DEVELOPING AN UNDERSTANDING OF THE FACTORS RELATED TO THE EFFECTIVE FUNCTIONING OF COMMUNITY HEALTH COMMITTEES IN NELSON MANDELA BAY MUNICIPALITY

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"Despite longstanding policy support and experience, the term 'participation' appears to have many meanings, to be poorly operationalised and often ambiguously used in health systems."

René Loewenson, (2005).

KEY WORDS

- Community Participation
- Community Involvement in Health
- Primary Health Care
- Community Health Committee
- Clinic Committee
- Health Organisation
- Co-operative Governance
- Health Promotion
- Health Volunteers

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ABSTRACT

As part of South Africa's commitment to comprehensive primary health care, it has recognised that formal structures for community participation are an essential component of the health system. In terms of the operationalisation of this approach, Community Health Committees or Clinic Committees, outlined as statutory bodies in the National Health Act, 61 of 2003, serve to facilitate such participation. Given the policy framework, Community Health Committees ought to be supported by the Department of Health to become effective structures for community participation. However, those that exist within Nelson Mandela Bay Municipality, within the Eastern Cape Province, South Africa are perceived by the Municipal Health Directorate not to be functioning effectively.

This research aimed to investigate the factors related to the functioning of Community Health Committees in Nelson Mandela Bay Municipality. It intended to elicit information on factors which promote and inhibit their effective functioning. It used the qualitative research methods of focus group discussions, conducted with a sample of Community Health Committee members, and in-depth, individual interviews with key informants. The contents of the transcriptions of all focus group discussions and in-depth individual interviews were analysed so as to identify the recurring themes and key suggestions made by respondents.

The findings indicated that Community Health Committees are not functioning as per their original intention and that the relevant policies have not been accurately

translated into practice. Their membership composition was found to be a major contributory factor inhibiting their effective functioning. Community Health Committees appear mostly to be composed of health volunteers who are in receipt of a stipend, and serve as an extension of the services of the health facilities. There was little evidence of the membership composition including local government councillors and health facility staff participation as required by legislation.

The study highlighted other inhibiting factors which could broadly be categorised as a lack of institutional arrangements, co-ordination and support for Community Health Committees; an absence of operational guidelines; and a lack of resources for their effective functioning. It was also found that the current context within which these committees operate was considered to limit effective functioning. In relation to the context, two conditions were identified to be of particular importance: the poor socio-economic conditions within Nelson Mandela Bay Municipality; and secondly, a perceived change in the political terrain, which is considered not to sufficiently encourage and support community volunteerism. These factors collectively contribute towards the regularly reported perception of Community Health Committee members that they are not being afforded recognition for the contribution they make.

Recommendations have been made at the end of the study. It is hoped that these will assist the Eastern Cape Department of Health to provide future support for Community Health Committees, both in Nelson Mandela Bay Municipality and in other parts of the Eastern Cape Province.

DECLARATION

I declare that *Developing an understanding of the factors related to the effective functioning of Community Health Committees in Nelson Mandela Bay Municipality, Eastern Cape Province, South Africa* is my own work, that it has not been submitted for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.

Full Name: Thérèse Marie Boulle Date: 01 November 2007

Signed:

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ABBREVIATIONS

CHC(s)	Community Health Committee(s)
CLO(s)	Community Liaison Officer(s)
DoH	Department of Health
EPI	Expanded Programme of Immunization
FGD(s)	Focus Group Discussion(s)
HCC(s)	Health Centre Committee(s)
IDP(s)	Integrated Development Plan(s)
MEC	Member of the Executive Council
NHC(s)	Neighbourhood Health Committee(s)
NGO	Non-Governmental Organisation
NMBM	Nelson Mandela Bay Municipality
NMMU	Nelson Mandela Metropolitan University
PHC	Primary Health Care
PPHCN	Primary Progressive Health Care Network
TARSC	Training and Research Support Centre
VCT	Voluntary Counselling and Testing
VHW(s)	Village Health Worker(s)
WHO	World Health Organisation

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CHAPTER 1: A DESCRIPTION OF THE STUDY

1.1. Introduction

Integral to comprehensive primary health care and the district health system is the principle of community participation. In South Africa one legislated mechanism for promoting community participation is the establishment of Community Health Committees (CHCs).[1] CHCs comprise an elected body of people (usually ten to 12 in number) who serve as representatives of the community at the local health facility together with the head of that health facility and the local government councillor. They serve an important function in partnering with the health services to ensure that the broad health needs of the local community are addressed. Their intention is to involve communities in the planning and provision of health services, promoting public accountability and encouraging communities to take greater responsibility for health promotion. In essence, they are intended to serve within a dynamic partnership, to liaise between the community and the health facility, and to foster co-operative governance. Representation is intended to be tiered: from representation at the local level of the CHC, towards representation at the sub-district, then district and ultimately, provincial level. (See Appendix 1 for an illustration of this representative structure).

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[1] The current terminology is confusing. Two terms, *Clinic Committee* and *Community Health Committee*, are used for the same entity. *Clinic Committee* is the older term more commonly used throughout the Eastern Cape Province by both health personnel and community members. It is the term used in the National Health Act (61 of 2003). The terms holds within it limitations in relation to the purpose, functioning and potential of such committees. For example, the older term suggests that committees be established *by* health personnel and primarily be constituted to support activities of the clinic. The newer term, *Community Health Committee*, more accurately describes the inclusive and participatory nature, purpose and intention of these structures. It is the term used in the White Paper for the Transformation of the Health System in South Africa (Republic of South Africa, 1995) and the Eastern Cape Provincial Health Act (Act 10 of 1999). For these reasons, the researcher will use the term *Community Health Committee (CHC*) in this research study.

In order for CHCs to function effectively and meet the identified community needs, CHCs are required to link with the structures of local government. Local government councillors (as per requirement of the National Health Act, 61 of 2003) are required to participate within CHCs. It is via an informal system that ward committees[2] have, in the past, had representation within CHCs via an elected Health Desk representative from within the ward committee. The community needs, identified by the CHC, should then be reflected within the Integrated Development Plan (IDP)[3] of the relevant local authority. (See Appendix 2 for an illustration of how community representation is intended to be incorporated into the management and political structures at facility, sub-district, district and provincial levels.)

1.2. Nelson Mandela Bay Municipality

This study was carried out within Nelson Mandela Bay Municipality (NMBM) which comprises the three towns of Port Elizabeth, Despatch and Uitenhage. According to the NMBM Integrated Development Plan (2007), there are 1,3 million people resident within the municipality. 52% of the population is female and 37% constitutes youth below the age of 20. 8,5 % of the adult population is functionally illiterate. "The situation analysis of Nelson Mandela Bay indicates high levels of poverty and unemployment. 44% of the economically active population is unemployed and 38% of the total households is (sic) indigent." (NMBM, 2007: 130). The prevalence of HIV and AIDS among pregnant women is 34,5%.

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[2] Ward committees are comprised of elected community representatives of a geographically distinct local government ward. The representatives serving on the committee have a two-year period. They are political structures which enable a direct link to be established between the local government structure and the community. The ward councillor convenes meetings of the ward committee.

[3] IDP. As a way of redressing the legacy of apartheid, the concept of "developmental local government" has emerged. In essence developmental local government aims to work with citizens and groups within the community to find suitable ways to meet their social, economic and material needs and improve the quality of their lives. In accordance with the Municipal Structures Act of 1998, all municipalities must undertake an integrated development planning process to produce five year strategic development plans.

NMBM constitutes a health district, which is further divided into three geographically distinct sub-districts. Each of these areas consists of an approximately equal population size, according to the norm set by the World Health Organization (WHO). Within NMBM, two health departments operate: the Municipal Directorate of Health, responsible for delivering primary health care (as a delegated responsibility from the Provincial Department of Health) to 42 health facilities; and the Provincial Department of Health, which manages 11 health facilities within NMBM. A policy of functional integration and an understanding of collaborating and working together in a co-operative way directs their current operations. The current arrangement between the Province and the Municipality is, however, currently under review, with the possibility that responsibility for all personal health care may revert to the Province in the future.

1.3. The Legislative Framework

The National Health Act (61 of 2003) provides for the establishment of clinic and community health centre committees at the health facilities. Whilst the legislation is fairly brief, it does outline that clinic or community health centre committee membership "must at least include (a) one or more local government councillors; (b) one or more members of the community served by the health facility and (c) the head of the clinic or health centre." Section 42 of the Act delegates the task of the establishment of a committee and its functions to Provincial legislation.

In turn, the Eastern Cape Provincial Health Act (10 of 1999) commits the Member of

the Executive Council (MEC) to "creating viable mechanisms for community participation in the development and implementation of health policies and practices". (Section 20). Chapter 17 of the same Act is more specific: it deals with district health councils, community health committees, hospital boards, advisory committees and forums. The responsibility for the establishment of terms of reference for CHCs rests with the MEC for Health. It is, however, silent on the substantive issues of roles, responsibilities, decision-making powers and channels of communication.

One of the key health policy documents, the *White Paper on the Transformation of the Health System in South Africa* (1997:19) highlights a few important principles:

1. All South Africans should be equipped with the information and the means to identify behavioural change conducive to the improvement of their health.
2. People should be given the opportunity of participating actively in various aspects of the planning and provision of health services.
3. The Department of Health should provide the public with regular updates on progress, results and emerging issues related to its work, and should ensure that people participate in the development of national policy.

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The White Paper also provides for a list of implementation strategies which include: election of community representatives; working closely with all groups in the community, especially women and youth; identification of under-served groups; negotiation of Primary Health Care (PHC) packages; provision of requisite technical support and motivation to communities; and the establishment of simple community-based information systems for identification of priorities and "monitoring of progress

towards locally-established objectives and decisions on actions to be taken.” (1997: 21).

The national policy document, the *Development of a District Health System for South Africa* (1995) also provides for formalised community participation. The document describes health facility governance structures as Community Health Committees and Community Health Forums, where users of the service organise into structures that relate to the health system. CHCs would “be part of governance structures of the health facility, and participate in needs analysis, planning, implementation and education of primary health care in the area” (Bennett, Thétard, Msauli & Rohde; undated). This document has, however, been subject to criticism because of the apparently restricted process followed in its drafting and some aspects of its content, particularly related to its relationship to the structures of local government. (Pillay, McCoy & Asia; 2001). Interestingly, the document is not easily accessible, as it is no longer available on the Department of Health website and on requesting the document from the District Health Development Services at the National Department of Health in Pretoria, the researcher was informed that health officials were unable to locate it.

At a provincial level, the purpose and intention of CHCs follows the same principles as outlined in these national policy documents. These are encapsulated in the draft *Concept Document on Establishment and Functioning of Community Health Committees for the Eastern Cape* (May 2006):

- Involve communities in planning and provision of health services;

- Establish mechanisms to improve public accountability and promote dialogue and feedback between the public and health provider;
- Encourage communities to take greater responsibility for their own health promotion and care; and
- Build capacity at the provincial, district and local and community level to develop plans based on priority issues and ensure appropriate and cost-effective intervention. (2006, 3)

The Municipal Structures Act (117 of 1998) and The Municipal Systems Act (32 of 2000) create mechanisms within local government for the participation of communities to govern the affairs of the local community. Ward committees and local government councillors are elected representatives, who serve to promote and enhance participatory democracy.

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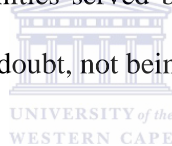
Despite policy commitment to the inclusion of community participation within governance and health more generally, there appears to be a gap between policy making and the translation of this policy into practice.

1.4. Problem Statement

An audit of CHC functioning in NMBM was conducted in March 2006. Of the then 49 potential CHCs at fixed health facilities within NMBM, 24 have CHCs which are described by health personnel as "operational"; seven described as "limited functioning" or "barely functioning"; and 18 have no committee at all (Bala, 2006).

(See Health Promotion Manager Report, Appendix 3). Whilst there were no formal criteria determining these categories, it was apparent that any health facility with a consistent group of community members meeting on a relatively regular basis constituted an "operational" CHC. It appeared that for the most part, the "operational" CHCs held elections to determine an executive structure to which the health services could relate. Those described as "limited" or "barely functioning" appeared to have some community members serving at the health facility, but this was neither necessarily consistent nor organised in a coherent way.

The figures above indicate that just over 50% of the health facilities in the study do not have active community representation and participation via CHCs. The health needs and opinions of the communities served by these facilities are, therefore, not being properly represented and, no doubt, not being adequately addressed.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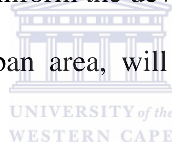
Evidently, the problems experienced by NMBM with regard to CHCs are not confined to NMBM. In 2006, the Deputy Director, District Development, in the Eastern Cape Provincial Department of Health approached the Community Development Unit, Nelson Mandela Metropolitan University, (the unit in which the researcher is employed) to request assistance in strengthening the CHCs of their 25 designated "Clinics of Excellence". These are intended to serve as role models for other health facilities throughout the province.

It had also been recognised by the Policy Directorate within the Eastern Cape

Provincial Department of Health that there is a lack of direction and guidance for CHCs. In May 2006, the Eastern Cape Provincial Department of Health, in discussion with various stakeholders, drew up a draft document entitled "*A Concept Document on the Establishment and Functioning of Community Health Committees"* (Eastern Cape Department of Health, 2006). Its purpose was to develop a policy framework to assist in regulating the establishment and functioning of CHCs in the province. To date, this document is still in draft format, although it has been disseminated and discussed within the Department of Health and the Local Service Areas (LSAs[4]) throughout the Eastern Cape Province.

It is hoped that this research study, by focusing on the factors related to the effective functioning of CHCs, will serve to inform the development of the proposed guidelines and although conducted in an urban area, will bear relevance for the rest of the province.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At the onset of the research study, the researcher put forward a range of potential reasons in an attempt to explain some of the current problems faced by CHCs. Appendix 4 provides an illustration of the range of potential problems, many of which are explored in greater detail during the process of this research study.

[4] Local Service Area: A geographically distinct area demarcated within a health district for purposes of ensuring efficient management and addressing the specific local health needs.

1.5. Study Purpose

Given the problems outlined above, this research aimed to develop an understanding of the factors that either promote or inhibit the effective functioning of the CHCs in NMBM. It served to elicit the opinions of local CHC members of the challenges they face as community representatives on the CHCs, and asked them to identify the factors that they consider assist or prevent the effective and sustainable functioning of their local CHCs.

The study also considered the opinions of key stakeholders working within NMBM, who were asked to provide an explanation for the problems being encountered by the CHCs and to suggest possible ways of overcoming the present problems. From both these perspectives, it was anticipated that a coherent understanding would emerge of the factors that promote and hinder the effective and sustained functioning of CHCs. From these findings, a set of recommendations for future health service practice were then developed.

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CHAPTER 2: THE LITERATURE REVIEW

2.1. Introduction

The literature review has drawn together readings from a wide range of sources. Organisational reports, articles from books and journal articles provided the primary sources. A search of the data bases of peer-reviewed articles provided much information on community participation in health, but was more limited in its information on formalised structures that facilitate community participation. Amongst the literature is information from African countries and their experience of community health structures, which provided resonance with the South African context.

The literature review provides a broad overview of the issues related to formalised community health structures. Initially, it touches on the relevance of community participation in primary health care, and then the structures through which community participation is facilitated, drawing on examples from a range of countries. It develops an understanding of these structures and the lessons learned from international examples. It further examines the requirements for, and challenges to, their effective functioning.

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2.2. Comprehensive Primary Health Care and Community Participation

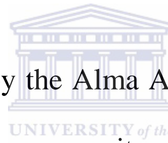
Primary health care (PHC) recognises health as a basic human right, resting on the principle of equitable use of health resources, especially with regards to coverage and effectiveness of health care. It addresses the main health problems in the community, "providing promotive, preventive, curative and rehabilitative services" (World Health

Organisation, 1978). The District Health System, as a model for the implementation of PHC, with its policy of decentralisation, seeks to locate authority and decision-making at the level of the district, in an attempt to ensure that the health system is responsive to local needs. Community participation is fundamental to the PHC approach, and "perhaps distinguishes PHC from other strategies for the promotion of health and health care provision" (Sanders, 1992: 191).

PHC encourages and seeks to provide an opportunity for community members to participate in determining their health requirements. In order to make PHC accessible to the community, maximum community and individual self-reliance for health development is required. (Macwan'gi & Ngwengwe, 2004; Baum & Kahssay, 1999). To attain such self-reliance requires community participation in planning, development, organisation and management of PHC. Zakus and Lysack (1998), in their review of community participation, concur with this view and assert that it is a process whereby community members assume responsibility for assessing their health problems and needs, plan and implement solutions, create and maintain their organisations and evaluate their efforts. Community participation is, therefore, a strategy that provides people with the understanding that they can solve their problems collectively. Werner (2000) notes that the wellbeing of a community depends on the opportunity of all people living within a community to participate, as equals, in the decisions that determine their health and wellbeing.

2.3. Community Health Structures Providing Opportunities for Community Participation in Health: An International Perspective

In order to achieve participation, however, suitable mechanisms are required. Baum and Kahssay (1999), in their multi-country review of 'health development structures', found a range of community structures serving to promote health. These varied in their levels of formality: from informal social clubs and NGOs to government supported initiatives. All provided opportunities for the health services to interact and partner with the community. It was their finding, however, that these community structures were largely ignored by the health services and hence a valuable resource and opportunity for promoting health remained "untapped". (Baum and Kahssay, 1999: 96)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Since the health reforms initiated by the Alma Ata Declaration (WHO, 1978), policy makers have included elements of community participation within the policies and legislated frameworks for health in numerous participating countries. From these countries, their community participation processes, and studies that have been conducted, are lessons to be learned for this study. Formalised community health structures, be they Health Centre Committees in Tanzania, Village Health Committees and Health Centre Committees in Zimbabwe, Neighbourhood Health Committees and Health Centre Committees in Zambia or Community Health Committees in South Africa are all intended to serve a similar purpose: providing an opportunity for community members to participate, interact and partner with the health services to promote health within local communities. The intention is to further elevate

participation to the level of the district, where increased authority and management of health services is located. Communities would then have the opportunity to become instrumental in directing health services.

The Zambian experience has been well documented. (Macwan'gi & Ngwengwe, 2004; Ngulube, Mdhluli, Gondwe & Njobvu, 2004 and Ngulube, Mdhluli & Gondwe, 2005). Ngulube *et al.* (2004) administered a semi-structured questionnaire, interviews, focus group discussions and workshops in Zambia in their research on governance and participatory mechanisms and structures in the health system. Their findings indicate that at the local clinic level, Neighbourhood Health Committees (NHCs) have been well supported by the community. Roles and functions of the NHC have been clearly defined and are understood. NHC members have been formally trained, a weekly radio programme supports this training and members graduate as 'community mobilisers.' The results of their efforts have been promising. There have been positive changes noted, especially with increased community participation in health promotion and specifically with the uptake of water purification.

Together with Traditional Birth Attendants and Community Health Workers, Neighbourhood Health Committee members also serve to support the elevated tier of the Health Centre Committees (HCCs), a further formalised structure supporting community participation in health. There seemed to be consensus from all stakeholders in the study that HCCs have a positive impact on the clinics and are of value to the health system. Channels of communication within the health services

were developed and clear. Some concerns were raised: HCCs seemed to have limited impact on issues of equity and coverage; the voice of the most vulnerable groups within communities was not being articulated; and HCCs were not included in important decision-making, such as in the determination of clinical care services for health centres.

Interestingly, a further study by Macwan'gi and Ngwengwe (2004) investigating the effectiveness of District Health Boards in interceding for the community, found different results to those of the study on HCCs. At the further elevated tier of the District Health Boards (DHBs), communities were found to have limited knowledge of their existence and understanding of their roles and functions; participation was weak because of this lack of knowledge; structures were, therefore, not effective in carrying out their functions; and gender issues had not been addressed in terms of composition of its membership. In effect, this seems to indicate that whilst the community participation structures are working effectively within the health system at the level of the health facilities (in the form of Neighbourhood Health Committees and Health Centre Committees), at an elevated level, the District Health Boards seemed less responsive to community needs. This has implications for the local health facilities as planning and budget allocation is conducted at the level of the District Health Board, and hence, without community needs and priorities being communicated to this level, resource allocation is determined by the health authorities alone.

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Lessons can also be learned from studies conducted in Zimbabwe. Loewenson, Rusike and Zulu (2004) conducted a case-control study, conducting interviews and focus group discussions at eight sites in Zimbabwe in assessing the impact of Health Centre Committees on health system performance and health resource allocation. A few important findings were indicated in this study. Firstly, Health Centre Committees are associated with improved health outcomes. Loewenson *et al.* (2004) were able to indicate that there were more staff, higher budget allocations, more Expanded Programmes of Immunization (EPI) campaigns and better availability of drugs at health facilities with Health Centre Committees. Secondly, there were improved PHC services at the facilities. Lastly, there was a better understanding of community needs, especially those for environmental health and service quality, and a perception that there was an active response to these needs. Loewenson *et al.* (2004) were able, in the process, to identify factors limiting the effectiveness of the Health Centre Committees: there was weak formal recognition of them by the health authorities; roles were not clearly delineated and, therefore, specific areas of authority were not established; and there were unclear reporting structures. What was of interest, however, was the researchers' further conclusion that despite the resource constraints affecting the economy in Zimbabwe, and this having an impact on resources for health, PHC was, none-the-less, able to function effectively.

In an interesting report to the World Bank, Narayan (1997) was able to show that participation within community groups significantly improved the social wellbeing of households and had an impact on poverty. Narayan explored poverty and social

capital in Tanzania. The study addressed community participation in a wide range of groups, e.g., churches, sports clubs and co-operatives, rather than those with a specific health focus. The research team conducted Participatory Poverty Assessments, key informant interviews and household surveys, in an attempt to better understand poverty from the perspective of the poor. The study found that membership of community groups and networks was a significant contributor to households' social wellbeing. They were able to quantify this and show, for example, that four years of formal education was less beneficial for social wellbeing and economic stability than participation in the community structures. The research demonstrated that the investments community members made in terms of their active participation in community groups reaped rewards both to the community and to their households. The improved social wellbeing has clear and positive implications and links to health, as it starts to address the underlying causes of ill-health and in particular, that of poverty. The research serves to confirm that the establishment and support of formalised structures in health offer potential for improved wellbeing, which will serve the interests of the health sector. Baéz and Barron (2006) confirm that linking health to broader community concerns, such as the development challenges of poverty, was a factor promoting community participation.

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2.4. Lessons Learned from a Community Health Committee in South Africa

Whilst recorded South African examples abound of communities participating in health through non-governmental organisations and community research processes, there appears to be little documented evidence of formalised CHCs. It was only

within the literature review of Baéz and Barron (2006) that an example of a formal CHC was found. In Monyakeng Location, a group of youth, who had been active in HIV and AIDS prevention activities, initiated the "Clinic Committee". They are active in their support of the clinic and health-promotion activities and meet regularly. They have been able to show through their participation that notable successes have been achieved: firstly, in increasing the cure rate for TB and decreasing the defaulter rate; and secondly, in their extensive outreach campaign focusing on HIV and AIDS into the schools. Despite their successes, they "feel ignored by the authorities" (Baéz and Barron, 2006:11) and "work on their own, with practically no resources, with the exception of abundant training that is not planned on the basis of locally specific needs." (Baéz and Barron, 2006:11) It was also noted, similarly to the Zambian experience, that their voice was not heard beyond the geographic limits of clinics and local area.

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2.5. Further Factors Affecting Formalised Community Participation in Health

2.5.1. A Supportive Political Context

Of further interest in the research conducted in Zambia and Zimbabwe, were the substantial differences in the contexts of the two countries. The Zambian studies, despite the poor performance of the economy, indicate increasing government support for PHC by changing the health budget around from a 30% (pre-1992 and the introduction of health reforms) to a 70% resource allocation to PHC (Ngulube *et al.* 2005:19). The Zimbabwean study, on the other hand, was fraught with concern about decreasing governmental and health service support for community participation and

the deterioration of previous post-independence health achievements. This serves to indicate that community participation has increased potential to thrive and thus, contribute to the development of a health service that engages with and is responsive to the needs of the community – one of the cornerstones of the PHC approach that strives to achieve its purpose of improved “Health for All.” (WHO, 1978)

An interesting example to highlight this was found in Malawi, described by Baéz and Barron (2006). A Community Score Card was introduced into the health service, where both health care users and providers afforded scores to the various components of the health services. An important finding from the study indicated that communities considered that the area of programme planning was the sole responsibility of the health care services and that, as communities, they had no role to play in this activity.

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> This aspect of the health system reflects the status of community participation in general in Malawi, which is weak, owing to the authoritarian political climate inherited from the Banda era. Until there are more supportive district structures, community participation will remain localised. (Baéz and Barron, 2006:13).

Sanders (1992) indicates that PHC does not function outside of a supportive political framework. This premise is supported by Baum and Kahssay (1999: 110): “District-level health development is likely to be most effective in places where it enjoys strong political and bureaucratic support.” It is within the context of democratic practice that the opportunities and potential for real community participation thrive. Community

participation contributes towards building a participatory democracy, in which individuals and communities are empowered to have control and exert a real influence over their lives and the services and structures within them.

2.5.2. The Translation of Policy into Practice

Levers, Magweva & Mpofu (2006), in their literature review of district health systems, address the issue of community participation in policy making within a supportive political context.

> A huge gap exists between policy ideals and what actually exists in practice. Government documents encourage community participation with few indicators for translating or operationalising the ideals associated with community participation. It seems that governments consider one-way/top down communication as qualifying as community participation. (Levers *et al.* 2006:17)

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They indicate that one of the key lessons learned through their review of the literature was that:

> it is not enough for governments to state in their policies that they intend to seek the participation of ordinary citizens. They must take one step further and construct and invest in reality-based mechanisms and processes for participation, citizen-friendly avenues for participation. (Levers *et al.* 2006: 19).

This is confirmed by Baéz and Barron (2006: 41), who also indicate that policy is often poorly translated into practice:

> One of the reasons for this seems to be the lack of a concerted political effort to create the right enabling environment for policy to be accepted and translated into action.

Baéz and Barron (2006) continue this theme by showing that policy implementation is often at the interpretation and discretion of the District Health team and that this requires not only a thorough understanding of the intention of the policies, but also the right attitude by health service personnel for transformation and support of community participation. Baéz and Barron (2006) state that whilst communities seem prepared for transformation, the health services, managers and workers, who are the implementers of the policies, are often more conservative, authoritarian, bureaucratic and have an inflexible style of operating, which serves as a barrier to effective participation. Likewise, Ngulube *et al.* (2005) note that health workers frequently demonstrated a reluctance to share power and were stuck in outmoded and hierarchical ways of working. Klugman (2004) (as quoted in Levers *et al.* 2006:12) asserts in her discussion of community participation in policy development that government regarded community participation as a useful adjunct to providing them with information, "rather than gaining input as to how to shape policy."

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2.5.3. <u>The Important Role of the District Health Structure in Implementation</u>

The level of the district appears to be pivotal to the interpretation of policies and the success of the community health structures. Baéz and Barron (2006) note that it is supportive and effective district-level management structures that can make the difference between the success and failure of community health structures.

In South Africa, the District Health Councils[5] provide an opportunity for the promotion of co-operative governance and co-ordination of planning, budgeting,

[5] District Health Councils are required by the National Health Act (61 of 2003) to be established for every health district to promote co-operative governance and "ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services". (Section 31.3(*b*))

provisioning and monitoring of all health services. Elected local councillor representation is included within the structure, which provides an opportunity for the articulation of community needs. It appears, however, that these structures have been slow to be established. An example is provided from the context of this study where within NMBM, it was reported by the Acting Executive Health Director, E. Hoosain, that the first meeting of the DHC had taken place in March 2007 (Speech at District Health Summit, 17 August 2007).

There was an indication from Macwan'gi and Ngwengwe (2004) that District Health Boards, which have a similar role to DHCs, were reluctant to trust in the communities' ability to identify their needs and make decisions regarding their health. At the District level there appear from the reviews of Levers *et al.* (2006) and Baéz and Barron (2006) to be no examples in the south-eastern African context of community participation in budget preparation, resource allocation and planning. In fact, the Zambian study (Ngulube *et al.* 2004) indicates that plans generated by the community at the level of the Neighbourhood Health Committees and Health Centre Committees were 'finalised' by the District Health Board, frequently omitting some of the community suggestions. This meant that the proposals and decisions made by the NHCs and HCCs were, in effect, wholly undermined by the district health authorities.

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Apart from the level of the district, both Baéz and Barron (2006) and Levers *et al.* (2006) indicate that there is a serious lack of community representation at the national

level. They argue that if community participation is to make a significant impact on issues, such as planning and resource allocation towards a more equitable health system, then the voice of the community is required to be heard at the national level. Apart from a few NGOs and lobby groups, they found no indication that the localised structures had access to national health roleplayers.

It appears from the above examples that it is at the local level, where the health facility is located, that some authority appears to have been granted to the community health structures that have been developed, and that are enjoying most success. It is at this local level that community members have direct access to the services and can exert influence on their operations.

2.5.4. The Important Role that Health Services Personnel Plays

Importantly, there were a number of lessons that were learned from the various research studies noted above, specifically about the factors affecting their functioning. A number of key areas were highlighted as contributing to or hindering their effective functioning.

Zakus and Lysack (1998: 9) state that in order for these structures to be effective and sustainable, community participation "must become a successful and integral part of the entire community's common experience and not remain as a structure imposed from outside". The implementation of community participation, they argue, is the responsibility of the local programme initiators, echoing the findings of Baum and

Khassay (1999: 112), who described health services personnel as “catalysts”. In addition, in order for the ‘health development structures’ to function effectively, Baum and Kahssay (1999:102) argue for the need for resources: “Overwhelmingly, the most frequently mentioned obstacle to the effectiveness of health development structures was the lack of resources for the promotion of better health.”

2.5.5. Links to the Structures of Local Government

Zakus and Lysack (1998) continue by indicating that these structures need to have strong links with and support from local political structures. They suggest that the health structures serve to provide the link to local government for the articulation and representation of community concerns. Baéz and Barron (2006: 31) note in particular the role of local councillors whose “potential power and influence must not be underestimated.” Local government councillors are elected by their local communities and are, therefore, accountable to this constituency. However, a study conducted by Baéz (2002), (as cited in Baéz and Barron, 2006) in the Chris Hani district in the Eastern Cape Province, South Africa, showed that local councillors were lacking in knowledge about health programmes and policies. Baéz and Barron (2006) assert that there is, thus, a need to build the capacity of the councillors, and to include them within training programmes so as to better understand health and their roles and functions.

2.5.6. Capacity Development Required to Promote CHC Functioning

Capacity development, in general, was an area of weakness identified by Baéz and Barron (2006: 43).

> Institutions and organisations need to develop the capacity to ensure the functioning of fundamentally differently oriented health systems. … This required capacity includes adequately developed human resources, particularly health workers and community members involved in health issues.

Specific areas were highlighted for such capacity development. Ngulube *et al.* (2004) note that community members regarded their lack of medical knowledge and skill as a barrier to effective participation. Levers *et al.* (2006) highlight leadership as an important capacity building requirement for the committees. Other areas included finance management and technical empowerment, especially in understanding the District Health Information Systems. Technical training for community representatives and health managers was also presented by Baéz and Barron (2006:35) as an important enabling factor.

In her study, which focussed on the requirements for capacity development programmes for Community Health Committees in the Western Cape, South Africa, Levendal (1999:56) suggests further capacity development skills for the effective functioning of CHCs. These include skills, such as needs assessment skills, and identification and prioritisation of health problems; general organisational skills, such as how to conduct meetings, understanding of roles for portfolio holders and effective committee functioning; general life skills, such as language skills, public speaking and presentation, facilitation skills and how to run campaigns and finally "general health and health care-related skills", such as HIV and AIDS, nutrition and counselling skills.

However, Levendal (1999: 59) cautions:

> It [capacity development] should always be based on a training needs analysis which would specify the expressed needs of the committee members and which considers the prior knowledge and experience of the people themselves.

2.5.7. Guidelines for Clarity on Roles and Responsibilities are Required

Whilst capacity development is important for improving the levels of skill of all participants within the formalised community participation processes, the primary area for such capacity development appears to be focussed on the roles and functions of the committees. It was apparent, however, that in many instances, the community health structures were not clear about their roles and functions. Where there was clarity on roles and responsibilities, as in the case of the Zambian NHCs, there was a high level of satisfaction reported with their performance (Macwan'gi and Ngwengwe, 2004). Ngulube *et al.* (2004) concurred, finding that HCCs which performed well were involved with distinct roles: decision making, priority setting, monitoring expenditure and quality of services. Loewenson *et al.* (2004) noted that when HCCs were lacking in clearly designated areas of responsibility and authority, their effectiveness was compromised. Associated with roles and responsibilities, are the lack of guidelines and procedures that have been suggested as a further reason for poor functioning of community health structures. It was suggested by Baéz and Barron (2006) that for community health structures to remain relevant, they should be involved in the periodic review of policies and guidelines.

A clear message from Levers *et al.* (2006) in terms of a role that community health

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structures play is their involvement in the planning and management of health facilities. Communities are required through the community health structures to identify their own needs and solutions, based on assessments and analyses that they conduct. Baéz and Barron (2006) concur, stating that the programmes that are developed need to be specific and culturally sensitive to the local context. They add that the involvement of other stakeholders and roleplayers in a multi-sectoral approach to developing an understanding of the underlying causes of ill health and in designing strategies for addressing them, provides the opportunity for increased participation and for integrated programmes to be developed.

Other roles for the health structures can be gleaned from the above: determination of services, quality of care monitoring, resource allocation, budgeting, and promotion of health programmes aimed at improving health outcomes.

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2.5.8. Composition of Membership Needs to Adhere to Policy Guidelines

Composition of membership of the community health structures has also been raised as an important factor contributing to their successful functioning. Representative legitimacy, as in receiving a mandate from the local community through an election process, was regarded as important. It was found, however, to be frequently flawed. (Baum and Kahssay, 1999; Ngulube *et al.* 2004). Baum and Kahssay (1999), Loewenson *et al.* (2004), Baéz and Barron (2006) concur that whilst it has been shown that inclusive democratic practice is required for sustainable health and development outcomes, little effort has been made to include marginalised and

vulnerable groups within health processes. Baum and Kahssay (1999) raised concerns that too few community members and too many health professionals were often included in the formal health structures. In their Jamaican study (Baum and Kahssay, 1999), local elites (considered to be useful because of their access to resources) and the very poor did not participate in the health development structures. Beaglehole & Bonita (1997) address the issue of people living in poverty, noting that the poor remain poor because they are marginalised from political and economic decision-making processes. They argue that people who are poor are mostly afforded no opportunity to participate in the allocation of health or more general public resources, and, therefore, decisions are influenced by those who are more powerful and whose interests they, therefore, serve to protect. Thus issues of equity are most likely not being adequately addressed.

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Criteria and mechanisms for the selection of these governance structures are required to have been determined with communities in advance of elections but in most instances, this has not occurred. Democratic election processes to promote community participation allow community members to hold community representatives accountable for more community-oriented healthcare systems.

2.5.9. Channels for Communication and Reporting Need to be Clearly Established

Another factor linked to representivity and accountability identified by Loewenson *et al.* (2004) is communication. They indicate that the effectiveness of the HCC is dependent on community linkages and communication. Whilst the HCCs appeared to

relate well to subsections of the community, they were apparently unable to mobilise widely and involve broader community participation. "Poor communication, lack of structures to communicate and channel for flow of information severely hamper community participation" (Loewenson *et al.* 2004: 4). Added to this is the issue of reporting. Reporting structures for community health structures were not always clearly defined, leading to confusion, and served as a factor to inhibit effective functioning.

2.5.10. Acknowledgement to Community Members for Contribution Made

An important factor to be considered for the effective functioning of community health structures is acknowledgement of the community members. It seems that in many instances, community members report that the health services do not recognise their efforts and value their input. They indicate weak formal recognition as a deterrent to their sustained functioning.

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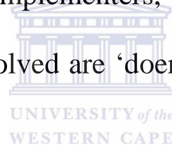
2.6. Some Encouraging Findings

Despite the factors, many of which are cautionary, Baéz and Barron (2006) indicate an important finding that some of the difficulties *are possible* to overcome at a local level with the motivation and willingness of all within the community-based partnership. "Local initiative and motivation often overcome lack of clear guidance" (Baéz and Barron, 2006:42). This is confirmed by Baum and Kahssay (1999: 112) who indicate, as noted earlier, that health personnel, in particular, hold much potential as 'catalysts,' to the successful functioning of community health structures.

Community participation in income-generating projects aimed at addressing public health problems was identified as an appropriate and encouraging activity for community health structures. Baéz and Barron (2006) add that combating the AIDS epidemic provides structures, such as these, with an important role and opportunity to deepen community participation.

Finally, of significance for this study is a point repeatedly articulated in the article by Baéz and Barron (2006): that there is a paucity of information on localised examples of community participation. They argue that more information is required on the "less obvious factors that influence the form and content of community participation, such as power relations between different stakeholders." (Baéz and Barron , 2006: 45) They pose this as a challenge to implementers, for it is their contention that at the local level, the people who are involved are 'doers' and do not sufficiently document the processes.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> they do not have time to write - they are busy doing things. … the availability of information on the policy implementation process does not represent or reflect the reality at district and community levels in the region. In addition, even when information is available, there is little evaluation and analysis of lessons learnt that can serve as a guide for other programmes to improve their sustainability. (Baéz and Barron, 2006:42)

2.7. Conclusion

The literature review sought to develop an understanding of the current practice of community participation in health, and, more specifically, of its formalised community health structures. It drew on examples from around the globe and more particularly from the experience of African countries to understand current levels of functioning of community health structures. From this, a number of lessons were learned. Key to these was that whilst community health structures may be operating efficiently at the local level, it was important that participation be elevated to the district and national levels. Participation at these levels would have the potential to improve efficiency and have increased impact. The review also developed an understanding of the factors that serve to promote and inhibit effective functioning of the community health structures. These were varied and included issues, such as political commitment, composition of membership, inclusive democratic practice, directed capacity development, knowledge of roles and responsibilities; and an expansion of these roles and functions to include planning, budgeting and resource allocation. There was acknowledgement, too, that the community members' contribution was not always recognised by the health service.

Finally, the review sought to identify gaps in the current research that this study might attempt to address; and found that there was a need for local-level documentation, paving the way forward for this study.

CHAPTER 3: STUDY AIM AND OBJECTIVES

3.1. Introduction

This study aims to develop an understanding of the factors related to the effective functioning of Community Health Committees in the Nelson Mandela Bay Municipality, Eastern Cape Province, South Africa.

The **objectives** of the study are:

1. To explore with key stakeholders the factors they believe inhibit and promote the effective functioning and sustainability of CHCs in NMBM.
2. To identify the factors that CHC members believe inhibit and promote the effective functioning and sustainability of CHCs.
3. To synthesise the above findings and develop a set of recommendations that can be used as a foundation for the development of guidelines for strengthening CHCs in NMBM.

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3.2. Methodology

Study Design: The study is a descriptive study. It utilised qualitative research methodology, given that it sought to explore the perceptions, opinions and experiences of key stakeholders and local CHC members about the functioning and sustainability of CHCs. By utilising a qualitative approach, the researcher was able to develop an in-depth understanding of the current role of CHCs within NMBM and the factors influencing their effectiveness and sustainability. The multi-method approach of interviews and focus group discussions is a feature of qualitative research.

3.3. Sampling

In this research, the study population is comprised of 52 CHCs and five key stakeholders associated with their operation within NMBM. Two focus group discussions were conducted with purposively selected CHC members.

In the first instance, a focus group discussion was held with seven members of a CHC described as "operational". This was one of the categories that the Municipal Directorate of Health developed on 23 March 2006 during a meeting to conduct an audit of CHCs, to describe levels of functioning of the CHCs (Bala, 2006 See Appendix Three). This was a descriptive term, with no formalised criteria, given to CHCs by health facility supervisors to describe their level of functioning. As outlined earlier, this description was not clarified, but seemed to indicate that a consistent group of community members, organised into a formal structure, constituted this CHC. CHCs within this category were known by the health service personnel, held elections to determine a governance structure (most supervisors could identify the chairpersons) and met as a group fairly regularly. It was anticipated that in selecting a CHC described as "operational", the researcher would draw on the experience, knowledge and understanding of a group of people who constituted a CHC which was functioning effectively. Their perspectives would be invaluable in understanding the characteristics of a functional CHC and the requirements to establish and maintain a CHC.

A second focus group discussion was conducted with 13 purposively selected CHC

members on 27 March 2007. The members were selected from a group of CHC members who attended a planning meeting on 13 March 2007 to which the 52 CHCs within NMBM had been invited. This focus group discussion included representatives of CHCs that were previously described both as "operational" and "limited functioning". The description of "limited functioning" at the meeting of clinic supervisors seemed to indicate that community members were in attendance at the clinic, but there was no consistency or organisation associated with its functioning. The second focus group discussion, thus, provided some diversity in terms of the experiences of committee members and their participation in differently functioning CHCs. It was anticipated that these experienced members of CHCs, given their history with CHCs, would provide a rich source of information and be able to provide valuable insights into the factors affecting CHC functioning.

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3.4 The Selection Process for the Focus Group Discussions

The Health Promotion Manager, Municipal Directorate of Health, whose job description includes management of CHCs, was requested to assist in the purposive selection of both focus group discussions; the first comprised a CHC previously described as "operational" and the second, a group of CHC members from diversely functioning CHCs.

During the research process, an opportunity arose to purposively select both focus groups. All 52 health facilities within NMBM were invited, by the NGO,"TB Free" [6], to send two representatives from their CHCs to a meeting on 13 March 2007 to

[6] "TB Free" is a non-governmental organisation working in collaboration with the Department of Health to reduce the prevalence of tuberculosis nationally. It has an office and staff within NMBM. It services NMBM and OR Tambo Districts.

discuss the events being planned for World TB Day (24 March 2007). 12 people attended the meeting representing nine CHCs. Given the nature of the research and the links the NGO had with Nelson Mandela Metropolitan University, the researcher was invited to attend the meeting. During the meeting, an opportunity was provided for the researcher to introduce the research study and request the support of the CHC members. There was a positive response from the CHC members, who immediately indicated their preparedness to participate. The Participant Information Sheet (Appendix 8) and Consent Form (Appendix 9) were given to all those present to provide written information and for their perusal. It was agreed that the researcher would contact all participants at a later date, after consultation with the Municipal Health Promotion Manager to discuss further co-operation in the study.

After the meeting, the Municipal Health Promotion Manager was consulted for guidance in selecting both the "operational" CHC and the focus group discussion of a mix of CHC experience. Together it was agreed that it was important that the "operational" CHC, described as such a year prior, would need to continue to be described as such currently, if it was to yield useful data. Of the CHCs that attended the "TB Free" meeting, it appeared that only two CHCs met this criterion. Of those two CHCs, it seemed that one had consistently been strong and had a large and apparently vibrant membership; thus, it was selected to represent the "operational" CHC.

For the second focus group discussion, the Health Promotion Manager and researcher

together agreed that the spread of CHCs represented at the "TB Free" meeting was suitable for the required mix of "operational" and "limited functioning". From our calculations, it seemed as though a year previously, five CHCs would have been described as "operational" and the remainder as "limited functioning". It appeared that most members had been participating within CHCs for a number of years and so presented the requisite experience. There was some overlap as two members from the first focus group discussion were included in the second focus group discussion. It was considered whether to invite members from other CHCs, but was decided that a reasonable spread of diversity was available and the size of the group was correct for a focus group discussion.

3.5. The Key Informants

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For the individual in-depth interview process, five key informants were identified, based on their experience and the positions they hold within the Directorate of Health in NMBM in relation to CHCs. These included:

- The Portfolio Councillor for Health and Environment, a political appointee who is responsible for motivating the budget and its allocation for health within NMBM. The councillor is also a member of the Executive Mayoral Committee and, as such, is in a powerful position to influence decision-making in the city;
- The Health Promotion Manager, Directorate of Health, NMBM, who has the management responsibility for CHCs;
- A former CHC member with eight years experience as a health volunteer and

CHC member. Because of the experience gained during this time, he was appointed to manage a health-related non-governmental organisation which works in close collaboration with Municipal Directorate of Health.

- A professional nurse, who now works for a donor organisation in support of quality management in the Directorate of Health, NMBM. She was previously involved in an NGO which introduced, established and trained CHCs in NMBM. Her involvement was sought during the research process because the researcher was experiencing difficulties in securing an interview with the Health and Environment Portfolio Councillor. It was considered that this key informant would be able to provide similar information as it appeared from experience in working with her, that she has a good understanding of the political requirements for the effective functioning of CHCs. She continues to work within NMBM to promote effective CHC functioning.

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- A further additional key informant was identified during the process of the second focus group discussion. He was the Chairperson of both a local CHC and a health forum for a sub-district within NMBM. It was evident during the focus group discussion that he had carefully considered the factors affecting the functioning of CHCs and had a wealth of experience and understanding to contribute. It was also clear during the discussion that he was sensitive enough not to dominate the discussion, and that he had more insights and experience to offer the study.

3.6. Data Collection

Data was collected from the two focus group discussions and five key informant interviews. The combination of both focus group discussions and key informant interviews was expected to yield a rich source of data from which an understanding of the factors related to CHC functioning could be elicited.

3.6.1 The Procedure for Conducting Focus Group Discussions and Key Informant Interviews

Once the 'operational' CHC had been selected, arrangements were made to meet with CHC members to elicit their support for the research process. Contact was made with the Chairperson and a letter was sent to the Manager of the relevant health facility. Arrangements were made with the Chairperson to attend a monthly CHC meeting to present the proposal, and request the members' support and co-operation. This meeting presented an opportunity too, for the researcher to observe the operations of a CHC regarded as functioning effectively. The initial meeting was held on 26 March 2007 at the health facility in a room reserved for health volunteers. Thirteen members were present at the meeting: 11 women and two men. At the start of the meeting the researcher presented the research proposal. Members received the proposal positively. They immediately wanted to raise issues affecting CHC functioning. It was, however, agreed by all at the meeting to meet a week later to resume a more lengthy discussion in the form of the requested focus group discussion. All CHC members were provided with a Participant Information Sheet and Consent Form to peruse and ensure that clarity of the research intention were assured. (Notes from the

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general CHC meeting are contained in Appendix 7.)

The focus group discussion took place as scheduled at the same venue a week later. Seven of the 13 members were present. According to those present, the remaining six CHC members were not in attendance at the meeting because they were “boycotting” the facility because of non payment of their monthly stipends. It was put to the group whether the focus group should be postponed until a later date when more members would potentially be available. The group and researcher together, however, decided against a postponement as group members were concerned that there was no indication as to when there would be resolution of the matter of the stipend, since its non-payment had been ongoing for a number of months. Those present felt that they could adequately represent the views of the broader membership, having spent much time working together and discussing issues of concern. It was, therefore, decided to continue with the focus group. The group was comprised of females. Two members had been participating within the CHC since 1997. Others had served less time on the structure; one member had joined the previous year. The discussion was 1 hour and 30 minutes in duration.

The procedure for the second focus group discussion was different. Once the CHC members had been identified, they were contacted telephonically and requested to attend a focus group discussion ten days later. All agreed to participate in the focus group discussion. A message was sent out to all participants two days before the arranged time reminding them of the focus group discussion. One person apologized

for not being able to attend the focus group and another CHC member brought a new member to the group. Twelve people (six men and six women) formed part of this second focus group, representing nine CHCs of varied levels of functioning. All had received some training as health volunteers and worked daily at the health facilities. One participant had been involved in CHCs since 1998; the rest had commenced their involvement over the period of the past six years. The focus group discussion was held for 1 hour and 40 minutes.

A set of questions was used to guide the discussion of the focus groups. The questions had different emphases for the two groups but were intended to elicit the same information. The participants of both focus groups were reimbursed for their transport to and from the venue and were provided with a meal following the discussion. The researcher was provided with translation assistance from a colleague, who is Xhosa speaking. Very little translation was required although the introduction at the outset of the second focus group discussion was translated. This was to ensure that all participants were clear as to the purpose and intention of the research. The researcher's colleague also acted as note-taker during the focus group discussions and assisted the researcher to record non-verbal cues. She later commented on the researcher's interpretation and analysis of the data. The questions and prompts for the focus group discussions are contained in Appendix 6.

The focus group discussions and key informant interviews were tape recorded with the tapes being transcribed by either the researcher or a paid typist.

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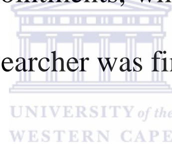
In-depth interviews with five key informants were held. The researcher contacted the key informants telephonically, informed them about the study and requested an interview. They were provided with the Participant Information Sheet and a Consent Form prior to the interview. Interviews took place at the offices of the key informants and at a time that was convenient to them. The interviews were individual, face-to-face and semi-structured. The interview guide for these individual interviews is contained in Appendix 5.

Four of the five key informants were willing to share their opinions and experiences. The fifth person interviewed was the Health and Environment Portfolio Councillor and the interview was more difficult to secure. It took four months (from March until June 2007) and nine scheduled appointments, which were either missed or postponed by the key informant, before the researcher was finally able to conduct the interview.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3.8. Rigour

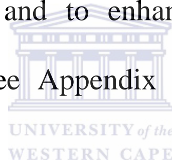
Triangulation of data sources through meeting with CHC members and five key informants assisted to increase validity by corroborating descriptions. Triangulation of methods by utilising focus group discussions and individual in-depth interviews also served to increase rigour. The researcher summarised key points at the end of each focus group discussion to verify with the participants that her understanding and interpretation of their experiences, perceptions and opinions was accurate.

The researcher was assisted in the focus group discussions by her colleague from

work. After the focus group discussions, time was allocated for discussion of the groups to check on the researcher's interpretation and understanding of the group and its dynamics. This proved to be a most useful tool for deepening understanding of the group processes.

The researcher is committed to the practice of community participation in health. Her work serves largely to strengthen this. Reflexivity is demonstrated with the researcher stating clearly her belief in the process of community participation and partnership in health.

A diary of personal thoughts and feelings was maintained throughout the research process for personal monitoring and to enhance understanding of the research processes and its challenges. See Appendix 12 for a personal account of the qualitative research process.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3.9. Analysis

A thick description of the data was collated from the focus group discussions and individual interviews. Reading through the contents of the interviews and focus groups at least three times familiarised the researcher with the data. The researcher was then able to start to analyse its content, eliciting recurring themes related to the effective and ineffective functioning of CHCs, and the factors affecting this functioning. The transcripts were thoroughly scrutinised so that every aspect of their content was understood and could be coded. The "cut and paste" method was used to

categorise the data. This was assembled on sheets of cardboard, which were then displayed on the walls of the room in which the researcher was working. This process of coding and categorising the content of the data was used to assist in bringing meaning to the responses of respondents and provided the basis for comprehensive content analysis. It is from this thematic analysis that a more in-depth analysis of the data was made by the researcher. For a more detailed description of this process, refer to Appendix 12.

3.10. Ethical Considerations

A letter was sent to the Acting Executive Director of Health within NMBM outlining the nature of the research and requesting permission and co-operation from the Health Directorate for the research. A Municipal Research Request form was also completed. This, together with the research protocol, was submitted to the Municipal Directorate of Health.

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Participation in the study was voluntary for all CHC members and key informants. They were each provided with a letter explaining the research study, requesting their participation and assuring them of confidentiality (Participant Information Sheet Appendix 9). Their consent was sought and a consent form was then available for them to sign if they were willing to participate in the research study (Participant Consent Form Appendix 10). All participants provided their consent. Given the nature of the research, it was most unlikely that the informants would perceive the research as threatening or invasive. It was anticipated that the research would cause no harm to

the research participants. However, a professional counsellor from NMBM Health Department was available should any of the informants have required emotional support or counselling as a result of the research process.

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CHAPTER 4: RESULTS

4.1. Introduction

Whilst there were discrepancies between the CHCs, such as the size of the group, the working relationship with health facility staff and an understanding of the purpose of the CHCs, it was, none-the-less, possible to develop an understanding of the factors affecting CHC functioning. The response of only nine CHCs to the invitation by "TB Free" to a planning meeting which was sent to all 52 health facilities in NMBM provided some early indication of the weakened state of CHCs. A brief summary of the findings will be presented before exploring these in greater depth

These factors could broadly be categorised as follows:

- The composition of the membership of the CHCs is important in determining their effective functioning.

- The institutional arrangements, support and co-ordination of CHCs are important elements necessary for the development and sustainability of their effective functioning.
- The lack of guidelines to direct the operationalisation of CHC functioning is inhibiting their effective functioning.
- It was apparent that the context in which CHCs were operating was perceived to limit the effective functioning of them.. A recurring theme in the interviews and focus group discussion was the poor socio-economic condition of communities. An additional contextual theme was the current political context, perceived to impact negatively on CHCs' effective functioning.

- The result of the above inhibitory factors was shown to impact mostly on the CHC members themselves, demoralising and demotivating them as volunteers. These members regularly described a lack of recognition for their efforts. This despondency served as a further inhibitory factor, as there are no advocates for CHCs from within local communities; thus, CHC growth and development is stunted, which undermines the potential for their effective functioning.

To understand these factors, more detailed explorations and discussions of the findings are described below.

4.2. The Composition of CHC Membership

The most starkly obvious and evident factor inhibiting CHC functioning was their membership composition. The statutory requirement for membership of the CHC is the inclusion of one or more local government councillors; members of the community served by the health facility; and the head of the clinic or community health centre. Whilst designated and specific roles have not been clearly determined and assigned to these members in any of the documentation available to the researcher, it would seem evident that each of these three membership components would serve a specific, useful function for the effective operationalisation of the CHCs. Despite this, there was little evidence that these three membership inclusion requirements were being met. In fact, it seemed that for the most part, it was the community component that was the mainstay of the committees, with varied support from the head of the health facility and seemingly no support from the local

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government councillors.

4.2.1. The Community Membership Component

It appeared that the community membership component was made up mostly of health volunteers[7]. All the focus group discussion members who formed part of this study were local health volunteers. Health volunteers support the services at health facilities within NMBM. It appears that these health volunteers differ from the traditional understanding of a volunteer, as one who freely offers their services without reward or remuneration. Currently, the term "health volunteers" is used to refer to people from the local community, who work to assist and serve daily in support of the health facility and receive a monetary stipend in return. The volunteers have been requested, either by the health facility staff or volunteers already in service at the facilities, to join them in volunteering. The volunteers appear largely to have received training as single purpose workers, i.e., they are not trained more broadly as community health workers. They are Tuberculosis Directly Observed Treatment Supporters (TB DOT Supporters), home-based carers, personal sellers (marketing Voluntary Counselling and Testing, VCT) assistant birth attendants and lay counsellors. Volunteers function to extend health services and report on their duties to staff members. Some volunteers are indistinguishable from staff members as they, too, wear uniforms. Volunteers, therefore, are closely aligned to the staff within the facilities and are not neutral as to community interests. These volunteers are eligible to receive a stipend of R600 per month made available by the Department of Health. In return, they are required to

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[7] Health volunteers are those people from the community serving at the health facilities. Most of volunteers were found to be in receipt of a stipend. This called into question the term 'volunteer'. The *Chambers Twentieth Century Dictionary* (1978) defines a volunteer as "one who enters any service of his own free choice. … – *v.i.* to enter any service of one's own free will or without being asked." This definition excludes reference to payment or remuneration which lends itself to continuing the commonly used term of volunteer or health volunteer in the text of this study.

work for the health facility for four hours daily. The Department of Health makes stipends available for seven volunteers per clinic and ten volunteers for the larger 24-hour Community Health Centres.

In the focus group discussions, it was not possible to differentiate between participants' role as health volunteers and their participation within the structure of the CHC. They seemed to have merged these functions and were functioning as health volunteers constituting the CHC. It appears that the volunteers elect an executive structure amongst themselves and are then known as the 'clinic committee'. This committee satisfies one aspect of the membership requirements of the National Health Act that "one or more members of the local community served by the health facility" is included within the CHC.

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Interestingly, the issue of the community membership component of the CHCs was raised by key informants as a matter of concern and as a factor negatively affecting CHC functioning, but it was not raised within the focus group discussions by the CHC members themselves. It appeared that the CHC members were less aware that the current community composition of CHCs may be a factor inhibiting their effective functioning.

A key informant tried to explain how this could have come about:

> We first had these health committees and community members were involved. That was the time that government said that our communities are important. But it was

> also a time that more clinics were being made available to communities and there was a big rush on the clinics. So then the volunteers were established and the people to come forward [to volunteer] were the clinic committee members. And so volunteers and committee members, they all became the same, and so the committees have changed from groups which represented the communities to groups representing the volunteers. So that now when you go to the clinics and you want to find out who is the clinic committee, they say: 'I am the clinic committee' and I ask 'What are you doing?' and they say 'We are volunteers'. So they no longer fulfil their role to have oversight of the public servants to ensure they do their work properly and address the needs of the community.

The blurring of roles between CHC members and health volunteers was highlighted by a further key informant, who provided a further explanation:

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> But what I discover is that CHC members they want to be volunteers and the reason being some of the volunteers, they get benefits such as training, they end up being treatment supporters, DOT supporters, counsellors ***and*** they get paid. And many people who are involved in these health committees are unemployed people. I think the trend is changing because they see themselves volunteering all these years but the people they are nominating are getting the benefits, and then that's why they end up being volunteers themselves. … And then there is no clear distinction. According to previous guidelines [apparently produced by an NGO which had assisted with early establishment of CHCs], the role of the community health worker and the Community Health Committee is totally different, but in actual practice that has changed. … Because the CHCs are the ones who are helping and advising the management of that

> clinic, they are also the people responsible to identify and select volunteers to help communities and liaise with clinics and monitor all those processes. But what I did discover [then] is that some CHC members, they want to be volunteers. … And then we should really see who should run the establishment … without neglecting the volunteers as well because they're all contributing to community participation in health. But there must be a clear distinction.

During the focus group discussions, members were asked to provide an indication of the composition of their CHCs. Their descriptions were confined to lay community membership, omitting the membership components of the local government councillor and health facility personnel. None of the participating CHC members attended their CHC as a representative of a community-based organisation, nor had they been elected to the CHC at a broader community meeting which was inclusive of other organisations within their local community. There was therefore little sense of broader community participation and representative legitimacy within the CHC. A key informant was clearly concerned about the issue:

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> There's no accountability. And you don't know whether these people when they come as elected, who sends them. Do they have a mandate? Or are they just individuals who come because they have access to information?

A further key informant spoke of the composition of CHCs during the late 1990s when CHCs were in the process of being established, indicating that community membership has changed over the past years:

> We used to do that as [a non-governmental organisation], to make sure that representation in those committees is from structures and organisations in that particular catchment population and not just individuals. So the elections are done according to proper guidelines.

Another key informant, talking of the early part of this decade, confirmed that community membership had been different:

> So fortunately New Brighton clinic had a lot of vibrant people, you know. They were people who were much more experienced than myself. …. There were some reverends, elderly and respected people of the community, [they] were all part of that committee. You don't just get people being part of that committee. You had to be somebody who was nominated because of your track record in the community to serve on that committee.

When asked about broader community representation within the focus group discussions, a few explanations were provided. In one instance where community members had initially been requested by the volunteers to participate in the CHC as representative of the community, they had subsequently become health volunteers. A focus group discussion participant explained:

> There are 13 volunteers in our committee. Those that were [initially] part of the community [subsequently] joined to be volunteers. Now we all volunteers. Six people get a stipend and the rest stay because they were promised a stipend and they filled in the forms, so they expect to receive a stipend very soon, if not in this month.

Another focus group member recounted how he had tried to increase community

representation by personally inviting two "influential" community members to attend the CHC meeting.

The *White Paper on the Transformation of the Health System in South Africa* (1997:19) is clear that mechanisms are required for public participation at district, provincial and national level "to ensure that people participate in the development of national policy". CHCs could provide such opportunity for representation to be elevated towards formalised representation at provincial and national levels. The lack of formal community representation at the local health facility level, however, has ramifications at the subsequent tiered levels. Quarterly meetings are held between municipal health management and CHCs at which information is intended to be shared. Because CHCs seem mostly to be composed of health volunteers, it is also these volunteers who attend the district meetings; and it is frequently their interests that are reflected most at these meetings. As an example, the main item on the agenda for the first meeting of 2007 was clarification on the issue of stipends for health volunteers.

4.2.2. The Local Government Councillor and Head of Health Facility Membership Components of CHCs

It appeared from the focus group discussions that the other statutory membership requirements of the local government councillor and head of the health facility were similarly not considered as necessary membership requirements of the CHC, and was something which ought to be critically adhered. Ward councillor and health facility

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staff representation on the structures appeared to be erratic and often absent. There was a sense, particularly from the focus group participants, that the health facility management and councillors were not deemed to be official membership components, and that the community component was, in fact, essentially responsible for the effective functioning of the CHC.

Focus group participants discussed health facility staff involvement as ‘supportive’ of the structures. They described CHC members meeting *with* health facility staff, as though the staff was outsiders and they, CHC members, were grateful for their support. There seemed to be little understanding that the staff was a necessary and requisite component of the CHC. It appeared that health facility staff varies in the extent of their involvement and engagement within the CHC. Some focus group members spoke of regular monthly or fortnightly meetings with the professional nursing managers, others described more limited support. Some members described that their CHC meetings were never attended by staff members and that communication with the staff were more informal, meeting as the need arose and seldom with the whole committee.

It appears that in the past, the staff was considered to be *ex-officio* members of the CHCs. The long-serving community members remember this and are not abreast of the current statutory membership requirements. This is causing confusion as to the staffing membership of the CHC. As a focus group participant explained:

> Our sister-in-charge, she is an ex-officio member, she wants to be the boss of our

> committee, but we have to be straight with her and tell her she is not our boss. She is not the ruler of the house.

Prior to the commencement of the initial meeting that the researcher attended with the 'operative' CHC, there was much discussion about the general lack of staff involvement within the CHC. Members present at the meeting decided that the head of the facility should be specifically requested as a matter of urgency to attend the meeting with immediate effect. A member of the group then went to fetch the sister-in-charge. She arrived, apologised for her non-attendance and agreed to attend the meeting for the first 20 minutes. It was clear that this facility manager too did not understand that her membership was an important statutory requirement of the CHC. (Notes from this meeting are contained in Appendix 7.)

Ward councillor involvement with the CHC seemed, for the most part, to be absent. None of the focus group members was aware of any involvement of the local government councillors within their structures. Whilst some of the more experienced members were aware that there had been ward committee member representation in the past in the CHCs, none was aware of local government councillor involvement. Ironically, a local government councillor was present for a short while at the observed 'operative' CHC meeting. At the subsequent focus group discussion, the researcher asked about the councillor's participation within the CHC. It was explained that this was a unique occurrence, had never happened previously and the councillor attended only to resolve the specific issue related to the ward committee member's

participation in the CHC. As one key informant noted:

> Ward councillors do not take clinic committees seriously. They mostly do not attend the meetings and ignore their responsibilities there. Actually I think they are probably ignorant of their role in these committees. At most they might delegate their functions. They regard the ward committees as the more important section of their work.

Another key informant noted that the local government councillors' participation could be a vital factor promoting the successful functioning and long-term sustainability of CHCs. She emphasised the role the councillor could play in addressing specific needs identified by the CHC through the channels of local government. She noted, however, that in order to succeed in gaining their participation, a considerable measure of political will and leadership was required from the councillors, the Constituency Portfolio Councillor and the office of the Mayor. This would mean that a specific request and motivation to this effect would be required from the Health and Environment Portfolio Councillor and the Executive Director, Municipal Directorate of Health.

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4.3. Institutional Arrangements, Co-ordination and Support Related to CHC Functioning

Both the Provincial Department of Health and the Municipal Directorate have responsibility for PHC and strengthening community participation in NMBM. In order for CHCs to function effectively, it is necessary that the health authorities

manage, co-ordinate and lend support to the CHCs. If they supported a vibrant and adequately staffed Health Promotion team, which was motivated and geared towards the support of community participation and, in particular, CHCs, then despite other challenges, CHCs would have the potential to function effectively within NMBM. The health facility staff, too, would have a useful resource and would be assisted to render support for effective CHC functioning.

4.3.1. District Health Management Support and a Resource-Poor Health Promotion Programme

Less visibly obvious than the composition of the CHCs, but probably more significant in terms of directing the operationalisation and functioning of CHCs, is the lack of institutional support for CHCs, especially from the level of district management from where the various health programmes are co-ordinated. Whilst focus group discussion participants were aware that support and co-ordination for CHCs from district health management were lacking, they seemed not to be aware of the extent of the management staffing shortfall. Even within the Health Department, key informants tended to address factors *outside* of their department and not address the critical shortfall within. It was only at the prompting by the researcher, asking direct questions about the capacity of the health departments, that key informants addressed district health institutional issues.

The perception that district health management was not doing enough to promote and support CHCs was expressed by a focus group member as follows:

> Also [district health] management is lacking to encourage and motivate Community Health Committees. One of the causes is their lack of communication. In some instances we think that really wrong people have been placed really. I am talking of managing, wrong people in places where to give direction for Community Health Committees. Because they [the district management] don't support them [CHCs]

Another focus group participant concurred:

> Once a month we meet with the in-charge but the problem is with management. The in-charge of the clinic is just the link between us and management. He doesn't resolve our problems. He takes our problems for management consideration. Then he will come back but most of the time there will be a nil response or most of the time there is nothing positive coming [back].

It is the Health Promotion Programme within the Municipal Directorate of Health that holds responsibility for facilitating community participation in health, including the management of CHCs and health volunteers. The Health Promotion Programme of the Municipal Health Directorate, NMBM consists of a single Health Promotion Manager, with no additional staff in support of this key position. Previously, CHC functioning was a core competency of the Health Promotion Programme for Provincial Department of Health. However, this has shifted to the Directorate of District Development and there appears to be no personnel within the current staffing arrangements within Provincial Department of Health, NMBM to take responsibility for the CHCs. Whilst there ought to be a working relationship between the municipal and provincial health departments operating within the same district, on improved

CHC functioning, this has been negligible; therefore, very limited management support has been available for CHCs. This has left community participation, and CHCs in particular, a neglected component of the health system.

4.3.2. The Staff at the Health Facilities

Staff at the facilities can play an important role in supporting CHC functioning. Focus group discussion members indicated that with increased support from the facility staff, CHCs would function more effectively. It was perceived, however, by some focus group participants that the serious health problems which communities are currently facing, such as HIV & AIDS and TB, took precedence over community participation. The focus group participants described this as a lack of understanding by health personnel of the *potential* that community members have in contributing to the improvement of health within local communities. In addition, it was suggested that staff may not be clear of the purpose and importance of CHCs. As one key informant noted:

> They [health facility staff] are not knowledgeable of the importance [of CHCs]. I am sure they are not knowledgeable as to the importance of clinic committees. … From my experience as I've said, as health workers at clinic base level, we need to buy the concept and be positive about it and know why the government of the day decided to establish CHCs, [and understand] their origin. We need to understand all that. … and we need to market that to our staff, and market that enthusiastically.

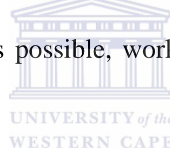
There was consensus amongst the key informants that there needed to be specific

training for health professionals to work with communities; however, it appeared that such training had not been undertaken. A key informant explained:

> Sometimes staff feels threatened because they are also not capacitated to work with these committees. So we [health authorities] haven't prepared the staff for this function.

A common concern raised during the focus group discussions and key informant interviews was about the general shortage of staff at the health facilities. The research participants remarked how many staff members appeared to be suffering burn out. As a result, commitment and morale amongst staff at health facilities is perceived to be low. The vision of *Batho Pele* (the provision of quality services) is perceived to be neglected. An experienced CHC member described the performance of some staff:

> They come to work as late as possible, work as little as possible and knock off as early as possible.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The consequence is that assistance and support for the development and maintenance of a CHC, often apparently perceived as an additional and seemingly non-essential function, is neglected. The unavailability of some staff to manage CHC-related issues along with the high workload they face, was an item for discussion at both focus group discussions. As one focus group participant remarked:

> It's when there's a problem and you can't find the sister you want to relate the problem to – they can't come or they're too busy or you see something like that … they're always gone for meetings or they are gone for that and they've gone for that, so that's one of the problems we've got.

A key informant agreed:

> I don't blame them [the health facility staff] because of [the staff] shortage. Because our clinics are full and then a person has low morale because of shortage of staff. [It] seems to be a buzz word across the province: 'Shortage of staff.' And when people are overworked it is difficult for them to show interest in any other sectors.

In addition, a focus group participant suggested that some health facility staff appeared to be reluctant to negotiate a common ground between their schedules and that of CHC members, which in turn affected the functioning of the CHC:

> The sister-in-charge does not want to attend meetings in the afternoons or evenings. But any working people [from the community] can only meet in the evenings. But then she said she won't attend our meetings. She's always got church meetings and so on. So I said she must delegate someone to attend in her place. But the others [staff members] say 'No, she [the sister-in-charge] must be there.' So if she is not there then we must still go on with the meeting.

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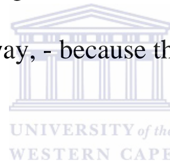
It appeared that in the past, health personnel had, in some instances, felt threatened by CHCs which negatively impacted on the functioning of the CHCs. A CHC member explained:

> At that point, [early on in the process of establishment of CHCs] [the] challenge was that we had to deal with the territorial issue with the staff. The staff felt highly threatened by us, so that they would even restrict us from other areas of the clinic. They felt we were there to take their jobs, or were there to tell a higher authority what they were doing. … They never saw us as partners. And then again, we, the very

> same health committee members, needed to inculcate that [concept] to the professionals. Now that was a lot, thinking back now. It was a lot, but it was something we had to do. We had to tell them that we are part of you, we want to assist you. Now you need to tell us too what are your problems.

There was, however, also a very different example of a committee at a local community health centre, which was made up of volunteers who had been specifically selected by the sister-in-charge. Here, the opposite situation was perceived to be taking place: where nursing staff were perceived to be controlling and dominating of the CHC. This, too, was perceived to discourage active community participation and inhibit effective functioning of the CHC. A focus group member explained:

> Sometimes the sisters-in-charge love to take over at the Community Health Committee, let me put it this way, - because they are professionals.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4.3.3. Training Programmes and Capacity Building for Community Health Committees

It seems that at the time that CHCs were introduced to NMBM, efforts were made by the health services to improve the levels of skill of CHC members. Capacity-building programmes were introduced which increased the skills level of CHC members and health volunteers. This resulted in CHC members gaining skills which were marketable, and a number of CHC members who had also become health volunteers were subsequently successful in securing jobs.

Non-governmental organisations used to perform a useful support function in assisting the health authorities within NMBM to establish, train and monitor CHCs. Previously, the National Health Department had outsourced training for CHC members to the Progressive Primary Health Care Network[8] and, at a local level, the NMBM Health Directorate had similarly outsourced training requirements to NGOs, such as the Community Development Unit, NMMU. Currently, however, NGOs are utilised by the Municipal Health Directorate on a more limited scale in relation to CHCs. They are generally requested to provide training on an ad-hoc basis, usually for one day and this is not conducive to the sustainability of the CHCs. For example, within the past two years, two training workshops for CHCs were held within NMBM, each within separate sub-districts and both were allocated a single day. The workshops attempted to develop an understanding of the rationale, operationalisation, roles and functions of CHCs for representatives from the various sub-district CHCs. These expectations, given the time allocated of six hours for training, were unrealistic. There appears to have been no systematic programme directed towards the empowerment of the CHC members to assume control and authority for the effective functioning of the CHCs. For CHCs to be effective, it would be necessary for comprehensive and well-planned training programmes to be developed. As one key informant highlighted:

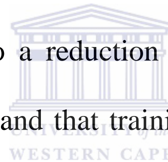
> People [CHC members] are not trained. We always list these roles. 'This is what we are supposed to do' but there never has been formal training under each role of what is expected. It's supposed to be NGOs that are supportive. It's supposed to be NGOs that are helping with training and guide the process of helping the CHCs. … For me,

[8] PPHCN was an NGO aimed at promoting and improving Primary Health Care Services. It has however since closed.

> it's induction and guidance and support. … Even if they [health authorities] can identify NGOs or institutions that should give guidance and then they even identify who should help them. They should invest time in those institutions or organisations.

Repeatedly, longer serving CHC members referred to a sustained capacity-building programme in project management which they received in 2000. It was a comprehensive, accredited and part-time, year-long programme. They queried the reasons for stopping such courses as they were perceived to have been most helpful, and to have provided skills which opened opportunities for some CHC members. In fact, one key informant explained how he had benefited from the training:

> It was through such training that I am where I am today [managing a health-related NGO].



A key informant attributed this to a reduction in the budget for municipal health services after the training in 2000 and that training for community participation had been cut as a result.

4.3.4. A Lack of Political Support and Co-ordination with Structures of Local Government

It appeared from the interviews and focus group discussions, that there is limited liaison with structures of local government to support CHC functioning. Co-ordination with the local government councillor and ward committees have the potential to provide a useful avenue to access resources and to impact on the municipal planning mechanisms such as the IDP. Previously, the ward committee

structures had representatives on a Health Desk who also served as representative on the CHC. A key informant explained:

> Because the Municipal Structures Act came after we had already established [the CHCs], so now the problem is we need to link with the ward councillor and the sub-district level. We need to link those forums with the ward committees. That's where the problem is and that should be driven politically but they are now driven by health officials. On structural issues there must be clear policies. … The other problem we started this thing before other structures were in place, like the ward committees, and the portfolio committees for health. So the Constituency Office is supposed to be [the] driver with that, that is dealing with communities. So there is some confusion because that is the highest political structure that is also dealing with ward committees; and then the ward councillors are responsible for health and are supposed to strengthen the Community Health Committee. The Province also is supposed to work closely. So there is no co-ordination.

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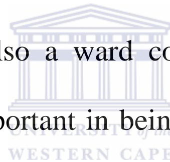
The system of the ward committee Health Desk representative appears to have fallen away and has been replaced by a system of representatives to a Health Portfolio Committee who attend bi-monthly meetings with the Constituency Office. These representatives appear to have no relationship with the CHCs currently. In fact, many of the CHC members interviewed seemed unaware that such changes have taken place. A focus group participant was clear that the current situation was not working effectively:

> The Health Desk [within the ward committee] does not work. The ward committee member should be part of the ward committee, also part of the health committee, and

> should take the information back to the community. But we don't have such people, because they are there but they don't know themselves what are their roles. They don't know what it is to be on the Health Desk – don't know whether the guidelines on that side are lacking. But that has an impact - the question of not working hand in glove with the councillor's office. Yes, that has an impact.

There were three CHCs which included volunteers who were also ward committee members. It appeared that they were not optimising their potential and being utilised efficiently as they were not formally channelling reports into the ward committee nor to the ward councillor. This reporting was done on an ad hoc basis and as decided by the individual CHC member. A focus group participant described how fellow members of her CHC had, for more than a year, been unaware that a particular volunteer within her CHC was also a ward committee member. These political structures at the local level are important in being able to relate to local government and potentially impact upon the IDP.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The Health and Environment Portfolio Councillor has overall political responsibility within NMBM for directing the health services and health budget. The position carries much influence within NMBM as the current councillor is also a member of the powerful ten-person Mayoral Executive Committee. This committee has extensive powers for decision making within NMBM. The length of time expended on securing a meeting with the Health and Environment Portfolio Councillor during this research process, seemed to mirror this more general political neglect of the

CHCs.

On a wider scale, there appeared to be no evidence of intersectoral collaboration in the activities of the CHCs. CHCs seem not to extend their outreach to include other sectoral role players; thus, other sectoral representatives are not present to support CHCs in a collaborative and potentially powerful health-development partnership. It was only one key informant who raised this issue of intersectoral collaboration, which seems to indicate that CHC members probably have little expectation of support from other sectors. The lack of involvement of organisations, government department and structures of civil society from other sectors (beyond health) was perceived by the key informant, however, to impact negatively on the effective functioning of CHCs. The key informant noted that this as an inhibitory factor and explained:

> And also we [NGO working for establishment of CHCs] said, when we said to them [health services] to establish these committees, the departments such as Nutrition and Social Development should involve these guys [within the CHCs] to identify income driven projects in the community so that they are occupied and they can also start developing things for themselves – garden projects so that they can have something. So we are also suffering because there is nobody supporting them. There is no intersectoral collaboration.

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4.4. The Absence of CHC Guidelines and the Lack of CHC Resources

Apart from the information on CHCs contained within the National Health Act (61 of 2003), the Eastern Cape Provincial Health Act (10 of 1999) and the *White Paper on*

the Transformation of the Health System in South Africa (Department of Health, 1997), there are no guidelines to specifically direct and detail the operationalisation of CHCs. The White Paper notes that the roles and powers of the elected representatives should be clarified but to date, within the Eastern Cape, the Terms of Reference for CHCs in the Eastern Cape Province are still in draft form; thus, in effect, CHCs are operating without any guidelines, which inevitably limit their effective functioning. In the absence of such guidelines, CHCs have changed from their original character. There are no guidelines to direct them back to their intended purpose. A focus group participant put it succinctly:

> If we can talk on the grounds that CHCs are all volunteers today, it's because of, as I have mentioned, guidelines. There are no guidelines.

Importantly, during the focus group discussions a number of issues regarding CHC membership were raised that could be addressed with a set of guidelines. These are outlined below.

4.4.1. Guidance Required for the Selection Process, the Term of Office and Code of Conduct for the CHC Membership

The issue of CHC membership has been discussed previously (Chapter 4, Section 4.2). However, what became clear during the course of the focus group discussions was that there were further issues related to membership which, if clarified in a set of guidelines would assist in supporting the functioning of a CHC. For example apart from clarifying the composition of CHC membership, the selection process for community representation and term of office for such representation needs to be

outlined.

There is a currently a lack of clarity on the term of office of CHC members. It appears that no specifications have been given as to the length of term of office for CHC members. The Eastern Cape Health Act is confusing as it provides for appointments to the community structures to be made for a period of two years, and at the same time, the duration of the structure to be for no more than one year. In the past, it appeared that members were elected for two-year terms. This was mentioned by the longer-term CHC members and key informants. Currently in practice, however, this seldom seemed to be carried out. It appeared that elections were introduced in 1995 but were not sustained after that. In some instances, where elections were held post 1995, they did not endure for more than three two-year periods. During this time (in the late 1990s), volunteers were introduced at the clinics and other selection practices then developed. Key informants noted that without elections to replace and renew the membership of CHCs, instances of stagnation of the membership and of dwindling membership numbers within CHCs became commonplace. It may also have contributed to the demise of some of the CHCs. Selection practice has, in many instances, changed so that CHC members are often now recruited by either nursing staff or volunteers. The lack of continuity and absence of a formal process to replace 'old members' was a concern raised by a key informant:

> The problem is that some of the people which we started with in the 90s, some members are still there. And we never comply with the regulation because they are so good and committed that we don't want to part with them. So we don't come up

> with new people and then those old ones can be replaced. … And then that following the guidelines that people should serve in these committees for a certain period and after that 50% of them should be removed and have new people.

It seemed, too, that in the past, the progress of CHC members towards improved levels of skill which training programmes facilitated, had led to a members leaving the CHCs. This process had not been adequately monitored and managed so as to replace those CHC members who have left. The impact of this lack of planning was described by a key informant:

> And also it was our making as well. Because we said that if there are opportunities of job creation, the priority should be the people who are doing voluntary work – those health committee members. So some of them you find out they are employed by the department, some universities have given them some courses. So they are growing but we never managed that situation properly, once they moved. You get upward mobility and you never come up with new ones [replacement members of the CHC].

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Associated with membership to guide them in their performance, is a code of conduct. There is no such code of conduct for CHC members which establishes a set of standards to guide the members and to which they are required to comply. This was discussed in a focus group and by a key informant:

> That code of conduct needs to be stipulated. You cannot be part [of the CHCs] without a plan. So if you are taking that position, you need to know [that it is compliant with a code of conduct].

Also associated with membership and the effective functioning of the committee structure is governance. For the CHCs to function effectively, a small executive structure is required to facilitate and direct its smooth functioning. Most committees appear to have elected an executive committee structure with the portfolios of chairperson, vice-chairperson and secretary. Most committees had no treasurer, since it appeared that most did not administer funds. There seemed to be consensus that for the most part, these executive structures were operational. In the case of two CHCs, there was some indication that the governance functions and portfolio positions were not always clear. As one focus group discussion participant described:

> The chairperson is working as an individual, [he] goes to some places without notifying the committee, so people are afraid and when he comes with something, we must accept what he is saying and people are afraid to talk you know, and that is taking us to a lower level.

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<u>4.4.2. The Roles and Responsibilities of CHC Members Require Definition</u>

There are no guidelines which outline the exact roles and responsibilities of CHC members. A booklet produced by The Equity Project, entitled *Strengthening Community Participation in Health* (undated) directs each CHC to determine their own specific roles and functions. In practice, however, this appears not to have been implemented, and a common request from key informants and focus group participants was for clarification on the roles and responsibilities of CHC members. A key informant explained:

> Roles and responsibilities is a major problem. Because they [CHC members] don't seem

> to know or understand what is expected of them. At times they think they are there to police the nurses, they are watchdogs for the community against the nurses, monitoring for how long they have gone for tea. They are not there for that. They are there to bridge the gap, to bring the nurses and the community closer together. They are the middle men.

The *White Paper on the Transformation of the Health System in South Africa* (Department of Health, 1997) instructs that people should be afforded an opportunity to participate in the planning and provision of the health services, indicating a clear role for the CHCs. This would entail working in a cooperative way with the health services to develop an understanding of community needs and planning to address these. There was, however, no evidence of community participation in planning. Issues related to planning, such as resource allocation or budgeting at the health facilities, equally appeared not to involve CHC members. It seemed that facility and district-level budgeting and planning activities are conducted by health management alone, with little input or involvement from the CHC. A focus group participant illustrated this:

> We raised concerns about the budget with the clinic. Is the clinic not running on its own budget? But they [health facility management] are only requesting items from various sections [within the Health Directorate]. If they need someone, then they ask HR. If it's equipment, they will go to the building section. I don't have any answers to the budget concern. I thought to myself: 'Hey now I am bored that we as a community are unaware'. … And also we wanted to start something. So I would say the question of the Advisory Body that we requested some years ago, wherein there is this planning together. … That platform has long been requested [by CHC members].

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> … But that body never existed. Instead they are paying these consultants a lot of money to tell them what we have been telling them for many years. They don't listen to us.

A key informant confirmed this:

> That involvement of health committees in planning courses, programmes and brochures, when the department is, is not involving those health committees. They are doing it themselves, without the health committees. They [CHC members] must be there.

This issue was most starkly evident within the focus group discussions of CHC members. This was not so much in the content of discussion, but more in its omission from the content, specifically in relation to the discussions on roles and responsibilities related to co-operative governance. Thus, much of the discussion in the focus groups and within the meeting of the 'operational' CHC, centred on volunteer issues: lack of payment of stipends; problems with room space for counselling; increased training for volunteers to become multi-skilled; and perceived exploitation of volunteers. Issues related to health within the community and the issue of broader community participation were only raised at the prompting of the researcher.

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Key informants and focus group members spoke of the *potential* for CHC members to perform a monitoring role within facilities, ensuring that the quality of services being delivered are of acceptable quality and to the satisfaction of the local community. As

one key informant suggested:

> They are being used in campaigns and endorsing plans but they are never being capacitated to monitor the health outcomes, the performance of the clinic and the proper management of that clinic. So they are stuck there.

Some CHCs have remained involved in project work and a number of CHC-initiated projects were noted as being successful. In relation to this, various projects were described which aimed at addressing poverty within the local communities. Examples were provided of projects which have established and maintained vegetable gardens and soup kitchens at the health facilities. CHC members had successfully accessed funds and donations for these projects. Other projects promoted health, such as school awareness campaigns on HIV and AIDS and circumcision practise; CHC members conducted health promotion talks; they implemented litter clean-up campaigns within their neighbourhoods and hosted annual parties for clients with TB. The success of these projects was described with much pride by focus group participants. Projects and their successful implementation seemed to be important in encouraging and promoting CHC functioning.

There appeared to be some frustration amongst CHC members at not being able to raise funds. It appeared that in the past, CHC members had been supported by the health services to raise funds for projects. CHC members from the 'operative' CHC described their frustration at the lack of support from the health facility management in providing them with an official letter to support their fundraising efforts; without

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which they were unable to fundraise.

The more experienced CHC members expressed their concern that the roles and responsibilities of CHC members appeared to have diminished over time, and that the health services were not fully conversant with CHC roles and functions. One focus group participant expressed their frustration about this.

> If they can only allow us to be full participants of the health system and can recognise that we raise valid concerns of the day, then I think the health system will flourish.

4.4.3. The Channels of Communication within the Health Facility, Health District and with the Community Require Elaboration

There appears to be no formal procedure for communicating with the health facility, district health management and with the local community and as a result, the pattern of communication between the health service and the CHCs is inconsistent. As one focus group participant remarked:

> It's poor communication that's the main factor which makes the clinic committee ineffective.

Most committees, as currently composed, meet as a group regularly: some fortnightly and others monthly. Since it seems that health facility staff is not represented at CHC meetings, it appears that special arrangements have been made to communicate with them. One of the CHCs represented in the focus group met with the health facility management on a regular fortnightly basis and two other CHCs met with staff on a

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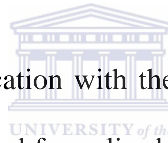
monthly basis. Other committees meet irregularly with staff and then seemingly 'as the need arises' (focus group member). Others still, have no formal structure for meeting with health facility staff: those volunteers seem to meet with the staff individually as they require.

Based on the accounts and experiences of CHC members and the existence of somewhat idiosyncratic communication arrangements between the health staff and the CHC members, the guidelines need to clearly indicate that the head of the health facility is a necessary membership component of the CHC. If health facility management is included in the CHC structure, communication between community members and health facility services would be immediately be improved.



In addition, channels of communication with the community appear to be even less organised. There appear to be limited formalised procedures for community members to communicate and express their needs and interests. Suggestion boxes are available at all health facilities for community members to communicate with the health services. They appear to be utilised to a limited extent, but they exclude those who are illiterate from voicing their concerns.

There was no evidence from the focus group discussions or the key informant interviews that any consultation with surrounding communities was occurring. When the issue was raised by the researcher, CHC members appeared to be satisfied that their residence within the locale of the health facility provided them sufficient access

to information on community health-related needs and interests. There appeared to be no attempts through meetings with the local community or its structures to gain other relevant information about community members' health status, their opinions about the facility and its services or their level of information about key health issues. Within the study sample of CHC members interviewed, none of them had held public meetings to engage with their constituencies. It appeared, too, that there was no mechanism to ensure that the voice of the most vulnerable within the communities was able to be articulated.

Despite these gaps, CHC members in the focus group discussions seemed to be comfortable that community interests were reflected within the CHC meetings and relayed into the health facilities. They were satisfied that they had community interests at heart and would reflect these to health facility staff as required. No one, however, reflected on the fact that this approach was dependent on the willingness and the discretion of the CHC member to raise a particular concern in the first place, and that there was no system in place to make sure such a concern, in fact, reached the health services, leaving significant opportunities for concerns and issues to be overlooked. A focus group member explained the current operations:

> Members of our community all know us because they see us [as volunteers] at the clinic every day. When they have problems they come to our houses and we help them. Sometimes we bring their problems to the clinic but otherwise we just look after them our selves.

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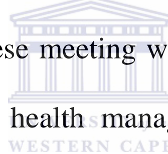
Given the lack of activities and information about CHCs, it is likely that communities and their organisational structures have limited, if any understanding of CHCs and their functioning. There was seemingly no marketing of CHCs within the health facilities. A focus group participant tried to illustrate his frustration at the consequences that communities were not aware of the potential role of CHCs:

> At one time we invited street committees to be part and parcel of our health structure at our clinic and there was three or four guys that came along and all of a sudden they disappeared. ….. And ja, the people do not, they are not eager to be on that board but I'm still trying and praying and asking God but why are my people like that.

Opportunities are provided for communication with the District Health Management at quarterly meetings and an annual summit. Representatives from each CHC within the district are invited to attend these meeting with the Executive Director of Health of municipal health services and health management staff with the intention of exchanging information. Whilst representatives from the CHCs have an opportunity to ask questions and raise issues, there is no formalised system of presenting reports at the quarterly meetings. The Health Summit provides an opportunity for the three sub-districts to present reports. However, with the community tier of CHCs functioning ineffectively, the subsequent tiers are also rendered ineffective in adequately and accurately conveying broader community concerns. It appears that no mechanism exists for formalised community representation to be elevated to provincial level. The guidelines for CHCs would, thus, also need to include and specify the terms and operationalisation of community representation at the district and potentially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provincial levels.

Whilst the quarterly meeting with the District Health Management has the potential to be a most useful platform for reporting and monitoring, it seems that the CHC members believe it serves more for the Municipal Health Department to disseminate information and answer questions from the CHC representatives. It seems that it does not provide an opportunity for formalised reporting and monitoring of the structures.

4.4.4. A Mechanism for Monitoring the Input and Activities of CHCs Ought to be Outlined

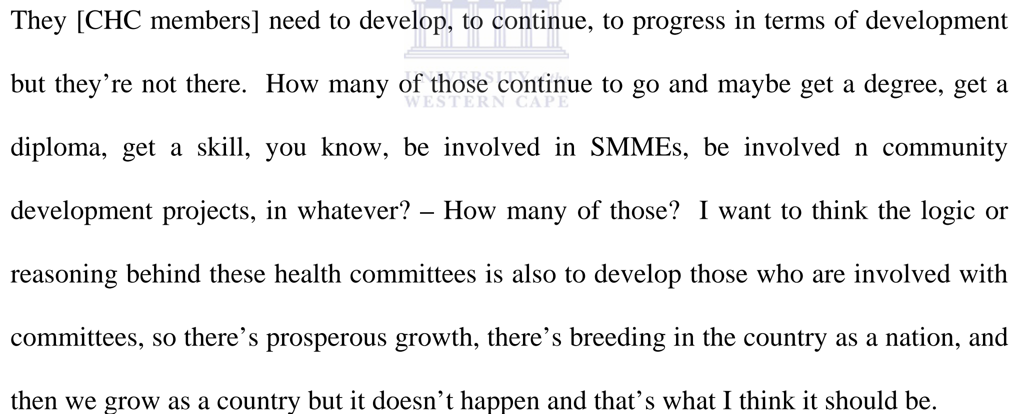
CHC members discussed their frustrations at having no formal channels for the reporting of problems, monitoring of health service responses and more importantly, for follow-up when matters are not properly handled. The following account by a focus group participant provides an indication of this frustration and demonstrates, too, the potential of community participation in being able to avert a crisis.

> I live in *X informal settlement*. It's a squatter area, you know. All our houses are tin. I reported that there was a problem in our area with the children and their running stomachs. I noticed that there were 2, 3, 6 children in my area with this thing, diarrhoea. Then there were a lot with this running stomach. I reported [this information] to the clinic. I reported to the sister-in-charge but nothing happened. 'Til today nothing has happened. They tell me it's the toilets but we have long time had those toilets. It's not the buckets. It's those ones with the holes in the ground. They have not bothered to come. And there is nothing I can do further.

Monitoring of the functioning of the CHC does not appear to be occurring. The *Clinic Supervisor's Manual* (Department of Health, 2003) provides some detail for the oversight and monitoring of the CHC. It indicates that checks are required to be made with the health facility management that the CHC is operative, but this monitoring does not seem to be put into effect. So whilst it would seem that a system has been designed, its implementation is not operationalised.

4.4.5. CHCs Ought to Provide Capacity Building Opportunities for CHC Members

There seemed to be consensus from both key informants and CHC members interviewed, especially those more experienced in working with or being part of the CHCs that CHCs ought to provide a platform for people to grow and develop skills. A key informant explained:



> They [CHC members] need to develop, to continue, to progress in terms of development but they're not there. How many of those continue to go and maybe get a degree, get a diploma, get a skill, you know, be involved in SMMEs, be involved n community development projects, in whatever? – How many of those? I want to think the logic or reasoning behind these health committees is also to develop those who are involved with committees, so there's prosperous growth, there's breeding in the country as a nation, and then we grow as a country but it doesn't happen and that's what I think it should be.

A focus group participant concurred:

> Because after the volunteers have been trained, they are not being placed in positions where they can exercise their skills. That was always the understanding. Instead they are just left and dumped there. … Because we can relay to our community members, you can

> get involved and do this voluntary work, maybe you will be trained, and you can help your community you know and be like me, I am today. … So you cannot tell a community member that because you are going to come to a stop and say 'I am a volunteer'.

A key informant explained how in the past opportunities were made available:

> We developed them a lot. Many of them are in business, social services, the department. Others are Pharmacy assistants, others are DOT supporters, others are still in one place (and they always complain). It's supposed to be like that. There must be upward movement.

Whilst it appears that there are discrepancies in the views expressed about whether sufficient opportunities for CHC members are being created, it was apparent that in the past, there had been some progression and increase in levels of skill and capacity of CHC membership. A key informant, a former CHC member who had progressed to the position of an NGO manager was an indication that such a system could work effectively. It seemed, however, from the accounts of the CHC members that there was less opportunity currently.

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4.4.6. Clarification on the Issue of Stipend Provision for CHC Members

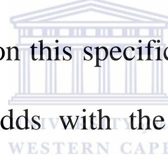
No provision is made for CHC members to receive a stipend for their participation as members of a CHC. The Eastern Cape Provincial Health Act makes allowance for disbursements to cover travel expenses associated with CHC meetings; it seemed

however that none of the CHC members received these disbursements.

Some health volunteers receive a stipend but not all health volunteers receive one. Those volunteers without a stipend seem to remain within the system because of the promise of one. This issue has caused conflict and been very divisive since it was introduced in 2004. A CHC member explained:

> When they [stipends] were introduced, it didn't come for all volunteers or CHC members. It only affected certain individuals. So others didn't get stipend and others did get stipend. When the question of stipend arrived, it was very divisive, and others left the clinic.

The guidelines discussed above, which would serve to support the operationalisation of CHCs, ought to provide clarity on this specific issue, especially since it appears to be common practice, but is at odds with the more traditional understanding of community representation, as outlined in the policy documents .

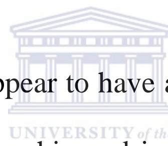


<u>4.4.7. The Resources Available to Support the Effective Functioning of CHCs should be Clarified</u>

Whilst a key informant argued that there were only limited resources that were required for effective CHC functioning, CHC members were clear that they do not have access to necessary resources. Focus group participants mentioned items, such as diaries, stationery, name tags, and access to telephones as requirements for their effective functioning. They indicated their frustration at not being availed of these

resources, especially since as these were perceived to be “easy items for the health services” (a focus group participant). It appeared that in many of the facilities, space was a constraint, which meant that there was no office or meeting room available for CHCs.

The Provincial Health Act (10 of 1999) requires that CHCs prepare and submit an annual report to the MEC. Whilst it appears that CHCs have not been meeting this requirement, the production of such report would require access to some resources. It would also require that CHC members were sufficiently assisted or competent to produce such a report. There seem to be no specific staff delegated to attend to and support effective CHC functioning.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Very few current CHC members appear to have access to and be aware of legislation and policies governing their membership and involvement at health facilities. When asked in the focus group discussions if they were aware of the National Health Act (61, 2003) and its requirements for a “Clinic Committee,” most were not aware. Some believed their involvement in the committee was because of their volunteerism, and had limited understanding of their potential further roles and functioning.

Only a few of the more experienced members were aware of the legislation, and the membership requirements for a committee. These members feel used by the health system in meeting community participation requirements. An experienced CHC member and focus group participant explained how this was evidenced:

> A lot of what we are doing is for paper [to meet the health facility requirements]. Actual implementation doesn't take place. … If they [health facility staff] cannot move without me, why are they always asking for my presence at meetings. … Sometimes they need to write a document to Bhisho [Provincial Head Office] and it [is required to] indicates that the community members were present.

CHC members indicated their willingness to participate in community-led projects, especially those aimed at addressing public health needs. In order for them to successfully implement such projects, they would require the support and assistance of the health services. In some instances this required their networking with other government services. An example was provided of the supply of free seeds by the Department of Agriculture. To obtain the seeds required the liaison of the health facility staff with the relevant Department of Agriculture officials. If this was not undertaken, the seeds were not acquired. Thus, there is an uneven spread of food gardens at the health facilities, dependent on a variety of factors, including staff motivation, networking and liaison.

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Access to training to improve levels of skill and build capacity as a necessary resource requirement for the effective functioning of the committees has been discussed earlier in Section 4.5.

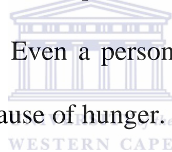
As has been mentioned earlier, the limited staffing, particularly within the Health Promotion Programme, means that there is limited supervision and support for CHCs.

In effect, there is no designated responsibility for individual CHCs; therefore, their requirements and support for effective functioning are neglected.

4.5. The Socio-Economic and Political Contexts in which CHCs Operate

At each interview and within both focus group discussions, the issue of poverty was raised. Both focus group participants and key informants were concerned that poverty and an unequal distribution of wealth within communities inhibited effective community participation and effective CHC functioning. A focus group participant described:

> The other thing – the patients are there, there's a lot of poverty there because we are living in a very small house there in Extension *X informal settlement*, and really near *Y,* [a well known informal setttlement], that is a shack area too and *Z area* too. Even they are suffering of hunger. Even a person who is allowed TB treatment doesn't want to drink those tablets because of hunger.



A key informant concurred:

> To me this whole thing why CHCs aren't functioning properly, it's poverty related…. So there is so much unemployment and the socio-economic status it is also contributing.

The consequences of poverty were expressed by focus group participants, commenting on an informal settlement within New Brighton, (a township suburb of Port Elizabeth) which is characterised by poor infrastructure and the bucket systems for sewerage:

> I was exposed to these people in the communities who are sick and because New

> Brighton consists of Red Location, White Location, all those areas, so people were not working, people are highly sick in that area – even today, I think they are still.

There was a sense from key informants and CHC members that volunteering in its traditional sense of working for no reward, was waning. There is an expectation that such volunteering should be reimbursed with stipends. From some key informants, there was a perception that community members were not prepared to provide their services for no reward. The introduction of the stipend for volunteers was considered to have exacerbated this perception as there was now an expectation of incentives for any assistance being offered to the health services. A key informant explained:

> And then the socio-economic context where people don't want to do nothing for nothing. 'What am I going to get?' 'I have been a committee member for so long what is being done about us?' They end up confusing a committee member and a volunteer.

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CHC members explained that with the introduction of stipends, most volunteers and CHC members that were excluded from receipt of the stipend, left the health facilities.

4.5.1. The Current Political Context has an Impact on CHC Functioning

There was a common perception that the current political context was not conducive to voluntary community participation. This was highlighted by a key informant as the most critical issue related to CHC functioning. In subsequent interviews and focus group discussions, when asking about this aspect, participants confirmed and elaborated on its relevance. The key informant described that when CHCs were first

introduced in 1995 and continuing into the first part of the decade, the political context was conducive to the flourishing and growth of CHCs. Government was perceived to be oriented toward service delivery, there was a sense of optimism and communities believed there was opportunity for transformation and change. CHC members saw themselves as important and instrumental to that process. One of the focus group participants described this as follows:

> So we were all in this thing, this time of change in the country at that time, to say: let us be involved. And so we came with that passion, that energy that encourages you to say: 'Hey, this is a chance. This is our government, where we can be involved. Let us change the system.' Our mandate was to transform the system, the health fraternity, to say: 'It's a community service. People are entitled to the service and we can do it – nobody else!'

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In 2001, the president of the country, Mr Thabo Mbeki, made a call for community members to volunteer "in the spirit of *Letsema*," [meaning collective effort] and communities responded. A CHC member explained this as follows:

> President Mbeki made a statement that South Africans need to be involved in government structures to assist government in the spirit of helping. In those days the forums that were developed really clicked: community forums and police forums, you name them, they started then, that was 2000, 2001 … And we all went there.

One of the key informants was a nursing sister at the time and explained:

> We had a lot of work to do motivating them [community members] because we were introducing something new. But on grasping the concept and because of the political

climate at that time, a person was keen to work for her community.

The political context, however, is perceived to have changed so that community members no longer feel motivated to volunteer and participate in community structures. A key informant was articulate in describing this:

> Participatory democracy means that it is from the bottom up. It is not the other way round, from higher authority downwards, which is happening now. It should not happen that way. …… We participated then in that democracy. So now the rules have changed. What is happening is that people are demotivated. They are dejected. There is a lot of corruption in the country. People that the community looks upon, these influential leaders, so how do you then ask them [community members] again to go and volunteer when they're not getting anything? … Nowadays everybody wants to be a contractor. Everybody wants to have a company. Everybody wants BEE, and it doesn't assist. And the politics of the country have changed in that our leaders that were respected are involved in such criminal activities. Those things do filter right down to our communities.

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A focus group participant described it similarly:

> The government initiated the right plan with the right approach, but the people to implement this for the government were the wrong people. Politics, the question of nepotism, corruption, contributed. Mismanagement of funds, all such things contributed. So people will never volunteer for that thing because they can see that people are enriching themselves out of those volunteers. Because everything should be transparent to people now.

This current political climate is being experienced at a local level where people feel they do not have access to their local representatives. A CHC member described the following:

> Councillors are supposed to be community people who are going door-to-door. They are supposed to be people who don't even have cars. How are they seen when they drive cars? I mean he comes out of his garage and goes to the council and talks for the whole day, the whole week in meetings. Weekends he goes away with his or her family.

Ward committee structures, as a conduit for community health concerns to be channelled into the municipality, were perceived by focus group members and key informants to be in disarray. Ward committee members were apparently frequently not known to local communities.

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Within NMBM, the Mayor and executive committee members host annual local *Imbizos*. These meetings serve to provide opportunities for communities to meet with elected officials to exchange and share information. They provide an opportunity for the CHCs to voice their concerns. None of the CHC members mentioned their attendance at them. They seemed also not to be aware of the potential impact they could make to the IDP process through the ward committees and IDP consultation processes within NMBM.

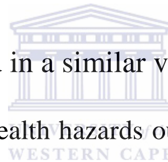
4.6. A Strong Commitment by CHC Members versus a Lack of Recognition for their Efforts

All the factors described above seem to weigh heavily and impact upon CHC

members, who describe their experience as a lack of recognition from health services. Lack of recognition and acknowledgement were the most frequently heard frustrations raised by CHC members in the process of the interviews and focus groups. Members felt they were not given credit for the ongoing assistance and were not taken seriously by the health authorities. They felt that their assistance required much commitment, both as a volunteer and CHC member.

A former CHC member talking of his experience between 1998 and 2006 explained:

> It was an issue that was close to our hearts and is still close to my heart and I think if we didn't have the passion and the heart to do it, we would not have done it because it was extremely difficult.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A focus group participant explained in a similar vein:

> I wanted to help. There are health hazards out there. People in my area were dying of HIV and TB and I wanted more knowledge. I had to do this for my community. If I didn't do this, then who will? I can't expect this from the other people if I can't do this.

Alongside commitment, the members demonstrated an immense capacity for being generous. A common feature of the focus group participants was not only to provide emotional support, but to provide materially to their clients. This is illustrated by a CHC member:

> I came to the clinic and I asked the sister, because I've got four patients that was HIV

> positive and the clinic sister didn't even know about it. I had to bring the patients to the clinic, have them tested, get a bed for them at the House of Resurrection [A residential care centre and hospice for people living with HIV and AIDs]. I even took it out of my own pocket – money to get transport for them to take them there. I gave R10 for a face cloth, soap, gave something like a nightie or something to wear because there's nothing like that there. And this community really, our health committee in *X community* are very strong because of what the volunteers do for the community outside.

The commitment CHC members perceived to be an essential factor for successful CHC functioning is in stark contrast to the lack of recognition that CHC members perceive and repeatedly articulate.

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A focus group participant explained:

> The other reason why it's not working effectively is that volunteering is not being promoted in the department due to the fact that people from the clinic and volunteers because of what they are seeing, and how we feel inside. So we won't have too many chances for recruiting other people because there are also staff inside that will cause other members to leave voluntary work.

CHC members complain that their voice is not being heard by health authorities:

> Requests that we made four years ago are the same requests we make today.

These are small requests for diaries, stationery and name tags.

CHC members appear to feel they are being used by health facility staff to satisfy statutory requirements of community participation. A CHC member put it succinctly:

> They [the staff] ask us to participate so that we can put management's records straight.

CHC members understand that the relationship with the health facility should be mutually beneficial and a constructive partnership but claim that this is lacking:

> We are in partnership with management that is Department of Health. Our partner doesn't actually encourage or motivate those who are on board to sustain us.

The impact of the lack of recognition is a stagnation of the structures, since CHC members describe a reluctance to recruit new community members and advocate for CHCs. This was described by a key informant:

> For now to go and ask people and call people to a clinic from their houses and ask them to volunteer their services ….`What do I have to offer?' 'What does this institution which is Health, this public sector, have to offer these people?' 'What does it have to offer?' That's the question really. – And the answer is 'Nothing, not even recognition'.

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This was confirmed by a current CHC member:

> There are no incentives for people who are doing volunteer work to recruit much more better. Because when you are recruiting someone in a desert area that person will never be motivated, to be eager to you as they can see you are not in a happy position yourself. You are talking about problems instead of recruiting.

A further consequence of the current lack of recognition was that CHC members

expressed feeling demotivated and even abused. One focus group participant described this as follows:

> People are feeling abused. There is a general feeling that volunteers are being abused by the Health Department. Let alone that we find in other departments even within the Metro some other departments treat volunteers in a very different way. There's no question of transport. They are being trained. When there are vacancies, they are being placed within departments.

It was evident that this issue of recognition needs to be considered seriously by the health services. The contribution and voice of the CHC members need to be acknowledged and 'heard' by the health service. This would not only be of benefit in terms of CHC sustainability, but also community participation in health as an essential principle of primary health care – and one which the provincial and local health services ought to be embracing.

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4.7. Summary of Results

The key themes that have emerged from the research findings indicate a broad spectrum of factors affecting the functioning of CHCs. These range from the contextual external factors of the poor socio-economic conditions, as well as the perceived change in the political context; to those within the health services. It seems apparent that it is a whole system for the operationalisation of CHCs that is malfunctioning. Within this, factors such as a lack of district management support, a poorly resourced health promotion team and health facility staff shortages inhibit

effective CHC functioning. Findings included a more general lack of coordination, support and guidance for CHC functioning. The membership composition of CHC has shifted to include health volunteers only, omitting the head of the health facility and local government councillor. There was also found to be a lack of sufficient guidelines to direct the operationalisation of CHCs. Within the CHCs, there were challenges from the membership, who perceived the failure of a system as a reflection of a lack of recognition from the health services for the contribution they make. Together these factors contribute to the poor performance and functioning of CHCs within NMBM.

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CHAPTER 5: DISCUSSION

5.1. Introduction

This study set out to understand the factors related to the effective and sustainable functioning of CHCs in Nelson Mandela Bay Municipality, Eastern Cape, South Africa. Despite there being broad consensus about the critical role that community participation structures like CHCs play in supporting health development, both within the international literature and within the South African health policy framework, its operationalisation within the study site appeared to be beset with problems.

A range of factors related to the functioning of CHCs has been determined through the focus group discussions and key informant interview process. These factors were categorised into key themes, which have been found to be mostly inhibitory, addressing the issues which prevent and hinder the adequate and effective functioning of the CHCs. Given that the municipal health department considered that over 50% of the health facilities in the study site do not have community representation and participation via the CHCs; and the findings of this study indicating that even those CHCs considered to be functioning effectively are not adhering to the spirit of community participation policies; it followed that more inhibitory than promotive factors were elicited. It was seemingly easier for the participants to identify the factors contributing to the breakdown of the system for community participation than to identify those factors promoting the growth and development of the CHCs. This appeared to reflect the participants' experience of the limited functioning of CHCs.

Understanding the linkages and relationships between the factors and comparing these with other studies will serve to assist in developing a deeper understanding of those factors and assist in generating recommendations to strengthen the functioning of CHCs in the future.

The following diagram provides a schematic representation of the findings of this research study, indicating the gap between the policy framework and its implementation in practice. Importantly, the diagram identifies the context and the factors which largely serve to inhibit the effective functioning of CHCs, and contribute to maintaining this poor translation of policy into practice.

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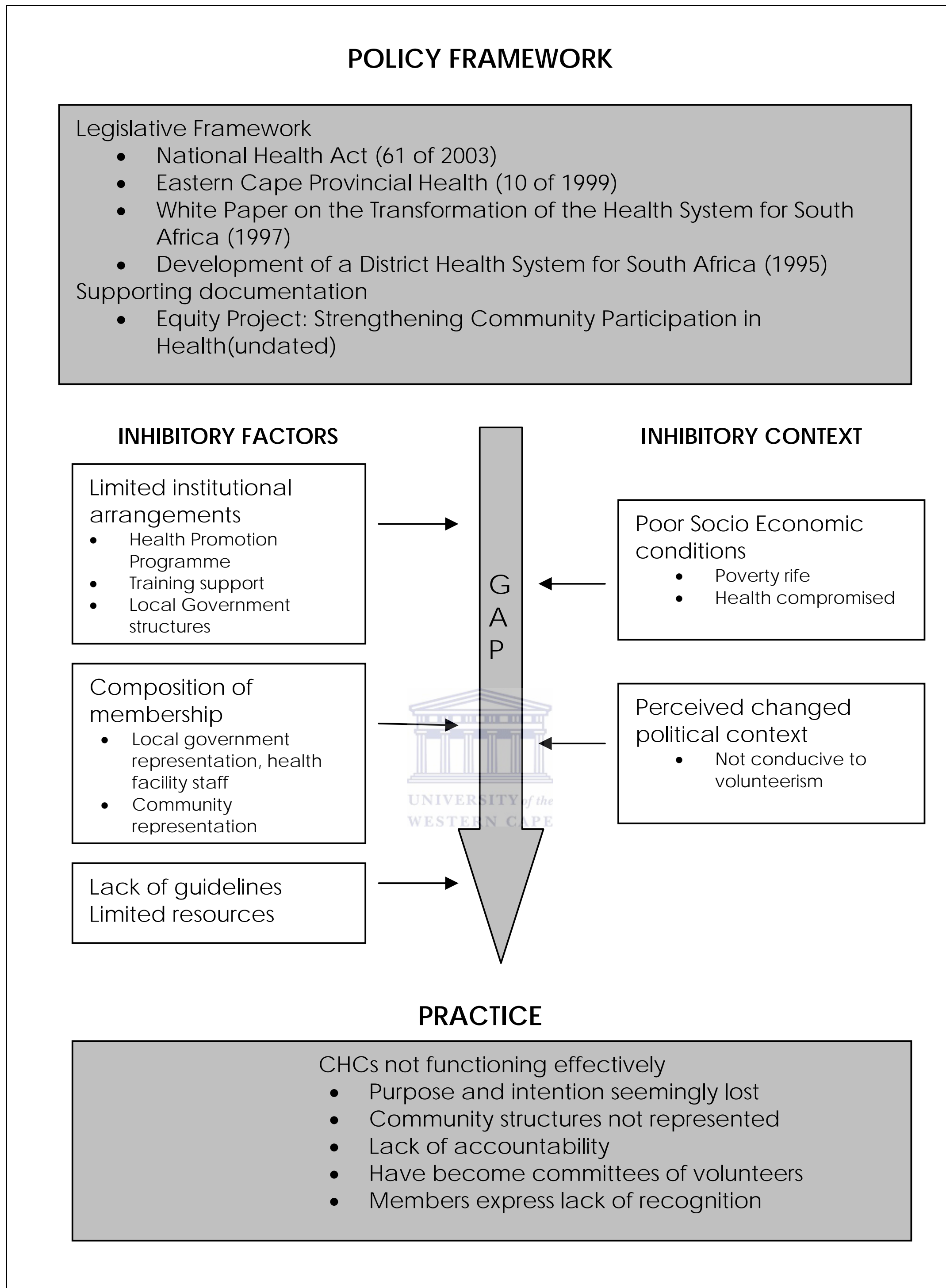

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DIAGRAM 1: The gap between formalised community participation policy and current practice, with contributory inhibitory context and factors

5.2. The Gap between the Policy Framework and the Practice of CHCs.

As has been outlined already, commitment to community participation, through PHC and the District Health System, is unequivocal. The National Health Act (61 of 2003) legislates for the existence of 'clinic committees' but delegates terms of reference to the Provinces. The Eastern Cape Provincial Health Act (10 of 1999) provides for the establishment of Community Health Committees but defers establishment of Terms of Reference to later legislation. Whilst the Eastern Cape DoH is in the process of generating guidelines for Community Health Committees, the process has been ongoing for more than a year and a hiatus remains in this regard. Whilst gaps exist within the current legislative framework and policy papers, they are none-the-less clear in their support for CHCs and provide some detail on the implementation strategies.

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Levers *et al* (2006:17) in their literature review on district health systems found a "huge gap" between policy and practice with regard to community participation.

> Government documents encourage community participation with few indicators for translating the ideals about community participation into reality.

Whilst it would appear from their review that Levers *et al.* (2006) found insufficient evidence of opportunity and mechanisms for community participation, this does not appear relevant to the South African context. They state that:

> 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. (Levers *et al.* 2006:2)

Within the South African context, the mechanisms for community participation are explicit. It appears, however, that there is insufficient management and monitoring to ensure that the policies are being implemented as they were intended. More relevant to this study is the finding of Levers *et al.* (2006:2) that:

> 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.

It would appear that the CHCs, as they are currently operating within NMBM, have become "socially constructed" and are, indeed, obscuring the "authentic process."

Baéz and Barron (2006: 34) have a slightly different understanding of policy-related problems. They state that it is policy interpretation at the level of the district that is of importance, but that essentially, community participation has not been prioritised:

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> District health structures' main potential area of flexibility is in designing strategies to implement policy … the introduction of local-level governance structures was envisaged as part of an operational strategy within the health reforms, to handle the new locally generated resources in a relatively more autonomous way, to achieve what government could not, namely to provide more cost effective and efficient services. However, the original rationale for the PHC approach of promoting community participation in order to empower individual and communities, and strengthen the democratic process, has not appeared to be a priority.

Although not specified by any of the participants of this study, the current practice of

CHCs does not match the expectations and intention of the policies. Between the policy framework and the practice of CHCs, there is a disjuncture. Whilst the current structures at the facilities provide for limited compliance with legislation, they are seemingly not functioning as intended. A simple example where the policy has not been translated into practice is provided on the issue of community representation. The *White Paper on the Transformation of the Health System in South Africa* (Department of Health, 1997) clearly states that communities should elect individuals to represent them on CHCs. At none of the facilities within the study was there evidence of broader community involvement in election procedures and representative legitimacy. It appears as though the details of the policies, now more than ten years in existence, have not been a priority, and that only limited aspects of those policies remain in practice.

The factors contributing to the disjuncture between policy and practice as indicated in Diagram 1 are the factors identified within this study: namely, the membership composition of CHCs, which has become distorted; limited institutional arrangements for support and coordination of CHCs; and an absence of guidelines and limited resources that contribute to the undermining of the policies. The political and socio-economic contexts were identified as contributing negatively and inhibiting the effective functioning of the CHCS. Within this context, it is possible for CHCs to assume a form different from the original intention, and become "socially constructed". This gap between policy and practice has also been described by Loewenson *et al.* (2004) and Ngulube *et al.* (2004) as leading to a distortion in

practice of the original intention of the policy.

5.2.1. Current CHC Practice Provides for Limited Compliance with Legislation but Lacks Commitment

The presence of CHCs at the health facilities ensures limited compliance with the legislation. Both a health facility supervisor and the manager can be satisfied that the necessary policy requirements have been met, despite their intended purpose being ignored. This issue of compliance versus commitment has been documented previously by Werner and Sanders (1997: 102):

> Although the rhetoric of participation and empowerment proliferated, in policy implementation emphasis shifted from encouraging the strong participation of decision-making control to the weak participation of compliance.

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This limited compliance to legislation without the health services commitment is evidenced in the limited support from health services for CHCs and leads to the current weakened CHC functioning.

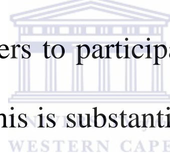
The CHC members, however, were clear that they were committed and were prepared to adapt and improve CHC functioning as required. This strong commitment is also required from the health services, demonstrating their commitment to community participation, and investing in the growth and development of CHCs. In practice, this means that the health services have to develop confidence and trust in communities, believing that they are capable of delivery. For the health services, this means investing in training, resources and development to ensure that CHCs are sufficiently

skills-resourced to function effectively.

Baéz and Baron (2006: 21) indicate the commitment that is required in delegating authority to the level of the community:

> It seems that national-level health planners' and policy makers' interpretation of decentralisation and community participation is reflected in the way that authority is granted in practice to the lower levels. This lack of clarity often acts as a barrier to community participation.

An example to illustrate this point is of the limited authority for CHCs in planning. The *White Paper for the Transformation of the Health System in South Africa* (Department of Health, 1997: 20) is clear: "… community health committees should be established to permit service users to participate in the planning and provision of services in the health facilities". This is substantiated in the literature where planning to meet the needs of the local community is a vital function, and against which levels of functioning can be assessed. (Baum and Kahssay, 1999; Loewenson *et al.* 2004; Ngulube *et al.* 2004.) Within the participating CHCs, there was no indication that any integrated planning for health services was taking place. Given the problems with staff shortages and budgeting being conducted at the level of the district, CHC members may be justified in feeling that the scope for their involvement is limited. Certainly the indication from CHC members was that decentralisation practices stopped at the level of the district.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5.2.2 Revisiting and Popularising the Legal Framework.

It was apparent from the study that the key policy documents relating to CHCs are not made available to CHC members. It was only the more experienced members of CHCs who had participated in training programmes in the late 1990s, who were aware of the policy framework for CHCs, had a good grasp of the intention of CHCs and understood the current shortfall in practice. Otherwise, most of the CHC members who participated within this study seemed to be unaware of the current CHC guideline development process, which had at the outset involved a few stakeholders within NMBM, including one of the CHC members interviewed.

Given the current state of CHCs, it would appear that it was not only CHC members who were unaware of the existence of the Department of Health's policy framework for community participation. It appeared that even with those within the Municipal Health Directorate too were not utilising the existing policy framework to guide their practice. Thus, it seems that health policies for CHCs need to be revisited to build towards committed compliance from the health services of the policy framework.

5.2.3. A Discrepancy in the Policies of the Naming of the CHCs

An additional issue which is of importance as it seems to symbolise the problems being experienced by CHCs, is the discrepancy within the policy framework of the nomenclature for the CHCs. The National Health Act (61 of 2003) adopts the term "clinic committees." Other policy documents and the Eastern Cape Provincial Health Act (10 of 1999) refer to Community Health Committees. Common practice within

NMBM appears to be to call these community participation structures "clinic committees". There is an obvious bias within the latter name, suggesting that the committee is there to support for the health facility. The term "Community Health Committee" more accurately describes the structures' intended purpose, conveying the spirit of inclusion and a partnership with the community. There is, thus, at present discordance between the National Health Act and its supporting policy documents and legislation at provincial level in terms of the terminology being used to describe these formalised community structures.

5.3. Institutional Arrangements for the Support and Co-ordination of CHCs

In terms of the operationalisation of the CHCs, it is necessary to locate the responsibilities for CHC functioning within a specific portfolio within the Health Directorate. The hub of the co-ordination and support for CHC functioning is at present the Health Promotion Programme within the Municipal Health Department. It is served by a single manager without additional support and is, therefore, severely under-resourced, given that 41 of the 52 health facilities fall directly under that management. The Municipal Health Directorate's collaboration with the Provincial Department of Health in NMBM, in terms of 'functional integration' has to date, been minimal.

A minimum service is, thus, being provided by the Health Promotion Programme, which is essentially translated into compliance with its annual requirements of hosting three 'quarterly' meetings and one summit for CHCs annually. Whilst this is an

important aspect of the tiered system of representation for CHCs as it offers a platform for representation to the district, with the current state of CHCs, it serves little more than a forum for volunteers, namely the TB DOT Supporters, lay counsellors, and home-based carers who are in receipt of a stipend. Whilst this is useful for volunteers, providing opportunities to meet together and engage with the Municipal Health Management, it does not fulfil the requirements of promoting *broader* community participation in health.

The relationship between the Health Promotion Programme and CHCs, therefore, remains superficial as it only interacts with representatives of CHCs at quarterly meetings and has no further contact with CHC members between these meetings. There is no additional management or monitoring of CHCs from the district. This allows for "socially constructed" (Levers *et al.* 2006:2) adaptations of the committee structure to unfold and to continue unnoticed by District Health Management.

With a well-resourced coordination hub, such as the Health Promotion Programme, some of the factors hindering the development and effective functioning of the CHCs, within the institutional arrangements can be minimised:

- A budget for training and capacity development can be obtained and an NGO appointed to deliver requisite training and support for the CHCs. The NGO can be commissioned to assist with the further drafting of CHC guidelines. Mentoring and evaluation can be ongoing;
- Staff training related to community participation structures can be co-

ordinated;

- Liaison with the Health Councillor and Constituency Office for political support by ward councillors and ward committees can be established; and
- Intersectoral collaboration within and via the CHCs can be promoted.

The Health Promotion Programme, which should serve as the champion for CHCs within the district, has seemingly been rendered ineffective. Without a vibrant, well-staffed and resourced Health Promotion Programme, CHCs cannot function effectively. In addition, the lack of staffing and resources for the Health Promotion Programme creates the impression that the Municipal Health Directorate is not absolutely committed to community participation in health. The creation of the single post of Health Promotion Manager, who apart from his/her other health promotion activities, also has to support and manage 41 CHCs seems at very least to indicate a token commitment to operationalising the policy and principles related to community participation in health.

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The situation, however, is not without remediation. Zakus and Lysack (1998:4) provide an optimistic note:

> The organisation charged with implementing community participation activities must also be sensitive, open and knowledgeable about collaboration and coordination with other individuals and programmes, skills which if not present initially can be taught and learned.

The Municipal Health Budget and its constraints have not been explored within this study. It would be most useful to understand the health budget history and current budgetary allocations to have a better understanding of the municipal health priorities and constraints and how these may have shifted over time. This illustrates a limitation of this study.

5.4. The Composition of the Membership of the CHCs

The findings of this study indicate that even those committees that were considered to be operative are not fulfilling their intended purpose. They have become committees of paid-volunteers, who might by default address some of the expressed needs of the community, but whose main purpose is seemingly to fulfil community-based outreach activities of the health facility and represent the interests of their fellow volunteers. The current composition of the CHCs, with the majority of members being paid volunteers, presented the most compelling evidence of the functional disarray of the CHCs.

5.4.1. The Health Volunteers

The health volunteers are in a vulnerable position. Either they receive a stipend or await the promise of a stipend for their daily assistance at the clinic. Because of the socio-economic conditions of poverty and large-scale unemployment, even a small income is important and is jealously guarded. Challenging the system that provides the stipend is potentially hazardous for the volunteer; therefore, current health volunteers cannot be regarded as neutral or independent. They are an extension of the

clinics' health service provision, and are supervised as such by staff. Volunteers, therefore, cannot represent the community's needs and interests at the health facility.

It appears that the introduction of the volunteers' stipend in 2004 served to decrease community participation, and, therefore, inhibit effective CHC functioning. CHC members concurred that at its introduction, those who were seemingly unlucky in not receiving a stipend, whether a health volunteer or CHC member, left the service of the health facilities. The system for the selection of recipients of the stipend at that time, according to the CHC members interviewed, was without criteria and was regarded as lacking in transparency and being grossly unfair. Whilst criteria have subsequently been issued, the volunteers have already been selected. This stipend-related problem has occurred in Zimbabwe and been documented by Sanders (1992: 212):

> In the words of an organiser of the Bondolfi VHW [Village Health worker] scheme: 'When the government started the scheme and some [volunteers] were paid 33 dollars a month, others stopped working because they were not being paid.' Although there are other reasons, this factor was undoubtedly significant in the slow demise of the Bondolfi programme.

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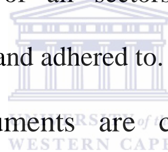
The health volunteers have many grievances and require a system to represent their interests. Whilst a functional CHC system would provide the opportunity to channel volunteers' concerns and needs, in its absence, the volunteers have availed of the opportunity presented by the CHCs. In the process, however, because of the vulnerable position of the volunteer, the potential power of the CHC has been eroded,

and the voice of the volunteer is, in fact, rendered very weak. Whilst their grievances are heard at the level of the district through the quarterly and annual summits, without a powerful representative base, their voice can be ignored.

5.4.2. Accountable Community Representation

What is unequivocal from key informants and experienced CHC members, is that members of CHCs should be *elected* representatives of structures within the local community. This is confirmed by Baum, 1998; Baum and Kahssay, 1999; Bracht *et al.* 1999; Loewensen 2004; Sanders, 1998; Torimo and Fowkes, 1989. Baéz and Barron (2006: 24) clearly articulate:

> … genuine democratic representation requires that clear selection criteria, that take into account representation of all sectors of society, in particular the most disadvantaged, be established and adhered to.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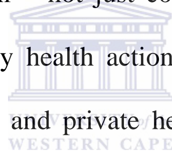
The South African policy documents are clear that accountable community representation is expected from the CHCs. Without it, communities remain unaware of the opportunities for participation and remain recipients of health services rather than active participants "negotiating the essential PHC package, … to ensure that priorities perceived by the communities are addressed and that communities have a clear understanding of their entitlements." (*White Paper on the Transformation of the Health System in South Africa*. Department of Health, 1997: 20). Clearly the current system is failing the local community at the health facilities.

The community membership composition of CHCs not only inhibits their effective

functioning at the local level but has ramifications at the elevated tiers of potential representation, for the voice of the community is then not articulated into the Provincial and National Health Department. Baéz and Barron (2006) indicate that the Provincial Health Councils may provide an opportunity for community voice, but are still in process of being established and implemented; therefore, there is as yet no indication of community voice at this level. Whilst it appears that these channels are indeed lacking, with a vibrant local CHC, members could be lobbying and advocating for this improvement, but without it, the status quo remains. Loewenson (2004) and Baéz and Barron (2006) are clear that the voice of the community is essential and a necessary requisite at a national level.

> If communities want to play an effective role they need to make their voice heard at all levels of the health system – not just community level. Communities need to participate in and monitor any health actions. Their role is to advocate for their interests and influence public and private health systems at national, regional and global levels. (TARSC / Ifakara, 2005:91)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5.4.3. The Delicate Balance of Power between Communities and Health Facility Personnel

Whilst a vibrant, accountable and representative CHC would ensure that a delicate balance in power relations between community and staff is maintained at the clinics, a committee constituted of TB DOT Supporters, lay counsellors and home-based carers in receipt of a stipend allows the balance to tip in favour of the health personnel. The current situation serves the interests of the health facility staff as the volunteers

present no threat or challenge to the operations and functioning of the facility.

This is not an uncommon occurrence as Ngulube *et al* (2005: 17) found in Zambia, where community representatives "owed their allegiance to health workers they worked with, and not the communities they served, leaving them powerless to intercede on communities' behalf." Interestingly, their study also noted that community representation at the health facilities was found to be known to only 20% of the community and in addition, the community representatives were also uncertain of their mandate. Whilst this current study did not address the issue of the community knowledge and understanding of CHCs, one would imagine that the composition and status of these structures do not lend themselves to the popularisation of CHCs, and for communities to take more ownership of them.

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In the absence of accountable community representation, other important aspects of community participation are unable to thrive - such as mechanisms to promote a dialogue between the health workers and community members about their health and the personal or environmental factors that might place them at risk of disease, or by the fostering of greater community involvement in the decision-making around the allocation of a health facility's budget, or the prioritization of health programmes within a community.

5.4.4 The Health Facility Staff Membership and Support Functions

The National Health Act (61 of 2003) is explicit in its inclusion of the head of a health

facility being a full member of the CHC. In the interviews conducted, there was no indication that this membership requirement was being adhered to in NMBM, which provides a further indication of the discrepancy between the policy and its practice; and is a further contributory inhibiting factor to CHC functioning. Baum and Kahssay (1999: 107) indicate that health professionals had the potential to be "important catalysts" in both the creation and sustainability of the community health structures.

The support of health staff of CHCs was regarded by CHC members and key informants who participated in this study as important to the effective functioning of CHCs. However, the issue of staff shortages within the public health system is a well-known problem. The Director for Health Services reported at the Health Summit that "just under 70% of posts within the facilities of NMBM are filled" (Report to District Health Summit, T. Oliver, 17 August, 2007). Staff are therefore required to have increased patient loads and are perceived by CHC members and key informants to have become frustrated and suffer burnout. Since there are seemingly no instructions or directives from Municipal Health Directorate Management for specific staff members at the facility level to take responsibility for supporting CHC functioning, this support would currently need to be provided on an *ad hoc* or voluntary basis from health facility staff. CHC functioning is, therefore, further compromised as there are apparently few staff members who, in addition to their routine work, will also provide support to CHCs.

Baum and Kahssay (1999: 98) are clear that in developing networks and working with

local communities, health facility staff are required "to work outside their established hierarchies and organisations and to develop networks and forms of collaboration that are significantly different from traditional working patterns in the health sector." With little training and direction being currently provided to staff by health management to support such community development activity, the possibility of staff being able to engage with communities in this way is rather dependent on their own resourcefulness and the personal initiative they might take.

5.4.5. Co-operation with the Structures of Local Government and Local Government Councillor

The Municipal Systems Act (32 of 2000) and Municipal Structures Acts (117 of 1998), together with the health policy documents and Provincial Health Act, create the opportunity for communities to debate how to develop the link between legislated community processes in health and local government. It is through the mechanisms of local government, ward councillors and ward committees that opportunities of access to resources and the IDP are opened.

Councillors are obliged by law to be part of the governance structures at the health facility. Baéz and Barron (2006: 31) are explicit that "their potential power and influence must not be underestimated". CHC members and communities need to be made aware of their potential and their obligations. Sanders (1992: 202) agrees:

> The Councillors are the people who have to make the community accept this programme [VHW and community participation] as *their* programme. They have to

teach the people what PHC means, why the Government has chosen it and also encourage the community to be self reliant.

Increased co-operation between the Health Promotion Programme and Health and Constituency Portfolio Councillors within NMBM would assist in opening up these opportunities.

5.5. Lack of Guidelines and Resources

Without guidelines to direct the processes of CHCs, there will be no coherence to their operationalisation. They will remain fragmented and disparate. Their characters, roles and function will largely be dependent upon the individuals who make up the committees as has been described earlier by Levers *et al.* (2006:2) when they describe such structures as being "socially constructed." The lack of CHC guidelines means there is no consensus or clarity on the critical issues of community representation, channels of communication, monitoring and evaluation. This has been confirmed by studies undertaken in Zimbabwe, at the time immediately after independence, when programmes to promote equity and access to health were being successfully pioneered. Guidelines were noted as being essential and were provided for all participating stakeholders, such as councillors, health committees and the local community. (Sanders, 1992)

Whilst guidelines would provide direction for how CHCs could be operationalised, the guidelines would also need to instruct and direct the training requirements for the CHC members. Zakus and Lysack (1998: 5-6) pick up on this theme, emphasising

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that training is an investment and suggesting areas in which training is required:

> There must be an investment in the training of new members of community organisations in the domain of health planning and other managerial tasks. Although the actual skills necessary are particular to each specific project, competency is required in five major domains: community organising; problem solving and priority setting; health information collection and analysis; health intervention planning and delivery; and finally, programme evaluation.

Along with such training, technical support in areas such as monitoring and evaluation, and the necessary political commitment and management support to such initiative, the Health Directorate could be reasonably assured that a set of clear and detailed guidelines would provide the necessary impetus for the health facility staff to promote and support more effective CHC functioning. Appendix 11 contains a list of recommended contents for the CHC guidelines.

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5.6. The Political Context and Socio-Economic Conditions within which CHCs Operate

The political context has been shown to be important in promoting PHC and community participation within it. Baum and Kahssay (1999: 110) assert:

> Clearly, district level health development is likely to be most effective where it enjoys political and bureaucratic support. It was evident from the studies that the political context in each country was important in determining the operation of the health development structures.

Similarly Zakus and Lysack(1998:1) echo: “Attainment of good health was thought to

centre on concepts of underlying democratic vision – concepts like empowerment, health promotion and collective action.”

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

Community health committee members felt that this situation has changed and that the space for their involvement in order to effect change has diminished. They were discouraged by the current trend of promoting consultants and contractors, to the detriment and neglect of community members who voluntarily gave of their time to support the health facilities.

Cherry (2006) has conducted longitudinal studies of political involvement in KwaZakhele, a township of Port Elizabeth, which previously boasted the largest branch of the African National Congress within the country. Her research indicates concurrence with these findings that residents are disillusioned and despondent with the current political context, rendering them less likely to participate in the activities of civil society and its organisations. Sanders (1992; 214) provides a motivation for strengthening community participation in this context: “The most potent and reliable constraint on nepotism, bureaucratisation and anti-democratic practice is the encouragement and extension of popular democratic control.”

Werner (1981) (as cited by Sanders 1992; 191-2) provides the political rationale for the pursuance of community participation in health. He states: **"**…that the PHC strategy itself could form the basis in the health sector for developing political strength, organisation, and awareness of the popular classes, essential ingredients in the struggle against underdevelopment, and for health".

CHCs provide an opportunity for communities to actively engage in health-related issues which serve the broader development and political goal of deepening participatory democracy.

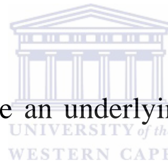
5.6.1 The Poor Socio-Economic Conditions of Communities of NMBM

Baéz and Barron (2006:35) state that there is "considerable evidence" which indicates that increasing levels of poverty have left communities marginalised from health processes. Espindola (2000), (as cited by Baéz and Barron, 2006:35) puts forward that "poverty is a fundamental obstacle for the implementation of democratic governance". Poverty was frequently proposed by participants in the study as contributing to the poor functioning of CHCs. With 38% of total households recognised within NMBM as being indigent (Integrated Development Plan, NMBM 2007), it is evident that the effects of poverty deserve consideration.

Repeatedly, the refrain of "nothing for nothing," was made by interviewees emphasising that volunteers could not be expected to participate without receipt of some gain - usually financial. The fact that community members left the health

facilities after the first stipends were received, was provided as evidence to support this contention. However, this does not take into account the context of poor management, mistrust and lack of transparency with which these stipends were distributed. Had this process been handled differently, there might have been a different result. Baéz and Barron (2006: 35) concur:

> In the past, community participation was mainly limited to participation in specific, stand-alone health programmes. Nowadays if people don't see an opportunity to meet their socio-economic needs they are not interested in volunteering or being involved in campaigns or any other health related activity. However, there is evidence that an important aspect of community contributions, namely local level control and management of funds, functions far better than payment of fees to anonymous government officials who do not report back on the use of the funds.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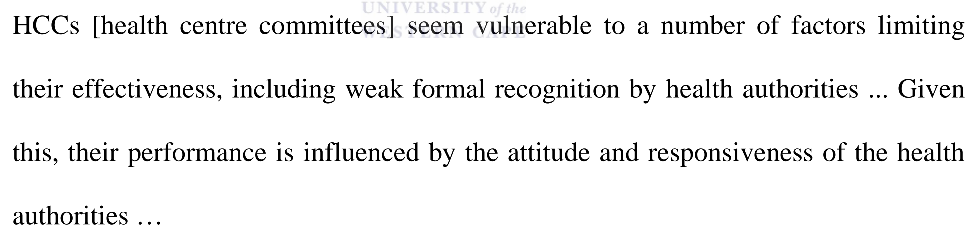
Poor socio-economic conditions are an underlying cause of ill-health. An important function of CHCs is to address the needs of the local community, including socio-economic needs. This presents opportunities for locally developed solutions to some of the community needs, concerns and challenges to be implemented. A pervasive feature of the interviews and focus groups was the discussion on the extent of poverty in local communities. The consequences are devastating to health and development (Sanders, 2001; Werner and Sanders, 1997). Some attempt has been made by CHCs to address this issue by developing food gardens and establishing soup kitchens. The projects initiated by the CHCs were spoken of with pride, and seemed to indicate a positive factor promoting the effective functioning of CHCs.

The potential to address poverty through more innovative programmes would be increased with broader community participation and support. Baéz and Barron (2006: 36) support this: “The literature also suggests that the scope of community participation in health is broadened when the developmental challenges produced by poverty and its consequences are addressed”.

5.7. The Consequence of a System Breakdown is Demoralising CHC Members

CHC members appear to bear the brunt of a health system that has clear policy guidelines for community participation, but that is not functioning effectively. They feel there is no recognition for their assistance, achievements and commitment. This leads to them feeling “abused, demoralised and unhappy” (CHC member). This situation has been described by Loewenson *et al.* (2004: 5)



> HCCs [health centre committees] seem vulnerable to a number of factors limiting their effectiveness, including weak formal recognition by health authorities ... Given this, their performance is influenced by the attitude and responsiveness of the health authorities …

CHC members felt it was their responsibility to be ambassadors for community participation, demonstrating a positive front to the community, both as volunteers and CHC members. In this way, other community members would feel encouraged to participate, and community participation in health would thrive. In the current context they did not view this as possible.

5.8. Summary of the Discussion

The factors identified in this study concur closely with those identified by Baéz and Barron (2006) and Levers *et al.* (2006). Bracht *et al.* (1999: 104) investigating problems associated with community participation was in general agreement with these authors, and encapsulated these factors in a list as follows:

> (a) selecting community representatives, (b) establishing effective partnerships, (c) achieving mission clarity and programme boundaries, (d) identification of resistance, (e) establishing evaluation and tracking missions, (f) successfully managing and reinforcing volunteer involvement, (g) conducting ongoing training and skills development, (h) recruiting field staff with appropriate competencies and experience and (i) securing resources for maintenance and durability of effort.

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It is evident from the findings of Bracht *et al.* (1999) that the problems experienced *in general* with community participation within their study were similar to those experienced by the formalised community participation structures within this study. Of particular note is the authors' prioritisation of the selection of community representation, which emerged as an important factor inhibiting the functioning of CHCs in this study. The problems identified seem to concur with the factors identified within this study as inhibiting effective CHC functioning.

CHAPTER 6: CONCLUSION

It would seem fitting to conclude this study with a reminder by Zakus and Lysack (1998:1) of the rationale and importance of structures, such as Community Health Committees, in achieving health:

> This Declaration [Alma Ata] formally alerted nations worldwide that physician-centred care and hospital-based programmes were inadequate to achieve global health. Rather attainment of good health was thought to centre on concepts like empowerment, health promotion and collective action. With its campaign, the WHO and several of its member governments launched an unprecedented international revival of interest in wellness, prevention of illness, and local control of services to improve people's health. At the core of these efforts was community participation.

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Given the findings of this study, it would appear that in many ways, this vision of community participation in health has waned within NMBM. This study indicates a system within the health services which is failing in its commitment to community participation. It is not functioning to promote and support CHCs. It is therefore, not surprising that the Health Directorate itself reports that over 50% of the committees at the facilities are not functioning. The findings of this study indicate that even those CHCs described as "operational" are not functioning as the policy framework intended. In fact, there appeared to be a disjuncture between the practice of CHCs and the original health policy framework.

The factors related to the effective functioning of CHCs were found to be mostly

inhibitory, reflecting the experience of the CHC members and key informants of a state of weakened CHCs. They identified factors which are able to be remedied within the health services. These are factors, such as the composition of the membership of CHCs, the institutional support and co-ordination for CHCs and provision of guidelines and resources for their effective functioning. Other factors which the local Health Directorate has less influence over, but which were shown to impact negatively on the CHCs, were the poor socio-economic conditions of communities and the perceived political context which deterred active community participation.

Baum and Kahssay (1999: 98) provide an optimistic note indicating that health development structures like CHCs:

> support the work of the district health service; they can mobilise local people for health care activities, and where resources are available, they can contribute directly to health service delivery at the district level. … They can be involved in broader socio-economic development initiatives at the district level and they can take on an advocacy function, promoting awareness of local health problems.

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Community participation in health provides a great opportunity for the health authorities. The words of a key informant provide a glimpse of how an investment in CHCs would benefit health and development:

> Actually if we're a vibrant community health committee, we won't have children wondering around not attending school. We'll have greening of that area. We won't

have crime, if we're a vibrant community. So really, we are not investing. We won't have people who are defaulting in treatment of TB if we did our work. There will be people trained and you won't have a problem like you have people reporting now: 'we have diarrhoea', and then nobody is attending. You will phone your Community Health Committee chairperson and that chairperson will know what to do. … It's supposed to be like that.

6.1. Limitations

The following could be considered as limitations to this study:

1. The research was limited in terms of the number of interviews and focus group discussions held. Thus, instead of the more rigorous pursuance of the research question until saturation is reached, this study was limited to five interviews and two focus group discussions. Some useful other sources of data collection would have been staff at the facilities and community users of the health facilities.

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2. The study did not explore Municipal health budgetary implications, and how these may have shifted and shaped the current functioning of CHCs. This leaves a gap in the understanding of the current functioning of CHCs.

6.2. Recommendations

Based on the findings of this study, the following recommendations have been made.

This study provides the basis to develop an understanding of the current factors related to the functioning and sustainability of the CHCs in NMBM. It is, thus, recommended that the findings of this study be discussed by both the Municipal Health Directorate and the Provincial Health Department operating within NMBM. In order for CHCs to function effectively, there needs to be a concerted effort on behalf of both departments to take responsibility for CHC functioning and operationalise these and to work together in this endeavour. The departments need to demonstrate their commitment to community participation in health, and CHCs in particular, by prioritising this issue. Close collaboration is required in designing and implementing a comprehensive, co-ordinated and integrated programme to promote and support CHC functioning. In addition, sufficient staffing, budget and resources will be required to be allocated to the section within the departments that will be handed responsibility for the promotion of effective CHC functioning.

Secondly, it is recommended that the legislative and policy framework (The *White Paper on the Transformation of the Health System in South Africa*, The National Health Act and the Provincial Health Act) be revisited by the health departments within NMBM to bridge the gap between policy and the practice of CHCs. The implementation of the CHCs at the health facilities need to reflect the intention and principles of the primary health care approach as embodied in the White Paper.

Thirdly, it is recommended that detailed but practical CHC guidelines be developed by the Provincial Health Department, which outline the national and provincial legislation and policies associated with the CHCs. The proposed composition of CHC membership, the role of CHCs and the way in which they can function effectively should be included within the guidelines. These guidelines would serve as a most useful resource for facility managers, their colleagues and community representatives and would serve to guide the operationalisation of CHCs at a facility level. They could be utilised throughout the Eastern Cape Province. Appendix 11 contains an outline of the suggested contents of such guidelines.

Fourthly, it is recommended that a system or mechanism be developed to ensure that there is formal, tiered representation so as to facilitate representation of community interests from the District, to the Province and into the National Department of Health. Such a system is discussed within the policy document on *Development of the District Health System for South Africa* (Department of Health, 1995). It is important that the voice of the community is heard at a national level, something which both Municipal and Provincial Health Departments within NMBM can advocate for at provincial level.

Fifthly, it is recommended that the links between the health services with the structures of local government need to be strengthened. Local government councillors need to be informed of their responsibilities with regard to CHC functioning and adherence to this legislative requirement needs to be monitored by the

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Constituency Portfolio Office in NMBM. CHCs need to interact with the structures of local government, such as ward committee representatives, and make their voices heard so that requirements for health are met.

Sixth, it is recommended that CHC members need to be given appropriate recognition for their volunteerism and their contribution to and involvement within the CHCs. The municipal and provincial health departments within NMBM need to develop creative ways of acknowledging the contribution made by communities in health development.

Seventh, whilst CHCs provide the appropriate channel to represent community concerns, it would appear that at present, given the gravity of grievances of the health volunteers, a separate system of representation is required for them and their focussed outreach activity. Ideally, this system or forum would need to work closely with the CHCs but given that they are paid a stipend by the Department of Health and essentially perform the department's outreach work, it would be more appropriate that their grievances be heard and managed through a different form.

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Lastly, it is recommended that the Parliamentary Committee on Health and National Department of Health need to recognise the discordance within the legislation with regard the name of the Community Health Committees and they need to be lobbied to amend the National Health Act (61 of 2003), to reflect the name "Community Health Committees".

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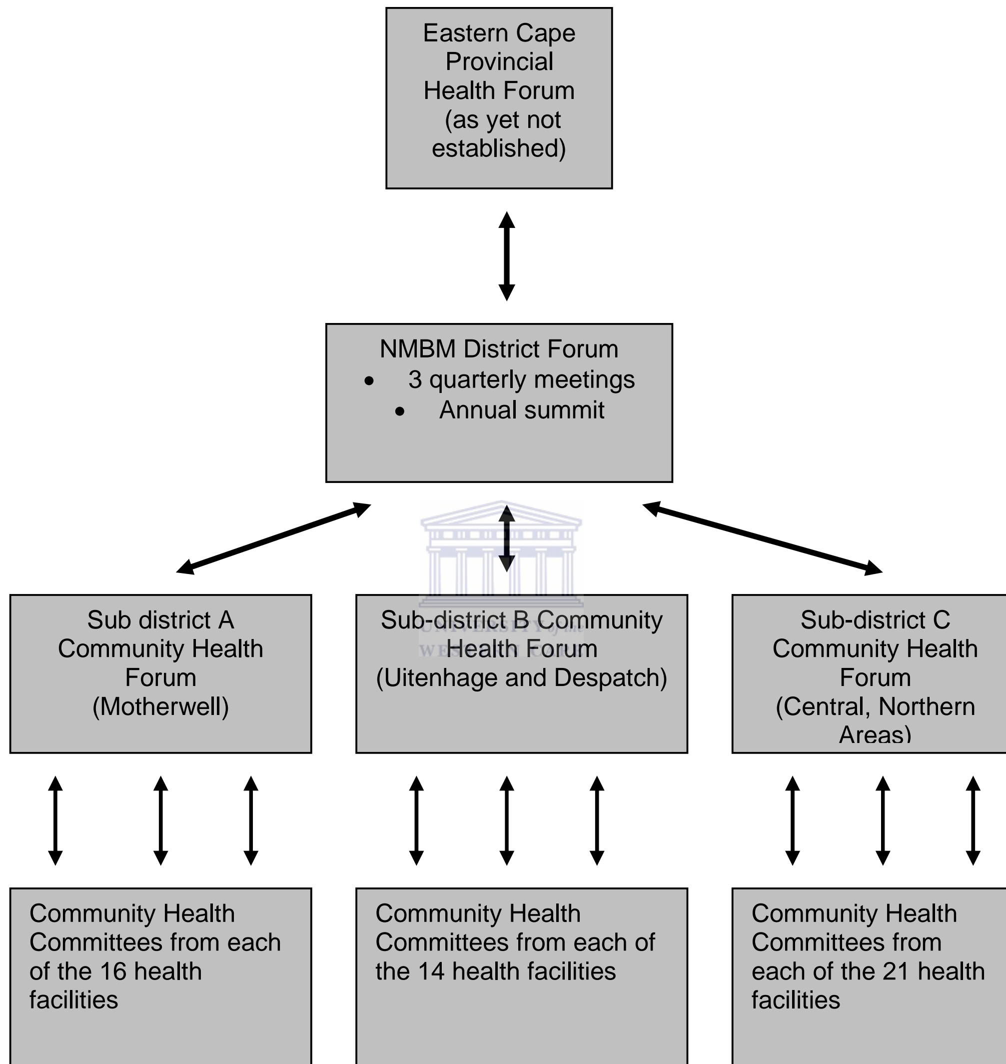
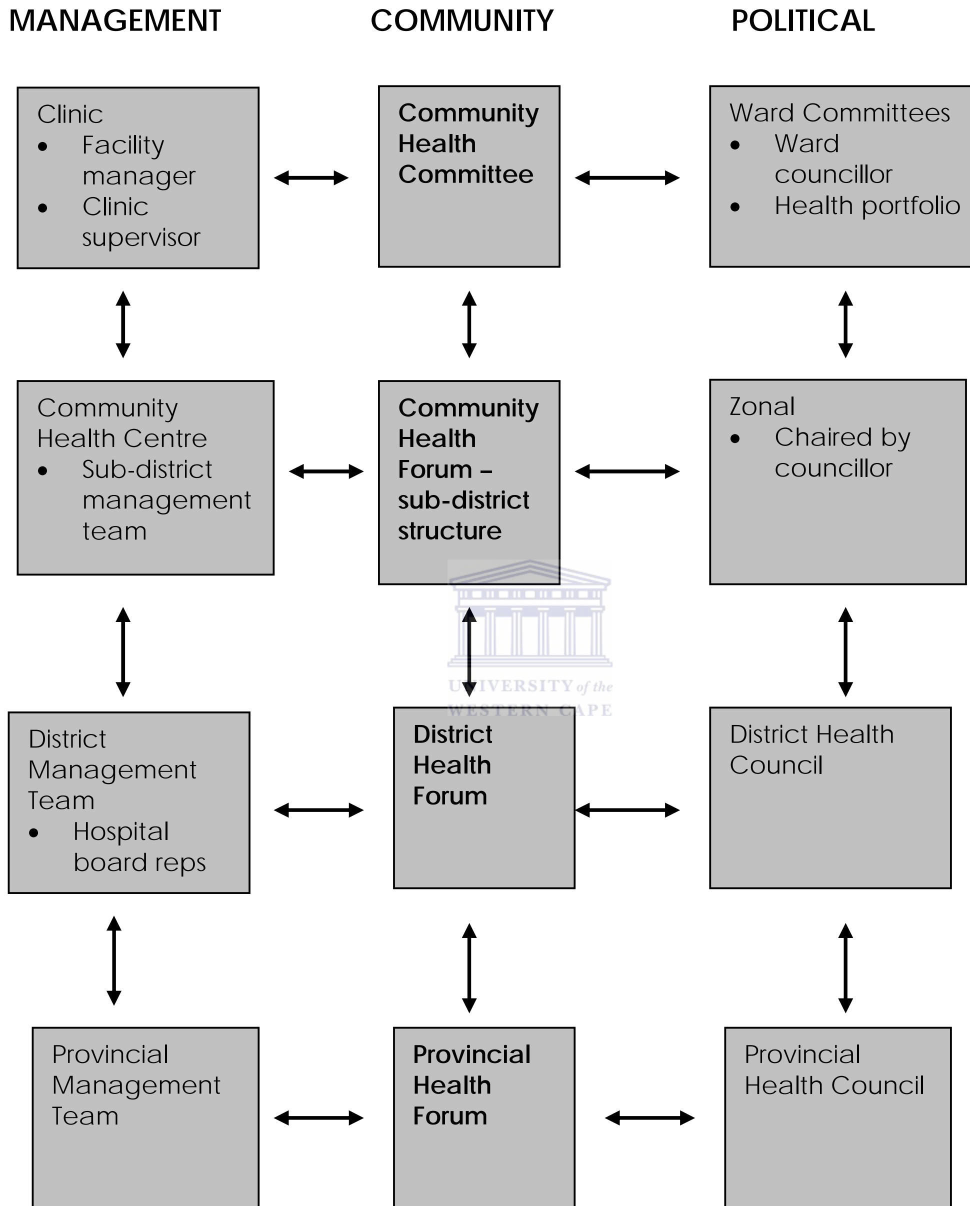
APPENDIX 1

A diagram of the intended tiered system of representation for CHCs, as set out within the *Guidelines for the Development of a District Health System for South Africa* **(1995) and adapted to NMBM, Eastern Cape Province, South Africa.**



APPENDIX 2

Representation and Collaborative Political and Management Structures for Community Health Committees at Various Levels of Participation: Local, Sub-District, District and Provincial.



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APPENDIX 3
Report from Health Promotion Manager, NMBM Health Directorate, which includes report on proceedings of a meeting of 23 March 2006 in which an audit of CHC functioning was conducted. No minutes of that meeting are available.

HEALTH PROMOTION PROGRAMME.
STANDING COMMITTEE REPORT.

1.COMMUNITY PARTICIPATION.

1.1 COMMUNITY HEALTH COMMITTEES
A situational analysis of all committees within our clinics was undertaken. The results were as follows: Out of 49 fixed facilities, 24 committees are functioning fully, 7 need to be revived, and 18 need to be started from scratch. Ward councillors and ward committee members are requested to be part of these committees so as to strengthen them. Health Department is having a working relationship with the Community Development Unit of NMMU to train and assist community members serving in these committees.

PLAN OF ACTION.
The functioning clinics were praised and encouraged to continue meeting on a monthly basis. Minutes for all meetings to be kept. The diversity of the committee members was also emphasized. Various influential people from the catchment area to be recruited and motivated to join the committee. These could be a traditional healer, retired teacher, a businessman, a minister of religion, or a politician.

WAY FORWARD.
The 25 committees that were not functioning as expected were the priority for the stakeholders who had planned the situational analysis exercise. The National Health Act, (Act No 61 of 2003) Chapter 6, Section 42, states that local government councillors must be part and parcel of these committees. The stakeholders then proposed to follow the route of engaging politicians as a support base for sustaining these community health committees.

2. ANNUAL HEALTH SUMMIT.
This auspicious occasion is a platform for the Business Unit–Health and Environment to report to communities about our challenges, achievements, threats, and opportunities. Our partners from both private, business sector and the Eastern Cape Department of Health are also regular attendees. The proposed date for this year is the 11th of August 2006. Planning meetings are being held on a monthly basis, with the next meeting on the 20th April 2006.
Portfolio committee members on health and environment are requested to be part of these meetings from the initial stages.

ANTI-TOBACCO TASK TEAM.
As a Health Promotion drive, a meeting of various stakeholders within the Metro was held on the 17th April 2006. The main objective is to create awareness about the advantages of quitting smoking, together with strategies to assist those of us willing to quit. . A follow-up meeting will be held on the 29th April as not all invited stakeholders could attend this meeting. Various sectors like politicians, youth, people with disabilities, moral regeneration desk, gender desk, older persons are all invited. Departments like tourism, education, social services, safety and security, taverns and shebeens are also invited to be part of the task team.

WORLD "NO TOBACCO DAY".

30th May 2006 is World "No Tobacco Day", and this year's theme is " Tobacco, dangerous in any form or guise". We are aiming at formulating clear policies and posters displayed at all Metro buildings. All our schools to be declared No Smoking Zones

Miss B Bala
Programme Manager: Health Promotion.

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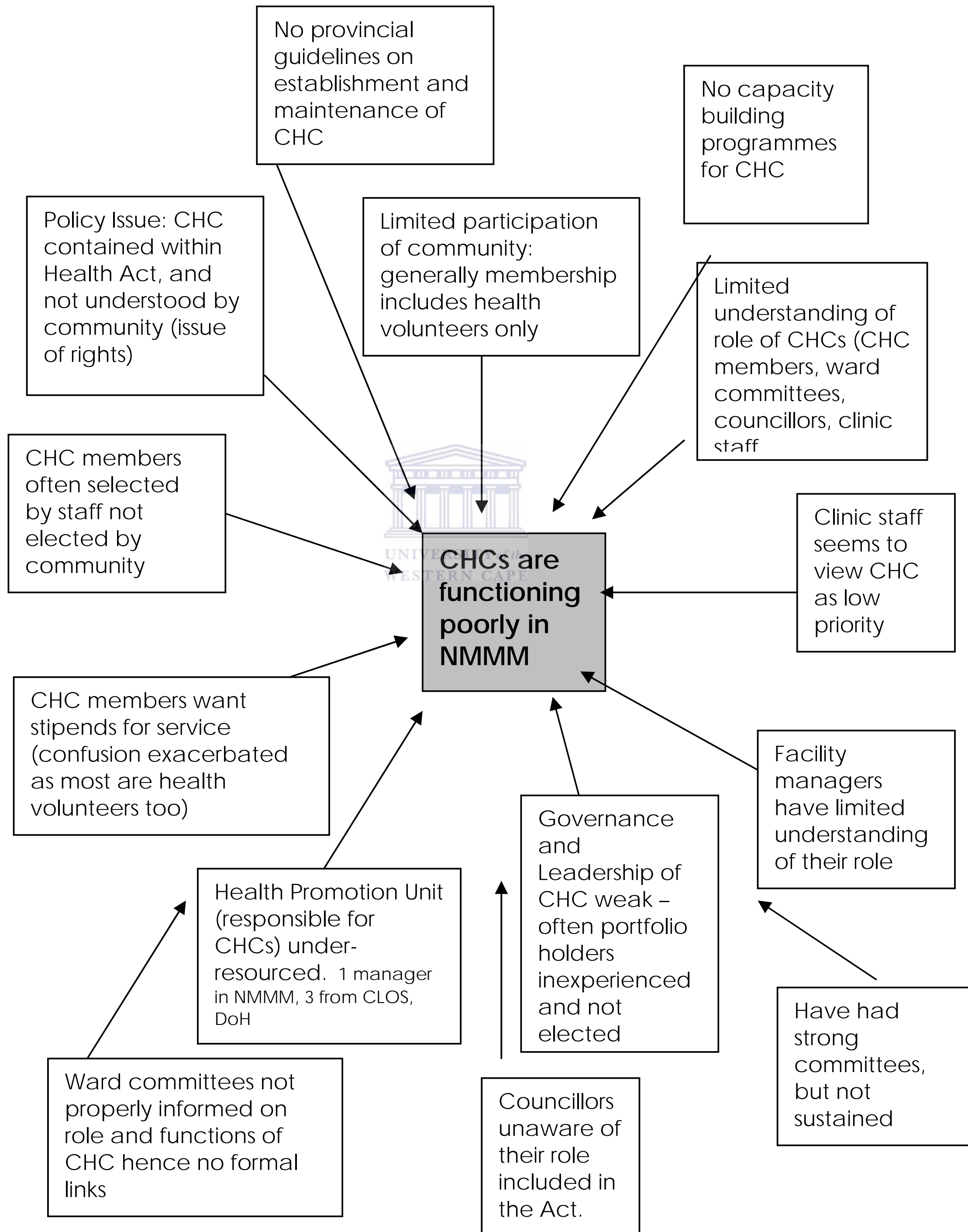
APPENDIX 4

Problem Analysis Diagram
In considering the potential factors contributing to the problem prior to the study, the researcher generated this problem analysis diagram (June 2006)



APPENDIX 5

List of Key Informants for In-Depth Interviews

1. Portfolio Councillor and Mayoral Committee Member for Health
2. Health Promotion Manager : Municipal Health Department
3. An experienced former CHC member, who through his work within a CHC, has secured employment in an NGO in NMBM.
4. A Chairperson of a CHC and of the sub-district Health Forum
5. A Quality Assurance Manager who previously worked for an NGO promoting CHC functioning

Guide Themes for Individual Interviews

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- Your experience of CHCs
- Your perceptions about their current functioning
- Suggestions as to factors which promote and inhibit effective functioning
- Suggestions to strengthen CHC functioning and sustainability

APPENDIX 6

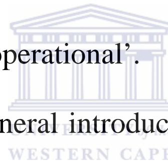
Guide to Conducting Focus Group Discussions with CHC Members

1. Group with 'experienced' CHC members from a diversity of CHCs:

The researcher would provide a general introduction to explain to group its purpose. She would talk about the poor functioning of the CHCs in the NMBM and ask:

- For participants to share the problems they have encountered with the CHCs?
- From your experience, why is it that CHCs are not functioning? Why don't they work?
- Can you provide examples of where CHCs have worked?
- What makes a CHC work?

2. Group with CHC described as 'operational'.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The researcher would provide a general introduction to explain to group its purpose. She would be talk about the poor functioning of the CHCs in NMBM, and note that this CHC had been described as successful.

- She would ask the group to describe their work and some of their achievements.
- She would ask participants to share what it is that makes the CHC work well?
- What would disrupt this smooth and efficient functioning?

APPENDIX 7

Notes from the Regular Meeting of the 'operational' CHC

26 March 2007

Thirteen members, two men and eleven women, attended the regular CHC meeting which was held in a large room at the back of the Community Health Centre, allocated for the health volunteers. It is the place at which the volunteers gather in the mornings before work and during their breaks. There was much informal chatting before the meeting: from this the researcher gathered that members were well acquainted and familiar with one another. At the outset of the meeting, the researcher was introduced by the Chairperson who had previously attended the "TB Free" meeting. The researcher outlined the nature of the research and requested the support of the CHC in collaborating further in a subsequent focus group discussion. The researcher's request to attend and observe the remainder of the meeting was accepted without any concerns or objections being raised. The meeting was 55 minutes in duration.

The meeting focussed on two agenda items. In the first instance, a couple of members were concerned about the status of their current chairperson who had apparently in the previous month been elected to the local ward committee. They challenged that she should relinquish her role as chairperson and asserted that she should become an *ex-officio* member of the CHC. The matter was seemingly resolved by the local government councillor who attended the meeting to address this agenda item. He told the CHC that it was an unnecessary discussion item which should not have caused

concern. He said it was in their best interests to maintain the Chairperson in her current position both for the CHC and for the community; that CHC members should concern themselves with harmony and peaceful relations, not ‘fomenting trouble’ and that there should be no reason for further discussion on the issue. It was apparent that there were political tensions underlying this intervention, but the matter was not discussed further.

The second issue revolved around the non payment of the monthly stipend to health volunteers. There was much dissatisfaction expressed by CHC members during the course of the meeting that the monthly stipend for all health volunteers had not been paid. They were keen that this should be rectified and noted by the researcher, in anticipation that the research process might support their cause. There was heated debate and dissatisfaction about the current state of non-payment. There was also dissatisfaction that only ten of the thirteen members were in receipt of a stipend. It appeared from the meeting that members felt there were inadequate criteria and selection procedures for the initial selection of the volunteers in receipt of a stipend, despite this having been determined more than a year prior to the meeting. There was agreement that should the stipend not be paid at the end of the current month, a delegation would be sent to meet with the Portfolio Councillor for Health and Environment; failing which, a picket would be held at the offices of the Council.

The meeting was a most useful observation tool for the researcher for a few reasons. Firstly, it became apparent in the meeting that all CHC members were health

volunteers, serving at the health facility. The meeting served to represent health volunteer interests. It did not appear that the members of CHC selected as "operational" were more broadly representative of the local community and its organisations and structures. The exception was that of the Chairperson, who served as a ward committee member, and it was this membership that was being challenged. At no time in the meeting was any reference made about the broader community, issues affecting health within the community or issues relevant to the operations of the health facility.

The second interesting observation related to the lack of facility staff involvement in the CHC. Much dissatisfaction was expressed at the outset of the meeting that health facility staff were "never available" for the CHC meetings, and the manager was then specifically requested to attend. She attended the first 20 minutes of the meeting and thereafter excused herself to attend to other matters. It seemed that the current membership was not aware of the statutory requirement that the head of the health facility be a necessary member of the CHC. They seemed grateful for her limited attendance and expressed this on her departure from the meeting. Similarly, it was apparent that the health facility manager attended to show support for committee, but seemingly did not regard her role as key to the operations and functioning of the CHC.

Thirdly, there was a surprise in that a local government councillor attended the meeting. The issue of ward councillor representation on the CHCs was raised at the

meeting of clinic supervisors in March 2006 with concern that in spite of this legislated requirement, councillors were generally absent from CHCs. The councillor's attendance, however, was quite instructive. He was present to resolve the issue related to the ward committee member's involvement as chairperson of the CHC. Ward committees' effective functioning is the responsibility of the ward councillor and hence, it was in his best interests to secure the chairperson's continued participation as a full member of the CHC. Once he had spoken on the issue, he declared the issue resolved and no further discussion on the topic was entertained. The councillor then left the meeting and the chairperson resumed her position.

A further observation was that the meeting agenda and proceedings were brief and narrow in their focus. The Health Centre is located in an area characterised by poverty, with informal settlements in very close proximity, yet no issues related to these circumstances and the resultant health issues were addressed in the meeting. There were no issues related to services within the facility, to complaints from the suggestion boxes, or planning for the facility. It appeared to the researcher that the meeting would more accurately be described as a meeting of health volunteers than a structure representative of the local community.

The above observations were of concern to the researcher for it had been anticipated that the CHC could be considered as functioning effectively; and yet it was evident that this 'operational' CHC might not, in fact, be considered as a role model of effective CHC functioning.

APPENDIX 8

Workplan and Budget

WORKPLAN FOR MINI-THESIS Community Health Committees in NMMM, Eastern Cape Province			
Timeframe	**Action**	**Persons involved**	**Comments**
Jan 07	Complete research proposal for submission to Higher Degrees Committee. Includes Participant Information Sheet.		
Feb 07	Discussion of research proposal with key health personnel for approval and buy-in. Continue with reading for Literature review	Acting Business Unit Manager Health; Health Promotion Manager NMMM;	Preparatory phase
Feb 07	Contact made with CHC members to establish time for focus group discussion.	To be identified with HP Manager: 1 CHC "operational" and participants for group of *experienced* CHC members Identify assistant for transcription of tape recordings.	Preparatory phase
Feb 07	Contact made with interviewees to establish practical arrangements to meet	Health Promotion Manager NMMM; Mayoral executive committee health portfolio Experienced ward committee member now working in Business Unit Health.	Start of implementation phase
End Feb 07	Write up Literature Review	Researcher	
Until Mid March 07	Conduct interviews and conduct two CHC FGDs.	As above	
Mid March 07	Transcribe all interviews and focus groups, to be done concurrently with research interview and FGD process.	Pay assistant to transcribe interviews	Transcription to happen concurrently to prevent delays with analysis

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Mid March to end April 07	Coding and interpreting data, and writing up mini-thesis		Will require some time off work to write up
End April 07 End May 07	Submission of mini-thesis to supervisor for comments and reworking Submission to SOPH for examination		

BUDGET FOR MINI-THESIS
Community Health Committees in NMMM, Eastern Cape Province

Category	Unit Cost	Multiplying Factor	Total
Personnel Costs			
Facilitator/Researcher	R500 per day	2 days preparatory; 5 days implementation (a)	R 3,500.00
		20 days writing research	R 10,000.00
Transcriber	R25 per page	120 pages	R 3,000.00
Sub Total (I)			R 16,500.00
Transport Costs			
Travel costs for facilitator	R2 per km	400 km(b)	R 800.00
Travel costs for CHC members.	20 members	R20 per member	R 400.00
Sub Total (II)			R 1,200.00
Consumables			
Stationery and printing			R500.00(c)
Telephone Calls			R300.00 (d)
Refreshments for CHC members attending focus groups	R250 per group	2 groups	R 500.00
Sub Total (III)			R 1,300.00
TOTAL (I + II + III)			R 19,000.00
5% Contingency			R 950.00
GRAND TOTAL			R 19,950.00

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Notes to Budget

(a) 5 days = 2 days for focus groups and 3 days for interviews

(b) 60 km per focus group and 160 for the interviews. One of which is in Uitenhage = 70km

(c) An estimate for stationery requirements to produce the report and copies

(d) An estimate for telephone calls for duration of mini-thesis

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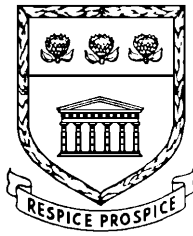
APPENDIX 9: Participant Information Sheet



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School of Public Health
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-9592872
http://www.soph.uwc.ac.za

Participant information Sheet

April 2007

Dear ……..

Thank you for your willingness to hear about this research. What follows is an explanation of the research project and an outline of your potential involvement. The research is being conducted for a mini-thesis. This is a requirement for the Masters in Public Health which I am completing at the University of the Western Cape. If there is anything you do not understand or are unclear about, please ask me. My contact details and those of my supervisor are recorded at the end of this memo.

TITLE OF RESEARCH

Developing an understanding of the factors related to the effective functioning of Community Health Committees in Nelson Mandela Bay Municipality, Eastern Cape Province, South Africa.

PURPOSE OF THE STUDY

This research is trying to understand the challenges that Community Health Committee members face, and the requirements for the committees' effective functioning. It is hoped that with your participation, a better understanding will be gained of the reasons for the poor functioning of the Community Health Committees and that suggestions can be presented to improve their functioning. This research will inform the development of a set of guidelines which will aim to support the more effective functioning of Community Health Committees within the Nelson Mandela Bay Municipality.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

The study will include focus group discussions with Community Health Committee members and individual interviews with key people involved with Community Health Committees. Questions about your experiences of Community Health Committee functioning will guide the interview that I have with you.

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CONFIDENTIALITY

Your name will be kept confidential at all times. I shall keep all records of your participation, including a signed consent form which I will need from you should you agree to participate in this research study, locked away at all times and will destroy them after the research is completed.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

Your participation in this research is entirely voluntary ie you do not have to participate. If you choose to participate, you may stop at any time. You may also choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

BENEFITS AND COSTS

You may not get any direct benefit from this study. However, the information we learn from participants in this study may help in guiding Community Health Committees, and the relevant health facility and department staff to support their more effective functioning in the future. There are no costs for participating in this study other than the time you will spend in the interview.

INFORMED CONSENT

Your signed consent to participate in this research study is required before I proceed to interview you. I have included the consent form with this information sheet so that you will be able to review the consent form and then decide whether you would like to participate in this study or not.

QUESTIONS
Should you have further questions or wish to know more, I can be contacted as follows:
Thérèse Boulle
Student Number: 2402644
Cell phone: 083 651 8838
E-mail Therese.Boulle@nmmu.ac.za
Telephone at work 041 504 4005 / 4028
Fax number 041 504 4002

I am accountable to Nikki Schaay, my supervisor at UWC. Her contact details are 084 211 5544 / 021-788 4186.
Or c/o The School of Public Health
Fax 021 959 2872
By e-mail at schaay@mweb.co.za
WEBSITE: www.uwc.ac.za/comhealth/soph

APPENDIX 10: Informed Consent

ON UWC LETTERHEAD

INFORMED CONSENT: March 2007

TITLE OF RESEARCH

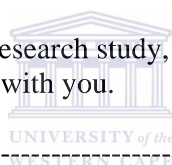
Developing an understanding of the factors related to the effective functioning of Community Health Committees in Nelson Mandela Bay Municipality, Eastern Cape Province, South Africa.

As was mentioned in the *Participant Information Sheet: y*our participation in this research is entirely voluntary, i.e., you do not have to participate. Refusal to participate or withdrawal from the study will not result in any penalty or any loss of benefits to which you are otherwise entitled.

If you choose to participate, you may stop at any time. You may also choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

The information collected in this interview will be kept strictly confidential.

If you choose to participate in this research study, your signed consent is required before I proceed with the interview with you.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I have read the information about this research study on the participant information sheet*, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction.*

I consent voluntarily to be a participant in this project and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study.

My signature says that I am willing to participate in this research.

____

Participant name (Printed)

____ _______________

Participant signature *Consent Date*

____

Researcher Conducting Informed Consent (printed)

____ _______________

Signature of Researcher Date

APPENDIX 11

Recommended Contents for CHC Guidelines

- An explanation and understanding of the relevance and importance of community participation in health.

- An understanding of Primary Health Care and the District Health System.

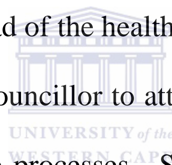
- All legislation and policies related to formalized community participation.

Issues specific to Community Health Committees:

- A defined timeline for CHCs to develop their skills and to provide meaningful roles in terms of their participation within the structures of local government. This timeline would start with an induction programme for new CHC members.

- Induction programme for new CHC members:

  - Membership:
    - 10 - 12 members per committee;
    - Must include the head of the health facility;
    - Local government councillor to attend and serve as link between CHC and ward committee processes. Supports in feeding information into the IDP;
    - Accountable community representatives elected at local community meeting. Local community organisations invited to send delegates, who have mandate from organisations and must feed information back to their respective organisations;
    - Suggested representation to be drawn from such groups as follows: Community-Based Organizations; Religious Bodies; Traditional Practitioners; Women's Groups; Youth Formations; Non-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Governmental Organisations; Private Sector; Academic Institutions; Other Government Departments; Disabled Persons;

    - Identification of vulnerable groups essential to ensure voice of most marginalised within community is heard.

- Term of Office:
    - To be elected for two-year term;
    - Staggered membership so as to develop continuity;
    - Annual elections.
- Constitution for CHC to be drafted. A draft CHC constitution could be provided as an example for CHCs.
- Roles and Responsibilities:
    - Serves as the dynamic two-way link between community and health facility;
    - Analysis of needs of community and reflect these to health facility;
    - Ensure appropriate and good quality services at health facility, and the principles of *Batho Pele* are maintained;
    - Identification of vulnerable and underserved groups in the community;
    - Participate in planning and budgeting of services at the health facilities;
    - Promote links with ward committee processes;
    - Develop community-based projects aimed at addressing needs within community;
    - Market the CHC and its responsibilities to the local community.

- Representation of community interest, and escalating these to include tiered representation from local, sub-district to the district and ultimately to provincial and national level.
- Communication Channels:
    - Need to be clearly stated;
    - Regular monthly meetings as CHC;
    - Must have understanding of health hierarchies for communication.
- Systems for Reporting:
    - Minutes to be kept of all meetings;
    - Formalised quarterly reports to District Health Management;
    - Annual reports to MEC for Health in the Province;
    - Reporting to local community on annual basis.

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- Monitoring and Evaluating:
    - Clinic Supervisors to monitor functioning of CHCs.
- Liaison with the Structures of Local Government:
    - Establish links with ward committee;
    - Involved in IDP processes.
- Networking and Linking Community Structures.
- Governance of CHCs:
    - To include portfolios chairperson, vice-chairperson, secretary, treasurer, organiser.
- A Code of Conduct for Membership to be Established.

- Induction and Training requirements for CHCs: (to include head of health facility and local government councillor):
    - Modules to be developed to include the following (as per thesis of E. Levendal (1999):
        - The community;
        - Health;
        - The committee;
        - Life skills;
        - General health-related skills.
- Marketing of CHCs.
- Clarification on the Issue of Stipends

APPENDIX 12:

Personal Reflections on the Qualitative Research Process

Having read extensively about qualitative research, I thought I was fairly prepared for the task I was embarking upon when I started the mini-thesis. But nothing could have prepared me for the pre-occupation and exacting nature of the qualitative research process. I understood about being immersed in the research but did not expect that it would be with me when I woke in the morning, as I drove in the car, when I went for a run or a cycle. I knew the intensity when a brief long weekend holiday opportunity arose and I opted to stay home for the tranquillity and peacefulness that the writing process demanded, rather than be with my family and friends. It was an intense, challenging and very rewarding experience.

This is the first time I have been engaged in a formal research process. I knew that I would need to set aside time from my work to dedicate to the process. I took off four weeks. I knew, too, the demands of my family and decided that the only peaceful time in which to concentrate and write would be from 03h30. Each morning I would awaken early, cycle around my village with my dogs, returning wide awake to continue the process.

The research process was stimulating. After the protocol was successfully submitted, the data collection process started. This was a little nerve-wracking. I was anxious that there would be insufficient data generated and that I would not be alert to all the

issues that the research participants were providing for me. I was acutely aware that I needed to develop an in-depth understanding of the topic. Would this be possible with the data I had generated?

I read and re-read and re-read my data, made notes in the margins and started to draw out themes. This process allowed for a great sense of relief – the data was starting to draw out patterns. I was engaged in an ongoing process of comparing the words of one key informant with another or a focus group discussion. I bought large sheets of coloured paper and started to cut and paste the data into themes. Once pasted, I stuck these up around the walls of the room which I had commandeered for the thesis writing. I looked at these many themes and tried to condense them still further into categories.

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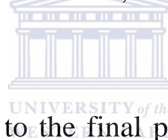
Then Thinking! I found my runs to be the most productive times for reflection. I was quietly on my own then, away from the demands of the family, running along the coast, and my thinking was able to focus on the study. I kept a dairy of my thoughts and feelings through the process. Looking back now, these echo with a variety of emotions: frustration, elation, ah-hah moments, irritation and humour. I spoke to my family about the findings and in this way, was able to debate and prioritise issues such as the crucial role of a coordination hub for successful functioning of CHCs. In this way, I immersed myself into the research process. It was demanding, stimulating and exciting.

I wrote the whole mini-thesis and then submitted it to my supervisor, who had been away for the month of my writing. And then the real work of writing started! From my supervisor I learned the importance of each word, the exactness of meaning and the precision that was required. I learned to look at each sentence, make sure it said what was intended and that it linked to the next and the previous; and then to the paragraph before and after. It was a rigorous process. I learned a vast amount.

I restructured the thesis to meet the objectives I had originally determined. I added more content to the methodology. I paused and returned to the original data. The literature review was re-written again! I could see that the study was starting to take shape. Finally the document seemed to be nearly complete, a few more corrections and additional pondering and then it was over, barring these personal reflections.



The difference from the first draft to the final product is substantial. I feel pleased with the work I have completed. I am greatly indebted to a supervisor who patiently coaxed the study into shape. It was an enormous effort and required a sturdy commitment but was immensely worthwhile.

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