Rapid appraisal of health committee policies in South Africa

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Introduction

Community participation in public health delivery has a long history in South Africa. With the National Health Act 2003, health committees at the primary health care level became statutory bodies. However, research (Padarath and Friedman 2008, Boulle 2008, Haricharan 2012) suggests that these structures are not functioning optimally and that their participation is often 'limited' in that they are not involved in decision-making processes or in ensuring that the needs of their communities are met. Lack of clarity regarding their role and function has been identified as one of the main reasons for their limitations. It has been posited that this could potentially be linked to health committees existing in a policy vacuum. The National Health Act stipulates only composition of health committees, but leaves it to provincial legislation to stipulate the role and function of health committees. The purpose of this report is to present a status of provincial health committee policies, draft policies or guidelines for health committees. It compares existing provincial policies with regard to composition, role and function, formation of health committees, and support available to health committees.

Background

Community participation and legislative framework for health committees

Community participation in health 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 and 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

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> 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" (emphasis added). It also emphasises the importance of establishing mechanisms to improve accountability as well as promote dialogue and feedback between the public and health providers.

Health committees became statutory bodies through the National Health Act of 2003 (no. 61 of 2003). Section 42 of the Health Act 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.

However, provincial legislation has been 'in varying stages of development' as noted by Padarath and Friedman (2008). For instance, in the Western Cape a draft policy was written in 2008, but not implemented. In 2011, the provincial health department took a decision not to implement the draft policy, but rather amend the Health Facility Boards Act to provide a legislative framework to health committees.

Benefits and challenges of community participation

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 suggests that 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, while Gryboscki et al (2006) suggests that community participation can result in more equitable health outcomes. 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." (.....) David McCoy et al (2011) conducted a systematic review of health

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committees and concluded that these have the potential to impact positively on improving health services.

Despite this, community participation is fraught with problems and in many cases both ineffective and limited. A number of studies suggest that health committees in South Africa are not functioning optimally (Padarath and Friedman, 2008, Glattstein-Young, 2010, Haricharan 2011). 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, limited participation by facility managers and local government councillors, 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.

Several studies emphasise lack of consensus 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. Haricharan (2011) suggests that health committees' participation is 'limited' because they have limited involvement in decision-making, but rather act as a voluntary workforce.

Research also identified lack of clarity on role and function of health committees as a major barrier for effective community participation through health committees (Haricharan, 2012, Glattstein-Young 2011). Haricharan linked this lack of clarity amongst health committees in Cape Town to lacking (provincial) legislation for health committees.

Research justification, research question and method

Acknowledging the impact of a policy vacuum on health committees in Cape Town, The Learning Network on Health and Human Rights, a network of academics and civil society organisation, decided to do a rapid appraisal of health committee policies in South Africa's nine provinces to gain a better understanding of the policy issue nationally. The aim of the appraisal was to:

1) Identify which provinces had legislation, draft legislation or guidelines on health committees.
2) Analyse existing policies, draft policies and guidelines to develop benchmarks for role and function of health committees.

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3) Compare commonalities and differences in provincial legislation, draft legislation and guidelines.
4) Assess to what degree policies are allowing for forms of meaningful participation, including ensuring that health committees are representative structures.

The rapid appraisal was conducted between November 2012 and March 2013. Telephonic interviews were conducted with representatives of all nine provincial health departments. A snowball method was used to identify people with knowledge of health committee policies, draft policies and guidelines. Where these existed, copies were requested, and compared and analysed.

Framework for understanding community participation

As one of the aims of the rapid appraisal was to analyse to what extent policies allow for meaningful participation, what follows is a conceptual framework for how this appraisal understands meaningful participation.

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. The conceptualisation of participation used in this appraisal is based on three authors: Rifkin (1986), Arnstein (1969) and Potts (2009). Potts, Rifkin and Arnstein share an understanding of meaningful participation as entailing participation in decision-making and a shift in power.

Sherry Arnstein's *A ladder of Participation (1969)* 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.

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.

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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.

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?

This report uses the term meaningful community participation. It acknowledges that there are many different forms of participation and that South African health committees constitutes a specific form of community participation as health committees are linked to the health services, or more specifically to local clinics. It therefore makes sense to talk about community participation in health governance in relation to health committees. Drawing on Rifkin, Arnstein and Potts, the rapid appraisal is based on the following definition of community participation in health governance: community participation in health governance 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. In this context meaningful participation, therefore entails health committees being part of governance (i.e. making decisions, setting the agenda, identifying problems, finding solutions etc) as well as structures ensuring accountability through monitoring and evaluating services. This conceptualisation entails that health committees are representative

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structures meant to ensure that the views and needs of the community is heard and taken into account.

Findings

The table below provides an overview of existing policies, draft policies and guidelines:

Province	**Policy/draft/ guidelines exist**	**Form**
Eastern Cape	Yes	Policy
KwaZulu-Natal	Yes	Section in provincial Health Act
Free State	Yes	Section in provincial Health Act
Mpumalanga	Yes	Guidelines
Gauteng	Yes	Draft guidelines
Limpopo	Yes	Policy (we were told policy exist, but have not received copy)
Western Cape	No	Provincial Health Department in process of amending Health Facility Boards Act
North West	?	We have not been able to verify existence of policy
Northern Cape	?	We have not been able to verify existence of policy

As the table shows, six of nine provinces have legislation, draft legislation or guidelines. One province, the Western Cape, has no policy, but a process to create a legislative framework through amending the Health Facility Boards Act has been initiated. In the remaining two provinces, North West and the Northern Cape, we found no evidence of legislation.

The polices, draft policies and guidelines vary in length and in content The Eastern Cape, for instance has a 28 page policy on the establishment and functioning of clinic and community health centre committees, while the Kwazulu-Natal Provincial Health Act contains two pages on health committees (called Clinic or Community Health Centre Committees).

Role and function of health committees

Provincial policies also vary in detail on role and function. However, there are some commonalities worth noting. Firstly, all the existing policies contain an aspect of what could be considered health committees carrying out a governance function. The list below provides an overview of functions that can be considered 'governance function' in the various policies.

Province	Governance Function
Eastern Cape	• Oversee adherence and provision of the primary health care packages

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	• Identify health related problem in the community for purposes of planning and inform the health facility accordingly
Kwazulu-Natal	• Oversee the administration of human resources, financial resources, assets, facilities and the general affairs of a clinic or community health centre
Free State	• Advise management of the health facility within its area of jurisdiction • Review and approve local health delivery plans
Mpumalanga	• Support PHC facility management with policy and strategy formulation • Provide expert advice and inputs to the PHC facility management
Gauteng	• Advise the management on the formulation of PHC facility policies and strategies • Participate in strategic planning and operational processes with a view to advising the management • Ensure that measures are taken by management to improve the performance and quality of services • Take measures to ensure that needs, concerns and complaints of clients and the community are properly addressed by management

There are also commonalities with regard to health committees' oversight role, as the table below shows.

Province	Oversight role
Eastern Cape	• Monitor and report the extent the health facility is meeting and achieving the health indicators and targets set for primary health care • Receive regular reports on the performance of facility management in meeting the objectives of the facility as determined by achievement of indicators and targets • Monitor the extent to which the management of the health facility addresses and resolve complaints submitted by communities and or patients • Monitor adherence of the health facility to departmental opening and closing times • Monitor the effectiveness of routine channels of communication between management and communities • Hold management accountable for implementing decisions taken in committee meetings
KwaZulu-Natal	• Report any maladministration of a clinic or community health centre to the responsible Member of the Executive Council (MEC) • Provide the responsible Member of the Executive Council with bi-annual report on the performance of clinic and community health centres
Free State	• Investigate administrative complaints in respect of a health facility within its area of jurisdiction and make recommendations regarding the solutions of complaints to the District Health Council who must forward them to the MEC if the former is unable to address the complaints • Investigate health service delivery problems in respect of a health facility within its jurisdiction and make recommendation to the District Health Council who must forward them to the MEC if the former is unable to address the complaints.
Mpumalanga	• Monitor the investigation and resolutions of complaints
Gauteng	• Fulfil an oversight role with respect to the performance, effectiveness and

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	efficiency including the maintenance of the PHC facility

Most policies also assign the health committee a networking and liaising role between stakeholders, primarily between the community and the clinic. The table below indicate this.

Province	Network/liaise role
Eastern Cape	• Foster partnership with other community stakeholders with intentions to profile the utilisation of the health facility programmes.
KwaZulu-Natal	• Act as a link in ensuring collaboration with stakeholders in all provincial and national health related initiatives
Free State	• Liaise with and share information with other health organisations and facilities that are situated within the area of local municipality
Mpumalanga	• Forming a close link between the community and PHC Facility • Expand community participation by means of open Committee meetings, and open days at the PHC Facility, in conjunction with the PHC Facility Management • Ensure report-back meetings and the dissemination of information to the community through meetings and wide dissemination of annual reports.
Gauteng	• To (give) feedback to the community together with the head of the facility • Build support for the PHC facility by fostering partnership in the wider community

Three provinces, stipulate that health committees must raise funds either for the facility, the committee or primary health care activities, shown in the table below.

Province	Fundraising/sponsorship
Eastern Cape	• Develop a fundraising policy to enable to the committee to raise funds to promote primary health care activities • Raise and manage the committee funds in terms of Treasury guideline and in compliance with the Public Finance Management Act requirements
Mpumalanga	• Raise additional funds for the PHC Facility in accordance with relevant legislation and prescripts and assist management in deploying these funds appropriately • Improve patient facilities through sponsorship of relevant needs
Gauteng	• Raise additional funds for the PHC Facility in accordance with relevant legislation and prescripts and assist management in deploying these funds appropriately.

Two provinces, Eastern Cape and Mpumalanga, stipulate that health committees should 'represent' the clinic or act as an 'advocate' for the clinic. See table below for details:

Province	Represent/advocate for clinic
Eastern Cape	• Always act in the best interest of communities by advocating the utilization of

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	primary health care services as the first point of entry of health care • Represent the interests of clinics within the catchment area of the CHC by sending one representative per cluster of three clinics to be an ex officio member in the CHC committee (CHC refers to community health centre committees. i.e. day hospitals, covering a larger geographical area than clinics) • Represent the interest of their clinics within the catchment area of the district hospital by sending one representative to be an ex officio member to the Hospital Board of a District Hospital.
Mpumalanga	• Act as advocate of PHC Facility interest to the community at large
Gauteng	• Act as advocate of PHC Facility interest to the community at large

Three provinces, Eastern Cape, Free State and Mpumalanga specify that health committees should assist patients with complaints and providing a platform to hear complaints. While complaints form part of the oversight role, the provisions below relate to assisting patients and provide forums to hear complaints, but does not contain any prescription of dealing with or ensuring that complaints are addressed.

Province	Assist patients with complaints
Eastern Cape	• Provide a platform for patients and community to air their grievances by following the departmental complaints procedure
Free State	• Assist users in following the complaints procedures
Mphumlanga	• Provide a forum to hear commendations and complaints of patients and the community at large

The Eastern Cape, the province with the most detailed roles and functions, also has a section on social mobilisation with the following roles:

- Develop strategies to strengthen ownership and support of the health facility amongst local communities to ensure that the facility is utilised effectively.
- Sensitises communities about the presence, activities and programmes of community health committees that are geared towards the implementation of primary health care services.
- Facilitate community health meetings for the purpose of giving feedback (taking mandates from the community).
- Mobilise communities to report any health hazards or challenges around their families, schools and catchment area that need the urgent attention of the health facility.

The guidelines from Mpumalanga require that the health committees should do the following:

- Provide a visible presence at the PHC Facility on a regular basis to build relations with staff and gain an understanding of PHC Facility working conditions in order to enhance community participation in PHC Facility affairs.
- Take an active interest in the welfare of patients and the development of an ethos of caring at all levels in the Facility.

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Composition of health committees

The National Health Act stipulates that a health committee should be composed of community members, facility manager(s) and local ward councillor(s). Three provinces follow the National Health Act with regard to composition, viz. health committee is composed of facility manager, ward councillor and community member. However, two provinces, Free State and Eastern Cape have policies that deviate from this composition. Instead, their policies suggest that health committees should be composed of representatives from certain sectors. The table below shows which sectors are represented in the two provinces.

Sector	Eastern Cape	Free State
Traditional leaders	√	
Local government councillor	√	
Facility management	√	√
Organized labour	√	
A local government councillor responsible for health and community services	√	
Representative for CBOs	√	
Representative for religious community	√	
Representative from traditional practitioners/leaders	√	
Representative for women's groups	√	
Representatives for youth formations	√	
Representative for NGOs	√	
Representatives for disabled persons/organisation of people with disability.	√	√
Representative for local business community		√
Traditional health practitioners council		√
Representative for ward committee responsible for health issues		√
Two community members (users)		√
Not more than three members with expertise in health services		√

Formation of Health Committees – nominated or elected

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Policies vary with regard to how health committees are formed. There are three approaches. In the Free State, Mpumalanga, and KwaZulu-Natal, committees are appointed by the MEC for health after being nominated by stakeholders. In the Eastern Cape, delegates representing various organisations and constituencies elect the committee. The Gauteng policy is not clear on formation. It talks about the committee being elected by the local community, but also about the MEC appointing after receiving nominations.

The table below provides an overview.

Province	Formation of health committee
KwaZulu-Natal	• The responsible Member of the Executive Council must, by notice in the Gazette and within 12 month after the coming into operation of this Act, establish a clinic or community health centre for each clinic or community health centre or for a group of clinics or community health centres in the Province.
Free State	• The MEC must, after consultation with District health council, establish a clinic committee for a ward in which a clinic is situated.
Mpumalanga	• The MEC will appoint the Committee after receiving nomination from stakeholders.
Eastern Cape	• Participants to elect office bearers (committee members) will be delegates representing various organizations and constituencies in the catchment area.
Gauteng	• Members to be elected by the local community served by the PHC facility. • The MEC will appoint the committee after receiving nomination from stakeholders.

For most provinces, policies do not contain a clear process for how committees are formed – whether elected or nominated. The Eastern Cape is the exception with a detailed process, leaving the responsibility of forming an organizing committee (to organise elections) to the facility manager. This includes responsibilities of various stakeholders in the process.

Support for health committees

Three provinces have provisions in their policies for some form of financial support for health committees. These are KwaZulu-Natal, Mpumalanga and Gauteng. The financial support comes in the form of reimbursement for travel costs and other expenses, as well as allowances. In the Free State and the Eastern Cape, no provision is made for financial support.

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Province	Financial support
Mpumalanga	• The MEC shall, with the concurrence of the MEC of Finance determine the fees, allowances and other payments payable to members of the committee.
Gauteng	• The MEC shall, with the concurrence of the MEC of Finance determine the fees and other payments payable to members of the committee for Travel and incidental expenses of members which may be revised from time to time. • Members will be paid an hourly allowance for attending regular meetings and for other time dedicated exclusively to the work of the facility.
Kwazulu-Natal	• A member of the clinic or a community health centre committee may, in respect of his or her functions as a member, only receive reimbursement for reasonable actual subsistence and travelling expenses necessitated by the actual attendance of a meeting of the clinic or a community health centre committee.
Free State	• None
Eastern Cape	• None

Other forms of support, such as secretariat support, are provided in Mpumalanga, Gauteng and Eastern Cape. In KwaZulu-Natal and the Free State, the policies do not specify any support provided for health committees.

Province	Support
Gauteng	• The head of the PHC facility will provide Health Committee members with access to telephone, fax, computers (if available) and photocopier to facilitate the smooth running of the committee. • The Head of the PHC facility will provide the secretariat for the committee. Should the head of the PHC Facility be absent at any meeting he is to send a representative.
Mpumalanga	• The Committee shall appoint the head of the PHC Facility as the secretary. The head of the PHC Facility will provide the secretariat. Should the head of the PHC Facility be absent at any meeting he is to send a representative.
Eastern Cape	• The office of the Hon MEC for Health will put in place processes and systems that will ensure that elected members are empowered to carry out their mandate. • Facility management must facilitate and provide venue and necessary logistics for the meetings of the committee. • Ensure that secretariat support is provided to the committee to render committee work.
Free State	• None
KwaZulu-Natal	• None

Only one province, the Eastern Cape, has made provision for training of health committees.

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Terms of Office

All provinces have three years term of office. Furthermore, in the Eastern Cape, the policy prescribes that 1/3 of the serving members should be retained in order to ensure continuity of the committee. In Mpumalanga, the MEC may ensure continuity by retaining members. In addition, all provincial policies besides Kwazulu-Natal have rules for vacancies and termination of membership.

With regard to meetings, three provinces state that health committees should meet monthly (Free State, Gauteng and Eastern Cape). The policy in Mpumalanga states that health committees should meet quarterly, while Kwazulu-Natal's provincial health act suggests minimum three times a year.

Linkages with other structures and responsibilities of stakeholders

Only one province, the Eastern Cape, suggests that health committees should be linked to other structures. Thus, the Eastern Cape policy provides for the establishment of sub-district health fora and a District Health Forum to facilitate co-ordination of the activities of the clinic committees. It is the District Health Forum's responsibility to submit reports about the activities of the clinic and community health centre committees to the District Portfolio Councillor for Health via a subcommittee of the District Health Council.

The Eastern Cape is also the only province, which stipulates role and responsibilities of various stakeholders in relation to the health committee. The stakeholders listed are the health facility management team, organised labour, district portfolio councillor, councillors, health district manager, and sub-district manager,

Discussion:

Roles and responsibilities

The findings show that there is consensus on the following roles: governance, oversight and strengthening community participation. Thus, all existing policy documents contained aspects of these roles. Some policies could expand on health committees' role as oversight structures. For instance, there is no consensus on whether oversight entails both being involved in complaints, and monitoring services at the local clinics. Some provincial policies allow for health committees to be involved in complaints, but not monitor services (Mpumalanga), while for instance Gauteng's policy stipulates that health committees should play a monitoring role, but the policy does not indicate that they should be involved in complaints..

Overall, the policies suggest a conceptualisation of health committees consistent with a view of meaningful participation, as adopted in this report, namely that health committees should be

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governance structures, ensuring that the voice of the communities are heard, and promote accountability.

It is evident that health committees' sphere of influence is at a local level – at the clinic level. While health committee policies grant health committees considerable influence at facility level, it is evident that their influence is limited as there are no linkages to other governance structures and for health committees' views to be heard at a higher level such as in District Health Councils or Provincial Health Councils.

Interestingly, only the Eastern Cape policy conceptualises health committees as structures that should also address the social determinants or the underlying causes of ill health.

It is important to note that there is some discrepancy between the governance and oversight role described in most policies and the role many health committees currently play. Research has identified that health committees often support the clinics with day-to-day tasks and have limited say in decision-making (Haricharan, 2012). Padarath and Friedman (2008: 48) noted that clinic committees were involved in activities such as problem-solving between staff and community, health education, volunteering, home based care, DOT support and community gardens. They concluded that clinic committees do not fulfil their intended role of being involved in the planning, prioritizing and managing of health service, contributing to the development of district health plans and partnering with health staff, to strategically guide the operation of the clinic to make it more responsive to the needs of the community.

Provincial policies contained numerous other roles such as advocacy, fundraising, health promotion and social mobilisation. Should health committees be responsible for fundraising or ensuring sponsorship? Is it reasonable to expect marginalised, resource-deprived communities to raise funds for primary health care activities or for their committees? Research has shown that health committees suffer due to financial constraints and that members often struggle to attend meetings due to this. As Potts (2011) argues, people should not be obliged to pay for 'the cost of participation', including raising funds related to the cost of running a committee.

Another contentious issue, which the findings bring to the fore, is that many health committees are seen as advocates for the clinic, but more rarely as advocates for the community. This contrast with the view that health committee members are community representatives and that their role is to ensure that community voice is heard and the clinics respond to community needs, not the other way around.

Composition

Another critical aspect is the composition of health committees. There are two approaches with regard to composition. Three provincial policies follow the composition outlined in the National Health Act (facility manager, ward councillor and community representatives). Two provinces have representatives for specific sectors, henceforth called the 'sector approach'. In other words, these sectors have pre-designated seats on the committee. No rationale is given for why certain sectors are represented, but it is clear that stakeholders considered to be important partners are one group

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(e.g. NGOs, churches, traditional healers). Another group consists of vulnerable groups such as the disabled.

The sector approach may have advantages such as helping groups coming together and solidify community engagement. However, consideration needs to be given to the rationale behind the composition. There may be advantages in selecting certain groups because they represent particular vulnerable/marginalised groups or because their co-operation with the health services is needed. However, there are other marginalised groups that are not represented – such as refugees and sexual minorities to mention two. There may also be vulnerable groups that are not represented by community organisations and would not be represented on the committee due to sector representation. With regard to stakeholder-representation, there is a lack of rationale behind which stakeholders are represented. While it may make sense to have churches and businesses represented, it is worth questioning why other stakeholders such as health workers and environmental health officers are not represented. Again, there should be a rationale for inclusion/exclusion criteria of stakeholders.

It would be worth considering outlining principles for composition rather than pre-designated sector representations. These principles could relate to broad/fair representation of sectors present in the local area, based on principles such as diversity and striving for representation of vulnerable and marginalised groups.

An argument for the sector approach (which has come up in discussions with representatives) is that these 'sector' representatives are accountable to the sectors in the communities that they represent and accountability is therefore enhanced. However, a counter-argument would be that this is a limited form of accountability as it is only accountability to certain organised groups within a community rather than the community per se. Thus, it would be worthwhile to consider other ways of ensuring a more inclusive form of accountability.

Irrespective of which approach is chosen, it may be valuable to outline the principles and rationale behind these. As health committees are conceptualised as structures representing community interest, composition need to ensure that these committees' represent all sectors of the community. Thus, even if committees do not take a sector approach, committees could still strive to have broad community representation and principles of ensuring that the needs of vulnerable groups are met. Composition of health committees should reflect an understanding of what health committees are and what principles they embody. If these are to be representative bodies, accountable to communities, then the principles of representivity and accountability should guide composition. More knowledge is needed on the advantages or disadvantages of the sector-approach and the composition outlined in the National Health Act.

Interestingly, the Eastern Cape policy deviates from the National Health Act with regard to the local government representative. The Eastern Cape policy suggests that a local councillor responsible for health and community services should be represented. While it may make sense to have a councillor responsible for health on the health committees, it is questionable how feasible this is as there are limited numbers of councillors responsible for health. More knowledge is needed on how this works in practice.

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Formation of health committees: Elected or nominated

It should be noted that there is no consensus on whether health committees are elected or appointed. The most common approach to forming a health committee is for the MEC to appoint members after these have been nominated by stakeholders or after consultation with the District Health Council. In the Eastern Cape, stakeholders elect the committee. The Gauteng policy is unclear whether health committees are formed through elections or through appointment.

Little is known on the formation of health committees in practice and how the different approaches work. However, it is evident that having the MEC appoints members – whether this is after consultation with stakeholders or consultation with the District Health Council – is not ideal for meaningful participation and community ownership. There are at least two reasons for this. Firstly, it is difficult to reconcile this approach with an understanding of health committees being representatives of *communities.* Clearly, as structures representing communities, they should be selected/elected by communities rather than through a top-down approach through the MEC appointing them. Even when these appointments are based on nominations from relevant stakeholders – or organisations and constituencies in the catchment area - it is difficult to envision them as truly 'representative' structures. Again, having certain stakeholders nominating members may limit inclusivity.

Furthermore, it is difficult to see how an MEC would have the knowledge and capacity to appoint health committees for each and every clinic. In the Cape Town Metropole alone, there are more than 150 clinics. There is limited – if any – knowledge on how the appointment process is practiced. It is unrealistic to expect that the MEC has sufficient knowledge to appoint members. A likely scenario would be that he/she delegates the responsibility. This raises the question of who is responsible for selecting nominees. Research in the Cape Town metropole (Haricharan, 2012) indicates that facility managers often play a role in selecting health committee members. One of the consequences of this is that health committees are often closely aligned with the facility rather than representing the community. This raises the question of whether facility managers are an 'influential' stakeholder that the MECs rely on to appoint members. Such a practice is dubious as it is impossible to reconcile with health committee as representing communities.

As with composition of health committees, more research is needed to understand how health committees are formed. An approach that ensures that these structures represent communities is imperative for the realisation of health committees as vehicles for effective community participation.

Minimal support for health committees

Provincial policies vary greatly in their logistical and financial support to health committees, but overall there is minimal support for health committees. This is an issue of concern. Only three provinces have made provision for reimbursement of expenses such as transport cost or, in the case of Gauteng, an allowance. Research has consistently shown that lack of reimbursement for expenses

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such as travel cost is a major barrier for health committees, as many committee members cannot afford to pay for their own transport (Padarath and Friedman, 2008; Glattstein-Young, 2011; Haricharan, 2011). In many cases, this results in poor attendance at meetings and sometimes members resigning. It is important to keep in mind that health committee members often come from disadvantaged communities and it seems unfair that they are obliged to 'pay for the cost of participation'. Furthermore, lack of reimbursement may impact on representivity as it is likely that the poorest section of a community that struggle the most will not be able to pay for their own transport.

Three provinces have clauses in their policies that oblige the PHC facility to provide secretariat support to the committees. Furthermore, in Gauteng the policy states that the health committee should have access to telephone, fax, computers and photocopier to facilitate the smooth running of the committee. How any of these forms of support work is unknown. However, it is important that health committees do have support as lack thereof is another barrier for well-functioning committees (see Padarath-Friedman, 2008; Glattstein-Young, 2010; Haricharan, 2011).

Of note, two provincial policies state that the head of the PHC facility must be the secretary of the committee. This is in contrast with other provincial policies that suggest that the facility manager should be an ex-officio member. Again, little is known about how the policies are implemented and whether having the facility manager as the secretary is a workable solution.

Research has identified the lack of a venue to hold meetings as a barrier for many health committees (Haricharan, 2012). Yet, only one policy stipulates that the facility should provide a venue. On a more general note, there is sufficient evidence to suggest that lack of logistical support impacts negatively on the functioning and sustainability of committees.

The Eastern Cape policy states that "The office of the Hon MEC for Health will put in place processes and systems that will ensure that elected members are empowered to carry out their mandate." While this significant statement acknowledges the need to ensure that health committee members are capacitated for their role/mandate, the detail of its execution is missing. Very little is known about how health committees are empowered.

The Eastern Cape is the only province that makes provision for training with the following paragraph: "The training and induction of new clinic community health centre committee members shall take place within a period of three months from the date of appointment of the committee." While training is important, and it is commendable that the Eastern Cape policy acknowledges this, the policy provides no clarity on whose responsibility it is to organise and conduct training. Neither does the policy suggest how training should be funded.

In other provinces, policies are silent on training of health committee members. This is a serious ommission. Again, considerable research highlights the need for health committee members' capacitation to fulfil their role. A number of studies (Padarath and Friedman, 2008; Boulle, 2007; Haricharan , 2011) confirm that often committees are unsustainable due to the lack of requisite skills. Cognisance must be taken of health committee members' educational background and that they often come from 'marginalised' communities. Hence, training is of utmost importance not only to create functioning committees but also to ensure an inclusive and fair process.

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No linkages to other health governance structures and stakeholder responsibility

This appraisal suggests that health committee policies do not provide for health committees to be linked to other governance structures. Furthermore, there is only provision for umbrella bodies or co-ordinating bodies in one province, the Eastern Cape. In this province, health committees (called clinic committees) are represented at community health centre committees and the District Health Council. The latter is particularly important as it provides health committees with an avenue to address health issues at a higher level.

The weak linkages in other provinces are of concern. Firstly, the lack of umbrella bodies and overarching structures to co-ordinate, oversee and support health committee, could significantly weaken these structures. Without these structures, health committees could end up being local structures with no link to the wider health system. There is also no 'space' for sharing experiences and discussing topics which has relevance more broadly. Furthermore, issues and problems which may occur at a local level but require intervention at a higher, systemic level may not be raised at this level. This will in effect render health committees less effective. It is difficult to see how health committees can represent communities at this level. This is particularly relevant to the policy context.

It may be worth exploring how a tiered health governance system in which representatives from local tiers are represented at district, provincial and national levels, would work. This would make for a more coherent and integrated health governance system.

If communities are to participate effectively in health governance it is important that their views be considered and the trends in the problems they raise be considered across the health system. For example representatives from health committees or their representative bodies should be able to provide inputs and raise issues, along the hierarchy, at the district health council, the provincial consultative health forum, the provincial health council or even the National Health Council. For meaningful participation and inclusive governance, it is crucial to understand the alignment of all these health structures, their relationship, and effectiveness.

Only the Eastern Cape policy assigns certain responsibilities to stakeholders, such as facility managers. It would be worth considering how this impacts on the effective functioning of health committees, and more knowledge is needed on this issue.

Conclusion and recommendations

The rapid appraisal reveals that there is consensus that health committees should play a governance role. It is necessary to expand on what this role entails. For instance not all policies talk about accountability or stipulate how health committees could be involved in monitoring and evaluating services or in managing/finding solutions to complaints. It should also be noted that there is some

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discrepancy around the formation of health committees and there is a need to look at how the rationale behind the sector approach to composition. It is also worth exploring how accountability can be more inclusive. On that note, there is a need to reflect on how policies best ensure that health committees are 'representative' of the communities they live in and accountable to these. As stated, not much is known about process of forming health committees. Most policies state that health committees should be appointed by the MEC. This may conflict with a view that health committees are representative of the 'communities' served and are an independent voice that can convey the needs of the community.

Finally, the limited financial and other forms of support to health committees require further discourse. That only one provincial policy considers the importance of training health committee members is huge policy gap as there is no doubt that health committees need to be capacitated if they are to play a meaningful role and be effective structures. It is noteworthy that none of these policies consider how health committees fit into the bigger picture of the health system. Are they intended only to function at the primary/clinic level or should their voices also be elevated through the vertical health system at district, provincial and national levels. If so, what are the avenues for this to happen? Finally, it would be worth considering whether the Eastern Cape policy stipulating stakeholders' responsibilities in relation to health committees is something worth emulating in other provinces.

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