

Submission to the Western Cape Government Health Department: Amendments to the Western Cape Health Facilities Board Act, 2001

Submitted jointly by:

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Background

Community participation is widely recognized as a pillar of the Primary Health Care approach, and as instrumental to the right to health¹. Further, community participation in health has been argued to improve the effectiveness and sustainability of health interventions, programs and services in various ways – for example, by lowering costs for service delivery through voluntary community efforts and mobilization of resources from outside the health sector², increasing service responsiveness³, enabling more equitable client-provider relationships with improved feedback⁴; and increasing a sense of responsibility for health and ownership amongst community members resulting from new skills and securing control over resources⁵. Community participation in health has been shown to improve health outcomes and ensure more equitable access to health services. Research in Zimbabwe⁶ has shown improved health outcomes where structures for community participation in health are functioning well. A systematic review conducted in 2011 found that there was some evidence of the effectiveness of Health Committees in contributing to improving the quality and coverage of health care, and impacting positively on health outcomes⁷.

Successful implementation of community participation therefore has the potential to strengthen the health system and to have positive impacts on trust and relationships between patients and health workers. It allows communities to participate in defining models of care and resource allocation in health and for communities to become involved in dealing with the social and economic determinants of health. It provides a structured framework for accountability. With effective community participation, community members are no longer passive recipients of health care, but actively participating in the creation of a health care system that serves their specific needs⁸.

In addition, work emanating from the office of the UN Special Rapporteur on the Right to Health⁹ has proposed a range of indicators for measuring the right to health in a health system perspective, amongst which are measures reflecting the extent to which health systems actualize community decision-making in health. This work reflects growing international interest in making the concepts adopted in the Declaration on Primary Health Care (PHC) at Alma-Ata in 1978 realizable in practice.

A conceptual framework proposed to benchmark health facility committee performance¹⁰ highlights the role of health facility factors (staff attitudes, skills and resources), health

committee features (clarity on roles and functions, on mandate and authority, accountability arrangements, and capacity and resources), and community factors (social, political, cultural and economic). This framework provides a useful starting tool to develop interventions and monitoring indicators to assess effectiveness of participation (see Figure below).

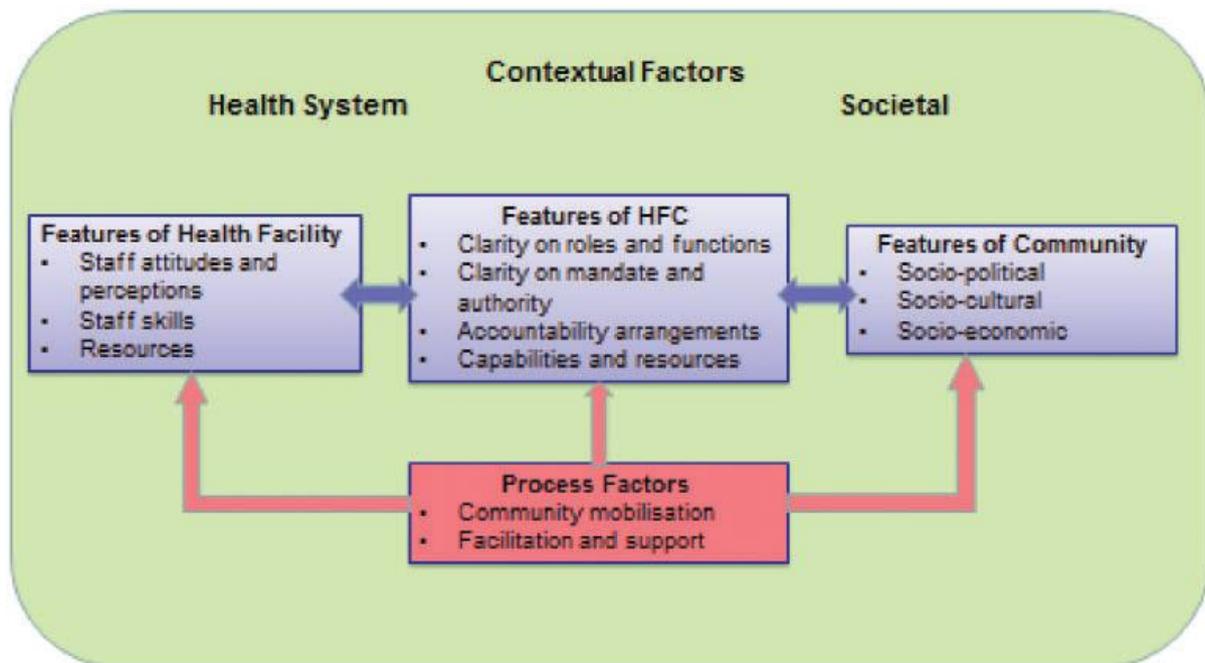


Figure: Conceptual framework for the determinants of health facility committee performance (From: McCoy et al, 2011)

The South African legislative and policy framework

The National Health Act is the bedrock of our Health System. As stated in its preamble, it provides a “framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws...”

The importance of community participation is evident in different places in the Act.

Firstly, the Act speaks of Primary Health Care services. Though not elaborated in any detail within this Act, the concept of Primary Health Care made community participation a central pillar of the PHC approach. By implication, planning for a health system based on Primary Health Care services implies recognition of the place of community participation in health, a position confirmed in the White Paper on the Transformation of the Health System (1997)¹. This is further reinforced in section 30 which deals with the division of health districts into sub-districts. In this section, the relevant MECs (for Health and for Local Government) are

¹ The White Paper states in its discussion of the Mission of the Department of Health in relation to the people of South Africa, that “without their active participation and involvement, little progress can be made in improving their health status.” It also includes as one of the objectives of the health system – “To foster community participation across the health sector” which includes involving “communities in various aspects of the planning and provision of health services” and establishing mechanisms to improve public accountability and promote dialogue and feedback between the public and health providers”, as well as encouraging “communities to take greater responsibility for their own health promotion and care.” Lastly, it confirms community participation as one of the principles for a transformed District Health System.

expected to “pay due regard to ... Constitutional principles ...” and relevant legislation, inasmuch as they relate to various principles, one of which is that of community participation. [Section 30(c) (2)].

Secondly, the Act imposes responsibilities on both national and provincial health departments to “promote community participation in the planning, provision and evaluation of health services”, in sections 21.2(h) and 25.2(t), respectively.

Thirdly, the Act explicitly creates structures for community participation. In the case of hospitals, Section 41(4) to (9) deal with the establishment of hospital boards and Section 42 (1) to (3) deals with clinic and community health centre committees. However, the Act stops short of indicating the precise roles and functions of any of these structures, leaving to designated authorities to finalise these roles. In the case of central hospitals, the functions of their hospital boards are designated as to be prescribed by the national Minister of Health, whereas in the case of other hospitals, community health centres and clinics, to be promulgated through provincial legislation. The Western Cape took the step of regulating roles and functions of its hospitals in the Western Cape Health Facilities Boards Act of 2001. However, as will be explained below, this Act is poorly adapted to serve as the regulatory framework for the Health Committees described in Section 42 of the NHA and existing in the Cape Metro currently.

Lastly, section 31, which follows immediately and which deals with the establishment of District Health Councils is entirely silent on the matter of Community Participation. Section 31.3 describes the role of a district health council as being too “(a) promote co-operative governance; (b) ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district for which the council was established; and (c) advise the relevant members of the Executive Council, through the Provincial Health Councils, and the municipal council of the relevant metropolitan or district municipality, on any matter regarding health or health services in the health district for which the council was established.”

Inasmuch as community participation can be subsumed under “any matter regarding health or health services”, it is not inappropriate for the DHC to address mechanisms for community participation; however, it is not explicitly stipulated. This is a weakness both of the NHA and of the Western Cape District Health Council Act. As argued below, the intent of the NHA and the White Paper for the Transformation of the Health System are to set up effective structures for community participation, but these structures lack clear roles, articulation with the District Health Council, and an overarching framework in which to operate, which seriously undermines the possibility of realising effective community participation. This is the focus of this submission on the Western Cape Health Facility Boards Act.

It is the case that a Draft Policy Framework for community participation/governance structures for health was developed in the Western Cape in 2008 but has never been formally adopted. The policy framework responds to many of the drivers identified in national legislation and in national policy, but predates the more recent adoption of the District Health Councils Act.

Experiences of Community Participation in the Western Cape – what evidence can we draw on?

A limited number of studies are available on the effectiveness of health committees as community participation structures in South Africa¹¹. Of these, three examined different aspects of health committee effectiveness in the Western Cape Metro. Glattstein-Young compared three health committees with different levels of functioning in the Cape Metro. Her main finding was that participation by and attitude of facility managers and ward councillors were critical to the success or failure of health committees. Haricharan identified the critical need for clarity on roles and functions of Health Committees so as to inform capacity building; and, in the absence of any guidelines, great variability in how committees were constituted, with one extreme including appointment of members by the facility manager, which seriously compromised the committee's credibility in the community and, hence, their effectiveness in terms of community voice. Lastly, Purdue et al, identified the policy hiatus that needs to be addressed to ensure that health committees have meaningful input to decision-making in health. In particular, the latter two studies showed how Health Committees exist in a policy vacuum, and that they need to be located in policy framework that enables health committees to have a structured articulation with other community participation structures (Hospital Boards) and with the District Health Council. Taken together, these three studies indicate that there is an opportunity to create synergy in setting up a new policy framework that makes community participation through health committees effective. This is one of the main points made in this submission.

The studies are attached as annexes to this submission for information.

Proposals for revision of the Health Facilities Board Act

Given the need for legislative changes to bring health committees into a framework for community participation, we make proposals for revision of the Health Facilities Board Act. We do so, first, by identifying elements within the existing Act that require attention/revision/rewriting if health committees are to be included in the ambit of the Act, and propose how the Act might be changed to address these problems. Thereafter, proposals are made for additional clauses or elements needed. Lastly, a set of implementation activities to support changes in the Act are also detailed.

1. The current Act: Changes needed

- a. Firstly, it should be noted that. Although section 5 of the Act implies 'any health facility' could fall under the ambit of the Act, it is clear that the Act is primarily intended to address Hospital Boards and is poorly adapted to Health Committees. Indeed, the section outlining repeals of other legislation refers to a previous Hospital Ordinance, indicating the concerns of the Act to bring hospital governance into line with the provisions of the National Health Act. However, the NHA clearly distinguishes Hospital Boards from Health Committees. The terms used in the Act therefore need to accommodate both.

Action: The overall structure of the Act should be amended to target (all) "Health Facilities" and these should be defined in the beginning of the Act as including hospitals (one group) and clinics and CHCs (another group). The Act can then refer to Health Facilities when speaking in general and to each group when provisions are specific to either hospitals (boards) or, one the other hand, to clinics

and CHCs (committees).

- b. The Act currently provides for Ministerial appointment of Boards (section 6). This would not be entirely appropriate for local structures intended to represent the community, where the emphasis should be on election rather than appointment. Not only would this defeat the purpose of community participation, but it would, in all likelihood be unworkable to expect the MEC to have the time to apply his or her mind to the composition of 70+ health committees in the Cape Metro. The research referred to above indicated that the functioning of some health committees was, in part, adversely affected by a lack of legitimacy in how they were established. The process of setting up a new health committee, or re-electing its membership should be such as to strengthen its role and mandate.

Action: The Act should specify in broad terms that membership of a Health Committee should include a majority of elected member from the local community, with some designated appointments ex-officio (ward councillor, facility manager). The Act should defer the details of how those elections take place and the constitution of health committees to regulations which could be promulgated after some pilot work establishes the best options for such procedures (see 3.1 below).

- c. The composition of health committees is stipulated in the NHA as including the ward councillor, facility manager and one or more representatives of the community. The current section dealing with composition of hospital boards (section 6) is appropriate for large hospitals but is not suited to health committees for CHC and clinics because of the diverse range of persons stipulated.

Action: A separate section needs to be included specific to health committees and reflecting the contents of section 42.2 of the NHA. This would allow for separate processes to be followed for Hospital Boards and for Health Committees – both for election/nomination and for filling of vacancies (section 8).

- d. The functions identified for Facility Boards are more or less suited to a health facility environment, whether hospital or clinic/CHC. There are 10 functions listed in Section 9, and all the functions identified in the Draft Policy Framework for community participation/governance are covered by these functions. However, the strength of health committees as vehicles for community participation lies in their local representivity and engagement. For that reason, we would propose that clause 9(f) ensure that health committees are expected to participate in the resolution of complaints (and would be empowered to do so). This would be consistent with the revised National Complaints Management Guideline released recently by the National Department. Section 3.2 below proposes pilot work to establish how best to effect such participation.

Action: Clause 9(f) should be amended to include explicitly the participation by the Board or Health Committee in the resolution of complaints.

- e. Further, consideration could be given to a more active role for Boards and Health Committees in relation to formulation of strategies and policies, and mission, vision, and values. Health committees are ideally suited to help contribute to the

identification of community needs. Rather than merely approving or advising, meaningful community participation could include active participation by representative and competent Health Committees in the shaping of these elements.

Action: Clauses 9(a) and (b) should be amended to include the role of providing input to shaping mission, vision, value, policies and programmes.

- f. A second problem in the functions identified for Facility Boards is in clause 9(h). The role of a Board (or Health Committee) should not be to raise funds for the Board (or Health Committee) but for the facility, or for specific health projects. The funding of community participation structures must be a departmental responsibility, given the NHA's very clear mandate which obliges the national DG for health and the provincial Heads of Health to promote community participation (sections 21.2(h) and 25.2(t)).

Action: Amend Clause 9(f) to reflect a function in which the Board or Health Committee is empowered to raise funds for the facility or for defined health projects.

- g. Section 13 correctly points to the importance of cooperation between boards and facility management, since, without good cooperation, the value of community participation is greatly reduced. The same measures should apply to Health Committees at Clinic and CHC level.

Action: The Act should identify the same importance accorded to good cooperation between facility managers and health committees, with measures to resolve any problems arising. Moreover, this implies consistent investment in capacity building, both of providers/managers and health committees to ensure good relationships can be built based on a shared vision. (See 3.3 and 3.4 below).

2. Additional Comments

- a. The Act is silent on the place of groups of health committees in a sub-district. Although it refers to the possibility of groups of facilities forming a Health Facility Board (Section 5.1), this is not the same as a group of facilities, each of which has a Board (or its clinic or CHC equivalent of health committee) and which function in a sub-district. Notably, the NHA recognises that there might be a need for sub-districts and considers community participation as one of the criteria to determine how those sub-districts are formed (in section 31.3 of the NHA). It is therefore important to establish a community participation structures contiguous with these sub-districts.

Action: The Act should recognise sub-structure aggregations of health committees.

- b. A second reason why sub-district aggregation of health committees would be helpful relates to the value of sharing of experiences amongst health committees, with a view to identifying best practice. It is not only cooperation between boards/committees and facility managers (Section 13) that is desirable, but also

cooperation between clinics, between boards and between clinics and boards. A platform at which health committee and facility board experience can be shared, problems clarified and solutions identified would be in the interest of a responsive health system.

Action: The Act should add a set of structures in which committees and boards are able to come together. Whether this is similar to the existing Cape Metro Health Forum in the Metro district, or adapted to take account of hospital boards may need to be discussed further.

- c. A third reason why a structure akin to the Cape Metro Health Forum may be important is in resolving the policy gap between the intent of the NHA to “promote community participation in the planning, provision and evaluation of health services” and the failure of the Western Cape District Health Council to speak to the structures established in Sections 41 and 42 of the NHA. Given that the DHC has key responsibilities in overseeing the planning of health services and approving budgets, the place of community participation should be structured consistent with the intent of the NHA that facility boards and health committees act as vehicles for community participation. Such structures are important to ensure proper feedback between different levels of governance so as to ensure that issues that are identified at a 'local' level are addressed at a 'higher' level.

Action: The Act should include reference to community participation structures being represented on the DHC. This should be included as an additional function in section 9, as well as meriting a special section to explain how the structures articulate with the DHC.

To achieve the intended policy intent of the changes proposed above, a set of implementation activities would be helpful, either to provide evidence for guidelines or regulations, or to strengthen capacity to manage community participation in the services. These are outlined below. The LN is developing a research and evaluation programme under the auspices of a EU-funded project related to enhancing the patient experience through community participation, which give us the opportunity to test out many of these ideas in support of legislative reform to enhance community participation.

3. Implementation possibilities.

- a. Establishment of Health Committees (point 1(b) above):
To develop the evidence for the best methods of establishing health committees, we propose that evidence be tested in one or more pilots in different setting. Different provinces have adopted different approaches to the establishment of health committees and the Learning Network is in the process of assembling experiences from different provinces as to how they have gone about it. The LN would also like to test out different approaches to setting up a new health committee to identify what steps would be most helpful in establishing credibility with both communities and providers. A current partnership project is reviewing the experience in the Nelson Mandela Bay Metro in setting up health committees, which will be shared locally as part of identifying best practice.

- b. Complaints procedures (point 1(d) above):
 The APP currently contains an indicator for the resolution of complaints, but it is well recognised that the validity of this indicator is unknown. Partly for this reason, and because of the provincial commitment to enhancing the patient experience, the Health Impact Assessment Directorate has been working with selected facilities to enhance the effectiveness of complaints systems. The LN has also intends to propose two pilot projects in which a structured engagement of health committees with health facility managers in the identification and resolution of complaints is tested over a 6 month period. The focus of this pilot would be to identify the health system gaps that give rise to the complaint and opportunities for resolution. The rationale is that local collaboration with community structures, that is seen to result in changes, however large or small, that contribute to avoiding a recurrence of the problem, can trigger a ‘virtuous cycle’ and build mutual trust between the community and the services. Too often, complaints are reduced to adversarialist conflict, which is unlikely to move a problem towards resolution or help build long-term system sustainability. This pilot work can contribute to developing SOPs for facility managers and health committees so that complaints are managed in an agreed and structured way, with real changes representing an enhanced degree of service responsiveness. The newly release revised National Complaints Management Guideline from the Department of Health recognises the potential for Health Committees and Hospitals Boards to be part of complaints resolution.
- c. Training and capacity building health committees (point 1(f) above):
 To be able to implement the many functions identified in Section 9, Health Committees will need to be capacitated. Many of these training needs have been identified in previous research. Confirmation of the roles and functions of health committees will need to inform the training required. Support for health committee capacity building is also part of the proposed programme of work for the LN, which we aim to implement in collaboration with the CMHF and with the Health Department.
- d. Training and capacity building of facility staff (point 1(f) above):
 Similarly, for systems of community participation to work, health workers and managers need to be supportive. Training and capacity building of health workers and managers therefore will need to be in place. Support for health worker / manager capacity building is also part of the proposed programme of work for the LN, which we aim to implement in collaboration with the Health Department. Some pilot work in this regard has already been taking place in collaboration with the DIALHS project in Mitchells Plain.

Conclusion:

The opportunity to amend the Western Cape Health Facility Boards Act provides an opportunity to give effect to the intent of the National Health Act and the White Paper on the Transformation of Health Services with regard to community participation. It also provides an opportunity to fill the policy gap between the District Health Council and those structures created by the NHA precisely for the purpose of community participation – health committees. These are structures which have a long history in the Western Cape and with whom the Health Department has travelled a long journey, and in which considerable efforts have been invested to date. These proposals aim to capitalise on what strengths we can draw

from this history. We would urge that the Department ensure there is an adequate process for consultation on the revisions of the Act, which is well communicated to communities, with adequate time for inputs.

¹ Potts, H. (2008a). *Participation and the right to the highest attainable standard of health*. Colchester: Human Rights Centre, University of Essex. Retrieved 02 January 2009, from http://www.essex.ac.uk/human_rights_centre/research/rth/projects.aspx

² Brownlea, A. (1987). Participation: Myths, realities and prognosis. *Social Science and Medicine*, 25(6), 605-614; Martin, G. P. (2006). Representativeness, legitimacy and power in public involvement in health-service management. *Social Science & Medicine*, 67(11), 1757-1765; Stone, L. (1992). Cultural influences in community participation in health. *Social Science & Medicine*, 35(4), 409-417.

³ Potts H. (2008b). *Accountability and the right to the highest attainable standard of health*, Colchester: Human Rights Center, University of Essex. Retrieved 02 January 2009 from http://www.essex.ac.uk/human_rights_centre/research/rth/docs/HRC_Accountability_Mar08.pdf; and Brown, *ibid*.

⁴ Nichter, M. (1984). Project community diagnosis: Participatory research as a first step toward community involvement in primary health care. *Social Science & Medicine*, 19(3), 237-252; Vuori, H. (1984). Community participation in primary health care- A means or an end. In H. Vuori, & J. Hastings (Eds.), *Patterns of community participation in primary health care* (pp. 339). Copenhagen: WHO Regional Office for Europe.

⁵ Craig, G., & Mayo, M. (1995). Community participation and empowerment: The human face of structural adjustment or tools for democratic transformation? In Craig, G. & Mayo, M. (Eds.), *Community empowerment: A reader in participation and development*. London: Zed Press; Oakley, P. (1989). *Community involvement in health development: An examination of the critical issues*. Geneva: World Health Organization.; Stone, *Ibid*.

⁶ Boulle, T., Makhamandela, N., Goremucheche, R., & Lowensen, R. (2008). *Promoting partnership between communities and frontline health workers: Strengthening community health committees in South Africa* (EQUINET PRA paper No. 8). Harare: EQUINET.

⁷ McCoy DC, Hall JA, Ridge M. A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Policy and Planning* 2011;1-18.

⁸ Thomas J. and London L. (2006) *Towards Establishing a Learning Network to Advance Health Equity Through Human Rights Strategies*. Final Project Report to the Centre for Civil Society. University of Kwazulu-Natal, Durban; Vega R, Torres M. The role of the civil society in the building of equitable health systems. *Rev Cub Salud Pública* 2011; 37: 145-154..

⁹ Backman, G., Hunt P., Kholsa R., Jaramilla-Strouss C., Mikuria Fikre B., Rumble C., et al. Health systems and the right to health: an assessment of 194 countries. *Lancet* 2008; 372: 2047-2085.

¹⁰ McCoy et al, 2011, *ibid*.

¹¹ Padarath A, Friedman I. (2008). *The status of clinic committees in primary level public health sector facilities in South Africa*. Durban: Health Systems Trust; Glattstein-Young GS. Community health committees as a vehicle for participation in advancing the right to health. (2010). MPH Thesis, University of Cape Town; Haricharan H. Extending Participation: Challenges of Health Committees as Meaningful Structures for Community Participation. A study of health committees in the Cape Town Metropole. Human Rights Programme, School of Public Health, University of Cape Town and the Learning Network on Health and Human Rights, Cape Town, 2011; Meier BM, Pardue C, London L. Implementing community participation through legislative reform: a study of the policy framework for community participation in the Western Cape province of South Africa. *BMC International Health and Human Rights* 2012 (in press).