



A REVIEW of the FUNCTIONING of HEALTH COMMITTEES in NELSON MANDELA BAY HEALTH DISTRICT – with particular emphasis on IDENTIFYING KEY CHALLENGES

Health Care Users' Experience as a Focus for Unlocking
Opportunities for Quality Health Care

A Programme of the Learning Network, School of Public Health and
Family Medicine at University of Cape Town, sponsored by the
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INTRODUCTION

The Learning Network at the School of Public Health and Family Medicine at the University of Cape Town is implementing a programme to strengthen health committees in the Western Cape and in Nelson Mandela Bay in the Eastern Cape. Overall objectives are to strengthen the capacity of health service users to be agents for realising their rights to health; and to build reciprocal skills for providers to be responsive to user demands^{1,2}.

Health committees are an important component of the health system. They are established at each primary health care facility and provide an opportunity for active community participation in pursuit of universal health coverage, equity and improved access, especially for those within local communities who are vulnerable and marginalised. Their stated purpose is to provide governance so as to promote public accountability, a platform for monitoring and dynamic dialogue between communities and the facilities. This level of community participation affords the opportunity for all people to participate as equals in decisions that determine their health and well-being. This serves to promote a vibrant and dynamic democracy with a citizenry that is active and engaged.

It is important at this time, where the health outcomes, especially with regard to the MDGs, have “made insufficient progress” in South Africa.³ “The health sector continues to face significant challenges, which include a quadruple burden of disease, economic and social inequity, barriers to accessing health services, inequitable distribution of health resources, and continuing human resource capacity needs.”⁴ Communities are required to participate. They need to know, understand, participate, support and question the state of health within local communities. They need to be empowered to support the promotion of health and mobilise communities to take greater responsibility for health. Health committees, made up of representatives from organisations and groups within the local community provide an opportunity to achieve this.

¹ London, L (2012) UCT Application Form to the European Union.

² Specific objectives are to: (1) Strengthen capacity, mandate and authority of Health Committees in Western and Eastern Cape;(2) Enhance CSO capacity to advocate for health rights; (3) Enhance the capacity of health care providers to engage meaningfully with needs of vulnerable patients and communities; (4) Evaluate patient-oriented quality assessment tools

³ Schaay, N., Sanders, D. & Kruger, V. (2011) Overview of Health Sector Reforms in South Africa. A paper produced for DFID, Human Development Resource Centre, to support the revitalisation of Primary Health Care

⁴ *ibid*

This report has been compiled by the Learning Network (UCT) team in Nelson Mandela Bay after meeting with individual health committees in Nelson Mandela Bay over a period of six months. There are 49 primary health care health facilities in the district. A request to facility managers to provide a brief update on committees revealed that twenty-two facilities were without functional committees. Thereafter meetings were held with committees. Where committees were not functioning effectively, previous members were requested to attend a discussion about the state of the committees. Some committees however had not been functioning since 2011. These committees were regarded as non-functional.

The research team followed up. At 14 clinics, focus group discussions with committee members were held. Discussions focussed on key challenges and successes with some exploration of recommendations and suggestions to further the progress of the committees. Twenty six meetings with committees were observed. A discussion on their operations, challenges and successes was tagged as an additional agenda item with the Learning Network researcher. A short statement survey was conducted with committees. The results of eleven committees, with 94 respondents have been collated. All committees had lost members. Only one committee remained strong with 11 members, having lost only one member since 2010.

With further investigation and following up with the original members of committees, it seemed possible to revive some of the committees categorised as “not functional”. It appeared that because of staff changes, the provincialisation process and changes within the health committees themselves that contact had been lost between facility and members. With a little nudging and prompting, and in a couple of instances the co-option of additional members, most committees were able to become operational again.

The layers of ‘operational’ are however many and varied. Prior to 2010, research findings in NMB indicated limited clarity and coherence with the roles of the committees. The promulgation of the policy in 2009 has promoted this understanding. In 2010, the Community Development Unit of NMMU was contracted to establish and train the health committees in adherence to the new policy. Thus at all facilities within the health district, a committee was established and all members were provided with a three day training course. Since then however, there has been limited support for the committees; and their success seems to have hinged largely on the support of the facility manager and an engaged committee.

This report serves to identify progress, policy gaps and some of the implementation challenges. Two examples are used from the health committee visits to support the points being made.

SOME KEY CHALLENGES

THE POLICY GAPS

Scene Setter : The Case of Zandile⁵ Primary Health Care facility

⁵ An assumed name, not the real name of the clinic

A short scenario about a health committee in Nelson Mandela Bay Health District is described below. It's an extreme example but real. It has posed the most difficult challenge to the UCT health committee support team. The scenario is not indicative of the state of health committees in the district. Its serious difficulties however serve to highlight some of the key challenges we've identified for health committees. These challenges are common to all committees.

PHC facility is situated in an area characterised by poverty. Swathes of informal housing and some very old and dilapidated apartment blocks are evident on arrival there. Waste water runs down the streets and large piles refuse dumping are prolific. The clinic is situated opposite the flats where downpipes and drains are overflowing.

The health committee at the clinic has been 'disbanded'. Their chairperson has been 'expelled'. The committee has been at loggerheads with the staff and has 'been told to leave', which they have done. This happened more than a year ago and nothing has happened since.

In an effort to understand the circumstances, a meeting with the "disbanded" committee was convened (26 July 2013). Within five minutes of opening the meeting, the five women representing the committee were in tears. They claim that the staff are rude and disrespectful, they take extended lunch and tea breaks and have scant respect for matters of confidentiality. They explained that they had had a good relationship with the previous facility manager but the relationships with staff had soured once he had left. The process had been painful and left scars:

"They chased us from the clinic with the soup that we provided daily. This didn't happen to someone else. I'm not telling you a story of something that I heard about. This happened directly to me."

The charge of rudeness is borne out by committees at other clinics who claim an increase in patient numbers attending their clinics. They have apparently abandoned Zandile PHC facility because of staff attitudes.

The Learning Network team and district management are keen for the conflict to be resolved, the committee to be functioning and were seeking a way forward. We offered to hold a meeting with staff to hear their views; and thereafter to convene a joint meeting. We requested the continued support of the committee members. They were initially reluctant but conceded the value of the committee and were prepared to try a reconciliatory approach.

Two weeks later, a meeting was convened with all staff at the clinic. The staff were angry and resolute. They did not want this committee. They asserted that the committee was arrogant: the chairperson abused his right to make telephone calls; the members expected special favours; a committee member had brought soup to clinic whilst still dressed in pyjamas and were a hindrance in an over-crowded, small and resource-poor clinic. The previous manager had been 'too sweet' and generous with the committee. The staff had been pleased when the committee stopped functioning. Together with the manager, they had collaborated with the ward councillor to expel the chairperson. They state clearly that they were prepared to entertain only two options:

- *to establish a new committee, or*

- to operate without one.

The team convening the meeting were able to convince them that a more moderate approach was required. We were clear that a health committee was a legislated requirement and that the health facility staff did not have the authority to disband a committee. Reluctantly they agreed to hold a further meeting with the councillor and committee to try to plot a constructive path forward.

The health committee had demonstrated much potential during training in 2010. They were articulate, assertive, smart, understood the important role of governance and were led by a savvy chairperson. Something had gone badly awry. The accusations and counter-accusations have not been helpful in resolving the impasse.

A subsequent meeting has been held with between staff and committee. There was much tension in the meeting. It was evident that positions had been however agreed that the committee should continue to function, and that there would be co-operation and a willingness to strive toward the continued support of the facility by the committee. This will be proved in time.

The situation however provoked much thought and consideration. It also demonstrates some of the gaps in the current policy.

RELATED CHALLENGES

AUTHORITY and REPORTING

Some of the critical questions raised by the above case:

Who holds the authority for a committee?

Who has the authority to disband a committee and expel its chairperson?

In this instance the staff has arrogated authority for the disbanding of the committee to themselves, and there has been no further intervention by the district management to challenge this. The policy indicates that the MEC is responsible for health committees and that the health committee reports directly to this office. How this authority is delegated is unclear, except that the District Portfolio Councillor for Health is an intermediary.

From discussions within the health district and with members of the provincial management, it appears that the committee has two lines of authority: one via the district health authority and the other political, via the ward councillor. Neither of these routes appear to be operating effectively.

- The health route indicates the requirement for quarterly reports – but is silent as to whom these are to be sent. It further indicates the sub-district and district forums as a source of reporting.

Last year there were two forums per sub-district convened in anticipation of the Health Summit. This year two of the three sub-districts have convened forums. The committees

are expected to be represented and provide reports. The sub-district management team is intended to convene the forum but have been scantily represented, and sometimes not at all. At none of the sub-district forums has a report from health management been prepared, nor have answers to issues previously raised been addressed. The committees have become indignant and irritated by the perceived lack of concern.

- ii. The political route envisages active local government councillor involvement, with reporting to the Portfolio Councillor for Health and to the District Health Council. In one committee only, have we found active councillor involvement. In two others, the committee members have a good relationship with the councillors. The remainder of the committees explain that they have made numerous attempts to solicit councillor support, often with the support of the facility manager but have been unsuccessful. Most have given up trying.

The Portfolio Councillor for Health may hold the key to unlock the councillor impasse. However, all attempts by the UCT team via email, letters, visits to the office and phone calls so as to meet with the Portfolio Councillor have been ignored.

The case of Zandile clinic raises an even more pressing question about *the powers and authority of the committees*.

**What authority does the committee have to hold the health services accountable?
What recourse do they have when things go wrong?**

If a committee attempts to hold the health services accountable especially when addressing difficult matters such as staff rudeness, poor service delivery or health outcomes, what redress does the committee have if the staff ignores or rejects their input? How does the health committee hold the services to account? What power or legislated authority does the committee hold

In the case study above, the health committee gave up and withdrew. There appears to be no ready solution offered in the policy, nor in practice. The committee does not seem to have the authority or power to ensure that the staff at this clinic deliver a proper patient-centred service, clearly respecting and maintaining the health rights and dignity of their patients. It would seem that the real power and authority of the committee has not been put to the test legally but is seemingly without sufficient legislation which results in the committee holding very limited authority.

RESPONSIBILITY FOR THE COMMITTEES

Which portfolio in the district is responsible for the health committees? Who provides support, assistance and guidance to the committee?

In the face of fierce opposition from the facility management and staff, how does the committee continue to function?

To whom does it turn for support?

For more than a year, this committee has been disbanded. There have been no attempts to follow up on the situation. No support has been offered to the committee and seemingly little understanding of what has transpired has been gleaned, with no attempts to resolve the situation. The committee has quietly disappeared and stopped functioning. The sub-district management team is aware of the situation; and until recently has done nothing to repair the situation. More recently it has requested the UCT team to intervene.

IMPLEMENTATION ISSUES

The conundrum of the ROLES for Health Committees

Scene Setter: The Case at KwaNokuthula⁶

The committee at KwaNokuthula is at loggerheads with itself. The chairperson appears to be a kind, warm and positive person. On a daily basis he volunteers his assistance to the clinic. He supports the staff and understands the dynamics, their stresses and challenges.

The rest of the committee is not happy. There are complaints from the community about the rudeness of staff, about sick people arriving 'too late' in the morning and being turned away. They are worried and resentful, fearful that the clinic will be burnt down as they have heard such community rumblings. They find it difficult to talk with the chairperson about their concerns. He is considered too close to the staff.

Initial meetings with the committee have proved difficult. At pre-planned meetings it is either the chairperson with members of staff that arrive; or the rest of the committee and no staff turn up. There are clearly two sides to this committee and they present very different stories. It is only on the fourth attempt that the joint committee convenes without staff support. The chairperson dominates the discussion; others are silent until the end when they start to talk tentatively.

The question raised earlier about support is relevant here too:

Who holds the responsibility within the health district for health committees?

Who will support the committee that is struggling internally?

To whom do the members turn?

⁶ A name to anonymise the clinic. Not its real name.

But the more obvious question posed at KwaNokuthula and the one that this paper seeks to highlight however, is about the role of the committee. The blurring of these roles that is so evident when committee members volunteer their services at the facilities poses challenges. In some instances, committees have drawn up rosters to ensure full-time support to the clinic. Their members serve as queue marshals; provide education and awareness sessions to the overflowing waiting areas; clean the clinic and lead the community in early morning prayers. These committee members are present at the clinics for most of the day. Some facility managers and staff at these facilities actively encourage this level of involvement, becoming reliant upon health committee members to support the effective functioning of the clinic. Whilst the volunteering is understandable, this is not envisaged as the function of health committees.

Confusion with their roles has the potential to cause conflict within the committee as at KwaNokuthula but more broadly within the community. In the past there have been some complaints levelled against the committee members for being partisan and taking the side of the staff. Using committee members as volunteers within the clinic compromises their independence and objectivity. They tend to back the staff up. Health committee members are required to represent their organisations on the committee and to account back to their organisations. They need to be objective to be able to deliver an effective governance and oversight perspective.

In addition, the volunteering of time and services often means that such members have been and continue, to motivate for a stipend. They commit many hours of service, and return home empty-handed, often to families that are poor and can ill-afford for household members not to be earning.

In the instance of KwaNokuthula however, the varying roles within the committee has caused tension and conflict between the members which has limited and curtailed its effective functioning.

A STATEMENT SURVEY WITH HEALTH COMMITTEES

A short 16 statement questionnaire was conducted with eleven health committees across the three sub-districts.^{7 8} 94 responses were received. These are tabled below as percentages.

	STATEMENT	YES, I AGREE %	NO, I DON'T AGREE %	I DON'T KNOW %
1	Our clinic has a well -functioning health / clinic committee.	76	31	3
2	I know all members of the health committee.	88	10	2

⁷ There are more clinics that have been included but the data has not yet been collated.

⁸ This survey is the same as one that was carried out with health committees in Sub-district B in 2007 on an EQUINET sponsored programme. It will be useful to compare results.

3	I was included in the establishment and training process run by the University in 2010.	70	25	5
4	Community members are representative of organisations and institutions from the local area.	90	9	1
5	The health committee is important to bring community views to the staff at the clinic.	97	0	3
6	The health committee includes members of the clinic staff.	91	4,5	4,5
7	The health committee meets regularly to discuss issues affecting the health of the community.	72	26	2
8	The health committee can influence health plans in our area.	87	5	8
9	Communities should influence the way health budgets are spent.	60	14	26
10	The actions of the health committee in this area are known and appreciated by the local community.	65	27	8
11	Health services should report back to the community on the health services they provide.	85	8	7
12	The clinic staff have good relations with the local community.	69	20	11
13	The community members in the health committee do not understand their roles and functions.	30	54	16
14	Community members of the health committee discuss issues regularly with the local community.	55	37	8
15	The ward councillor has an interest and is involved with the health committee.	43	50	7
16	Oversight is an important role for the health committee.	80	13	7

The results indicate that committee members believe that 76% of their committees are functioning effectively. A quarter of the committee members were not trained in 2010, leaving a possible gap in their understanding of the role of health committees. 90% of the members indicate that they are representative of community organisations, which opens the potential for feedback to their community groups. This is important since 37% indicate that they do not discuss issues with the local community. It would seem that a large percentage (87%) believe they can influence health plans in the area, whilst 26% disagreed with the statement that committees are not meeting regularly to discuss health plans. 65% believe their actions are known in the community, which provides room for improvement.

A worrying statistic is that 69% indicate that the staff at the facilities have good relations with the community, which serves to indicate a key role for health committees. Unsurprisingly 50% indicate that they do not agree that the ward councillor has an interest and is involved with the health committee. Ward councillors seem remarkably absent from their legislated role.

This survey will be repeated at the end of the project.

FURTHER IMPLEMENTATION CHALLENGES

The remainder of the report will highlight the key implementation challenges faced by the health committees in the Nelson Mandela Bay Health District. They have been formulated and described briefly. Mostly these echo the findings of previous research (Harricharan, 2011; Boule 2007)

Policy Defined Roles and Functions

The formal policy-defined roles of oversight, social mobilisation, advocacy and fundraising are clearly described in the policy. These however are seldom adhered to rigorously. In most cases, it would seem that the health committee members do not know the policy, and thus are unaware of the gap between the policy and their practice. Indeed some of the committees' meetings are unstructured and dependent upon the most assertive individual's opinion of how a health committee should function. In a couple of cases, committee members explain that they have become weary of trying to assert themselves.

Oversight is seldom being implemented as outlined in the policy. At only two committee meetings have we witnessed managers presenting reports to their committees. Monitoring of the PHC package, understanding health targets and indicators, and local health trends are matters to be reported. Without this information, it is not possible to hold the health services accountable. Facility managers are required to "inform communities about the budget allocated to the facility at the beginning of the financial year."⁹ Mostly however facility managers themselves seem to be unaware of the budget.

Most health committee monitor the opening of complaints boxes. In order to ensure effective resolution, the follow-up procedure of the complaint should be reported at the committee meetings but at only one committee was this evidenced.

The committees have not been producing quarterly reports for submission to the MEC.

Social mobilisation takes the form of support for the calendar health days: TB Day, Anti-tobacco week, breast-feeding day and World AIDS Day amongst many others. Most committees are active in their support of these days and mobilise local communities to participate.

Some committees as in *Clinic X* have actively mobilised their communities around informal dump sites. The committee called the municipality's Waste Management and requested assistance in removing the rubbish. After it was done, they went door-to-door and held a localised community meeting urging residents to take ownership of the area in maintaining it rubbish-free. The sustainable maintenance of the area has proved the more difficult task!

⁹ Eastern Cape Department of Health (2009). Policy on the Establishment and Effective Functioning of clinic and community health centre committees.

We found no examples of committees actively hosting community meetings. Some indicate that the councillor is required to support this type of initiative, whilst others indicate that past attempts at community meetings have not proved fruitful. They say that meeting community members in the waiting areas of the clinics has a larger reach.

Advocacy has taken the form of bringing health related problems to the attention of the facility. Issues of a high incidence of TB, filthy rat-infested areas as is the case near *Clinic Y* and informal dump sites that cause problems are some of the problems. This role needs to be explored further.

The policy indicates **Fundraising** as one of the four key roles for health committees but most committees describe being unable to implement this. They are unsure how to proceed – should they establish an NPO and register with Department of Social Development? They have the necessary requirements of a constitution and a committee with portfolio holders. More critically however is the question of whether fundraising is indeed the role of a committee. Is the committee expected to raise funds for its own functioning; to support the services; or to support the calendar health days? There is no clarity on this matter.

It is apparent however that a number of committees have been able to mobilise in-kind donations for the clinics. In two instances the committees have obtained donations of paint and painted the facilities. In a further two facilities, donations for the catering of functions for the aged or orphans was sourced.

Below is a summary of some of the further challenges that have been discussed at the committee meetings. These have been categorised into the following:

- **within the health system;**
- **with legislated councillor involvement and reporting;**
- **within the committee; and**
- **with community accountability.**

Within the health system

Process of Provincialisation. Committee members have found the process to be stressful. Many changes with staff members and especially facility managers have been made. This is best indicated in Sub District B. Within sixteen PHC facilities in this Sub-district, nine facility managers have changed in the past year. Some committees considered that new facility managers had not been able to pick up on the continuity, and had overlooked the committee. There were also suggestions that the new facility managers were not aware of their role with the committee. In one case however, we found the reverse to be the case. At *Clinic C*, the committee had stopped operating but with a new facility manager, their committee was revived.

The role of facility managers. It is very evident that the role of the facility manager remains a key determining factor of the success of the health committee. The more the facility manager supports the committee, the more the committee thrives. Facility managers appear not to understand their roles as only two managers provided reports to the committees.

Facility – based resource challenges: Virtually all health committees complain of a lack of resources at their facilities: severe staff shortages; limited clinic space and stockouts of medication in their pharmacies. Other resource constraints include clinics that have neither telephones nor access to emails making contact and communication difficult and expensive.

The waiting queues are a concern for community members, especially about the elderly, and particularly in winter when it is cold and dark. Whilst the committees may complain about waiting times, it seems to have become accepted practice that community members arrive at the clinics between 04h00 and 05h00 every morning. It was frequently asserted that quite a number of clients attend the facilities as a way of socialising but there was no evidence to support this. It is certainly not safe to be out at that hour, and is often cold and miserable with very few facilities having proper facilities for people to queue. Many pensioners pay people to queue for them.

This seems to be a strange anomaly which intensifies when considering the time of completion for the long queues. Many of the visits to the facilities indicated no clients in the afternoon. As early as 11h00, some clinics have completed their work, and were cleaning up. There are certainly clinics that seem to operate well into the afternoon (and some like *Clinic M* work into the early evening), and quite a number that seem to use the afternoon to provide local school girls with contraception. Many clinics however have no clients in the afternoons. By 14h00 the queues are gone and staff are not visible. Often the parking areas for cars were empty, a potential indicator that staff may not be present.

As an outsider, it seems that this situation should indicate that there should be a solution to this ongoing challenge. If the afternoons are without clients, the facilities should surely be able to spread clients more evenly throughout the day. It must surely be possible to reduce the community burden of early rising and queuing for unenviably long hours.

The establishment of sub-district and district health forums. These forums provide an opportunity for committees to meet, share ideas and challenges. It also provides for meeting with sub-district management and for receiving their reports. The forums lend legitimacy to the committees. In 2010 and 2011 no sub-district forums were convened. In 2012 each sub-district convened two meetings with the specific intention of preparing for the health summit. There have been no district forums beside the Health Summit, which is a profile event to which the MEC is invited, and which the District utilises to show case the work of the committees.

With Legislated Councillor involvement and reporting

Councillor involvement. Only one committee has a councillor who attends meetings. Two other committees reported support from the councillors. This is an aspect that needs to be strengthened as it provides the avenue for communication and reporting to the District Health Council; potential access to funds (councillor discretionary funds) and opens communication channels with the local community. It also allows for the health committees to play an active role in the development of the ward based Integrated Development Plan (IDP).

Holding of Community Meetings. Without councillor engagement, holding community meetings is difficult. The councillors bring legitimacy to the meetings. Committees report that it is more effective to talk with the local community via the clinic waiting rooms than trying to establish community meetings in the absence of councillor support.

Introduction to the Community. Committee members have been expectant of a launch of the health committees since 2010. This was promised by the former portfolio councillor for health. Many committees emphasise that the failure to do so, has left them without recognition and status in their local community.

Within the committees

Consistency of Committee members. The number of members at most of the health committees has reduced. Some have left because of work, others have relocated to other cities but the majority appear to have left because they did not receive a stipend. Mostly, the members who remain are committed to the health committee. Some committees have co-opted new members who require induction and training, whilst others have continued to function with depleted numbers.

Formal recognition for committees is essential. For the committees to feel that they are valued, they require recognition. Only three clinics have photos of their health committees on display. Nametags are also a useful form of identification which committee members request. In only two instances did committee members have name tags.

Constant requests for Training: When trying to clarify this request, it seems that the training less about supporting and strengthening the health committees, and more about accredited training that builds and enhances the levels of skill of the members: counselling skills, home based care, first aid, running an SMME.

The issue of a Stipend. It seems that there is still confusion about the issue of a stipend; with some members still hoping and motivating. What is evident however is that members often have to use their own resources for committee work. This seems unfair especially as most committee members are unemployed. Phone calls and transport fares to attend meetings are required. Whilst most committee members (but not all) have access to facility telephones, members explain that they are not always able to get to the clinic to make the calls and that this becomes a financial burden.

With being accountable to the community

Holding committee members accountable to the local organisations and community.

Little clarity was given from committee members on the process of feedback and reports to the organisations or communities they represent. The feedback process seems to be fairly informal and unstructured.

WHAT ARE THE COMMITTEES ACTUALLY DOING?

The work of the committees appears to be varied. Most hold regular monthly meetings at which they discuss upcoming events, calendar health days, health hazards within the community, issues such as security at the clinic, and notification of upcoming meetings. Social mobilisation is an aspect of the committees' functions that seems to be working.

It seems that the committee is often useful in informing the community of particular challenges that the staff or facility may be experiencing. Both committee members and staff spoke of the beneficial role that communities play in this regard. Whereas staff assertions to the community to allay frustration generated by facility challenges (such as staff shortages, long queues or stockouts of medications) may not be heard by an awaiting group of patients, when addressed by committee members the awaiting queue is apparently often placated and more tolerant.

Many soup kitchens are run by health committee members, some of whom serve soup at the facilities.

There are some examples from the committees: *Clinic R's* committee organised a Valentine's lunch event for the elderly in the area. The members gathered donations from local shops, facility staff and community members to be able to provide a lunch-time meal. Whilst they intended to cater for about 30 elderly, about 60 people participated in the event. Its purpose was simple – a gesture of gratitude, care and support for the elderly. From it, the committee was able to gain an understanding of the conditions of the elderly, listen to their concerns and learn about a group that is fairly marginalised. It promoted goodwill and the committee was widely held in esteem by the local community for doing so. Whilst this had seemed a fairly onerous task for the committee, it yielded benefits beyond the expectations of the committee.

The committee at *Clinic L* hosted a similar event in December for vulnerable children.

Repeatedly the matter of clinic security was raised by the facility manager at a number of committee meetings. It is expected that the committee will know how to deal with such matters. Sometimes SAPS is requested to attend the meetings and together they arrive at a strategy to deal with the matter. Ownership of the health facility, with community members, especially the neighbours serving as the eyes to watch over the clinics at night, (as has been done very effectively with the Safer Schools Programme) could certainly be explored more.

RECOMMENDATIONS

The following recommendations arising from the report are made:

1. The possibility of **legislated authority** of the committees needs to be explored, to lend the committees real authority so that they may be able to take the services to court if necessary. This aspect needs to be referred to a legal team. Health committees need authority in order for them to properly implement their governance role. They need to have legal authority when addressing the facilities, and need recourse when things go wrong.

2. It would seem that there is a **real national interest** on health committees currently. Donors such as the EU and DFID are putting some of their funds to explore avenues to make these structures, as potential vehicles for public accountability. This provides an opportunity for the UCT team to collaborate and contribute. We need to participate comprehensively, contributing to the debates, engaging with the proposed national guidelines and support the development of a training manual.
3. The Eastern Cape Policy on health committees (2009) requires a three-yearly review. This is overdue. However there are some suggestions for consideration:
 - a. **Authority** for the committees resides with the MEC. This needs to be more clearly determined in the policy; and the MEC needs to take active responsibility for the committees. S/he needs to clearly delegate authority to the Portfolio Councillor for Health and the ward councillors, and ensure that it is properly being implemented. Reports from the District Health Council should be expected, with active implementation by the Portfolio Councillor. Demonstrable support for the health committees should be a performance indicator for councillors.
 - b. **Quarterly reports** from the committees need to be provided for the councillors. Councillors need to attend sub-district forums at least, and be available to receive these. This can be expedited through the establishment of the sub-district and district health forums. If these were operating as intended by the policy, then this has the chance of success.
 - c. **The Governance Role.** This aspect is insufficiently emphasised in the policy. The term is clear and it lends authority. It encompasses the objectives contained within the White Paper to involve the communities in the planning and provision of health services, promoting public accountability and encouraging communities to take greater responsibility for their health.

It may be useful to investigate the school governing bodies for some guidance?

“The main objective of the governing bodies is to promote the welfare of their schools and to ensure that the learners receive the best possible education. For this reason their most important task is to help their principals organise and manage their school’s activities in an effective and efficient way.”¹⁰

This quote could be translated directly and be applicable for health committees and facility managers.

4. There are a few strategic interventions that need to be made. These will serve to support the optimal functioning of the committees and enhance the development of their potential.
 - a. Engaging the Portfolio Councillor and the Portfolio committee for Health so as to emphasise their roles with the health committees.

¹⁰ Department of Education. Province of KwaZulu-Natal. (undated) Understanding School Governance. Manual One. Introduction to School Governance. Available at: www.kzeducation.gov.za/LinkClick.aspx?fileticket=_dBRtdkxct8%3d&tabid=264&mid=393

- b. Management responsibility for the committee needs to be clearly vested within a specific portfolio at the district level.
 - c. Managers at the District level need to be clear on the policy and explore how best to support the effective functioning of the health committees.
 - d. At the sub-district level, managers and supervisors need to be updated on the policy which probably means workshops which include an exploration of how best to support the committees so that they function optimally.
 - e. There is a need for Facility level support for the committee. The suggestion is that this can be provided by the health promotion team. The health promotion team needs to spend workshop time developing these options.
 - f. It is critical for the facility manager to be an active participant in the health committees. All research indicates that the manager is the key determinant of their success. However, facility managers are required to be clear on their roles. These are elaborated in the policy. Facility managers require training to understand the policy and to implement their roles effectively.
5. Practical support to improve the functioning needs to be enhanced:
- a. Training for committees to refresh the members on the specific roles. The oversight function in particular needs attention, with discussion on how to ensure adherence in the absence of support from the facility manager.
 - b. Ongoing mentoring support for the committees from the UCT team. This has proved invaluable in supporting the committees, especially in affirming the oversight and accountability roles.
 - c. Sub-district and district forums need to be convened. This supports the legitimacy and credibility of the committees, especially if the sub-district and district is earnest about these forums and presents reports on the current state of health. District management needs to understand their clearly defined roles especially with regards to the forums.
 - d. Recognition for the committees is essential. Photos of the committee members with their names and contact details should be displayed in the facilities. Name tags would also support this. A formal launch albeit very delayed would still be useful as a marketing exercise, supporting community knowledge of the committees.

- e. Building the profile and marketing of health committees and their roles would be useful. The production and distribution of posters and flyers would support this. Other avenues for marketing should be considered such as regular radio interviews, the use of social media such as the establishment of a Facebook group, twitter feeds.
- f. Develop a checklist based on the policy for all committee members to guide them in terms of the specified roles of the committees.
- g. It would be beneficial to conduct a community survey on the perceptions and knowledge of community members about the health committees.
- h. It would also be useful to have a more thorough understanding of the demographics of the community members who participate in the committees. A survey of the membership could fairly readily be conducted.
- i. The role of committee members as agents of change may be enhanced with an emphasis and understanding on social determinants of health. This would support the development of more active and engaged community members. Community mapping processes would promote this understanding and potentially prompt action.

CONCLUSION

There is much that needs to be done to promote and support the health committee in Nelson Mandela Bay. This report served mainly to highlight the challenges of the committees, and to address some recommendations so that the challenges can be addressed.

A more comprehensive report on the process of reviving the committees characterised as not functioning, as well as the reconciliatory processes with the conflict-ridden committees is required.

References

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