# Health Committee
## *Capacity Building*
## Manual

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# Training Introduction

## Purpose of the Manual

This manual is part of the **COMPLUS - Community Voices in Health Governance - Translating Community Participation into Practice in a World of Pluralistic Health Systems** - research project. COMPLUS is a partnership between researchers and communities - in 3 countries, South Africa, India and Brazil and is funded by NIHR.

**This training is focused on South Africa only**. The manual is meant to help us understand the local South African health system and how they work with Health Committee Members and patients/ clients in the country. This can help us improve our knowledge and help us work together. This can also help to promote partnerships between community health groups and health workers and managers and allow them to share information with the communities that they serve.

It is impossible to include all important topics in one practical manual. There is also other training material provided by other organisations which you may also find helpful. It is important to note that health policies can change quickly in South Africa as we come to terms with the major changes such as the National Health Insurance Act (NHI). This means the manual may need to be updated often and also you should try to keep up to date with the latest policy changes.

# Plural Health Systems

The title of this research project is **Community Voices in Health Governance - Translating Community Participation into Practice in a World of Pluralistic Health Systems**.

Plural or pluralistic health systems are where there are many different providers of health services which all fit together to provide healthcare for people. Some parts come from government-run hospitals and clinics, others from private clinics and hospitals, NGOs and charities, and sometimes may include traditional healers.

They are systems where the public sector and private healthcare providers are part of the same system. There are many different providers and parts, and they are meant to fit together in one health system. Other countries have plural health systems e.g., Brazil, China and Canada. Each system has its own type of plural health system. We will talk more about this when we learn about the NHI later in the training. This manual hopes to provide a deeper understanding of the ways in which South Africa is trying to respond to healthcare inequality through a plural health system using the NHI.

# Key Knowledge Outcomes

After the training, participants should be able to:

| | |
|---|---|
| **Understand** | Have a basic understanding of South Africa's Health System |
| **Clarity** | Understand important health concepts like Human Rights, Universal Health Coverage (UHC) and Primary healthcare |
| **Awareness** | Be aware of a number of important health policies in South African such as the NHI |
| **Knowledge** | Understand important parts of the policies/ laws that relate to Health Committees and community participation in the health system |
| **Familiarity** | Understand the opportunities to work with and communicate with healthcare providers in the public and private sector |

# Glossary of Terms

- PHC: Primary healthcare
- UHC: Universal healthcare
- WBPHCOT: Ward Based Primary Healthcare Outreach Team
- OHSC: Office of Health Standards Compliance
- NHI: National Health Insurance
- NHA: National Health Act
- DHMO: District Health Management Office
- DHC: District Health Council
- CUPs: Contracting Units for Primary Care
- COPC: Community Orientated Primary Care
- WHO: World Health Organisation
- ECDoH: Eastern Cape Department of Health
- WOSA: Whole-Of-Society Approach
- POPI Act: Protection of Personal Information Act or POPIA
- MEC: Member of Executive Council

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# 01

# Health and Human Rights


# Introduction

As we begin this learning journey through the South African health system it is important that we find a way to come to a shared understanding of some of the words that are used.

Healthcare and health systems are complicated. This involves the lives of millions of people who seek care at different levels, all the way from community outreach to clinics and hospitals as well as from traditional healers.

Health systems and the way that they are run are influenced by the country and history of the communities that they serve. The main focus is also impacted by the main diseases and health challenges that affect the country and the community.

If we can develop a shared understanding of important topics, it will help us to better discuss and analyse the ways in which our own health systems and societies can improve.

# Health is broad and Health is a Right

We need to see health in a much broader way. Health is about physical, mental and social wellbeing [1]. Health is a **right** for every human being regardless of race, religion, political belief, economic or social condition. **Governments have a responsibility** to provide good levels of healthcare and communities **have a right to take part in decision making in health**.

You may have heard of **Human Rights**. Rights are a set of basic standards that human beings need in their lives in order to live with dignity. They are deserved equally by all people, in all cultures and in all countries. There are international laws which support human rights.

We also have responsibilities, for example you need to make sure you don't discriminate against other people or harm someone just because of their race or gender or religion. We must all play a part in making this world a better place and respecting each other's rights and being a responsible citizen, is a good place to start!

*[1] World Health Organisation*

## Learning Exercise 1

### In the large group:

Can you share with the group some examples of what your responsibilities are as a community member/ citizen of South Africa?

Each country then has its own set of laws that have been developed over time.

In South Africa, we have our own Constitution and Bill of Rights. Let's take a look at the South African Constitution.

# The South African Constitution and the Bill of Rights

During the Apartheid System, many human rights were violated. After the fall of Apartheid, SA held its free elections in 1994 and the country approved the Constitution of the Republic of South Africa in 1996.

This document is the highest law in South Africa. There is a very important part of the constitution which is known as The Bill of Rights. This part of the constitution is important to us as health activists because it lists many of the Rights and Principles that we should look out for in our local health systems to ensure that they are being upheld. There are also many sections in the Bill of Rights that impact health but the most important is **Section 27**.

Section 27 - this is the most famous of health rights. The South African government has a responsibility to achieve this **PROGRESSIVELY. This means step-by-step based on available resources ; over time, it must improve access.**

## Section 27:
## The Right of Access to Healthcare, Food, Water and Social Security. No one may be refused emergency medical treatment.

Here are some of the important sections from the Bill of Rights that can help us when engaging with government around healthcare but there are many more:

- **Section 24:** The Right to a Healthy Environment (free from pollution)
- **Section 26:** The Right to Adequate Housing
- **Section 28:** The Rights of Children to protection, shelter and social services
- **Section 29:** The Right to Receive Education
- **Section 32:** The Right to Access Information held by the state.
- **Section 35:** The Rights of Prisoners including rights to medical care, nutrition, exercise and adequate accommodation

# The South African Patients' Rights Charter

We have included the Patient Rights Charter because it important and it lists both the rights and the responsibilities of people using health services. We all have roles to play. This keeps a balance in the relationship between patients and providers and that patients are able to take ownership of their own health.

## Rights

- A healthy and safe environment
- Participation in healthcare decision making
- Access to healthcare
- Knowledge about insurance/medical schemes
- Choice of health services
- Treatment by a named healthcare provider
- Confidentiality and privacy
- Informed consent
- The right to refuse treatment
- Referral for a second opinion
- Continuity of care
- Freedom to complain about poor quality healthcare

## Responsibilities

- Take care of your health
- Protect and care for the environment
- Respect the rights of other patients and healthcare providers
- Take care of health records such as clinic /hospital cards
- Give healthcare providers relevant, accurate information to facilitate diagnosis, treatment, rehabilitation and counselling
- Comply with the prescribed treatment and/or rehabilitation requirements
- Obtain information about local health services
- Enquire about costs of treatment and rehabilitation and make appropriate arrangements for payment
- Use, not abuse, the healthcare system
- Inform healthcare providers of the death of a patient

# Privacy, Confidentiality & Informed Consent

Now we will go on to talk about privacy and confidentiality and informed consent which are very important in health because we share sensitive information with health professionals. This is also about our rights and responsibilities. There has been changes in the law in SA about this and it's important for you to know.
The Patient Charter also speaks about protecting patients' information about their health and that sharing this information requires **informed consent**. What does this mean...

# Privacy vs Confidentiality

"Privacy" is about protecting people from having to share information when they do not want to share it. It talks about ways that health providers can collect and store information. If a patient does not want to share certain private or personal details because they do not feel it is important to their medical care, then that is your right. But sometimes that type of info is necessary for health workers to know how best to provide medical care.

Also, the health worker may need to share that info with other health workers to give you proper care. But they cannot allow the information to be made public
This is called **"Confidentiality".** The health practitioner must keep your information confidential even when receiving any patient information.

The sharing of patient information with other people, other than the main provider of healthcare, **needs informed consent. This means the patient needs to agree to this.** There are exceptions, for example, where there are certain public health concerns or direct court orders that allow the information to be shared. Remember COVID 19, we had to share information!

**Health conditions and treatments can carry stigma and prejudice, and so patients have genuine concerns that their privacy and confidentiality need to be respected.**

# POPI Act

This information may sound difficult, but it is important for you to know. You may have heard talk about the Protection of Personal Information Act (POPI). This law is very important to the health setting because of the sensitive information that is collected and stored by health providers. This means it is also important for health committees to know about.

If healthcare workers do not comply with the POPI act, this can result in direct fines and even criminal charges after submitting a complaint to the regulator.

Examples of the type of information that is protected under the POPI Act include: ID and Passport Numbers, Age and Date of Birth, all contact details, photographic and video imagery of patients, gender and race data, biometric data and marital status, criminal records, religious beliefs, financial details, criminal records and all physical/mental health data.

The law says that facilities are responsible for keeping patient information safe (both printed and online copies).

**Information/ Data may only be shared with the consent (approval) of the patient for use between the healthcare providers directly involved in the patients' care.**

Patients must be made aware of any information that is collected and how this information will be used and why it is being collected. The patient must be aware of this before giving consent to collecting their information. They can also ask to have access to their personal data and to have it removed or destroyed from any place where the information is kept.


# Batho Pele Principles

Now let's talk about another set of principles called Batho Pele which are also useful for health activists to know because it can help in monitoring health services.

Batho Pele" is a Sotho term meaning "People First." It is a set of principles that the government has been using since 1997 to help improve service delivery across all government departments (public sector).

**These principles are useful to us as health activists and providers as we can use them to monitor government service delivery and we can hold both ourselves and government to account.**

**There are 8 principles, and they are useful to have in the back of one's mind when assessing health facilities in general.**

**The 8 principles are as follows:**

- **Consultation:** People who receive government services should be consulted annually about the quality, cost and timeliness of the services they receive.
- **Service Standards:** People who receive government services should be informed about the level, quality and any cost of services they can receive. These services should be laid out in an annual "Service Charter."
- **Access:** There should be equal access to services by all, at all times.
- **Courtesy:** People accessing services should be treated with respect, at all times.
- **Information:** Users should be given accurate and user-friendly information about services they are entitled to.
- **Openness and Transparency:** Users should be informed about how departments are managed, how much is spent on service delivery and who is in charge annually.
- **Redress:** If service standards fail, users should be offered an apology, full explanation and solution within 30 days of a complaint.
- **Value for Money:** Services should match users' needs and financial capacity.

# Learning Exercise 2

We have spoken about many rights, responsibilities, laws, Acts, policies, principles. But what is written on paper is not always what you find in the real world.

Let's take a look.

Note: This can be done as a role play first and then a discussion in small groups. Or read the below together and then discuss in small groups.

A young woman enters a health facility to receive her ARVs. She takes a seat. The nurse calls out "*those coming for ARVs, please sit on the left-hand side, I will be with you soon*".

Some people move to the left-hand side and sit waiting for the nurse. Is this right? The young woman is extremely upset and is scared to join the others on the left side. She leaves the clinic without her ARVs.

## Small Group Discussion

**Discuss the situation above.**

- **Is this a violation of patients' rights?**
- **Why is the young woman concerned?**
- **What may happen to the young women because of this?**
- **Remember to discuss confidentiality and privacy.**

# 02

# Learning About Health Concepts

# Social Determinants of Health

We have spoken about health and human rights. There are many different things that impact a person's health and the health department cannot solve these problems alone.

The social determinants of health are social conditions which affect our health in the long run such as education, housing, water, sanitation, unemployment, access to food (food insecurity), pollution, climate change and many others. All these things impact our health. Many of these issues are not controlled by the Department of Health. Also, a lot of these issues are impacted by businesses. Many of these challenges have been created by colonisation and Apartheid.


Everyone has to play a part in solving these issues. The social determinants of health needs a "Whole-Of-Society" Approach (WOSA) to respond. This includes many other government departments but also the private sector and civil society/NGO's.

When social determinants are poor, this has a bad effect on the health of communities and can cause more sickness which means the health facility and the whole health system is under more pressure and gets weaker.

*Health forums can play an important role in responding to some of these issues within communities.*

# Universal Health Coverage

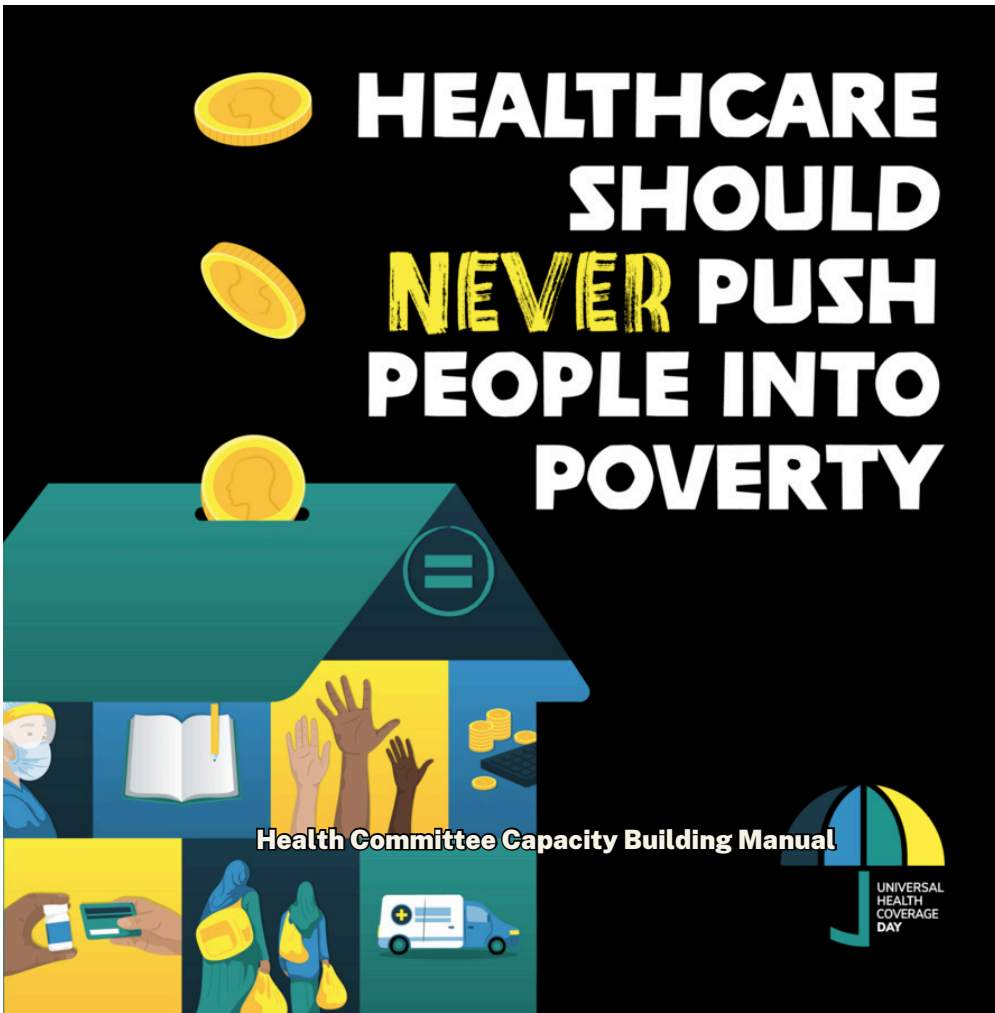
There are two other important terms to understand when looking at the health system. They are **Universal Health Coverage (UHC)** and **Primary healthcare (PHC)**.

UHC means that all people have access to the quality health services they need. You should have access to the health services when you need it and where you need it; without suffering financial hardship. The services must also be of good quality

Also, this should not be so expensive that it causes financial problems. UHC talks about the full picture of important health services which include health promotion which is about helping you live healthily. It also includes prevention of diseases and illnesses and also treatment, rehabilitation and palliative care.

UHC is an international health goal and countries are trying to achieve this including SA. The two principles of UHC are **access to quality services** and **protection from high health costs**.

UHC is a very important topic of debate in South Africa as we look to implement the National Health Insurance or NHI. The NHI is South Africa's way of working toward universal health coverage. There are many different ways in which different countries are trying to do this. We will learn to understand the NHI later in this manual.



# Primary Healthcare (PHC)

Another important concept you will need to understand is PHC. PHC talks about access to quality practical healthcare in communities and it must be at an affordable cost.

**It speaks strongly about making sure communities participate in the process. Participation is both a right and a duty.**

So, PHC is an approach which should be at the heart of our health system.

It should be comprehensive; it should cover many things. So, it should provide important services that promote good health, which prevent and cure illnesses, and rehabilitative services. It should also include health education, food supply, nutrition, safe water/sanitation, family planning, immunization and maternal, child and essential medical care.

It should include all departments of government and society, not just health, and it should include all forms of health workers, traditional practitioners and community health workers. It would benefit from a “Whole-Of-Society” Approach (WOSA).

Sometimes Primary healthcare is confused with Primary Care, which is the first level of care. It includes the first point of contact between people and the health system. Most clinics are called primary healthcare facilities, and many of these are in communities.
We can see that the PHC approach is very different from the way that healthcare is provided in many places today. There is more focus on spending on large hospitals and specialist care instead of focusing on Primary Level Care and the grassroots social determinants of health. We need to focus on all parts, access to clinics and hospitals that provide quality healthcare where and when we need it and we also need to focus on the broader parts of health. PHC is about all of this.

## Learning Exercise 3

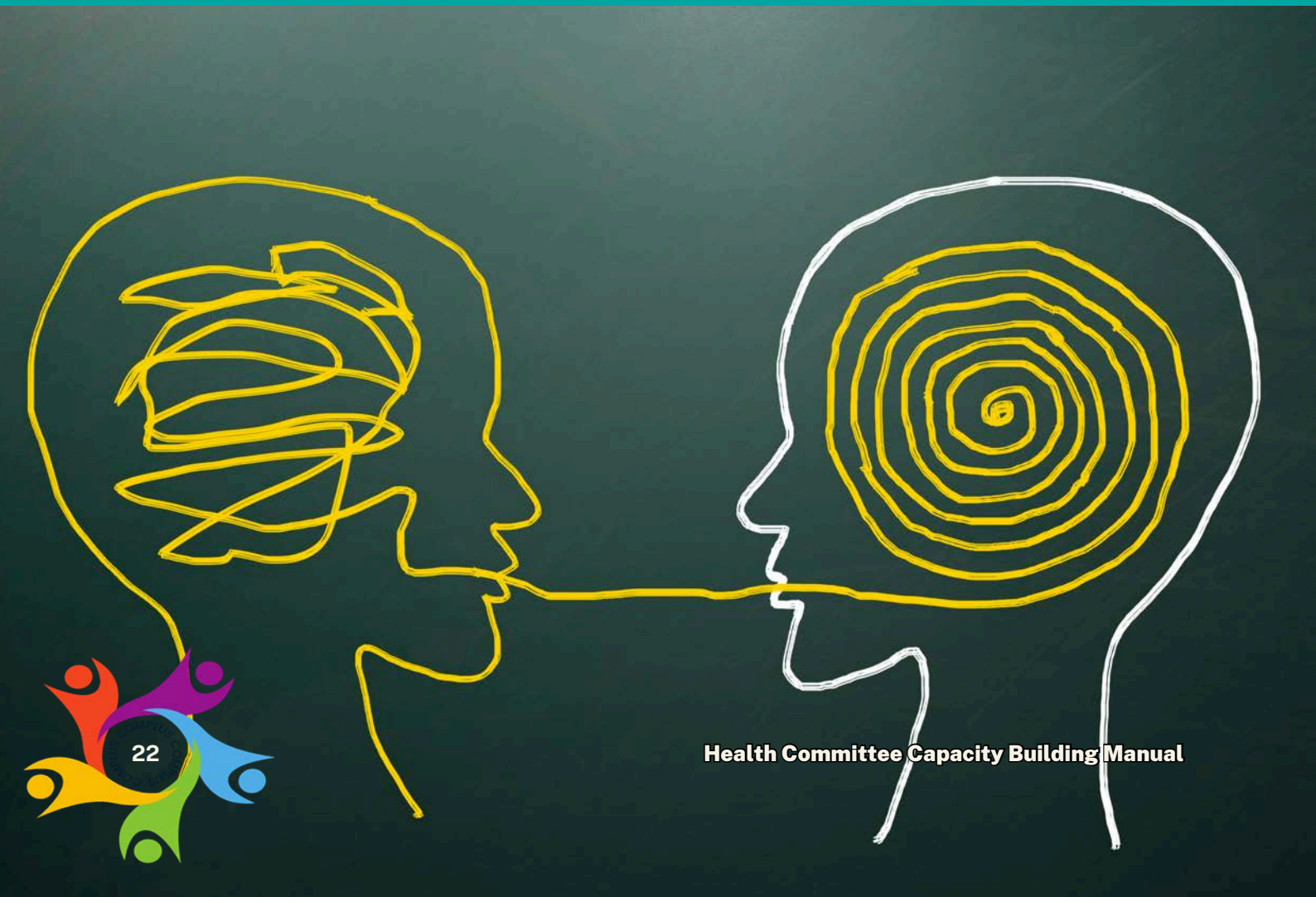
In small groups:
Lets discuss What are the main social determinants of health in your community?

What are the main challenges in your community:

- How do these things affect our health?
- How do these challenges affect the service at primary healthcare facilities in your community? For example, does the clinic get more overcrowded because of these issues?

# 03

# Understanding the South African Health System



# Introduction

Let us look at the way that the South African health system is made up. There are differences in public and private sector and even differences in services between rural vs urban areas.

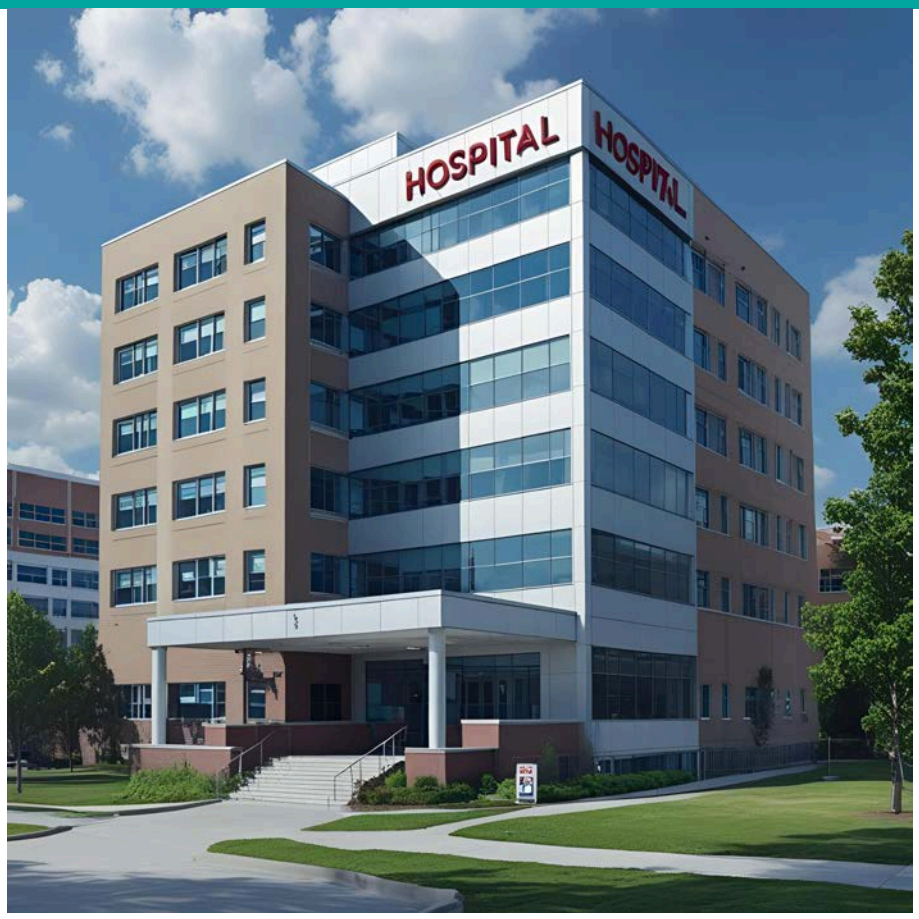
Health systems are complex and also each community has its own unique challenges and diseases which affect the health services. We will not be able to cover all the different parts of the health system, but we will discuss parts of the health system which may be useful to you.

Let's start first by discussing **levels of care** that are normally provided.

# Levels of Care

There are many different levels of healthcare that we can talk about. Hospitals and clinics are not all the same in the type of services that they provide.

Levels of care is an important concept to understand as it helps to manage expectations but also to help keep healthcare well-coordinated. It is not possible with South Africa's limited financial resources for every facility to have access to all forms of healthcare, specialist services and equipment. In fact, this is true all over the world.




So, the health system generally needs patients to follow a step-by-step process based on their needs.

We can roughly divide up the type of facilities into 3:
**Primary, Secondary and Tertiary care.**

## Primary Care Facilities:

- The first place where patients interact with the health system when they have an illness. For example, it might be the local PHC clinic, midwife obstetric unit or even local GP. Primary care should be able to provide for the basic and most common health needs of communities. Chronic conditions, routine checkups and screening and management of minor complaints and injuries should all occur at **Primary Care level**.

- **Primary Level Care** facilities have another very important role - that is to treat and manage emergencies and non-emergencies close to where patients live. They must then be able to assess whether patients need more specialised services, treatment or tests and refer patients to these other facilities.

## Secondary Level Care

- Secondary Level facilities include some regional hospitals where more equipment and resources are available to treat patients which cannot be managed at Primary Level Facility.

- Certain surgical procedures, tests, medications and scanning equipment are only available at this level.

## Tertiary Level Care

- Tertiary Level Care refers to the highly academic and very specialised forms of healthcare such as you might find at a teaching or Provincial Hospital. Sub-specialist services can be found at this level. For example, it is common in South Africa that radiation therapy for patients with cancer might only be found at a Tertiary Hospital.

- These pathways in the public sector are generally well set out but are not so clear in the private sector. There is more helpful information on levels of care in the last part of the training manual called the Appendices.

Now let us talk about some of the structures within the health systems.
The National Health Act is an important law that controls how healthcare is managed. There are different levels in the health system.

At the highest level is the Minister of Health and the National Department of Health.

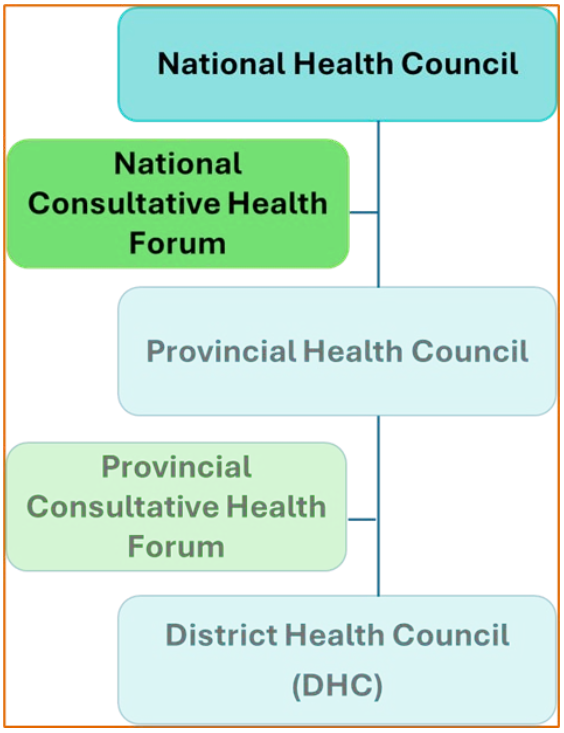
It is important to note that in theory, we may have a system with all these structures, but in reality, it is different, the system is not functioning as planned.

# National Health Council

The National Health Council (NHC) is the body that advises the minister on ALL aspects of health policy and management.

The NHC consists of:

- The Minister or a representative (to act as chairperson)
- The Deputy Minister of Health
- All of the MECs for Health from the provinces
- One representative municipal councillor
- The Director and Deputy Director General
- The Head of each provincial Department of Health




## National Consultative Health Forum

- A separate and related structure is the National Consultative Health Forum.
- This body is established by the minister to communicate between national departments, national NGO's and report back to provincial consultative bodies on any policy changes or decisions.
- It is meant to include relevant stakeholders and is appointed by the minister but there are no regulations on who should be included in this body.

# Provincial Health Councils

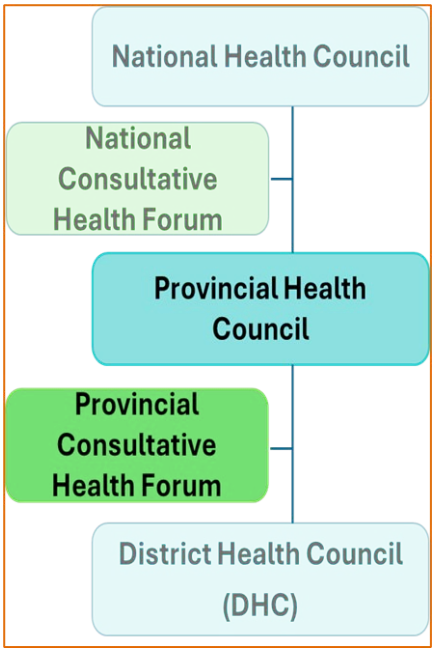
The National Health Act which divides healthcare into various parts and functions. There are national functions but there are also Provincial and District Functions.

One of the main structures at the level of the province is the Provincial Health Council.

The Provincial Health Council is therefore in charge of overseeing the provincial health services function and duties and also coming up with annual reports that are shared with the Director General for Health nationally.

Each Provincial Health Council includes:

- The MEC for health of that province or a representative
- One Councilor from each Metro Municipality[*1]
- One Councilor from each District Municipality
- The Head of the Provincial Department of Health
- Up to 3 representatives of local government[*2]
- Other advisors or experts appointed by the MEC.



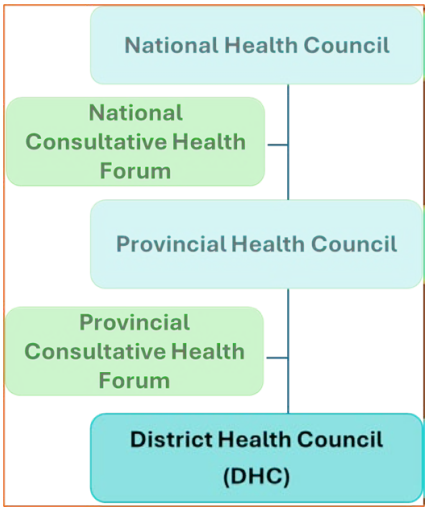

Note: There are differences between the provinces. For example, the Eastern Cape Department of Health (ECDoH) guidelines of 2023:
[*1] does not specifically require representatives from Metro's on this council,
[*2] calls these "Other departmental officials."

## Provincial Consultative Health Forum

- One of the other structures that is very related to these Provincial Health Councils is the Provincial Consultative Body. This is meant to be the structure that reaches out to include stakeholders from that province.

- It is set out in the National Health Act and members are appointed by the MEC to meet at least once every 12 months after it has been created. It is responsible for sharing or feeding back decisions made by the council to municipal and local government.

# District Health Councils




One of the other major structures that is involved both in the management of health and in engagement with communities are the District Health Councils or DHC's.

DHC's are a structure that are also laid out in the National Health Act of 2003 which sets out something called the District Health System.

The District Health System includes all of the various health districts which line up with municipal/district borders. Each province is responsible for setting out its own legislation to govern these Councils.

The MEC for Health in a Province together with any relevant MEC for Local Government set up the District Health Councils in consultation with the municipal council for that district. They then report to the Provincial Health Council and the Minister with annual reports.

Note: Remember different provinces have different legislation/ guidelines:
*[3] For example the 2023 Eastern Cape DOH guidelines; calls these members as "representatives of institutions/organisations".

**Each DHC must include:**

- A member of the metro or municipal council for that district (who acts as chair)
- A representative of the MEC for Health
- A member of the council of each local municipality in that district
- Up to 5 other members*[3] appointed by the MEC

Under the NHI section we will see that District Health Councils are going to become much more important structures for community engagement. Let's discuss community engagement at this level.

**We can see therefore that the DHC's are one of the main ways for the government of municipalities to engage with provincial government on health issues and setting priorities. Budgets and targets for health are all set at this level for the district.**

# Learning Exercise 4

In the large group:

Let's have a discussion:

- Does anyone in the group know about their local District Health Council?
- Has anyone in the group seen a district health plan before?
- How would you like engagement to work with the District Health Council?
- Who should be represented on these councils?


Now that we understand the high-level structure of our health system, lets discuss some of the main diseases which impact our communities and the health system.

This is called South Africa's Burden of Disease which is also driven by social determinants of health.

# South Africa's Burden of Disease

South Africa has a population of around 62 million people (national census 2022). There are many different illnesses in the world that affect communities and patients. They can be divided into different categories or groups.

In South Africa though there are 4 main disease groups that impact the health of many South Africans, and this is called a "disease burden" or "burden of disease"

## There are four main areas:

| | |
|---|---|
| **Communicable or infectious disease** | Those diseases that can be spread between people through infection - such as sexual transmission, coughing. This includes viruses and bacteria such as HIV and Tuberculosis (TB). |
| **Non-Communicable Diseases (NCD's)** | Diseases such as diabetes and heart disease, cancer and high blood pressure, chronic asthma and mental health. |
| **Maternal, Neonatal and Child Mortality** | These are all the conditions that affect pregnant women and their newborn children as well as all children up to the age of 5 years old. South Africa has made improvements in maternal and child mortality (deaths), but these are still very high, and it is still a problem. |
| **Injury and trauma** | South Africa has high rates of homicide (e.g., murder) and assault due to its crime rate, poverty and social challenges but also high numbers of accidental injuries from car accidents for example. Gender based violence and violence against children, are also high. |

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These diseases and injuries are some of the main challenges we face as South African people, and this impacts our health system.

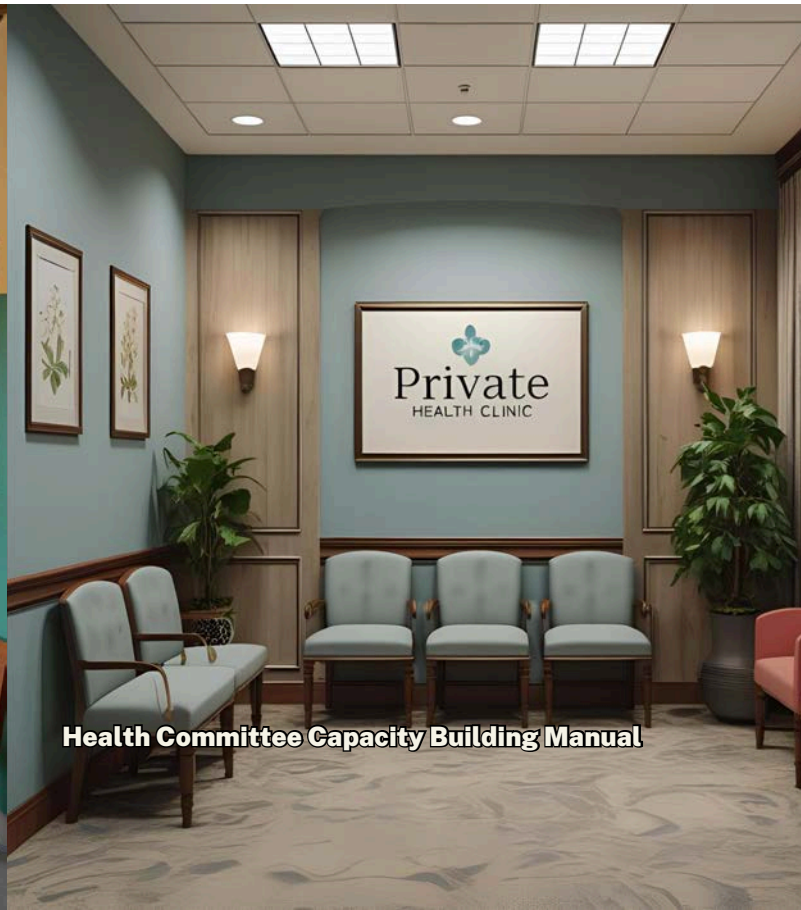
It is important for you to know because as health committees you will see how these health issues affect your communities and the services at your local health facilities and hospitals.

# The Public-Private Health Divide:

You may have heard our health system described as a “Two-tiered System.” This means that South Africans receive healthcare from two very different and divided types of services in the country. One is the public sector, which is government run facilities, and the other is the private sector. They operate separately and do not work together. Although government must regulate the private sector, it does so very poorly. As a result, there is a lot of inequity in access to and quality of healthcare in South Africa.

Most South Africans use public healthcare facilities (about 80% of South Africans). A very small number of people (about 20%) access private sector facilities as their first point of care.

Even though the private sector helps fewer people, a lot of money is spent in the private sector. Yes, a lot of this money in the private sector comes from the person who is receiving the treatment and their medical aid and is not being paid for by the government. But this is still a problem because only a few people can afford private medical aid. For the rest of the country, if a person wants to use the private sector and they do not have medical aid, they will need to pay for this from their own pocket. For example, to see some private GPs, patients pay in cash if they don’t have medical aid.



Then in the public sector, the quality of care is often reported or seen to be lower. The public sector has many more patients per doctor because it serves a much larger part of our population. This is very unequal.

The costs of care in the government hospitals and clinics (public sector) are paid for by taxes, and sometimes other contributions like external donors.

We can see that this is a very unequal system with some people getting better health services because they have the money to afford it. This is not fair. More money should go to the public sector in South Africa because it serves more people. Also, we have to find ways of making sure all South Africans get access to quality healthcare services which can include accessing these services from the private sector. The NHI is trying to help deal with this challenge but there are many different opinions on whether the NHI will be able to do that.

## Learning Exercise 5

In small groups, as a learning exercise can anyone who is comfortable to share; tell a story of how they had to go between different public and private health centres for treatment and what type of experience did you have.

For example, perhaps you first went to a traditional healer - then to a GP - then to a public clinic - and then to a public hospital - then you went to follow up again with your GP.
Or share an experience with a public or private facility.

**In small groups: Discuss your experiences:**

- Does anyone have experience of having to move between public and private facilities?
- What were the differences you experienced in care in the different sectors?
- Or tell us about your experience in either a public facility or private facility?

# 04

# The National Health Insurance

# The National Health Insurance

One of the most talked about health policies of the past 20 years is the National Health Insurance (NHI) Act which was signed into law by the President of the country on 15 May 2024.

You may have heard all sorts of things about the NHI. You may have heard good points and bad points. This may all sound very complicated but hopefully when we can go through some of the information on the NHI then it will become clearer. Also, there is so much that is still being decided by government, and there are many questions that cannot be answered now.

We hope that the information in this manual will help you to get a better idea of the true wording and principles of the NHI, so that you can decide for yourself. The NHI is going to have a huge effect on the way the health sector works. So, it is important that you know enough to talk about the NHI and answer the questions from members of your community and also to start asking questions.

There is still much work that needs to be done on how the NHI Act will work. Also, there will be many changes to different laws in SA because of the NHI. There is a lot more that still needs to happen before we can see the full NHI in place. It will also take many years before this policy is in full force and so we cannot expect to see these changes overnight. You may have many questions that still cannot be answered yet.

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The National Department of Health has stated that rollout of the NHI will happen in two stages. Phase 1 will continue from now until 2026, and Phase 2 will run from then until 2028. However, these dates could change.

- **1st Phase** — The first Phase will involve setting up all of the structures, boards and technology that is needed to run the NHI. This will also include improving the quality of public health services.
- **2nd Phase** — The second phase will focus on rolling out the NHI across all provinces.

# Important Points

We have spoken about South Africa's divided healthcare system and about the principles of Universal Health Coverage (UHC) and Primary healthcare (PHC). We spoke about some people having access to better healthcare than others and that this is unequal and unfair. The NHI Act is one way that SA is trying to close the gap between those who have good quality healthcare and those who do not.

This gap between the "haves" and the "have-nots" is one of poverty between the rich and poor, but it is also one of geography between rural and urban areas. This is also based on South Africa's history with the different racial policies of colonialism and Apartheid that divided the resources in our country up in unfair and discriminatory ways.

The NHI is trying to create one health system where resources are pulled together, and the public and private sector are brought together so that everyone can have good quality healthcare. When providers in the public and private sectors work together in the NHI, it is an example of a plural health system.

The NHI has gone through many changes since the beginning of our democracy in South Africa. A Commission of Inquiry into a National Health Insurance was started in 1995. The National Health Insurance (NHI) Act was signed into law by the President of the country on 15 May 2024. It has taken us a long time to get here and there is still a long road ahead.

# What Does The Act Say?

The NHI Act says that it aims to bring together all health resources in the country under one system. This will happen through the NHI Fund. The NHI Fund is the money that is needed to make sure that the NHI can be implemented. Remember, the NHI is about everyone getting access to good quality healthcare. This will need a lot of resources and funds, and the money will need to be sourced from different places.

The Department of Health has a public health budget, but it will need much more money than its current budget to make sure the NHI can be implemented and that everyone has access to good quality health services. The NHI fund will help to achieve this.

Most of the extra money needed for the NHI will come from different types of tax which will be collected from people and companies. The NHI Fund will then receive this money from the Department of Treasury. The NHI Fund does not sit within a government department and will be separate from the Department of Health. It will be a new government (public) agency. It will be using a lot of government funding and public money.

The NHI Fund will have a Board and a CEO. The CEO is recruited and appointed by the Board and is accountable to the board. The appointment of the Board and CEO are meant to be independent of the Minister to ensure the NHI Fund is able to be independent. But the current regulations (June 2025) are very unclear as to who appoints the Board and CEO and whether the Minister and Department managers can influence who is appointed. The regulations are currently out for comment.

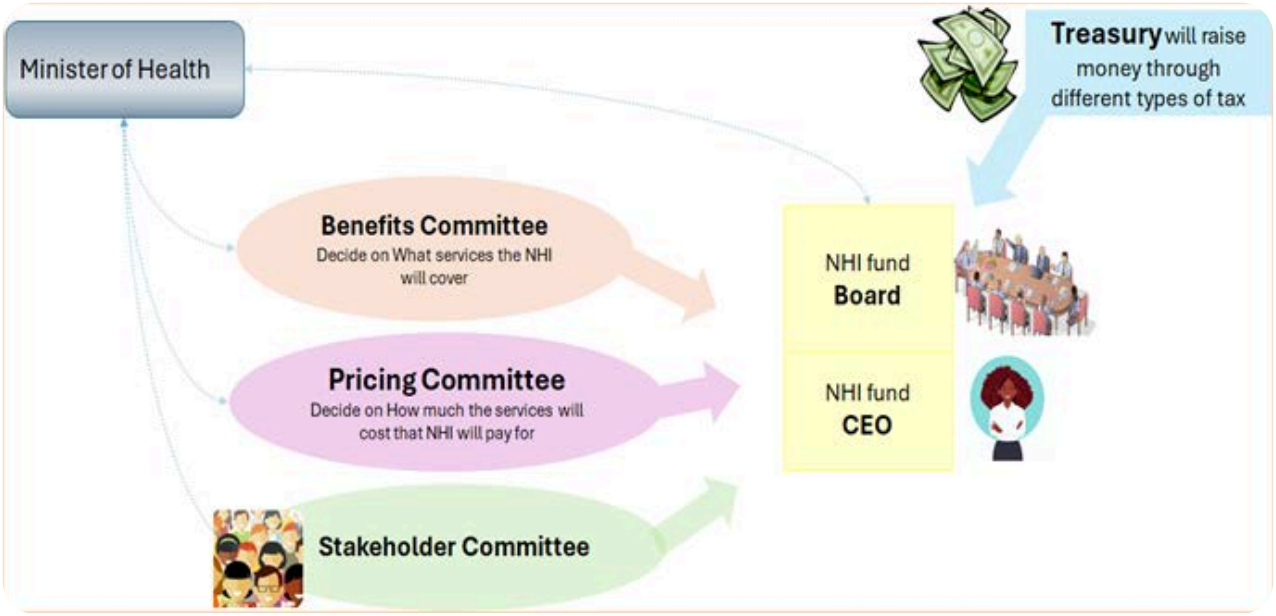
The Fund will then be responsible for buying services from healthcare providers (doctors, nurses etc) in both the public and private sector. You will not pay for the service at the point where you receive care. The NHI hopes to help people get healthcare even if they don't have money.

# Stakeholder, Benefits and Pricing Committees

The Minister will also appoint three committees to manage and advise them on how the Fund is working. They are:

- The Benefits Committee
- The Pricing Committee
- The Stakeholder Committee

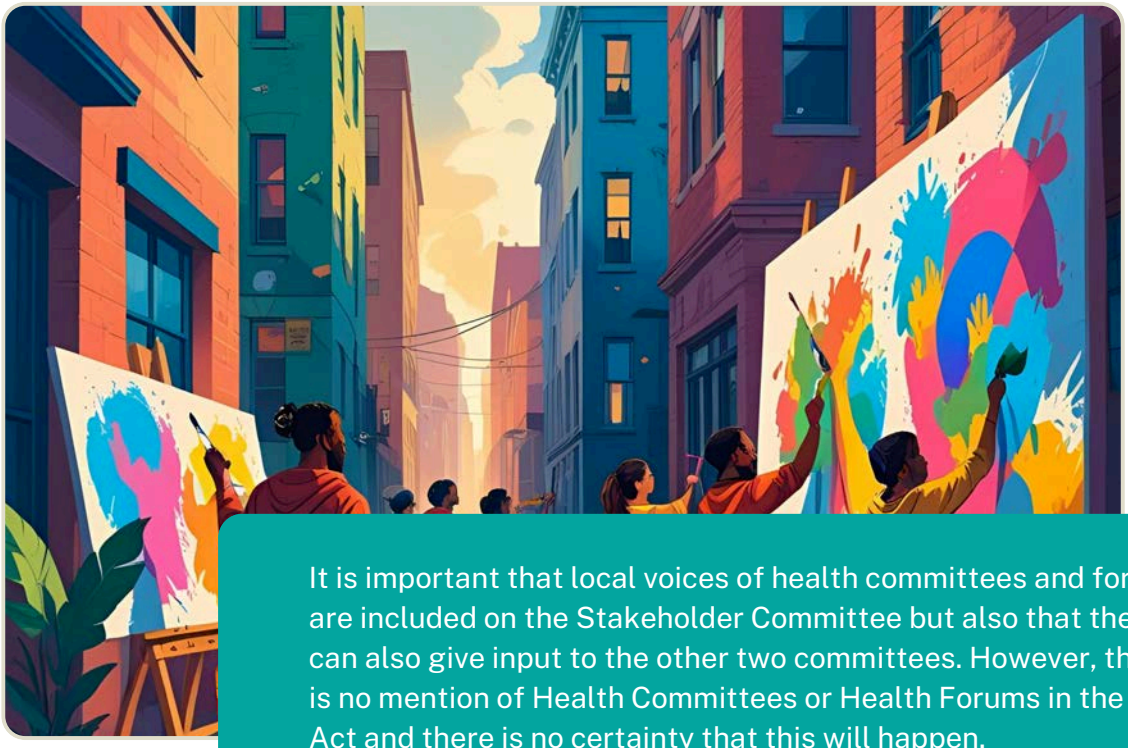
Who will sit on these committees, who they will report to and how they will be selected is still being figured out. The regulations for this are under discussion.




The **Benefits Committee** will be responsible for coming up with the list of services that people can get under the NHI. For example, this would include all the medications for most surgeries that the NHI offers. There may be some things that this committee decides the NHI cannot pay for – examples include glasses, plastic surgery or some drugs for rare conditions; but we do not know yet. If a service is not included, the NHI will not pay for it. You will have to pay for it privately.

The **Pricing Committee** will decide what the NHI will pay providers for these services and suppliers for these medications. All these fees will have to be set. The Pricing Committee will decide on the price for the service.

The **Stakeholder Committee** is where all civil society and other government and private stakeholders will come together to debate and discuss how the system is working and ways it can be improved. Again, we do not know who will be represented here and who will not be.



It is important that local voices of health committees and forums are included on the Stakeholder Committee but also that they can also give input to the other two committees. However, there is no mention of Health Committees or Health Forums in the NHI Act and there is no certainty that this will happen.

At the moment (June 2025), with the new regulations, there is a lot of confusion about who exactly appoints these committees, who they report to (the Minister? The Fund Board? The CEO?) and what powers they have (e.g. are they only advisory or do the make decisions).

# Learning Exercise 6

**Let's discuss in small groups.**

- Can you think of ways in which it would be useful to have Health Committees give feedback to the government at a local and national level on the NHI?
- 
- What are some of the dangers of not having community voice at a high level on these committees?

# Contracting Units for Primary Care (CUP)

There needs to be a way to group service providers together to know who can access services and who will provide those services and where. The basic unit of the NHI will be the Contracting Units for Primary Care or the CUPs. CUPs are a way of grouping service providers and teams, health facilities for a geographic sub-district area and will help implement the NHI. This may change and it is still not certain how it will be implemented.

But here is what we know for now:

A CUP for a geographic subdistrict area will include:

- a district hospital,
- local clinics or CHC's,
- Ward Based Outreach Teams
- Any **private providers** in the specific area (e.g., Private clinics, Private GPs)

In the NHI Act, the role of the Contracting Units for Primary Care is:

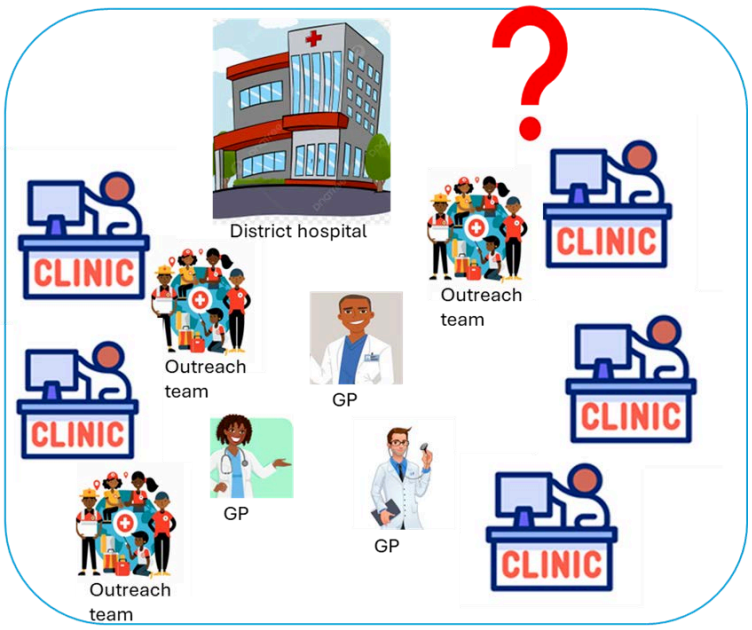
- To identify the particular needs for healthcare service in a sub-district
- To identify accredited public and private healthcare service providers at primary care facilities
- To manage contracts with providers and facilities
- To monitor the payment to providers and facilities
- To have access to information on the disease profile in the sub-district to plan
- To improve access to healthcare services
- To ensure the referral system is functional, including transport of users between the different levels of care and between public and private healthcare service providers
- To facilitate the integration of public and private healthcare services within the sub-district
- To resolve complaints from users

## Learning Exercise 7

**Let's discuss in a large group:**

- How could Health committees assist in these roles?

# Based on the above, a possible simplified picture of a CUP?




## What would it look like?

There may be between 400 and 500 CUPs across the country when the NHI is fully rolled out. This is still not finalised. Remember the NHI will be rolled out in phases. As said, this is still not certain, and things may change.

It is proposed that health budgets will be allocated to a CUP based on the size of the population it serves, but payments to providers will go directly from the NHI Fund. This means that CUPs do not sit with any money of their own but are responsible for monitoring these contracts and must engage with the District Health Management Office (DHMO) about what services are available and how they are spread out appropriately.

The CUPs are supposed to be made up of accredited facilities, medicine suppliers and health providers to treat patients. Later in this manual, we will explain what accreditation means and how it is done. These accredited providers and facilities can be public or private. The CUPs will report directly to the NHI Fund but should work closely or report to DHMO (see below). This is still very unclear how this will all work.

Now, let's look at another important structure, called DHMO.

# District Health Management Office (DHMO)

Then there will be a new structure that will be created called the District Health Management Office (DHMO) and it will be run by the Department of Health.

It is not very clear how DHMO will interact with other bodies such as the District Health Councils or with our community governance structures (such as clinic committees and hospital boards).

This DHMO will be responsible for coordinating Primary healthcare services in the district. This will include everything from accreditation to quality control, emergency medical services, and referral pathways.

The DHMOs will talk to the NHI Fund about challenges in their districts and be required to report annually. They will also have to talk to both Provincial and Municipal health managers.

Payments to providers will go directly from the NHI Fund. The exact working arrangement between the CUPs and DHMO is still unclear. But there are still a lot of changes happening. It is hard to say what will the CUPs do and what will DHMO do and how it will all happen. The Department of Health still needs to work a lot of this out.

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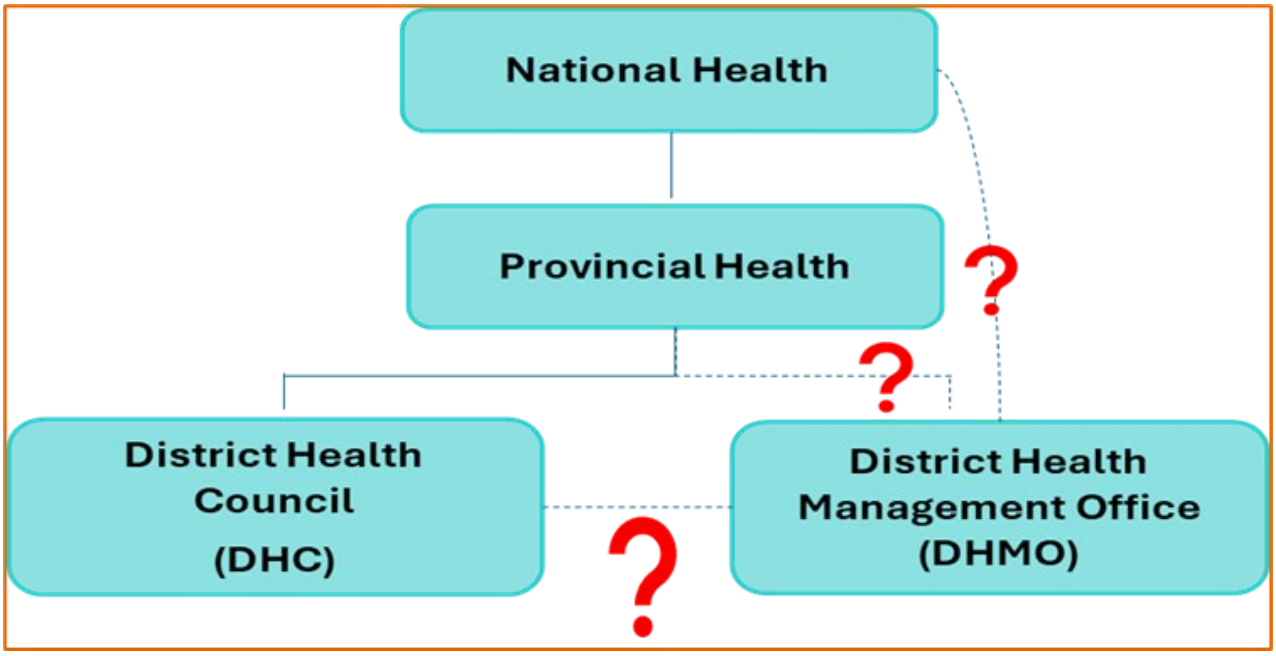
## Possible Structure: how would it work?



## How will it all work together?

It will be very important to see that community voices are included in District Health Management Offices (DHMO's) and District Health Councils (DHCs) and that there are ways for information and discussions around any decisions to feed back to communities. The Department of Health will have to amend the National Health Act to create the DHMOs, but the current information on how they will be formed, and which structures will be a part of them is still being figured out. They will serve the role of managing, coordinating and supporting primary healthcare services at the district level. We also know that there will be changes made to the National Health Act that give these DHMO's a responsibility to interact with community representatives through the District Health Council. There will also be an addition of a section in the National Health Act stating that the District Health Councils will now have a responsibility to "promote community participation in planning, provision and evaluation of health services."

**There is a lot that is still unclear, but it shows there are opportunities for community participation and that we need to advocate for access to these spaces.**

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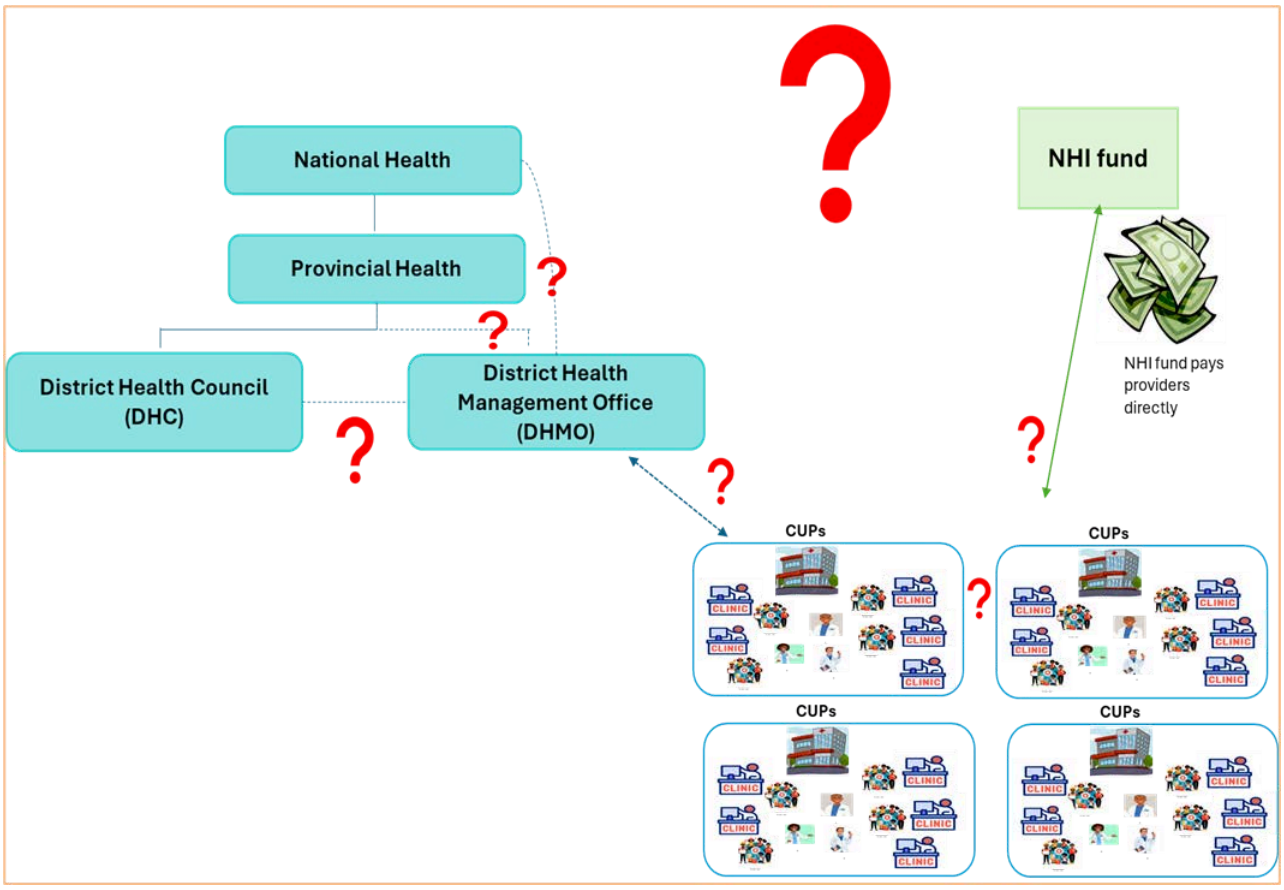
## What would it look like?



# Access to Hospital Services:

It is also important to note that the above talks about access to Primary Care services. NHI proposes that Hospital services will be accessed via the referral pathways e.g., via referral letter from a Primary Care facility or a GP, for example. Once again, how this all fits together with both public and private sector hospitals is still unclear.

## However, in summary:

- Hospital Services (private and public) which will follow referral pathways.
- To access hospital services, the patient has to follow the referral path from the primary care facility (except when it's an emergency).
- Patients/ Users should access the health system at Primary care level as the first point of contact.
- Depending on the additional care they need, they will access hospital or specialist services via a referral pathway.
- How will this work in reality is still unclear because under NHI, hospital services include access to private or public hospitals.

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Let's talk more about the processes that need to happen for you to access care and for service providers to provide care under the NHI.

What do you need to do?

What do service providers need to do?

# Registration, and Accreditation in the NHI

For a service provider like a GP or clinic or hospital to provide services under the NHI; they must be accredited and registered. Then for a person/patient, to access services under the NHI, you will need to be registered.

## Patient Registration:

Firstly, if you are a patient, you will need to register with the NHI. This means you should be a SA citizen, permanent resident, refugee or inmate. Asylum seekers and undocumented foreigners are only covered for emergency services and notifiable conditions - except for children who are fully covered.

A refugee is someone who is legally in the country because of a real fear of harm in their own country. There can be many reasons for this from war to politics.

Registering will happen the first time you attend an NHI facility and only requires a form of documentation. Patients will go to facilities that are closest to them and follow referral pathways in much the same way that they do now. They may also go to local GP's who are paid by the fund. "NHI facility" means, a facility that has been accredited and registered to offer services that the NHI will pay for (see below).

# Provider and Facility Registration:

All health providers and facilities will have to be accredited. This means that they must agree to the terms of the NHI Fund and meet certain requirements before they can be contracted. This means that they have met a list of minimum standards set out by something called the Office of Health Standards Compliance (OHSC) to make sure that they are of good enough quality. This makes sure that patients do not get forced to go to facilities that are falling apart and not keeping up with the demands.

Also remember; there is no law forcing the private sector healthcare workers to participate as NHI providers. It is the choice of private facilities or private providers whether they would like to sign up for participation in the fund. But if they do not register, then they cannot get paid for by NHI fund for providing services to patients that fall under NHI.

Also, one of the important parts of the NHI Act says that when NHI is fully in place, then medical schemes will no longer be allowed to provide payment for services that the NHI covers.

This means that medical schemes at some point in the future will only be able to pay for services that the NHI does not offer.

Remember the NHI benefits committee will decide what the NHI fund will pay for. There will be some things that the NHI will not pay for. Medical Aids can pay for things that the NHI will not cover.

If you want to have a medical service that is not covered by NHI, then you can still choose to pay for that yourself.

The lists of requirements for accreditation are still being worked on, but this is a very important area for health committees and health activists to watch. Knowing what a facility needs to get accredited is a great way to monitor where our local facilities are failing or succeeding. If you know what services the facility is meant to provide and at what quality, you can know what to expect.

All this sounds complicated but the more we talk about it and question government, the clearer it will become for everyone.

## Learning Exercise 8

There are a lot of details in the NHI that are still going to be figured out. Now that you are familiar with the Act - what do you think will be the impact (good or bad) on the following areas?

- Rural areas?
- Poor urban areas?
- Wealthy urban areas?
- People with medical aid?

05

# Looking at Clinic Committees and Hospital Boards and User Committees

# Community Participation


Community participation in social, economic and political change is very important. Communities should shape how their areas are improved and play a central role in deciding, managing and monitoring service delivery. Communities know and understand their issues and their strengths. Communities may not always have financial resources, but their knowledge and skills are an asset and must be valued. Being involved in your health and decisions on health is a human right.

Let us now take a look at some of the legislated structures for engaging with communities that already exist in South Africa's health system. Many of these are legislated to exist in the public sector. But there may be direct private sector comparisons such as with Hospital Boards. At the moment, there is no law that asks the private sector to work directly with communities.

The National Health Act of 2003 is an important law that has tried to formally include community participation in the South African Health System. It supports the creation of Clinic Committees or Community Health Centre Committees at Primary care level. It also requires community members in Hospital Boards in Central Hospitals.

The National Health Act also says who should be included in Health Committees. One challenge with the laws is that it allows provinces to decide how they will create these structures. Different provinces have different ways of setting up health committees and working with them.

## Learning Exercise 9

**Let's discuss in a large group:**

Why is community participation important for health services?

There are so many reasons; let us discuss some of these in a large group.

# Hospital Boards:

The National Minister of Health is responsible for appointing a representative board for each **Central Hospital or group of Central Hospitals.** While provincial MECs are responsible for appointing boards to all other hospitals. They must set out the functions of each board and how the boards must meet.

## Central Hospital boards are generally to include:

- One representative from any University attached to a hospital.
- One representative from National Department of Health (only for Central Hospitals)
- One representative from Provincial Department of Health
- Up to three representatives of the local community or interest groups around the hospital
- Up to five representatives of staff and hospital management (these members may not vote)
- Up to five experts in law, human resources or accounting

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They are appointed for 3 years, and any member can be removed by the Minister or MEC before this if there is a good reason.

In the Western Cape there is an Act called the Western Cape Health Facility Boards and Committees Act of 2016. This lays out how the Hospital Boards and Clinic Committees Work in this Province.

Provinces have different approaches, please read further below.

The Eastern Cape Department of Health (ECDoH) has updated its guidelines for the governance structures at local facilities in 2023. The document is called the Eastern Cape Department of Health Governance Structure Operational Guidelines of 2023.

# Provincial Hospital Boards

Provincial hospital boards must include not more than 14 members including

- community representatives (at least 50% of the committee),
- experts,
- the head of the facility,
- clinical staff and non-clinical staff
- and a university representative.

They may include municipal councilors and a provincial representative. Community representatives must be nominated and not be political party members and must come from a representative organisation like a forum or NGO.

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# Clinic Committees

Clinic Committees as we have said are left up to provinces to figure out. But the National Health Act does say that provinces must establish these committees for each clinic or group of clinics and that they must include at least:

- **One or more local councilors**
- **One or more members of the local community**
- **The Head of the Facility/Clinic/CHC**

In the Western Cape, legislation says that Clinic Committees must include no more than 12 members including community representatives (again at least 50% of the committee), municipal councilors, the head of the Primary Care facility or a manager appointed by the district.

Community representatives must be nominated and not be part of political parties but do not have to be part of a specific organisation as long as they “represent community interests.”

There are sometimes differences in how the provinces do this, please see below

# General Points: Western Cape

Some things to consider for both Clinic Committees and Hospital Boards are that race, gender, age and disability and the like, must be represented by its members.

They should be respected, care about the community and be people with integrity. Members should not be appointed for more than 2 terms of 3 years each in a row unless the MEC has a good reason.

Also, members must be above the age of 18, not have any prior time in prison or any conviction for fraud and not be currently in bankruptcy. Being bankrupt is when the court gets involved because a person is having financial problems and the court says that you have no money to pay all your debts. While someone is in this situation, they are not supposed to serve on a health committee.

If boards/committees do not meet at least 4 times a year they must be disbanded and a new one appointed. Vacancies must also be filled immediately.

Note: Clinic committees are also sometimes called health committees. There is a lot of confusion about what health committee is and what a clinic committee is. We will discuss this further below.

# Differences in the Eastern Cape

As we said above - although there is a National Act that mentions clinic committees and hospital boards - each province is responsible for coming up with their own policy to implement the programme.

In the Eastern Cape, the policy on the role of Health Committees says; Health Committees should oversee adherence and provision of Primary healthcare services. They should also identify health problems in the community and bring them to the attention of the facility. They should also monitor how the facility is doing in meeting its targets and indicators. They should receive regular performance reports from the facility.

They should monitor how well management at facilities have responded to community complaints from patients and themselves, they should monitor opening and closing times of facilities and allow for a complaint's pathway to management through a complaint's procedure.

In Western Cape, the Health Committees have the smallest role in governance compared to other provinces. Also, the MEC appoints committee members directly. The Eastern Cape has changed its appointment process for clinic committees. Clinic committees are still nominated by communities. In the past, the guidelines proposed community elections on these nominations. Now however, the nominations are submitted to the district where a selection committee screens the nominations and recommends ten members to the MEC for appointment.

In the Eastern Cape, some sectors that must be represented include traditional leaders, organised labour, a local government councillor and representatives from the religious community, women's organisations, youth groups and disability groups.

Training and resources for meetings should be provided by facilities where possible in both provinces.

# Powers of a Clinic Committee/Hospital Board

Remember that the powers of clinic committees will be different in the different provinces. Make sure you speak to the local clinic committees to find out the updated local policy in your province.

It is important to know what hospital boards and health committees are allowed to do and what powers they have so that you can hold them accountable. It also helps to see where we need to engage with other higher structures to get to our goals.

Clinic Committees are meant to monitor how the Primary Care facility is managed. They must communicate what the needs and complaints of the community are to the management. They are also responsible for getting the community to support the facility and not work against it. After coordinating with the management, they are allowed to conduct visits to the facility (as long as it does not disrupt work) and give written feedback to management on these visits. They can also encourage and coordinate volunteers who are able to help with general clinic duties.

They are empowered to conduct surveys, meetings and workshops in the community. They are allowed to share information with the community on the facility's policies, services, finances and performance. They can make reports and recommendations to the Head of the Facility or Municipality or to the Head of Department or to the Provincial Minister on any issues they find.

They are allowed to request information from the Head of Facility as long as it does not violate the rights of patients or staff to privacy and confidentiality. They are also allowed to request copies of any progress reports and to raise funds for the facility and the committee's functioning. All funds and donations must be accounted for.

## Learning Exercise 10

There are many other roles that a clinic committee fulfills beyond just admin.

### In small groups, lets discuss the below:

- What do you think clinic committees should do in your opinion; what should their main roles be?
- How will this role benefit the health facility?
- How will this role benefit the community?

# User Committees

User committees are a name that our project is using to describe committees that can be set up and linked to private sector facilities at primary care level i.e., at local GPs or local Private clinics. Remember there is no law saying that the private sector needs to include community participation in its governance and decision making. We hope this will change. But for now, users of private facilities can approach their GP or local private clinic or even hospital and discuss the importance of community participation with the facility. It can be done in a similar way to a clinic committee.

User committees at private facilities will ensure community voice in health governance at private facilities, like Health committees at public facilities.

### Proposed role and responsibilities of user committees at private facilities

These are suggestions: User committees could:

- Receive suggestions from the users/ patients and discuss them with private facility management. This could be done as part of suggestion and complaints management process at that facility. It could be seen as a way to help the service improve.
- Being part of the complaints process and discussing complaints with the clinic.
- Conduct patient satisfaction survey/ community scorecards.
- Health workers and community members should be involved in discussing the main health issues facing that community and ways of helping this improve. Private GPs for example know what illnesses are affecting that community. Community members understand some of the issues that are causing those health problems. Working together can be good for everyone. User committees is one way that private facilities can begin this communication on health. It should be two ways. No patient information needs to be shared to do this.

## Learning Exercise 11

**Let's discuss in a large group.**

- Do we need to 'monitor' the private sector? Why?
- What should the user committee's role be?
- Do you think private sector GPs will buy into this idea?
- How could private sector GPs be approached to get them to support this idea?
- What other ideas do you have to partner with private GPs/ how can communities work with private GPs in their local area?

06

# The Role of Health Forums

# Introduction


The clinic committees are in the law and are therefore the responsibility of government to create.

There are a lot of different ways that they are made and work in the 9 different provinces. However, we know that Clinic Committees are not always set up even though the law says they must. Also, sometimes they are not given proper attention at the facilities. This can affect the potential of clinic committees to achieve their goals. They are also government structures and so can be limited in their scope and the areas that they have the power to work in.

While clinic committees do have the power to run community training and surveys in communities, they are focused on healthcare and services at the clinic and health facility level.

Health Forums are slightly different to Clinic Committees and have a broader role. Sometimes there is a lot of confusion between the two, but they serve slightly different roles that can complement each other. It can be confusing because Health Forums are sometimes called Health Committees or Community Health Committees but for this manual we will stick to calling them Health Forums.

Remember the Social Determinants of Health; there are many parts that need to work together for healthy communities. Many of these parts of the health system fall outside of facilities. The clinic may not be able to always help with the social determinants of health and assistance may need to come from other parts of the health system or other government departments, businesses, funders.

This is where it is possible for Health Forums to play a part in the story. **Health forums can work together with many partners on what makes a community healthy!**

# How Are Health Forums Made

Health Forums are made up of community representatives of all the different areas of the health system but are based in communities and not at health facilities. This means that they can include representatives from local community groups, street committees, NGO's, faith-based organisations, and neighbourhood watches as well as respected community leaders or individual health activists. Once again, they are not legal structures and so can form how they see best based on the community that they serve.

They should include people who come from a range of different backgrounds - representatives of the youth, elderly, disabled and working class - and should have local knowledge of the challenges that the community faces.

They should know how the community works and the struggles in the community that affect health outcomes. They are not limited by the control and management of a facility but can work with facilities or existing Clinic Committees should they choose. They are free to set up in ways that make sense in the local area based on the strengths of the community.
We can see that because Health Forums are free to create themselves and are not legal government structures, they may end up being very different between different communities. It is important that we do not say that there is only ONE way to make a health forum. Also, because they are not government structures, funding is very limited.

# Here are some guidelines for Health Forums:

- **Health Forums should have a constitution.** This is a document that the Forum comes up with when it is formed, with input from all of the stakeholders involved. It includes details on the goals and aims of the forum, how the forum leadership is elected and their various roles.

- **They should have an Executive/Leadership group.** This should be stated in the constitution. It should include a Chair of the Forum, one or two deputies, a Treasurer and a Secretary. There can be many other roles that can be decided upon to include.

- **Health Forums should meet regularly in the community** - this can be decided in the constitution but meeting once a quarter at least if not more, is recommended.
- Health Forums should be "not for profit" - while they are able to raise their own finances from campaigns, donations or sales at events - this means that money raised or resources that are given to the forum should be used only for the work and meetings of the Forum.

- **Efforts should be made to include all parts of the community** - young, old, disabled, women and men and members of groups that the community decides are relevant. Health Forums should not be closed spaces and should be open and inclusive to all.

- **Efforts should be made to reach out to relevant community leaders, activists and organised groups and NGOs.** Some may not be aware that the Forum is being created or what a Health Forum is. They should be invited to participate and to join.

- **Community Ownership** - this means that members of the Health Forum should feel that they have a role in the Forum and can take part in its decisions.

- **They should want to improve Health in communities.** They should not be spaces for advancing political parties or personal motives. People are welcome to participate representing other organisations or groups but must adhere to the constitution and goals of the Forum.

- **They should operate democratically.** This means they must make sure they genuinely represent their community. For example, they should have regular feedback meeting and hold a regular AGM to elect or re-elect members.

It is important to note that the points above are guidelines and are not fixed rules.

Groups such as the People's Health Movement are advocating for Health Forums to be created in every community at least at the sub-district level.

# Private User Involvement in Health Forums

In this project we would propose that private sector users also sit in subdistrict health forums. Sub-district health forums will strengthen community participation at sub-district level, strengthen a comprehensive strategy to ensure service delivery at both public and private facilities and at the same time function as a forum for sharing experiences.

It would be good to have both users of private and public facilities working together for quality healthcare for all.

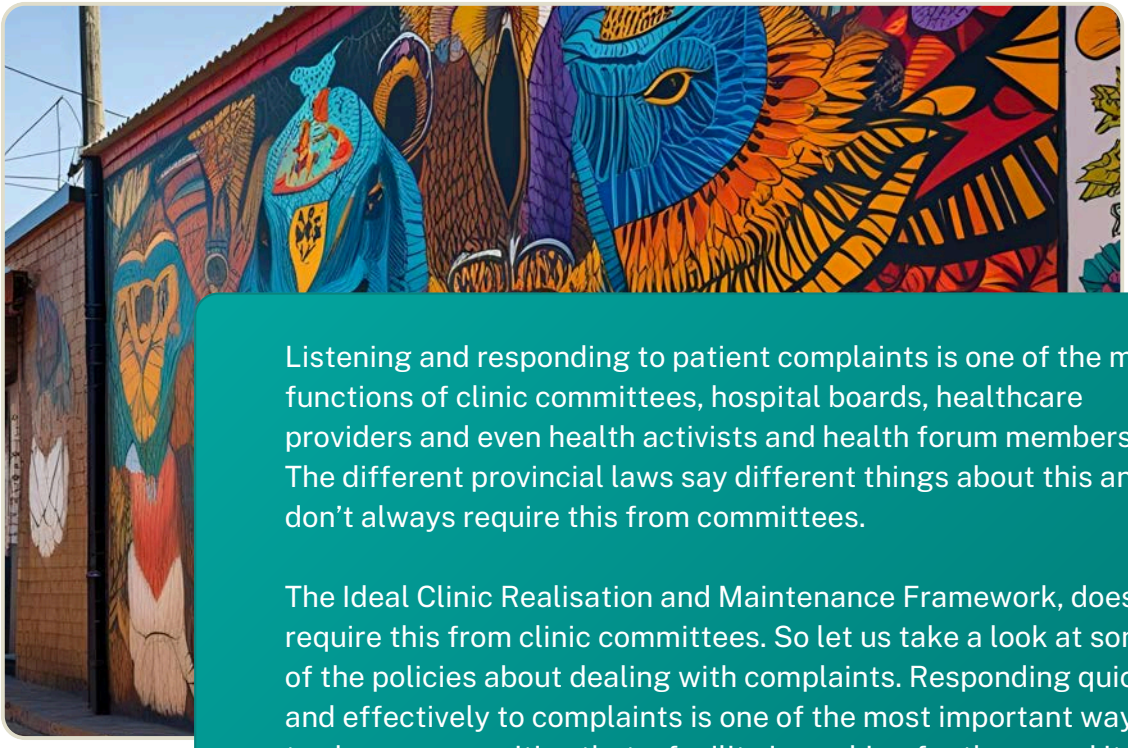
## Learning Exercise 12

Remember there is no legislation that sets out what Health Forums have to be, they can be free to decide on their own constitution/ priorities. Imagine that you are a newly formed Health Forum in your area:

- How would you go about recruiting private sector users to the health forum?
- Can you think of any activities or campaigns that can be done together to tackle community health challenges?
- How can private and public users help each other to improve healthcare at facilities?

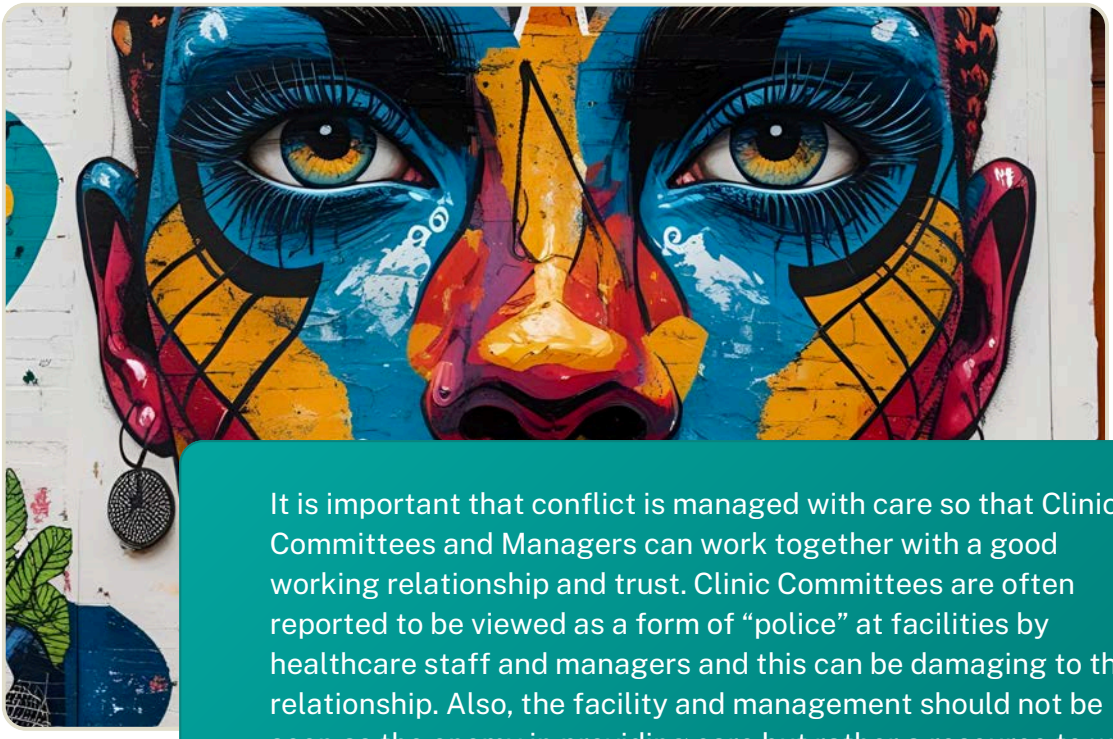
07

# Accountability Monitoring, Evaluation and Complaints



Listening and responding to patient complaints is one of the main functions of clinic committees, hospital boards, healthcare providers and even health activists and health forum members. The different provincial laws say different things about this and don't always require this from committees.

The Ideal Clinic Realisation and Maintenance Framework, does require this from clinic committees. So let us take a look at some of the policies about dealing with complaints. Responding quickly and effectively to complaints is one of the most important ways to show communities that a facility is working for them, and it can improve the relationship between staff and patients and improve patient ownership of their local health system.



It is important that conflict is managed with care so that Clinic Committees and Managers can work together with a good working relationship and trust. Clinic Committees are often reported to be viewed as a form of "police" at facilities by healthcare staff and managers and this can be damaging to the relationship. Also, the facility and management should not be seen as the enemy in providing care but rather a resource to work together to improve things. Everyone should see each other as partners in health. Let's start with Ideal Clinic.

# Ideal Clinic Realisation and Maintenance (ICRM) Framework

The ICRM framework aims to ensure that all clinics meet standards of quality care.

The ideal clinic approach is meant to help monitor and improve service quality by identifying a list of what is required for an effective Community Health Centre (CHC) to function well. This is used to assess the clinic; “audit”. The results of an Ideal Clinic audit should result in the manager developing a Improvement Plan to address the areas needing improvement that were identified in the Audit.

If the Health Committees know what has been said about which parts need improving, they can be part of assisting the clinic to improve and monitoring that the management is taking steps that they said they would. We have also developed other tools that can help Health committees monitor services.

These tools are aligned to the Ideal clinic and can also help health committees.

## Core components include:

- Availability of medicines and supplies
- Cleanliness and safety
- Qualified and respectful staff
- Reasonable waiting times
- Functional infrastructure
- Proper referral system
- Community engagement in governance: there a few indicators in the Ideal Clinic which as about the function of community governance structures.

# How Can This Be Managed By Health Committees?

Tools can help community monitoring of both public and private healthcare services in the subdistricts. These tools are meant to support Health Committees (HCs) and User Committees (UCs) in monitoring the quality and accountability of healthcare services at the local level, including both public and private providers. This below tool aligns with the Ideal Clinic Realisation and Maintenance (ICRM) framework. It can be used by Health Committee members and User Committee members.

## Monitoring scorecard Template

This scorecard helps Health and User committees to gather information and can be used by HCs and User Committees (UCs) during monthly or quarterly review meetings.

## Instructions

- This tool is to be used by a trained health and user committee member.
- Complete the scorecard every quarter, after community engagement sessions.
- For each indicator, rate the service quality from 1(very poor) to 5 (Excellent).
- Ratings and comments will be shared with clinic management to help improve service delivery.
- Keep comments brief but clear.
- Score and discuss each indicator collectively.

## Notes for filling out the scorecard.

- Discuss with 5-10 community members to get a range of views before rating.
- Use the comments section to write examples or explain your score.
- Be honest but respectful in your ratings.
- Keep the document safe and bring it to the next committee meeting.

## Monitoring scorecard

| Indicator | Explanation (linked to ICRM & Complaints principles | Score [1-5] | Comments |
|---|---|---|---|
| **Staff Availability** | Are staff present and working during expected times? | | |
| **Waiting Times** | Are waiting periods reasonable for patients? | | |
| **Cleanliness & Hygiene** | Is the facility clean, safe and functional? | | |
| **Medicine Availability** | Are essential medicines consistently available? | | |
| **Staff Attitudes and Respect** | Are patients treated with dignity and fairness? | | |
| **Complaints Handling** | Are complaints received, recorded and responded to? | | |
| **Cost Transparency (Private Providers)** | Are service fees explained clearly? Any hidden charges? | | |
| **Language & Communication** | Are services offered in a language patients understand? | | |
| **Referral Process** | Are patients referred appropriately with follow up? | | |

# Learning Exercise 13

As an exercise imagine that you are all together as the clinic committee for a clinic or CHC. Think of how the tool above can help you monitor the clinic's services. This will be good exercise to role play and to try out different responses.

- For example, how clean the facility is, what are the waiting times this month, is there enough stock of medicines, how many complaints were logged, how well are patient files stored etc?
- Do you think your committee would have enough time to check on these things every month?
- How would you give feedback to the facility manager?

## Clinic Committee Check list and Ideal Clinic

In the Ideal Clinic manual, there is an element (number 260) which is about whether there is a **"Functional Clinic Committee"** at the clinic. It gives guidance on clinic committees. Now that we have broken down how Clinic Committees are meant to be made up and what some of their roles are, you can use this checklist to help monitor your own Health Committees. (See the full list at the end of the training manual in the Appendices).

**Now let's discuss complaints and compliments and how to go about reporting these and keeping track of them.**

## Lodging Complaints and Compliments

There are many ways in which complaints can be brought to the attention of Health Facilities in both the public and private sector.

Also remember that information from patients or Health Committees can also be positive and does not have to be a complaint so that people can know where they are succeeding or where to give praise to healthcare workers or health committees to motivate good relationships and performance.

## National Guideline for Managing Complaints, Compliments and Suggestions

As we found in the Patient Right's Charter every patient has the Right to make complaints about poor quality services that they might receive. This is also included in the National Health Act. The National Guidelines is a long document that breaks down all the principles and approaches that can and should be followed or guide complaints and suggestions being made.

It is the responsibility of all facilities to have a complaints and suggestion process and to manage the process. This should be clear, accessible, easy to understand and confidential. There should also be a process for reviewing and appealing any decision that is made.
The National Guidelines to Manage Complaints, Compliments and Suggestions aim to improve how complaints area managed in the health system.

**Core principles:**

- Fairness: that is all complaints must be handled without bias.
- Confidentiality: that is complaint identity must be protected.
- Responsiveness: that is complaints must be responded to within timeframes.
- Transparency: that is, patients must be informed of the outcomes.
- Learning and improvement thus complaints are opportunities to improve service**s**

# Complaints Pathway (Based on National Guidelines)


**Note: Complaints in the private sector may be handled in their own specific way.**

## How can this be managed by Health committees?

Tools can help community monitoring of both public and private healthcare services in the subdistricts. These tools are meant to support Health Committees (HCs) and User Committees (UCs) in monitoring the quality and accountability of healthcare services at the local level, including both public and private providers. These tools include the principles from the National Guideline to Manage Complaints, Compliments and Suggestions in the Health Sector of South Africa and aligns with the Ideal Clinic Realisation and Maintenance (ICRM) framework.

# Community Complaints Logbook

Purpose: The purpose of this tool is to document and track community feedback about clinic services in a structured way, helping facilities to respond and improve care.

Instructions for use:

- Health and User Committee members should record all complaints, compliments and suggestions raised by community members.
- Record feedback as soon as possible after receiving it.
- Fill out all sections for each entry. Update status regular.

## Community Complaints Logbook Template

| Complaint ID | Date Received | Issue Summary | Raised By | Type of Complaint | Referred To | Action Taken | Feedback Given | Resolved |
|---|---|---|---|---|---|---|---|---|
| **001** | 06/01/2025 | Long waiting time | Anonymous | Operational Delay | Facility Manager | Queue restructured | Yes | Yes |
| **002** | 08/05/2025 | Rude staff behaviour | HC member | Staff Conduct | Facility Manager | Awaiting response | No | No |

## Notes for filling out the logbook:

- Do not include names or personal details of complainants if they prefer anonymity.
- Use clear, factual language to describe the feedback.
- Follow up on unresolved complaints in subsequent meetings.
- Share summarised trends with facility staff and community regularly.
- Complaints should be handled with confidentiality and follow the steps outlined in the National Complaints Guidelines including escalation if unresolved.
- Fill in as complaints arise. Track actions and follow-up.

## Additional Tools

- You may find it useful to have a summary report which could include the below points. Remember these tools are meant to assist you if you think they are useful.

# Monthly Summary Report Template

Facility Name:
Subdistrict:
Reporting Month:
Compiled by (Name)
Role in Committee:

- What were the major challenges reported this month?
- Were any complaints raised? If yes, what were they and how were they handled?
- Any success stories or improvement noted?
- Do patients understand the complaints process?

## Learning Exercise 14

As a learning exercise, imagine you are the Clinic Committee members who are responsible for opening the complaints box for the facility.

You open a complaint, and it is naming one of the clinic committee members and accusing them of poor behaviour or rudeness to a patient. How would you go about addressing this with the facility manager, with the clinic committee and with reporting back to the person making the complaint?

- The Clinic Committee member denies that they were rude and says that it was in fact the patient who was rude. Talk through the scenario and imagine you really had to come up with a detailed plan of the steps to go through to resolve the complaint for all parties. You can Role play different examples.

# 08

# Ward Based Primary Healthcare Outreach Teams and COPC

# Introduction

In 2011 South Africa decided to adopt the Ward-Based Primary healthcare Outreach Team (WBPHCOT) Strategy. This is one of the ways that South Africa is moving healthcare beyond hospitals and clinics into the community, by using outreach teams, taking health to the people.

The Department of Health hopes to achieve this through developing teams of Community Health Workers (CHW's) which are connected to Primary healthcare (PHC) facilities with nurse leaders.

The latest **WBPHCOT Policy Framework** and Strategy was launched in December 2017 to run until the end of 2024.

# WBPHCOT Policy Framework:

The policy framework lays out that CHW's should be well trained and supported with supervision and be given clear expectations and catchment areas and linked to health facilities.

The policy states that each WBPHCOT should be 6-10 CHWs, with 1 nurse outreach team leader (OTL) and a data capturer. The actual numbers of households would differ from around 250 households per CHW in urban areas to around 96 households per CHW in deep rural areas - this is because of distances and infrastructure. Facility managers should provide oversight.
WBPHCOT do not have any formal role within governance structures at facilities in the way that Health Committees do.

CHW's often focus on maternal/child interventions and monitoring chronic conditions but should provide generalist services including but not limited to medication delivery, conducting household health assessments and linking patients to care, conducting home visits for pregnant women, screening for TB and other infections, screening and health promotion in schools, adherence support and tracing defaulters, family planning counseling. They should also work with other departments such as Department of Social Work caregivers or environmental health workers.

This policy is a national policy - so let's take a look at the way it is applied at a provincial level.

# Community Orientated Primary Care

We have spoken above about Primary healthcare or PHC. This is a general principle that can be put into practice in many different ways - one of which is Community Orientated Primary Care (COPC).

The Eastern Cape and other provinces may follow their own type of Ward based approach. Different provinces can have different approaches. Let's talk about one example.

In the Western Cape Department of Health, a "Healthcare 2030" Policy was adopted which identified some priorities to achieve for the province by 2030. They included Primary healthcare (PHC), improving health promotion, providing person-centred care, providing care across the whole lifecycle. The policy also included a plan to adopt an approach called COPC for community outreach.

In other words - within the Western Cape the COPC approach has been adopted as a strategy to manage Community Health Worker (CHW) outreach teams and also to integrate the work of these teams with other forms of community and stakeholder engagement.

In general, the PHC team has its own area that it is responsible for and has about 10-15 CHW's (1 =per 250 homes or 1000 people), one CHW team leader, one professional nurse, one clinical nurse practitioner and one medical officer.

Other professionals like rehabilitation, social workers, dietician or family physicians may be included. Remember Primary healthcare is supposed to be about moving health outside of clinics and hospitals. It is also about involving communities in their health. There should be COPC meetings held in the different areas which should bring together different stakeholders and community engagement.

## Therefore, a very important part of COPC is:

| | |
|---|---|
| **Community Engagement** | The framework says that there should be engagement at all levels. This happens formally through Clinic Committees and Hospital Boards. It should also happen on the District Health Councils. There should be a forum for engagement. |
| **Stakeholder Engagement** | There needs to be engagement with other stakeholders such as NGO's, private practitioners, traditional healers and other government departments such as Education and Social Development and the local municipality. |

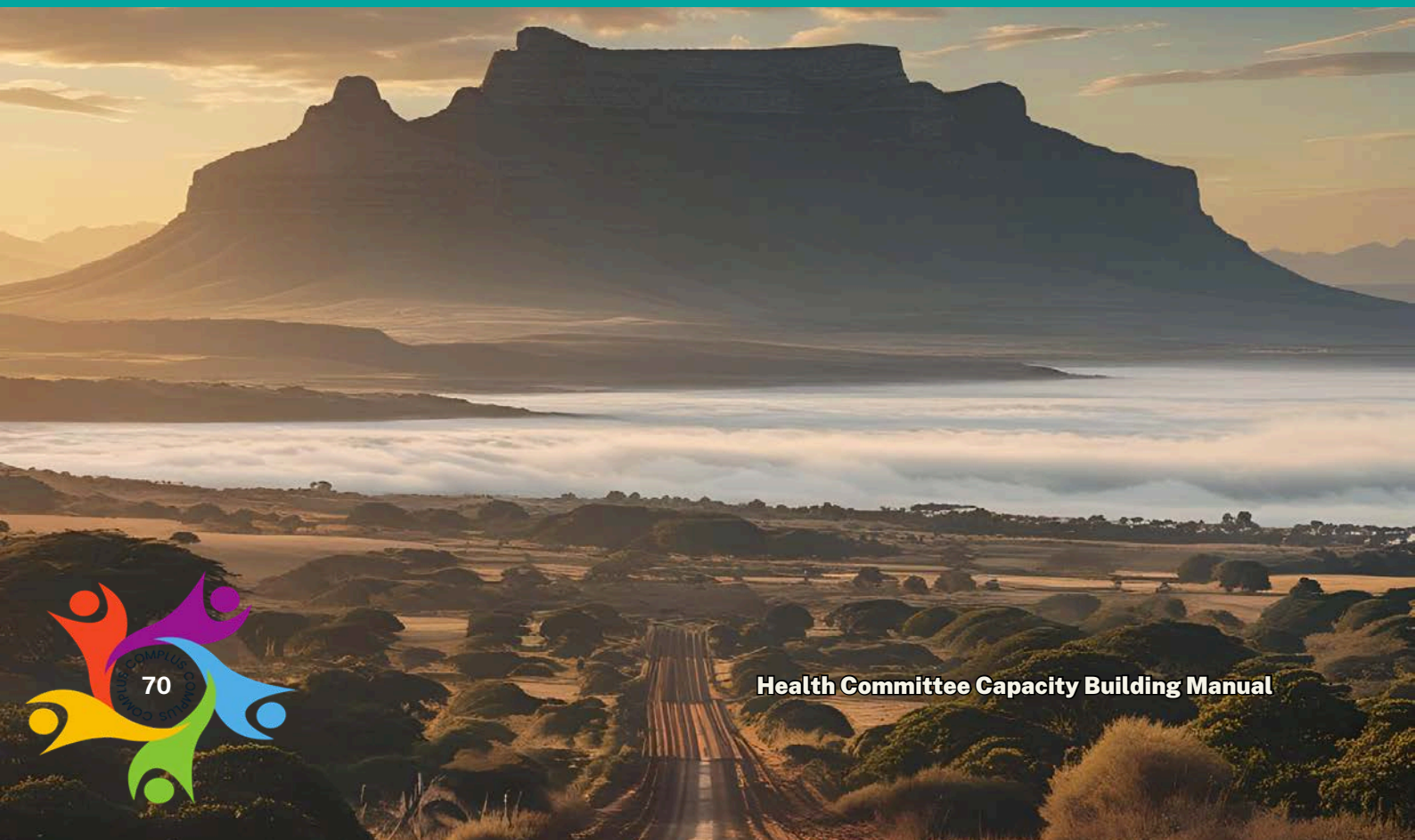
# Learning Exercise 15

### Let's discuss in small groups:

- How can Clinic committees/ health committees work with the PHC teams?
- How is the COPC or community health worker program at your facility working at the moment? Is it active and well established?

# 09

# Next Steps



# Our Learning Journey Summary

## Health & Human Rights:

We learnt about the broader picture of health and our rights but also our responsibilities. We talked about the South African constitution and the bill of rights especially Section 27 and many other laws and principles which are important for health. Patient rights were discussed and also privacy, confidently and informed consent.

## Learning About Health Concepts:

We learnt about the social determinants of health, universal health coverage (UHC) and primary healthcare (PHC).

## Understanding South African Health System:

We talked about the very unequal access to quality healthcare in South Africa which is a legacy of colonization and Apartheid, and which still affects millions of South Africans. Few people can access private healthcare. Most South Africans access government run facilities which are struggling because of the high numbers of people and lack of resources. We began to understand the main diseases that affect our communities and the health system. We also learnt about the National Health Act and the National Health Council, Provincial Health Council and District Health Councils.

## National Health Insurance,

Here we learnt about the NHI and how it hopes to make quality healthcare available to all South Africans. We looked at the structure of the NHI Fund, the different committees and other structures such as the DHMO and CUPs and how these may all work together as we still don't know exactly how it will be implemented. There is much that government still needs to work out like referral systems.

## Looking at Clinic Committees, Hospital Boards and User Committees.

We talked about the roles and responsibilities of different governance structures such as Clinic committees and hospital boards. We discussed the opportunity for a new structure called user committees which can be used for private facilities.

**The Role of Health Forums:**
We learnt about health forums and the potential that these provide and also how they can begin to include private sector users where possible.

**Accountability Monitoring, Evaluation and Complaints:**
We learnt about some opportunities to monitor health facilities and the tools that can help health committees and user committees to do this.

**Ward Based Primary Healthcare Outreach Teams and COPC:**
We learnt about other opportunities to participate and build partnerships for health in our local communities.

**Now let's talk about What are your next steps:**

# Learning Exercise 16

**In small groups:**
Reflect on what your main actions would be after learning all this new information:

- What will you do as an individual?
- What would you like to see your health committee do?
- How will you work with private sector users if you are a health committee/ health forum?

If you are a private sector user:

- How will you start to engage with health committee/ health forum?

Will you start to engage with your local private GP?

# Thank you for your participation

# 10

# Appendices

# Appendix A

## Learning Exercises possible feedback points

**1.Learning Exercise 1:**

The Bill of Rights, a key part of the constitution, protects basic freedoms like life, dignity, equality, and privacy, alongside other rights like freedom of expression and religion. Citizens have a responsibility to respect the rights of others and to contribute to a society where these rights are upheld.
These are some ideas:

- Making sure that we are respectful of all others,
- considering the rights of others,
- making sure that we all live in a clean environment,
- promoting a non-violent culture.
- ensure people have a right to free speech,
- supporting access to healthcare,
- promoting social justice.
- following the laws of the country.

**2. Learning Exercise 2:**

Yes, this is a violation of women's rights.

- Her confidentiality has not been protected because the nurse has spoken aloud to all those sitting in the waiting room and it is easy to see now that this woman is on ARVs. Well, we all know that this means she is living with HIV.
- We also know that there is still a lot of stigma and prejudice around living with HIV. This is the negative attitude that society may hold toward people living with HIV. It can lead to her feeling ashamed. This could have caused her to leave the clinic. So not only does she now not have her medication, but she has the additional burden of carrying the stigma of others. Stigma from others can affect her mental health and make her feel bad and ashamed of herself. This should not happen to anyone.
- What can be done to improve or respond to the situation:
- Lay a complaint, use the complaints box.
- Talk to a clinic committee member. The clinic committee member can raise the issue with the facility or operational manager so that the nurse can be supported to understand how she has broken patient confidentiality; and not do so in future.

# Appendix A

## Learning Exercises possible feedback points

**3. Learning Exercise 3: Social Determinants of Health Discussion**

Social determinants are the root causes of a lot of ill health.
Think about issues that may have an impact on health such as

- unemployment,
- overcrowding of living spaces,
- access to safe and affordable housing,
- access to food, safe water, clean air,
- violence, gender-based violence, young men are vulnerable to higher incidence of assault,
- access to affordable and reliable healthcare.
- education,
- language barriers, (consider too people who are deaf and use sign language)
- Consider the impact of an informal dump site where children may play, cattle may roam, water may be collecting and standing for a long time which can attract mosquitos and other bacteria; and dump sites will attract rats.

It also has effects on delivery of services.

- The clinic may be overcrowded as these social determinants will lead to many diseases.
- There may be more people with chronic disease conditions such as diabetes, hypertension due to food insecurity, poverty, lack of preventive care, or asthma because you live close to pollution.
- An increase in mental health challenges linked to unemployment, violence or lack of housing, alcohol and drug abuse can also happen.

We also need to think about how to work with other sectors such as the local ward councillor, schools, ECDs (early childhood development centres), social workers, environmental health, to address social determinants of health.

# Appendix A

## Learning Exercises possible feedback points

**4. Learning exercise 4:**

- It starts at the local level. We need to have discussions about health issues at our clinics and on our committees.
- Our structures support a tiered approach (meaning there are different levels) so that we send representatives to sub-district and district forums. These provide avenues for us to discuss amongst ourselves. We can raise issues of policy and debate them.
- Policy issues can be discussed with Department of Health district management representatives, asking for their support in escalating to a provincial level. Follow-up is required, which is why minutes of meetings are so important.
- We need to promote and advocate for formal clinic committee structures at provincial and national level to escalate our issues.
- If these are not working properly or don't exist, then we need to write our concerns in letters to the MEC for Health in our provinces and even to our Minister of Health.
- Without community voice, our health department may become alienated from the needs of the people.
- Community voice builds credibility such as in vaccination campaigns.
- Communities understand some of the barriers to health, especially cultural barriers and issues in the community like the social determinants of health.
- The voice of marginalized groups may be better understood so as to build trust.
- Communities can support the prioritization of resource issues.
- Consider how else you may engage with clinic committees locally, in the province and nationally. Social media platforms can be established to broadly market the work we are doing.

# Appendix A

## Learning Exercises possible feedback points

**5. Learning exercise 5:**

Try to draw out personal stories from the group members about their experiences but also remind participants they do not have to share the full details and only parts they are comfortable with:

- When do you go to a private practitioner?
- When do you make use of a traditional healer?
- Listen carefully to the responses.
- It may be clear that our groups believe that we will get healthcare more immediately from a private practitioner, and they may also feel that the private sector provides better care.
- The long waiting times at public sector (government) clinics and hospitals are a common problem experienced throughout our country. It is also a challenge in many other countries too.

**6. Learning Exercise 6: NHI**

- It starts at the local level. We need to have discussions about health issues at our clinics and in our committees.
- We need to monitor service delivery as the NHI is rolled out as these are important parts of the contracts that the NHI will be paying for. Are the various providers performing up to the performance standards? Communities need to monitor how the NHI is playing out in the lives of community members/ patients. Is it working? What are the challenges? Are people accessing quality healthcare, are facilities upgraded in our local communities, are private providers accessible, are referral systems working, are complaints being managed.
- Then also at a higher level, another example could be to make sure the benefit packages fit community needs and priorities.
- Also ensuring the stakeholder committee is a valued advisory contributor to the NHI fund and that Health committee representation is visible at this level. Health committees have a good understanding of community needs as well as service delivery at facility level and at hospitals and are excellent resource with valuable knowledge that should provide important input at the NHI related committees. These committees need more than technical experts; they need to value community experts who come with lived experience such as health committees.

# Appendix A

## Learning Exercises possible feedback points

**7. Learning Exercise 7:**

Discuss points on how Health committee experience can assist the CUP in roles like complaints management, help to understand if referral pathways are working from patient feedback. HCs also have insights into the community healthcare needs etc

**8. Learning Exercise 8:**

*Urban and rural:*

- The NHI is trying to make sure people can access quality health services. This service should not depend on you having a lot of money. All South Africans deserve this access. Also, you should not be left with financial problems because you had to pay so much money just to get quality healthcare. This should also be the case for people who live in cities and for people who live in rural areas.
- The NHI hopes to increase the number of clinics and mobile services in rural and underserved areas. We know that rural areas often face staff shortages such as for doctors and nurses for many reasons. The NHI won't necessarily be able to solve this challenge right now.
- We know that health facilities need to be accredited for the NHI. Many health facilities, both rural and urban, lack basic infrastructure which means that they need to be upgraded. How soon will this happen?
- Community health workers will provide access to primary healthcare services at the household level. This is meant to support poorer households to meet health needs.

*Medical aid users:*

- The NHI Act suggests limiting medical aid to services not covered by NHI, this means they will have a smaller role.

*Wealthy households:*

- May still be able to purchase their health services. They may be able to keep private care but at higher costs because they may pay twice (NHI taxes + medical aid) but may face limited private care options.

# Appendix A

## Learning Exercises possible feedback points

**9. Learning Exercise 9:**

- Community participation is essential for effective, equitable, and sustainable healthcare. This is important in our country to address many of our challenges such as including historical inequalities, diverse cultural needs, and some distrust in health systems.
- Community engagement helps to build trust such as in campaigns around HIV and vaccinations and others.
- They can support health messaging so that it is locally relevant.
- Communities can help to identify the health needs of local communities.
- They can identify social determinants of health such lack of clean water or hazardous informal dump sites.
- They can promote peer support groups in the community.
- Clinic committees can be the bridge between the health services and the local community.
- They can hold health services accountable and monitor to ensure quality health services.
- Something to consider for the future is participatory budgeting so as to determine health priorities.

# Appendix A

## Learning Exercises possible feedback points

**10. Learning Exercise 10**

- The clinic committee has many important roles to play. These are a few ideas.Each province has its own set of guidelines. You need to know what your provincial guidelines indicate as roles for the clinic committees.
- Oversight is one of these important roles. Oversight is different to management. We are definitely not managers. Oversight means having a “big picture” look over the services and the facility to ensure that the patients have quality services. It requires that patients are satisfied with the services. It requires close partnership with the facility or operational manager.
- Advocacy is another role. Advocating on behalf of the patients to the facility. And often equally advocating to the community on behalf of the clinic and healthcare workers. These are not always easy as they may contradict one another. It requires wisdom from the clinic committee members.
- Complaints management is also another important part.
- Social mobilisation such as with support in campaigns. Together with the health promotion team and community health workers, clinic committees offer valuable knowledge and experience of local communities. They may support them in addressing priority areas as well as issues.
- Marketing of the clinic committee and its roles through social media.

Remember that health facilities belong to the people, so we are responsible for maintaining good health services, holding the staff accountable through our relationship with the manager. It is important to try as best we can at all times to promote a good working relationship with facilities management. Where management and clinic committees have an honest and accountable mutual relationship, their communities may experience better services and be more satisfied.

# Appendix A

## Learning Exercises possible feedback points

**11. Learning Exercise 11:**

- Holding private providers to account will be important. It can help to ensure quality of care. We may be able to support patient feedback such as patient satisfaction surveys. We could support the development of apps to monitor patient satisfaction.
- We need to ensure that the system is operating in an equal way. We need to know how the services are spread between public and private health providers and if it is being done in a way that is fair and equal.
- It is also important to ensure a fair pricing structure for healthcare services and prevent overcharging.
- Connecting with GPs has not been easy. It has been difficult to connect with private providers, especially around the issue of the NHI and community participation. Their focus is much more on the effects of the NHI on their practice. Many are involved in proposing alternative ideas for the NHI. Most of the private providers agree that universal health coverage is important and that our system of healthcare is highly unequal and unfairly disadvantages people who are poor. Many know and believe it should change. So, that is a good baseline from which to start. It is possible to find ways of working with private providers on community health also and maybe this can start to build partnerships and trust.
- We need your ideas as to how to better connect with private providers. You can brainstorm more in your health committees.
- Remember - We need to protect whistleblowers.

# Appendix A

## Learning Exercises possible feedback points

**12. Learning Exercise 12:**

- This question is about the idea of health forums bringing together private and public health service users. In the Eastern Cape, we have forums that relate to sub-districts and districts that are composed of representatives of clinic committee members. In the EC, we are considering both public and private users in this scenario.
- The Western cape also has some health forums which are normally at subdistrict level. These are not part of the formal legal governance structures in the Western Cape, but many have a good reputation and relationship with Department of Health and have been at the forefront of championing health rights.
- Our suggestion is to start with private providers and/or their users (their patients) that you may know so that you are able to talk with them. Start with those you know first and then they can suggest others for you to talk to. So, one person can then refer you to another person or doctor. In this way, you are able to reach more private providers and their users because each one is then referring you to another provider, so it keeps growing.
- You will need to persuade the users of the benefits of establishing a forum. These are many:
- Together we can address health concerns in the local communities.
- We can work together toward the development of more equitable services, where everyone has access to quality healthcare.
- We can learn together and from one another about what is working in the private sector, and what works better in the public sector.
- Together we can strive to improve services.
- We can improve our levels of skill in acquiring training from service providers such as the Department of Health
- We can advocate on behalf of patients.
- We can hold services accountable.
- We can work on health campaigns together.

Important:
It will also require their time, with no remuneration and they need to be aware of this. They need to care about communities and others.

# Appendix A

## Learning Exercises possible feedback points

**13. Learning Exercise 13:**

- We are striving to achieve Ideal Clinics. There are criteria and standards that apply, and we have discussed some of these already. Remember, this is a tool we have developed to help you as clinic committees and the tool is aligned to the ideal clinic. Our clinic committee may sit together to consider a rating score from 1 to 5 in terms of the various components of this score card. For each score that is assigned, the clinic committee will need to motivate their answer.
- We cannot say to the facility manager that we give the indicator (the measure we are using) for “staff availability” a score of 3 but don’t motivate the response. We will need to prove and explain why we gave them this score. This means you must have evidence to support what you are saying.
- It would be valuable to conduct this exercise at each meeting of the clinic committee. What would be valuable is to consider if, over time, things in your clinic improve.There have been examples in the Eastern Cape where score cards have supported improved conditions in the clinic as well as services.
- One example was of a group of clinic committees who chose one indicator: “cleanliness of the clinic.” This they monitored and reported. Over a period of three months, there was a real improvement in all of the facilities.

# Appendix A

## Learning Exercises possible feedback points

**14. Learning Exercise 14**

- This will be good exercise to role play and to try out different responses.
- A complaint against a clinic committee member must be treated with as much seriousness as a complaint against a staff member. This is done together with the facility or operational manager. Clinic committee members do not resolve complaints on their own.
- Remember that it is always valuable to go into a process with a positive attitude. You are there to help to resolve the complaint and to make things better at the clinic. This may require that you dig deep into your resources. Most people do not come to a clinic to cause problems. They are as stressed as you and I. They have their own challenges. Clinics, with their long waiting times for being seen and for getting medication, can worsen levels of stress. We need to be understanding of this for both patients and for staff.
- We are always commenting on the behaviour that is displayed and never on the character of the person. It's their behaviour that may not be acceptable, not the person.
- The complaint needs to be thoroughly investigated as a joint initiative of the clinic committee and facility manager (in this instance. It may be that sometimes only a staff member intervenes, or the situation may be delegated to the clinic committee member to intervene) With this example, it will require talking with the clinic committee member as a first step so as to understand what may have happened. Please remember that we are not there to judge the situation, but to understand it.
- The situation may require further investigation with the complainant too (that is the person making the complaint). Understanding the cause of behaviour is important.
- If, as is suggested by the clinic committee member, it was the patient who was rude, then this needs to be investigated with the patient.
- Ultimately, it will be useful to bring both parties together to resolve the issue, for an apology to be rendered where necessary and to build a common understanding. This process can be healing for all.

**15. Learning Exercise 15**

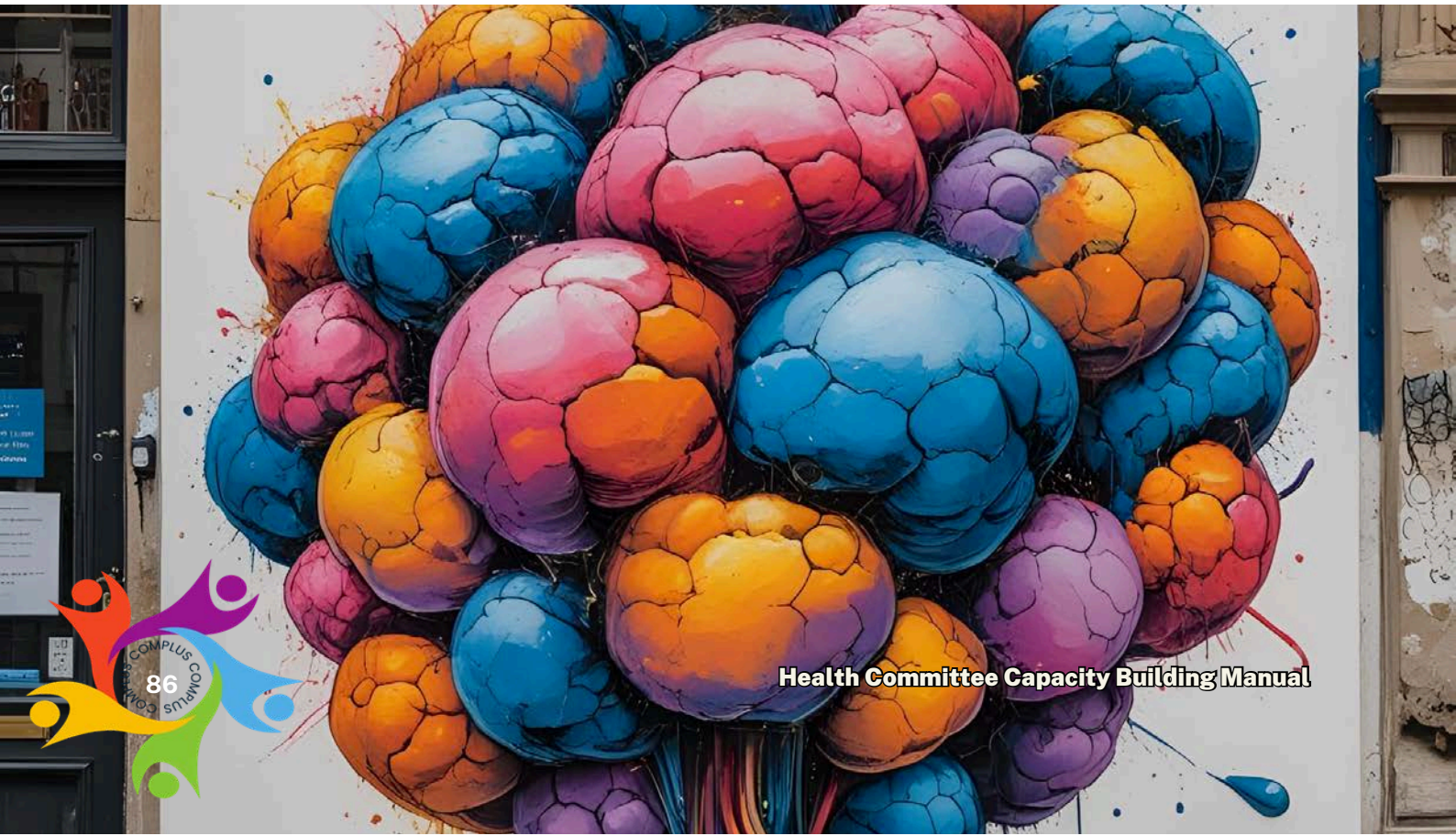
- Community health workers are the cornerstone of the COPC programmes. They are the frontline healthcare workers that work at the level of the household. Their knowledge and experience of health issues, of preventive health services as well as the chronic conditions that affect communities will be invaluable to clinic committees.
- Dynamic COPC forums will include intersectoral collaboration. We need to consider and engage broadly. Community organisations such as crime prevention forums, school governing bodies, local community organisations such as recycling organisations, as well as NGOs in the area should be invited and included. A partnership approach will be to your advantage.

# Appendix A

## Learning Exercises possible feedback points

### 16. Learning Exercise 16

- Think of your role as a committee member: establishing a relationship with the facility / operational manager representing the community; supporting the complaints process; be an active and engaged bridge with the community. Consider ways to provide feedback to the community.
- What will you be doing in your local neighborhood to take up some of the challenges - consider how you may be able to build civic pride.



# Appendix B

## Contact information for complaints and monitoring

**Office of Health Standards Compliance: (OHSC)**

The OHSC is an independent body in South Africa that is responsible for regulating and investigating both the public and private sector. The National Health Amendment Act of 2013 created it. It has a role in advising the Minister of Health on standards and investigating any conduct or concerns at facilities that do not meet these standards.
If a patient or community member is not happy with how their complaint is being addressed at the facility level, they are welcome to lodge a complaint with the OHSC.

The OHSC has developed a list of standards called the National Core Standards that it uses to judge the quality of services provided and to assess whether complaints are valid if a facility does not meet these standards.
This can be done through the OHSC website, or for ease we have included the email and contact details for the complaints call centre below.
Email: complaints@ohsc.org.za
Toll Free Call Centre Number: 080 911 6472/ Fax: 086 560 4157

**Professional Bodies:**

Healthcare Providers such as nurses, doctors and technicians are all required to have registration with their own professional bodies. These include the HPCSA for medical practitioners, SANC for nurses, SAPC for pharmacists, CMS for medical schemes and SACSSP for social workers.
Each one of these organisations has their own complaints procedure and process. See below a list of the various contact and complaints processes.

HPCSA (Health Professions Council of South Africa):
The HPCSA deals with complaints that relate to inappropriate or unprofessional conduct by registered allied health and medical practitioners.
Complaints to the HPCSA can be logged online after registering for a profile below.
https://hpcsaonline.custhelp.com/
Complaints forms can also be couriered to 553 Madiba Street, Arcadia, PRETORIA, 0001 posted to P O Box 205, Pretoria, 001 or emailed to legalmed@hpcsa.co.za

# Appendix B

## Contact information for complaints and monitoring

SANC (South African Nursing Council):
Complaints about unprofessional conduct of nurses can be sent to the SANC.
SANC Telephone: 012 420-1000
Email: professionalconduct@sanc.co.za
Fax: 012-343-5400
Website: https://www.sanc.co.za/lodging-a-complaint/

SAPC (South African Pharmacy Council)
Complaints against pharmacists or pharmacy practices can be sent to
Tel: 012 321 1479/92
Email address: professionalconduct@sapc.org.za

SACSSP (South African Council for Social Services Profession):
If there is a complaint to be lodged against a social worker for unprofessional conduct it can be made via
Tel: 012 356 8300/8315
Email: profcond2@sacssp.co.za

HASA (Hospital Association of South Africa):
In addition to the OHSC mentioned above, complaints against private health facilities may also be shared with HASA through their regular contact channels or website.
Email: Contact@hasanet.co.za
Tel: +27 11 784 6828
Fax: +27 11 784 6828
Website: www.hasa.co.za

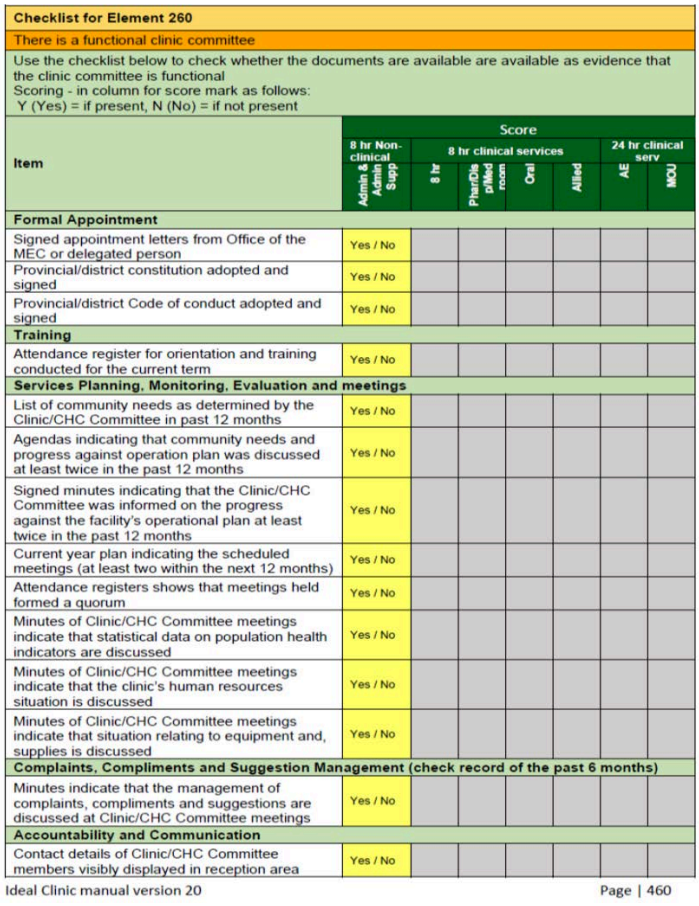
CMS (Council for Medical Schemes):
Complaints can be made against private medical schemes by patients if they believe that the medical scheme or insurance provider acted improperly in their care/services. They should first contact their specific medical scheme directly and follow their complaints process but may then go to the CMS if not satisfied.
Complaints forms may be sent to: complaints@medicalschemes.co.za

# 11

# Other Information that you may find useful

# What makes a Functional Clinic Committee?

We spoke a little about the Ideal Clinic. There are many different checklists that can be used from Ideal Clinic to assess and give a grade on how well a clinic is functioning. It also gives guidance on clinic committees. Now that we have broken down how Clinic Committees are meant to be made up and what some of their roles are, you can use one of these checklists (see below) to help monitor your own Health Committees. See the image below:



**Checklist for Element 260**

There is a functional clinic committee

Use the checklist below to check whether the documents are available are available as evidence that the clinic committee is functional
Scoring - in column for score mark as follows:
Y (Yes) = if present, N (No) = if not present

| Item | Score | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 8 hr Non-clinical | 8 hr clinical services | | | | 24 hr clinical serv | |
| | Admin & Admin Supp | 8 hr | Pharm/Displ/Med room | Oral | Allied | AE | MOU |
| **Formal Appointment** | | | | | | | | |
| Signed appointment letters from Office of the MEC or delegated person | Yes / No | | | | | | | |
| Provincial/district constitution adopted and signed | Yes / No | | | | | | | |
| Provincial/district Code of conduct adopted and signed | Yes / No | | | | | | | |
| **Training** | | | | | | | | |
| Attendance register for orientation and training conducted for the current term | Yes / No | | | | | | | |
| **Services Planning, Monitoring, Evaluation and meetings** | | | | | | | | |
| List of community needs as determined by the Clinic/CHC Committee in past 12 months | Yes / No | | | | | | | |
| Agendas indicating that community needs and progress against operation plan was discussed at least twice in the past 12 months | Yes / No | | | | | | | |
| Signed minutes indicating that the Clinic/CHC Committee was informed on the progress against the facility's operational plan at least twice in the past 12 months | Yes / No | | | | | | | |
| Current year plan indicating the scheduled meetings (at least two within the next 12 months) | Yes / No | | | | | | | |
| Attendance registers shows that meetings held formed a quorum | Yes / No | | | | | | | |
| Minutes of Clinic/CHC Committee meetings indicate that statistical data on population health indicators are discussed | Yes / No | | | | | | | |
| Minutes of Clinic/CHC Committee meetings indicate that the clinic's human resources situation is discussed | Yes / No | | | | | | | |
| Minutes of Clinic/CHC Committee meetings indicate that situation relating to equipment and, supplies is discussed | Yes / No | | | | | | | |
| **Complaints, Compliments and Suggestion Management (check record of the past 6 months)** | | | | | | | | |
| Minutes indicate that the management of complaints, compliments and suggestions are discussed at Clinic/CHC Committee meetings | Yes / No | | | | | | | |
| **Accountability and Communication** | | | | | | | | |
| Contact details of Clinic/CHC Committee members visibly displayed in reception area | Yes / No | | | | | | | |

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**https://www.idealhealthfacility.org.za: Checklist for element 260: Functional Clinic committee**

The checklist runs through a list of documents that the Clinic Committee should have available or create to ensure that it is functional and accountable.

It includes a signed constitution and appointment letters as well as a code of conduct, and attendance registers for any events.
Regarding the actual work of the Clinic Committee in communities, they should be able to produce a year plan with dates for future meetings, and a clear list of problems or community needs that they have identified after engaging with community members.

Also, they should show minutes of meetings discussing equipment, human resources, and operational challenges of the clinic they are based at, as well as discussions of any complaints lodged through complaints boxes at the facility. This helps to track all the issues.

# Other Local Approaches - SANAC, MSAT

**Introduction:**

While we have talked in a lot of depth about some of the structures that you might hear about in your day-to-day work, there may be a number of other structures or organisations that you come to work with.

Many other forms of community engagement have grown up in South Africa over time. Some of these structures are formal and some are informal. They may differ from province to province or even by municipality, with some only existing in urban or rural areas. Some of these engagement structures in health may deal with only specific parts of healthcare provision such as HIV/AIDS for example. It will be important for you or your health forum or clinic committee to come to learn about any of the engagement structures that are working in your area that we have not mentioned.
Let's mention some of the common groups.

**SANAC - South African National Aids Council**

One of the larger and still active forms of engagement in the country is what is called the South African National AIDS Council or SANAC. SANAC is a body that aims to bring together civil society, government, and the private sector to fight HIV, TB and sexually transmitted infections. It is chaired at the National Level by the Deputy Minister of Health. It hopes to provide advice to the government on any new policy relating to these illnesses and to monitor and report on progress towards any goals or targets in this area. It monitors the rolling out of the National Strategic Plan related to HIV, TB and STI's and is meant to coordinate the activity of all the different stakeholders so that they can collaborate.

Some other conditions/challenges have been included in the function and agenda of SANAC such as mental health services, social support and even viral hepatitis.
SANAC has its own Board of trustees and management.

SANAC has its own civil society forum that is made up of representative groups or organisations from 18 sectors of civil society. This includes everything from People Living with HIV and AIDS to sex workers, faith workers, education sector, labour, health workers, traditional healers, legal and children's groups.

In addition to the National AIDS Council, each Province has its own Provincial AIDS Council or PCA. These have secretariats that report to SANAC. They are chaired by the Premier for each province or overseen by the Provincial Minister of Health as the Premier decides.
Underneath the Provincial Aids Councils are the District AIDS Councils. These are meant to exist in every district and are chaired by District Mayors. Underneath this yet again are the Local AIDS Councils which are chaired by Local Mayors.
The strength of AIDS Councils differs by province with some being more or less functional and some being set up differently.

It would be useful to you as health committees to see that the interests of minority groups that you champion are adequately represented by the members on your local Provincial AIDS Council, district or local AIDS councils in the Province that you live in.

# Other Local Approaches - SANAC, MSAT

**MSAT's**

It is important to note that in the Western Cape there are no District or Local AIDS Councils at the moment. In some cases, these were replaced with something called the Multi-Sectoral Action Teams or MSAT's. It is good to see if the MSATs are operating in your local districts.

MSAT's operate at the local or subdistrict level. MSAT's are meant to allow for two-way communication with the Provincial AIDS Council, they are spaces for discussion of local HIV, AIDS, TB goals and for identifying and discussing challenges. All of the MSAT's are supposed to meet quarterly with a structure called the City HIV/AIDS and TB Coordinating Committee. This may have changed.

**Other Opportunities**

There are other forms of community engagement structures that you may be aware of in your community.

**Everything from neighbourhood watches to street committees, religious networks and trade unions.**

**You can also engage with the municipality through the IDP process (integrated development plan).**

As we have mentioned, most private facilities have their own types of boards or governance structures. They are not bound by the same requirements as public sector facilities. That said they do have legal obligations to their clients, their patients.

The existence of other community engagement structures such as Hospital Trusts, supporting NGO's or community fora within the private sector is a huge opportunity to grow trust and acceptance within communities. Whether dealing with the social determinants of health or trying to improve patient/client satisfaction with care, the use of forums or collaborative governance structures is of great value.

## More Detailed Version of Patients' Rights Charter

# THE PATIENTS' RIGHTS CHARTER

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realization of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this *PATIENTS' RIGHTS CHARTER* as a common standard for achieving the realization of this right.

This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

### A HEALTHY AND SAFE ENVIRONMENT

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

### PARTICIPATION IN DECISION-MAKING

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health

### ACCESS TO HEALTHCARE

Everyone has the right of access to health care services that include:

i. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;
iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
v. palliative care that is affordable and effective in cases of incurable or terminal illness;
vi. a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and
vii. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

### KNOWLEDGE OF ONE'S HEALTH INSURANCE/MEDICAL AID SCHEME

A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

### CHOICE OF HEALTH SERVICES

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guidelines.

### BE TREATED BY A NAMED HEALTH CARE PROVIDER

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers.

### CONFIDENTIALITY AND PRIVACY

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.

### INFORMED CONSENT

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.

### REFUSAL OF TREATMENT

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

### BE REFERRED FOR A SECOND OPINION

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

### CONTINUITY OF CARE

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

### COMPLAIN ABOUT HEALTH SERVICES

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation.

### EVERY PATIENT OR CLIENT HAS THE FOLLOWING RESPONSIBILITIES:

- Advise the health care providers on his or her wishes with regard to his or her death.
- Comply with the prescribed treatment or rehabilitation procedures.
- Enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
- Take care of health records in his or her possession.
- Take care of his or her health.
- Care for and protect the environment.
- Respect the rights of other patients and health providers.
- Utilise the health care system properly and not abuse it.
- Know his or her local health services and what they offer.
- Provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.

# The Triage System, Referral System and Levels of Care

Some of you will have heard of the term Triage before or know a little bit about the Triage system. This is something in place in all health facilities across the entire world. You may have heard of different colours - green, yellow, orange and red - being put on patients' files or of patients being brought to the front of the queue. You may even have heard doctors saying someone is a green or red patient or of the waiting times being different depending on what problem you come to the facility with.

**Triage has different definitions but can be defined as: "The process by which Healthcare Providers assess and decide on the priority and urgency of treating different patients."**

What this means is that health workers such as nurses, paramedics or doctors often make a first assessment of patients before they start treating them. If there is more than one patient there has to be a way to decide who is the most important patient to see first to help the most people in need.

The assessment may involve taking a quick history of the problem that the patient is coming to the facility with and may also involve some quick tests or checks like a blood pressure reading or a glucose/sugar test.

**How this Works in Practice**

**In the facilities that you visit and attend or in different provinces, there may be many ways that Triage has been put into practice.**

It is important to know about the triage system that is in place at your local facility so that you can be a source of information to communities about the process to avoid confusion and ensure that the system runs smoothly. Providing healthcare and seeking healthcare can be two very stressful experiences for workers and community members and so it is important that we avoid unnecessary conflict and confusion.

We normally see a Triage system in place in an Emergency Room. This is because it is not possible to have appointments or bookings for emergencies that happen day-to-day. If you were going to a chronic clinic for your TB or high blood pressure medication you might be given an appointment day or even a timeslot or number in the queue based on when you arrived at the facility. But emergencies happen at any time and people come to facilities at random times.

In the Western Cape, the triage system is mostly electronic. This means that when you arrive at a facility for a new problem or an emergency, you will report to reception, then you will be assessed by a nurse or health provider who will take some basic information and do some quick tests and you will be asked about the problem you have that day.

Based on the assessment that they do, they will either fill in a form or log the information onto a computer program called HECTIS. This will come up with a colour from most urgent to least urgent. Red being most urgent, then orange, then yellow and then green being the least urgent.

The doctor or nurse who will eventually see you will be able to see all of the files or a list of all of the patients waiting to be seen and see how many of each colour or “TRIAGE code” there are. They will then decide to see the most important patients first. We do this to make sure that severe conditions that can cause death or loss of limb; are treated first before less urgent conditions.

Sometimes, this is why it may seem that some people end up sitting for a very long time in a facility waiting room while others are rushed to the front of the queue.

In other provinces such as the Eastern Cape the system may run differently without an electronic system. Patients may be given stickers or simply told to wait in different areas based on their Triage or to put their file in a different pile.

Another part of the system is about prioritizing vulnerable groups. Facilities may have a policy that is separate from the Triage system where they make sure that certain people with priority conditions are seen first or have their own dedicated space and line. An example of this is that children or the very elderly may be brought to the front of the line in a clinic as the health providers decide. Another common example is that it is a policy in most facilities that the survivors of sexual assault/rape are seen first if there is not another emergency that cannot wait. This is to reduce the fear and stress that they experience.

Are you aware of the way that the Triage system works at your local facilities? Try to find out and see how the health committee can assist the facility and the community here.

# Levels of Care

We have discussed some of the areas of health systems earlier. There are many different levels of healthcare that we can talk about. Hospitals and clinics are not all the same in the type of services that they provide.

To make this more tricky, sometimes the same words hospital or clinic can be used to mean different types of things. For example, you might hear someone referring to a day hospital as something different from an academic or teaching hospital. Or when someone uses the word clinic some of you might think of nurse-led Primary healthcare Clinics (PHC Clinics) while others will think first of a Community Health Centre or CHC where X-Rays, doctors and other services are available.

Levels of care is an important concept to understand as it helps to manage expectations but also to help keep healthcare well-coordinated. It is not possible with South Africa's limited financial resources for every facility to have access to all forms of healthcare, specialist services and equipment. In fact, this is true all over the world. So, the health system generally needs patients to follow a step-by-step process based on their needs.

We can roughly divide up the type of facilities into 3. **Primary, Secondary and Tertiary care.**
**Primary Care facilities** are the first place where patients interact with the health system when they have an illness. For example, it might be the local PHC clinic, midwife obstetric unit or even local GP. Primary care should be able to provide for the basic and most common health needs of communities. Chronic conditions, routine checkups and screening and management of minor complaints and injuries should all occur at Primary Care level.

**Primary Level Care** facilities have another very important role - that is to treat and manage emergencies and non-emergencies close to where patients live. They must then be able to assess whether patients need more specialized services, treatment or tests and refer patients to these other facilities.

This is where we come across **Secondary and Tertiary Level Care.**
**Secondary Level** facilities include some regional hospitals where more equipment and resources are available to treat patients which cannot be managed at Primary Level Facility. Certain surgical procedures, tests, medications and scanning equipment are only available at this level.

**Tertiary Level** Care refers to the highly academic and very specialised forms of healthcare such as you might find at a teaching or Provincial Hospital. Sub-specialist services can be found at this level. For example, it is common in South Africa that radiation therapy for patients with cancer might only be found at a Tertiary Hospital.

With the levels of care, you as a patient or clinic committee member might find that someone with a condition is first seen at Primary Level and that a referral is made to a Secondary or Tertiary Level. Patients may also move down the ladder the other way, for example, after being discharged from a Tertiary Facility they may receive a down-referral to go to their local Primary Care clinic for help as they recover.

There is often a belief among patients and even among health providers that getting care from a specialist service or a higher level of care is better for the patient - but this is not always true. If referrals are made in the wrong way, it can clog up the health system and create long waiting times for patients that do need specialist care. Also, it can cause unnecessary expenses for both the health system and for patients of repeated testing and investigations. It can cause an unnecessary burden on patients in terms of stress, wasting time and travel. This is important to share with patients and their families as not being aware of the dangers of incorrect referrals can cause patients to become frustrated and upset if they believe that their condition is not being taken seriously.

Therefore, when we look at the referral system at your own facility it is important to learn the referral pathways so that you are able to keep patients informed about what services are in fact available at your facility. Monitoring the challenges that patients report when they do get referred to other Secondary or Tertiary Facilities for care, can help to support patients. For example, how is transport booked to these other facilities, is government support available for travel costs? What are the different facilities that your facility refers patients to and for which types of condition? What are the delays and waiting times at these facilities for common problems?

The referral pathways in the public sector are generally well set out based on where patients live. Health providers generally do not make referrals that do not match up with the address of a given patient. This is to avoid people being able to pick and choose to only go to the Secondary or Tertiary Facility that they believe is of a good enough quality. Similarly, most Secondary or Tertiary facilities do not provide care for patients without a referral in the form of a letter, appointment date or otherwise coming first from a Primary Level Facility.

Within the private sector these different levels can be difficult to understand as there are often not the same clear pathways for referrals based on where people live. GP's (General Practitioners), doctors' surgeries or private nursing practices might be well known in a local area. However, in the private sector it is often also possible to make appointments and bookings directly with specialists or to be referred to a specialist without a formal referral pathway. Private providers should also be linked to and able to refer to local public sector facilities. A GP might have certain private specialists that they prefer to work with or have worked with in the past. This does not follow the normal rules of keeping to one geographic area, like it does in the public health system. This can mean higher costs to the patient but also can mean greater flexibility in where a patient is able to go for care based on personal preference.
Of course, this may change with the NHI.

# 12

# Icebreaker Examples

*Each icebreaker should take 20-30 minutes.

**Day 1**

- Icebreaker 1: Tell us something that was done successfully in your clinic committee (past or present).
- Icebreaker 2: The colour game: participants select a different coloured item and answer the question assigned to the colour, i.e. Red: what inspired you to join the committee? Blue: what keeps you coming back to continue the work you do in your committee? Yellow: What is the one thing you think your committee needs to know in order for it to work effectively?
- Icebreaker 3: Please give us a comment on what you have learnt today.

**Day 2**

- Icebreaker 1: Tell us something that was done successfully in your sub-district forum (past or present).
- Icebreaker 2: Trading cards: Write down one learning outcome you would like for your committee on a card/ piece of paper and after random selection, read what is written to the group.
- Icebreaker 3: Please give us a comment on what you have learnt today.

**Day 3**

- Icebreaker 1: Tell us something that was done successfully in your district (past or present).
- Icebreaker 2: Advertise your committee: you have 1 minute to convince someone who might be interested to join your committee. Go!
- Icebreaker 3: Please give us a comment on what you have learnt today.

**Day 4**

- Icebreaker 1: Tell us something that was done successfully by Province DoH (past or present).
- Icebreaker 2: Billboard game: each committee gets a large piece of paper and they have to draw/describe the committee they want to leave behind for the ones that are coming after them.
- Icebreaker 3: Please give us a comment on what you have learnt today

# 13

# Social Accountability Templates

# Social Accountability Template

Monthly Summary Report
Facility Name
Subdistrict
Reporting Month:
Compiled by (Name)
Role in Committee:

1.What were the major challenges reported this month?

2.Were any complaints raised? If yes, what were they and how were they handled?

3.Any success stories or improvement noted?

4.Do patients understand the complaints process?

# Monitoring Scorecard

| Indicator | Explanation (linked to ICRM & | Score [1-5] | Comments |
|---|---|---|---|
| **Staff Availability** | Are staff present and working during | | |
| **Waiting Times** | Are waiting periods reasonable for | | |
| **Cleanliness & Hygiene** | Is the facility clean, safe and functional? | | |
| **Medicine Availability** | Are essential medicines | | |
| **Staff Attitudes and Respect** | Are patients treated with dignity and | | |
| **Complaints Handling** | Are complaints received, recorded | | |
| **Cost Transparency (Private Providers)** | Are service fees explained clearly? | | |
| **Language & Communication** | Are services offered in a language | | |
| **Referral Process** | Are patients referred | | |

# Community Complaints Logbook

| Complaint ID | Date Received | Issue Summary | Raised By | Type of Complaint | Referred To | Action Taken | Feedback Given | Resolved |
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