate to the needs of the communities they serve. There is also evidence suggesting that more equitable outcomes are achieved when communities are involved (Gryboscki et al 2006). While some question the correlation between community participation structures and improved health - such as Ngulube et al (2004) – the overwhelming body of literature suggest that community participation is central, both to improved health services and health status. Padarath and Friedman (2008) conclude that "community participation therefore provides an opportunity for community members and health care workers to become active partners in addressing local health needs and related health service delivery requirements. Community participation also

enables community members and other stakeholders to identify their own needs and how these should be addressed, fostering a sense of community ownership and responsibility."

Despite this, community participation is fraught with problems and in many cases both ineffective and limited. Some have argued that community participation is one key element that has been neglected in primary health care (Lawn et al 2008, Rosato et al 2008). Calling for a revitalisation of the principles of Alma Ata, Lawn et al (2008) argue that community participation "seem to be the weakest strands in primary health care".

A number of studies suggest that health committees in South Africa are not functioning optimally (Boulle et al, 2008, Padarath and Friedman, 2008, Glattstein-Young, 2010). Numerous factors have been identified as impacting negatively on the successful functioning of health committees. These include lack of political commitment, limited resources, limited capacity and skills, attitudes of health workers, lack of clarity of the role and mandate of committees, limited co-operation from health services, and lack of support (see Padarath and Friedman, 2008, Glattstein-Young, 2010). Finally, Boulle's study (2007) points to the importance of socio-economic context, arguing that poverty and inequality inhibit effective community participation as well as effective health committee functioning.

The current status of health committees in South Africa has been examined by Padarath and Friedman (2008) who carried out a study attempting to establish the distribution of health committees in South Africa as well as their functioning. Based on telephonic interviews with facility managers, their research found that 57 percent of clinics had a clinic committee, with the Free State having the highest coverage (78 percent) and Mpumalanga Province the lowest (31 percent). In the Western Cape, 48 percent of clinics were reported to have a health committee in 2008, an increase from 28 percent in 2003 when health committees became a legal requirement stipulated in the National Health Act. The research found the following reasons for not having a health committee were most often cited: apparent lack of community interest in forming a committee and failure on the part of members to attend meetings and a lack of stipends for clinic committee members. Padarath and Friedman also examined the participation by local councillors, as required by the National Health Act. They found that local councillors were reported to participate in 45 percent of health committees. Participation of ward councillors in the Western Cape was the second lowest with councillor participating in 30 percent of health committees. Furthermore, the study found that in most cases, facility staff - not always the facility manager - were members of the committees and played an important role in convening health committee meetings.

Several studies emphasise problems around an agreement on what community participation entails. Padarath and Friedman, as well as Glattstein-Young, found divergent views on community participation from health workers and health committee members. Participants in focus group discussions expressed "a diverse range of understandings of the roles and responsibility of clinic committee members. These ranged from purely health promotion role to having a watch dog role over staff." (Padarath and Friedman 2008: 44). Most health committees were involved with solving problems between the facility and community, with health education being the second most popular activity. Glattstein-Young (2010) found that service providers generally felt that health committees were not sufficiently visible in the clinic and were too complaints-focused, rather than assisting the facility on a day-to day basis with 'rude and unruly' patients.

Participation and the Right to Health

The literature on participation is vast and there are many different ways of conceptualising participation, from forms of participation where participants are passive recipients to forms of participation where citizens are part of the decision-making process. Some talk about meaningful participation, others about effective participation, genuine participation or active and informed participation. In this brief literature review, a human rights framework for the right to participation in health will be outlined. The conceptualisation of participation will be explored through focusing on three authors: Rifkin (1986), Arnstein (1969) and Potts (2009).

Numerous global and local human rights treaties outline the right to health and provide for participation. The right to health is outlined in WHO's constitution and access to health care is enshrined in the South African constitution. Furthermore, the United Nation's International Covenant on the Economic, Social and Cultural Rights (ICESCR) also describes a right to the highest attainable standard of health (article 12). In General Comment 14, which elaborates on the ICESCR's notion of the right to the highest attainable standard of health, participation is seen as critical to the right to health. A General Comment is an authoritative interpretation of a legal standard, based on state practice, and input from experts and NGOs, but is not legally binding. In relation to participation, General Comment 14 argues for the importance of "participation of the population in all health related decision-making at the community, national and international levels" (General Comment 14: para 11). Participation in health is also mentioned in a number of UN treaties such as the Ottawa Charter for Health Promotion and the Jakarta Declaration on Leading Health Promotion and the Alma Ata Declaration. Recently, WHO member states signed the Rio Declaration on Social Determinants of Health, which argues that

participation in policy-making and monitoring progress is essential to address the social determinants of health. The declaration, adopted in November 2011, pledges to promote participation in policy-making and implementation (www.who.int/sdhconference/declaration/en).

A number of authors have elaborated on what participation entails and how it should be understood. Sherry Arnstein's *A ladder of Participation (1969)* is one attempt. Arnstein defines participation as citizen power and develops a ladder with different forms of participation with eight different 'steps' signifying an increase in participants' power. The first two steps, manipulation and therapy, are according to Arnstein, actually, 'non-participation'. In the following three steps - informing, consultation and placation - there are degrees of participation insofar as participants are allowed to have a voice and to advice. But it is not 'genuine participation' because they "lack the power to ensure that their views will be heeded by the powerful" (Arnstein 1969:217). Arnstein argues that informing a community, consulting them or asking for their advice is not participation, though it can be seen as a first step. The next step towards what Arnstein calls 'genuine participation' is a partnership where citizens and power-holders agree to share planning and decision-making responsibilities. A further step occurs in 'delegated power' where citizens achieve a dominant decision-making authority over a particular plan or program. Finally, 'citizen control' completes the ladder. At this level, participants govern a program or an institution.

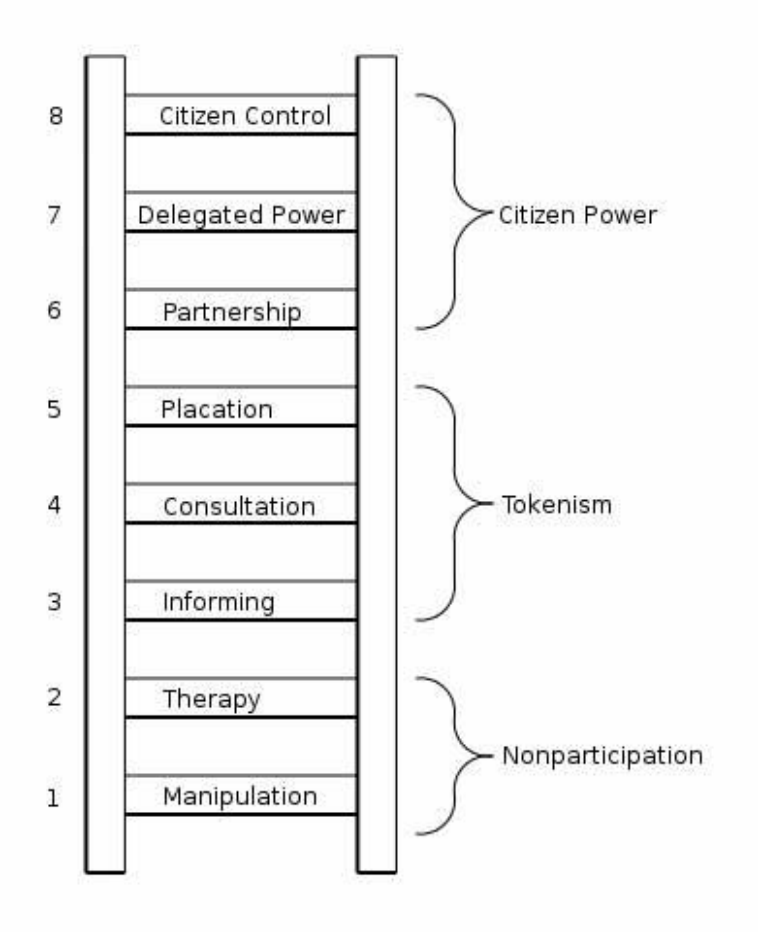

Figure 2 Arnstein's ladder of participation

Rifkin (1986) defines community participation as "a social process whereby specific groups with shared needs, living in a defined geographic area, actively pursue identification of their needs, take decisions and establish mechanisms to meet those needs" (Rifkin et al 1988: 933). Rifkin argues that there are varying degrees of participation. Like Arnstein, she sees power as a central concept and argues that a shift in power where decision-makers relinquish some of their power to citizens is necessary.

Helen Potts' monograph *Participation and the right to the highest attainable standard of health (2009)* uses the term active and informed participation. It argues that participation is an integral component of health systems. Furthermore, Potts situates participation within a human rights framework and argues that states have an obligation to ensure that participation takes place: "it is the state that has the ultimate obligation to guarantee the realisation of the right to health, and to develop the institutional mechanisms to ensure that participation takes place" (Potts 2009: 4). Potts argues that "individuals and

groups are entitled to active and informed participation with government in health related decisions that affect them." (Potts 2009: 4.) Furthermore, Potts states that the process of participation should be fair, transparent and accountable. Importantly, Potts lists a number of pre-conditions needed for informed and active participation. These are:

(a) A strong commitment and long-term vision on the part of the government that the right to health should be incorporated into the day-to-day work of health policy makers.
(b) Institutional mechanisms to ensure participation.
(c) Political will to support and encourage involvement.
(d) Sustained funding for capacity building and for the 'cost of participation'.
(e) Presence of an independent institutional mechanism such as a national human rights institution or health complaints commission with a mandate to develop guidelines for participation and conduct inquiries into participation and respond to complaints about the process.

Potts argues that the intention behind participation is that the voice of the community should be heeded in the decision-making process. Active and informed participation is defined as including participation in the following: identifying overall health strategy, decision-making, setting the agenda for discussion, prioritisation, implementation and accountability. Participation includes taking part in policy choices and monitoring and evaluating.

Effective participation is a similar term based on access to information, access to the decision-making process, and access to judicial redress if a dispute arises or the public wants to challenge a decision. Similar to Arnstein, Potts argues that participation is not simply education, information and consultation. Though important, they do not constitute participation on their own.

Potts also pays attention to the process of participation, which she argues is compromised of four elements: (a) an accessible and inclusive method, (b) a fair and transparent process, (c) indicators for monitoring and evaluating the method and process, and (d) an independent accountability mechanism and remedies. Finally, Potts argues that there are a number of indicators for monitoring the participatory process. These include whether there is a legislative requirement for participation. Whether there is an independent body that develops guidelines for the conduct of a fair and transparent process. Two of the important indicators for a participatory process are: Does the process provide for group-specific methods for participation? Does the process attempt to overcome the costs of attendance?

There are both significant similarities and differences in Potts', Rifkin's and Arnstein's understandings of participation. They share a common understanding of meaningful participation as entailing participation in decision-making and a shift in power. However, they differ on where the final decision-making power lies, with Potts arguing that it remains with the policy-makers, Rifkin talking about varying degrees of participation, and Arnstein advocating for full citizen control where participants govern programmes.

In this report, I use the term effective and meaningful community participation. Drawing on the literature review, this report defines effective and meaningful community participation in health in the following way: community participation is a process where 'community members' engage with health officials in matters related to health and health services, and where that includes involvement in setting the agenda, identifying problems, planning and implementing solutions, taking part in decisions, having an oversight function that entails monitoring and evaluation, and ensuring an accountable health system.

'Community member' refers to a person from a specific geographical area or the drainage area of a particular health facility. The term effective refers to community participation that achieves results, while the use of 'meaningful' refers to participation that involves being part of the decision-making process.

4. Aims of the Study

The aims of this study were:

(a) To establish the allocation and distribution of health committees in the Cape Metropole.
(b) To understand how health committees are functioning and identify factors that impact on their functioning.
(c) To identify training needs of health committee members.
(d) To make recommendations to strengthen health committees.

5. Methods

The approach to this study was explorative and used multiple methods, combining qualitative and quantitative methods. In the initial phase, health committees were identified through information from

the CMHF, the eight sub-district health fora, and through speaking to facility managers at individual clinics. Based on this information, a database was established.

In the second phase, interviews with key-stakeholders were conducted and focus groups were held with three health committees. These were chosen to be representative of the three language groups in Cape Town (English, Afrikaans and isiXhosa), as well as being representative of different socio-economic areas. The focus groups were used to gain a better understanding of health committees, their functioning and their challenges, and getting health committee members' input for the design of a questionnaire aimed at all health committee members. In addition, a draft questionnaire was tested. The qualitative data gained through the focus groups were used both to develop the quantitative component, a questionnaire, and form part of the analysis.

Though the CMHF's original concern related to skills and capacity of health committees, the qualitative data showed that issues of role and function of health committees was a key concern for health committees. Furthermore, it became evident that an assessment of skills needed for well-functioning health committees could not be separated from the question of what health committees were doing, would like to do, or believed to have the mandate to do. Finally, the qualitative data pointed to a number of other issues that affected health committees; and it was decided that the questionnaire should be designed to allow health committees to comment more broadly on barriers and give 'voice' to concerns raised by health committees.

The questionnaire was divided into four sections, exploring the following issues:

(a) Educational and other relevant experience of health committee members.
(b) Role and function of health committees.
(c) Skills and capacity of health committee members.
(d) Other barriers and suggestions.

The questionnaire, a project information sheet, and a consent form were translated into Afrikaans and isiXhosa. Data-collection with predominantly isiXhosa-speaking committees was conducted with the assistance of an isiXhosa-speaking fieldworker/researcher.

Meetings were set up with sub-district health fora with the purpose of facilitating access to health committees and to explain the research process. Subsequently, individual health committees were contacted. After access had been negotiated, meetings were arranged with individual health committees. After a briefing, which explained and discussed the research, as well as allowed for

questions, informed written consent was taken. To avoid misunderstanding, each question in the questionnaire was explained and discussed before the participants answered the questions. Members were encouraged to ask questions, and these often let to informal discussions. During these discussions, field notes were taken. Field notes were also taken during discussions prior to filling out the questionnaire. In addition, structured field notes were taken for each health committee, collecting the following data.

(a) Presence of facility manager and information on how often facility manager attends meetings.
(b) Presence of ward councillor and information on how often ward councillor attends meetings.
(c) Composition of health committee in terms of age and gender.

During the research process, a number of informal discussions and meetings with health committees, sub-district health fora, facility managers, and representatives from the Cape Metro Health Forum took place. Furthermore, during the research process, the Learning Network held meetings where preliminary results were presented. Preliminary results were also presented at the South African NGO week. Field notes were taken at all meetings, discussions, and telephone conversations and forms part of the findings and analysis.

Finally, the research process highlighted a number of issues pertaining to the functioning of health committees. Foremost amongst these were the functionality and instability of health committees. One indication of this was that a number of health committees had disbanded or failed to 'survive' the first year. To explore this issue further, in-depth-interviews with two health committees that disbanded within a year, and one in-depth-interview with an interim health committee struggling to establish a committee, were conducted.

All health committees were approached and asked to participate in the study, but some chose not to participate or it proved impossible to collect data from them, mainly due to their poor functioning during the time of the research. The research found that 82 clinics were linked to health committees. This represents about 55 percent of all clinics in the Cape Town Metropole (for a detailed overview, refer to the section on Limited Reach, p. 28). In total there were 62 health committees as some of the 82 clinics were clustered. 46 committees (72 percent) participated in the research, either through focus groups or completing questionnaires. Because clinics can cluster it is impossible to give a figure of how many health committees should exist. A total of 246 questionnaires were collected. It is impossible to give a percentage for how many health committee members participated, as no baseline exists. Membership was not always a straight forward issue. Health committees would often be uncertain as to

the number of members the committee consisted of, and membership would often be very 'fluid', with some members not attending meetings frequently and eventually stop attending altogether. For practical reasons this research was conducted with the members that were present at the meetings when the research was conducted.

Refer to Appendix 2 for the questionnaire.

Data analysis

The data from the questionnaire was captured in MSExcel. The questions were then post-coded and analysed. The qualitative data was analysed thematically using Nvivo 8.

Ethics and consent

All participants were explained the study by the researcher and asked to read a project information sheet. They were informed about their right not to participate and were promised confidentiality. If they were happy to participate, they signed a written consent form. Any questions raised were answered before they filled out the consent form.

This research was approved by the Research Ethics Committee at the University of Cape Town's Health Science Faculty (179/2007).

Challenges and limitations

A number of challenges, which also give insight into the findings of the study, were experienced during the research process. Firstly, identifying and contacting health committees was a lengthy process. This seemed partly to be due to many health committees fluctuating in their level of functioning and having periods where they did not have meetings. (The implications of this will be dealt with in the section on Findings: Sustainability and functionality of health committees, p. 30). There were also many shifts in leadership, which complicated the process. In addition, communication was often a challenge with telephone numbers changing frequently or members not having access to telephones.

Gaining access to committees and obtaining permission to conduct the research was often difficult. One of the reasons for this was communication between different structures - such as sub-district health fora and health committees - and between committee members and chairperson/contact person. Thus, when permission had been granted at one level, this was not always communicated as a result of which committee members were reluctant to participate. In these cases, access had to be negotiated several

times. Frequently, health committee members requested discussions before they gave their consent to participate, raising many questions about the research and concerns about the outcome.

The process was complicated by the way many health committees function. Thus, infrequency of meetings and many cancellations would often result in the research also being 'cancelled'. In the case of one health committee, eight meetings were required before the research could be conducted. In a few instances, it became impossible to conduct the research after the initial meetings, usually due to poor functioning of these committees.

'Buy-in' from health committees was also affected by a general sense of disillusionment. While many were vocal about their need for support and capacity building, there was often a lack of belief that the authorities would address issues of concern. Many questioned the usefulness of the research and expressed a lack of trust in the likelihood that changes would be forthcoming. Lengthy discussions were necessary to build trust and clarify issues of concern, especially related to the outcome of the research. However, there were both health committees and individual members of other committees that elected not to participate in the research.

Literacy levels emerged as a key issue. It was evident that many health committee members have low levels of formal education. Some struggled with the questionnaire, and more complex questions were often left unanswered or only answered partially. Furthermore, many preferred oral communication and would talk at length about questions posed in the questionnaire, but give very terse information when asked to write. In those cases, committee members would be asked whether they preferred assistance with writing. In that way, valuable data was gained from participants who would otherwise not have a 'voice'. However, it is important to note that the data collected may not be completely representative, but rather that members who are more articulate and comfortable with writing may have a stronger voice and their views be overrepresented. Furthermore, the weakest or poorly-functioning health committees were often the most reluctant to participate. In some cases, it became impossible to ensure their participation because it was impossible to set up meetings with them due to their poor functioning. In an attempt to capture these 'voices', interviews with 'defunct' health committees or health committees that failed to establish themselves were carried out. However, it is important to note that while qualitative data was gained in this way, their contribution to quantitative data is lacking.

6. Findings and Analysis

This research identified four key-challenges for health committees, viz.:

(a) They have **limited reach** with just over half of clinics being linked to a health committee.
(b) Many health committees are challenged by **instability and poor functionality**.
(c) Health committees play a **limited role as structures for meaningful community participation**.
(d) Health committees struggle to become **representative and legitimate structures** for community participation.

The findings of this study indicate that there are a number of reasons for the current status of health committees in the Cape Town Metropole, viz.:

(a) Lack of clarity on their role or function
(b) They exist in a policy vacuum and have limited knowledge of the Draft Policy
(c) Limited skills and capacity
(d) Limited participation by facility managers
(e) Very limited participation from ward councillor
(f) Lack of funding and resources
(g) Lack of support
(h) Limited commitment from committee members
(i) Perceived lack of recognition and political will
(j) Limited community involvement and interest
(k) Problematic process for forming health committees and alignment between health committees and facility managers
(l) Furthermore, questions of the best structure of community participation needs to be considered

Limited Reach

The Cape Town Metropole has a total of 148 provincial and municipal clinics, including 17 satellite clinics and mobile clinics. This research was able to identify 62 health committees connected to a total of 82 clinics. That is equivalent to 55 percent of clinics being linked to a health committee. There are, however, huge variations amongst the various sub-districts, as Figure 3 below shows. Mitchell's Plain

sub-district have the best coverage, with 84 percent of clinics being linked to a health committee, while the Southern sub-district has the least with only 27 percent of clinics being linked to a health committee.

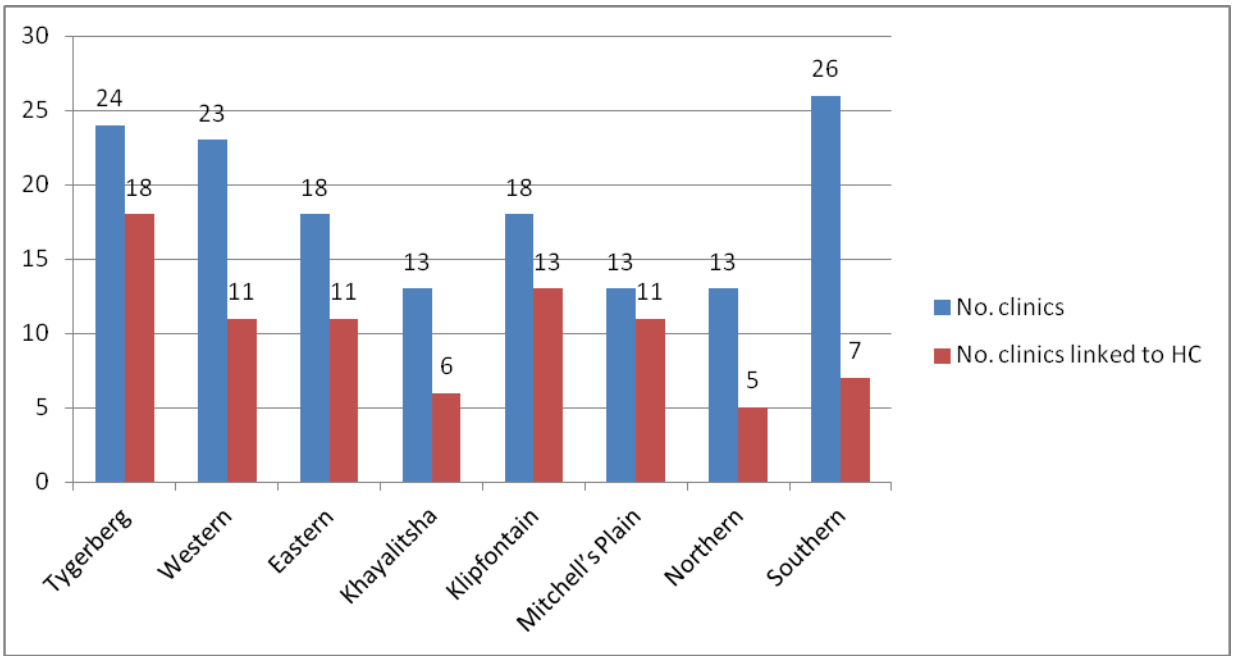

Figure 3 Number of clinics and number of clinics linked to a health committee in the 8 sub-districts in the Cape Town Metropole

Refer to Appendix 3 for the data for Figure 3.

This data need to be viewed with some caution. At times it was difficult to ascertain whether a certain health committee was functioning. Some health committees were at a stage where they had not had meetings for a lengthy period of time (e.g. 6 months). In other cases, it proved impossible to set up meetings with health committees. Answers given included the following: “it is not suitable at the moment”, and “better leave it for now”. In some cases, it would be impossible to get hold of the chairperson after the initial contact or meetings would be unattended. Whether these health committees were actually in a process of disintegrating is difficult to say, but the research found evidence that many health committees do disintegrate or go through cycles of disintegration and revival. On the other hand, the research found that a number of clinics/communities were in various stages of establishing health committees. Whatever the actual number of functioning health committees are, it is clear that health committees in the Cape Town Metropole fall short of the target set both in the National Health Act and the Draft Policy - that every clinic should have a health committee.

Sustainability and functionality of health committees

Sustainability and functionality of health committees emerged as a key theme and challenge to health committees. There were huge variations in functionality of health committees. However, several respondents raised it as an issue and many discussions focused on the question of how to maintain or sustain health committees.

There were several indicators of this during the research process. Numerous health committees did not have regular meetings, while others had frequent cancellations. The ad hoc nature of meetings is also exemplified by the fact that many meetings started very late, while others were organised as they happened with either the facility manager or the chairperson phoning members to inform them of the meeting taking place, sometimes successful in getting members to attend the meeting, at other times not.

There were some very big - and well-functioning - health committees in the Cape Metropole, but these were few. By and large, attendance was poor at health committee meetings. One indication of this is the fact that of the 45 health committees that participated in the survey, 15 – or one third - had three or less members participating in the meetings. Some committee members complained that two people would basically 'run' the committee. Others mentioned that members only showed up when there was a crisis. One heath committee member put it this way:

> If there is no emergency or crisis, it is difficult to sustain a health committee. But it is really at that time we should work and see what can be done. That is when we have time to sit down with the Sister and plan ahead.

Many health committees that have been established recently, have been established at clinics where previously there was a health committee. Numerous health committees would refer to previous committees that just 'disappeared', 'collapsed' or 'died'. The majority of these health committees were said to have high attendance after the annual AGM, but after a few months members stopped attending meetings, often leaving one or two members to carry on the committee if it did not cease to exist altogether. A chairperson of a committee that had not met for six months explained that a meeting with the committee could not be arranged for the following reason:

> At the moment this committee is not available for meetings. We are dedicating our time to a special meeting to revive the committee because committee members have just disappeared... At the AGM you have thousands of people, but in the following months they just disappear.

Some of these health committees would report that they were attempting to 'recruit' new members or 'co-opt' community members to come on board.

Thus, many health committees seem to be 'fluid entities', going through cycles of disintegration and revival. During the research period, a whole sub-district health forum was going through a process of reviving health committees with the assistance of sub-district health forum members. The sub-district health forum in question had also been revived after a dormant period. Two other sub-district health fora of the eight that comprise the Cape Metro Health Forum were not functioning at the time the research took place, but have been said to be revived since.

Finally, it was evident that many communities/clinics struggled to establish health committees. During the research period at least ten communities/clinics were in various stages of attempting to establish a committee, from clinic Sisters considering starting a health committee to communities where community meetings were planned. The problems with sustainability are perhaps best illustrated by the fact that several health committees had not survived their first year.

Functionality of health committees varied hugely. Many health committees were reported to have a constitution, meetings were held according to an agenda and minutes were taken. In other cases, meetings did not run according to an agenda and minutes were not always taken. However, the biggest challenge in terms of functionality appeared to be the financial management of health committees (see section on limited skills and capacity p. 50). During the financial year 2010, R 658,000 was allocated to the CMHF and the sub-district health fora. Each of the eight sub-district health fora received R 56,000. These resources were supposed to be distributed to health committees via the eight sub-districts. However, several health committees complained that they did not have access to these funds. One of the reasons given was problems with reconciling past expenses or previous financial 'mismanagement'. In some cases, health committees did not know why they did not have access to this funding or were not aware that funding was available. The implication of not receiving funding was huge for health committees. Expenses such as transport costs were meant to be reimbursed, but were not. This impacted negatively on community members' ability to attend meetings.

Representivity, legitimacy and visibility of health committees

Representivity was another key challenge for health committees. In order for health committees to be the link between the community and the clinic, they need to be representative and be seen as representing the communities and different sections of the communities. However, this research found that the majority of health committee members were middle-aged to elderly and female. Some committees were solely represented by senior citizens; others had only female members, while one committee consisted entirely of social workers employed by shelters in that area. Few committees had young committee members and several committees mentioned the lack of participation by young people as a problem. Representivity was also an issue in terms of lack of participation by particular vulnerable groups such as refugees and people with disabilities. Furthermore, health committee members were to a large extent drawn from the ranks of community health care workers. In one committee, the majority of members were home-based carers.

Many committees saw their relationship with the communities they are supposed to represent as a problem and complained that they were 'invisible'. Several health committees explained that people in the community did not know what the health committee was doing and therefore had no interest in the committee. In another case, community members claimed that the health committee was not legitimate because the election had not been advertised. Due to lack of financial resources, this health committee was unable to advertise their annual general meeting. Thus, lack of financial resources impacted negatively on the legitimacy of the committee.

Limited Role

Figure 4 below, based on the 246 questionnaires, reflect the activities health committee members are currently involved in, and also show the number of health committee members that would like to carry out that specific activity (but are not currently doing it).

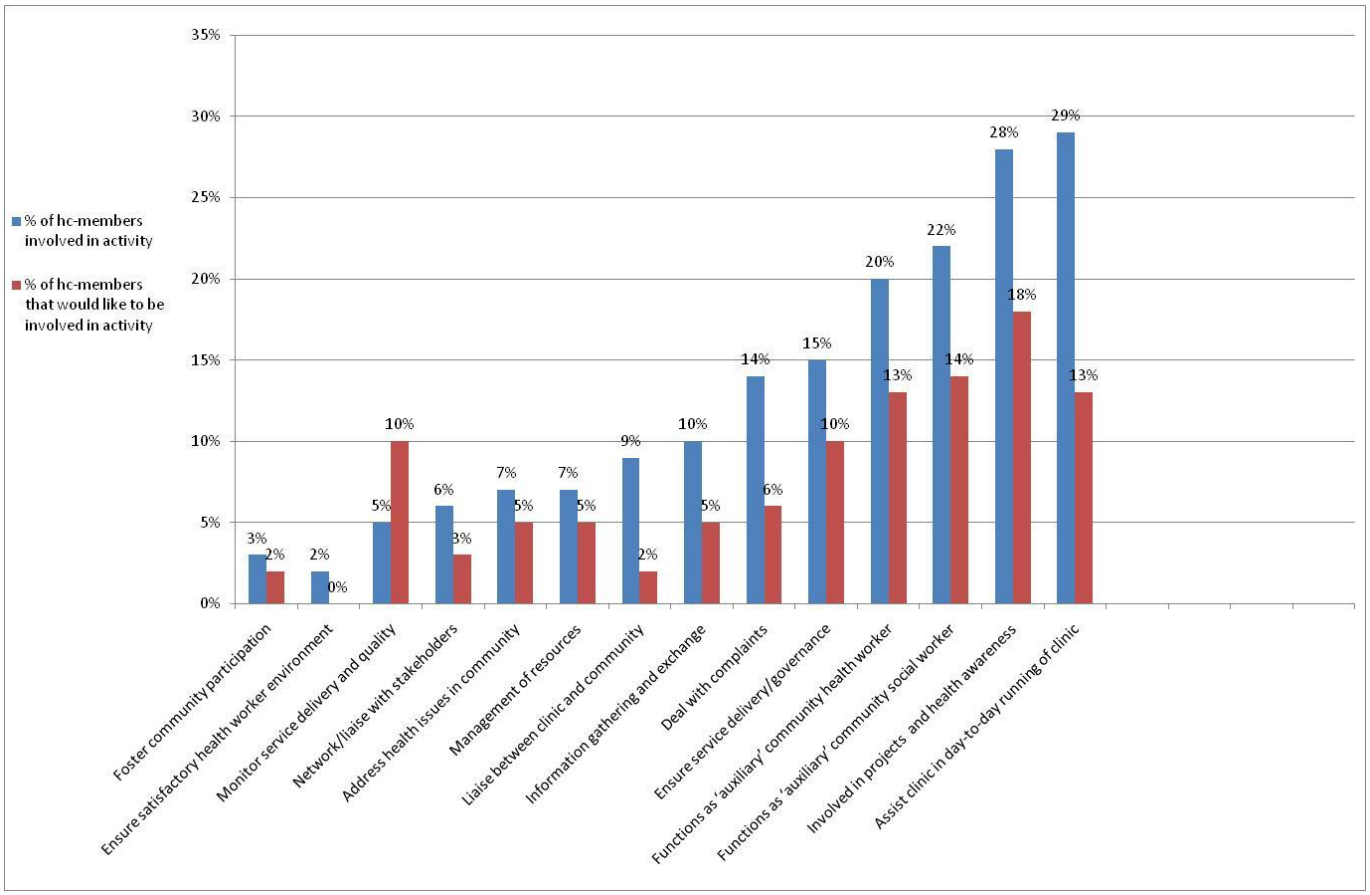

Figure 4 Current and envisioned activities of health committee members, shown as percentages of committee members involved in activity.

Refer to Appendix 4 for a more detailed description of current and envisioned activities.

Figure 4 above show that the most important activities health committees are currently involved in are:

(a) Assisting the clinic in day-to-day running of the clinic.

(b) Health awareness, health promotion and campaigns.

(c) Members function as 'auxiliary' community social workers.

(d) Members function as 'auxiliary' community health workers.

The research found that health committees play an important role in assisting and supporting clinics, as well as in raising awareness, assisting clinics in projects, and assisting patients in various ways including social 'upliftment'. The assistance they provide is defined by the facility manager and range from assisting with cleaning the clinic to assisting with patients' health needs. That health committee members are often viewed as voluntary workers is perhaps best illustrated through the words of a community member, interviewed about difficulties with starting a committee. Explaining, why the

facility manager was interested in having a health committee, he said: “It is such as quick help to them, you know.” Along a similar note, a deputy facility manager explained that the health committee’s role was to assist the facility with everything.

Fifteen percent of health committee members reported that they were involved in ensuring service delivery and ensuring that the needs of the community are met. However, a more detailed analysis of the responses shows that ensuring service delivery can entail many things. In some cases, health committees participated in planning, decision-making and problem-solving with management or health committees attempted to address issues of insufficient staff and equipment. In other cases, it entailed that health committees identified and reported gaps without being part of identifying solutions. Field observations also suggested that this role was rather complicated and that health committee members often struggled with how to ensure solutions as they had limited say in and access to the health system governance. The issue of how health committees participated in ensuring service delivery is thus a complicated issue that needs more attention. **Figure 5** below illustrates different levels of involvement in service delivery:

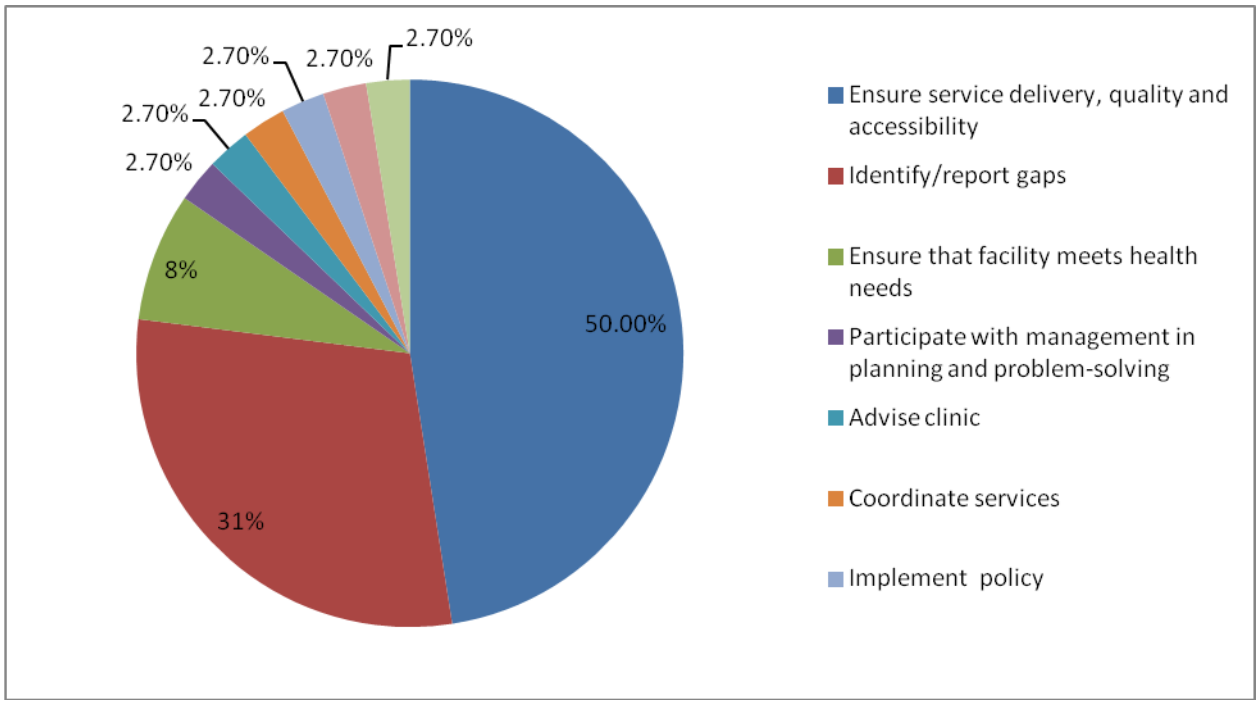

Figure 5 Degree of involvement in ensuring service delivery, shown as percentage of health committee members involved in ensuring service delivery.

Refer to Appendix 5 for the data for Figure 5.

A similar pattern can be observed with regards to complaints. 14 % of health committee members reported to be involved in complaints, but a closer look at how they were involved shows huge variety in how they are involved. 'Dealing with complaints' does not always mean that health committees were involved in investigating and addressing complaints. In half the cases, health committees received, recorded and handed over complaints to facility manager or they kept statistics of complaints. Thus, in half of the cases, health committees were not involved in addressing complaints or finding solutions to issues raised. None of the health committees were involved in a process of redress. **Figure 6** illustrates how health committees were involved in dealing with complaints.

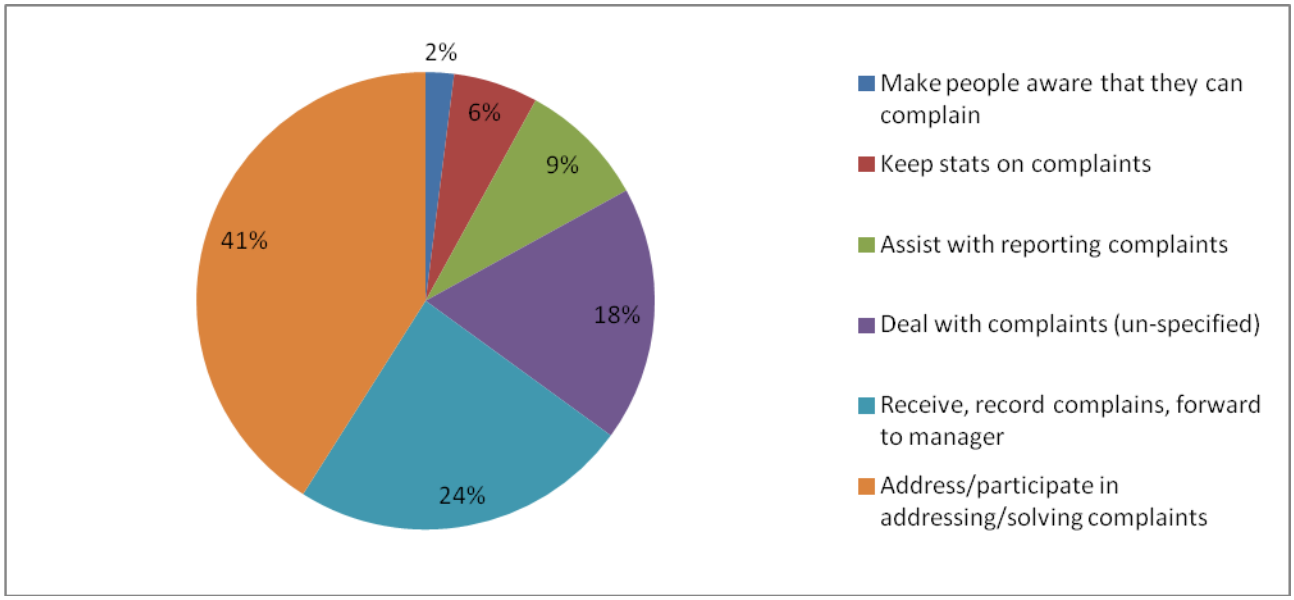

Figure 6 Degree of involvement in complaints, shown as percentage of members that are involved in complaints.

Refer to Appendix 6 for the data for Figure 6.

This finding was supported by observations during fieldwork where health committee members would explain that they did not deal with complaints as they believed this to be the role of the facility manager. "We do not deal with complaints. That is the sister's job as it relates to staff," commented one health committee member. In another instance, it was clear that the health committee was prevented from dealing with complaints by the facility manager and were powerless in ensuring a transparent and fair complaints procedure, even though they attempted to get involved. Instead, they explained that complaints were not dealt with at all but went missing. "We want to be involved, but the facility manager does not want us to have anything to do with complaints. When I handed in a written

complaint I asked for a receipt because I know that complaints just go missing, but I still have not heard anything," said another health committee member. The findings regarding complaints were supported by comments made to questions about their understanding of the Draft Policy. Responses showed wide variations in how complaints were dealt with. Several committee members commented that complaints were not being dealt with in a satisfactory manner: "They (facility management) do not look at them accordingly because they are doing nothing with the complaints." Another commented: "Patients' complaints and needs are not taken care of." Yet another response showed a process where a health committee was involved with the facility in dealing with complaints: "Once again, the executive will get together with the manager and workshop through the complaints." Other responses highlight the need for clear complaints procedures, suggesting that health committees should: "Ensure that there is a protocol as to how complaints are lodged. Liaise with management and officials to ensure complaints are adequately addressed."

Ten percent of health committee members were involved in information exchange, but again a more detailed analysis shows that this mostly consisted of health committees giving information to the community about services at the clinic, opening hours, and challenges faced by the clinic such as shortage of doctors. They were less frequently involved in giving information about health needs of the community to the clinic, Department of Health or the environmental health officer. Thus, while important information was passed on to patients, the activity of the health committees was primarily directed at getting patients to adjust to the health system, rather than at informing clinics and the health system of the needs of the communities. Furthermore, the process of providing information seemed to be separated from addressing problems. **Figure 7** below show health committee members' degree of involvement in information exchange.

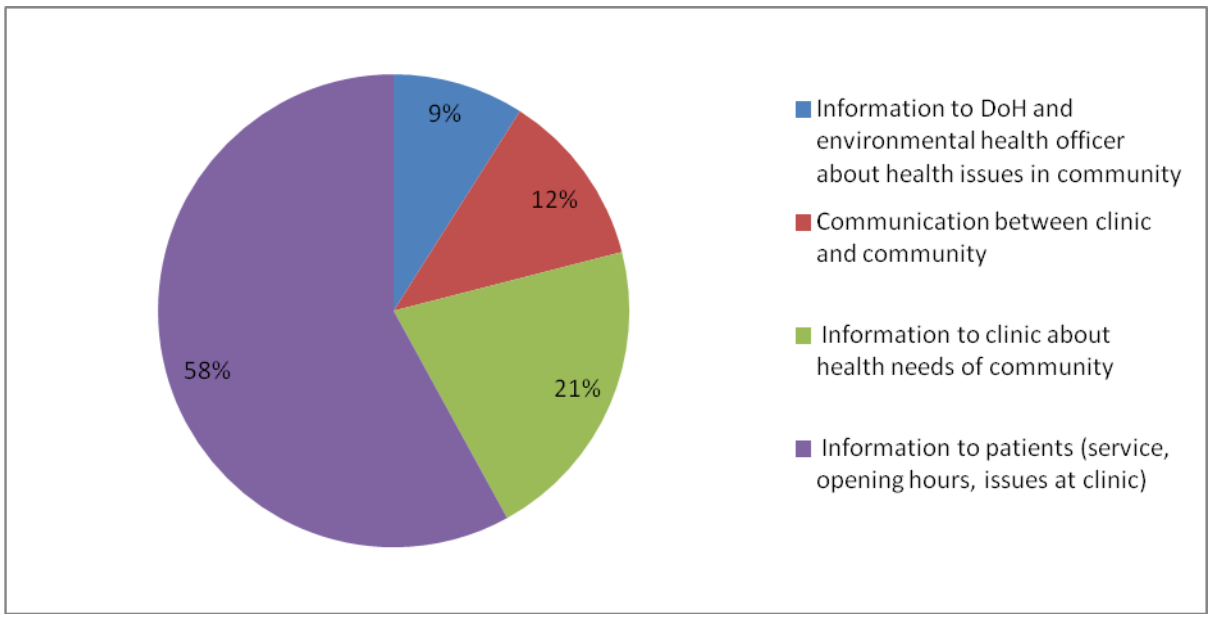

Figure 7: Degree of involvement in information gathering and exchange, shown as percentage of health committee members involved in information gathering and exchange.

Refer to Appendix 7 for the data for Figure 7.

Only 22 health committee members, slightly less than one in ten, viewed their role as one of liaising between the clinic and the community. Frequently, they would describe their role as being the 'eyes and ears of the community' or 'the voice of the community'. Fewer, 14, saw their role as networking and liaising with stakeholders such as health workers and the health department.

Health committees' involvement in managing resources was exclusively in the form of raising funds. None were involved in drawing budgets.

Addressing health issues in the community had a fairly low priority and was largely limited to two geographical areas; one community which attempted to improve the environment by addressing waste issues. This was mainly done by attempting to get the community to clean up streets. The other was a community that was involved in monitoring children in local crèches after a child had been diagnosed with TB.

Few health committee members (5 %) were involved in monitoring services at the clinic. Even fewer were involved in fostering community participation, something that may reflect relatively weak links between the health committee and community. The following activities also had very low priority

(below 2 %): promoting primary health care, ensuring that human rights are not violated, advocate and lobby. No health committee was reported being involved in influencing policy.

A look at health committee members' previous experiences may provide a reason for why they were primarily involved in tasks where they function as 'auxiliary' health care workers and social workers and in volunteering at the clinic. In total, 175 reported that they have valuable previous experience that they use in their work as health committee members. Of these, the vast majority answered that they drew on their experiences as home-based carers, retired nurses, DOT supporters, TB supporters, community 'workers', volunteers, support group facilitators, health promoters, family planners, working with children or the elderly, and working with HIV. It was evident that facility managers in some cases turned to home-based carers when attempting to start a health committee. This may explain why there was a blurring of roles between community health care workers/community workers and health committee members.

Participatory Roles

In this report, effective and meaningful community participation has been defined as a process where *"community participation is a process where 'community members' engage with health officials in matters related to health and health services, and where that includes involvement in setting the agenda; identifying problems; planning and implementing solutions; taking part in decisions; having an oversight function that entails monitoring and evaluation, and ensuring an accountable health system".*

This definition includes three key elements for understanding participation, which it shares with Potts, Arnstein and Rifkin:

(a) That participation entails being part of decision-making process.
(b) That participation entails being part of identifying problems and finding solutions.
(c) That participation entails power-sharing.

Based on these key-elements, the following 'participatory roles' can be used to analyse the level of participation that health committees are currently engaged in.

Participatory roles:

(a) **Assists** facility: Health committee assists facility. Facility identifies problem, initiates/defines activity and makes decisions. (Activity is part of facility's existing responsibility).

(b) **Supports** facility: Support facility in carrying out activities. Control and decision-making remains with facility.

(c) **'Filling a gap'**: Health committee 'fills a gap': Health committee assists patients and communities with health and social needs that should have been addressed by the health services.

(d) **Information exchange**: Health committee shares information with facility, but is not involved in identifying problems/solution or making decisions. Includes health awareness information to community.

(e) **Advises:** Health committee advises clinic, but is neither part of identifying problems or have power in decision-making.

(f) **Networking**: Health committee networks and liaise with clinic and stakeholders such as health care workers, health department and NGOs.

(g) **Participates**: Facility and committee jointly identify problems, make decisions and have joint control/power.

(h) **Has oversight**: Health Committee takes on an oversight function and has control/power.

(i) **Acts independently**: Health committee addresses issues pertaining to/impacting on health in their community independently at community level or system/political level. e.g. addresses environmental issues or addresses shortcomings in the health system, e.g. through lobbying and advocacy.

(a) - (d): represent varying degrees of 'limited participation'.
(e) - (f): is partly participatory.
(g) - (h): represent different forms of meaningful participation.
(h) - (i); reflects that health committees have an independent role.

Figure 8 provides an overview over what forms of participation health committees are engaged in.

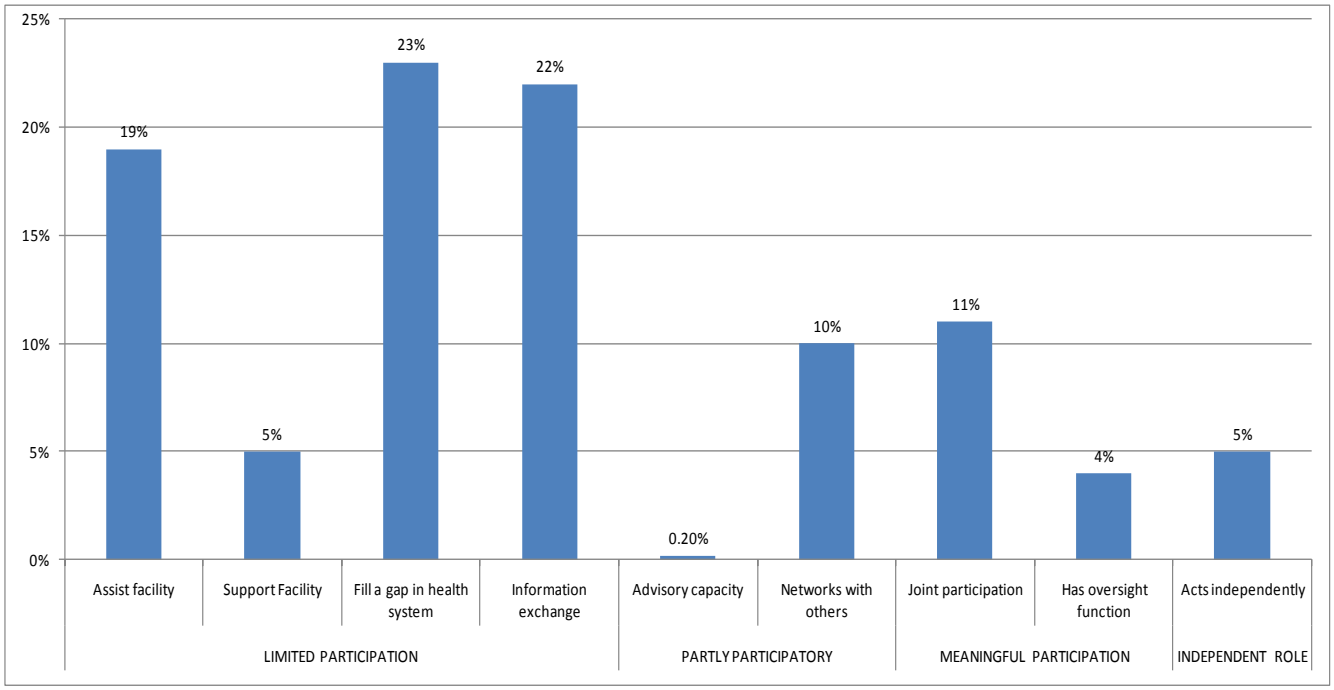

Figure 8: Participatory roles undertaken by health committee members, shown as percentage of health committee members

Refer to Appendix 8 for the data for Figure 8.

Worryingly, 69% of responses can be characterised as 'limited participation' where health committees were not part of the decision-making, but rather acted in a supportive participatory role to the clinic or partly participatory where health committees informed communities about health issues, clinic opening times, etc. 15% of responses indicated that health committees acted in participatory role where they either planned jointly, or had an oversight function. Ten percent indicated that health committees networked or liaised with stakeholders such as health workers or NGOs involved in health issues. Five percent of responses indicated that health committees acted independently, addressing either health issues in communities or at policy level. Overall, the findings suggest that health committees' participation was to a large extent limited, as shown in **Figure 9** below:

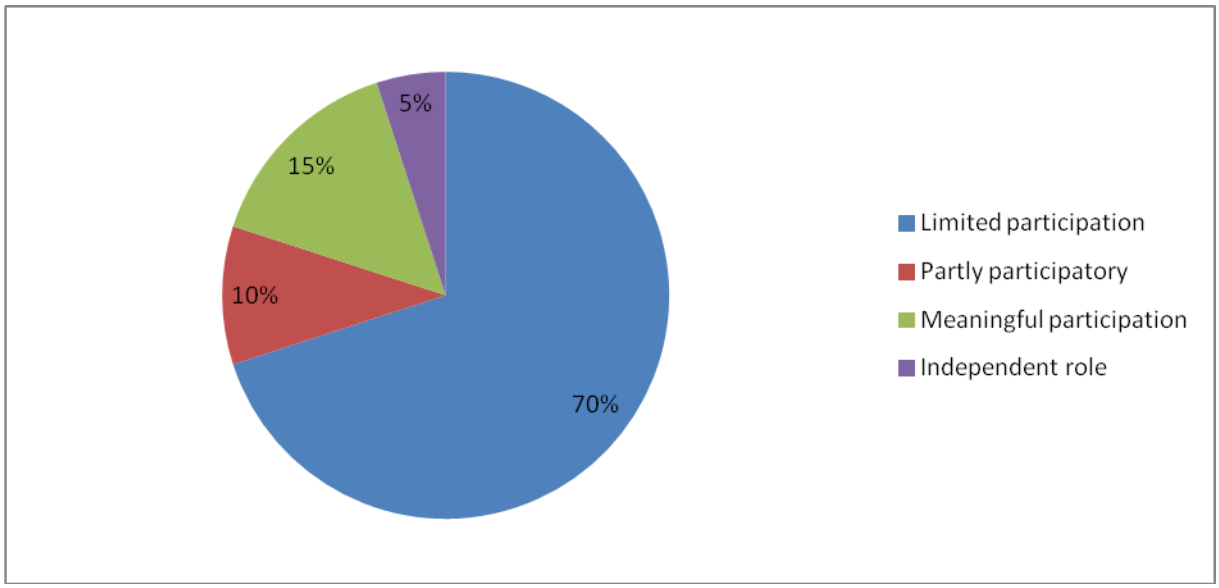

Figure 9: Degrees of participation.

Community members and facility managers often shared the view that a health committee's primary role was to assist the clinic. Asked by a prospective health committee member what a health committee does, one deputy facility manager explained the role of the health committee in the following way: "They assist us in everything we do." A chairperson of another health committee described the health committee's role as "carrying the clinic with the staff". Yet another health committee member described the role of the committee in the following way: "We are here (at the clinic) to help when staff members want us to help." Another comment echoed this view, saying that health committee members were there to work at the clinic. Many responses also indicated that health committee members see their primary role as 'working' or volunteering at the clinic. Thus, there was often a blurring of roles between health committee members and community health workers. There were also indications, that some saw being a health committee member as a step towards paid employment.

Another way of looking at this data is to argue that by assisting the clinic and health system, health committees are focusing their attention on assisting patients in adapting to the system and 'fill a gap' in the system to a much larger extent than directing their energies at changing the system. Thus, shortcomings in the health system were mainly addressed by health committees managing 'unruly' patients, informing patients about long waiting hours, doctors' shortages, etc., rather than addressing systemic issues such as poor service delivery.

Poor match with Draft Policy

The findings also suggest that there is a relatively poor match between the tasks health committees are currently involved in and the tasks stipulated in the Draft Policy. It is important to note that the tasks described by health committee members do not explicitly refer to the tasks in the Draft Policy. The table below is an attempt to match health committee members' description of what they are currently doing with the Draft Policy's tasks. For instance, complaints are listed as corresponding to the task described in the Draft Policy as "Ensure that the needs, concerns, and complaints are addressed by the facility" even though dealing with complaints only cover part of this task. Similarly, it is assumed that 'liaising between community and clinic' correlates to the task described in the Draft Policy as "Foster community support for the programmes and projects of the clinic" – even though it is unclear whether liaising always entails that. Basically, the corresponding task is an 'overestimation' in the sense that all task descriptions that may correspond to the Draft Policy have been counted as such. Thus, the table below should be seen only as an *indication* of how many activities currently carried out by health committees correlate with the tasks stipulated in the Draft Policy. **Figure 10** indicates how many health committee members are involved in tasks stipulated in the Draft Policy.

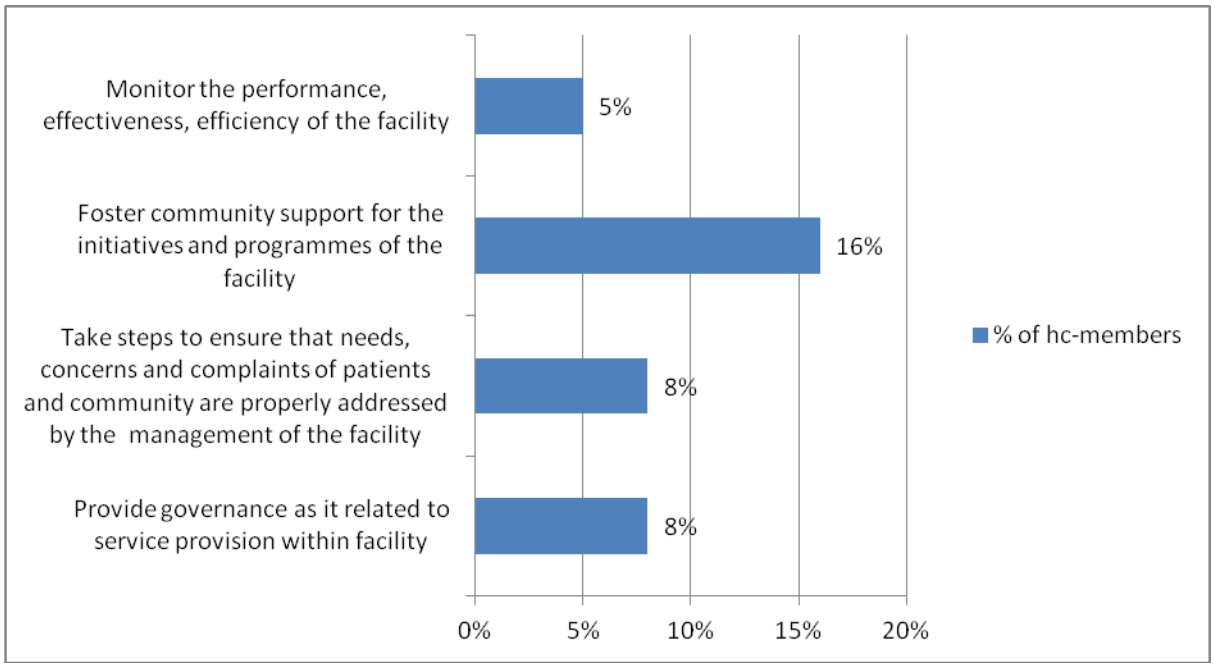

Figure 10: Health committee members' involvement in tasks, described in Draft Policy.

Refer to Appendix 9 for the data for Figure 10.

As the table shows, between 16 % and 5 % of the 246 health committee members that participated in the survey are involved in the various tasks described in the Draft Policy. The highest involvement is in the task that is the least participatory - fostering community support for programmes at the clinic. Only 5 % are involved in monitoring and evaluation. It is evident that some of the tasks most frequently carried out by health committees, such as contributing to the daily running of the clinic or being 'auxiliary' community health workers or social workers are not tasks that health committees should be involved in according to the Draft Policy. Overall, the table indicates that there is a poor match between the tasks described in the Draft Policy and the tasks currently carried out by health committee.

Limited vision/emerging vision

To get an overview over how health committee members envision their role (as opposed to what they are currently doing), they were asked to describe what they believe health committees should be doing in addition to what they already do. The results are reflected in **Figure 3** (p. 33**)**. By and large, health committees do not envision a significantly different role for themselves. The four areas they said they would like to be involved in are the same as the ones they are currently mostly involved in, i.e. assisting the clinic in daily running, functioning as auxiliary community health worker and social worker as well as being involved in health awareness and prevention campaigns with health awareness and promotion being the task most would like to be involved in. A significant number of health committee members also indicated that they would like to be involved in service delivery at the clinic, but it is unclear in what capacity. Notwithstanding the similarity in their current role and their envisioned role, there are some important shifts that may indicate an emerging vision for health committees. Significantly more health committee members responded that they envision their role as monitoring. Interestingly, two health committee members also believed that they should be involved in budgets, compared to none currently being involved. Similarly, two health committee members indicated that they believed health committees should influence policy, compared to none currently. More health committee members would like to investigate, identify and address health needs of the community. Also noteworthy is the fact the four respondents envisioned health committees as ensuring human rights, while only one said he/she was involved in this task. Along a similar line, more people described their envisioned role as one of lobbying and doing advocacy. Also significantly more health committee members would like to be involved with complaints and human rights. Though the numerical changes are statistically insignificant in all these cases, they may signal a beginning of a shift in how health committees perceive their role. Training wishes also indicate that health committees envision a different role. (See section on training needs, p. 54)

Thus, while the majority of health committees still view their role as being one of assisting and supporting the clinic, there are sign of a shift towards a role that is directed towards both the health system level and the political level through influencing policy and taking on advocacy and lobbying, as well as an oversight role. This emerging role is more in line with both the Draft Policy and the intention of community participation as described by authors such as Potts.

In summary, the analysis on the role of health committees concludes that:

(a) Health Committees mainly carry out tasks such as assisting and supporting the clinic and 'filling a gap' as 'auxiliary' social and community health workers.
(b) Participation is often limited as health committees are not part of a decision-making process.
(c) Health Committees rarely carry out the tasks described in the Draft Policy, especially monitoring and evaluation.
(d) Health Committees are rarely involved in policy or at health system level.
(e) Health Committees rarely have an oversight function.
(f) Health Committees' vision of their potential role is very similar to the role they currently play.
(g) There are nascent signs of a shift towards being more involved in decision-making in areas such as budgets and to influence policy, as well as in taking on a more 'oversight' role such as ensuring human rights and managing complaints.

Factors Impacting on health committees

The research identified a number of factors which impacted on functionality, stability, limited role and reach, and representivity of health committees. **Figure 11** below provides an overview of these factors.

Figure 11: Factors impacting on health committees

Clarity on role and function of health committees: Exist in a policy vacuum

Health committees exist in a policy vacuum. With the Draft Policy not being legislated and implemented, health committees are left without any guidelines on their role and function. Not surprisingly, lack of clarity on role and function of health committees is one of the most pertinent issues impacting

negatively on health committees. This was evident in a number of ways. During informal discussions with health committees as well as in focus groups, this issue came up repeatedly as the most important issue facing health committees. Comments such as the following were recurrent: “We don’t really know what we can do”; “we don’t know what we are supposed to do”; “what is a health committee all about. That is what I would like to know. What must we do?” Several facility managers also argued that they were unclear about what a health committee should do, with one Sister saying that clarity on role and function of health committee should be a priority as it affects the functioning of committees. Some committees argued that they did not know where the boundary between their ‘work’ and that of the staff and management was. When asked what they need to function well, several health committee members answered that they need clarity on their mandate or role and function. One example: “Firstly, everyone must know what a health community (sic.) is and what they must do.” Another argued, “I don’t know my duties and responsibilities and what are my boundaries at a health forum (sic).”

Lack of clarity on role and function was also an important issue for the health committees that did not survive their first year as well as for the interim committee, which failed to establish a committee. The former chairmen of one of the defunct committees identified lack of clarity on the role and mandate of health committees as a major stumbling block leading to lack of commitment, and ultimately resulting in the disbandment of the committee.

> I don’t think the people that joined the health committee knew what was expected of them. And I myself – I mean, as I said to you earlier, I myself didn’t know – that’s why when we had this meeting with the senior people from Cape Town, that’s why I asked for assistance – as I said to you, I was not geared up as to how about running this health committee and I needed some assistance from them to guide me as to what to do and how to do it. And of course that wasn’t forthcoming. So I couldn’t relate to people very well and tell them what to do and how to do it if I didn’t know myself...

In addition, the committee struggled with a lack of co-operation from the facility manager, difficulties finding a place to hold meetings and no financial support. After a few meetings, the committee fell apart.

For the interim health committee, lack of clarity on role and mandate was also the main issue impacting negatively on their attempt to form a committee. Two community members were asked to form a health committee by the facility manager. One of them, a ward forum member, were at the clinic, when

the water pipe burst and he assisted with solving the problem as he could easily access people who could help. Subsequently, the facility manager approached him and asked if he could assist in forming a health committee because the committee had 'disappeared'. He approached another community member and they selected a group of community members to form an interim committee and prepare for election of a health committee. The two community members then set out to write an interim constitution, seeking support from other health committees in the area as well as from the facility manager, but to no avail. They argued that lack of clarity on the role and mandate of health committees made it impossible for them to write a constitution and without a constitution they were unable to proceed with the health committee. Attempts to get hold of the old health committee's constitution were fruitless. They explained that as community leaders, they know how to write a constitution, but they needed to know more about the role of health committees to be able to write an interim constitution. Without any support and any luck in their attempts to get this information, they put the committee on hold. "Nobody can work without a constitution... So we are just waiting to have this constitution in our hands so that we can also give it to our committee, so they can see also what is the rules, what is the line, how far can we go."

The impact of lack of clarity on the role of health committees also came up in several responses to the questionnaire. When asked to choose what training they needed, most people chose "role and function of health committees" (80 %). Furthermore, many respondents argued that this was the most important topic that should be included in an induction programme for health committee members.

Lack of clarity of role and mandate of health committees has several repercussions for health committees. The policy vacuum leaves health committees powerless and confused about their role and mandate. In some instances, the facility manager takes 'ownership' and define the role of the committee - and the role assigned to them often becomes that of 'assisting' the clinics, filling the gap in an over-stretched health sector. In addition, it may also be a possible cause for the poor functionality of health committees. Uncertainty about the role of health committees was cited as one of the main reasons why people leave health committees. The fact that many health committees reported that 'people' only show up when there is a crisis, or that people show interest initially, but 'disappear' later on, indicate that lack of clarity on role and function impact on commitment and functionality and sustainability of committees.

Limited Knowledge of Draft Policy

Lack of clarity on role and function of health committees was exacerbated by the fact that the majority of health committee members had no knowledge of the Draft Policy, which could have functioned as a set of guidelines. The extent to which the Draft Policy was unknown can perhaps best be illustrated by the fact that a member of the Cape Metro Health Forum as well as health committee members that have served for more than 10 years indicated that they were unaware of the existence of a Draft Policy. As one respondent commented, "We did not receive the Draft Policy. We do not have the duties on the paper (tasks from the Draft policy, listed in the questionnaire) or a list of duties."

The research also found that health committee members struggled to understand the tasks described in the policy. Health committee members were asked to describe *how* they understood their tasks. Those that did not understand, were asked to answer no/don't understand. **Figure 12** below show that many health committee members indicated that they understood the various tasks. The task of providing governance scored the lowest.

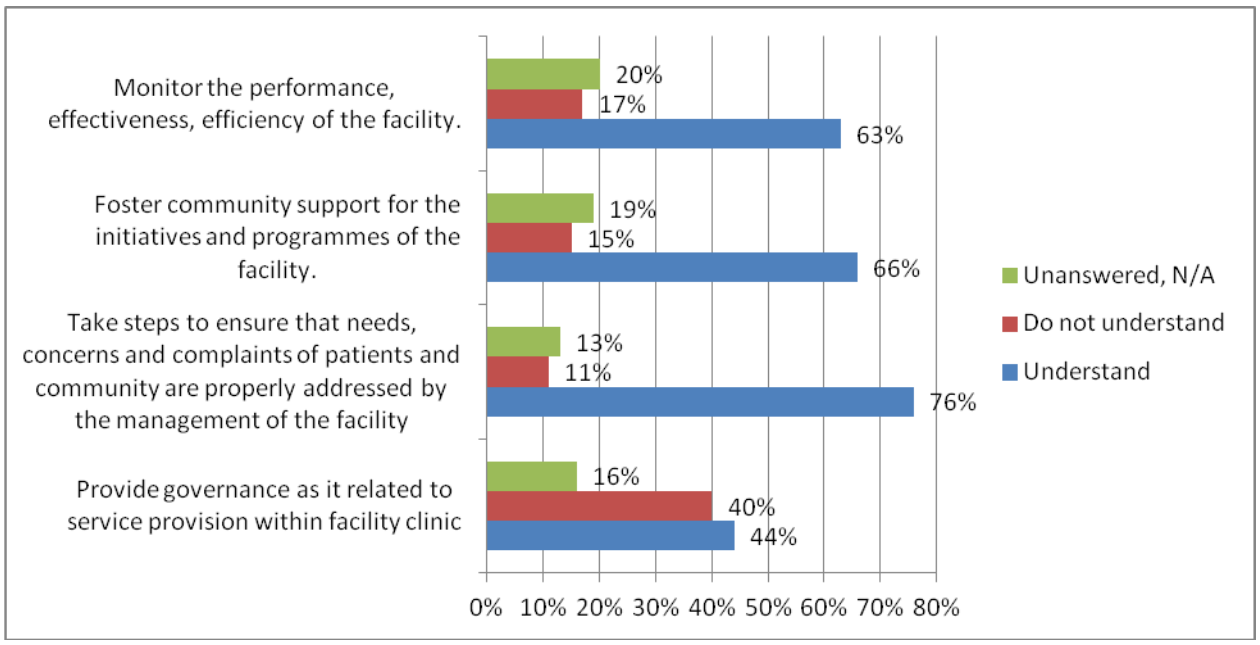

Figure 12: Health committee members' indication of whether they understood tasks in Draft Policy, shown as percentage.

Refer to Appendix 10 for the data for Figure 12.

Figure 13 below is based on an analysis by the researcher of health committee members' description of how they understood the various tasks. This analysis indicates that the majority of health committee members did not understand the Draft Policy or understood it only partially. In particular, many health committee members struggled to understand the task related to providing governance.

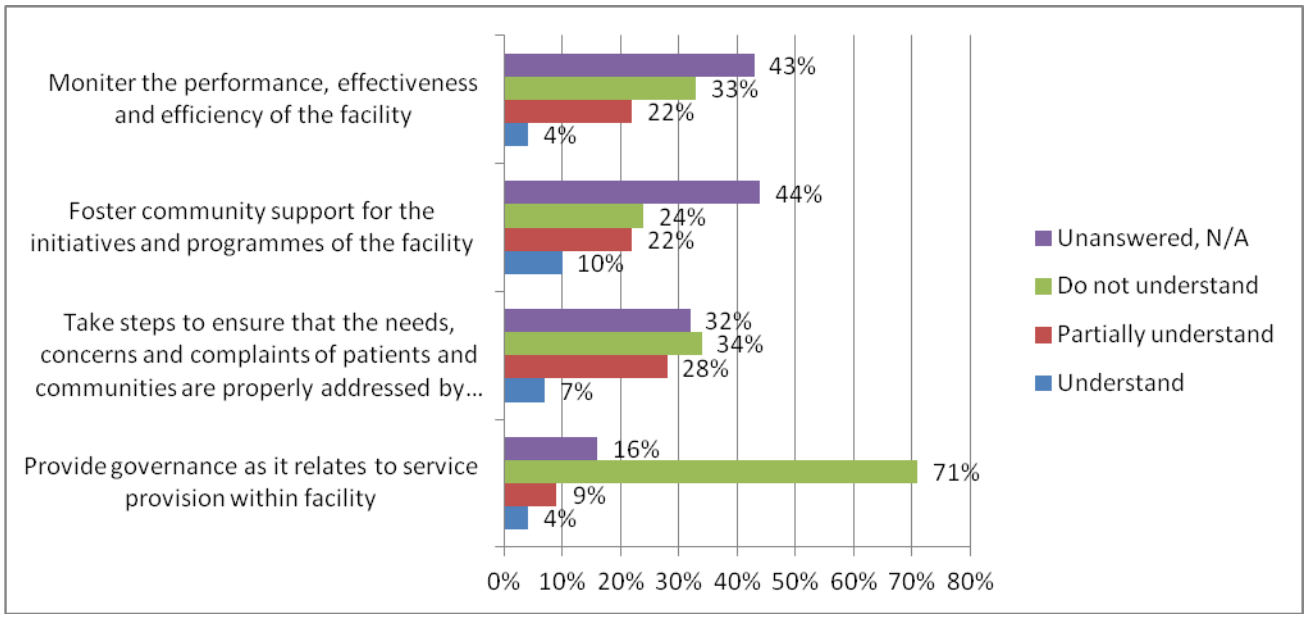

Figure 13: Health committee members' understanding of Draft Policy based on analysis of their description, shown as percentage.

Refer to Appendix 11 for the data for Figure 13.

However, it is worth noting that the results may be impacted by literacy levels as well as difficulties with written answers. Furthermore, many respondents answered by giving examples of how they carried out the task or why they were unsuccessful, instead of describing their understanding of the Draft Policy. Notwithstanding those limitations, discussions during the research process support the general finding that there was limited knowledge of the Draft Policy as well as a limited understanding of the tasks described in the policy.

The following quotes serve to illustrate the difficulties health committee members had understanding the task described in the Draft Policy as "providing governance regarding services at the clinic". This task was explained as: "You should have a person to work as a health worker" or "To make sure you are on time for work and how to work in the clinics." A facility manager answered in the following way: "To be able to guide the community as the service available at the clinic."

Limited skills and capacity

Limited skills and capacity was mentioned as another key factor. **Figure 14** below shows the educational level of health committee members. The majority of health committee members have not passed matric. It is worth noting that of the 38 that have post-matric qualification - 10 were nurses, facility managers or environmental health officers.

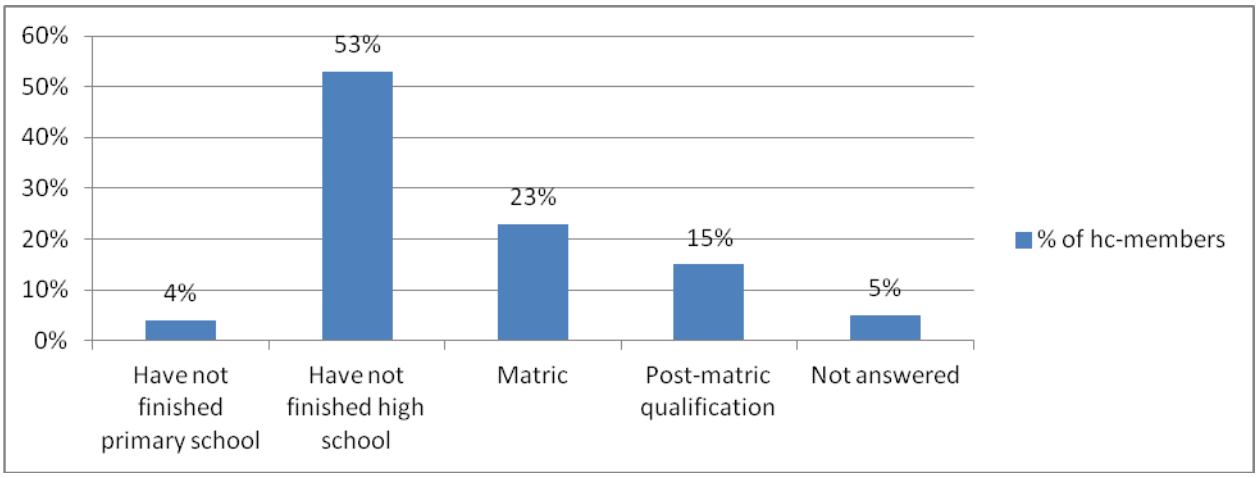

Figure 14: Educational level of health committee members, shown as percentage.

Refer to Appendix 12 for the data for Figure 14.

Figure 15 below show whether health committee members feel they have the skill to carry out the tasks they are currently involved in. The figure shows that 38% feel that they have sufficient skills to carry out their role, while 30% said they do not have skills or need more skills.

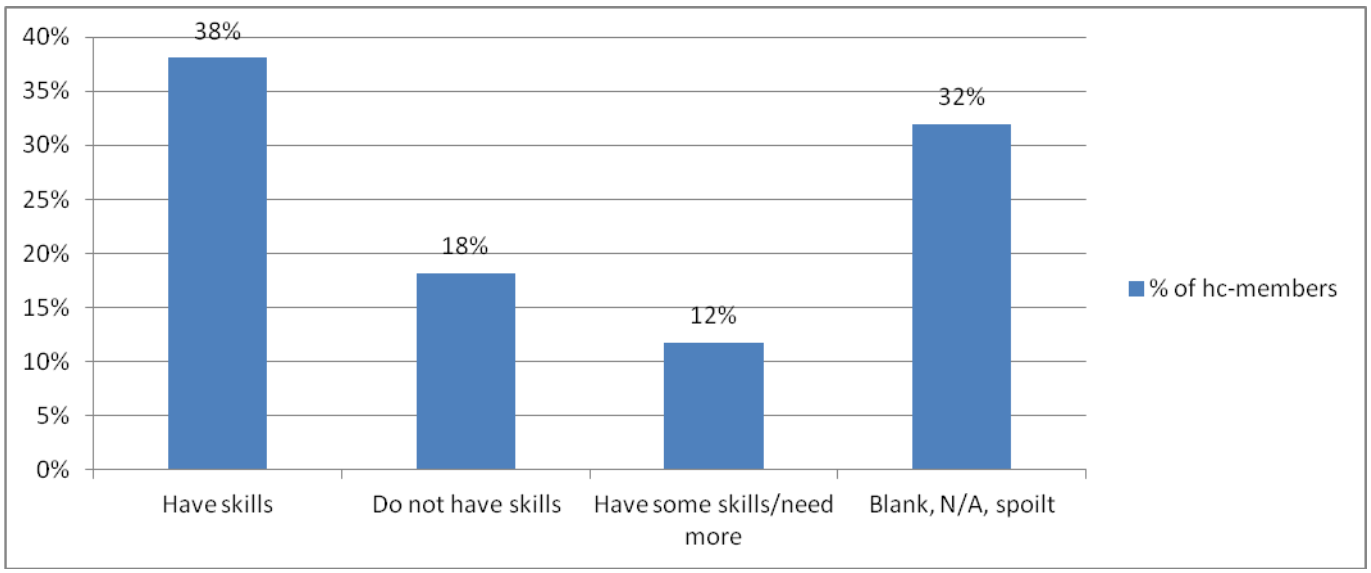

Figure 15: Health committee members possessing skills necessary to carry out current role

Refer to Appendix 13 for the data for Figure 15.

Figure 16 shows the number of health committees that have skills to carry out the role they envision.

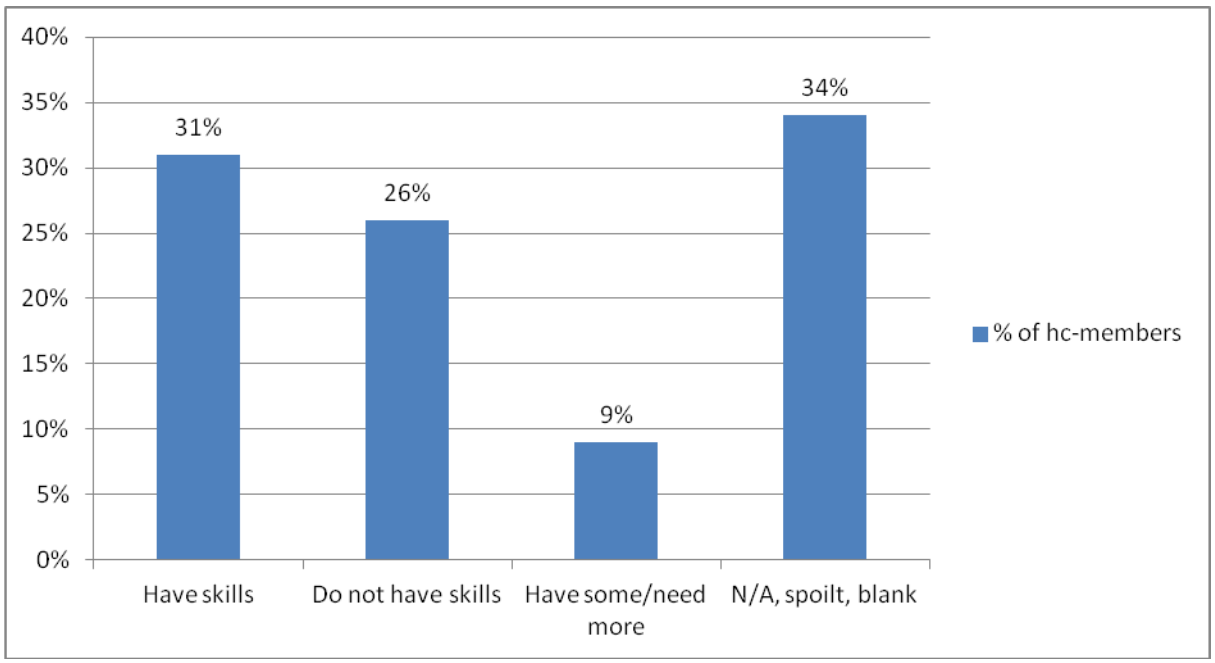

Figure 16: Health committee members possessing skills necessary to carry out envisioned role

Refer to Appendix 14 for the data for Figure 16.

A comparison between figure 15 and 16 show that fewer members indicated that they have the necessary skills to carry out the tasks they envision a health committee should be involved in: 38% think they have sufficient skills to carry out the tasks they are currently involved in, compared to 31% who believe they have skills to carry out the role they envision for health committees. More members (35%) reported that they did not have the skills to carry out the role the envisioned or said that they needed more skills. In comparison, 31 % reported to have sufficient skills.

Health committee members were also asked to specify which skills they possessed and which they did not. The answers revealed that the skills they possess were mostly skills required to assist the clinic and function as 'auxiliary' community health care workers. Thus, the areas for which most had skills in was in descending order: home based care, TB care/ DOT support, HIV/AIDS counselling, fundraising, complaints, first aid, health promotion and awareness, feeding/making food, being 'eyes and ears' of the community, and cleaning. Conversely, nobody indicated that they had skills to be involved in budgeting, lobbying or understanding the role of health committees. This indicates that there is a correlation between the tasks health committees carry out and the skills they possess. In other words, their limited role is partly linked to the skills they possessed. The same correlation was observed between the role they envisioned and the skills they possessed. It is important to note that the high number of health committee members that report to have the necessary skills does not necessarily reflect that they have skills to carry out a role that is congruent with a participatory approach.

The research also tried to establish whether health committee members have the necessary skills to carry out the tasks described in the Draft Policy. **Figure 17 below** reflects health committee members' assessment of their skills to carry out to the four tasks described in the Draft Policy.

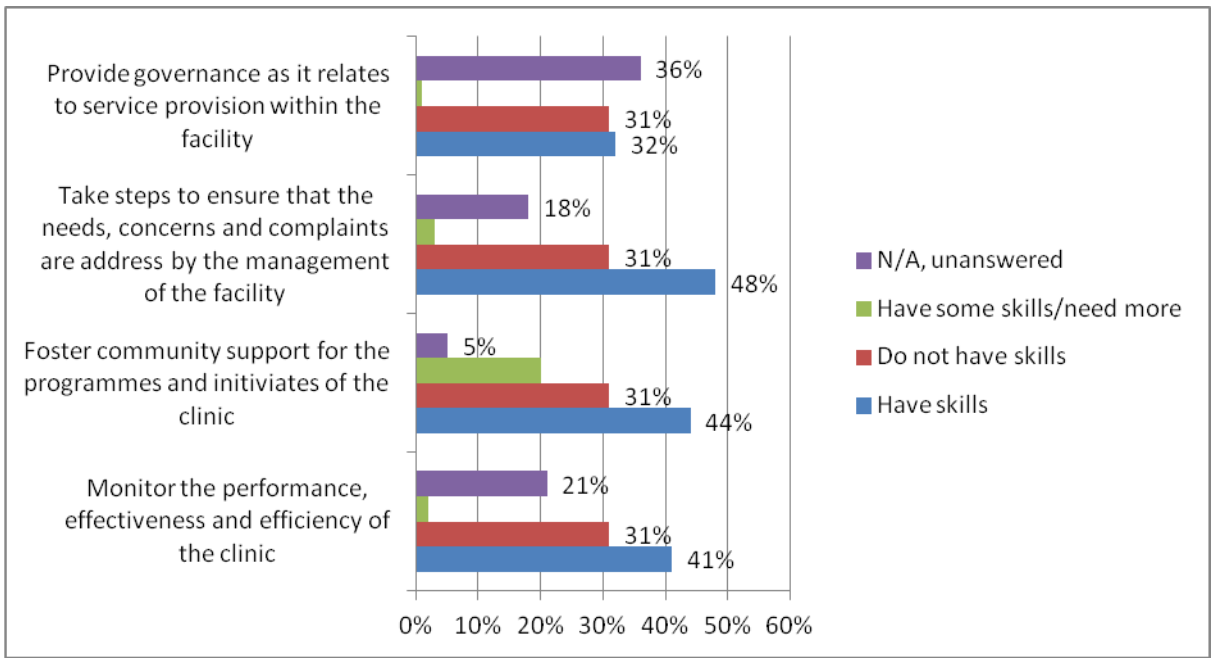

Figure 17: Health committee members possessing skills to carry out tasks in Draft Policy, shown as percentage.

Refer to Appendix 15 for the data for Figure 17.

The figure indicates that between half and one third of health committee members reported to have the skills necessary to carry out the functions described in the Draft Policy. Of the four tasks described in the Draft Policy, fewest health committee members reported to have the skills to provide governance. There is a correlation between the tasks most health committee members were involved in and the tasks for which they reported to have the necessary skills.

Due to the many blank and spoilt responses, these figures should only be taken as an indication. It may seem surprising that so many indicated to have sufficient skills, yet they also indicated a strong need for training (see section on training needs, p. 54), a need that was also expressed verbally by many committees.

In summary, the analysis of skills suggests that:

(a) Educational level is relatively low.
(b) Health Committee members have limited skills to carry out their current role and the role they envision.
(c) The skills most health committee members report to have are skills to assist the clinic as community health care workers.
(d) Limited numbers of health committee members have the skills to carry out the role described in the Draft Policy.
(e) There are indications of link between limited skills and limited role.

Training received

The research also attempted to get on overview of training received by health committee members. There is currently no sustained training and capacity building programme; and training appears to be organised in an ad hoc fashion. Only 28% (70) of health committee members participating in this research had received training as health committee members. Of those that had received training, training in the following areas were most common (in descending order): home based care (21), computer (15), HIV/aids (14), TB (14). Again, there seem to be a correlation between the training health committee members received and the role of health committee members as 'auxiliary' health care worker, suggesting that health committees' primary role is seen as that of assisting clinics. Five had received training in roles and function of health committees, while four had received training in the role of the function of office bearers.

Importantly, the vast majority of health committee members perceived the training they had received to be either valuable or extremely valuable. People commented that they learned a lot; felt they were better able to help the sick and the community. Several respondents that had received training in role and function commented that they achieved a better understanding of the role and function of health committees. "(Before) I had no idea what a committee should do," pointed one. Another commented: "As a new health committee member it acted as an induction for us to the health system and the role of the health committee in the community." One chairperson argued that training and capacity building is essential for health committee members to be able to 'voice' their opinion and be able to engage with medical staff. As one committee member mentioned "without knowledge, you feel small."

Training needs

Not surprisingly, many health committee members expressed a strong need for training. Several health committees argued that especially training about role and function was important. Health committee members were asked to select training topics they deemed valuable amongst a list of topics (see Appendix 2). The answers indicate that health committee members feel they need training, both on issues around health and on issues such as community participation, role and function of health committees, and patients' rights and responsibility. **Figure 18** below is a 'top ten' of the most requested training topics.

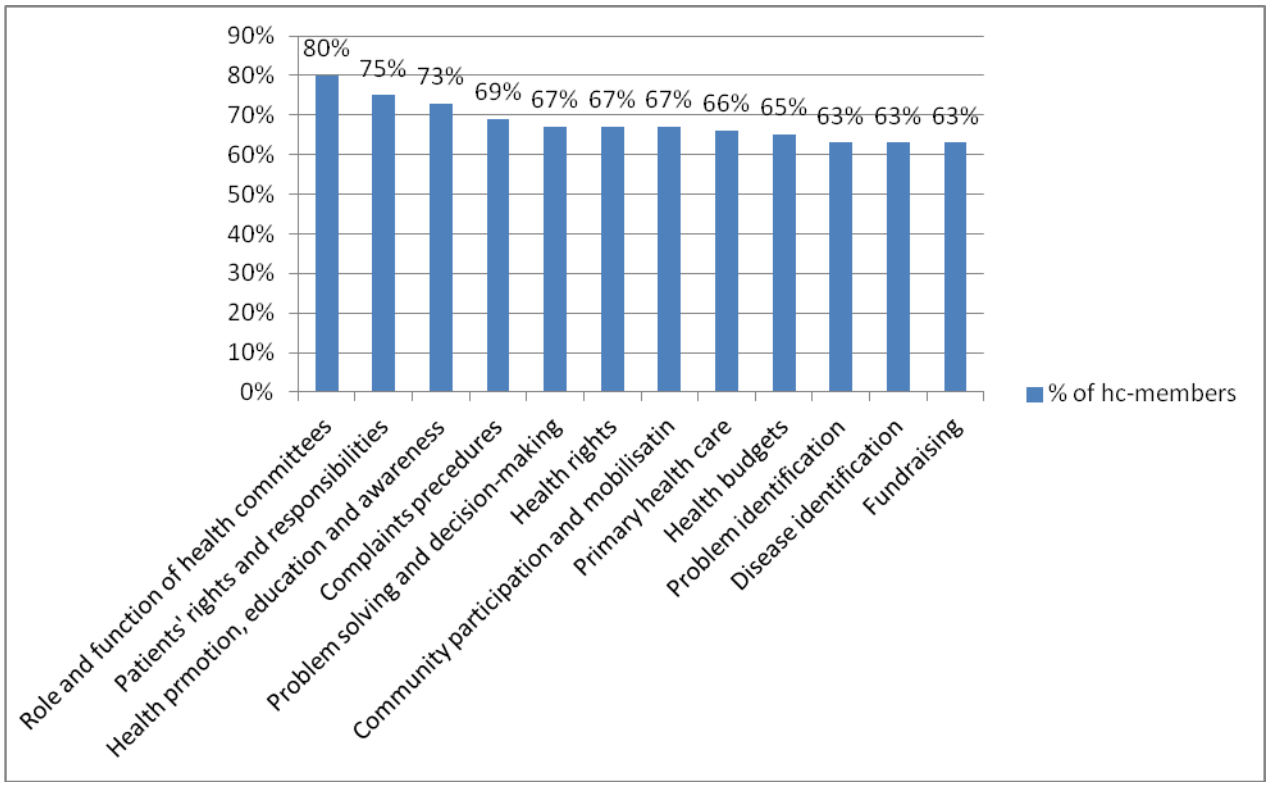

Figure 18: The ten most requested training topics, shown as percentage of health committee members that would like training in topic.

Refer to Appendix 16 for the data for Figure 18.

This list provides an interesting take on how health committees see their role as one can assume that there is a correlation between training wishes and their envisioned role. Again, it is worth noting that clarity on role and function is foremost on the list. This topic also 'topped' the list of topics health committee members chose as the six most important topics, as well as the single most important topic.

This is a clear indication that clarity on role and function of health committees is a priority for health committees.

The inclusion of topics such as community participation, budgets, complaints, health rights, and primary health care indicate that health committee members envision a wider role for health committees than the one they currently carry out, where the most important tasks were assisting the clinic and being 'auxiliary' health care and social worker (see section Limited Role, p.32). Health rights, primary health care and policy analysis also featured on the 'top ten' of topics chosen as the six most important as well as the single most important topic. The topics health committee members wish to receive training in would capacitate them to take on a more participatory role where health committees participate in decision-making and have an oversight role rather than assisting and supporting the clinic. One explanation for the discrepancy between the role they currently play and envision, and the skills they request on the other, could be that health committees' current and envisioned role was determined (and limited) by their skills. Their training wishes could be interpreted as a signal that if capacitated, health committees would like to play a different role. Thus, training should be viewed as a pre-requisite for meaningful participation.

Lack of capacity of health committees is also reflected in poor induction/introduction for new members. The majority of health committee members (57 %) did not receive any orientation or induction when they joined the health committee, and 46 (19 %) said they had received an orientation/induction, while the remaining did not answer the question. Of those who did receive an induction/orientation, this mostly consisted of an explanation from the chairperson or the facility manager. Some also received an orientation from the Cape Metro Health Forum or a sub-district health forum, while one indicated that he/she had been inducted by the Health Department.

Figure 19 below presents the most popular topics that health committee members would like covered in an orientation/induction programme.

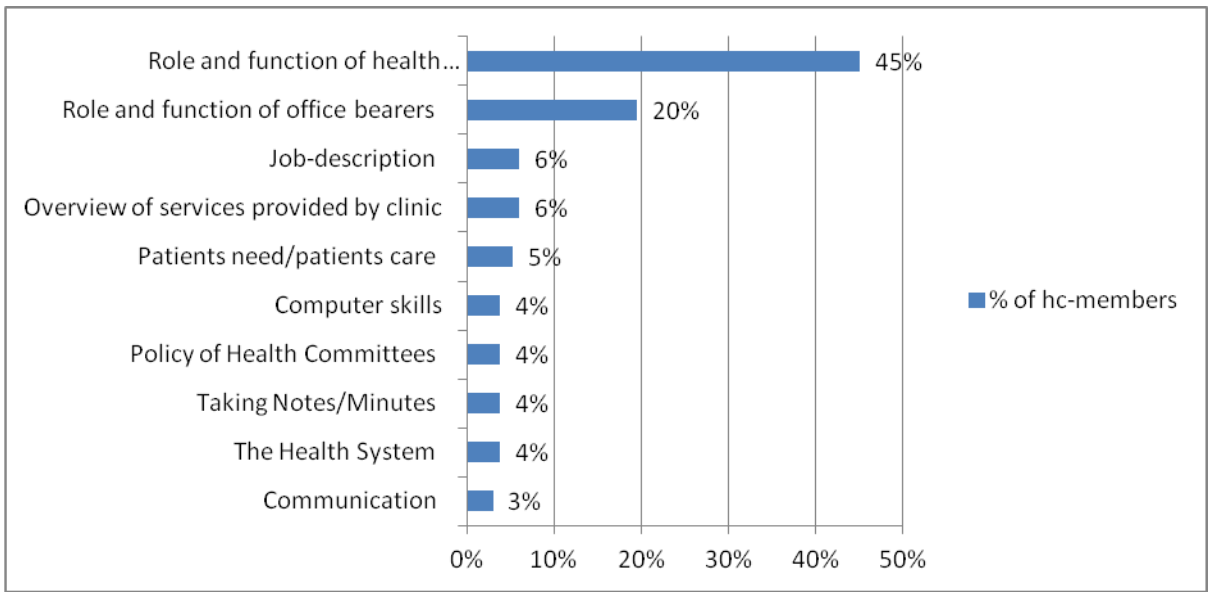

Figure 19: Most popular topics that health committee members would like covered in an orientation/induction programme

Again, the answers emphasize the importance of role and function of health committees, which was by far the most popular topic. Interestingly, many also answered that they needed knowledge about policies affecting health committees such as the Draft Policy. Another theme reflected in this list is the need for technical capacity to ensure the efficient functioning of a committee such as role and functioning of office bearer, computer skills and taking notes/minutes. The request for knowledge about the health system and service offered by the clinics are also important to note as a prerequisite for health committees to be able to function.

Few health committee members had been offered training that they had been unable to attend (11 percent). Of these the following reasons were given: time the training took place (6), personal/family reasons (5), lack of transport (5), work responsibilities (2), and too short notice (2). This obviously indicate a need to consider time, place and transport when organising training, something that also came across when participants were asked to give an indication of issues that need to be taken into consideration when organising training. Most respondents said that transport must either be provided or money given to cover transport cost. The second most important issue was the time of the week that training is offered, though there was no consensus on when is the best time. Most preferred weekends or evenings due to work responsibilities, while some preferred a week day. Some suggested that training should not be on a religious day (Friday or Sunday). Many pointed out that a certificate should be awarded, while some would prefer courses to be accredited. Refreshments and stationary was also

requested. Training should preferably be offered in participants' mother tongue or an interpreter should be available. Some argued that the facilitators must be considerate of the fact that 'people are different', while others said training should be adjusted to different literacy levels. Finally, health committee members point out that training should take place soon after election to enable members to fulfil their role from the start.

Presence and attitude of facility manager

Relatively poor attendance by facility managers at health committee meetings also impacted on the functioning of health committees. It is stipulated in the National Health Act that facility managers should be part of a health committee. This research found that facility managers were present at 44 percent of the health committee meetings, though they or a substitute were reportedly said to be present 'most of the time'/'often' in 61 percent of health committees. Many health committee members reported that the absence of a facility manager from the health committee had a negative impact on their health committee. As one health committee member pointed out: "the facility manager is really needed, but she does not attend meetings." Needless to say, the presence of facility managers as well as the attitude of facility managers is crucial if a health committee is intended to function as a liaison between facility and community. Health committees cannot become meaningful vehicles of community participation without co-operation from the facility manager. Neither can they fulfil the mandate stipulated in the Draft Policy.

There were many examples of health committees in which the facility manager played a positive and enabling role. In the well-functioning health committees, facility managers clearly see a value of having a health committee and assisted the committee in various ways such as providing resources and access to the facility. In some cases, facility managers would make an extra effort to support the health committees such as one facility manager who would transport health committee members to their homes after evening meetings. They also made use of the health committees in various ways. Many health committees were asked for instance to assist with a vaccination campaign. In one health committee, meetings were used to exchange important information. The facility manager would for instance ask the committee members to encourage women to have their pap smear. A Muslim committee member alerted the facility to the fact that Muslim women would only be able to have a pap smear if attended to by a female doctor and was assured that this wish could be accommodated. Women from an informal settlement were concerned that many women from their settlement could not have their pap-smears because they do not possess an ID book. Again, they were assured that they

would be accommodated. In another health committee, Sisters asked for assistance in how to deal with TB defaulters, while yet another was involved in monitoring health in crèches after a child was diagnosed with TB. Some health committees had discussions between health committee members and facility managers about lack of services and shortages of staff. This was dealt with in different ways: some committees dealt with the shortages and poor services by informing communities about lack of services and staff. Other health committees discussed ways of addressing shortage of staff and poor service delivery by approaching the Department of Health. Where facility managers saw a value of having a health committee, support was often forthcoming and access to facility was easy. Though not all of these examples suggest that health committees participated in a decision-making process, there was positive co-operation with the facility that addressed important health issues.

In many cases, facility managers seemed instrumental not only in setting up health committees, but also in calling meetings and setting the agenda. In some cases, it was also evident that facility managers functioned as the *de facto* chairperson. This could both be seen as helpful, but is a potential problem as they may 'take over' the committee. Evidently, some facility managers seemed to 'run' the health committee and took 'ownership' of them. Illustrative of this is facility managers who spoke about 'their' health committee.

In other cases, the relationship with the facility manager was complicated, and sometimes negative. One health committee complained that the facility manager would not allow the committee to be involved in dealing with complaints, and they were unsuccessful in having a say in how complaints were dealt with. Rather complaints were 'lost' at the facility and no feedback was given to complainants. Attempts to influence a standardised procedure to deal with complaints had been to no avail. Another health committee member complained that the facility manager did not co-operate with the health committee. Referring to the tasks described in the Draft Policy, she argued "(We are) already doing all of the above, but receive no feedback, thus always in trouble with management." Another health committee member commented on being 'ignored' by the facility manager, while yet another argued that managers did not share information with the committee. "Well some managers won't be open about some things, but one can get feedback via patients about service delivery."

Lack of cooperation with the facility manager was also crucial in the two health committees that disbanded within a year, as well as in the interim health committee. In one of the health committees, the facility managers attended only the first meeting. The chairperson commented:

> Normally, as far as the constitution indicates, the health care professional or the facility manager should be part of the health committee, and of course we must liaise with them at all times as to what's going on. They should be invited to meetings, they should know what we need to do and participate in the function of the health committee. And we never got to that stage. I think they attended once and then they just stayed away.

In the other disbanded health committee, the relationship with the facility manager was one of the main reasons for the health committee not functioning. The conflict between the facility manager and the health committee arose around a particular issue. Community members approached the committee with complaints that the facility manager disclosed their illness status publically. When the health committee approached the facility manager, they were told not to interfere with her work and not to listen to the community. This is the response from the health committee:

> She told us that we don't have to tell her what to do; she knows what she's doing. That was her attitude. You see, she didn't want us to be the mouthpiece of the community. But what could we do, that was how it should actually be.

The conflict was never solved, resulting in the community organising a petition to have the facility manager removed from her position.

Lack of co-operation with the facility manager was also cited in the other health committee that did not survive its first year. According to the former chairperson, the facility manager was not interested in working with the health committee. When the facility manager was approached to discuss what the health committee should be doing, she apparently showed no interest:

> The sister said, "oh, well, she's not in that capacity of helping and she's just here to do her daily chores" – ja, that was what she said - she's here to do her daily chores and from there whatever problems we have got, we need to phone the offices, their office (council office). And, you know, we never went around to doing that because that means to say we are labelling them that they're not interested.

In some cases, it was evident that facility managers felt that they were compelled to have a health committee, but did not see the value of it or were unclear about the role of a health committee. "I am told that I have to have a health committee," said one facility manager. In one of the now defunct health

committees, a health committee member asked the facility manager what a health committee should be doing and was just told that “a hospital must have a health committee”.

In some cases, facility managers seem to take ownership over the health committee, as the following case illustrates. Two community members who were asked to form a health committee reported that they approached a Sister at another clinic to get support and invite that clinic to form a cluster. They were reportedly told that the Sister had already ‘formed’ her health committee and was ‘screening’ her members to avoid problems, such as stealing. She was not interested in cooperating with others.

According to the Draft Policy, the facility should provide support to the health committee. However, while most health committees do use the facilities for their meetings, not all health committees are accommodated in that regard. Some raised the issue of not having access to the facility as hampering their work. One of the now defunct health committees was unsuccessful in getting the facility to accommodate the health committee and was sometimes left without a venue for their meetings. Libraries and civic centres were frequently used for meetings. In other cases, health committees met at a local madrassa, a shelter for homeless people, and one health committee found shelter in the local police forum.

It is evident that under the current institutional arrangements, there was limited power-sharing between community members and facility managers. This is primarily because health committees’ involvement in the decision-making process was limited and their role to a large extent defined as assisting the facility/staff. This role indicates that the power remains with the facility. Limited capacity and skills, and a lack of clarity on their role and mandate also restricted health committees’ power and influence. Where facility managers did not participate in committee meetings, there was obviously no power-sharing or partaking in decision-making.

In addition to this, some health committee members complained that their relationship with staff sometimes prevented them from carrying out their ‘work’ and suggested that if they had name tags or badges their access to facility and acceptance by staff would improve.

Presence of Ward Councillor

The National Health Act stipulates that one or more local ward councillors should be part of a health committee. However, ward councillors were only present in four percent of the health committee meetings attended. Ward councillors were reported to attend meetings ‘rarely’ or ‘occasionally’ in 17% of committees. No explanations were given for the low interest from ward councillors. Many

committees complained that they invited the councillors, but never received a response. There was a widespread perception that ward councillors were indifferent to the work of the health committees. The importance of ward councillors attending meetings is evident if health committees are seen as structures that should have an influence on the health system, and liaise between health system and community. It was evident that in the two cases where the ward councillors were present, health committees had the opportunity to discuss health matters as a political issue. Thus, a discussion around shortages of doctors resulted in a decision that the ward councillor should approach the MEC for health; in addition to the health committee working with the sub-district health forum on the matter. The ward councillor also promised to support the committee with much needed funds for their most important project. In the other health committee, it was clear that the ward councillor played a strong role in the committee. He gave feedback on attempts to extended services at the clinic, again showing that ward councillors can serve as a link between the committee and health authorities.

The general lack of interest from ward councillors could be interpreted as lack of political will to ensure meaningful community participation, but is also a reflection of the current institutional arrangements where no legislation provide for a meaningful role for committees, and health committees do not have any formal power. For health committees, ward councillors represent a link to the political system. As health committees are not linked to the District Health Council, weak with a broader governance system is weak. Not surprisingly, many health committee members expressed frustration at not having access to the political level with requests such as annual meetings with the Health MEC. Others talked about the importance of meetings with government officials.

Resources and financial support

The lack of resources such as telephone, fax, computers and stationary emerged as a key factor impacting negatively on health committees. The Draft Policy stipulates that the facility management must provide appropriate support for the optimal functioning of the committee, but the kind of support is not stipulated. Given that health committees often operate in a socio-economic constraint environment, support in form of access to facilities and resources such as office equipment is essential for the functioning of health committees. Again, there were huge variations in what kind of access health committees had to facility and office equipment.

When health committees do not have access to phone, fax and computers, they are forced to carry the ‘cost of participation’ in the form of using their own phone and paying for their own transport. Having to bear the ‘cost of participation’ places an undue burden on people, who often live in socio-economic

constraint circumstances. Consequently, it was a source of much frustration, and impacted on the functioning of committees. An illustrative example is a chairperson who threatened to resign due to the fact that she could not afford to pay the transport cost of attending meetings: "We do not even have money for transport. I have to pay out of my own pocket to go to meetings. And I can't do it any longer. We can't do anything because we do not have any funds." Asked about reasons for why one of the now defunct health committees fell apart, the former chairperson pointed to the issue of the 'cost of participation.'

> You know, I think a number of factors. Number one is: most of the people involved in the health committee at that particular time – you know, they came from poor backgrounds, poor communities – like myself, we come from a poor community here. And I know that there was a discussion around the money part of it, where they said there was, I think, R 1000 available from the provincial administration to sort of get this thing on the go and get it going. But you take for instance people coming from D. (in informal settlement areas) which is a long distance way – they have to take a taxi to get to the place where our meetings are in M and Y (formal areas). ....So that's how things started to crumble – because of non-attendance and people not being punctual and on time. And then we had to struggle with facilities because we had no facilities to have our meetings because the hospital is so overcrowded.

Funding is crucial for the functioning of health committees, as low attendance has sometimes been linked to the cost of transportation and poor communication. Lack of funding to cover the 'cost of participation' may also impact negatively on representivity as it effectively blocks the most disadvantaged from participation in community structures. Some also suggested that it is difficult to attract and sustain members because of lack of resources.

Frequently, health committees complained about lack of funding or access to funding for running projects as a major problem. A disillusioned health committee chair complained that as World AIDS Day approached, there were no funds to mark the day and raise awareness.

> We identify projects, but we do not have any funds to carry these out. We do not have any resources. After 10 years, we now receive R 200. When it is TB month, we do not have the funding to organise anything. If we got funding, we could do something about TB. We must bring the information to schools. We want to go out in the community, we want to raise awareness, but we can't because we do not have any funding. We are foot soldiers without ammunition.

Lack of financial resources was also cited as a reason for why one of the now defunct health committees failed.

> Everybody is keen to do something – but you know with nothing, it's not very much you can do. That's as far as it got. Without money you can't do anything, and you'll find that most people that do volunteer, they come from poor backgrounds, because, I mean, basically these things are established from poor communities here – because the people that attend day hospitals come from poor communities generally. They're financially strapped, and of course being a very bad economic climate at the moment nobody can afford to fork out money.

Budgets for health committees in the Cape Metro have increased. Currently, each of the eight sub-district health fora receives R56 000 per annum to be distributed amongst health committees in that particular sub-district. However, many health committees complained that they do not receive any funding. In some cases, the cause given is poor financial management and lack of skills required to reconcile funds previously received in order to access additional funds. Thus, the question of proper funding is not only a question of sufficient fund allocation, but also a question of how these funds are managed, how health committees can access these, and the skills required to administer the financial affairs of health committees.

Many health committee members raised the issue of incentives or a stipend for health committee members as a way on encouraging members to stay on the committee and to improve commitment. One such comment: "Health committees really try to make a difference in our communities. Yet accessing resources is so difficult. Most members are poor and I feel that they need some kind of 'reward' for their efforts." Another commented along the same lines: "The effectiveness of any health committee is largely dependent on the commitment of the members. People's needs are also financial and stipends can be made available for more full-time volunteers." Another suggested that some community members become health committee members, believing that they will get employed, and stop attending meetings when they realised that is not the case. However, it is also evident that the blurred border between health committee members and health community workers give rise to expectations of receiving a stipend.

Without doubt, the lack of funding is demoralising for health committee members and impact negatively on the way they are functioning and on commitment. Moreover, lack of funding also has a negative 'symbolic' value as it is perceived to signal lack of recognition. The following quote illustrates how one

health committee member linked lack of funding to a perceived lack of acknowledgement: “What we need most is resources, but nobody seems to care about our work.”

Commitment

Commitment from health committee members were mentioned by numerous health committee members as essential for a well-functioning health committee. Lack of commitment resulted in poor attendance, non-attendance, late arrivals, and meetings held in an ad hoc fashion. Ultimately, it was cited as one of the major reasons for health committees struggling to sustain themselves and in some cases leading to health committees disbanding. One chairperson lamented that the lack of commitment resulted in her and the secretary being the only ones that ‘keep the committee going’. Conversely, health committees argued that more members and more commitment would enable their committees to function better.

Commitment was related to other issues, such as confusion about role and function of health committees. As one Sister commented, “It is difficult to be committed when you don’t really know what you should be doing.” Another health committee member made a clear link between both lack of commitment and not being recognised, and given proper resources. “They (the health authorities) do not meet us, they do not listen. We just get a lot of directives, ‘health committees must do this, must do that’, but no resources. People get frustrated and move to other NGOs.” The former chairperson of one of the defunct health committees linked commitment to lack of motivation and a decreasing sense of ‘active and involved citizenship’ and diminishing social solidarity. He commented in the following way:

> My experience over the past few years being involved in these organisations is that people only attend or come to these meetings when something affects them personally. And then they’ll kick up one hell of a racket, they’ll moan and groan. And once you’ve solved their little problem, they go back to square one; they don’t attend after that anymore. And that’s the sad part about this country I think: people don’t care very much; they only think about themselves, they’re not giving enough.

Poor commitment resulted in lack of continuity and loss of experience. **Figure 20** below shows the duration of service of health committee members. The figure shows that about one third of health committee members have been members for less than a year.

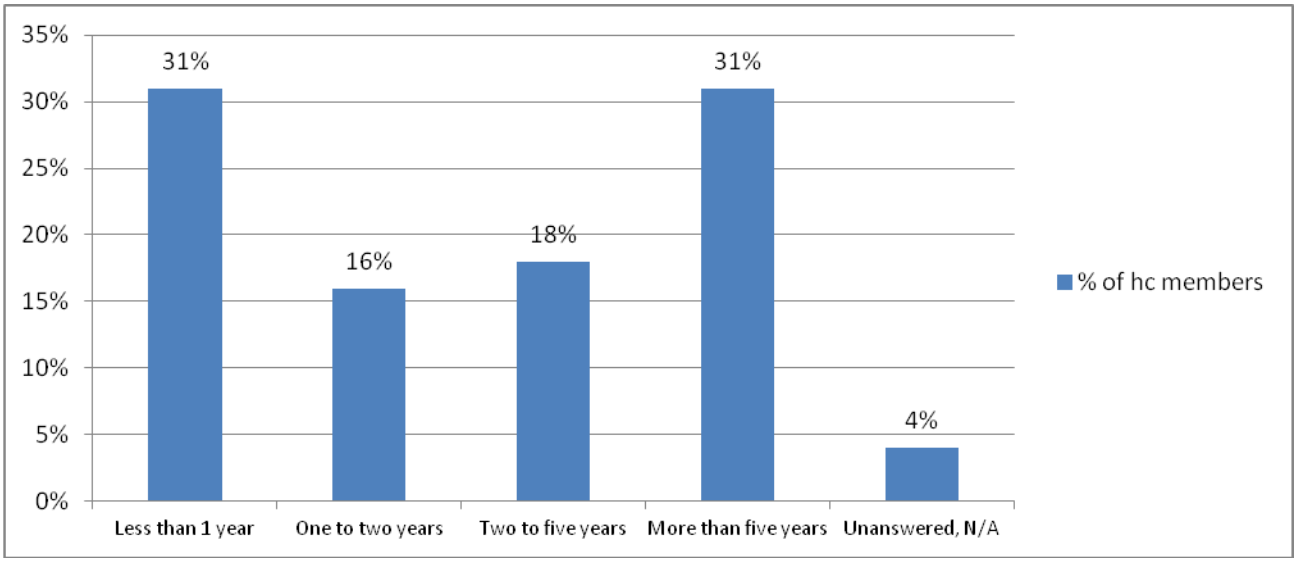

Figure 20: Years of service of health committee members, shown as percentage.

Refer to appendix 17 for data for figure 20

As mentioned many committees go through cycles of disbandment and revival. In that process, important skills, knowledge, and experience are lost. Hence, many 'new' or revived health committees have to start from scratch, such as the case for the interim health committee, which attempted to get information and documents, such as a constitution from the previous health committee - but to no avail.

> Firstly, we had thought that the clinic or the day hospital had something in place, even if the first committee has collapsed... So if the chairperson has vanished, the secretary, whatever, has vanished – there is something at the day hospital so that the new committee can carry on with what is left. But there were no minutes; there was no chairperson, treasurer, secretary's report: and they did not know how to get hold of the former chairperson.

One health committee member suggested that it was difficult for the health committee to attract new members because of lack of resources: "It is getting more and more difficult to get volunteers, more and more difficult to get committee people. We (the health committee) struggle because of that." As mentioned previously, others linked lack of commitment to socio-economic context and suggested it would improve with a stipend.

Lack of recognition/political will

For some health committee members, lack of commitment was also linked to a perception that health committees are not recognised and valued, resulting in disillusionment and sometimes in disengagement from health committees. Illustrative of this is a health committee that started with 15 members, but was left with five. The chairperson explained that the committee's contributions were not considered or valued by the facility. The most striking example of this was the lack of involvement by the health committee in a function to mark the opening of the new clinic. The health committee was not invited, but asked to clean up after the event. This left the committee disillusioned, as the following quote from one of the members show.

> We were just there to do the dirty work, to clean up afterwards (after the opening function). We did not know about the budget, nor did we have a chance to develop our skills. There was no discussion with the health committee about the event. It is our experience, that our contributions are not valued. But you can't just use us.

One of the defunct health committees had a similar experience. In this case, the health committee chair was asked to assist with organising an event for the opening of the new hospital, but was not invited to attend the function.

> They phoned me once or twice to say they have to arrange the opening of the new hospital. And they asked me if I would please assist them with that, which I did as well. I drew up a programme as to tell them what they needed and what they required, and how to go about doing those things. In the end, one or two officials of the City of Cape Town attended and I wasn't even invited.

Another health committee member commented that she understood that the health committee should provide governance to the clinic as described in the Draft Policy, but found it difficult to implement "because we need to be sure that our input will be valued and accepted at the various facilities." In a similar vein, another member argued that health committees are blocked from being involved in projects but 'expected to do the dirty work'. Yet another health committee member contended that the health committee in question found it difficult to implement the Draft Policy because staff would not accept changes. As the following quote suggests that lack of recognition often let to disillusionment and posed a challenge to commitment: "There is no acknowledgement – no recognition for our work. But I am tired of talking. There is too much talking, and I am tired of it all now."

Frustration at not being recognised was mostly directed at facilities, but had a much broader reach and was also directed at the political level. One health committee member appealed for health committees' views to be taken seriously with the following words, "when we as health committee members wish to express as what is needed in our communities, listen, please listen." Disillusionment with authorities' was also expressed through limited trust in their willingness to support community participation. Thus, many health committees questioned whether it was worth participating in this research as they doubted that recommendations would be implemented by the authorities.

Some health committee members suggested that there should be some kind of formal recognition such as a 'certificate' in recognition of their work and contributions as volunteers.

Lack of support

Lack of support was a crucial factor for the poor functioning of health committees. It was also a key element for health committees that failed to survive, as well as for the interim committee. The Draft Policy states that facility management should provide health committees with appropriate support. However, the kind of support is not stipulated, and in many cases little, or no support, is forthcoming (see section of facility manger attendance for examples of facility managers who provide support, p 57).

None of the two defunct health committees received support from the facilities in setting up their health committees. The interim health committee failed primarily because their attempt to find somebody who could assist them with writing a constitution failed. Their first step was to seek assistance from the facility. The interim chairperson explains:

> Our next step was to go back to the facility here at the clinic, and then tell them, "listen, you guys have to help us get this constitution or get someone that can help us. We've tried on our own. We spent our own time and money and petrol, and no one seemed to help us, so if you want us to get this thing going, you have to come back to us with something." And we left it there.

The interim health committee sought support from the sub-district health forum, but as that particular sub-district health forum was not functioning, at that time, it was to no avail. The committee also approached other health committees, facilities and individuals, but no assistance was available. As they were unaware of the existence of the Cape Metro Health Forum, they did not seek their help. Thus, with no support the health committee was not able to get off the ground.

> We, like I said, have decided we're not going to move any further because it is of no use for us. We don't get any help from the Department of Health. We believe we can make a difference, but because in today's light we cannot move anymore just on our feet and attend to things and there's no income or there is not stipend or nothing, there's you know - it is just not possible like it was before. We used to do things out of our pockets, but we cannot do that anymore in the long-term. And they are just going to tell us: you don't have a constitution that can guide you, you don't have any support, and there are no structures, you know - so we just decided to leave it.

The interim chairperson believed that the Department of Health should support health committees - an opinion he shares with the former chairperson of one of the defunct health committee.

> I think we needed more assistance from the senior people of the Health Department of the City of Cape Town. I think they should get more involved in getting this thing established. You can't just leave it to a group of people and say, "Oh look, we're going to start a health committee - without knowledge. You need them to get involved from the start. You need them to set up meetings or public meetings to say – well, look this is what we need to do: this is how we need to go about it; and these the people you require to do this type of thing.

Another health committee member emphasised the importance of political support.

> And how to go about doing it: you need to take it from the top-shot, the Health Department's got to get this thing on the go first of all. They've got to have regular meetings to tell the people what it's all about, and how they need to do these things, and what assistance and guidance, to get that assistance, which they don't do, and I think this is where they fall flat.

Formation of health committees and 'affiliation' with facilities

The research suggests that there are a number of reasons why health committees struggle to become representative bodies. Firstly, representivity was sometimes affected by the way health committees were formed. The more well-functioning health committees had general elections where community members elected health committee members. However, the formation of many health committees take place through a process where either the facility manager or a selected community member approach people to form a health committee. In some cases this is followed by a process where an election is held. While no data was collected on how many people participated in electing health committees, many committees explained that the annual general meetings - where health committee members are

elected - were poorly attended. Thus, many health committees end up consisting of community members that are recruited by either facility manager or chairperson. When health committees begin to disintegrate, the remaining health committee members tend to rescue the committee by approaching people they know to join the committee. Again, the process may resemble a selection process more than an election process.

Furthermore, a number of issues may 'prevent' people from participating. The majority of health committees meet during working hours, some to accommodate facility managers' participation. However, it is clear that this excludes people who are working. In addition, lack of financial resources to cover the 'cost of participation' means that the poorest section of a community may not be able to attend as the cost, for instance transport, is too high. Literacy levels and poor education may also prevent the most vulnerable from participating, as no attempt is made at providing support, skills and capacitation of these groups.

Another challenge to health committees as representative bodies is that they often 'affiliate' themselves with the facility rather than being community representatives. Illustrative of this is the way some health committees were involved in managing tensions in the clinic. They frequently saw the problem as being one of patients not having enough patience, and not understanding the staff. These committees saw it as their role to manage tensions by getting patients to behave in a way they deemed appropriate. Several health committees would talk about how they intervene through 'telling people to keep their mouth shut'. Another common response to patients' complaining about long waiting times was to tell 'patients to behave' and show respect to the service. As one health committee member argued, "The community must not complain about the poor service."

Mutual respect between patients and health care workers is without doubt important and should be encouraged by health committees. However, the last statement indicates that human rights is not always a priority for health committees - a view that also came across in the fact that very few health committees described ensuring human rights as a priority. This seems contradictory to the fact that health rights and patients' rights and responsibility were a priority for training. This discrepancy indicates that there is a need for training in human rights. It is also worth considering how the lack of a clear mandate impacts on health committees. In the current context, health committees have very limited power to ensure human rights or to ensure that complaints are addressed. Thus, health committee members may feel 'disempowered' with respect to their ability to ensure human rights and chose not to see this as their role.

Rather than attempting to address the problem at a service level, many health committees seemed to direct their energy towards managing patients and identify with the facility. This identification and allegiance with the facility was perhaps most clearly expressed by a health committee chair that described the role of the health committee in the following way, “we (the health) committee is here to carry the clinic with the staff... the staff work under severe pressure.” The perception that health committees are ‘an extension of the facility’ is consistent with the view that health committees assist the clinic.

There are many potential reasons for this situation. Firstly, many health committees are established on the initiative of the facility manager. As already mentioned poor community involvement in elections sometimes lead to a process where the election resembles a selection process. Secondly, the lack of formal status and power means that health committees to a large extend rely on the goodwill of the facility manager to carry out any work. They are also dependent on the facility for support. Currently, health committees have no other form of support.

Lack of community interest

Lack of interest from the community was cited as one of the reasons health committees struggled to become sustainable as it was difficult to find community members to serve on the committee. Furthermore, lack of community interest pose a challenge to representivity. Hence, community interest and participation is crucial in creating both sustainable and representative health committees. As one chair person argued, “The key is to get the people, participation by the people first – you’ve got to get the people involved in this thing.”

A chairperson for one of the now defunct health committees put forward the idea that lack of community involvement is linked to lack of a clear role and purpose for health committees. Communities do not see how health committees can assist them.

> I think they have to make people aware of what health committees can do for the communities, and how it can assist communities in their health problems. And I think the most important thing is that it’s clear that communities must participate in these things.

Structure of community participation

The structure of community participation in the Cape Metropole is not homogeneous. While most health committee members favour the three-tiered model described in the Draft Policy, there are alternative visions on how community participation should be structured. Amongst members of the so-

called health forums, there were arguments that health forums are necessary, either in conjunction with health (clinic) committees, or instead of these. They argued that health forums can address broader issues related to social and health problems than health committees. Another argument put forward by proponents of health forums was that it is difficult to sustain health committees because people attend more than one clinic and that it might be more feasible to get ward councillor participation in the bigger health forums. In addition, some of these (bigger) forums had representatives from City Health and the provincial Department of Health, ensuring that there was a link between community participation and the health system. Proponents for health forums argued that officials are more likely to be present in these bigger forums. Finally, some argued that health committees are too small or cover too small a geographical area. Along the same lines, an argument was presented that capacity issues could better be solved by having health forums rather than health committees. The model along which the Khayelitsha sub-district is structured also offers an alternative structure with ward health committees existing alongside health (clinic) committees.

7. Discussion

Limitations to Participation

This part of the discussion focuses on the role of health committees, structure of community participation, and how health committees fit into the broader health governance system.

This study presents a challenging picture of health committees as effective and meaningful structures for community participation in health in the Cape Town Metropole. The number of health committees in the Western Cape was, according to Padarath and Friedman's 2008 study, 48 %, while the national figure was 57 %. This study concluded that 55 % of clinics in the Cape Town Metropole were linked to a health committee. No data exist for current provincial coverage, but information from the Women on Farms Project suggests that coverage in rural areas is much lower than in urban areas. Whatever the figure, coverage in the Cape Metropole is below the national average in 2008 and far from the goal set in the Draft Policy and the National Health Act: viz., that all clinics should have a health committee. Furthermore, behind this figure lies a complex picture of health committees struggling to become sustainable, functional, and representative committees that play a 'meaningful' role in health governance.

The findings suggest that there are limitations to the type of participation health committees are involved in. They are primarily involved in participatory roles where they assist and support clinics, functioning as an extension of the health system, and assist patients with health and social needs. In addition, health committees are often involved in promoting health through awareness campaigns. Thus, health committee members often carry out tasks that are also carried out by community health workers, leading to a blurring of roles between the committees and the community health workers.

In contrast, health committees are hardly ever involved in identifying overall health strategy, setting the agenda, or take part in the decision-making process. Health committees rarely have an oversight function or ensure accountability. By and large, their work is directed at helping patients to adjust and adapt to the health system as well as to complementing the system. Limited effort is directed at changing the health system; and there is no involvement in policy-making. Thus, there may be a blurring of roles between health committee members and community health workers.

It is beyond doubt that health committees play an important role in improving health and access to health services. In that way, health committees are instrumental in realising the right to health. Tasks such as assisting patients in the clinic, health promotion, assisting clinic staff with campaigns, informing communities about health issues, and doing home-based care all contribute to realising the right to health. Assisting patients with procuring ID books and birth certificates help them access health services.

However, it is questionable whether this form of engagement/involvement should be called participation. Potts (2009) defines active and informed participation as including participation in the following: identifying overall health strategy, decision-making, prioritisation, setting the agenda for discussion. This includes being involved in policy choices, implementation and monitoring and evaluation. For Arnstein and Rifkin, being part of the decision-making process is also crucial to genuine or meaningful participation. General Comment 14 also identifies participation as being part of the decision-making process. This notion is carried through in the White Paper on Transformation of the Health System, which talks about participation in "various aspects of the planning and provision of health services." It also emphasizes the importance of establishing mechanisms to improve accountability. Based on these understandings of participation, this report defined participation as *"a process where 'community members' participate in a partnership with health officials in matters related to health and health services, and where that involvement includes involvement in setting the agenda; identifying problems; planning and implementing solutions; taking part in decisions; having an oversight function that entails monitoring and evaluation; and ensuring an accountable health system."* These definitions of participation contrast with health committees' current role.

Conversely, meaningful participation should entail being involved in monitoring services. Yet, few health committees took part in monitoring services. Even fewer were involved in fostering community participation, something that may reflect relatively weak links between health committees and communities. Other activities that should be part of meaningful participation – such as promoting primary health care, ensuring human rights, advocate and lobby – had very low priority. Meaningful participation should, according to Potts, also entail influencing policy. Yet no health committee was concerned with policy and the current arrangement of health government provides for minimal access for health committees to influence policy. The only forum where officials are present is the Cape Metro Health Forum plenary.

Importantly, Arnstein and Potts both argue that taking part in information exchange, consulting, and education is not true participation. It is evident that health committees are frequently involved in

providing ‘education’ in the form of health promotion, one of their most important activities. Yet, this activity is limited in terms of a participatory approach.

While the current form of involvement may not be participatory, it is important to take cognisance of the contribution health committee members make to health and health services. Through their current activities, health committees contribute to the realisation of the right to health. However, this contribution is not primarily through participation in health governance or through health system change but rather by health committee members becoming an extension of the health system in an assistant capacity.

There is, thus, a tension between health committees’ contribution to the right to health and an understanding of participation in health system governance. However, if realising the right to health is the ultimate goal of involving communities in health and health care services then this contribution should be recognised. This report takes the view that while these ways of contributing may not be participation; they make a contribution to the realisation of the right to health and encourage individuals to be more than passive recipients of services

Consequently, the report suggests that communities can contribute to the right to health through three avenues: involvement, participation and address social determinants.

(a) **Community involvement**, which entails communities being involved in supporting and assisting health systems, patients, and communities. They fill a gap and function as an extension to or complement services by carrying out functions such as health promotion, health care and deal with social issues.
(b) **Community participation**, which entails that health committees are part of governance, involved in setting the agenda, identifying problems and solutions, and part of the decision-making process. Participation also entails that health committees have oversight, deal with monitoring and evaluation as well as complaints, and function as structures ensuring accountability.
(c) **Addressing social determinants of health,** which entails that health committees addresses broader issues in societies and communities which affects health. Not linked to health facilities.

The report suggests that a conceptual distinction should be made between these different ways of contributing to the right to health. In particular, a distinction between involvement and participation is imperative.

This distinction leads to the following critical question: Can health committees function as truly participatory bodies, and at the same time function as 'assisting' clinics with health care and related issues. Or should the role of health committees be strictly confined to being an oversight body concerned with governance, monitoring and evaluation, and accountability. It is important that community participation structures reach consensus on this issue as part of defining the role of health committees.

If health committees are defined as oversight bodies concerned with governance and accountability, the following question needs to be considered: who should carry out the activities that are currently carried out by health committees, which this paper has defined as involvement? One suggestion could be to let 'sub-committees', group of volunteers or health forums carry out these tasks. In fact, some of the current health forums do function in this way as they co-ordinate NGOs' activities. It is also possible that the primary health care agents suggested in the Green Paper on the National Health Insurance should take on these tasks. However, even if such activities are defined as involvement, a more participatory approach could often be implemented. Co-operation between these different levels are obviously crucial.

Several arguments can be put forward for such a division. Firstly, from a capacity and human resource point of view, it may be unreasonable to expect a health committee to carry out a huge variety of activities that health committees are currently involved in. It seems unreasonable to expect health committees to have the time and the broad range of skills to provide governance and oversight and at the same time assist health facilities and patients as health care workers, health promoters and social workers. Secondly, if health committees' mandate is too broad attention may be diverted away from complex issues, such as providing governance and monitoring and evaluating services. Thirdly, it is worth considering whether the independence of health committees would be enhanced if they were defined as structures with a more 'narrow' mandate relating to governance, oversight and accountability. Finally, asking the broader community to be involved in specific tasks such as health promotion and assisting patients at the clinic may increase greater involvement from the community.

Defining health committees' mandate as participating in governance and have oversight is close to the vision embedded in the Draft Policy. The tasks of providing governance, and monitoring and evaluation correspond directly to the Draft Policy's description of what health committees should do. The Draft Policy's second task - of ensuring that the needs, concerns and complaints of the community are properly dealt with by the management of the facility - is to some extent consistent with this view. This

task could, however, be changed to a more participatory approach by emphasising that health committees could play a role in ensuring that the needs, concerns and complaints were addressed. Specifically, health committees should be part of dealing with and solving complaints in a constructive way to improve services. The third task of fostering community support for the programmes and projects of the facility entails a limited notion of participation and could be rephrased to encapsulate a more participatory approach such as involving communities in identifying and implementing projects and programmes at the facility. Participation in health programmes and projects could also happen at a higher level, such as via community participation through the District Health Council.

Structure of Community Participation

The role of health committees needs to be reviewed in conjunction with a review of the structures of community participation and in light of the re-engineering of the primary health care as suggested in the Green Paper on a National Health Insurance. In the National Health Act and the Draft Policy, health committees are called clinic and community health centre committees, though they are more frequently referred to as health committees. However, the names indicate that these are meant to be structures that deal with issues at a particular clinic/community health centre. In addition, there are structures called ward health committees and health forums. Consensus needs to be reached on whether these structures should continue to exist alongside health (clinic) committees. It is also imperative that agreement is reach on roles and responsibilities for the different community participation structures. A model for community participation structures that stipulates roles and responsibilities of different structures needs to be developed.

One option could be a model where clinic health committees are conceptualised as a structures for a clinic that deal with issues pertaining to the services at that particular clinic, while health forums/ward health committees could be forums that deal with the social determinants of health. The primary health care agents, to be implemented with the primary health care re-engineering, should be responsible for the activities previously described as 'community involvement' i.e. providing 'services' and assisting and supporting clinics. Primary health care agents could draw on wider community involvement in projects and programmes.

Consideration also needs to be given to how health committees fit into the broader health governance system. According to the Health Systems Trust chart of Governance Structures Flowchart (see Padarath and Friedman 2008), community health centre committees/clinic committees should refer to the District

Health Council. However, the recently passed District Health Council Act is silent on community participation and health committees; and these are not represented in the District Health Council. The current chairperson of the Cape Metro Health Forum serves as a community representative, but the Cape Metro Health Forum is not guaranteed representation in the Act. Consequently, it is hard to see how health committees or other community structures such as the Metro Health Forum fit into the health governance system. The omission of community participation in the District Health Council Act could be interpreted as health committees being excluded from broader health governance. Thus, this study suggests that a clear vision on where health committees fit into the broader structures of community participation and health governance is needed. One way of ensuring that health committees are represented is by allowing the Cape Metro Health Forum, and possibly also the sub-district health fora, to be represented on the District Health Council. This would allow for a continuum of community participation, a coherent structure and avenues for grassroots structures such as health committees to access a higher political level.

Such a structure would also allow for community participation in policy issues, an issue central to 'meaningful' participation. While individual health committees may want to give input on health policy issues, it may be more feasible if policy issues are taken up by an umbrella body such as the Cape Metro Health Forum, as policy issues often focus on broader issues. The tiered health governance system should allow for health committees to be primarily concerned with issues at clinic level , while referring broader issues to sub-district health fora, to the CMHF and finally to the District Health Council.

In general, the role of sub-districts health fora and the Cape Metro Health Forum needs to be considered. Currently, sub-districts are envisioned as co-ordinating as well as monitoring and evaluating the effectiveness of clinic/CHC committee sub-districts; while the CMHF is envisioned as co-ordinating, monitoring and evaluating sub-district health fora. It is worth considering, how these structures could play a role as intermediaries between health committees and the wider health governance system.

Consideration also needs to be given on how to address the limited participation of ward councillors in health committees. Ward councillors could provide a link between health committees and the council. It is in this light that some community members' request for an annual meeting with the provincial health minister or health authorities should be seen: as a reflection of concerns about limited access to the health governance system/political level.

Conditions for participation not in place: Creating a supportive environment for community participation

This section explores the lack of conditions conducive for effective of meaningful participation, which this study has highlighted. The institutional mechanisms (see Potts) to ensure participation are not in place. Currently, health committees in the Cape Metropole exist in a policy vacuum that renders them functionally sub-optimal and incapable of participation in a meaningful way. This research has shown that the lack of clarity on role and function, and lack of a clear mandate are important hindrances for effective and meaningful community participation. The need for a policy on community participation has been expressed in numerous ways by community members. This research has argued that a policy on health committees needs to be seen in relation to broader structures for community participation and a re-evaluation on the role of health committees. Furthermore, it is imperative that a policy is based on a shared vision for community participation – shared by policy makers, health workers, and community members. This vision needs to be formalised or carried out in legislation that outlines the role and function of health committees.

Adding to the confusion about role and function is the fact that the Draft Policy - which could have provided guidelines - was not widely known or understood. It is hardly surprising the health committees struggle to see their purpose and role. The Draft Policy provides a vision of community participation that is to a large extent consistent with the view on community participation taken in this report. The Draft Policy could provide a legislative framework for health committees and should be adopted either in its current form or with amendments.

When considering the legislative framework, it is important to consider the issue of power. Currently, health committees are advisory bodies with no formal power. In reality, most are not even advisory bodies, but rather an extension of services. As Glattstein-Young (2010) has noted, the success of a health committee depends on the willingness of facility managers to share power. A policy on health committees should ideally deal with what power health committees should exercise.

In addition to a policy on community participation, a set of guidelines that deals with the process of establishing health committees through a fair, accountable and transparent process is necessary. These guidelines should also deal with the issue of how to ensure that vulnerable groups are represented. It should establish guidelines for the elections of health committees, and assist in their establishment and

ensure community involvement in these structures. Finally, guidelines should outline responsibilities of key stakeholders such as health authorities, facilities, and ward councillors.

Secondly, the research showed that facility managers attended meetings in 44% of health committees that participated in this research, while health committee members indicated that facility managers participated 'almost always' or 'often' in 61% of health committees. These figures are significantly lower than those found by Friedman and Padarath (2008). According to these authors facility managers took part in most health committees. This discrepancy may be due to methodological issues. Padarath and Friedman's study asked facility managers about attendance, while this study was based on observations at meetings as well as information gathered from health committee members. However, the possibility that the involvement of facility managers has decreased remains. This is obviously reason for concern as health committees cannot carry out their function without the co-operation of the facility managers. Moreover, facility managers' attitude towards and co-operation with the committees was in some instances not optimal.

In contrast with Glattstein-Young (2010), this research did not find widely divergent views between community members and facility managers' view of community participation. While these did exist in some committees, the trend was much more toward an agreement on health committees supporting and assisting the clinic. In many committees, an 'alliance' between health committees and facility managers existed, often at the expense of 'the community'. Again lack of legislative status and power undermine the authority of health committees to become 'partners' with facility managers.

Another concern is the very limited participation from ward councillors. Padarath and Friedman's study found that ward councillors participated in 30% of health committees in the Western Cape, whereas the national figure was 45%. This study found a very different picture with ward councillors only present in 5% of the health committee meetings, while committee members reported that ward councillors attended 'rarely' or 'occasionally' in 17% of health committees. As with facility managers, a possible explanation could be the different methods used in the two studies. Whatever the case may be, councillors are by and large absent from health committees. The implications of an almost non-existing working relationship between ward councillors and health committees is that health committees are cut off from political influence as there is no other political avenues that health committees are linked to at this stage.

Political will

Poor participation by ward councillors could be interpreted as a reflection of lack of political commitment to community participation. According to Potts (2009), political will to support and encourage community involvement is a crucial prerequisite for community participation. Political will and commitment is seen as essential to community participation in other research (e.g. Padarath and Friedman, 2008, Boulle et al, 2009). This notion was also present amongst health committee members, with some arguing that political support is crucial to their optimal functioning. Whether political will exists is debatable. There are signs of increased political commitment, such as increased funding as well as the inclusion of the Cape Metro Health Forum in strategic planning meetings in both the Metro and the province indicate political commitment. Community participation is also acknowledged as an important component of primary health care in the strategic plan for the Department of Health in the Western Cape, 2020 The Future of Health Care in the Western Cape. Nevertheless, there is a widespread perception amongst health committees that there is a lack of political will and commitment to community participation. The continued lack of a capacity building programme could also be seen as lack of political will, or at least limited attention to health committees. The Cape Metro Health Forum has also expressed concerns about the lack of consultation in the passing of the District Health Council Act and the fact that it is silent on health committees, interpreting the Act as being unfavourable to community participation. There is no provision for the CMHF to be represented at the District Health Council. However, the CMHF successfully nominated its chairperson to sit on the council. Lack of progress in implementing a policy on community participation may be seen as another sign that community participation has not been a priority. Officials have previously indicated that a policy on community participation could be implemented once the District Health Council Act had been passed. This would provide a legislative framework for health committees to function within. It is imperative, that community structures be included in the process and that they decide on whether the current Draft Policy should be amended/changed. Taking steps to implement a policy on community participation would be a first and important sign on political commitment to community participation. A funding programme, development of institutional support as well as training and capacity development programmes, linked to the policy, would be other important signs of political commitment. Other forms of acknowledgement/recognition such as certificates may assist in changing the perception that health committees are not recognised.

Training and capacity development

The need for capacity building of health committee members demonstrated in this research is consistent with other literature on health committees (Padarath and Friedman, 2008; Boulle et al, 2008). It is also one of the pre-conditions that Potts lists for effective participation (Potts, 2009). This research has indicated that capacity building is crucial to address functionality of health committees. Suggesting that there is a link between health committees' limited participatory roles and their limited skills and capacity, this research has argued that capacity building is crucial for meaningful participation. However, it is important that capacity building is informed by a vision and a shared understanding of community participation. Thus, the list of health committee members training wishes (p.55) should be seen as an expression of how health committees perceive and envision their role rather than a list that reflects training needs. In other words: clarification on role and function of health committees as well as their position within a broader framework of health governance should guide a capacity building programme. A starting point for a capacity building programme could be to develop a common vision shared by health committees, health workers, health officials, and policy makers. This research has also highlighted specific areas such as financial management as crucial to achieve functional health committees, as well as training/workshop to discuss the Draft Policy, and unpack the difficult language. More broadly, training needs to capacitate office bearers to ensure optimal functioning of health committees. The request for knowledge about the health system and services offered are also important to note.

Capacity building and skills development of health committees should be viewed as a way of 'empowering' health committees and develop their 'voice'. It is central to ensure representivity as the most disadvantaged may be barred from participation due to limited skills. Finally, capacity building is essential for community members to engage with facility managers and health workers in an equal relationship and change the 'power' dynamics that may limit participation.

While the need for a capacity building programme funded by the authorities is urgent, it is important to note that health committees have the capabilities to assist each other in capacity building. Health committees should strengthen links and identify ways in which they can draw on own strengths and capabilities. Suggestions such as creating a learning network for health committees, creating a mentoring-programme where 'strong' health committees mentor 'weak' health committees, creating forums for sharing best practices, etc. are worth considering.

Resources and financial support

The need for funding and resources is consistent with other research (Padarath and Friedman, 2008, Boulle et al, 2008). It is also one of the pre-conditions mentioned in Potts work (2009). A review of funding for health committees needs to be seen in relation to their role and function. At minimum funding should be allocated to cover the 'cost of participation' such as transport and telephone cost. Funds should be allocated to ensure that health committees can function, such as funding for stationary (if not provided by facilities), refreshments, and communication. If health committees are to either co-ordinate projects/initiatives, then funding is needed for this. Funding is essential for functional health committees, but also to ensure representivity as the 'cost of participation' may prevent the most disadvantaged to participate. While funding has been made available for health committees, these have not reached many health committees. Clear guidelines on how to compensate for the costs such as transport costs needs to be implemented and systems put in place to ensure proper financial management.

Institutional Support

Currently, health committees function without institutional support. The need for some form of support was evident in this research and expressed by many health committees. In particular, support is required in facilitating the formation of new health committees and in supporting struggling health committees to avoid the current tendency for health committees to go through cycles of disbandment and re-activation, which causes loss of institutional memory/skills/capacity. The aim of establishing health committees in 100 percent of clinics, expressed in both the National Health Act and the Draft Policy, is unlikely to be achieved without some form of support.

The Draft Policy stipulates that the health facility should provide appropriate support. While health facilities may be able to provide support, such as a place to hold meetings, access to telephone, computer, etc, it is questionable whether health facilities can and should provide institutional support. This also needs to be considered in light of the following: a) Facilities may not have the capacity to provide support given the resource strain they work under. b) Facilities are not always favourable towards a participatory approach. c) Health committee members are sometimes too closely affiliated with health facilities, an association that may be reinforced if health committees are too dependent on facilities. Placing the institutional support for community participation outside the facilities may therefore contribute to the independence of health committees.

Subsequently, the question that needs to be considered is where support should come from. Support could be situated within the Cape Metro Health Forum and the sub-district health fora such as envisioned in the Draft Policy, which says that sub-district health fora should "co-ordinate the effectiveness of clinic/CHC committees and hospital boards within the sub-district" and that the CMHCF should "co-ordinate the effectiveness of sub-district health fora". Again, it is important to consider whether these structures have the necessary capacity. Support could also come from a paid community liaison person, accountable to community participation structures. A liaison person could focus of the following tasks: a) Give support to communities setting up health committees and initiate formation of health committees in areas where they are lacking, b) Provide support to struggling health committees/committees at risk of disbanding, c) Develop and implement a capacity building and training programme, d) Strengthen communication and co-operation between community participation structures, e) Collect and share best practices/manage institutional 'memory', f) Develop guidelines for administration of financial resources, g) Develop guidelines for a participation process that is inclusive and ensures representivity. A liaison person could be entrusted with addressing limited reach, functional and representivity of committees. It is worth noting, that previously there was a paid official servicing the CMHF.

The process of participation

This research did not attempt to look at the process of participation. However, it did find evidence that the process is in some instances flawed. The issue of representivity and of ensuring participation by vulnerable groups was flagged. Questions around the legitimacy and transparency of the process also require attention. More research is needed to understand the process of participation and how health committees are formed as well as develop guidelines on how to ensure both representivity and legitimacy.

According to Potts, the process of participation is compromised of four elements: a) an accessible and inclusive method, b) A fair and transparent process, c) Indicators for monitoring and evaluating the method and process, and, d) An independent accountability mechanism and remedies. It is clear that very little attention has been given to the process of participation and to ensure that the process is fair, transparent and inclusive. Institutional mechanisms as well as guidelines to ensure such a process are lacking.

Viewed from a human rights perspective, participation is not only a right in itself. It is also a right that is instrumental to the right to health, which is enshrined in the South African constitution. As Potts argues: "It is the state's obligation to guarantee the realisation of the right to health and develop the institutional mechanisms to ensure that participation takes place." With institutional mechanism's lacking, an argument can be put forward that the state is not meeting its obligation to ensure participation. Health committees should insist on their right to participation and on legislation that supports participation.

8. Recommendations

Based on the discussion above, the report makes the following recommendations for various stakeholders.

Recommendations to all stakeholders:

The Cape Metro Health Forum (CMHF) should take the lead in initiating the following recommendations, ensuring that all stakeholders are involved:

(a) Develop a **shared vision** for community participation that recognises the role of community participation as being concerned with governance and accountability.

(b) Develop a **model** for effective and meaningful participation with clear definition of role and mandate of health committees and the relationship between different structures for community participation. As part of this,

i. A review of health committees' role within wider health governance systems should take place. Attention should also be paid to identifying how community participation structures relate to other statutory structures with governance responsibilities – viz. District, Provincial and National Health Councils.

ii. It would be important to debate and reach clarity on whether the service role currently performed by health committee members should continue, or be handed over to other structures of personnel, such as ward health agents contained in the policy on PHC Re-engineering.

(c) Following the development of a shared vision and a model for community participation, stakeholders should consider identifying an **independent national body** that could act as an arbitrator in the case of disputes. The Human Rights Commission could be considered.

Recommendations to the National Legislature

(a) When the National Health Act is to be amended, consider an amendment that stipulates the mandate of health committees and the relationship between health committees and the District, Provincial and National Health Councils.

(b) Ensure that the National Health Insurance is congruent with other legislation on community participation and ensure that community participation is recognised in the National Health Insurance legislation.

Recommendations to the Western Cape Provincial Legislature

(a) Adopt the Draft Policy Framework for Community Participation/Governance Structures for Health in the Western Cape (the Draft Policy).

(b) Amend the District Health Council Act to allow for community participation through the inclusion of the CMHF and possibly sub-district health fora in the District Health Council.

Recommendations to the Provincial Health Department and City Health

(a) DEVELOP GUIDELINES

i. Develop written guidelines in accordance with policies and the CMHF's constitution to ensure that the process of forming health committees is fair, accountable and transparent, ensuring representivity and legitimacy of health committees. This should be done in co-operation with the CMHF and the health services. Guidelines should stipulate criteria for how health committees are elected and constituted and ensure that vulnerable groups are represented.

(b) FUNDING

i. Ensure that sufficient funding is made available and reaches health committees to cover:
   - Administrative costs: such as telephone, email, stationary, refreshments.
   - 'Cost of participation': such as transport money and airtime.
   - Cost to run projects/campaigns/programmes.
   - Funding for capacity building, unless provided centrally by the CMHF.

ii. Ensure that there is capacity to mange funds efficiently at health committee and sub-district health forum level.

iii. Develop procedures for the distribution of funds to ensure that funding reaches health committees.

iv. Ensure that all sub-district health fora and all health committees are aware of available funding and funding procedures.

(c) PROVIDE INSTITUTIONAL CAPACITY BUILDING SUPPORT

i. Develop an induction programme for newly elected health committee members. An induction programme should include, but not be limited to, the following topics:

- Role and function of health committees
- Role and function of office bearers
- Relevant policies such as the National Health Act and the Draft Policy
- Overview of services provided at the clinic
- Overview of the health system
- Technical skills for office bearers: Financial management, minute taking, chairing meetings etc.

ii. Implement a capacity building programme. Training should be designed in accordance with the vision for health committees. To strengthen a participatory role as suggested in this report, training should include, but not be limited to, the following topics. It takes into consideration that an induction programme has already covered the topic listed above:

- Community participation
- Governance
- Monitoring and evaluation
- Health and human rights
- Complaints procedures
- Primary health care
- Patients rights and responsibility
- Budgets
- Policy analysis
- Identifying health needs/problem identification
- Leadership training
- Training to become change agents
- Computer skills
- Training on the Annual Provincial Plan process
- Other training identified by health committees (see report for training needs) and based on local needs.

iii. Develop and implement training of facility managers, staff and ward councillors in community participation and the role of health committees and forums in health care provision and governance.

iv. Ensure that health committee members are able to participate in training by taking the following

issues into consideration: time (outside working hours), provide for transport/reimburse transport cost, ensure that training is conducted in a language understood by participants and take their level of knowledge and experience into consideration. Issue certificates for completed training.

v. To ensure that health committee members use the skills they acquire through training, health committee members should be encouraged to sign an 'Agreement of Commitment' when they receive training, committing them to be of service as a health committee member for a specified period of time.

vi. In order to build institutional capacity of health committees, there should be a paid community liaison officer with the following responsibilities:

(a) Provide support to communities setting up health committees
(b) Initiate formation of health committees in areas where these are lacking
(c) Provide support for struggling health committees
(d) Develop and implement a capacity building and training programme
(e) Strengthen communication and co-operation between community participation structures
(f) Collect and share best practices
(g) Manage institutional memory
(h) Assist health committees in writing a constitution

(d) ENSURE THAT PRACTICAL CONDITIONS FOR PARTICIPATION ARE IN PLACE

i. Ensure that health committees have a place to hold meetings. Facility managers should plan to make space available.

ii. Ensure that health committees have an office or access to an office with equipment such as phone, fax, and computer with email/internet.

(e) RECOGNISE HEALTH COMMITTEES

i. Recognise the Cape Metro Health Forum as an umbrella body for community participation and provide for inclusion of the CMHF in planning and provision of health care.

ii. Recognise health committee members' contribution through issuing 'certificates of service.'

Recommendations to the CMHF and sub-districts health fora

(a) REVIEW CONSTITUTION AND POLICIES

i. Review the CMHF's constitution to ensure that it is in line with the vision on community participation and the Draft Policy Framework.

ii. Review policies on community participation periodically and suggest amendments where appropriate.

(b) LOBBY FOR POLICIES AND SUPPORT FOR COMMUNITY PARTICIPATION

i. When the National Health Act is to be amended, consider suggesting an amendment that stipulates the mandate of health committees and the relationship between health committees and the District, Provincial and National Health Councils.

ii. Lobby for an amendment to the District Health Council Act to allow for the inclusion of the CMHF and possibly sub-district health fora in the District Health Council.

iii. Continue lobbying for the adoption of the Draft Policy.

iv. Continue lobbying for institutional support for health committees.

(c) ENSURE ACCOUNTABILITY

i. Ensure that the CMHF functions according to its constitution and ensure proper financial management.

ii. Report to the Departments of Health (Metro and City) on the work of the CMHF, sub-district health fora and health committees.

(d) REPORT ON ATTENDANCE

i. Report to the relevant chief whip on participation of ward councillors in Health Committees.

ii. Report to sub-district managers in the City and the Cape Metro on participation of facility managers in Health Committees.

(e) **STRENGTHEN INTERNAL CAPACITY**

i. Ensure efficient feedback to health committees and strengthen communication between committees, sub-district health fora and the CMHF.

ii. Establish fora (learning networks, 'circles of good practice') where health committees can share ideas and learn from each other.

iii. Establish a peer mentoring programme where strong committees can assist poorly functioning or new committees.

iv. Document and share best practices.

v. Ensure that health committees are aware of Draft Policy and other relevant legislation.

Recommendations to Health Committees

(a) CARRY OUT DRAFT POLICY'S MANDATE

i. Ensure that health committees carry out the mandate stipulated in the Draft Policy. Health committees should deal with complaints and complements in a constructive way with health facility managers to identify structural problems that can be addressed to improve quality of services.

(b) STRENGTHEN RELATIONSHIP WITH COMMUNITIES

i. Raise awareness about health committees and their role.

ii. Strengthen relationship with communities through engaging with and including communities in various issues.

iii. Report to community.

(c) TAKE STEPS TO IMPROVE FACILITY MANAGER AND WARD COUNCILLOR ATTENDANCE

i. Monitoring of ward councillor and facility manager attendance.

ii. Report on attendance of ward councillor and facility manager to CMHF via the sub-districts.

(d) IMPROVE ACCOUNTABILITY

i. Ensure proper financial management and that money spent is accounted for.

ii. Ensure that health committees adhere to a constitution, that elections are advertised, that meetings are run according to an agenda, which is sent out timely, and that minutes are kept.

Recommendations to facility managers

(a) Recognise and support health committees.

(b) Include health committees in governance, identifying health needs, monitoring and evaluation, and complaints. Health committees and facility managers should deal with complaints and complements in a constructive way to identify structural problems that can be addressed to improve quality of services.

(c) Attend and participate actively in health committee meetings.

(d) Ensure that the clinics' staff members are familiar with the health committee and the principles of community participation.

(e) Provide, where appropriate, logistic support for the Health Committee, in terms of access to phone, fax, and a place to hold their meetings.

(f) Release staff to go for training.

Recommendations to ward councillors

(a) Attend and participate actively in health committee meetings.

(b) Provide feedback between council and health committee and report on health issues.

9. Conclusion

The importance of community participation in health is documented in a number of international and national documents. It is seen as a key component of primary health care. Research has shown that community participation can have a positive impact on health and health services, ensuring a more responsive and equitable health service. Yet, research also shows that health committees are not functioning optimally.

In South Africa, a vision for community participation in health planning and provision was outlined in The White Paper on Transformation of the Health System (Department of Health, 1997). Community Participation has been formalised in the National Health Act 61 of 2003, which requires health committees to be established at all clinics. However, the National Health Act is silent on outlining a mandate for health committees, leaving it to provincial governments to provide legislation that stipulates the role and function of health committees. In the Western Cape, a Draft Policy Framework for Community Participation/Health Governance Structures for health is still not implemented. The recent passing of the District Health Council Act for the Western Cape is silent on community participation and do not allow for health committees or other structures to have a voice in this council. Guidelines for ensuring that community participation is a transparent, fair and accountable process are also lacking. Health committees, by and large, exist in an environment which is not conducive for meaningful and effective community participation. Currently, the health system in South Africa is undergoing restructuring with the National Health Insurance policy, which includes a re-engineering of primary health care. How this re-engineering will impact on community participation is unclear. The Green Paper is very broad with big gaps and little reference to community participation. The only citation is in relation to primary health care agents that will be responsible for community involvement.

This research identified four key challenges for health committees in the Cape Town Metropole:

(a) Health Committees have limited reach with just over half of the clinics being linked to a health committee.
(b) Health Committees struggle to become sustainable and functional.
(c) Health Committees struggle to become representative and legitimate structures for community participation.

(d) Health Committees play a limited participatory role, where they mainly support and assist clinics, but have limited influence on governance, monitoring and evaluation and oversight. Their role in decision-making and their power is limited.

The research identified a number of reasons for the current situation. These include: a lack of clarity on role and function, lack of formal mandate, limited skills and capacity, limited cooperation with ward councillors and facility managers, lack of commitment, perceived lack of recognition, lack of funding and support, and lack of material resources.

The current situation for health committees is, thus, that they exist in a policy vacuum with limited political and institutional support. Optimal conditions for participation are wanting.

The research found that health committees do play an important role in realising the right to health, but this role is more through extending (and complementing) health services rather than through participation. It identified a need to strengthen a participatory approach, suggesting that health committees should be identified as structures involved with governance, oversight, monitoring and evaluation, and accountability. In addition, the report suggested that clarity on where health committees fit into broader health governance is imperative for an effective health governance system.

In order for community participation to become truly 'participatory, meaningful and effective', a shared vision needs to be developed with participation from all stakeholders: communities, health workers, and health authorities. Based on this, legislation that stipulates role, responsibility and mandate needs to be implemented. Furthermore, a supportive context and support to building institutional capacity for participation is needed, so as to ensure that participation becomes 'meaningful', health committees become legitimate and representative community structures, as well as to ensure that they become functional and sustainable structures.

10. Appendices

Appendix 1: Draft Policy Framework

WESTERN CAPE DEPARTMENT OF HEALTH

DRAFT POLICY FRAMEWORK FOR COMMUNITY PARTICIPATION/GOVERNANCE STRUCTURES FOR HEALTH

1. BACKGROUND:

1.1. Regulatory/ Policy Context:

The following key policy/legislative document provides the context for the development of a standardised policy framework for the Western Cape:

i) The Western Cape Provincial Health Plan for 1995 articulated a commitment to community participation in planning of local health services. The plan proposed the establishment of health committees, with representation of community organizations operational in drainage area of the health facilities, and the establishment of community health for a with wide representation of the community structures, to facilitate the co-operation between the public, private and NPO health sector in defined geographic areas;

ii) The National District Health System (DHS) policy framework of 1996 provided a policy framework for the establishment of the district health system in South Africa, which included a structure for community participation within the District health System;

iii) The Western Cape Provincial Health Facility Boards Act of 2001 (no.7 of 2001) established a regulatory framework for the establishment of hospital boards in the Western Cape. The Act provides a clear framework for the governance role of hospital boards in the effective functioning of hospitals in the Western Cape;

iv) The National Health Act of 2003(no.61 of 2003) provides the regulatory framework for the establishment of the DHS in South Africa. It provides for the establishment of a National Consultative Health Forum , Provincial Consultative Health For a, Provincial Health Councils, District Health Councils and clinic ad community health centre committees;

v) The Western Cape Comprehensive service Plan (CCP) provides the policy framework for the restructuring of health services in the Western Cape. It is based on the implementation of the DHS, and provides for district management structures that replace the regional management structures that have been in the province since 1996;

1.2. Current Situation in the Western Cape:

The Cape Metro has a Cape Metro Health Forum, 8 sub- district health fora and 86 clinic committees (serving single facilities or clusters of smaller facilities).each of these structures has a standardised constitution, but act as voluntary advisory structures with no formalised status. The MDHS provide an annual financial allocation of R15 000 to the CMHF and to each of the 8 sub-district for and the health committees within the sub-districts.

There are sub-strict health fora and health committees in each of the 5 rural districts (west Coast, Cape Winelands, Overberg, Eden and Central Karoo) in the Western Cape. These structures act as voluntary advisory structures with no formalised status.

2. INTRODUCTION:

2.1. PURPOSE:-

To provide a policy framework for the establishment, appointment and functioning for community participation structures within the District Health System in the Western Cape.

2.2. RATIONALE :-

To co-ordinate and formalize community participation structures within the DHS in the Western Cape:

i) District health councils;
ii) The Cape Metro Health forum
iii) Sub-district health fora;
iv) District hospital boards;
v) Clinic and community health centre committees

2.3. Guiding Principles:-

The following guiding principles should be observed in establishing community participation structures:

i) PHC principles as articulated in the Alma Ata Declaration and the NHA of 2003;
ii) Strengthen governance of service delivery structures and facilities through effective participation of civil society;

iii) A focus on working in partnership with other stakeholders to improve the quality of care at all levels of the health system;
iv) Involving communities in health service delivery and health promotion activities;
v) Establish mechanisms to improve public accountability and promote dialogue and feedback between the public and all relevant stakeholders;
vi) Building a responsive organization within legal and political frameworks guided by the constitution and various pieces of legislation;
vii) Involve communities in various aspects of the planning and provision of health services;
viii) Encourage communities to take greater responsibility to their own health promotion and care.

2.4. Strategic Objective:-

To establish effective community participation structures in all districts in the Western Cape.

2.5. Specific Objectives:-

The strategic objectives will be achieved through the following specific objectives:

i) To establish functional district health councils in 100% of the health districts in the Western Cape;
ii) To establish functional hospital boards at 100% district hospitals in the Western Cape;
iii) To establish functional clinic/community health centre committees to achieve 100% coverage of all PHC facilities in the Western Cape;
iv) To establish functional sub-district health fora in 100% of the designated health sub-districts in the Western Cape.

3. TERMS OF REFERENCE FOR THE COMMUNITY PARTICIPATION STRUCTURES:

3.1. District Health Councils:

The terms of reference for the districts health councils will be contained in the Western Cape District Health Councils Draft Bill that will be processed through the provincial legislature before the end of 2008. The legislation will clarify membership, functions, tenure of office, etc.

Consideration should be given for the establishment of District Consultative Health For a, along the lines of the National and Provincial Consultative Health For a, as stipulated in sections 24 and 28 of the NHA of 2003.

3.2. Cape Metro Health Forum:

3.2.1. Establishment and composition of the Cape Metro Health Forum (CMHF)

i) The membership of the CMHF executive will consist of 1 representative from each of the 8 sub-districts in the Cape Metro;
ii) The management of city Health and the Metro DHS will nominate 1 manager to serve as ex-officio members on the CMHF executive;
iii) The CMHF will have 4 plenary meetings during a calendar year, which will be open meetings for all members of sub-district fora and health committees;
iv) Representatives from other relevant civil society organization can be invited to participate in the plenary meetings;

3.2.2. Tenure of office members:

A member will serve for a term of one year, and may be re-appointed (depending on the member's status in the sub-district fora)

A member may be removed from the committee by the Minister or the Chairperson of district health council, if the member: i) declared to be unsound of mind, ii) convicted of any offence; iii) incapable to perform his/her duties.

3.2.3. Functions of CMHF executive:

The executive must:

i) Co-ordinate the effectiveness of sub-district health fora;
ii) Plan and implement strategies to achieve optimal community participation structures across 8 sub-districts in the Metro;
iii) Monitor and evaluate the effectiveness of health for a, health committees and hospital boards across all 8 sub-districts in the metro;

3.2.4. Meetings of CMHF executive:

i) The CMHF executive must establish rules for its proceedings, in terms of frequency of meetings, chairpersonship, minute-taking, distribution of minutes, follow-up of planned actions, etc;

ii) The CMHF executive must meet monthly;
iii) A quorum for a meeting is at least half of the members plus one;
iv) The CMHF executive must strive to reach its decisions by consensus, but where a decision cannot be reached by consensus, the decision of the majority of the committee is the decision of the committee.

3.2.5. Support for the CMHF executive:

The management of the City Health and the Metro DHS will provide appropriate support for the optimal functioning of the CMHF executive and its plenary meetings.

3.3. Sub- district Health Fora:

3.3.1. Establishment and composition of sub-district health fora:

i) The membership will consist of 1 representative from each health committee within the designated sub-district;
ii) 1 representative from each district hospital board will serve on forum;
iii) Two managers from the sub-district health management team (one from City & one from MDHS in metro) will be added to the forum- ex-officio; (Issue of Environmental Health representation needs to be considered)
iv) Representatives from other relevant civil society organizations can be added to the forum;

The names of the committee to be formally endorsed by the ISDMT's (Metro) or the district manager (rural districts);

3.3.2. Tenure of office of members:

A member will serve for a term of one year, and may be re-appointed (depending on the member's status in the health committee and hospital board).

A member may be removed from the committee by the CMHF Exec, if the member is: i) declared to be unsound of mind, ii) convicted of any offence; iii) incapable to perform his/her duties.

3.3.3. Functions of sub-district health fora:

The forum must:

v) Co-ordinate the effectiveness of clinic/CHC committees and hospital boards within the sub-district;
vi) Plan and implement sub-district strategies to achieve optimal community participation structures within the sub-district;
vii) Monitor and evaluate the effectiveness of clinic/CHC committees and hospital boards within the sub-district;

3.3.4. Meetings of sub-district health fora:

i) The forum must establish rules for its proceedings, in terms of frequency of meetings, chairpersonship, minute-taking, distribution of minutes, follow-up of planned actions, etc;
ii) The forum must meet monthly;
iii) A quorum for a meeting is at least half of the members plus one;
iv) The forum must strive to reach its decision by consensus, but where a decision cannot be reached by consensus, the decision of the majority of the committee is the decision for the committee.

3.3.5. Support for sub-district health fora:

The management of the sub-district will provide appropriate support for the optimal functioning of the forum.

3.4. District Hospital Boards:

The terms of reference for hospital boards are contained in the Western Cape Health Facility Boards Act of 2001 (Annexure 1).

3.5. Clinic and community health centre committees:

3.5.1. Establishment and composition of clinic and community health centre committees:

i) Section 42 of the NHA of 2003 provides for;

1. The establishment of a committee for a clinic or group of clinics, a community health centre (CHC) or a clinic and a CHC, or a group of clinics and CHCs;
2. The committee must include one or more local councillor, one or more members of the community served by the health facility and the head of the facility;
3. The functions of the committee must be prescribed in provincial legislation
4. The names of the committee to be formally endorsed by the ISDMT (Metro) or the district manager (rural districts);

ii) The following interim framework should be implemented, until appropriate provincial legislation has been enacted:

1. 3 to 8 members to be elected by patients and communities in the drainage area of the facility/facilities served by the committee, at an annual general meeting (AGM);
2. The head of the facility/facilities served by the committee will be added to the committee;
3. A local ward councillor (ex-officio) from the geographic area served by the committee will be added to the committee.
4. The names of the committee to be formally endorsed by the ISDMT (Metro) or the district manager (rural districts);

3.5.2. <u>Tenure of members:</u>

i) A member will serve for a term of one year, and may be re-appointed (depending on the member's status in the health committee and hospital board).

ii) A member may be removed from the committee by the CMHF Exec, if the member is: i) declared to be unsound of mind, ii) convicted of any offence; iii) incapable to perform his/her duties.

3.5.3. <u>Functions of the clinic and community health centre committees:</u>

The committee must:

i) Provide governance as it relates to service provision within the facility/facilities;

ii) Take steps to ensure that the needs, concerns and complaints of the patients and the community are properly addressed by the management of the facility;

iii) Foster community support for the initiatives and programmes of the facility/facilities;

iv) Monitor the performance, effectiveness and efficiency of the facility/facilities;

v) The Minister or Chairperson of the district health council will implement appropriate actions to monitor the performance of the committees.

3.5.4. Meetings of clinic and community health centre committees:

i) The committee must establish rules for its proceedings, in terms of frequency of meetings, chairpersonship, minute-taking, distribution of minutes, follow-up of planned actions, etc;
ii) The committee must meet monthly;
iii) A quorum for a meeting is at least half of the members plus one;
iv) The committee must strive to reach its decision by consensus, but where a decision cannot be reached by consensus, the decision of the majority of the committee is the decision for the committee.

3.5.5. Support for clinic and community health centre committees:

The facility management will provide appropriate support for the optimal functioning of the committee.

4. IMPLEMENTATION PLAN:

It is proposed that the Minister table an implementation plan at the provincial health council for endorsement. The plan should speak to the specific objectives articulated in section 2.5., and will be implemented within each of the districts of the province, in a phased manner. The following is proposed:

4.1. Rural Districts:

4.1.1. The district Council representative on the PHC to establish a District Health Co-ordinating Committee, with representatives from each of the local authorities in the District, and that the District office provide secretariat for the committee (this structure will be replaced by the District Health Council when the provincial legislation is passed);
4.1.2. The representatives of the local authorities on the District Health Co-ordinating Committee establish sub-district health fora within each local authority area within the districts;
4.1.3. The sub-district health fora co-ordinate the establishment and strengthening of clinic and CHC health committees within the districts.

4.2. Cape Metro:

4.2.1 The MAYCO member for Health in the City of Cape Town establish a consultative meeting with the Cape Metro Health Forum Executive, the Chief Director: Metro DHS and Executive Director City Health on a quarterly basis, in preparation for the PHC meeting (this structure will be replaced by the District Health Council when the provincial legislation is passed);

4.2.2 The Cape Metro Forum Executive meets monthly with the member of the City Health Management Team and the Metro DHS Management Team as ex-officio members, with a standing agenda item at the monthly DEX (Metro District Executive Committee) meeting;

4.2.3 The sub-district health fora be strengthened to optimize the functioning of the clinic and the CHC health committees within the sub-districts;

5. **MONITORING AND EVALUATION**:

The implementation of the plan will be monitored via normal monitoring and evaluation mechanisms within the department of Health, as well as at the Provincial Health Council on a quarterly basis.

6. **CONCLUSION:**

This policy framework needs the endorsement of the Minister and the Provincial Health Council by 30 June 2008. It is proposed that it be implemented as from 1 July 2008.

Appendix 2: Questionnaire

LEARNING BY DOING AND DOING BY LEARNING:

A CIVIL SOCIETY NETWORK TO REALISE THE RIGHT TO HEALTH

Skills and training needs questionnaire

1. How long have you been a member of this health committee?

2. How long have you been a member of any health committee (this committee and any other as well)?

3. What is your current highest educational qualification?

4. Please describe the most important functions of your health committee:

4.a. Do you have the necessary skills to carry out the tasks described above (question 4)? Please specify for which tasks you have the necessary skills and for which tasks you do not have the necessary skills.

5. What do you think a health committee should be doing (in addition to the task described in 4)?

5.a. Do you have the necessary skills to carry out the tasks described above (question 5) Please specify for which tasks you have the necessary skills and for which tasks you do not have the necessary skills.

6. The draft policy framework for community participation/governance structure for health (that is a draft of a law that will set guidelines for health committees' work) says that health committees should carry out the following tasks (listed as A,B,C,D):

    A. "Provide governance as it relates to service provision within the facility/facilities"

6a. How do you understand this task? Please describe in your own words:

6b. Do you have the necessary skills to carry out this task?

Yes No N/A

B. “Take steps to ensure that the needs, concerns and complaints of patients and the community are properly addressed by the management of the facility”

6c. How do you understand this task? Please describe in your own words:

6d. Do you have the necessary skills to carry out this task?

Yes No N/A

C. “Foster community support for the initiatives and programmes of the facility”

6e. How do you understand this task? Please describe in your own words:

6f. Do you have the necessary skills to carry out this task?

Yes No N/A

D. “Monitor the performance, effectiveness and efficiency of the facility/facilities”

6g. How do you understand this task? Please describe in your own words.

6h. Do you have the necessary skills to carry out this task

Yes No N/A

7. Please list the training that you have attended as part of a health committee in the following table:

Training Course	How long was the course?	Who offered the course?	Did you receive a certificate? (Yes or No)	How useful was the training? (Rate on a scale of 1-5, 1 is completely useless and 5 extremely useful)	Please describe briefly why it was useful or not?

8. Which training course/s was/were the most useful you have received whilst a Health Committee member that you feel you are currently using in your role as a committee member?

9. What previous experiences have provided you with skills useful to be a health committee member?

10. What are the six most useful skills that you use most often in your work as a health committee member?

11. When you joined the health committee, did you receive any orientation or induction? Please explain.

12. What training do you think an orientation and induction programme for new health committee members should include?

13. Please tick any of the training below that you think would be useful to you as a committee member:

Role and function of community health committees	
Community participation and mobilisation in health	
Advocacy and Lobbying around health	
Health budgets	
Primary Health Care	
The health system (incl. services offered and the referral system)	
Health promotion, education and awareness	
Problem identification	
Problem solving and decision making	
Developing strategies and plans	
Policy analysis	
Organising events	
Patients rights and responsibilities	
Complaint procedures	
Facilitate cooperation with traditional healers and faith healers	
People skills	
Health rights	
Participatory research methods	

How to address authorities efficiently	
Meeting skills (procedures etc.)	
Minute taking	
Public speaking	
Presentation skills	
Negotiation skills	
Management skills	
Information management	
Basic computer skills (including email/ internet)	
Financial management (including accounting)	
Leadership skills	
Fundraising	
Proposal writing	
Report writing	
Monitoring and evaluation	
Time management	
Conflict management and mediation	
Communication skills	
Workshop facilitation skills	
Project planning and implementation	
Networking skills	
Media advocacy	

Recruiting tactics and skills to get health committee members to persevere	
Administrative duties in reception area	
Assessing health needs	
Environmental health	
Disease identification	
Childhood illnesses (including diarrhoea)	
Childcare (including taking temperature on babies and immunisation)	
Basics of HIV	
Basics of TB	
Basic counselling	
Basics of infectious diseases (such as flu, including swineflu)	
Women's health	
Home based care	
First Aid	
Chronic diseases – causes and management	
Assisting patients with DOT	
Basic knowledge of drugs and substance abuse	
Causes of disease	
Disease prevention	
Dealing with women and child abuse	
Dealing with gangsterism	
Dealing with defaulters (e.g. TB)	

Ethics and confidentiality	

14. Are there any additional training/skills you can think of that have NOT been listed above. Please list them here:

15. What are the six most important training courses you think you would need?

16. Of the above six which would you consider the single most important?

17. Have you been offered any training that you were unable to attend?

17a. If you answered yes to question 17: what was the reason for not being able to attend the training?

18. Is there anything else that you think should be taken into consideration when organising training for health committees?

19. Is there anything else you need to perform effectively as a member of a health committee?

20. Any other comments/suggestions you would like to make:

Appendix 3: Number of health committees in the Cape Town Metropole

Sub-district	Nr of clinics (incl. satellite and mobile clinics)	Number of clinics linked to health committee	Percentage of clinics linked to health
Tygerberg	24 (4)	18	75
Western	23 (3)	11	48
Eastern	18 (3)	11	61
Khayelitsha	13	?6	46
Klipfontain	18 (3)	13	72
Mitchell's Plain	13	11	84
Northern	13	5	38
Southern	26	7	27
Total	148	82	55

Appendix 4: Roles and activities of health committees;

Role	Activities	Nr of H.C. members involved in activity	Nr. Of H.C. members that are not involved in activity, but envision a health committee should be
H.C. assist clinic in carrying out core function and ensure smooth daily running of clinic	a. cleaning, security, physical condition, practical problems at clinic	10	8
	b. administrative work	3	2
	c. assist health workers with health related matters	19	8
	d.assist generally at clinic/volunteer		
	e. assist patients (advice + questions)	23	15
	f. monitor patient flow	9	4
	g. assist in conflict management	2	1
	h. contact defaulters	6	3
	i. 'look at the needs of the hospital'		1
			1
TOTAL		**71**	**33**
H.C. function as 'auxiliary' health worker/community health worker	a. home based care, home visits, deliver medicine at home, look after sick people	33	26
	b. TB carer/DOT supporter	7	
	c. First Aid/emergency responder	8	1
	d. Transport sick people to clinic		3
			1

TOTAL	e. Volunteer at day-care centre	**48**	1 **32**
H.C. function as 'auxiliary social worker'/community social worker	a. assist patients with grants, pensions, ID books, birth certificates b. provide support for vulnerable groups (elderly, abused, children disadvantaged, handicapped) c. Social upliftment projects and events for vulnerable groups (food garden, sewing projects etc) d. Facilitate patient support group d. Counselling/Life still training e.Assist/support community (unspecified) f. House visits to check how people survive. g. encourage people to go to clinic	7 9 27 4 5 2 **54**	9 9 2 13 1 1 **35**
H.C. involved in projects, programmes and health awareness	a. Health awareness b. Health projects/promotion/campaigns and events	51 18 **69**	36 8 **44**
Support clinic and health systems in improving Health and Health services	a. Support clinic in goals of community health b. Support health officials in supplying adequate health service to community	1 1 **2**	1 1 **2**
Management of Resources	a. Fundraising b. Budget (allocation of resources)	18 0 **18**	10 2 **12**

Information gathering and exchange TOTAL	a. Information to patients (service, opening hours, issues at clinic) b. Information to clinic about health needs of community c. Communication between clinic and community d. Information to DoH and environmental health officer about health issues in community	14 5 3 2 **24**	4 7 **11**
Ensure service delivery/governance TOTAL	a. Ensure service delivery, quality and accessibility (e.g. sufficient staff and equipment) b. Identify/report gaps c. Ensure that facility meet the health needs of community, identify health needs d. Participate in planning, decision-making and problem-solving with management e. Advise clinic f. Coordinate services g. Implement policy h. Outreach to ensure vulnerable groups use facility i. Investigate, identify and address health needs of community	18 11 3 1 1 1 1 1 **36**	11 2 1 11 25 **26**

TOTAL			
Monitor service delivery and quality **TOTAL**	a. Monitor (unspecified)clinic supervision b. Ensure patient satisfaction c. Monitor the way nurses treat patients d. Monitor cleanliness of clinic **e.** 'ensure that community is treated right'	4 5 3 1 **13**	5 8 9 **22**
Address health issues in community **TOTAL**	a. Ensure clean environment (clean streets) b. Provide a network to discuss and address health issues in community c. Monitor health issues in community (TB in crèches) d. Ensure community health/improve health, dealing with health	8 3 5 2 **17**	5 3 1 4 **13**
Network and liaise with other stakeholders **TOTAL**	a. Facility manager b. Staff/health workers c. Health department/government d. Other organisation/stakeholders	6 3 2 3 **14**	2 2 4 **8**
Deal with complaints	a. Deal with complaints (un-specified) b. Receive, record complains, forward to manager c. Assist with reporting complaints d. Address/participate in addressing/solving complaints e. Keep stats on complaints f. Make people aware that they can complain	6 8 3 14 2	10 2 2 1

TOTAL	g. Manage complaints	1 **34**	 **15**
Ensure satisfactory health worker environment		5	
Ensure/foster community participation **TOTAL**	a. Promote community participation b. Ensure health committee is visible c. Become more involved with community	7 1 **8**	 2 3 **5**
Advocacy and lobbying **TOTAL**	a. Lobbying/advocacy (unspecified) b. Fight against closure of clinic	1 1 **2**	3 **3**
Ensure human rights are not violated		1	4
Liaise between clinic and community (be the voice of the community)		22	6
Influence policy	a. Generally b. Should be involved in Health bill		1 1
Not sure/would like to know more		3	2
Promotion of primary health care		1	
N/A, unanswered		10	2

Appendix 5: Health committees' role in ensuring service delivery

Activity	Health committees role in activity	Health committee members currently involved	Health committee member that would like to be involved
Ensure service delivery/governance	Ensure service delivery, quality and accessibility (e.g. sufficient staff and equipment)	18	11
	Identify/report gaps	11	2
	Ensure that facility meet the health needs of community, identify health needs	3	
	Participate in planning, decision-making and problem-solving with management	1	
	Advise clinic	1	
	Coordinate services	1	
	Implement policy	1	1
	Outreach to ensure vulnerable groups use facility	1	
	Investigate, identify and address health needs of community	1	11
TOTAL		**36**	**25**

Appendix 6: Health committees' involvement in complaints

Activity	Health committees' role in activity	Health committee members currently involved	Health committee members that would like to be involved
Deal with complaints	a. Deal with complaints (un-specified) b. Receive, record complains, forward to manager c. Assist with reporting complaints d. Address/participate in addressing/solving complaints e. Keep stats on complaints f. Make people aware that they can complain g. Manage complaints	6 8 3 14 2 1	10 2 2 1

Appendix 7: Health committees' involvement in information gathering and exchange

Information gathering and exchange	a. Information to patients (service, opening hours, issues at clinic) b. Information to clinic about health needs of community c. Communication between clinic and community d. Information to DoH and environmental health officer about health issues in community	14 5 3 2	4 7
TOTAL		**24**	**11**

Appendix 8: Participatory roles

'Limited participation'	Assist facility	83 (19%)
.....	Support Facility	20 (5%)
.....	Fill a gap in health system	102 (23%)
	Information exchange	99 (22%)
Partly participatory	Advisory capacity	1 (0.2%)
'Meaningful participation'	Joint participation	49 (11%)
	Has oversight function	19 (4 %)
Independent role	Acts independently	20 (5 %)
	Networks with others	44 (10%)

Appendix 9: Health committee members' involvement in task described in Draft Policy

Task according to Draft Policy	Corresponding task described by health committee members	No. of respondents involved	Percentage of HC members involved in task
"Provide governance as it relates to service provision within the facility"	Ensure service delivery, quality and accessibility Participate in planning, decision-making and problem-solving Advise clinic	20	8
Take steps to ensure that the needs, concerns and complaints of patients and the community are properly addressed by the management of the facility;	Ensure that facility meet the health needs of community Address/participate in addressing complaints	19	8
Foster community support for the initiatives and the programmes of the facility/facilities	Health projects/promotion/campaigns and events Liaise between clinic and community	18 22	7 9
Monitor the performance, effectiveness and efficiency of the facility/facilities	Monitor service delivery and quality	13	5

Appendix 10: Health committee members' understanding of Draft Policy

Task	Understand	Do not understand	Unanswered, N/A
Provide governance as it related to service provision within facility clinic	107 (43 %)	100 (41 %)	39 (16 %)
Take steps to ensure that needs, concerns and complaints of patients and community are properly addressed by the management of the facility	187 (76 %)	27 (11 %)	32 (13 %)
Foster community support for the initiatives and programmes of the facility.	163 (66 %)	37 (15 %)	46 (19 %)
Monitor the performance, effectiveness, and efficiency of the facility.	154 (63 %)	42 (17 %)	50 (20 %)

Appendix 11: Analysis of health committee members' understanding of tasks in Draft Policy

Task	Understand	Partially understand	Do not understand	Unanswered N/A
Provide governance as it related to service provision within facility clinic	11 (4 %)	21 (9%)	175 (71 %)	39 (16 %)
Take steps to ensure that needs, concerns and complaints of patients and community are properly addressed by the management of the facility	16 (6 %)	69 (28%)	83 (34 %)	78 (32 %)
Foster community support for the initiatives and programmes of the facility.	25 (10 %)	55 (22 %)	58 (24%)	108 (44%)
Monitor the performance, effectiveness, and efficiency of the facility.	11 (4 %)	54 (22%)	80 (33%)	106 (43%)

Appendix 12: Educational level of health committee members

Educational level	Numbers	Percentage of total
Have not finished primary school	10	4
Have not finished high school	130	52
Matric	56	23
Post-matric qualification	38	15
Not answered	12	5

Appendix 13: H. C. members possessing skills necessary to carry out current role

	Numbers	Percentage of total
Have skills	94	38
Do not have skills	45	18
Have some skills/need more	29	12
Blank, N/A, spoilt	79	32

Appendix 14: Health committee members possessing skills necessary to carry out envisioned role

	Numbers	Percentage of total
Have skills	76	31
Do not have skills	64	26
Have some/need more	21	9
N/A, spoilt, blank	85	34

Appendix 15: Health committee members possessing skills to carry out tasks in Draft Policy

	Task 1	Task 2	Task 3	Task 4
Have skills	79 (32 %)	117 (48 %)	107 (43%)	101 (41 %)
Do not have Skills	77 (31 %)	72 (29 %)	77 (31 %)	73 (29 %)
Have some skills/need more skills	3 (1%)	8 (3%)	49 (20%)	5 (2%)
Blank, N/A, spilt	87 (35%)	49 (20%)	13 (5%)	67 (27%)

Appendix 16: Training requested by health committee members

Role and function of community health committees	198
Patients rights and responsibilities	186
Health promotion, education and awareness	180
Complaint procedures	169
Problem solving and decision making	166
Health rights	166
Community participation and mobilisation in health	164
Primary Health care	162
Health Budgets	160
Problem identification	157
Disease identification	157
Fundraising	156
The health system	155
Basic computer skills (including email/ internet)	154
Dealing with women and child abuse	154
People skills	151
Recruiting tactics and skills to get health committee members to persevere	150
Assessing health needs	149
Leadership skills	149
Meeting skills (procedures etc.)	148
Organising events	146
Proposal writing	146
Report Writing	146
First Aid	146
Proposal writing	146
Report writing	146

Basics of TB	145
Public speaking	144
Childhood illnesses (including diarrhoea)	144
Basics of HIV	143
Advocacy and lobbying around health	143
Basics of infectious diseases (such as flu, including swineflu)	142
Home based care	142
Communication skills	142
Basic knowledge of drugs and substance abuse	141
How to address authorities efficiently	140
Presentation skills	140
Management skills	140
Dealing with defaulters (e.g. TB)	139
Ethics and confidentiality	139
Negotiation skills	138
Project planning and implementation	138
Basic counselling	137
Women's health	137
Minute taking	135
Disease prevention	135
Environmental health	134
Conflict management and mediation	134
Financial management (including accounting)	131
Chronic diseases – causes and management	129
Networking skills	129
Monitoring and evaluation	128
Policy analysis	127
Information management	126

Assisting patients with DOT	125
Administrative duties in reception area	123
Dealing with gangsterism	123
Time management	121
Causes of disease	120
Facilitate cooperation with traditional healers and faith healers	117
Media advocacy	117
Participatory research methods	116

Appendix 17: Years of service of health committee members

	Nr of health committee members	% of hc members
Less than 1 year	76	31 %
1-2 years	40	16 %
2-5 years	44	18%
More than 5 years	76	31 %
Unanswered, N/A	10	4 %

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