Produced by Learning Network for Health and Human Rights, School of Public Health and Family Medicine, UCT with Training and Research Support Centre In the Regional Network for Equity in Health in East and Southern Africa

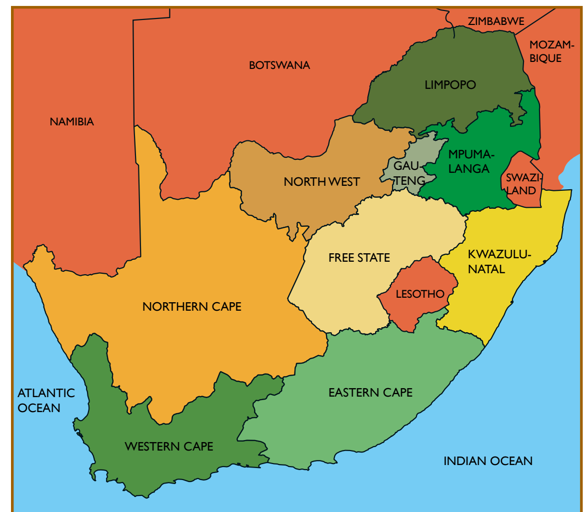
Case Study Brief — *March 2015*

Communities shaping health centre committee roles and policy in Eastern Cape Province, South Africa

South Africa's health profile

Population	52 386 000
Percent population urban	62
Gross national income/capita PPP US$	11 010
Percent population living on <US$1/day 2011	9
Adult literacy rate 2011	93
Life expectancy at birth	59
Under 5 year mortality rate	45
Maternal mortality /100 000 live births	140
Adult HIV prevalence	11.6
Antenatal care coverage, one visit + 2009	92
Antenatal care coverage, four visits	47
Measles immunisation in 1 yr olds	79
Nurses and midwives / 10 000 people 2012	49
Per capita expenditure on health PPP$ 2008	843

2012 data unless otherwise specified.
Source: WHO Global Health Observatory 2015



South Africa map showing provinces
Creative commons Htonl 2011

South Africa is a middle income country, with higher per capita income than many other countries in the region, but also very high levels of socio-economic inequality. The Eastern Cape Province is located along the southern coast of South Africa, with Port Elizabeth its biggest city and Bhisho its capital. The country is experiencing four "colliding epidemics" of HIV, tuberculosis and communicable disease; chronic conditions and mental health disorders; injury and violence-related deaths; and maternal, neonatal and child mortality. South Africa is in a process to transform its health system from a centralised and largely curative model to a district health system implementing primary health care and addressing the social determinants of health. South Africa spends more on health than other African countries, but in a two-tiered system where the 14 percent of the population that access the private health sector benefit from up to 60 percent of the national health expenditure. In 2010, to address these health inequalities and widen access, the Department of Health introduced a dual strategy of re-engineering primary health care (RPHC) and introducing National Health Insurance (NHI).

These strategies depend on an effective district health system. The 1996 Constitution provides for the right to health, health care, participation and association, and for public participation in policy-making. The 2003 National Health Act provides for participation at community level in clinic and community health centre committees. They are referred to by different names: clinic committees, community health committees and health committees. Their members should include local government councillors; members of the community served by the health facility; and the head of the clinic or health centre. Their functions should be prescribed in provincial law. The 1988 Municipal Structures Act and the 2000 Municipal Systems Act create mechanisms within local government for communities to participate in decisions on local community developments through ward committees and local government councillors. These frameworks for participatory democracy need follow up to realise them in practice.

Cover, Eastern Cape policy document on HCCs 2010

Establishment of health centre committees in Eastern Cape

In September 2014 a National Colloquium found that while many provinces have established committees, there is a lack of clarity on their roles, affecting their functioning. The Department of Health at national level issued draft guidelines for HCCs in 2014 to address this gap. In the Eastern Cape, a policy was published in 2010 on the establishment and functioning of clinic and community health centre committees. It describes the roles, linkages, reporting and accountability of those in the committees. The policy seeks to involve communities in the planning and provision of health services, as a link between the community, health facility, and district health council and to foster co-operative governance. It describes four roles for the HCCs:

- An oversight role, to monitor the delivery of primary health care and hold services accountable for their performance against targets through monthly reports from the facility manager, a complaints process and ad hoc facility visits
- HCC members advocate on behalf of health services and communities on health concerns and needs.
- A social mobilization role, where HCC members sensitise and mobilise communities to participate in health programmes and facilitate public meetings, and
- A fundraising role for primary health care activities.

The policy requires a maximum of fifteen members to be included in the HCC, including ex-officio members. Ex-officio members include the facility manager and another staff member, traditional leaders, local government councilors and labour representatives. Community representation is drawn from women, the religious community, youth, non-government and community based organisations, traditional health practitioners and disabled people, with flexibility to include social groups relevant to the local context. In the Eastern Cape, health committees report quarterly to the Member of the Executive Council for Health via the district portfolio councilor for health, who makes their reports available to the district health council. This structure, while set in policy, is only slowly being operationalized in the districts. While in some districts the HCCs may be less functional, in the Nelson Mandela Bay Health District, where additional support has been provided by the university to the fifty clinics, all the committees except one are functional. Forums are held at sub-district and district level, as required by the policy, to monitor and support the committees and their members.

Community involvement in setting and implementing HCC roles

Communities in the Eastern Cape have played a role in formulating and implementing the guidance on their roles and functioning. In the Nelson Mandela Bay Health District, for example, health

Empowered HCC in Ikamvelihle PHC facility
© Z Sofayiya 2014

HCC members at Nomangesi Jayiya studying the policy
© T Boulle 2014

committees had been operating since 1996 but in a haphazard and variable manner, without guidelines for their functioning and erratic staff and management support. This frustrated members.

In 2006, a team from the Eastern Cape Provincial Department of Health invited health committee members, health service, local government, community and other local stakeholders to a meeting to contribute and to provide substance to the policy on health committees. This workshop served to frame the draft policy, which was later sent to all districts for discussion before further review and feedback by HCC representatives. The amendments made in this process were integrated into the final policy that was adopted in 2009 by the legislature in the province and published in 2010.

The policy provides for three-yearly review. In 2014 a review was initiated with HCC members, in consultation with the province. Workshops were held with the committees, facilitated by University of Cape Town. These reviews helped to make the policy more accessible, to support understanding of roles amongst HCC members, to raise roles that had been overlooked, challenges in implementation of functions and suggestions on improvements. It demonstrated tangibly to HCC members that their voices can be heard in amending and adapting policy to improve it. Reviewing the policy also made the HCC members clearer on how to monitor its implementation and the duties of service providers.

Some issues were raised during the policy review: Greater support was urged from facility managers and local government councillors who were seen to be critical members for the functioning of committees, but inadequately involved. Communication between communities and services was observed to be weaker than set in the policy. Community members were found to distrust the complaint box process where HCCs monitor the opening of complaints boxes, recording and resolution of complaints. The committees noted that very limited resources are made available to support their work, including for transport, communication or capacity development.

The HCCs made various proposals in the review, to

- ensure that the process for establishing a committee is as inclusive as possible of community members and that committee members are re-elected every three years;
- formally recognise and maintain a record of HCC members;
- make the reporting obligations of facility managers clearer;
- include ongoing capacity building and skills development in the policy;
- proactively support opportunities to discuss and engage with local communities and give feedback on issues to communities to build confidence in the system.

To support the roles a generic training manual has been designed and made available to all health committee members, with an understanding that facility managers also attend the training and that training be provided to staff, even if separately.

Facility managers reviewing processes for HCC establishment Port Elizabeth. © T Boulle 2014

In the Nelson Mandela Bay Health District a reference group made up of key members of district health management and local government provided useful oversight and advice in the training of committees and helped to overcome hurdles. Sub-district and district health forums allowed for exchange between committees on good practices and challenges. The district has now appointed an HCC steward who has responsibility for HCC functioning.

Lessons to share

The process taught lessons about how people can shape and use their policies for participation on health. HCC members feel empowered when they know policies, not only to understand their own roles and responsibilities, but to ensure that they are enforced and that service and local government personnel are accountable for their roles. For example at Thanduxolo, the committee motivated the local government councillor to organise the local government department to clean an informal dump site, whilst the committee met with community members and discussed maintenance of the site. At Ikamvelihle, committee members tackled underage drinking with a letter from the Department of Health, approaching all tavern owners in their local area, warning them of the hazards of selling alcohol to young people and mobilising the police to support them in enforcing the law.

The lessons from the experience suggest the need to

- Get the basics right. Establish the committees with broad community participation to interact with all sectors of the local community.
- Make time for induction of HCC members on the policy, and for three yearly policy reviews.
- Promote health literacy in the HCCs and in the community.
- Provide mentoring and ongoing education and training to HCC members.
- Use local and social media to keep communities and HCCs informed on health system developments.
- Get the support of the facility manager, the district manager and district management team in the health sector, including through good communication.
- Set up sub-district and district forums that are scheduled and meet every few months where HCCs can exchange experience and learning.
- Provide HCCs with resources to do their work, including access to computers for emailing and compiling reports and minutes, telephones, stationery and with transport costs.
- Support exchange visits between districts and provinces to share ideas and experiences, raise confidence and enthusiasm.
- Convene a National Colloquium for all health committees with high-level presence and report from research, policy and practice communities.

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