THE STATUS OF CLINIC COMMITTEES IN PRIMARY LEVEL PUBLIC HEALTH SECTOR FACILITIES IN SOUTH AFRICA

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The Status of Clinic Committees in Primary Level Public Health Sector Facilities in South Africa

Ashnie Padarath and Irwin Friedman
Health Systems Trust

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401 Maritime House
143 Salmon Grove
Durban 4000
South Africa

Tel: 27 31 307 2954
Fax: 27 31 304 0775
Email: hst@hst.org.za
Web: http://www.hst.org.za

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ABBREVIATIONS

ALP	Aids Law Project
CC	Clinic Committee
CHC	Community Health Committee
CIH	Community Involvement in Health
DHB	District Health Board
DHC	District Health Council
DHS	District Health System
DHIS	District Health Information System
DOH	Department of Health
EC	Eastern Cape
EPI	Expanded Programme on Immunization
FS	Free State
FGD(s)	Focus Group Discussion(s)
HCC (s)	Health Centre Committee(s)
HCP	Healthy Cities Programme
HST	Health Systems Trust
IDP	Integrated Development Plan
KZN	KwaZulu-Natal
MEC	Member of the Executive Council
NHA	National Health Act
NHC	Neighbourhood Health Committees
NCHF	National Consultative Health Forum
NGO	Non Governmental Organisation
NHC	National Health Council
NPPHCN	National Progressive Primary Health Care Network
PHC	Primary Health Care
RDP	Reconstruction and Development Programme
RKS	Rogi Kalyan Samiti
SA	South Africa
WHO	World Health Organization

EXECUTIVE SUMMARY

Community participation is widely accepted as a desirable feature of any health system and is considered to be an important aspect of developing and fostering effective governance at various levels of the health system. Good governance is a fundamental tenet of South African health care and the National Health Act No. 61 of 2003, makes provision for formally constituted, broad based governance structures which include community representation at various levels of healthcare delivery. Effective governance of the health system is critical to ensure both access to quality health services and the accountability of the health services to communities.

In South Africa, governance structures in the form of clinic committees, hospital boards and district health councils are intended to give expression to the principle of community participation at a local and district level. Clinic committees, hospital boards and district health councils are intended to act as a link between communities and health services and to provide a conduit for the health needs and aspirations of the community to be represented at various local, district, provincial and national levels. A tiered system of representation is envisaged in which the voice of ordinary community members eventually makes its way from the local to the provincial level.

This study aimed to assess the functioning and effectiveness of health governance structures in the form of clinic committees in order to identify opportunities for strengthening their role in governance. The study sought to ascertain the number of clinic committees associated with public health facilities in all nine provinces in South Africa. In addition, the study intended to identify the factors that are perceived by clinic committee members to either facilitate or impede the effective functioning of clinic committees. The study was conducted in two phases: the first phase consisted of a cross sectional survey which was administered with the aim of collecting information on the nature, scope and extent of community participation through clinic committees at public health facilities in the nine provinces; in the second phase of the study, three focus group discussions (FGDs) were undertaken with the members of three clinic committees and were directed at providing a more in-depth understanding of the information collected in phase one, as well as documenting the factors that are perceived as facilitating or impeding the effective functioning of clinic committees.

While 57% of facilities reported having clinic committees, the study found that there are a range of factors that impact on the functioning of these structures. The results also suggest that more clinic committees exist in provinces where there has been explicit political support for the creation and building the capacity of these structures. The data also suggests that most clinic committees have come into existence since the promulgation of the National Health Act, 2003. Poor socio-economic conditions and a context of poverty are important determinants of whether clinic committees flourish as the study found that a failure to attend meetings (often due to transport costs) and the lack of a stipend for clinic committee members are some of the reasons why facilities do not have clinic committees. Encouragingly, in two provinces, more than 30% of those facilities which did not have clinic committees reported being in the process of establishing committees. The low level of local councillor membership (45%) in clinic committees is cause for concern as this is a statutory requirement that is not being complied with. This has important implications for the envisaged tiered system of representation articulated in the National Health Act, 2003. The results also suggest that while most clinic committees meet on a monthly basis, the activities of the clinic committees appear to be mostly confined to problem solving between the community and the health facility, health education and volunteering their services in the facility. The issue of the roles and responsibilities of clinic committee members' needs attention as the research has highlighted the gap that exists in this regard.

The results from this study indicate that while national legislation has created a political climate receptive to community participation, the lack of provincial guidelines, inadequate resource allocation, and the limited capacity of committees constrain their abilities to actively fulfill their intended roles and responsibilities.

Recommendations include:

- developing a comprehensive national framework for clinic committees;
- implementing a training and capacity development programme for clinic committee members;
- conducting a best practice study of clinic committees;
- developing effective models of providing support to clinic committees;
- establishing tiered representation of clinic committees up to national level;
- strengthening the relationship between clinic committees and local government representatives; and
- effective monitoring and evaluation of clinic committee activities.

CHAPTER 1: A DESCRIPTION OF THE STUDY

1.1 Introduction

Effective governance of the health system is critical to ensure both access to quality health services and the accountability of the health services to communities. Good governance is a fundamental tenet of South African health care with the National Health Act No. 61 of 2003 making provision for formally constituted, community-based governance structures at various levels within the healthcare delivery system.

The principle of community participation is internationally accepted as a desirable feature of any health system. Since its inclusion in the Alma Ata Declaration thirty years ago (WHO, 1978), countries have attempted, with varying degrees of success, to incorporate this principle in their health systems. The concept goes beyond simply being involved in the curative services of the health system and extends to incorporate both promotive and preventative health strategies as well. Preventative health is generally seen as taking positive action on health, diet, exercise and lifestyle while promotive health refers to the process of enabling people to increase control over and improve their health.

In South Africa, governance structures in the form of clinic committees, hospital boards and district health councils - in line with national policy - are intended to give expression to the principle of community participation at a local and district level. They are intended to act as a link between communities and health services, and to provide a conduit for the health needs and aspirations of the communities represented at various local, district, provincial and national levels. A tiered system of representation is envisaged in which the voice of ordinary community members eventually makes its way from the local to the provincial level (Department of Health, 2004).

1.2 Legislative Framework

A variety of policy documents give expression to the necessity of community participation – and its implementation in South Africa. The international context is framed by the 1978 *Declaration of Alma-Ata*, which proclaims the peoples' right and duty to be active participants in their healthcare planning and implementation (WHO, 1978). Eight years later, the importance of community action towards better health was reiterated in the *Ottawa Charter for Health Promotion* (WHO, 1986). South African policy and legislative documents that adopt the overall spirit and intention of these international policy documents include the following:

The White Paper on Transformation of the Health System in South Africa refers to the need for communities to participate in the planning and provision of services (Department of Health, 1997). The paper sets out the importance of people being given the opportunity to actively participate in the planning and provision of their health services and provides a number of methods for this to take place. These include ensuring that women and children, and vulnerable and under-served groups are included in participatory initiatives, and the development of simple community based information systems which would facilitate the identification of locally determined needs and the monitoring of related achievements.

Similarly, the Department of Health's (DOH) *Norms and Standards for PHC Framework* emphasizes the need for community participation (Department of Health, 2001), as does the *Comprehensive HIV and AIDS Management, Care and Treatment Plan for South Africa* which acknowledges the critical role of community participation in ensuring that the Plan is successful and sustainable (Department of Health, 2005).

The need for community participation is also articulated in the policy paper entitled the *Development of a District Health System for South Africa*. This paper describes health facility governance structures as "Community Health Committees and Community Health Forums", where users of the service organize into structures that relate to the health system" (Boulle, 2007: 10).

As already noted, the overarching legislative framework for facilitating community participation through governance structures in health had been laid out by the National Health Act 61 of 2003 (Department of Health, 2004). The Act also sets out the parameters for the creation of official bodies that the various governance structures can then interact with.

The Act establishes the highest policy making body, the National Health Council, which is comprised of the Minister of Health, the Members of the Executive Council (MECs) for Health and representatives of local government and the military. The National Consultative Health Forum (NHCF) is made up of stakeholders in the health sector. The Minister of Health consults and shares information on national health matters with this forum (Department of Health, 2004).

Similar structures are also created at provincial level – the Provincial Health Councils and the Provincial Health Consultative Forums - which are meant to facilitate the sharing of information on provincial, district and municipal health issues.

The Act also establishes the District Health System (DHS), which consists of various health districts that coincide with the municipal boundaries, and the creation of District Health Councils (DHC). The objectives of a DHC are to promote co-operative governance, ensure co-ordination of planning, monitor the budget and service provision, and monitor all health services that affect residents of the health district.

Section 42 of the National Health Act provides for clinic committees and community health centre committees which are required to include:

- one or more local government councillors,
- one or more members of the community served by the health centre and
- the head of the health centre.

The Act also requires each province to develop legislation for the establishment and functions of such committees. Provincial legislation to this effect is in varying stages of development.

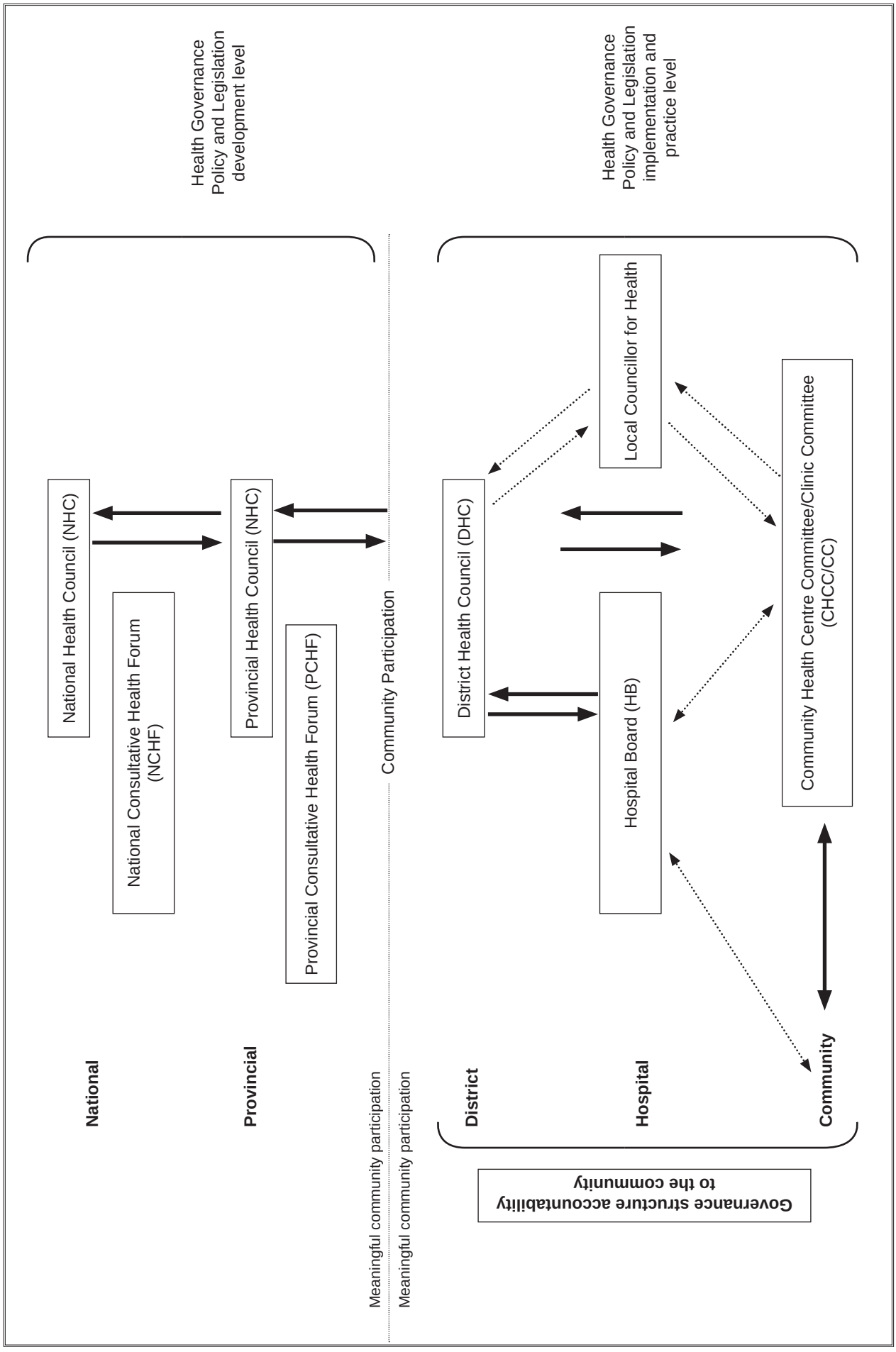
Diagram 1 illustrates how governance structures were intended to function and communicate with each other and the dynamic interplay envisaged between the governance structures at various levels and tiers.

1.3 Problem Statement

Despite the plethora of policy documents related to community participation that exist within the public health sector, and the spirit and intention of achieving this ideal within the national health system, there is a lack of information on how the various governance structures are functioning or whether they actually are functioning as envisaged.

The most updated information in this regard exists in the form of the National Primary Health Care Facilities Survey (NPHCFS) which was conducted in 2003. The survey found that a clinic committee or community health centre committee existed in three out of five facilities in the country and that this figure had remained static since 2000, with only 35% of these structures reportedly having met in the recent past (Reagon, Irlam & Levin, 2003). In addition, the survey provided the follow provincial information regarding governance structures at primary care level.

Diagram 1: Governance structures flow chart



Source: Health Systems Trust, 2007

Table 1: Clinic committees and community health centre committees in South Africa

Province	% CHC that had met recently	% health workers	% community members	% female community members	% male community members	% young community members 18-24years
Eastern Cape	57	18	82	52	48	6
Free State	26	16	84	57	43	9
Gauteng	11	21	79	67	33	14
KwaZulu-Natal	55	21	79	45	55	6
Limpopo	48	18	82	48	52	0
Mpumalanga	28	16	84	53	47	14
Northern Cape	17	16	84	56	44	8
North West	18	10	90	71	29	4
Western Cape	28	21	79	70	30	8
South Africa	35	18	82	55	45	7

Source: Reagon et al. 2003

Given the paucity of information that exists on health governance structures such as clinic committees and community health committees, and specifically since the promulgation of the National Health Act in 2004 which formally provided for their establishment, this study aimed to provide a more up to date account of the existence and functioning of clinic committees in the 9 provinces in South Africa.

1.4 Study purpose

The study took the form of an audit of all clinics and community health centres with reliable telephone numbers in the country in order to ascertain whether clinic committees existed at each of the public health facilities at a primary care level. In addition to this, the study also sought to gather information on the composition, membership and activities of existing clinic committees. Finally, the study also sought to gather information on the factors that hinder or facilitate the effective functioning of clinic committees.

The collection of such information is considered to be particularly useful for the various stakeholders within the public health sector given that there is currently no updated national information, subsequent to the promulgation of the National Health Act, on how many clinic committees exist in the country. It was envisaged that both the quantitative and qualitative information collected in this study would provide some salutary insights into the extent and nature of community participation through the mechanism of clinic committees.

Additionally, the findings of this study will help to identify those clinics and community health centres that might possibly be in need of some support in forming their clinic committees, which will subsequently assist in the community taking an active role in the needs analysis, planning and prioritisng of health of services, development of Integrated District Plans (IDPs) and implementation of general primary health care in their catchment areas.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This literature review seeks to contextualize community participation as it exists in the form of health governance structures within a broader primary health care paradigm and to provide an overview of different approaches that fall under the rubric of community participation. Some of the factors that influence community participation in health are discussed and examples of similar initiatives – particularly in developing countries - are offered. The review concludes by examining legislative and policy frameworks shaping the functioning of health governance structures in the South Africa.

The review has been compiled from a wide variety of sources. These include peer reviewed articles, official South African Department of Health documents, reports from organizations working with health governance structures particularly in developing countries, as well as grey literature on the topic. While every attempt has been made to ensure that this review contains the most recent and an exhaustive list of literature, it must be noted that there is a paucity of literature on community participation as it is found in the form of public sector health governance structures. There are very few documented examples of the form, structure and work of health governance structures, particularly at clinic level, making it difficult to contextualize this study within an established body of work.

2.2 Defining community participation

There are a wide variety of terms and definitions that are associated with the terms "community participation", "community involvement" and "community involvement in health". While these three terms are often used interchangeably, there are subtle meanings inherent in these terms that convey different meanings.

Community involvement in health (CIH) has been defined as a process:

> **Whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the conditions for sustained better health, and in supporting the empowerment of communities for health development (WHO, 1991: 9).**

Community participation was defined in the Alma Ata Declaration as follows:

> **The process by which individuals and families assume responsibility for their own health and welfare and that for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. These enable them to become agents of their own development instead of passive beneficiaries of development aid (WHO, 1978).**

For the purposes of this paper, the term 'community participation' as implied by the definition adopted at Alma Ata will be used as this term is broader and includes many different types and levels of involvement, while community involvement refers to a more specific type of partnership associated with completing a task or a particular project within a defined period of time.

Commentators (Loewenson, 2000a; WHO, 2002; Gryboski, Yinger, Dios, Worley & Fikree, 2006) have pointed out that there are varying degrees or levels of community participation. However, it has been conceded that moving up this ladder is an incremental process for which supportive political structures are required and that the higher the degree of community participation, the greater the degree of control the community has over the identification of problems, allocation of resources, and design and implementation of programmes (Loewenson, 2000a).

Table 2: Levels and forms of community participation

Degree	Community Participation	Example
High	Has control	Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Has delegated power	Organisation identifies and presents a problem to the community, defines the limits and asks the community to make a series of decisions which can be embodied in a plan which it will accept.
	Plans jointly	Organisation presents a tentative plan subject to change and open to change from those affected. Expect to change plan at least slightly and perhaps more subsequently.
	Advises	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Is consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.
	Receives information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
Low	None	Community told nothing.

Source: Loewenson 2000a

Health governance structures are one of the vehicles through which community participation can be achieved. This study focuses specifically on one type of structure for community involvement in primary health care clinics, the clinic committee. Clinic committees are defined as follows:

> **part of the governance structures of the health facility and participate in needs analysis, planning, implementation and education of primary health care in the area (Bennett, Thetard, Msauli & Rohde, undated: 5).**

2.3 Community participation and primary health care

Community participation is one of the cornerstones of primary health care (PHC). At the adoption of the *Alma Ata Declaration* in 1978, PHC was defined as:

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

The basic philosophy of PHC was the "development of a comprehensive health strategy that not only provided health services but also addressed the underlying *social, economic and political causes of poor health*" (Werner and Sanders, 1997: 18). This represented an important paradigm shift as it noted that there were a variety of factors that impacted on the health system and the health outcomes that were outside the domain of the health service. In addition, it also recognized the critical role that people could potentially play not only in planning and evaluating their own health services but in broader socio- political and development issues.

Community participation was thus deemed essential for determination of health priorities and the allocation of scarce resources. There is also consensus that a successful implementation of the District Health System (DHS) requires the meaningful inclusion and participation of community voices in local health delivery (Baez and Barron, 2006).

2.4 Approaches to community participation

Rifkin (1986) distinguishes between three approaches to community participation. She terms the first approach as the medical approach which defines health as the absence of disease and in which community participation is conceptualised as activities undertaken by communities under the supervision and guidance of medical experts in order to reduce illness. The second approach, the health services approach, shares the same definition of health as the WHO definition i.e. "the physical, mental and social well being of the individual" and conceptualises community participation as " the mobilisation of community people to take an active part in the delivery of health services" (Rifkin, 1986: 244). The third approach, the community development approach, conceptualises health as an outcome of social, economic and political development and sees community participation being about community members taking action to change these conditions.

Asthana (1994) differentiates between two main approaches to community participation viz. as a *means* in order or to achieve something or as an *end* in itself. She describes the former as being consistent with a "consensus view of society" where the benevolent state is interested in ensuring that poor communities benefit from national development and growth, while the latter is based on a conflictual theory of society where the poor and 'disenfranchised' struggle with more powerful groups for access to and control of power and resources which is mediated by the state in the interests and on behalf of the rich and powerful.

In a publication entitled *Public Involvement in Health*, contrasting approaches to community participation have also been summed up by Ngwenya and Friedman (undated) as follows:

Table 3: Contrasting approaches to community participation

Type	Approach
Coercion	participation is used as a means of control
Compliance	participation is used as a vehicle for the provider to achieve predefined goal
Contribution	recognition is given to the added value that participants can offer
Organisation	participation is used a vehicle for structural development
Empowerment	participants are better able to use resources available and take increasing control of their own lives
Partnership	control is shared between provider and community participants
Governance	participants actively mange all aspects of the programme, supported by services

Source: Adapted from Ngwenya and Friedman (undated)

Ngwenya and Friedman suggest that attempts to promote community participation can either be community supportive or community oppressive with the latter being characterized by jealous guarding of knowledge and status and rigid standardization by the health workers. For example, the health programmes facilitated by the Department of Health during the apartheid-era in South Africa were aimed at achieving community compliance in vertical health programmes such as immunization and family planning while the more progressive programmes that were more supportive of communities were in fact initiated and championed by civil society movements as part of a larger attempt to build the mass democratic movement.

Sanders (1992) points out that community participation and the process of democratising the health sector is inextricably linked to political democratisation processes at all levels of society and as such, reflect broader struggles within a society. This idea has also been borne out by Gryboski *et al.* (2006) who suggest that the political, social and economic context of a country may inhibit community participation in places were there is a history of repression. In Malawi for example, community participation was found to be "weak owing to the authoritarian political climate inherited from the Banda era" (Baez and Barron, 2006: 13). The authors conclude that the increase of community participation in Malawi is likely to be linked to a greater and deepening democratisation of Malawian society.

2.5 The benefits of community participation

It is widely documented in the developmental literature that the involvement of communities in interventions is desirable (Oakley, 1989; Chambers, 1997; Gryboski *et al.* 2006). Communities have a good sense of the dimensions of the problems they are facing as well as what solutions are amenable to their community and can be feasibly implemented in their situation (Leonard, Purnima & Rutenberg, 2001). Sound community partnerships with health establishments lead to the strategic guidance of clinics and improved quality and quantity of operations (Khosa, Ntuli & Padarath, 2005). In Zimbabwe, Loewenson, Rusike and Zulu (2005) found a positive relationship between the existence of health centre committees and improved health outcomes even in resource poor communities and clinics, while in Malawi, communities involvement in planning and managing health facilities at district level resulted in a more responsive health service (Baez and Barron, 2006). In Jamaica, community health clinics were responsible for providing fencing, a water tank, the kitchen and refrigeration for a health centre (Baum and Kahssay, 1999). In South Africa, researchers (Padarath, Searle, Pennings, Sibiya & Ntsike, 2006) found clinic committees can act as a strategic entry point in facilitating and catalyzing HIV and ARV services. The research showed that where functional, they have played a significant role in education on HIV and AIDS and facilitating dialogue between the community and health centre. In Zambia, Neighbourhood Health Committees (NHCs) have embarked on income generating projects to provide home based care for HIV affected families, provide health information, food and medicine during home visits (Baez and Barron, 2006).

Oakley (1989) argues that community participation in health is a basic right which develops self esteem, encourages a sense of responsibility and develops political awareness. He suggests that given the limited resources with which many health services operate, community participation is essential to make the health service more responsive and appropriate to the needs and perceptions of local communities.

Some of the benefits of participation include increased and extended coverage of a service and greater efficiency and effectiveness brought about by a coordination of resources and outputs. Equitable outcomes in that those with the greatest need and greatest risk are served and increased self reliance is achieved when people's sense of control over their lives is enhanced which resulting in positive health behavioural change (WHO, 1991; Jacobs and Price 2003; Gryboski *et al.* 2006).

In a review of health development structures,[1] Baum and Kahssay (1999) found that these structures appear to engage in a wide variety of activities at district level. They found, for example, that these structures are involved in mobilizing people for local health events, play an educational function and are sometimes involved in broader socio-economic development issues as well as in advocacy campaigns.

There is also growing consensus that involving communities, peers and family members is crucial for large-scale roll out and increased coverage of public health programmes. Lessons from tuberculosis and river blindness programmes, for example, show that systematically engaging communities can improve treatment outcomes and generate more effective local responses (Grubb, Perriens, & Schwartlander, 2003).

Community participation therefore provides an opportunity for community members and health care workers to become active partners in addressing local health needs and related health service delivery requirements. Community participation also enables community members and other stakeholders to identify their own needs and how these should be addressed, fostering a sense of community ownership and responsibility.

2.6 Mechanisms for community participation

Community participation in health takes many forms and can be manifested at an individual or collective level; it can be formal or informal and occur on an ad hoc or more structured basis. At an individual level, forms of community participation include the use of community health workers, home based carers and lay counselors to augment the services provided by the formal health services. Participation can also take the form

1 Defined as "Groups and organizations, government or non-government, formal or informal, that can be used to bring about socioeconomic and health transformation in a given area(Baum and Kahssay, 1999: 97).

of involving communities in conducting needs assessments and joint planning of health services, and assisting in the delivery and monitoring and evaluation of these services (Bennet *et al*. undated; Baez and Barron 2006; Gryboski *et al*. 2006).

Communities are seen as having a pivotal role to play in health promotion activities. One such example of this is the Healthy Cities Programme (HCP) which endeavours to enable the development of healthy public policy. Community participation is seen as pivotal to the HCP and many of its core principles resonate with the guiding principles of the Alma Ata Declaration (WHO, 2002).

Bennett *et al*. (undated) suggest that there are essentially two main modalities though which communities can impact on their health. The first is through participation in health activities within the community; for example, community based health care, and secondly, representation on structures which deal with the management of health issues. These structures include a community health committee or clinic committee "which are accountable to the community and which is part of the governance of the clinic" (Bennett *et al*. undated: 3). This represents a more formalised mechanism of community participation and is the subject of this study.

2.6.1 Health governance structures

"Governance refers to the way in which control is exercised over hospitals and other health services, and the powers vested in the governing body, in this case the health authorities, at district, provincial and national level to exercise such control" (Bennett Msauli & Manjiya, 2001: 20).

In general, health governance structures are the actions and means taken by a society to organise itself in the promotion and protection of the health of its population. A governance structure can be an existing board, committee, council or commission that has been authorised to fulfill governance duties and responsibilities (Dodgson, Lee & Drager, 2002).

In South Africa, the term, 'health governance structures' is used to refer to clinic committees, community health forums, hospital boards and district health councils. These structures have been created to provide an avenue for communities to give input and feedback into the planning, delivery and organisation of health services and to play an oversight role in the development and implementation of health policies and provision of equitable health services.

There is a paucity of literature on health governance structures both internationally and in the South African context. For example, a review by Bogue, Hall & LaForgia (2007) on hospital governance in Latin America found that the theory and research on hospital governance is inadequate. This is also true for health governance structures situated in clinics and community health centres which traditionally have less resources and interest. An extensive literature search of various databases and search engines was conducted using key words such as 'health governance structures', 'clinic committees', 'community boards in health', 'community involvement in health' and 'community health committees'. The search on South Africa yielded very few examples of such literature with the most comprehensive account being written by Ngwenya and Friedman (1995) more than ten years ago.

2.7 Factors influencing community participation

Despite community participation having been accepted as a desirable and necessary feature of a comprehensive primary health care system, it has not been fully realised. A 1991 WHO study group report noted that while more than 70% of WHO member states had developed mechanisms for community participation in health, health services had been slow in instituting the organizational and operational changes in making appropriate investments of money and staff time and in seizing existing and emerging opportunities for making health care and health development the joint concern of communities and the health sector (WHO, 1991: 1)

The report suggests that efforts to promote community participation have erroneously focused on how to make communities participate rather than on the "development aspects or the context in which involvement takes

place" (WHO, 1991: 1). Levendal, Lapinsky & Mametja (1997) concur with this point in reflecting that despite the stated political commitment to community participation in health, implementation has lagged behind.

It has been observed that factors that influence the successful performance of health development structures (including clinic committees) include the allocation of sufficient resources, adequate community representation, building on the latent strengths of communities and political and bureaucratic support (Baum and Kahssay, 1999).

2.7.1 Political commitment

Political commitment and local institutional support is critical for the successful functioning of health governance structures. The literature suggests that a significant determinant of the success of health governance structures appears to be linked to the level and type of support that is provided at district level (Baez and Barron, 2006).

In their review of health development structures in nine countries, Baum and Kahssay (1999) found that these structures were mostly ignored by the formal health services and hence represented a missed opportunity in terms of harnessing their potential for health promotion.

Where the necessary political and material support was provided at district level, NHCs in Zambia flourished, while in the Free State province in South Africa and in Zimbabwe, weak district structures and a failure to incorporate community voices at district and provincial planning meetings are implicated in the less than optimal success of community participation initiatives (Baez and Barron, 2006).

Boulle (2007) points out that resource allocations, which is often an expression of political commitment, impacts on community participation initiatives. For example, in Zambia, governmental support for PHC was illustrated by an increase in resource allocation to PHC from 30% to 70%. In Zimbabwe, on the other hand, governance structures were operating in an environment where there was "concern about decreasing governmental and health service support for community participation" (Boulle 2007: 22).

The National Progressive Primary Health Care Network (NPPHCN) (1996) points out that community participation is an organic process that cannot be introduced in the same manner in which a health facility is built in an area and suggests that the manner in which communities are asked to participate is linked to the success or the failure of the initiative. Thus the political context of the country in which governance structures operate is an important factor. In contexts where national health policies create strong support and stewardship for a holistic approach to health that includes social, political, environmental and economic dimensions of health and disease, health development structures flourish. (Baum and Kahssay, 1999; Ngwenya and Friedman, 1995). However, supportive health polices must be accompanied with resources (WHO, 1991). Other key issues which affect the functioning of governance structures include shrinking government resources for health and the privatization of health services with an emphasis on efficiency above other priorities (Baum and Kahssay, 1999).

While broad political support is important in creating an on overall supportive context and in providing stewardship, it is at the district and local levels that community participation is operationalised. District level support or lack thereof is a crucial determinant of the success of community participation initiatives (Baez and Barron, 2006; Boulle, 2007). Ngulube, Mdhululi, Gondwe & Njobvu (2004) for example, cite the case of health plans which were drafted by the NHC being changed by the District Health Council. In keeping with this theme, Chrislip (2004) warns against the tendency of incomplete community participation where the community participates but decisions or decision making takes place at another level without community consultation.

2.7.2 Resources and sustainability of governance structures

Baum and Kahssay (1999) contend that a lack of resources operates as a significant deterrent to the successful operation of health development structures. This refers to both a lack of resources from the health services as well as for the operational expenses of the structures themselves. They point to evidence which suggests that decentralization which is an essential precondition for successful community participation has often coincided

with economic recession thereby placing an even greater strain on already overstretched resources particularly in a developing country context. In their study of District Health Boards (DHBs) Macwan'gi and Ngwengwe (2004) also point out that the capacity of such entities to perform their functions was constrained by inadequate resources. The WHO study (1991) reports that community participation flourishes in socio-economic conditions which are conducive to development. These include adequate staff, logistics and other resources which may be difficult to secure in a resource poor country. The impact of poor socio-economic conditions on the functioning of governance structures has also been noted by Boulle in her study of community health committees in the Nelson Mandela Bay Municipality where she found that there were insufficient resources allocated to provide the necessary support to community health centres leaving community participation a "neglected component of the health system" (Boulle, 2007: 62).

Traditionally, the voluntary nature of serving on governance structures can affect the long term sustainability of these structures. This can have negative effects particularly in contexts of high poverty and unemployment, where serving on governance structures can be seen as a means of generating income. In South Africa, for example, Health Systems Trust (HST) found that clinic committee members felt aggrieved that members of hospital boards received stipends, while they did not. Clinic committee members expressed interest in finding routes to being appointed on hospital boards as this was seen as a more lucrative and prestigious appointment than serving on a clinic committee (HST, 2007). In a similar vein, but in a different economic context, the South Australian Health Department has acknowledged that community participation through governance structures is essential in improving and providing health services. However, they also caution that the voluntary nature of the local health boards is not sustainable due to the added pressures with which these local health boards have to deal. According to an Australian study "there are ever increasing pressures and demands that mean that existing volunteer structures are stretched, in some cases, beyond their capacity" (County Health – South Australia, 2006:1).

2.7.3 The capacity of communities to participate in health services and adequate training for community members to enable participation

Community members may be reluctant to participate in health services due to a perceived lack of skills, knowledge and confidence to engage with health facility staff.

Local people have few opportunities to develop their formal skills in relation to participating in health development (Baum and Kahssay, 1999). Communities often lack the language, information, cohesion, organisational structures and capacities for effectively engaging in these structures and can become disempowered and distrustful in the process (Loewenson, 2000b). Communities may also lack the necessary structures, be unfamiliar with medical terms and be apprehensive about engaging in debate and dialogue with health professionals. Programmes therefore, must be explicit about the mechanisms and methods that will be used to overcome these obstacles and should include community education and capacity building as a key component of budgeting and planning for health services (Grubb *et al*. 2003). Ngulube *et al*. (2004) found that some of the weaknesses in the performance of health centre committees (HCC) included the fact that members had an inherent fear of talking to educated people, were unclear about their roles and lacked the resources to fulfill their responsibilities. This is borne out by work carried out by the HST in South Africa which showed that confusion and uncertainty around roles and responsibilities are potentially the most enduring problems facing governance structures. Research showed that that power and authority which is perceived to rest with the health facility staff plays a strong role in constraining the effectiveness and agency of governance structures. As a result, inappropriate power struggles and escalating tension between the two groups have evolved (HST, 2007).

A failure on the part of the relevant health authority to train and build the capacity of community members can also lead to less than optimal community participation. There is often a need for long term support and capacity building of community members elected onto governance structures. In Kenya, for example, researchers reported that it took up to two years for a basic understanding of the district health system and appropriate support systems to be established (NPPHCN, 1996). In the Free State in South Africa, Baez and Barron (2006)

indicated that while the clinic committee had received training, this had not been determined or planned in conjunction with the community, or had taken into account their training needs. Still in South Africa, Boulle has suggested that "there appears to be no systematic programme directed towards the empowerment of CHC [community health committee] members to assume control and authority for the effective functioning of CHCs" (Boulle, 2007: 66). Interestingly, Boulle also found that in that some instances where governance structures members had benefited from capacity building programmes, their skills base had improved, thereby increasing their marketability and employment prospects resulting in attrition of the members of governance structure.

In O'Neill's 1992 study of Quebec's attempts to create governance structures for hospital boards (as cited in NPPHCN, 1996), researchers found that the ability of the members on these structures to act effectively was hindered by the lack of experience and confidence and a poor understanding of their roles and responsibilities. This was largely due to the health service not providing any training or support for these members once they were placed on these boards. As far as the Canadian experience goes, it has been pointed out that legislation to democratise hospital boards in Quebec "led to the institutionalisation of community members on Boards but did not empower communities" (NPPHCN, 1996: 13). This example illustrates that the top down approach to community participation is not effective as in this instance the government determined the agenda and asked people to participate in their preset plans.

2.7.4 Attitudes of health workers to community participation initiatives

Health professionals can act as important catalysts for successful community participation initiatives. They often are not recognized for their efforts in promoting community participation and often get little support from the health services (Baum and Kahssay, 1999). Loewenson (2000b) suggests that constraints to community participation include poor health worker appreciation of the value of participation and a lack of stable planning structures for joint planning between communities and health services. In addition, there are few incentives for health care workers to work in partnerships and they seldom have the benefits of doing so explained to them. Ngulube *et al*. (2004) for example found that while HCCs were an accepted feature of the Zambian health landscape, there was still evidence of resentment from health workers towards these committees. Research in Kenya (cited in NPPHNC, 1996) also suggested that health workers might not be the most appropriate choice to facilitate community involvement as there was a danger that this could reinforce existing power imbalances and lead to manipulation by health workers. Ngwenya and Friedman (1995) also found that one of the most important factors contributing to the success of community involvement was the motivation and encouragement of the community by nursing staff. However, tension between health care workers and communities is also likely to arise over conflicting needs: the medical needs as identified by the health services and basic health related needs such as food, water and sanitation determined by local communities themselves.

2.7.5 Roles and responsibilities of community members in participatory structures

One of the potentially most enduring problems facing governance structures is uncertainty about roles and responsibilities. Where these are unclear and have not been clearly articulated, progress and achievements of governance structures have been slow (Loewenson, 2004; Boulle, 2007; HST, 2007). Conversely, in instances where there has been clarity on the expected roles of governance structures as in the case of the HCCs in Zambia, these structures have flourished (Ngulube *et al*. 2004). Confusion about roles and responsibilities has been borne out by Bogue *et al*. (2007: 6) citing the findings of Harding and Preker who point out that "public hospitals in developing countries generally lack good governance due to poorly defined and unclear objectives…political interference and lack of information".

Boulle's study of CHCs in the Nelson Mandela Bay Municipality confirmed the reduced efficacy of governance structures in the absence of clearly defined roles and responsibilities. She reports that discussions about roles and responsibilities in the focus group discussions (FGDs) she conducted as part of her study, centered more on issues such as the lack of payment of stipends, problems with room space and training matters rather that on the broader issues of health within the community and community participation which were only raised at the

prompting of the researcher. Boulle also reported that older, more experienced members of CHCs expressed concern that the roles and responsibilities of CHCs had "diminished over time and that the health services were not fully conversant with CHC roles and functions" (Boulle, 2007:78).

This has also been borne out by work conducted by the HST which found that confusion regarding roles and responsibilities of the clinic committee members had sometimes resulted in strained relationships between health facility staff and clinic committee members. The HST study showed that, due to a lack of communication and guidance on the roles and responsibilities of clinic committees, some clinic committees had attempted to exercise an inappropriate watchdog role over health facility staff with negative impacts (HST, 2007).

2.7.6 Representative Legitimacy

Communities are not homogenous groups and are often stratified along race, class, gender and ethnic lines. This diversity poses the danger that in creating participatory structures such as health governance structures, existing power and status differentials could simply be replicated and reinforced, excluding the people whose interests and views most need to be represented. In Colombia, for example, the following reasons were cited for why people did not participate in solving problems at a collective level: mistrust of leaders, absence of training, lack of community meeting places, lack of resources and fear of political manipulation (Baum and Kahssay, 1999).

In facilitating community participation initiatives, the following caveats are instructive. Firstly, the people with the requisite skills and knowledge who are willing to participate may often be perceived by the general population as elites and may not be supported by the public (Zackus and Lysack, 1998). It is thus important to ensure that ensure that all interest groups in the community including the extremely poor and marginalized are represented. In Jamaica, for example, it was noted that health development structures did not traditionally involve the local elites or the very poor and marginalized (Baum and Kahssay, 1999). Zackus and Lysack (1998) cite the findings of Stone's 1986 study of PHC in Nepal where she found that that minority groups preferred not to engage in participatory structures and preferred that professionals handle and serve on community health structures.

Government created structures were also found to be less representative than local informal structures (Baum and Kahssay, 1999). For example, Boulle found that members of CHCs were often "health volunteers" who received a monetary stipend for providing daily support to health facility staff. She contends that these volunteers who were invited to join the CHC by health staff are "indistinguishable from staff members … closely aligned to the staff within the facilities and are not neutral as to community interests" (Boulle, 2007: 51).

Arising out of a review of the health governance structures in Kenya the following recommendations were made to improve functioning of such structures: committee or governance structure positions should be advertised in the media; predefined criteria for eligibility for governance structures should be set and principles of gender parity should be followed (Owino, Odundo & Oketch, 2001). In a similar vein, Zackus and Lysack (1998) recommend that people serving on community health organisations should be directly elected from the population and should comprise representation from specified interest groups as well as secondment from local government and or political parties. Macwan'gi and Ngwengwe (2004) also make similar recommendations in their study where they found that it was mostly prominent people that served on the DHBs and suggest that selection and appointment procedures for DHBs in Zambia should be reorientated towards general community members and women.

2.7.7 Non health system issues

Community participation initiatives are also mediated by the political and socio-economic contexts under which people live. Boulle (2007: 88) for example found that "poverty and an unequal distribution of wealth within communities inhibited effective community participation and effective CHC functioning". She reports that commitment to volunteering is waning because of the dire poverty that people lived in. This has also been corroborated by Baez and Barron (2006) as well as Russel and Schneider (2000) who suggest that community participation is constrained in contexts of poverty and in environments where resources are limited. They

further point out that the concept of community in the South African context is "particularly complex" given the country's "history of migrant labour policies, community removals, political conflict and urbanisation" (Russel and Schneider, 2000: 10).

The level of community participation can also be influenced by factors that lie outside the health system. Issues such a lack of transport, poor weather, inhospitable topography which makes travelling difficult and long distances from the health facility affect participation in local governance structures.

In a survey of the factors influencing community participation in health in one district in the Eastern Cape, Friedman and Hall (undated) found that there was no single or uniform way in which community participation evolved. Forty percent of the participants felt that the long distances of people from the clinic or poor access due to roads or unfavourable geography combined with a lack of transport or an inappropriate vehicle were the greatest obstacles to achieving successful community participation. This has been corroborated by Baum and Kahssay (1999) who found that community participation was often dependent on the availability of transport, whether or not people felt safe moving about in the community and the amount of free time they had. Researchers also found that the level of community participation varied from year to year and from season to season (NPPHCN, 1996).

2.7.8 Strong social capital

Social capital refers to:

> **those features of social relationships such as interpersonal trust, norms of reciprocity and membership of civic organizations which act as resources for individuals and facilitate collective action for mutual benefit (Kawachi, 2000:1)**

Social capital in this context refers to the ability of communities to solve problems at a collective level and is thus an influencing factor in the functioning of health governance structures. Civic participation, density of civic organizations and high levels of trust in government are indicators of a community's social capital (Kawatchi, Kim & Coutts 2004). For example Jacob and Price point out that establishing and sustaining community participation in health is "facilitated when the community had a history of common struggle, a tradition of voluntarism and a politically supportive environment" (Jacob and Price, 2003:399).

It has been postulated that "social capital may enhance health through indirect pathways such as encouraging more egalitarian patterns of political participation that …ensure provision of adequate health care…and other social services" (Kawachi, 2000: 1). Strong social capital and cooperative community links and appear to be stronger in rural areas (Baum and Kahssay, 1999) where the social fabric is stronger and modernity and its attendant individualistic lifestyles are less entrenched. Social capital is also mediated by issues such as geographic and social isolation. Thus where communities are fragmented and where low levels of reciprocity and trust exist between community members, participation in governance structures is likely to be low.

2.8 Impact of community participation and health governance structures

The literature has yielded mixed results with regard to the relationship between health outcomes and the existence of governance structures. The following sections will review evidence of the impact of health governance structures predominantly in Zimbabwe, Zambia and India.

In Zimbabwe, Loewenson *et al.* (2004) found a positive relationship between HCCs and improved health outcomes. Clinics with committees, on average, had more staff, ran more expanded programmes on immunization (EPI) campaigns and reported better drug availability than those clinics without committees. They suggest that this is possibly due to an increased ability to access and absorb health resources and posit that a virtuous cycle is formed where HCCs exist. Community health indicators were also reportedly higher in areas where HCCs existed. They found that in general, HCCs were able to take up community issues and that successful resolution of these were more likely when local resources were mobilized rather than relying on resources from the health department.

However, based on their work with HCC's in Zambia, Ngulube *et al.* (2004) suggest that these structures need to play more of an active role in promoting hygiene and disease prevention efforts at individual, household and community level as their research points to the fact that the activities of HCCs have no direct influence on the health status of the communities in which they are based. Similarly, Baum and Kahssay (1999) found that in Colombia the existence of a committee to coordinate health activities did not result in improved health development.

The use of the Community Score Card System has been documented in India and Malawi (Pitre, 2000; Baez and Barron, 2006). In India, a health care calendar was implemented in over 100 hamlets. The calendar showed (in pictures) the scheduled dates and times that the auxiliary nurse midwife and multi purpose workers were due to visit the area with the villagers monitoring and marking off their visits. Research conducted on the effects of the system showed that village visits by the health personnel had almost doubled (Pitre, 2000). In Malawi, services are scored by users and the results are then collated and presented by village health committees to the health facility staff. Results are used to improve services and target unmet needs (Baez and Barron, 2006).

Box 1 below illustrates the case of the Rogi Kalyan Samiti (RKS) Project in India which was introduced by the government to increase community participation in health.

Box 1: The Rogi Kalyan Samiti Project

The Rogi Kalyan Samiti (RKS) or the Patient Welfare Committee started as a pilot project in the Indian city of Indore in the State of Madhya Pradesh where government had expressed an interest in increasing community participation in governance structures. The RKS was set up in an attempt to improve the delivery of primary health and membership consisted predominantly of community members with minimal representation by government. The RKS was given control of the local hospital's assets and was authorized to take whatever policy decision was required to improve the functioning of the facility. It was also authorised to institute user fees and raise additional funds as required. Activities of the RKS include the following:

- ensuring regular maintenance, repair and construction to facilities;
- ensuring cleaning, security, hospital waste management;
- purchase of equipment and other necessities;
- providing an improved atmosphere and facilities and improved medial facilities;
- introduction of appropriate methods of medical waste;
- providing medical care to the poor.

Source: Rogi Kalyan Samiti (undated)

Since its inception the RKS concept has been replicated in more than 450 institutions in India and has worked well in both rural and urban areas. A review approximately 3-4 years after the RKS system was instituted, showed improvements in the efficiency of doctors, reduction in the deterioration of facilities, improvements in the conditions of medical institutions and an increase in the number of patients using the government hospitals (Rogi Kalyan Samiti, undated). This has also been borne out in a study by Loewenson *et al.* (2004) who found that wards without HCCs have a statistically significantly higher likelihood of not using health services (12.1%) compared to those with HCCs (9.8%).

2.9 Background and history of health governance structures in South Africa

The pre-democracy health system in South Africa was predominantly a curative one which was predicated on the use of health technologies and purely biomedical interventions. Opportunities for meaningful community participation were limited. For example Ngwenya and Friedman (1995) cite the results of a national survey conducted by the NPPHCN in 1994 which found that only 7% of respondents indicated that there was an elected community health committee through which they could participate. This idea of limited community participation prior to 1994 is borne out by a publication by Bennett *et al.* which states that "the former government

policy of apartheid effectively denied the bulk of the population any real participation in planning managing and evaluating their health services" (Bennet *et al*. undated: 4).

A NPPHNC survey (1996) suggested that the vast majority of people wanted to be involved in the running of the local clinic - 86% in modifying the negative attitudes of staff; 82% in deciding on clinic opening times; 76% in structuring fees and 55% in appointing staff.

The election of the first post-apartheid government saw the amalgamation of fourteen differently resourced and oriented health departments amalgamated into one Health Department with a commitment to redressing the inequities of the past and to implementing a district health system as the structural mechanism to effect this transformation. (NPPHCN, 1996). It is against this backdrop that PHC was introduced by the newly elected democratic government with a plethora of policy documents aimed at giving expression to a more people centered health service. For example, Bennett *et al* (undated) suggest that it was the new government's Reconstruction and Development Programme (RDP) which placed community participation firmly in the arena of a PHC approach and recognized the critical role community participation played in improving health status.

The main challenges for the health system since 1994 have evolved from the establishment of an appropriate *policy* framework to include the urgent need to put in place structures necessary for effective policy implementation.

The absence of strong community engagement with health care providers in the planning and monitoring of health services has been a limiting factor in strengthening access to and quality of care, especially in disadvantaged areas of the country.

Post-apartheid SA saw the debate on whether community participation was desirable shifting to how it could be achieved. Friedman (1998), responding to suggestions that the preoccupation of creating governance structures for SA was misplaced and that community participation could be better channeled through existing political structures, reaffirmed the critical role that clinic committees had to play in improving the delivery and accountability of health services.

2.10 Conclusion

This literature review has sought to provide a synopsis of the relevant literature relating to community participation particularly as it exists in the form of health governance structures. After locating the concept of community participation within a primary health care paradigm, the review provided an overview of the benefits and the factors that influence community participation. The review found that the benefits of community participation includes improved and more equitable health outcomes, a more responsive health service, equitable outcomes and increased coverage and usage of the health services. Based on a review of the existing literature, political commitment, adequate resources and training for governance structure members and the attitudes of health care workers emerged as significant factors that impact upon the functioning of health governance structures.

The review looked at the modalities through which community participation can be achieved and outlined the current legislative and policy framework that currently provides for community participation through governance structures.

A review of local and international literature shows that there is a paucity of information on the functioning of governance structures particularly at clinic level. It is hoped that this research will contribute to filling this gap.

CHAPTER 3: METHODOLOGY

3.1 Aims and Objectives

The aim of this study was to assess the existence and functioning of health governance structures in the form of clinic committees in order to identify opportunities for strengthening their role in governance.

The objectives were as follows:

- To ascertain the number of clinic committees associated with public health facilities and to outline the composition of their current membership, and their scope of activities.
- To identify the factors that are perceived by clinic committee members to either facilitate or impede the effective functioning of clinic committees.
- Arising from the findings of the research, to make recommendations regarding the existence, functioning and possible support required by clinic committees.

3.2 Methodology

The study consisted of two phases: the first phase consisted of a cross sectional survey which was administered with the aim of collecting information on the nature, scope and extent of community participation through clinic committees associated with clinics and community health centres at a particular point in time. As part of the survey, a structured questionnaire was used to collect the required information from facility managers which was then analysed. The questionnaire sought to elicit information on whether facilities had clinic committees, their composition and activities.

In order to augment the information from phase one and to provide a contextual framework within which governance structures operate, three focus group discussions (FGDs) were carried out with clinic committee members. This comprised the second phase of the study and was directed at providing a more in-depth understanding of the information collected in phase one as well as to document the factors that are perceived to facilitate or impede the effective functioning of clinic committees and to extract best practices and lessons learnt. Additionally, it was hoped that the FGDs would also provide insights into the contextual factors that affect the functioning of clinic committees which would then be used to inform policy and decision making both at national and provincial levels.

3.3 Definition of terms

There has been some debate about the nomenclature used to describe community participation in health through governance structures. Boulle (2007:6) for example, points out that the term 'clinic committees' is self limiting with regard to the "purpose, functioning and potential of such committees" and suggests that the term 'community health committee' is more appropriate as it captures "the inclusive and participatory nature, purpose and intention of these structures".

For the purposes of this study, the term 'clinic committees', includes structures known as 'community health committees'. Despite the differences that are implicit in these terms, policy documents use these terms interchangeably. 'Clinics' in this study refers to public sector primary health care clinics and includes community health centres.

The Department of Health defines a clinic as "an appropriately permanently equipped facility at which a range of Primary Health Care services are provided. It is open at least 8 hours a day at least 4 days a week." A community health centre is "a facility which is open 24 hours a day, 7 days a week, at which a broad range of Primary Health Care services are provided. It also offers accident and emergency and midwifery services, but not surgery under general anaesthesia" (Department of Health, 2006).

3.4 Study population

For the first phase of the study, the study population consisted of the 3479 fixed public sector clinics and community health centres across the country. Satellite and mobile clinics were excluded from the survey as they operate for only a few hours a day and offer limited services.

The names and contact details of each facility were extracted from the District Health Information System (DHIS). These contact details were further augmented by obtaining a separate list of facility contact details from each provincial department of health office. The details were subsequently entered onto a spreadsheet, compared and updated. A final composite list containing the names of the clinic, the telephone number of the facility from the DHIS as well as the telephone number of the facility as provided by the relevant provincial office was generated and handed to each fieldworker. All clinics were numbered. In the event that the contact details of a facility were inaccurate, alternative methods of tracing the telephone number of the facility e.g. phoning the local district health office, local hospital or the Telkom directory service were explored.

The facility managers (or an appropriate equivalent) of all the clinics were telephoned and were asked a set of pre-determined questions. An appropriate equivalent was usually the clinic sister or the person who answered the telephone, who by their own assessment, felt sufficiently able to answer questions about the facility and the clinic committee.

For phase two, clinic committees comprised the study population.

3.5 Sampling procedure and sample size

As this study took the form of an audit, every primary health care facility with a reliable telephone number in the three provinces was contacted. The final number of facilities included in the study is 2762. The clinics that were excluded (717) from the study did not have telephones. Each of the four fieldworkers was given a complete list of clinics together with telephone numbers. Fieldworkers were then allocated specific pages of a provincial list until all clinics had been contacted.

For phase two of the study, the focus group discussions, a convenience sample was used. All FGDs were held in areas where either the researcher or the fieldworkers had pre-existing relationships with the facility staff and in some cases the governance structures. This allowed for ease of access to the governance structures and facilitating meeting arrangements. The first FGD was conducted in the Ilembe district in northern KwaZulu-Natal. The second FGD was held with members of a clinic committee in the Motheo District of the Free State Province. The final FGD was held in Qaukeni district in Eastern Cape Province.

3.6 Data collection

Prior to collecting the data all fieldworkers participated in a one day training course which focused on explaining the rationale of the study, ethical collection of data and on the data collection techniques that were to be used. The training was followed by a role play in which each field worker had to role play an interview with a facility manager.

Data were collected by administering a structured questionnaire to facility managers. The questionnaire consisted of closed ended questions.

The questionnaire was divided into 3 main sections. The first section consisted of basic information about the facility (such as the facility's name, the name of the facility manager, whether the manager was available and willing to participate in the study).

The second section of the questionnaire focused on contextual information about the facility. Thus questions about the hours of operation of the facility , whether the facility had a reliable water supply, electricity and working toilets for staff and patients were put to the respondents.

The third section of the questionnaire focused on finding out information about the clinic committee (such as

how long the clinic committee had been in existence, the composition of the committee's membership, the term of office of its members and the activities of the clinic committee).

The questionnaire was pre-tested in three clinics and several questions were modified to improve clarity and avoid ambiguity.

Quality control of the data took place through a regular review of the collected information, consulting the fieldworkers on outliers and unusual information, and phoning the clinic to clarify information in instances where the fieldworker could not provide the missing or additional information that was required.

For phase two of the study, telephonic contact was made with the facility manager where the objectives of the research were outlined and the contact details of the chair of the clinic committee were sought. Contact with the chairperson was subsequently made and arrangements for a meeting with the clinic committee were finalized. In all instances, arrangements were made to meet with the clinic committee on the same day that they were due to have an official meeting at the clinic. This was done to minimize transport costs, disruption to other plans and to increase the likelihood of a high attendance and participation in the FGD. The facility manager was then consulted to ascertain if s/he was amenable to the FGD being conducted on the stipulated day and to finalise meeting arrangements.

The FGDs were conducted by two fieldworkers who in each instance spoke the local language of the area. Both fieldworkers had completed an accredited facilitation skills training programme and had significant experience in conducting FGDs as part of their broader work.

The FGDs were guided by a set of questions. The questions were divided into three main sections: the first section sought to elicit information on how respondents had become members of clinic committees. The second section sought to gather information on the roles, responsibilities and activities of the clinic committees. The third section focused on the factors that facilitate and impede the effective functioning of clinic committees.

The focus group discussions were taped with the tapes being transcribed (into Zulu and Xhosa) within 24 hours of the interview taking place. These transcripts were subsequently translated into English. The tapes were transcribed by a transcriber and returned to the fieldworkers to check for accuracy.

3.7 Validity and reliability

The information for the first phase of the study was collected through a structured questionnaire and the systematic adherence to the questions and format contained in the questionnaire has enhanced the reliability of the study.

For phase two of the study validity was enhanced in the following ways: key points which arose during the discussions were summarized at the end of the FGDs and reflected back to the participants who then either confirmed or corrected the fieldworker's perceptions; the tapes which were transcribed were returned to the fieldworkers to check for accuracy of meaning and nuances. Additionally, a Peer Review process was instituted where the research processes and the data were reviewed by HST's Research Director.

3.8 Data analysis

For phase one, preliminary analysis of the data was conducted on Mobile Researcher which provides a high level analysis of the information collected. This high level analysis simply presented the aggregate findings across all provinces and did not allow for provincial variations to emerge. The data was subsequently exported into Microsoft Excel which allowed for a more in-depth analysis of the information. Here the information was disaggregated by province and compared.

The results are presented as a descriptive analysis. The analysis focused on analysing the existing data to develop a set of baseline data on how many facilities had clinic committees and further disaggregating the information by province.

For phase two of the study, a transcript of the various FGDs was compiled.

Key emerging themes were noted. The data was coded, categorized and labeled. Memos and notes were used to record additional observations and emerging relationships between the various themes.

3.9 Ethical considerations

The study involved eliciting information on the nature and extent of community participation though clinic committees. All respondents were informed about the nature of the study and that participation was voluntary. Study participants were also informed that the information they provided would be considered confidential and that although names of clinics and respondents were recorded for administrative purposes, no names or other identifiers would be used in the analysis or final reporting stages of the project. Participants were also informed that they would not directly benefit from the study and that the information collected would be used to strengthen governance structures in the country.

The study was approved by the Senate Research Committee of the University of the Western Cape and prior to commencement, permission was sought from all Provincial Departments of Health to carry out the study. In some cases, letters of support from all district managers were required before the provincial office would issue a letter of permission for the study to be undertaken in the province.

3.10 Study limitations

Limitations to the study include the following: Firstly, the focus group discussions were conducted in areas where the research institution at which the researcher is based has been working with governance structures. This pre-disposes the study to selection bias and the possibility that the study findings may not be generalisable to other contexts. Secondly, the study also relied on self-reported data from facility managers (or equivalents) and their account of whether a committee existed at their facility, and nature of the activities their committees were involved in. This introduced the element of social desirability bias as respondents may have provided information that placed their facility in the best possible light. Finally, researcher bias and subjectivity in the analysis of the focus group discussions is a further potential limitation of the study.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter reports on both the results of the telephonic survey as well as the key findings emerging out of the focus group discussions. Where relevant, the quantitative data and the qualitative data from the focus group discussions have been included together to complement and elaborate on some of the issues; integrating the qualitative data is intended to add value and depth to the information collected from the surveys. Where there are no complementarities between the data from the survey and focus group discussions, they are discussed separately.

4.2 Response rate and overview of the study population

The following is a breakdown of the number of facilities that were interviewed in each of the 9 provinces.

Table 4: Response rate and overview of facilities included in the survey

Name of Province	Total number of clinics and CHCs in the province as listed in the DHIS	Number surveyed	Percentage of facilities contacted	Percentage of national	Number & percentage of facilities contacted who agreed to participate in the survey	
Eastern Cape	689	529	77%	15%	485	92%
Free State	234	174	74%	5%	174	100%
Gauteng	347	315	91%	9%	303	96%
KwaZulu-Natal	587	515	88%	15%	500	97%
Limpopo	434	385	89%	11%	352	91%
Mpumalanga	282	240	85%	7%	216	90%
Northern Cape	211	98	46%	3%	95	97%
North West	333	289	87%	8%	282	98%
Western Cape	362	217	60%	6%	182	84%
TOTAL	**3479**	**2762**	**79%**	**100%**	**2589**	**94%**

Seventy-nine percent (79%) of the facilities listed in the District Health Information System (DHIS) were contactable by telephone and were thus included in the survey. There was a high degree of co-operation from facility managers and the overall response reflects a 94% participation rate of the facilities contacted. Reasons for the high participation are likely due to the fact that most facilities had reliable telephone numbers; the interviews were of a short duration (between 10 to 15 minutes) with the nature of information being solicited possibly being perceived as largely straightforward. In KwaZulu-Natal (KZN), all district managers had approved the research and these letters of approval were faxed to the facilities. In other provinces the letters of authority from the provincial heads of health were sent to the facilities. This support from the Department of Health (DoH) most likely increased the participation in the survey. Another possible contributing factor could be the respondents' familiarity with the institution conducting the research.

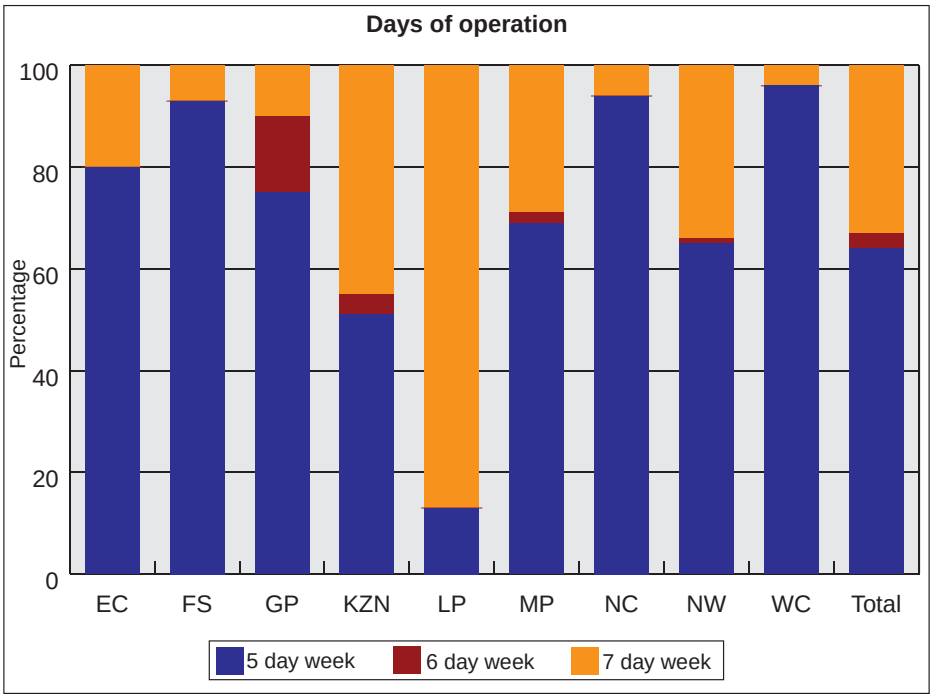
The highest percentage of facility managers refusing to participate in the survey was in the Western Cape Province where 16% of facility managers refused to participate. Reasons from facility managers for declining to participate included being too busy to answer questions; their immediate supervisors had not authorised them to participate in the survey (despite faxing proof of permission obtained from provincial authorities) and fear of being identified by name and of being quoted. In the Free State Province, all respondents contacted agreed to participate in the study. This could be due to the fact that HST has been conducting training for governance structures in the province and is thus well known.

In 81% of cases, fieldworkers conducted the interview with the facility manager and in 18% of cases the interview was conducted with an equivalent person which was usually the professional nurse working at the facility. Only in 1% of cases was there reportedly no-one available to answer the questionnaire.

4.3 Basic information

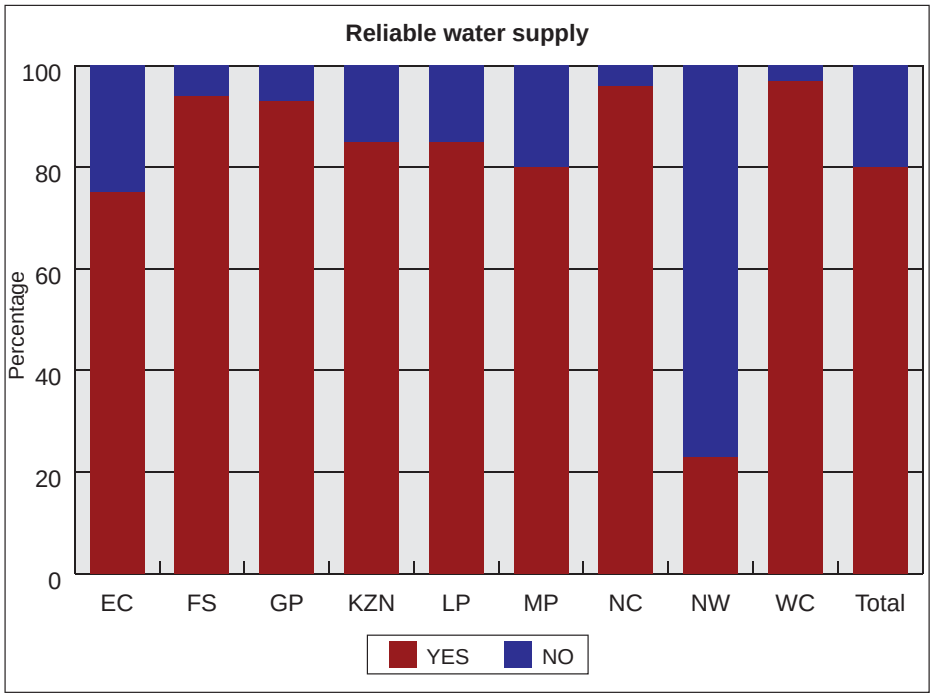
A range of basic information was collected during the study in order to provide some background into the context within which clinic committees are meant to function. Information on hours of operation as well as access to water, electricity and sanitation was collected.

Figure 1: Days of operation



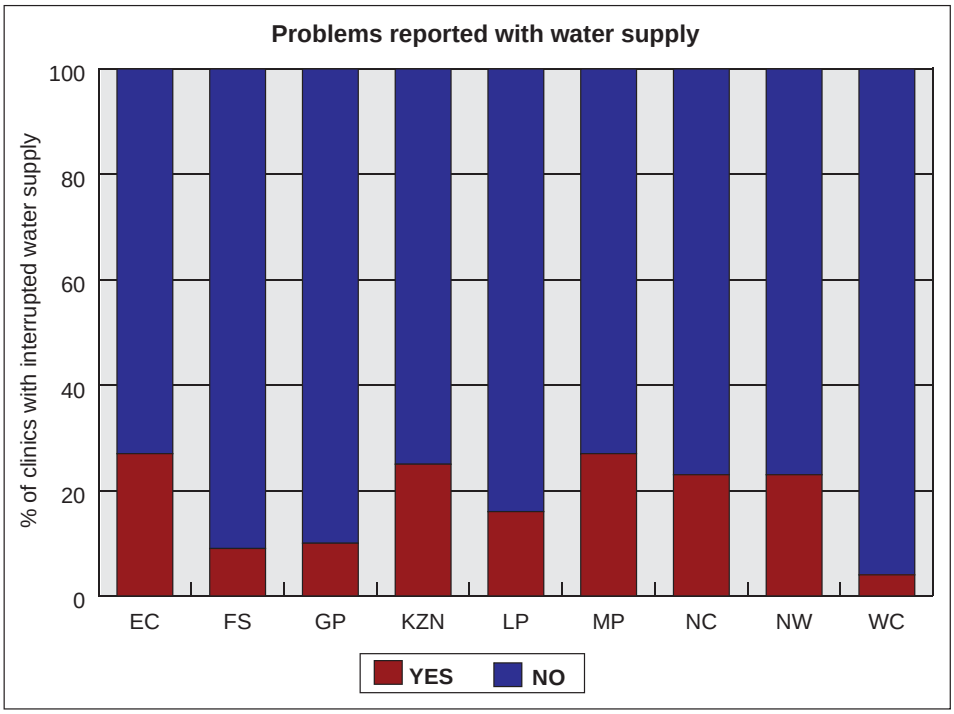
Sixty-five percent of the facilities surveyed operated for 5 days a week. Three percent of clinics operated 6 days a week and 32 % of the clinics involved in the study were open for 7 days a week.

Figure 2: Water supply in clinics



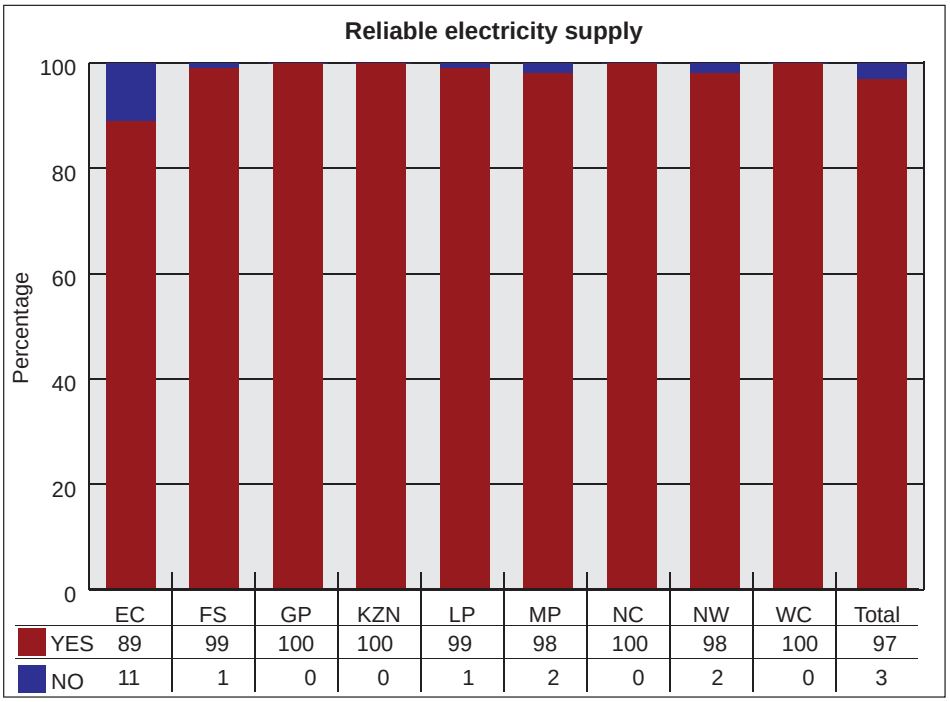
Nationally, 80% of facilities surveyed reported that they enjoyed a reliable water supply. When availability of water is broken down by province the figures are as follows: Eastern Cape 75%; Free State 94%, Gauteng 93%, KwaZulu-Natal 84%; Limpopo 85%, Mpumalanga 80%, Northern Cape 96%, North West Province 23%; and the Western Cape 97%.

Figure 3: Problems with water supply



Twenty-seven percent of respondents reported having experienced interruptions with their water supply, at their facility in the last month in the Eastern Cape and Mpumalanga provinces; 23% in the North West Province reported similar problems with their water supply while in KwaZulu-Natal this figure was reported at 25%. When compared to information in the 2003 Facilities Survey (Reagon *et al*. 2003), it would appear that in some instances the proportion of facilities experiencing problems with water supply has increased: In 2003, 8% (compared to 27%) of facilities in the Eastern Cape had reported interruptions to their water supply in the month prior to the survey, and 21% (compared to a reported 25%) in KwaZulu-Natal. In some cases, the situation has improved significantly; in 2003, 50% of facilities in Mpumalanga reported having experienced interruptions to their water supply in the past month while in this study 27% of facilities reported experiencing such problems.

Figure 4: Electricity supply in clinics



	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Total
YES	89	99	100	100	99	98	100	98	100	97
NO	11	1	0	0	1	2	0	2	0	3

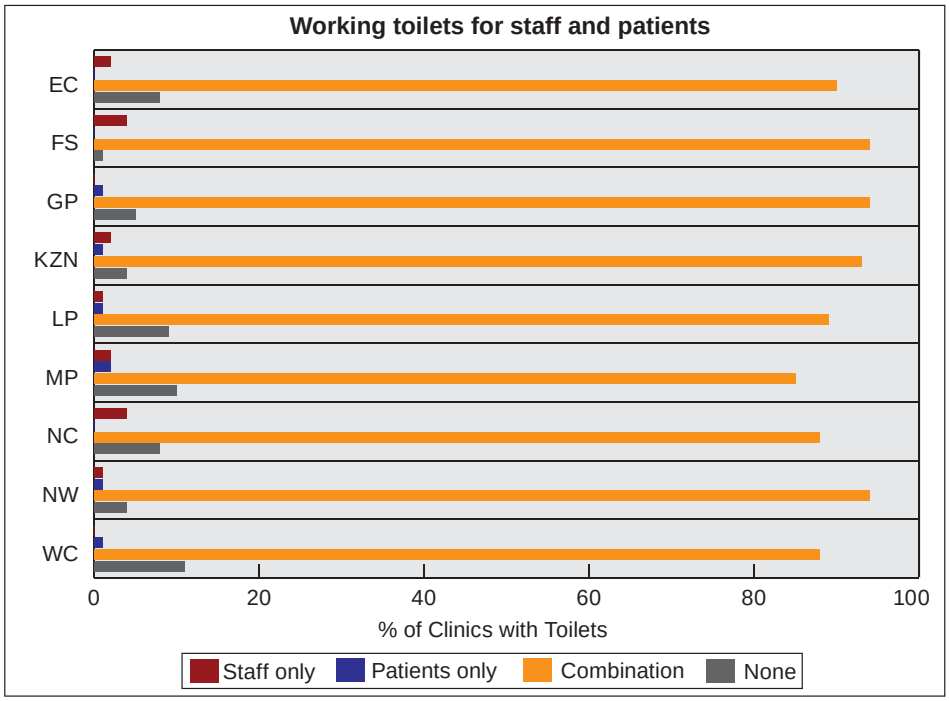
In terms of whether the facilities had electricity, nationally, 97% of facilities reported having access to electricity. In Gauteng, the Northern Cape and the Western Cape, 100% of facilities reported having access to electricity.

The Eastern Cape reported having the lowest access to electricity – at 89%. Again, when compared to information in the 2003 Facilities Survey, it would appear that access to electricity in the Limpopo and North West Provinces have increased – in 2003, 14% of facilities in Limpopo and 6% of facilities in the North West Province reported not having access to electricity.

Table 5: Access to electricity by Province: 2003 and 2008

Province	2003	2008
Eastern Cape	87	89
Free State	100	99
Gauteng	100	100
KwaZulu-Natal	100	100
Limpopo	86	99
Mpumalanga	100	98
Northern Cape	98	100
North West	94	98
Western Cape	100	100

Figure 5: Working toilets for patients and staff



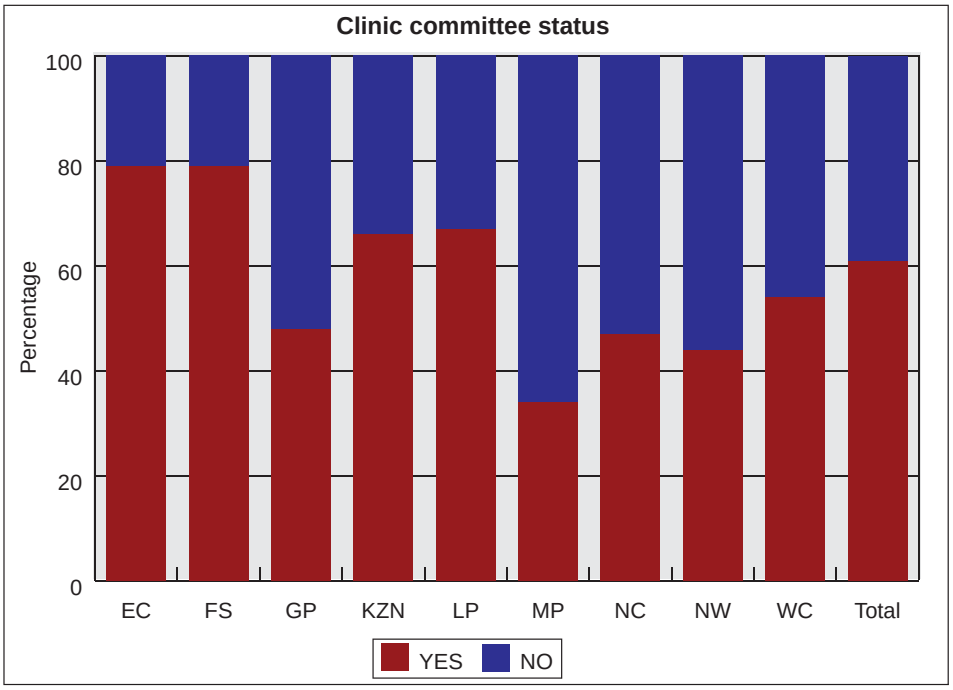
90% of facilities had working toilets for staff and patients. The lowest reported percentage was in Mpumalanga Province where 10% of facilities did not have working toilets for staff and patients.

4.4 Existence of clinic committees

On average, 57% of facilities surveyed reported currently having clinic committees. From a provincial perspective, the Free State Province had the highest percentage of clinic committees at 78%; this is followed by the Eastern Cape Province where 73% of facilities reported having clinic committees. The lowest percentage of facilities reporting having clinic committees was in the Mpumalanga Province where 31% of facilities reported having clinic committees. The high number of facilities in the Eastern Cape and the Free State that reported having clinic committees could in part be attributed to the fact that both provinces have expressly indicated their political support for the establishment of clinic committees after the promulgation of the National Health Act of 2003. The Eastern Cape Province for example, has developed a document entitled *A Concept Document on the Establishment and Functioning of Community Health Committees* which sets out a policy framework to guide the establishment and functioning of clinic committees in the province (Eastern Cape Department of Health,

2006). Similarly, the Free State Province has outlined its policy commitment to the establishment of governance structures in their Provincial Health Bill of 2007 (Free State Province Department of Health, 2007). In addition, both the Free State Province and the Eastern Cape Province have been involved in initiatives to strengthen the functioning of governance structures. In the Eastern Cape, the Provincial Department of Health has been working with the Nelson Mandela Metropolitan University to strengthen the "CHCs of their 25 designated 'Clinics of Excellence'...which are intended to serve as role models for other facilities throughout the province" (Boulle, 2007: 12). The presence of projects such as the Equity Project in the Eastern Cape which placed a high premium on community participation could also in part, account for the strong thread of community participation found in the province. The Free State Department of Health has demonstrated their commitment to capacity building and enabling clinic committees by commissioning and supporting the training of all their governance structures in the province.

Figure 6: Clinic committee status



The 2003 Facilities Survey found that while 59% of clinics reported having clinic committees, only 35% were functional and had met recently. The table below provides a comparison between the existence of clinic committees as per the findings of the 2003 Facilities Survey and the results from this study.

Table 6: Comparison of existence of clinic committees 2003[2] and 2008[3]

Province	2003(%)	2008(%)
Eastern Cape	57	73
Free State	26	78
Gauteng	11	46
KwaZulu-Natal	55	64
Limpopo	48	61
Mpumalanga	28	31
Northern Cape	17	45
North West	18	42
Western Cape	28	48
TOTAL	**35**	**57**

2 Existence of functional clinic committees as per 2003 Facilities Survey.
3 Existence of clinic committees as per this study.

The increase in the number of functional clinic committees is most likely due to the expressed political commitment to governance structures outlined in the National Health Act which legislated for the existence of these committees and delegated a provincial mandate to articulate the terms of references for these committees. As discussed earlier the manner in which provinces have complied with legislation has affected the development of these structures. The results also indicated that the imperative to form clinic committees was seen as an initiative that was sanctioned by the President of the country which had led to the active campaigning for committees to be formed. One respondent described the formation of their clinic committee thus:

> *The clinic didn't have a committee and the President wants all the clinics to have a committee. And the sister in charge went to the community to inform them that the President wants each and every clinic to form a committee.*
> **FGD, Eastern Cape Province**

The data shows that in the Eastern Cape, 10% (i.e. 11 out of 106 facilities) of the facilities with no water also had no clinic committee. In the Free State, 8% (i.e. 3 out of 39 facilities) of those facilities without a reliable water supply also reported not having a clinic committee and in KwaZulu-Natal, 11% (20 out of 175 facilities) of the facilities without a reliable water supply also reported not having clinic committees.

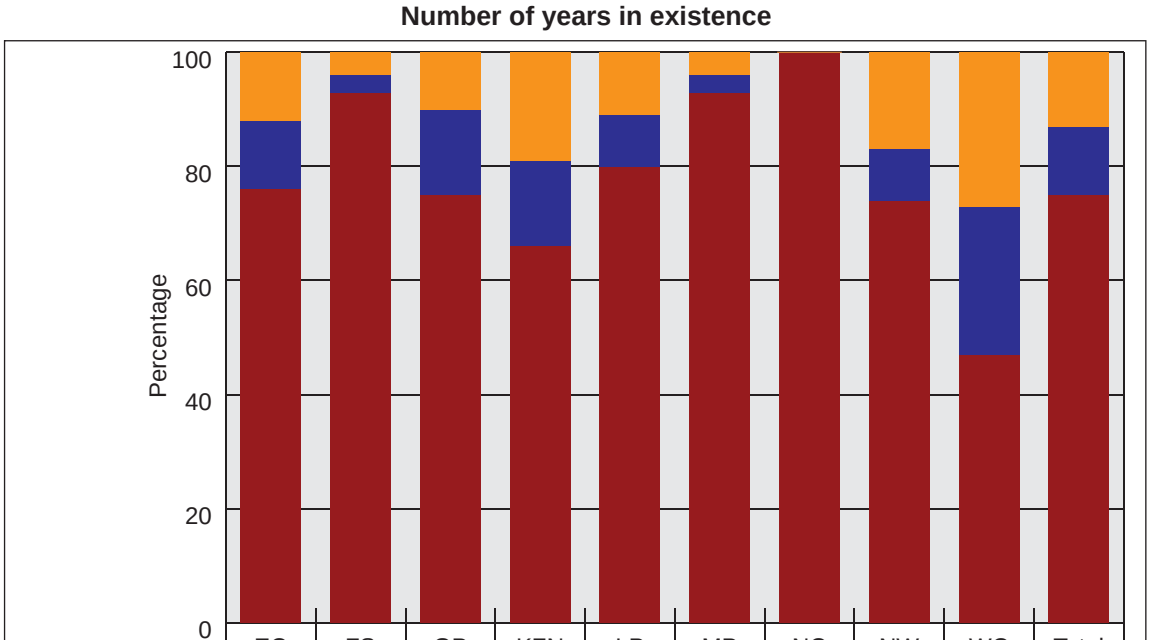
4.5 Reported reasons for not having a clinic committee

A wide variety of reasons were suggested as to why facilities did not currently have a clinic committee. These reasons are clustered into in four main themes which emerged across the provinces. An apparent lack of community interest in forming a committee, and that the facility was in the process of forming a clinic committee were the two dominant reasons. The other reported reason for not having clinic committees was a failure on the part of members to attend meetings and a lack of stipends for clinic committee members.

4.6 Number of years in existence of current clinic committee

The mean number of years that the current clinic committees had been in existence was 3.5 years. This refers to the actual number of years that the clinic committee had been in existence. The range was 1-12 years.

Figure 7: Number of years in existence



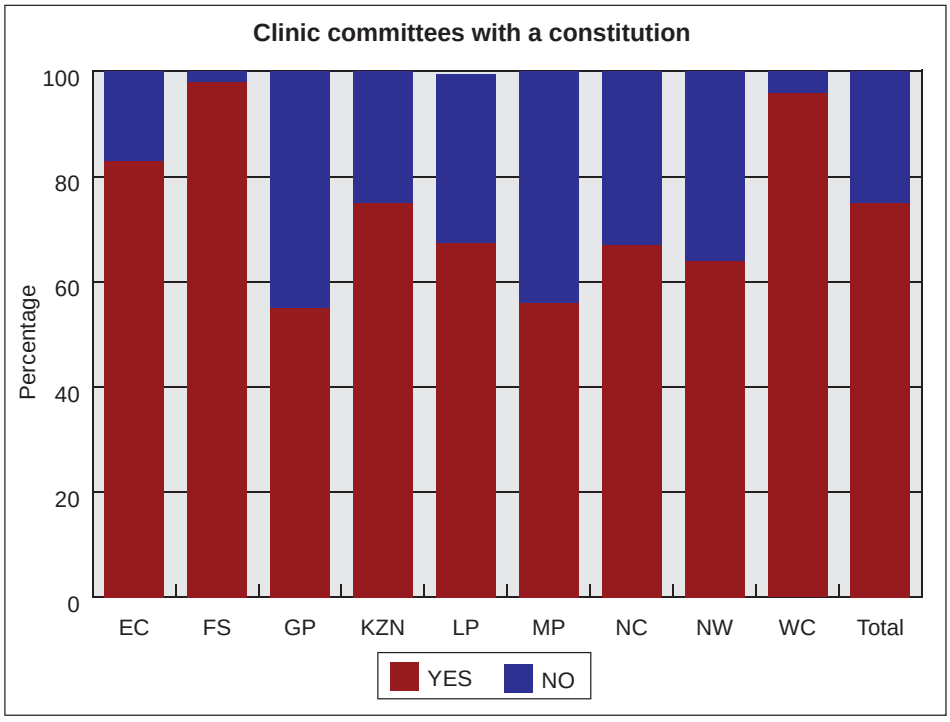
	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Total
5 Years or less	76	93	75	66	80	93	100	74	47	75
6-10 Years	12	3	15	15	9	3	0	9	26	12
11 Years or more	12	4	10	19	11	4	0	17	27	13

An interesting picture emerges with regard to how long clinic committees have been in existence at the facilities. Across all the provinces, 75% of clinic committees had been in existence for 5 years or less; 12% had been in existence for 6-10 years and 13% had been in existence for 11 years or more. In the Northern Cape 100% of clinic committees had been in existence for 5 years or less while in the Free State and Mpumalanga Provinces, 93% of clinic committees had been in existence for 5 years or less. Thus the data suggests that in most provinces, clinic committees have been in existence from roughly around the time that the National Health Act laid the framework for the existence of governance structures. However, in the Western Cape, 47% of clinic committees had been in existence for 5 years or less with 26% being in existence for 6-10 years and 27% for 11 years or more suggesting that clinic committees have been in existence for much longer in the Western Cape than in other provinces.

4.7 Clinic committee: constitution and convener

Clinic committees require a constitution to govern the manner in which they operate and to add weight to the roles and responsibilities of the members of the committee. Nationally, 75% of clinic committees reportedly have constitutions. This figure conceals large inter-provincial disparities with as many as 98% of clinic committees in the Free State having a constitution and 56% of clinic committees in Mpumalanga reportedly having a constitution.

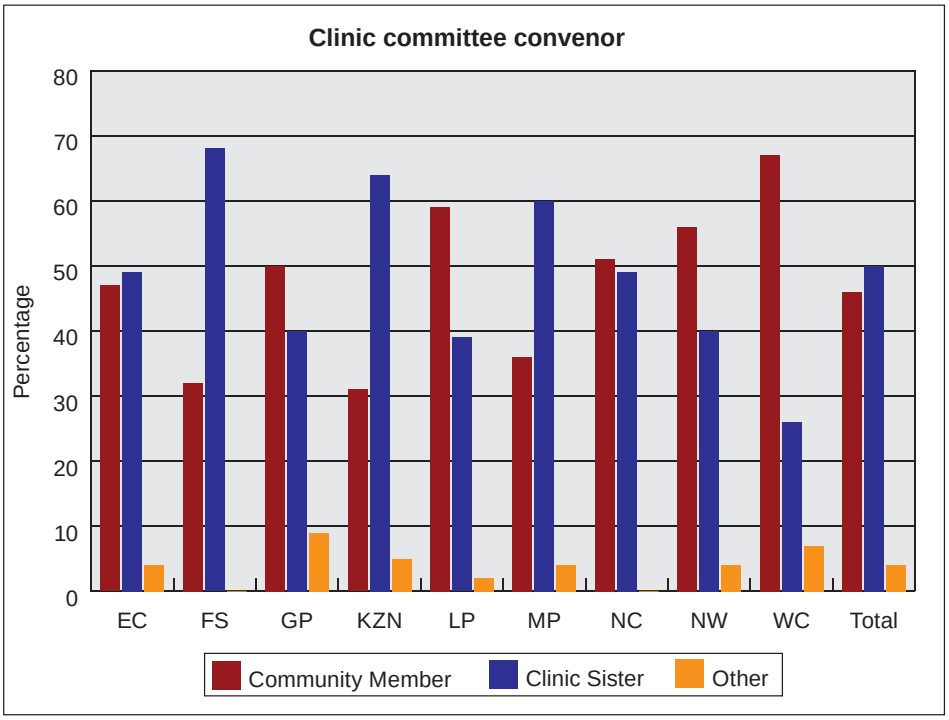
Figure 8: Clinic committees with a constitution



Despite the high number of facilities that reported having clinic committees, respondents in the focus group discussions in KwaZulu-Natal described working without any guidelines and requested assistance to develop a constitution:

> **We just work without any guidelines and we have to decide and see what work needs to be done and how. There is no constitution. We are very happy now that you are here and hope that you will help us to eventually have our constitution.**

Figure 9: Clinic Committee Convenor

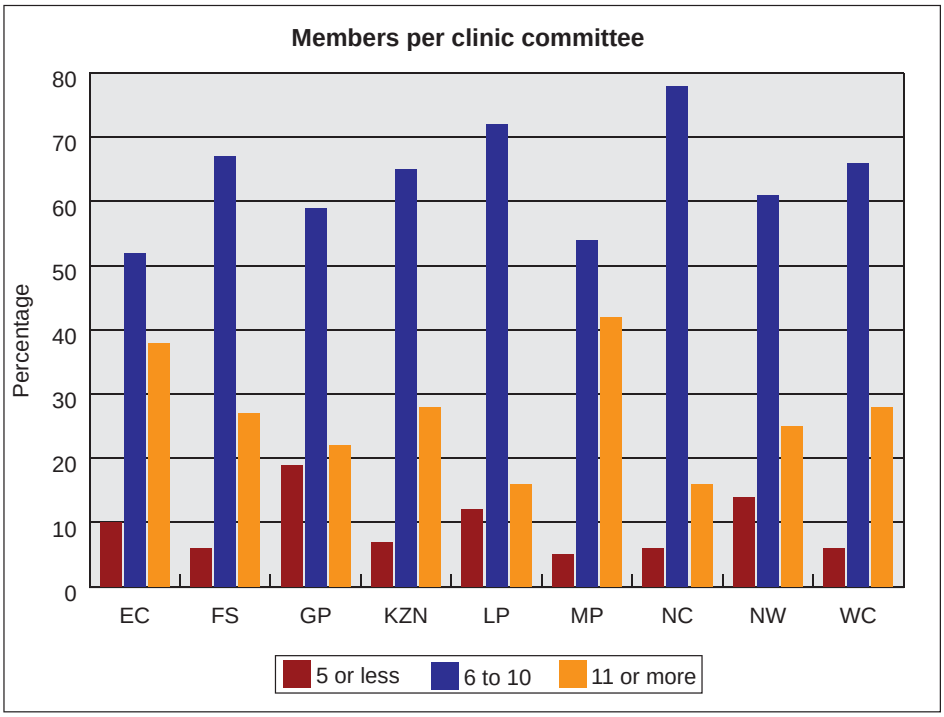


In 50% of cases nationally, the responsibility for convening the clinic committee currently rests with the clinic professional nurse. However, provincial variations do exist. In the Free State and KwaZulu-Natal, these proportions are more strongly weighted in favour of the clinic professional nurse acting as the convener of the clinic committee at 68% and 64% respectively.

4.8 Number of members on clinic committees

Seventy-six percent (76%) of clinic committees reportedly had 11 or more members. In the Eastern Cape, 38% of clinic committees reportedly had between 6-10 members which was followed by the North West Province where 18% of clinic committees consist of between 6 to 10 members.

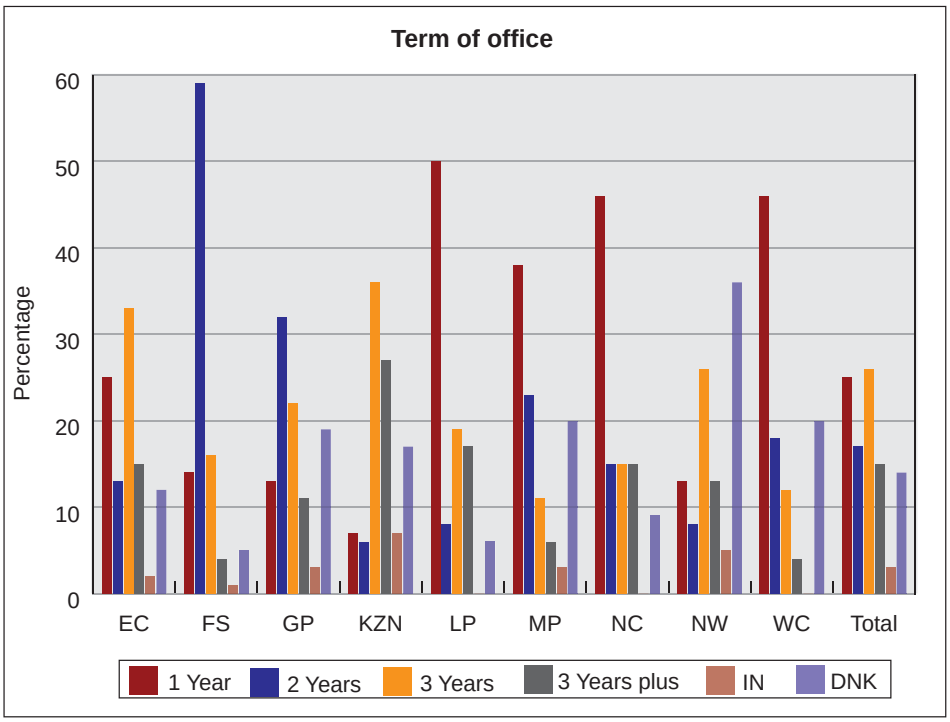
Figure 10: Number of members per clinic committee



4.9 Term of office for clinic committees

The period of time for which a clinic committee serves has important implications for continuity of the work, institutional memory, skills preservation and incrementally improving on performance of the committee. A short term of office might mean that the committee is disbanded before it has had an opportunity to fully engage with its mandate and constituency, or use the skills that might have been acquired during any training offered. Equally, a short term of office also has implications for the committee being able to meaningfully interact with district health planning and budgeting processes which take place over multi-annual periods.

Figure 11: Term of office

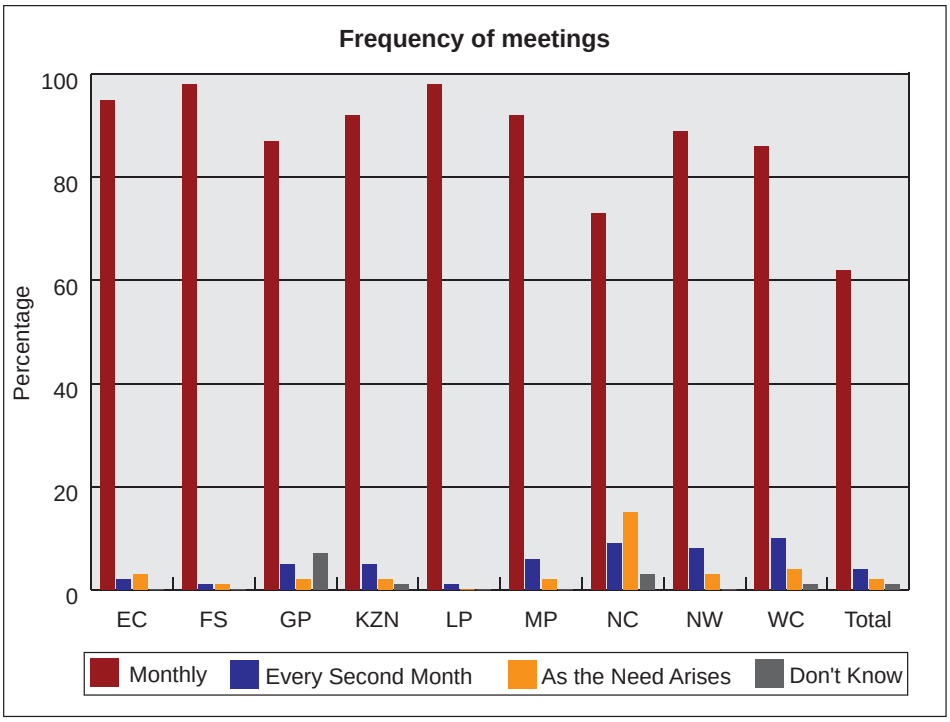


Seventeen percent (17%) of facilities reported that their clinic committee had a term of office of 3 years or more. Twenty-six percent (26%) of facilities surveyed reported that their clinic committees had a 3 year term of office; and 25% indicated that their clinic committees had a one year term of office In KwaZulu-Natal and the Eastern Cape, 36% and 33% of clinic committees respectively reportedly had a 3 year term of office. In the Free State Province, 59% of clinic committees reportedly had a 2 year term of office; it was disconcerting to note that nationally, 14% of the respondents reported not knowing what the term of office for their clinic committees were. The highest figures were in 36% in the North West Province, 20% in Mpumalanga and Western Cape and 19% in Gauteng. Nationally, 3% of clinic committees reportedly do not have a fixed term of office with the highest being in KwaZulu-Natal where 7% of clinic committees do not have a fixed term of office.

4.10 Frequency of meetings

Ninety-three percent of clinic committees meet monthly; 4% meet every second month; 2% meet as the need arises and 1% of respondents indicated that they did not know how often the clinic committee met.

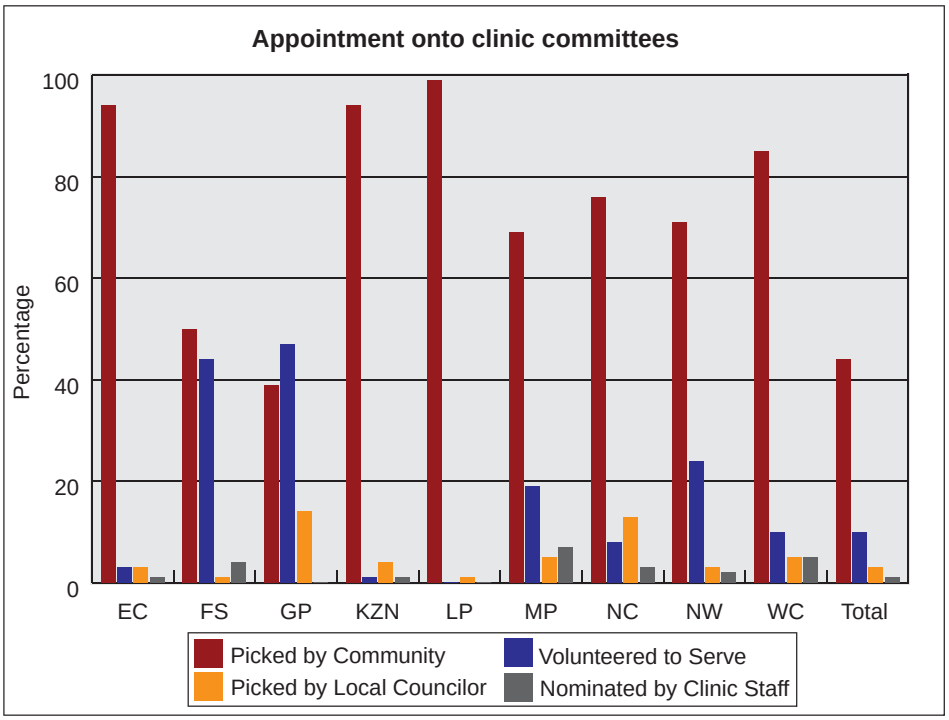
Figure 12: Frequency of meetings



4.11 Process of appointment onto clinic committees

Community representation on clinic committees is one way of ensuring that the needs and concerns of the community are adequately represented and acted upon. Out of the total facilities surveyed, 81% of clinic committee members were elected or chosen (either at a community meeting or by a show of hands from the community at a special meeting to constitute the clinic committee). The next most frequent method through which members joined clinic committees was through members themselves volunteering their services (13%); provincially the figures for Gauteng and the Free State Province for volunteering to serve on the clinic committee was 47% and 45% respectively. Approximately 14% of clinic committees in Gauteng and 13% of clinic committees in the Northern Cape reported that clinic committee members were selected by the local councillor – this percentage is high compared to other provinces which reported this practice to lie between 3% and 5% (Mpumalanga 5%; KwaZulu-Natal 4% and 3% in the Free State).

Figure 13: Appointment onto clinic committees



During the FGDs, respondents indicated that there was no uniformity in the process that led to people being appointed onto the clinic committees and the process appears to vary between provinces. For example, in one site a clinic committee member reported that he had joined the committee at the invitation of the committee chairperson while another member reported being nominated by the community.

> *The chairperson wanted me to come onto the committee.*
> **FGD, Free State Province**

> *The sister in charge told me to join the clinic committee and I did.*
> **FGD, Eastern Cape**

> *There was a community meeting where people were selected and I was selected.*
> **FGD, KwaZulu-Natal**

4.12 Composition of the clinic committees

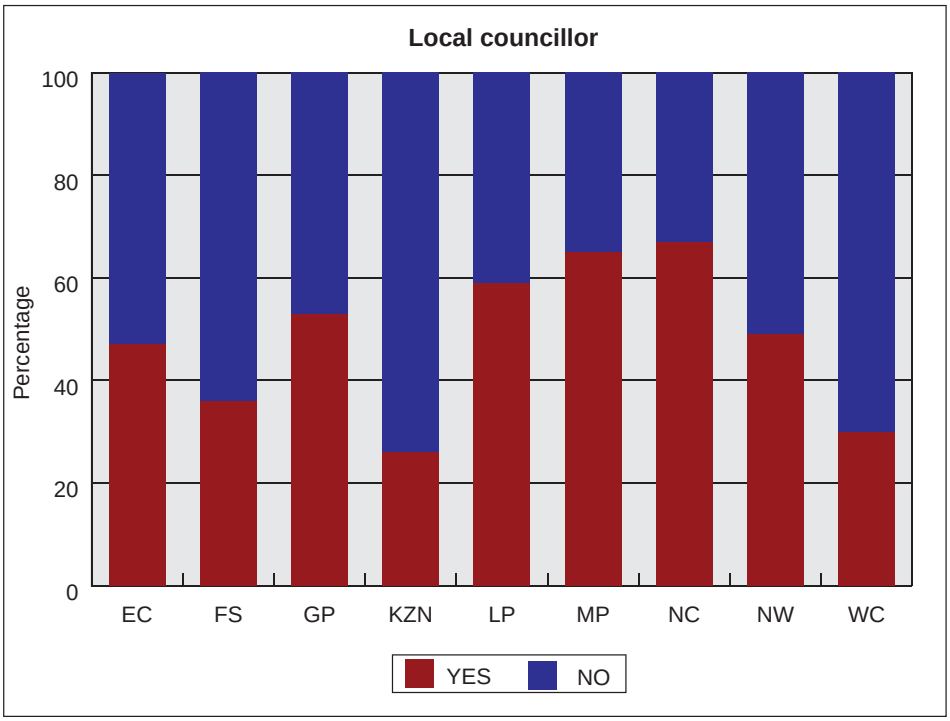
Section 42 of the National Health Act, 2003 stipulates that the following people must be members of clinic committees.

- one or more local government councillors
- one or more members of the community served by the health centre and
- the head of the health centre.

4.12.1 Local Government Councillors

In 45% of cases, the local government councillor was reported to be a member of the clinic committee. The data shows large provincial variations with the Northern Cape and Mpumalanga Provinces reporting the highest percentage of local councillor membership on clinic committees (67% and 65% respectively). KwaZulu-Natal and Western Cape recorded the lowest percentage of local councillor membership at 26% and 30% respectively. These low percentages are a cause for concern particularly as the National Health Act stipulates that one or more local councillors should form part of the membership of each clinic committee.

Figure 14: Local councillor membership



4.12.2 Clinic staff membership

The results also indicate that a high proportion of clinic committees in the country reportedly had at least one member of the clinic staff on the committee. In the Northern Cape, all facilities with clinic committees reported that clinic staff were members of the clinic committee. In the Free State and Western Cape this figure stood at 98% and 99% respectively, while in the North West and Limpopo provinces, 92% of clinic committees reportedly have clinic staff as members of the clinic committee.

4.12.3 Members of the community

Most clinic committee members (81%) are reportedly elected by the community – although significant provincial variations did emerge. However, the results of the focus group discussions suggest that there is no uniform way in which members of the community are elected onto clinic committees and that members were often appointed by the clinic sister, the local councillor or at the intervention of the clinic committee chairperson. This discrepancy between the information received from the quantitative survey and the focus group discussions may be one of the limitations of the former method, and the study itself, as the information is obtained from clinic managers in a survey-type questionnaire and thus not only may contain biases but also did not allow for elaboration of the responses.

The informal method of the appointment of clinic committee members as reported in the focus group discussions requires attention as there is the danger that the most vocal, well known and influential members of the community are appointed with little attention being paid to representative legitimacy and including all sections of the community.

4.12.4 Gender representation

From a gender perspective, the results suggest that women are adequately represented on governance structures – in all provinces their representation on governance structures exceed those of men (54% of all members are women). However, the literature suggests that the presence of women on participatory structures "may turn out to be supportive of a status quo that is highly inequitable for women" (Cornwall, 2000:3). While an examination of this issue was outside the ambit of this study, this is nonetheless an important issue, the examination of which could yield some salutary lessons about the composition of governance structures and the challenges associated with their formation from a gender perspective.

4.12.5 Head of the health facility

The study indicates that in most cases, facility staff (not necessarily the head of the health facility) are officially members of the existing clinic committee. The results also found that facility staff play a significant role in convening the clinic committees. However, this has not really translated into a true spirit of partnership between the health facility and the governance structures. From the FGDs, it was evident that clinic committee members make a clear distinction between themselves and health facility staff, which should not ideally be the case as the head of the health facility is required to serve as a fully functional member of the clinic committee. Evidence that clinic staff, particularly the head of the health facility, do not see themselves as part of the clinic committees was confirmed by the fact that no clinic staff attended the clinic committee focus group discussions held.

During the focus group discussions, respondents reported the following response from the head of the health facility when the issue of the attrition of clinic committee members was raised:

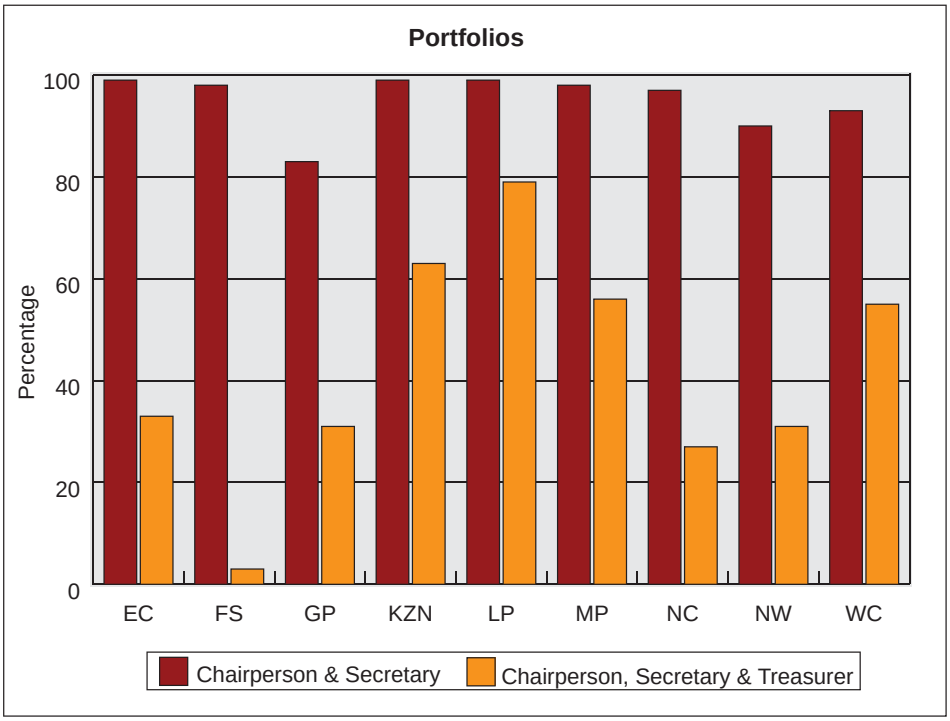
> *She [head of the facility] said we must write a letter to say what's wrong.*
> **FGD, Free State Province**

4.13 Portfolios

The data suggests that a high number of committees are formally constituted. Ninety-five percent of clinic committees in the country have appointed a chairperson and a secretary. The proportion of clinic committees

with a chairperson, secretary and treasurer is much lower which is not unusual given that clinic committees do not deal with finances. However, some anomalies did exist. For example, 79% of clinic committees in Limpopo and 63% of clinic committees in KwaZulu-Natal reportedly have a chairperson, secretary and treasurer; by contrast in the Northern Cape Province this figure was at 27% and in the Free State Province this figure stood at 3%.

Figure 15: Portfolios



4.14 Activities of clinic committees

Problem solving between the facility and the community appears to be the most common activity of clinic committees across all facilities surveyed with 84% of committees reportedly being involved in this type of activity. This was confirmed in the FGDs where respondents described their role as follows:

> *To ensure that there is no conflict between the patients and the nurses and to see that the clinic is running right, is clean and staff get all the support they want from the clinic committee to comfort them [the staff] and to see that the nurse and the patients are not hating each other.*
> **FGD, Free State Province.**

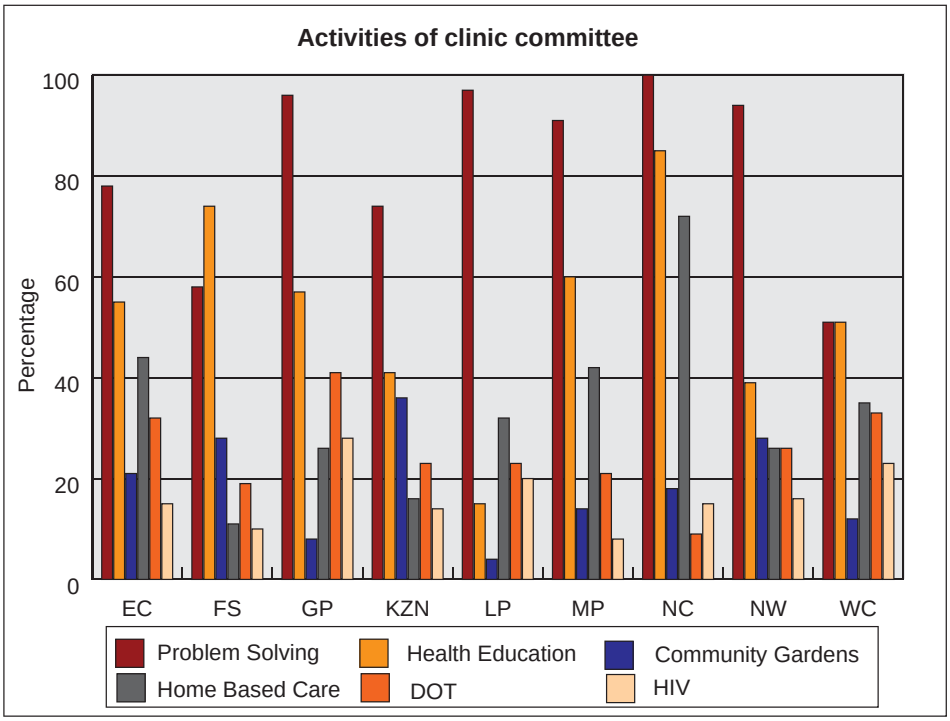
> *We tell the community about the lunch time of the nurses and about the shortage of medication.*
> **FGD, Eastern Cape**

Involvement in health education appears to be the second most widespread activity across the facilities surveyed with 47% of clinic committees reportedly being involved in educational activities. In some provinces the figures were as high as 85% for example, in the Northern Cape, and 74% in Free State Province. In the Free State Province, one respondent described the clinic committee's activities in health education activities as follows:

> **We also visit schools because we want them to know what AIDS is. I even go to the different churches for donations. We are divided in groups. Some go to prisons, some to schools and some do health education in the church.**

Other activities that committee members were reportedly involved in include volunteering in the clinic (18%), running community gardens at the clinics (21%), and directly observed treatment (DOT) (26%) and home based care (HBC) initiatives (30%). Here some provincial variations were noticeable with 72% of clinic committees being involved in HBC in the Northern Cape as compared to 11% in the Free State Province.

Figure 16: Activities of clinic committees



Findings from the study reveal that while clinic committees are involved in a wide range of activities, these appear to be mostly linked to playing an oversight and mediating role between the health facility and the community. This is evidenced by the fact that all clinic committees in the Northern Cape, 97% of clinic committees in Limpopo Province and 94% of committees in the North West Province reportedly play a problem solving role between the community and the health facility. The activities of clinic committees do not appear to be linked to any broader primary health care framework and appear instead, to be confined to narrower once off activities. For example, none of the clinic committees were reportedly involved in activities related to the broader socio-economic determinants of health such as water and sanitation, income generating activities and advocacy related activities.

The following quotes by FGD participants describe what they see as some of the key responsibilities of their clinic committees:

> *Our role is to come here everyday to see how the nurses do their work; the time they have to start working and finish; to make the patients enjoy attending the clinic*
> **FGD Eastern Cape**

> *(Our role is) to ensure that there is no conflict between the patients and the nurse. To see that the clinic is running right and that the clinic is clean; to ensure that staff gets all the support they want from the clinic committee.*
> **FGD, Free State**

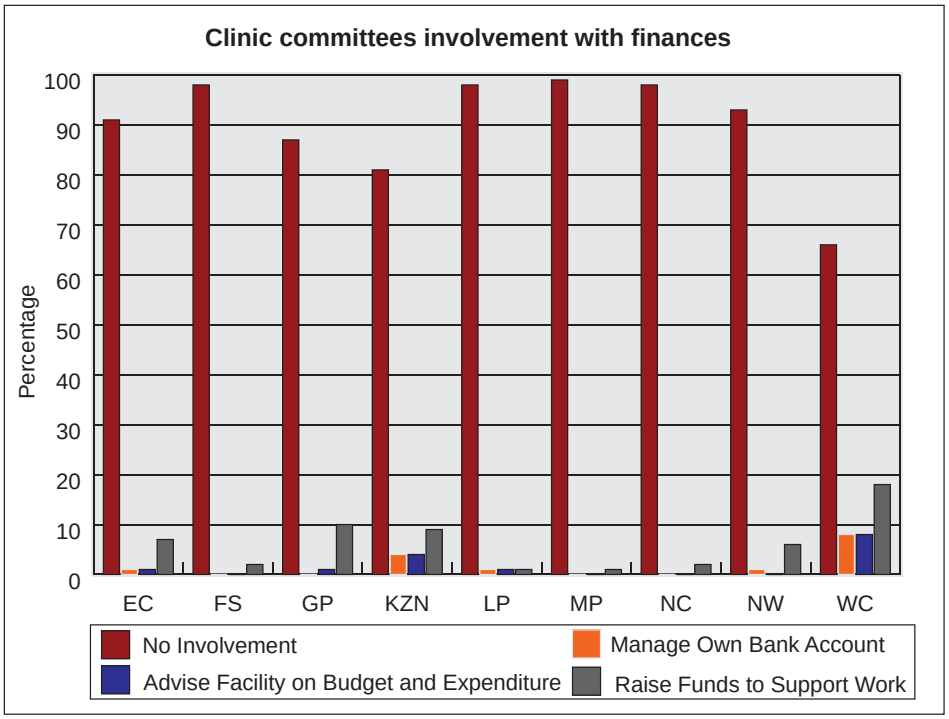
> *We are aware that there are people who enter the clinic premises drunk and they misbehave. All that disrupts that work of the nurses. We see to the wellbeing of nurses and as well as that of the community.*
> **FGD, KwaZulu-Natal**

4.15 Involvement with finances

Clinic committees do not appear to have much involvement with finances with 93% of committees in country reportedly having no involvement in finances at all. However, clinic committees in some provinces reportedly raise funds to support their work. Eighteen percent (18%) of clinic committees in the Western Cape, 10% of

clinic committees in Gauteng and 9% of clinic committees in KwaZulu-Natal reportedly raise funds to support their work. In Gauteng and KwaZulu-Natal, 8% and 4% of clinic committees are reported to be involved in the budgeting and expenditure processes of their respective clinics and reported managing their own bank accounts.

Figure 17: Involvement with finances



The lack of involvement of clinic committees with finances either in an advisory role to the facility or to fund and manage its own activities and needs is cause for concern. In the case of the former, the needs and requirements of the community are not factored into the budget of the facility which results in care being delivered at primary health care level which is not always inclusive of the priorities that the community considers important to support and resource. In the case of the latter, there is the danger that clinic committees are required to operate on unfunded mandates in that they are expected to perform certain actions for which no budget is provided - which could hinder their effective functioning:

> *There is no money for our work. There is a thing we call a support group. Support groups here depend on food that is grown here at the clinic for them to survive. There are old people in this group and to keep them we often have to pay out our own money, the sister-in-charge and us…we buy some tea and bread. Now most people think that this is money we get as a committee, but it's our own money.*
> **FGD, KwaZulul Natal**

Linked to this, are the poor socio-economic positions of the members themselves who find the costs of travel to the clinic to fulfil their duties onerous.

> *It's very difficult to work for my community I live very far from here and I cannot ask for a lift….. and I end up not going to meetings.*
> **FGD, KwaZulu-Natal**

> *Our problem is that the committee became demoralized; we lost a lot of members because they didn't have enough money to come to the meetings.*
> **FGD, Eastern Cape**

Respondents also indicated that the community wrongly perceived that there were benefits associated with serving on clinic committees.

> *The problem is that the community believes that we get lots of things by being clinic committee members. They do not believe that we would leave our home chores and other tasks to be here for nothing. In actual fact, we sometimes don't even have money to come here. Like today, I had to ask my brother here to pay my taxi fare for me and I do not know how I am going to be getting back home. We are just volunteers; this is very difficult for us. We do not have money.*
> **FGD, KwaZulu-Natal**

> *They [the community] don't want to help us financially. They think we are doing this for ourselves and there is money.*
> **FGD, Eastern Cape**

Clinic committee members reported that they were not provided with resources to fulfill their mandate and therefore felt that their committees were ineffective. Respondents expressed the need for clinic committees to be given fixed budgets to conduct some of their activities and for stationery and other equipment as illustrated by the following statements:

> *What we need is computers because sometimes we need to print, write and to create something but we can't because we don't have computers. We need those small TVs like the ones that the lecturers use so that we can explain something to the patients and to the community.*
> **FGD, Free State Province**

> *We have never been told if we have a budget or not. We have no money to do awareness campaigns*
> **FGD, Eastern Cape Province**

The allocation and lack of resources thus features as a significant issue for governance structures at various levels. Where unemployment and poverty is rife, a failure to reimburse members for transport and other opportunity costs incurred to attend meetings can operate as a deterrent to serving on clinic committees. In addition, the lack of a dedicated budget for governance structures has contributed to feelings of impotence and a limited ability to engage in community outreach projects.

This lack of financial or logistical support may in part, explain why some of the reasons offered for the facility not having a clinic committee included lack of community interest and members not attending meetings.

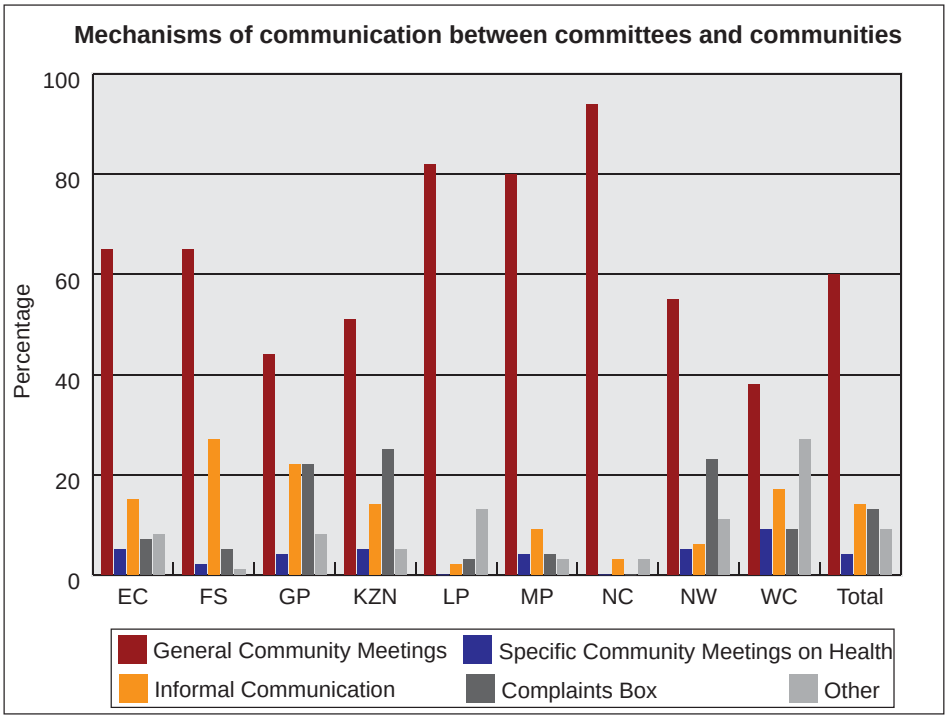
In order to understand if health facilities in underserved areas (measured through access to basic services) had more difficulty in establishing and maintaining clinic committees, analysis of the results also attempted to ascertain whether there was any relationship between those facilities that lacked basic resources such as water and electricity and the existence of governance structures at those facilities. The rationale for such an analysis was based on the premise that these conditions could also have an impact on the existence of clinic committees. However, the results do not point in any conclusive direction in this regard as they suggest that only 10% of the clinics with no water also did not have a clinic committee. It is likely that a more nuanced approach would be needed to address this issue.

4.16 Mechanisms of communication between clinic committees and communities

The data indicates the absence of formalized methods for clinic committees to communicate with their constituencies. Most committees (60%) communicate with the communities they represent via general community meetings. Informal communication was also cited as a method for communicating with communities (14% nationally) with the figure ranging from 27% in the Free State Province, 22% in Gauteng to 17% in the Western Cape. Thirteen percent of clinic committees cited the complaints box in the facility as their means of

receiving communicating from their catchment communities (25% in KwaZulu-Natal, 23% in the North West Province and 22% in Gauteng).

Figure 18: Mechanisms of communication



While most clinic committees reportedly meet on a monthly basis, there does not appear to be a systematic way in which clinic committees communicate with each other or with the communities they represent. None of the governance structures had any formal communication channels with the community, hospital boards or district management. Communication between and among governance structures themselves is weak, ad hoc and inconsistent. While provision for such communication might exist on paper, it is not known in practice. None of the respondents, for example, were able to provide information of how they communicated with other governance structures. There is no evidence to suggest that clinic committees, hospital boards and district health councils have coherent and co-coordinated mechanisms to communicate with each other. Nor are there any mechanisms to facilitate lateral communication between the governance structures.

4.17 Roles and responsibilities

Findings from the FGDs suggest that there are a diverse range of understandings of the roles and responsibilities of clinic committee members. These ranged from a purely health promotion role to a watchdog role over staff.

> *In my view it's to look out for the community. The community may do or see something wrong, they cannot as a community all come to the clinic to report this but there needs to be a community representative looking at a number of issues, for example, to see if the staff treat patients well, is the staff working well, are clinic queues moving faster or slower? What are the problems in the facility? We check if the clinic has supplies to assist the community. We look into the space at the clinic, and we are able to discuss these and we give feedback that the community has a problem with this and this is how you can help the community. We also oversee things that if patients need to go to hospital they do. We also talk to the referral hospital for them to bring some of the hospital services here, to help the clinic.*
>
> **FGD, KwaZulu-Natal**

A common theme emerging out of all focus group discussions was the perceived breakdown of the social fabric of their communities and their desire to assist vulnerable members of their communities.

We need to have our own things to assist in the community like food parcels and blankets. We want to see our committee develop and our community get everything they want. As we told you that we are unemployed but we wish to help the street kids and those children who finish the school to do something. It hurts us to see the children staying at home and doing nothing. We need a place to take care of the orphans.

FGD, Eastern Cape

We want to help orphans and elderly persons. We often encounter these people and we discuss them here in the committee and we cannot even help them. We are also looking for areas where they keep orphans so that they do not get abused here in the community.

FGD, KwaZulu-Natal

4.18 Training needs

The findings of the research suggest that governance structures are made vulnerable by limited capacity, lack of training and confusion over mandates and areas of functioning, and there is often a need for long term support and capacity building of community members elected onto governance structures.

Respondents in the focus group discussions expressed the need for training as follows:

We have not received any training. We will learn. As I have said before there are situations where one gets stuck and you do not know what to do. There are lots of things like training that will help give us direction as to what we can do and what we cannot do.

FGD, KwaZulu-Natal

We are asking for a training that will help us balance the information for all people concerned, so no one has more information than the other.

FGD, Eastern Cape

4.19 Summary of results

The key findings that have emerged out of this audit suggest that there are a range of factors that impact on the functioning of clinic committees. The results suggest that more clinic committees exist in provinces where there has been explicit political support for the creation and capacitation of these structures. The data also suggests that most clinic committees have come into existence since the promulgation of the National Health Act, 2003. Poor socio-economic conditions and living in a context of poverty are important determinants of whether clinic committees flourish as the study found that a failure to attend meetings (often due to transport costs) and the lack of a stipend for clinic committee members are some of the reasons why facilities do not have fully functional clinic committees. Encouragingly, in two provinces, more than 30% of those facilities that did not have clinic committees reported being in the process of establishing a clinic committee. However the low level of local councillor membership (45%) of clinic committees is cause for concern as this is a statutory requirement which is not being complied with and which has important implications for the envisaged tiered system of representation articulated in the National Health Act, 2003. The results also suggest that while most clinic committees meet on a monthly basis, the activities of the clinic committees appear to be mostly confined to problem solving between the community and the health facility, health education and volunteering their services in the facility. The issue of the roles and responsibilities of clinic committee members needs attention as the research has highlighted the gap that exists in this regard.

CHAPTER 5: DISCUSSION

5.1 Introduction

This study set out to assess the existence and functioning clinic committees in order to identify opportunities to strengthen their role in governance. Among the objectives of the study was ascertaining the number of clinic committees associated with primary level public health facilities in the country and to outline the composition of their current membership and nature and scope of activities.

The study has found that a range of factors are related to the effective functioning of governance structures. These factors can be categorized as either enabling or hindering factors. The overall impression created by the findings of the study is that while the number of governance structures in the form of clinic committees and community health committees (CHCs) has increased due to a supportive political context; there are a wide range of systemic factors that prevent clinic committees from operating as envisaged.

5.2 A supportive political context

The findings show that approximately 57% of primary level facilities have clinic committees. Data available prior to the promulgation of the National Health Act 2003 indicated that nationally, 35% of clinics had functional clinic committees (Reagon *et al.* 2003). There has thus been a substantial increase in the number of facilities with clinic committees with 78% of facilities in the Eastern Cape and the Free State Province, 48% of facilities in the Western Cape and 46% of facilities in Gauteng now reportedly having clinic committees. As indicated earlier, this increase could be attributed to the supportive political context created by the National Health Act.

The positive effects of a supportive political environment has also been noted by Boulle (2007: 119) who found that:

> **CHCs were at their most effective when community members believed that they were supported politically, when there was a strong call from national leadership, indeed the President, for citizens to volunteer the services in pursuit of a transformed South Africa.**

There is thus presumably a positive relationship between the policy and legislative landscape (and perceived political commitment) as it relates to community participation and the increase in the number of clinic committees in country. In addition to the National Health Act, 2003 (Department of Health, 2004), documents such as the *White Paper on the Transformation of the Health System in South Africa* (Department of Health, 1997), the *Development of a District Health System for South Africa* (Department of Health, 1995) and the *Norms and Standards for PHC Framework* (Department of Health, 2001) which set out the vision for a post apartheid public health system have all contributed to creating a policy environment conducive to community participation. This phenomenon of supportive political contexts has been noted by Sanders (1992) and Gryboski *et al.* (2006) who confirmed the positive synergies that exist between community participation and political democratisation. Baum and Kahssay (1999) and Baez and Barron (2006) also found a positive link between political commitment and the existence of governance structures. This study found that there has been a 22% increase in the existence of clinic committees since the introduction of the National Health Act, 2003.

The link between supportive political contexts and the increase in the number of clinic committees was also evident from the number of years that clinic committees had been in existence. However, the mere presence of enabling policies and legislation does not necessarily translate into the effective functioning of governance structures. Boulle (2007:102) for example (quoting Levers *et al.* 2006) cautions against the following:

> **Without strategic implementation and deliberate training, policies that are intended as user friendly do not always translate as such: a socially constructed sense of participation often obscures an authentic process for establishing community voice and for delineating roles at the district health level.**

In her study, Boulle (2007) concluded that due to the lack of management and monitoring to ensure that legislation and policies were being implemented in accordance with their original intention, community health centres were in danger of assuming a form that was different to the original intention and could therefore become "socially constructed". In this way, the establishment of a clinic committee could become an end in itself rather than a means for effective community participation in health governance structures.

In a commentary on the National Health Act, the Aids Law Project (ALP) has similarly pointed out that:

> **As of September 9 2008, no provinces had finalised legislation required [by section 42 which deals with the formation of clinic committees] of the NHA. Unfortunately because section 42 isn't proclaimed and no provinces have finalised legislation, these committees – which are meant to include community representatives – have not been established in the manner intended (ALP, 2008: 63).**

5.3 Compliance and implementation

Results of the study suggest that there is a substantial degree of compliance with national legislation and policy documents which provide for community participation through governance structures. A high number of clinic committees are formally constituted with 82% of committees reportedly being governed by a constitution; clinic committees meet regularly and most clinic committee members are elected by the community. However further scrutiny suggests that while there may be a high degree of compliance with the legislation, the composition of these committees, their link to other levels and mechanisms of community representation and the nature of their activities indicate that these structures are not functioning within the spirit and intention of the legislative framework and indeed may be operating in parallel to these envisaged processes.

As Levers *et al* (2006) quoted by Boulle (2007) suggests:

> **It is not enough for governmental Ministries to author policy documents that outline and promote participation by the citizenry; they must also construct mechanisms for participation and citizen friendly avenues for participation (Boulle 2007:101).**

The study has shown that while governance structures do exist, the lack of attention from policy makers as to how they should function and what the focus of their work should be, suggests that many facilities are mechanistically complying with the legislation with little attention as to how to maximise the efficiency and operations of these clinic committees. Without formal policy guidance on the roles and responsibilities of clinic committees, there is little standardisation between facilities in how committees are established and what roles they play in governance. There are also no official indicators on which to measure clinic committee performance, making it difficult to track whether committees are functioning as legislation intended.

5.3.1 Composition of the clinic committees

The composition of clinic committees as stipulated by section 42 of the National Health Act is not being adhered to. As indicated previously the National Health Act makes provision for one or more local government councillors, one or more members served by the health centre and the head of the health centre to serve as members of the clinic committee.

In 55% of clinic committees the local councillor was not a member of the clinic committee. The absence of such councillors in more than half of clinic committees is cause for concern as local councillors are seen to play an important linking role in the committees between provincial government structures and local government.

Boulle (2007) for example, points out that:

> **Co-ordination with the local government councillor and ward committee have the potential to provide a useful avenue to access resources and to impact on the municipal planning mechanism such as the [Integrated Development Plan] IDP (Boulle, 2007: 67).**

The low level of local councillor representation (45%) illustrates that whilst a significant number of clinics comply with the legislative imperative of having a clinic committee, there is limited compliance with the finer details of the legislation as regards composition of clinic committees. Baez and Barron (2006) suggest that one reason for this poor translation of policy into practice is that policy implementation often takes place at district level which leaves it vulnerable to the discretion and interpretation of the staff at district level. Indeed, they note that it is at district level where the failure or success of community participatory structures are decided through the existence of supportive and effective district level policies and commitment to the process.

Transparent and fair policies and procedures for being nominated and appointed onto governance structures which are developed in conjunction with community representatives and are widely publicized will assist in ensuring uniformity in the appointment of clinic committee members. These policies and procedures should be available and displayed in every health facility – in a language that is accessible to the local community. In addition, clarity is also required on the geographical jurisdiction of such structures as the National Health Act stipulates that provincial legislation must at least provide for the establishment of a committee for a clinic or a group of clinics. Clarity on whether committees are to be set up for individual clinics or groups of clinics will assist in clarifying and refining the nomination and appointment processes as well the terms of reference for the committees.

It is likely that that the poorest groups do not routinely participate in community activities and steps must be taken to ensure that these groups together with other vulnerable groups such as women and youth are represented on governance structures. A failure to do this will result in the composition of governance structures resembling existing power relations which has the potential to reinforce and perpetuate existing inequities.

The National Health Act also makes provision for the head of the health facility to serve as a member of the clinic committee. This has not been borne out by the study and none of the facility staff attended any of the meetings held with clinic committee members. This attitude of seeing themselves as separate from the clinic committee was also evident in Boulle's (2007) study which she described as follows:

> **Focus group participants discussed health facility staff involvement as 'supportive' of the structures. They described CHC meetings with health facility staff, as though the staff was outsiders and they, CHC members, were grateful for their support (Boulle, 2007:57).**

5.4 Individualised activities versus a primary health care approach

The adoption of the Primary Health Care (PHC) Approach at Alma Ata in 1978 was considered a major victory for health activists who took a broader, multi-sectoral approach to health and health care.

The basic philosophy of PHC was the "development of a comprehensive health strategy that not only provided health services but also addressed the underlying social, economic and political causes of poor health" (Werner and Sanders, 1997: 18).

Under the rubric of a primary health care approach, participatory initiatives such as governance structures are meant to be involved in the planning, prioritizing and managing of health services; contributing to the development of district health plans and the budgeting processes and actively partnering with health facility staff to strategically guide the operation of the clinic to make it more responsive to the needs of the local community (Oakley 1989; Baum and Kahssay, 1999, Baez and Barron, 2006). *The White Paper for the Transformation of the Health System in South Africa* (1997) for example, explicitly outlines a role for governance structures in "the planning and provision of health services" (Department of Health, 1997: 20). However current practice has not adhered to the spirit and intention of such policy documents.

Clinic committees were involved in a range of activities, yet these activities do not appear to be linked to any broader integrated primary health care approach and appear rather to take place on a more ad-hoc, irregular basis. They appear to be fulfilling narrow, mediatory and watchdog functions rather than displaying a sense of agency in tackling the root causes of ill health.

5.5 Impact of clinic committees

Some of the benefits of community participation initiatives include improved health outcomes, greater efficiency and effectiveness, equitable outcomes and extended coverage of services. Given the mostly individualized and mediatory role played by most clinic committees, it is questionable whether the majority of health facilities with governance structures in the country are directly or even indirectly contributing to the benefits described above. However some encouraging initiatives were reported by clinic committees. In the Eastern Cape for example, respondents indicated that they had successfully intervened in securing emergency medical transport for patients in their catchment area and had also helped to ensure that there was a more consistent supply of medication at the clinic. In KwaZulu-Natal, respondents reported successfully negotiating with the local chief for land to be used to construct accommodation for nurses working at the facility.

Significantly, viewpoints which conceptualized governance structures as being essential in order to improve health outcomes and quality of care in line with a primary health care approach were noticeably absent from all FGDs held with respondents. There is thus a need to encourage and facilitate creative thinking and new understanding of the roles of governance structures. New ways thinking should reflect a move away from seeing these structures as having purely mechanistic, watchdog functions to reflect a role which embraces a more participatory and developmental approach to health service delivery – borne out of a collaboration between the health services and the community.

5.6 Factors influencing functioning of clinic committees

A wide range of factors was found to either inhibit or facilitate the functioning of clinic committees at local level. These include the support received from health facility staff, availability of resources, capacity building and the socio-economic context within which governance structures operate.

5.6.1 Support from health facility staff

The attitudes of the health facility staff towards community participation and governance structures is an important determinant of the effectiveness of structures such as clinic committees. Some of the problems difficulties associated with the relationship between health facility staff and governance structures include poor health worker appreciation of the value of participation, perceptions of being policed by governance structures and little support and direction from the health services.

While almost all clinic committees reportedly had at least one clinic staff member on the clinic committee, the findings of the study suggest that health care workers do not appear to be active, committed and fully functional members of clinic committees. This was to some extent also corroborated by Boulle (2007) who in her study of community health committees (CHC) in the Nelson Mandela Bay Municipality found no evidence that the head of the health facility was consistently a full member of the CHC. Boulle further found that in the context of the current human resource shortage in the country that health care workers felt overstretched and did not necessarily prioritise support and engagement with governance structures. On the subject of the clinic committees and the community's relationship with the health facility staff, clinic committees said the following:

> *Sometimes she [the clinic sister] comes to ask us for assistance but we don't go to ask something from her.*
> **FGD, Free State**

> *Another thing that is a problem is the poor manner and approach from the nurses.*
> **FGD, KwaZulu-Natal**

The absence of guidelines and direction on the need for governance structures and how to support their development and functioning can contribute to a situation where the support given by health facility staff is based on the personal preferences and competing priorities of the clinic staff rather than on clearly articulated

policies and procedures. This clearly limits clinic committees from developing into structures that can play an active role in the governance of health facilities.

5.6.2 Resources

The lack of allocation of resources to support the operational and logistical needs of governance structures has been implicated in the failure of many community participation initiatives and various commentators have pointed out the importance of buttressing political and legislative support with appropriate resources at a local and district level (WHO, 1991; Baum and Kahssay, 1999; Macwan'gi and Ngwengwe, 2004).

5.6.3 Training

The literature confirms the importance of ensuring that community members are provided with training and support to fulfill their roles in participatory structures (NPPHCN, 1996; Baez and Barron, 2006; Boulle, 2007). However findings from the research suggests that training for governance structures mostly does not take place and if it does, it is not executed in a consistent or co-ordinated manner. Indeed, where such training does take place, it is usually a once off occurrence which does not involve health facility staff (HST, 2007). This can lead to a disjuncture between clinic committee members and health facility staff's understanding of the roles and responsibilities of governance structures as both parties have not been trained on the same issues and would therefore not necessarily have developed a consensual understanding of their respective roles and responsibilities.

Training must be ongoing and continuous as research conducted by Nordberg (1984 as cited in NPPHCN, 1996) in Kenya found that it takes up to two years for a basic understanding of the district health system and appropriate support systems to be established. It is equally important that the content of the training is developed in conjunction with the governance structures themselves (Baez and Barron, 2006). Lack of continuity and loss of institutional memory due to resignations, expired terms of office and general attrition can be addressed by developing a sustainable and continuing education programme which will provide updates on relevant issues, refresher courses and initial training for new members of governance structures.

In order for training to be successful and for the barriers to effective functioning of governance structures to be addressed, it is essential that provincial and district managers support health facility staff to develop their understanding and appreciation of the positive role that governance structures can play in the health system. Joint training for health facility staff and governance structures will address this shortcoming.

5.6.4 Socio-economic contexts

A recurring theme from the FGDs conducted in this study is the impact that living under poor socio-economic conditions has on effective functioning of governance structures. The lack of a stipend and or a travel allowance to facilitate transport and access to health facilities operates as a significant barrier to governance structures being able to fulfill their mandates. The study thus suggests that community participation is constrained in contexts of poverty and in environments where resources are limited.

5.6.5 Guidelines

The varying processes for appointment onto clinic committees and the confusion around the roles and responsibilities and a variety of other issues that currently beleaguer the functioning of governance structures could be an be addressed through the development of a more comprehensive national set of guidelines.

There are no literature and policy guidelines for the establishment and development of clinic committees at district and local level. This could lead to the practice of simply ticking off requirements that must be complied with at a district or regional levels which could lead to artificially constructed structures with no real mandate or clearly understood role. One of the indicators used in the National District Competition[4], for example, was

4 The National District Competition run by the National Department of Health rewards excellence in competing health districts.

that community participation structures are in place. However, no guidelines are provided by the Department on how to put these structures in place or on how to measure or evaluate their effectiveness.

The existence of such guidelines could be beneficial for those working at a local level as they could incorporate a transparent and acceptable monitoring and evaluation system which will enable role-players to critically assess the functioning and effectiveness of governance structures. Such a system must also build in mechanisms for soliciting community views and perceptions of the structures being evaluated as their comments will provide objective feedback on achievements and areas for growth. The guidelines should also provide for a remedial plan to address the findings of such monitoring and evaluation exercises.

CHAPTER 6: CONCLUSION

Whilst the number of functioning clinic committees has increased at primary care level in all provinces since the inception of the National Health Act 2003, there are nonetheless a variety of issues that impact on the effective functioning of such governance structures. Among these is the fact that the composition of the membership of clinic committees is not conforming to the dictates of the legislation. Specifically, weak representation of local councillors on clinic committees results in a limited ability of governance structures to meaningfully interact with other district and municipal processes and effectively denies clinic committees any avenues to articulate the needs and concerns of communities at higher levels of decision making. Further, the research indicates that clinic committee members are not elected in a transparent and uniform manner, which may limit the ability of these committees to represent their communities. In addition, the lack of established, formal mechanisms whereby the clinic committees are able to access input from the communities which they represent on a regular basis compromises their ability to adequately represent the interests and needs of the communities they serve.

In addition, there appears to be a lack of clarity on the range and types of activities that clinic committees are expected to perform and the absence of any national guidelines to this effect has resulted in clinic committees fulfilling mainly a narrow, mediatory and problem solving function between facility staff and local communities. There appeared to be no evidence of any intersectoral collaboration or a primary health care approach which locates health within the broader socio-economic determinants of health. For example, none of the clinic committees in the study were reportedly involved in issues related to water and sanitation or the equitable distribution of health services.

Clinic committees are also beleaguered by a lack of financial and technical support from the health authorities which is exacerbated by the poor socio-economic conditions under which they live. The lack of a stipend or travel allowance to attend clinic committee meetings as well as the lack of a dedicated budget to conduct their activities places a burden on people already living in poverty and hampers the ability of the clinic committee to function effectively. In addition, training and capacity building for governance structures is weak or absent. None of the provinces have a coherent and systematic training programme for clinic committee members. This compromises the ability of members to feel empowered to adequately represent the interests of their communities and engage in a meaningful way with the facility staff and the health service planning processes that committee members ought to be a part of.

In order for governance structures like clinic committees to successfully carry out their mandates, it is essential that the key issues raised in the study and highlighted above are considered and deliberated by decision makers in the National Department of Health. However, it is equally critical that there is a political commitment not only to conforming to the dictates of legislation but also to an underlying philosophy that recognizes the value and benefit of a truly participative, accessible and responsive health care system. For this to happen managers at both a national, provincial and district level within the Department of Health need to provide more substantial guidance as to how the policies on community participation that currently exist on paper are to be implemented in practice – particularly at a local level.

RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made:

1. The development of a comprehensive national framework for clinic committees

The study has shown the limitations of operationalising governance structures through delegated legislation. In order for governance structures to function effectively, it is recommended that a set of national guidelines be developed. The target audience for these guidelines includes health professionals, district and local staff as well as members of governance structures. The purpose of these guidelines would be to establish coherence and certainty on what governance structures are meant to do and how they should be constituted and operate.

The suggested content areas of these guidelines are as follows. Firstly, the guidelines should be developed with a view to articulating the philosophy as well as spirit and intention of the principle of community participation. The guidelines should locate the principle of community participation within a broader primary health care paradigm as outlined in the White Paper and should make the link between the broader socio-economic determinants of health and the potential role of governance structures in addressing these factors. Secondly, the guidelines should clarify a wide range of procedural issues related to how governance structures should be constituted and ought to operate. Some of these issues include nomination procedures, term of office, roles and responsibilities, communication channels and codes of conduct.

2. Design and implement a training and capacity development programme for clinic committee members

If governance structures are to fulfill their envisaged role, it is critical that a detailed training programme is developed and conducted for clinic committee members. Training should concentrate on building a critical mass of community health activists who are knowledgeable on both substantive (e.g. roles and responsibilities) and procedural issues (e.g. method of election, term of office etc.) related to the functioning of governance structures as well as on the broader community health related issues such as health promotion, understanding community needs and conflict resolution and dispute management. Training should take place on a regular and continuous basis and could be conducted by the community liaison officers/community development officers at district level.

3. Commission a best practice study of clinic committees

It is recommended that the National Department of Health commission a qualitative Best Practice Study on Clinic Committees. Districts, governance structures and communities could be requested to submit best practice examples of how a facility has established and worked collaboratively with a clinic committee (e.g. joint planning of health services). The best examples of these could be included into the national guidelines (as proposed in recommendation one) so as to provide practical examples of how the legislation is implemented in practice. The study should examine the various factors that impact on the effective functioning of the chosen governance structures and should aim to distil good operating practice for national use.

4. Investigate and implement a model of providing support to clinic committee members

The current system of governance structures having an unfunded mandate to conduct their work is less than optimal. The research has clearly shown that the current system of governance structures members operating without any financial or material support is not sustainable. Innovative methods and models of providing support to members must be explored. For example, the impact a stipend or travel allowance would have on the functioning of clinic committees and allocating a budget at district and local level for the operational expenses related to running a clinic committee could be

explored. Other possibilities such as the professionalisation of clinic committee members (who could possibly receive a nominal salary for serving on a clinic committee for a fixed period of time) should be explored. These members would then fall under the same ambit as community health workers and home based carers and would receive certification of training, subscribe to a code of conduct and be subject to performance agreements. In order to reach finality on these issues, a costing of the implications of doing this on annual basis/facility could be calculated.

5. Provide effective avenues for tiered representation of clinic committees up to national level

It is recommended that the Department of Health give further consideration as to how best to ensure that community voices and needs are not only represented and addressed at local level, but carried forwards and conveyed at district, regional, provincial and national levels. Possible mechanisms could include community advisory boards or task teams focusing on community participation in health governance at district, regional, provincial and national level, mechanisms to ensure that regular report backs on community participation are on meeting agendas, and are part of key performance areas for health managers at all levels and the establishment of an oversight and advisory board to govern and evaluate the performance of clinic committees.

6. Strengthen the relationship between clinic committees and local government representatives

It is also recommended that links between the local government and the health services be strengthened in order to ensure that the issues that are capable of being solved at local government level are done so accordingly. Ward councillors must also be educated on their role within governance structures and their compliance with this should be monitored as part of their key performance areas.

7. Monitoring and evaluation of the functioning of clinic committees at district level

The research has shown that mechanistic compliance with legislative requirements to form clinic committees is insufficient. A monitoring and evaluation system must be designed to measure whether these structures exist, how they are operating and their achievements. It is recommended that responsibility for implementing this monitoring and evaluation system is delegated to district level and should form part of the indicators for a functional district health system.

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