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IMPROVING PRIMARY HEALTH CARE THORUGH COMMUNITY PARTICIPATION IN HEALTH

Hanne Jensen Haricharan, School of Public Health and Family Medicine, University of Cape Town, Falmouth Building, Health Sciences Faculty, Anzio Rd, Observatory 7925, South Africa
Hanne.Haricharan@uct.ac.za

ABSTRACT

Community participation is a key tenet in the primary health care approach. Research has shown that community participation can improve health services and outcomes, and ensure a more responsive and equitable health system. South Africa is currently reforming its health system through the introduction of a National Health Insurance (NHI) and the re-engineering of the primary health care system. The aim of this paper is to discuss how community participation can become an effective mechanism in health. The paper begins by outlining different forms of participation and suggesting a distinction between community participation and community involvement. It conceptualises community participation as active engagement in identifying problems, finding solutions and taking part in decision-making. In contrast, it defines community involvement as community members supporting the health system in a voluntary capacity through carrying out tasks defined by the health facility. Based on these definitions, a study of health committees in Cape Town concludes that health committees' role are to a large extent involvement rather than participation. This paper argues that their contribution would have more impact if they were involved in strengthening the health system through meaningful participation, being involved in governance and oversight. The paper links health committees' limited participation to lack of clarity on role and to a policy vacuum with regard to health committees' mandate. The paper then asks whether the NHI can provide this policy framework. It argues that the NHI is problematic for several reasons: 1) it does not take cognisance of current structures for community participation such as health committees, which are statutory bodies, stipulated in the National Health Act (NHA) 2003 2) it is incongruent with a national draft policy on health governance structures 2) its conceptualisation of community participation resembles community involvement. The paper concludes that they NHI needs to rethink its notion of community participation and health committees' role the in the re-engineering of primary health.

INTRODUCTION

"When we as health committee members want to express what is needed in our community, listen, please listen," health committee member, Cape Town.

Benefits of formalised community participation through health committees

The above quote from a health committee member in Cape Town encapsulates an important rationale for community participation, namely the importance of listening to local knowledge and letting people identify their own needs. There is increasing evidence that taking heed of 'local' knowledge through community participation can have a positive impact on the health system. Research has shown that community participation in health has the potential to impact positively on health and health service delivery. Glattstein-Young (2010) demonstrated that some health committees in the greater Cape Town area were able to advance the right to health and improve service delivery. An 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 clinics with health committees generally had more staff, expanded programmes, and better drug availability. She suggested 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. There is also evidence suggesting that more equitable outcomes are achieved when communities are involved (Gryboscki et al, 2006). Lawn et al (2008) argue that community participation is the most neglected aspect in primary health care.

In a literature review, Padarath and Friedman (2008) concluded that community participation provides an opportunity for community members and health care workers to become active partners in addressing local health needs. McCoy et al (2011) infer in a systematic review that "HFCs (Health Facility Committees) are therefore not a simple and ready-made solution to the problems of poor health services. But they *can* have a positive impact provided they are designed and implemented with care." (McCoy, 2011: 13).

Despite the potential impact, community participation is fraught with problems and in some cases both ineffective and limited. 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 impact on their functioning. 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. Some studies emphasise problems around an agreement on what community participation entails. Padarath and Friedman (2008), as well as Glattstein-Young (2010), found divergent views on community participation between health workers and health committee members. 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.

Community participation as part of a primary health care approach in South Africa

In South Africa, community participation is part of a wider health system reform post-apartheid, which aims to move away from a centralised, mainly curative health system, to the establishment of a decentralised district health system. The notion of participation feature prominently in a policy paper called the White Paper on Transformation of the Health System (Department of Health, 1997), which states that active participation is essential in achieving the goal of implementing a primary health care approach.

Importantly, the White Paper conceives that participation entails that communities are involved in "Various aspects of the *planning and provision* of health services" (Department of Health, 1997: chapter 1) [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.

Community participation in South Africa 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. With regard to health committees, the Act stipulates that each clinic/community health centre or a cluster of these should have a health committee, composed of 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 nine provincial governments must develop legislation that stipulates the role and functioning of health committees. At present, six out of nine provinces have included provisions for health committees in Provincial Health Acts, policy papers or guidelines. In 2013, the National Health Department initiated a draft policy for health governance structures. This draft policy conceptualises health committees as governance structures, concerned with planning, oversight and accountability. The policy's intention for community participation structures is a substantive one, as articulated in its two objectives: a) Involve communities in the various aspects of planning and provision of the health service within their local and/or catchment areas; b) Establish mechanisms to improve public accountability and promote dialogue and feedback between the public and health providers, i.e. public hospitals, clinics and community health centres (Department of Health, 2013).

Furthermore, the introduction of a National Health Insurance, which includes a re-engineering of the primary health care, is underway. It is unclear how this will impact on community participation. The policy 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 allocated a certain number of families. The policy Paper (2011) 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." (National Health Insurance Policy Paper, 2011: 26). The policy paper does not mention health committees or other structures, stipulated in the National Health Act.

The Western Cape context

In the Western Cape Province, a Draft Policy Framework for Community Participation/Governance Structures for Health (henceforth the Draft Policy) was developed in 2008, but never implemented. Currently, the provincial Health Department is suggesting an amendment to the Health Facility Boards Act to give legislative effect to health committees. The Draft Policy's description of health committees' role and function is in line with the national draft policy, as they are envisioned to provide governance and oversight (Western Cape Draft Policy, 2008).

A strategic planning framework, "2020 The Future of Health Care in the Western Cape", is also under way. This plan 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 that could include an "active role in governance of health facilities" (Western Cape Government 2012: 21), as well as involvement in campaigns around healthy lifestyles. Of importance to the legal framework for community participation, is also the District Health Councils Act for the Western Cape (2010), which makes provision for the establishment of a District Health Council. However, this Act makes no provision for representation by health committees or articulation between the three sets of participation structures, viz. health committees, hospital boards, and the District Health Council.

Currently, in the Greater Cape Town Metropole, community participation at clinics and community health centres is a three-tiered system. Health Committees constitute the first layer. The second layer consists of eight sub-district health fora with representatives from all health committees in that sub-district. The last layer consists of the Cape Metro Health Forum, constituted by members of the eight sub-district health fora. At present, all these bodies are voluntary structures with no formal status. Previously, the province funded the Cape Metro Health Forum and health committees, however, this funding was withdrawn in 2012 following the province's decision not to implement the policy.

Understanding participation as decision-making

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. This paper will present an understanding of participation based on the work of three authors, viz. Arnstein (1969) Rifkin (1986) and Potts (2009). In *A ladder of Participation (1969),* Sherry 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', designed by those in authority to control any pressure for accountability. 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 advise. 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). 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 programme. Finally, 'citizen control' completes the ladder, where participants govern a program or an institution.

Meanwhile, Potts (2009) defines active and informed participation as including participation in the following: identifying overall health strategy, decision-making, prioritisation, and setting the agenda for discussion. This includes being involved in policy choices, implementation and monitoring and evaluation. For Arnstein (1969) and Rifkin (1986), being part of the decision-making process is also crucial to genuine or meaningful participation. These three authors argue that power-sharing between community members and health managers or officials is essential to meaningful participation.

Aim of paper

The aim of this paper is:

1. To analyse to what extend health committees in Cape Town are engaged in meaningful participation and examine their degree of participation
2. To identify factors that impact on their participation
3. To analyse to what degree current policy initiatives such as the National Health Insurance and the Draft Policy on Health Governance Structures provides for meaningful participation
4. To make suggestion on how to strengthen participation

METHODS

This paper presents data from a study conducted with health committees in Cape Town as well as an analysis of policy context. The study was an exploratory and inductive study. It used multiple methods, combining qualitative and quantitative methods such as in-depth interviews, focus group discussions, participant observations and a survey (questionnaire). In the initial phase, health committees were identified through information from the Cape Metro Health Forum (CMHF) and health facilities. Based on this information, a database of health committees was established.

In the second phase, interviews with key-stakeholders were conducted and three focus group discussions were held with health committee members. 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 qualitative data gained through the focus groups were used both to develop the quantitative component, the questionnaire, and formed part of the analysis.

The questionnaire was divided into four sections, exploring the following issues:
1. Educational and relevant experiences of health committee members;
2. Role and function of health committees;
3. Skills and capacity of health committee members;
4. Barriers to health committee function; and,
5. Suggestions.

Health committee members completed the questionnaire at health committee meetings under the guidance of the researcher. At these meetings informal discussions were held. During these discussions field notes were taken.

The data from the questionnaires was captured in MS Excel. The questions were then post-coded and analysed. The data on role of health committees were analysed according to degree of participation.

Framework for analysing participation

A framework to analyse how participatory health committee activities were, was developed inductively, based on health committees description of what they do, but using Potts (2009), Arnstein (1969) and Rifkin (1988) as a reference. This framework is based on three key-elements in meaningful participation, shared by the authors:

1. Participation entails involvement in decision-making;
2. Participation entails involvement in setting the agenda, identifying problems and finding solutions; and,
3. Participation entails some form of power sharing between community members and health officials.

Using these three characteristics, three degrees of participation can be identified and used to analyse health committee members' description of their current role:

- **LIMITED PARTICIPATION**: Control and decision-making remains with facility; health committee is not part of identifying problems and solutions and has limited power. Includes activities where health committee assists and supports facility, but where facility initiates/defines activity and makes decisions. Also includes activities where health committees assist patients and communities with health and social needs that should have been addressed by the health services. Limited participation also includes information exchange, where health committees carry out information and awareness based on the clinics' assessment of needs.

- **PARTLY PARTICIPATORY:** Health committee is asked for input, gives advice or approves, but has limited role in identifying problems, finding solutions or making decisions.

- **MEANINGFUL PARTICIPATION:** Health committee is part of identifying problems and finding solutions. They are part of decision-making processes and have joint control/power with the facility. Health committees have an oversight role (monitor and evaluate).

However, an analysis of health committees' description of their work, suggests that a fourth category of activities is necessary. This category does not correspond with Rifkin, Potts or Arnstein's understanding, as it captures activities outside of health care, related to social determinants of health. This role is identified in the following way:

- **INDEPENDENT ROLE:** Health committees address issues pertaining to health in their community independently at community level or system/political level. This includes addressing social determinants of health. In contrast with other roles, this role is not linked to the health services.

Community involvement and participation: A conceptual distinction

A further conceptual distinction is made between community involvement and community participation – two main forms of community engagement in health. The definitions of involvement and participation were developed inductively by looking at community members' engagement in decision-making and influence within and outside the health system. This distinction allows for an understanding of community participation that includes addressing social determinants of health as well as engagement at a policy level.

- ***Community involvement*** occurs when communities are involved in supporting and assisting health systems, patients, and communities. They

function as an extension to or complement health services by carrying out functions such as assisting in the day-to-day running of the clinic, functioning as unpaid support staff, carrying out health promotion and assisting patients with social issues. Community involvement can be categorized as limited participation.

- ***Community participation*** demands that health committees are actively involved in identifying and addressing health issues facing their communities, finding solutions to problems and participating in decision-making processes. This understanding of community participation acknowledges activities that promotes and enhances health, such as addressing social determinants of health, when this does not entail a partnership with health officials. It also recognizes community participation at a policy level. Thus, in this understanding community participation can occur though:

  a. Participation in health governance at facility level. Includes involvement in identifying needs and ensuring these are met; as well as in oversight, where they deal with monitoring and evaluation and complaints.

  b. Participation at a political level, where community participation structures engage in policy issues, either pertaining to health or social determinant of health.

  c. Participation in addressing social determinants of health in

  d. Participation in addressing social determinants of health in communities (at local level), where community members are part of identifying problems and finding solutions or at a political level.

The study identified health committees linked to 82 clinics. This is equivalent to 55 percent of all clinics in Cape Town. 72 percent of these health committees (n=59) participated in the research either through focus groups or through health committee members completing the questionnaire. Some health committees chose not to participate, in other cases it proved impossible to collect data due to committees' poor functioning. A total of 246 questionnaires were collected from 56 health committees. The qualitative data was analysed thematically using Vivo 8.
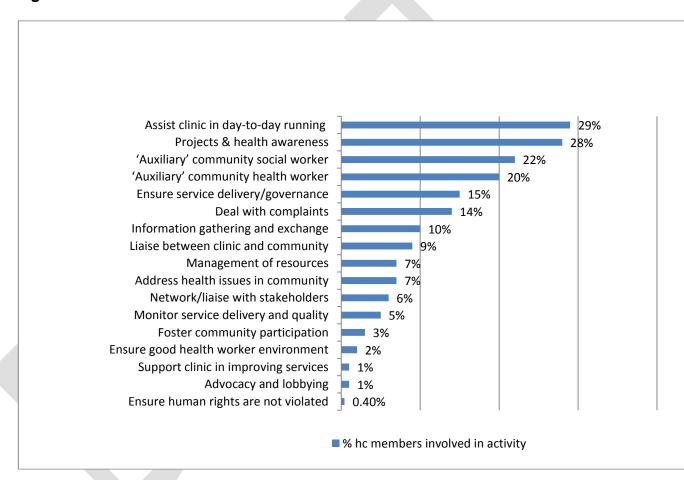
This research was approved by the Research Ethics Committee at the University of Cape Town's Health Science Faculty (179/2007). All participants signed a written consent form.

FINDINGS AND ANALYSIS

This section will present findings and analysis of the following aspects: health committees' activities, degree of participation, followed by presentation and analysis of key-factors impacting on health committees' limited role: lack of clarity on role and function, narrow vision of community participation, policy vacuum.

Health committees' activities

Figure 1: Health committees' activities

Activity	%
Assist clinic in day-to-day running	29%
Projects & health awareness	28%
'Auxiliary' community social worker	22%
'Auxiliary' community health worker	20%
Ensure service delivery/governance	15%
Deal with complaints	14%
Information gathering and exchange	10%
Liaise between clinic and community	9%
Management of resources	7%
Address health issues in community	7%
Network/liaise with stakeholders	6%
Monitor service delivery and quality	5%
Foster community participation	3%
Ensure good health worker environment	2%
Support clinic in improving services	1%
Advocacy and lobbying	1%
Ensure human rights are not violated	0.40%

■ % hc members involved in activity

The survey found that the most common activities were assisting the clinic in day-to-day running (29 %). This included members who functioned as security guards, cleaners, receptionists or assisting health staff with issues such as managing tensions in the clinic. Many health committee members (28 %) reported that their health committee was involved in assisting the clinic with projects or health awareness such as giving talks at the clinic. Similarly, many health committee members indicated that health committees members were 'auxiliary' community health workers (22 %) assisting the clinic with a number of health issues such as immunisation campaigns or 'auxiliary'

social workers (20 %) taking on tasks such as helping people procure ID documents and birth certificates, run soup-kitchens, feeding schemes, etc.

In these cases, the assistance provided was defined by the facility manager. They were not involved in decision-making and they did not take part in identifying problems and finding solutions to them. Health committee members were often viewed – and viewed themselves - as voluntary workers, something that was illustrated in many comments made by both facility managers and community members. One health committee member commented that having a health committee "Is such as quick help to them (the facility), you know." Along a similar note, a deputy facility manager explained: "The health committee's role is to assist the facility with everything." Many participants described their role as helping the staff: "We are here to help the staff wherever we can" and "We come to the clinic to be of any help."

The least important tasks of the health committees were being involved in monitoring services at the clinic (5 %), fostering community participation (3 %), ensuring a good health worker environment (1%), supporting the clinic in improving services (1 %), advocacy and lobbying (1 %), and ensuring that human rights are not violated (0.4 %). No health committee was reported to be involved in influencing policy or in drawing up budgets.

As Figure 1 shows a reasonable number of health committee members were involved in tasks such as governance (15 %), deal with complaints (14 %), or information gathering or exchange (10%). However, a more detailed analysis of their involvement in these areas indicates that this involvement did not always entail their participation in decision-making or in identifying problems or finding solutions. Rather, their role was often limited, in that they had no part in decision-making.

The way health committees were involved with complaints is an example of their limited role. Amongst the 14% of health committee members that reported to be involved in complaints, there were huge variations in how they were involved. 'Dealing with complaints' did not always mean that health committee members were involved in investigating and addressing complaints. In half the cases, health committees received, recorded, and handed over complaints to the facility manager or they kept statistics on complaints. They were not involved in addressing complaints or finding solutions to issues raised. None of the health committees were involved in a process of redress. Forty-one percent of health committee members did not indicate how their health committee was involved in addressing/solving complaints.

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 (nursing) Sister's job as it relates to staff," commented one health committee member during a discussion while filling out the questionnaire. In another instance, it was clear that the health committee was prevented from dealing with complaints by the facility manager. Instead, they explained that complaints were not dealt with at all but went missing. "We
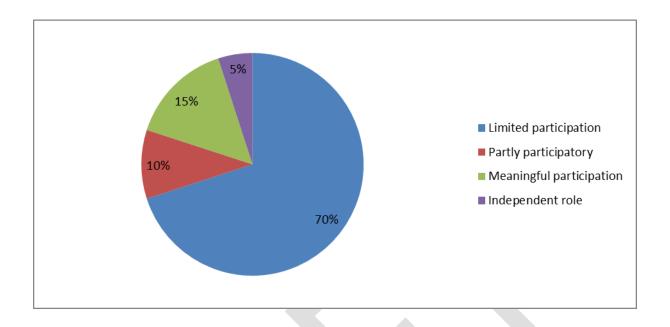
want to be involved, but the facility manager does not want us to have anything to do with complaints. When I handed in a written complaint I asked for a receipt because I know that complaints just go missing, but I still have not heard anything," said a health committee member, while filling out the questionnaire.

A similar pattern was observed with regard to how health committee members were involved in information exchange. Ten percent of health committee members reported that they were involved with 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 (58 %). They were less frequently involved in giving information about health needs of the community to the clinic (21 %), Department of Health or the environmental health officer (9 %). Twelve percent did not specify how they were involved in information exchange. Thus, information mainly flowed from the clinic to patients and was aimed at getting patients to adjust to the health system rather than health committees informing the health system of the needs of the communities. Furthermore, the process of providing information was separated from addressing problems.

Degrees of participation

These examples suggests that to understand how participatory health committees are, it is necessary to analyse *how* they were involved in various tasks rather than just look at which activities they were involved in. In other words: how did they participate, were they part of identifying problems, finding solutions and making decisions or did they carry out work identified by the facility manager. The categories developed in the framework for analysing participation was used to analyse health committee members' tasks according to the various participatory roles viz. 'limited participation'; 'partly participatory'; 'meaningful participation'; and 'independent role'.

Figure 2: Degrees of participation

As the figure above shows, 70% of responses can be characterised as 'limited participation' where health committees were not part of the decision-making process, but rather acted in a supportive role to the clinic. Fifteen percent of responses indicated that health committees acted in participatory role where they either planned jointly with the facility, or had an oversight function. In these cases, health committees provided governance and oversight. This included cases in which health committee members were involved in resolving complaints and addressing the issues raised in these complaints. Other examples include health committees and facility managers seeking to find solutions to issues such as staff shortages or how to make the facility accessible and acceptable to specific groups such as Muslim women and women from informal settlements. Activities in this category also include health committee members being involved in advocacy, ensuring human rights are not violated, and working with the clinic to improve health services.

Ten percent described their role consistent with the 'partly participatory' level. In these cases, the facility manager would ask the health committee for advice or approval, but the health committees would not be part of setting the agenda or be actively involved in identifying issues or finding solutions.

Five percent of responses indicated that health committees acted independently, addressing either health issues in communities or social determinants of health, such as refuse removal.

However, using the distinction between community participation and community involvement, this role is included in community participation as addressing social determinants of health is considered an important aspect in the primary health care approach. For the purpose of this paper, activities that were only partly participatory will be considered 'community participation'. Using this distinction, the findings suggest that

30 % of activities can be categorised as community participation, with 70 % being characterised as community involvement.

Lack of clarity of role and function of health committees

Many reasons were given for health committees' limited participation. Firstly, health committee members and facility managers often shared a vision of health committees as structures mainly concerned with assisting the clinic. In response to a question on what HC members believed a health committee should do, the majority view was that health committee members should: "Carry the clinic with the staff," as stated by a HC chairperson during a meeting. This was echoed by many health committee member such as expressed in the following quote: "(It is our role) to be at the clinic to help when staff members want us to help." A small number of members indicated that they would like to be involved in issues such as complaints, ensuring human rights, governance, and influencing policies.   This may constitute a nascent sign of a shifting vision, though it is a minority view.

Secondly, lack of clarity of the role and function emerged as a significant reason. It was raised on numerous occasions during informal discussions with health committees as well as in focus groups and in responses to the questionnaire. "We don't really know what we can do," lamented one health committee member during a discussion. "We don't know what we are supposed to do," commented another health committee member. These expressions were resonant with most health committee members. Several facility managers also argued that they were unclear about the mandate of health committees. A nursing Sister called for clarity of the role and function of health committees as a priority as this affects their functioning. 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 required to function well, many health committee members answered that they need clarity on their mandate or role and function. One stated: "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 are." When asked what training was needed, the most popular choice (80%) was "role and function of health committees" (80 %), again indicating the need for clarity.

Several health committee members linked confusion of role and function to the fact that there is no policy stipulating health committees' role and function. Notwithstanding its indeterminate status, the Western Cape Draft Policy was unknown by the majority of respondents.

Qualitative data also suggest the way health committees are formed impacts on their role. In many health committees, facility managers play a crucial role in the formation of committees, selecting community members to form a committee rather than forming committees through community members electing their representatives. As a consequence, many committee members are strongly aligned with the facility manager

and are often committed to represent the facility and its interests rather than the community.

DISCUSSION

The first part of the discussion will look at health committees' limited role in comparison to scholarly literature on meaningful participation. This leads to a discussion of health governance structures and an elaboration on an effective and meaningful model for community participation. The discussion will then focus on the question whether the current policy initiatives - the NHI and the National Draft Policy on Health Governance Structures - provide a policy context that will allow for meaningful participation. It suggests that a policy on health committees is paramount and should be linked to a shared vision of meaningful participation.

Limitations to meaningful participation

This paper started with an emphatic plea, from a health committee member, that the views and insights from communities are to be taken seriously. The member's statement captures an important aspect of what community participation could be about – namely, ensuring that communities' health needs are met through their active role in identifying their needs and finding solutions.

The review of scholarly literature underlines governance and oversight as fundamental elements of meaningful community participation. Interestingly, this view is carried through in the National Draft Policy on Health Governance. There is therefore a current move at high level towards conceptualising health committees as governance structures. However, the findings of this study imply that this view of community participation differs significantly from the experience of the health committee members in the Cape Town Metropole. Health committees' current roles are divergent from contemporary understanding of meaningful participation as well as with provincial policies and the national Draft Policy.

The study presents a challenging picture of health committees. In many instances their involvement does not meet the basic principles of meaningful participation such as being part of decision-making processes and having a governance or oversight function. Rather, health committees are primarily involved in narrow participatory roles assisting and supporting clinics in day-to-day operational tasks and providing assistance to patients. In these roles, they have marginal input in decision-making processes, overall health strategy, setting the agenda or in identifying health needs and suggesting solutions. Other meaningful participation activities – promoting primary health care, ensuring human rights, advocacy and lobbying, oversight and governance – recorded low priority.

While it is important to acknowledge health committees' current contribution to improving access to health services through assisting clinic staff in their day-to-day operational tasks, assisting patients with health issues and social issues, running campaigns and informing communities about health issues etc.; it is equally important to stress that this contribution is limited. It is also critical to note that their contribution does not focus on improving the health system. Rather, many health committees serve to fill a gap on a voluntary basis. They become an extension of the health system and focus their effort on assisting patients in adapting to the system. Far from addressing shortcomings, health committees act to sustain the system in the face of its shortcomings through managing 'unruly' patients, informing patients about long waiting hours, doctors' shortages etc.

This paper contends that health committees' would be more effective in helping to address systemic issues such as poor service delivery if they participated meaningfully in health governance and in monitoring and evaluating services. In such a capacity, health committees' would focus on improving health service delivery and ensuring that the health services would meet the need of the communities they serve.

Structures for integrated community participation

The conceptual distinction between community involvement and community participation could be useful as an organising principle for community engagement in health. This would mean that health committees should primarily be involved in health governance and oversight at facility level, ensuring that the health system meets the need of communities and is accountable. The paper suggests that 'community involvement' activities such as assisting the clinic in operational day-to-day tasks should not be core functions for health committees. Other community structures could be identified to carry out these tasks such as groups of community volunteers, community health care workers or the primary health care agents, as suggested in the National Health Insurance strategy. Health committees could potentially facilitate the involvement of volunteers from the communities. Involving the local communities in these tasks could strengthen the links between the facility, health committee and community, possibly creating a stronger sense of 'ownership' in the community.

This paper also proposes that meaningful community participation requires involvement in policy development and implementation, an issue also emphasised by Potts (2009). Clarity is needed on how health committees could give input to policy processes. Health committees' are likely to encounter issues relevant to policies; therefore it is beneficial for health committees have access to bring up issues at a policy level. However, it may not be feasible that all health committees are engaged directly in policy processes, but rather structures co-ordinating health committees present their views. One option for participation in policy processes is through a tiered model of community participation. In this model, umbrella bodies such as the Cape Metro Health Forum, district health forums, district health councils, provincial health councils or the National Health Council could consider policy inputs from health committees. However, the current institutional

arrangements in the health sector provide minimal access for health committees or their collective co-ordination structures to influence policy, as these structures are not represented at higher levels of health governance.

By implication, the role and function of health committees needs to be seen in relation to other health governance structures and clarity should be reached on how health committees relate to other structures. A model where health committees are represented in these bodies could allow for community voices to be heard in policy debates.

Another area where community participation could have a wider impact would be through engaging with social determinants of health. The findings from the study with health committees in Cape Town suggest that this role is limited. Again it is important to consider whether this is a role that should be undertaken by health committees or other community participation structures such as the Multi-Sectorial Action Teams (MSATs). In line with a primary health care approach, it would be important that community participation structures address social determinants of health. A possible distinction could be between clinic committees that are concerned with health facility/services and health committees that are concerned with issues impacting on health, seeking a more inter-sectorial approach. As with health governance, social determinants of health should be addressed both at a local level and at a higher level/policy level. Health committees could therefore address these issues at the local level and refer policy issues to other structures such as those described above.

Creating a comprehensive policy for community participation

This paper has highlighted that health committees currently exist in a policy vacuum that renders them functionally sub-optimal and incapable of participating in a meaningful way. The introduction of a National Health Insurance (NHI) and pending national policies on health governance structures presents an opportunity to rethink and create a policy environment that allows for meaningful participation.

In this context, it is important to note that the National Health Insurance Policy paper is vague on how it understands community participation and to what extend it will adopt a notion congruent with other policies such as the National Draft Policy on Health Governance Structures, and evidence in the scholarly literature. The current text does not explicitly recognize health committees; neither does it refer to other policies on community participation. Instead it suggests that primary health care agents will be responsible for community involvement and participation.

This study has suggested that a lack of clear conceptualisation of community participation with clearly defined roles, function and mandate, results in weak community participation structures. PHC agents are almost certainly likely to affect a form of community participation that is long the lines of community involvement. It is not only unclear what role community members will have in relation to these primary health care

agents, but also which form community participation will take. For instance, will community representatives be elected or chosen by the community to represent their interest or will the facility manger/clinic staff select community members. The policy states that a health professional will head the team of primary care agents, which will facilitate community participation. The primary objective for community participation in the NHI seems to be to identify families at risk and to influence health behaviour. Given this mandate, it is very likely that PHC agents will be chosen for their technical skills. In contrast, the National Draft Paper on Health Governance Structures stipulates that health committees are elected and thus represent community interest. This bottom-up approach contrasts with the NHI proposal, which conceptualises community participation as a top-down process, where health workers are in 'charge' of community participation and involvement. A consequence of this approach is likely to be weak forms of participation, void of real input from communities.

The research with health committees in Cape Town suggests that health committees' roles are closely linked to their formation and to how they see themselves and whose interests they represent. It is therefore imperative that the National Health Insurance rethinks how to engage with community participation structures and how it conceptualises the notion of community participation.

In addition, a policy needs to consider the role of various community participation structures and how these form a comprehensive engagement that allow community voice to be heard at all levels of decision-making from the local clinic to policy level. Similarly, it is important that policies reflect a consistent view of community participation structures and processes and these policies are aligned with each other.

Finally, it is imperative that stakeholders such as health committees, facility managers and health officials develop a shared vision for community participation – shared by policy makers, health workers, and community members. Such as vision should then be carried through in all policies that engage with community participation such as the National Health Insurance and a policy on health governance structures. Policies should also include an effective model for community participation that allows communities to be involved at both local level and at higher level, where community input can influence policy. More research is needed to develop a model for community participation that ensures that community structures become effective and meaningful participants in ensuring a well-functioning health system.

CONCLUSION

This paper has suggested a conceptual distinction between *community involvement*, where community members assist health facilities with day-to-day tasks and health promotional activities; and *community participation*, where community members are involved in decision-making and take an active role in identifying problems and finding solutions. This paper demonstrates that community health committees in the Cape metropole fall within former conceptualisation - they are engaged predominantly in activities with limited influence and decision-making. A greater role in governance and

oversight is essential for effective and meaningful health committees. To achieve impact, health committees will require an appraisal of the inadequate current policy imperatives relating to community participation structures' governance and oversight roles.

Furthermore, government policy-makers need to improve policy coherence and alignment regarding community participation. The policy paper for a National Health Insurance in South Africa is vague on community participation. The paper does not recognise structures such as health committees and it proposes a form of participation that is both top-down and incongruent with understanding community participation structures as governance structures. In contrast, a draft paper on Health Governance Structures is explicit in its understanding of health committees as governance and accountability structures. The NHI should re-examine its notion of community participation to ensure that it recognises current structures such as health committees as legislated in the National Health Act.

Additionally, to promote integration and co-operation, a tiered model of community participation is suggested. This model would ensure that policy issues raised at community level are dealt with by other structures such as district health councils, provincial health councils and the National Health Council. Strong linkages, preferably through representation, between the various tiers are necessary to ensure that the voice of communities are heard and issues raised at the local level are addressed at a higher level.

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