HEALTH CARE USERS' EXPERIENCE AS A FOCUS FOR UNLOCKING OPPORTUNITIES TO ACCESS QUALITY HEALTH SERVICES

UCT School of Public Health and Family Medicine

Partners:

- Kings College, London
- Cape Metro Health Care Forum
- DEAFSA
- Learning Network for Health and Human Rights

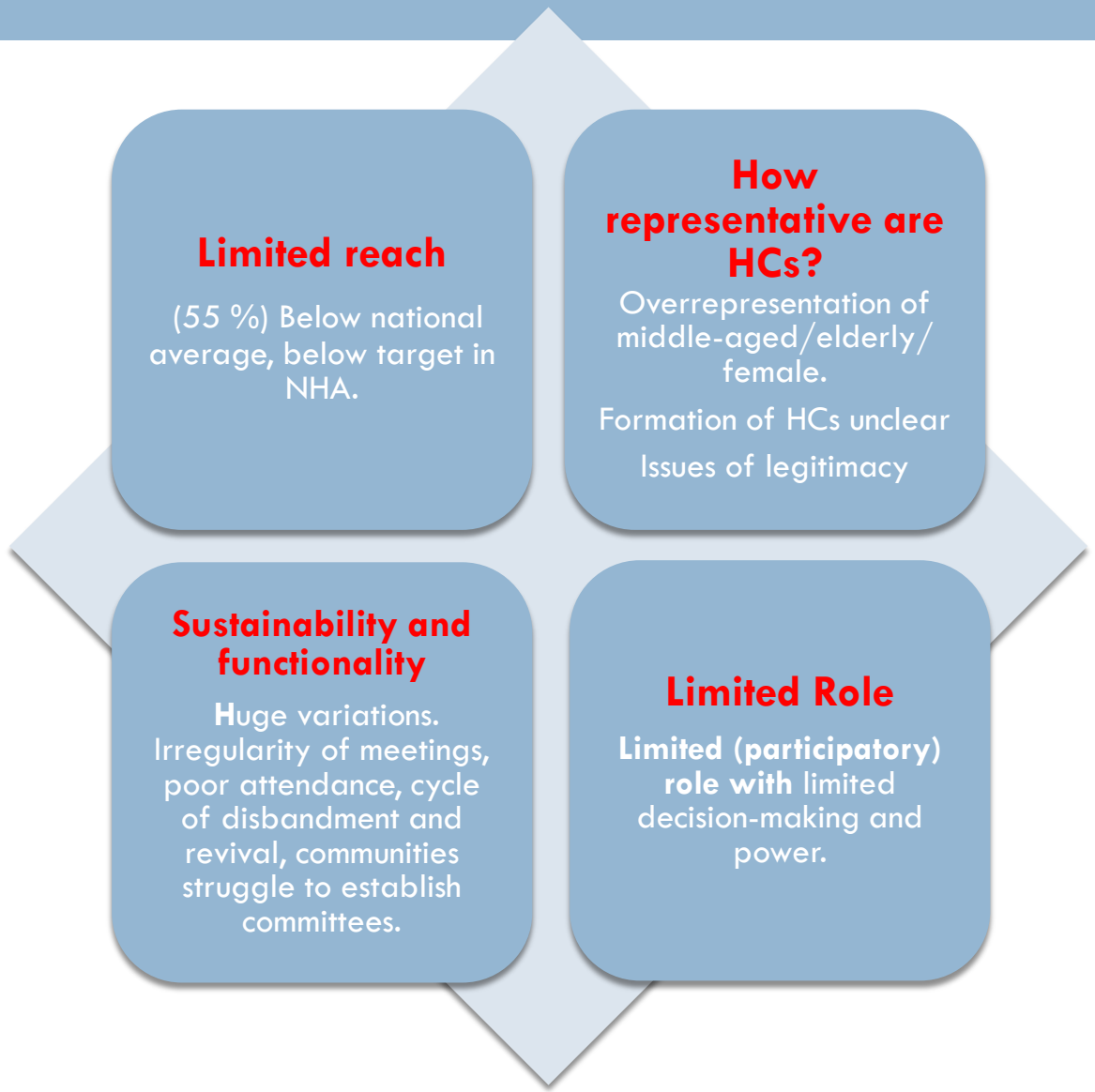
Background: Community Participation in Health

- **Alma-Ata:** "People have the right and duty to participate individually and collectively in the planning and implementation of their health care …"
- **Benefits** of Community Participation
- **White Paper** on Transformation of the Health System (1997): Participation in *planning and provision* of health services. Ensure *accountability*.
- **National Health Act** (2003) :

  a) Each clinic should have a health committee composed of: Facility manager, ward councillor, community members.

  b) **Provincial legislation** to stipulate roles and functions.

Preliminary findings (Haricharan, 2012): Health Committees in Cape Town

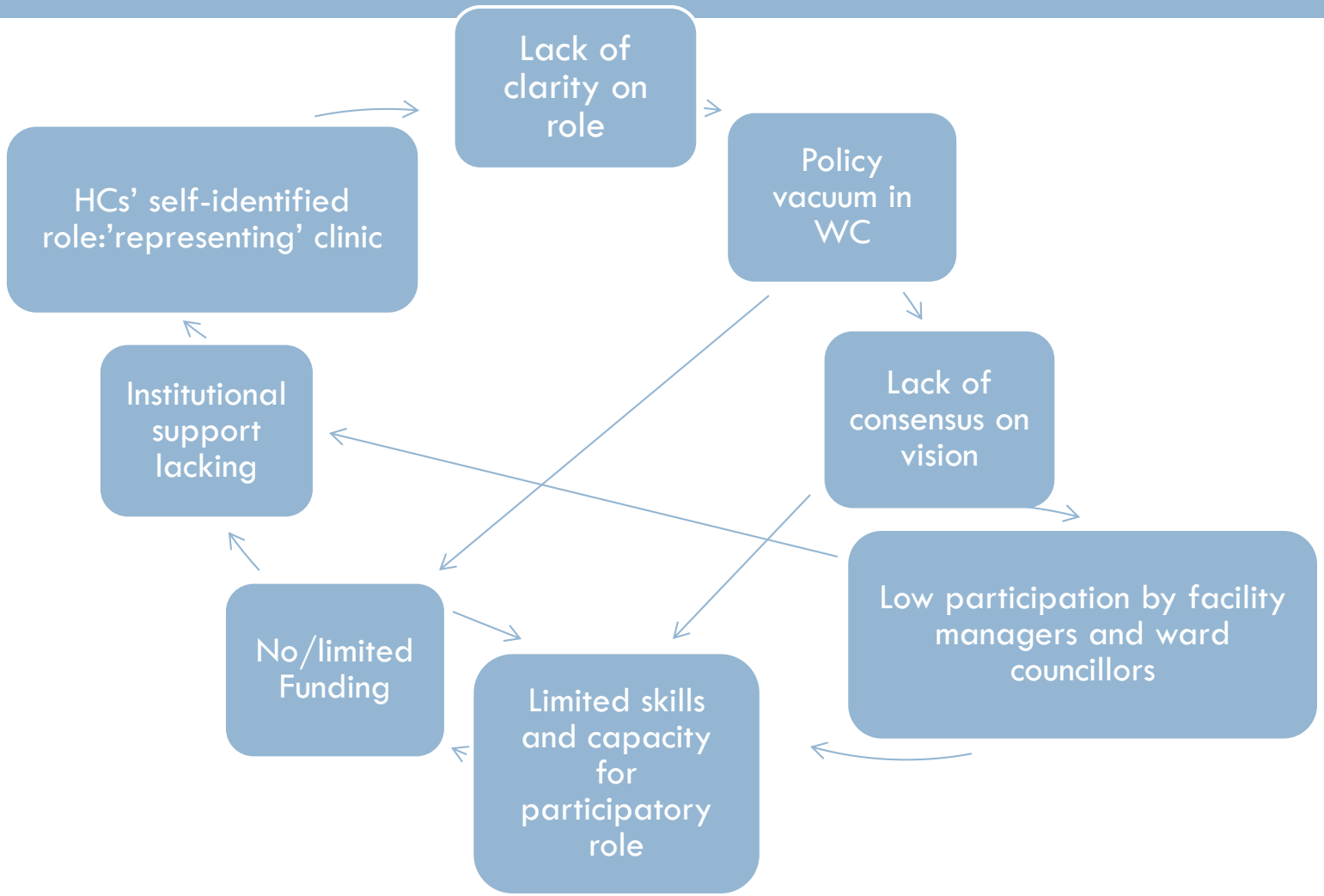


Challenges for community participation

- Previous research in LN:
  - Agency critical for realising rights
  - Problems in meaningful community participation (Glattstein-Young, 2011; Pardue et al, 2012; Haricharan, 2012)
- Two roles: "Poles apart?"
  - Governance/accountability
  - Service support, extension of services
  - HCs mainly assist clinic rather than governance/accountability (Haricharan, 2012)

- Policy vacuum:
  - NHA establishes H Committees at every facility/grouped facilities; mandates composition but silent on role
  - Roles and functions left to provincial legislation
  - Draft WC policy on H Committees never adopted

Factors impacting on HCs



Responding to the quadruple BoD

- 2012 EU support to SA govt: → Strengthen PHC
- ***Health care users' experience as a focus for unlocking opportunities to access quality health services***

Two principles:

- Community, civil society agency critical to change conditions of vulnerability that give rise to ill-health, social exclusion, inequity
- Actions to support PHC need to be underpinned by clear commitments to the right to health

Reach:

Target Groups:

- Health committees in Cape Metro under the CMHF and in the NMBM
- CSOs comprising the Learning Network, and CSOs for Deaf patients and the elderly
- Provider, managers responsible for community engagement; and service providers at PHC level
- Policy makers

Final Beneficiaries:

- Health care users, particularly women and the deaf

Duration: 30 months – extended to 34 months.

Objectives

1. Strengthen capacity, mandate, authority of Health Committee in W and E Cape; 10 packages
2. Enhance CSO capacity to advocate for health rights; 4 packages
3. Enhance capacity of health care providers to engage meaningfully with needs of communities; 4 packages
4. Evaluate patient-oriented quality assessment tools 3 packages

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1. Strengthening Health Committees

	Package	Where?
1	Rapid national appraisal policies and practices (desktop+)	National
2	Dialogue to establish H Cx roles	W Cape
3	Implementation review	E Cape
4	Capacity building H Committees: training, materials	W Cape
5	Capacity building H Committees: training, revision materials	E Cape
6	Model complaints process at facility as learning opportunity	W Cape
7	Mentoring HCxs: CLO, set up forum	E Cape
8	Sharing best practice: HC exchanges; mentoring	W+EC
9	Model establishment new HCx; develop guidance	W Cape
10	National Colloquium – aim for consensus	National

2. Strengthening CSO advocacy

	Package	Where?
11	CSO Materials: Rolling out toolkit, training of trainers, CD resource	W Cape
12	CSO networking: Building LN, support amongst CSOs	W Cape
13	Pilot of SASL interpreter service for deaf	W Cape
14	Advocacy actions by Civil Society	W Cape

3. Strengthening Providers & Managers

	Package	Where?
15	Development of Curriculum, DVD for health worker training	W Cape
16	Implementation HW training	W Cape (& E C)
17	Language (Afrikaans/Xhosa) competency students	W Cape
18	Language (Afrikaans/Xhosa) competency staff	W Cape

4. Patient-oriented quality improvement tools

	Package	Where?
19	Patient Related Outcome Measures (PROMS): Testing in primary care facilities; training staff in use; evaluating	W Cape
20	PCAT: Adapting for SA; Testing in primary care facilities; training staff in use; evaluating	W Cape
21	Chronic Disease Audit: adapted to assess patient experience; pilot; evaluate; move to PC based tool	W Cape

Health Committee Interventions

W Cape (CMHD):

- 3-day training addressing leadership, roles: 355 HC members in 7 of 8 sub-districts
- Mentorship through Learning Circles: 7 LCs, 75 HC members
- Exchanges of HC members W and E Cape
- Policy dialogue with health authorities, DH Council
- Model Complaints Process – 2 reviews
- 2 pilots to develop guideline for establishment of HC
- Advocacy around legislation

E Cape (NMBM)

- Short training (202 HC members from 4 s/districts) compared to intensive mentoring of 9 HCs
- Both sites: Training with health facility staff; Materials development: Manual, DVD (see http://salearningnetwork.weebly.com/projects.html)

Rapid appraisal	Wide variability across the provinces ito roles, selection, support; generally conceived as governance str's; practice?
Dialogue	A much longer process than anticipated! Role of DHC; W Cape finally put out draft bill; unclear if vision shared
EC Implem. review	Many gaps; no identified stewardship; no resources; no support
HC Capacity building	It works! Materials must be based on adult learning principles; participatory learning; ongoing support essential; as HC empowered, expect difficulties in HC-Facility relationship; HCs having to grapple with SDH all the time
Complaints process	No one-size-fits-all; confidentiality issues; HW reluctance
Mentoring HCxs	It works and is vital to success! Learning circle model may obviate need for external mentors.
HC exchanges	Learning opportunities; morale boosting; investment worth it; it costs money!
Model for new HCx	Clear guidelines needed; danger co-option for party political benefit; code of conduct; marginalised groups represented; election versus nomination
National Colloquium	Consensus possible in broad terms: devil in the detail; resources allocated at provincial and district level
H Workers	Finding common ground possible but requires effort. http://www.publichealth.uct.ac.za/phfm_resources-hhr

- DVD – Better health together

- http://www.publichealth.uct.ac.za/phfm_resources-hhr

Strengths	Weaknesses
Responds to community needs	Substituting for core DOH business?
Targets vulnerable – capacitated community members	Staff see patients rights as threat
Enhanced community voice	Lack of coherence provincial response (both WC and EC)
Has influenced legislative process	Under-resourcing (no resourcing) of community participation
Sustainability: - Capacitated HCs in Communities - SETA award for languages work - Pt voice integrated in NCD audit	Sustainability: Trained HCs will require support; buy-in of Provincial H Depts not consistent
Strong support from NDoH	Unable to address HC challenged by SDH
Matched interventions with HC to interventions with H Workers	Policy moments unpredictable: Alignment of policy movement with project timing hard to anticipate
Comprehensive in approach	
Able to draw in post-graduate students	

Policy Coherence

- NHA: Sets framework, leaves details to provinces
- ICESCR: Makes participation a key element of the right to the Highest Attainable Standard of Health
- NHI: Silent on participation
- National Development Plan

NDP (Ch 10):

- "… The fundamental importance of full community participation and the role of Civil Society has been underplayed … The culture of valuing and respecting the expressed needs of communities has faded replaced by a top-down approach…"

  Community Voice
- "Health services need to be revitalised so that they are specifically directed to patient needs …"

  Community involvement in planning
- "There should be an effective governance and management framework … with emphasis on user/community level accountability."

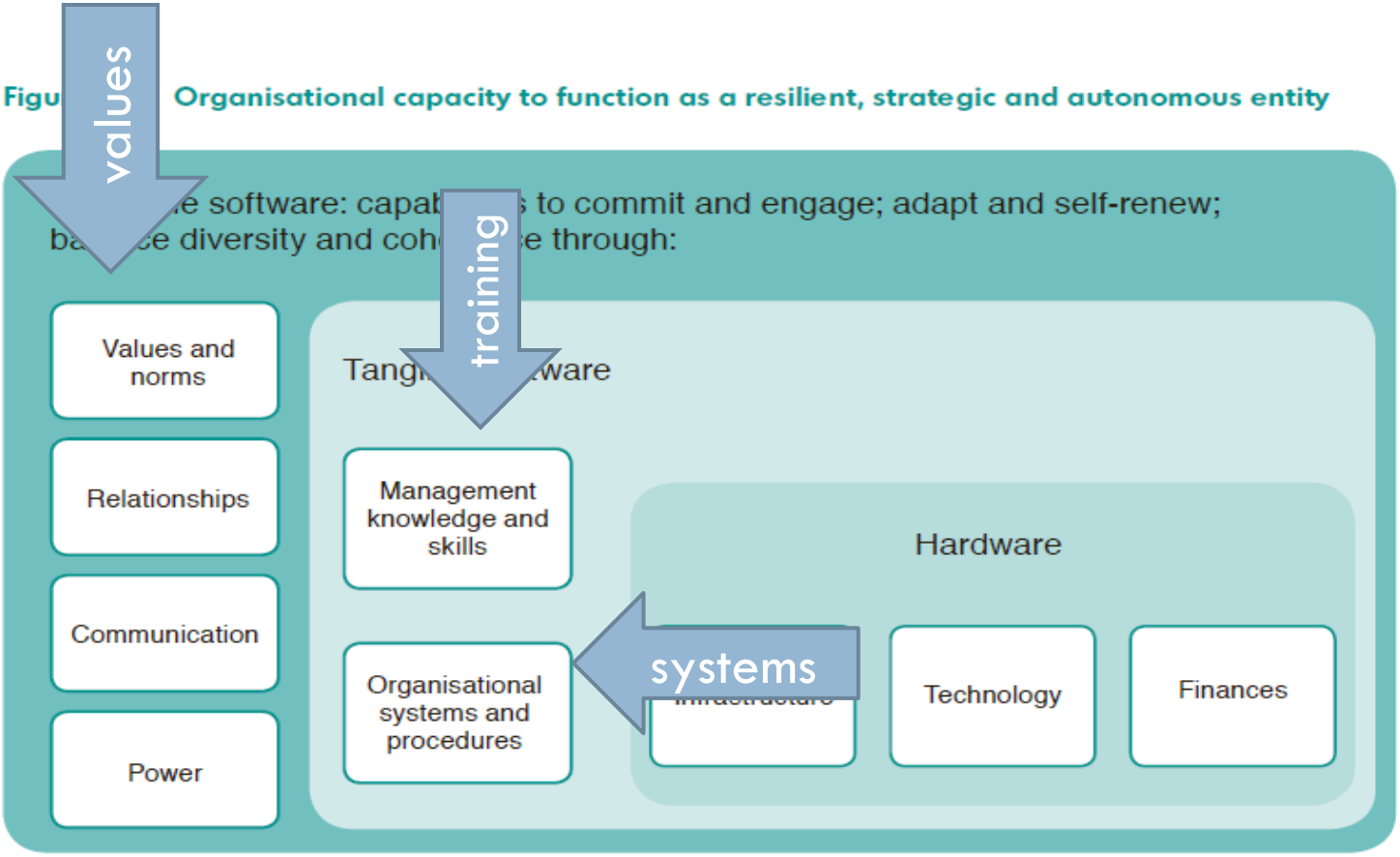
  Monitoring, complaints, NCS, problem solving
- "Statutory structures need to be bolstered and resourced for community representation in health systems governance – it is widely acknowledged that these structures mostly function poorly. If greater accountability to communities could be secured through such mechanisms, it is likely that the quality of management and service delivery would improve."

  Strengthen evidence base for HCs as governance structures

Innovations

- Developed materials to involve HCs in planning (APP) and NCS – work in progress
- Model of Learning Circles
- National (and regional) networking
- Understanding the balance of service versus oversight – HCs as vehicles of democratic governance

Understanding HCs as governance structures: The role of intangible software



Source: Elloker S, Olckers P, Gilson L, Lehmann U. Crises, Routines and Innovations: The complexities and possibilities of sub-district management. In (Eds) South African Health Review 2012/13. Chapter 13, pp 161-173. Durban: Health Systems Trust.

Bottlenecks / challenges

- HW training:
  - Community participation should be everyone's business – and thus part of HW in-service training
  - Management commitment needed
- HC members come from communities with multiple Socio-Economic challenges
  - HCs must deal with much more
  - Voluntarism, incentives and the lure of a job
- Some NGO "dis-co-ordination"
- No obvious commitment to resourcing participation from provincial governments

Levels of government

- Provincial government key to HC success
- CT Local Government relatively supportive
- NMBM – District has been provincialised
- National – sets broad parameters but no traction on the ground
- Other community participation structures exist for other government departments (violence prevention, municipality MSATs, etc)

Conclusion

Critical gaps & opportunities:

- Trust and shared values
- Rights-based approach to health
- What is understood by governance remains disputed

- Not only hardware (laws, systems) and tangible software (training, skills) important
- Intangible software – relationships and values – are as important