Preliminary Findings:

Community Health Committees

Vehicles for participation in advancing the right to health
Clinics and community health centre committees

42. (1) Provincial legislation must at least provide for the establishment in the province in question of a committee for-
   (a) a clinic or a group of clinics;
   (b) a community health centre;
   
(2) Any committee contemplated in subsection (1) 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 in question.

(3) The functions of a committee must be prescribed in the provincial legislation in question.
Cape Metropolitan Area:

- 84 Health Committees (HCs)

Pilot phase

- HCs = Structures intended for community participation in health but often not effective participation
3 Health Committees:

- **Well functioning**: active, >10 members, regular meetings, ongoing involvement at HF
- **Moderately functional**: operates with difficulty, very few members (<5), rarely involved at facility
- **Non-functional**: < 2 active members, no regular meetings, no involvement
1. To elucidate best practice for community participation in health through Health Committees in the Western Cape.
1. To **elucidate best practice** for community participation in health through Health Committees in the Western Cape.

2. To **clarify if and how community participation** through HCs can assist the progressive realization of health rights.
DEFINITION: Community Participation

‘a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet those needs’

Rifkin *et al.*, 1988, p. 933
### Methodology: Mixed Methods

3 communities in the Cape Metropolitan Area:

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<th>Questionnaires</th>
<th>In-depth Interviews</th>
<th>Key Informant Interviews</th>
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Totals

1. | 45 | 14 | 15 | 14 | 1 | 1 |
PRELIMINARY FINDINGS
PROGRESSIVE REALIZATION OF THE RIGHT TO HEALTH

ACTUAL & POTENTIAL
ACTUAL
4 Pillars Used to Measure Progressive Realization:

- Accessibility
- Acceptability
- Availability
- Quality
ACCESSIBILITY

4 overlapping dimensions:

- non-discrimination
- physical accessibility
- economical accessibility (affordability)
- information accessibility

→ Health facilities, goods and services
Pharmacy transition
- Microphone at pharmacy
- Assistance within clinic and in community ("glue children", knowledge of systems)
- Filing systems – streamlined, transparency
- Translation
- TB/HIV patients in the community
- Grants (TB & HIV patients)
Health facilities, goods and services:

- respect medical ethics;
- are culturally appropriate;
- sensitive to gender and life-cycle requirements;
HC ↑ ACCEPTABILITY

- Liaison
  - Patient attitudes & understanding
  - Staff attitudes & understanding
- Patient privacy
- Toilets
- Translation
Functional health care facilities, goods and services in sufficient quantity.
Dissemination of information to free-up clinic staff

Pressurize service providing bodies (DoH, City Health):

- Increase number of staff
- Increase clinic size (strong & moderate)
- Increase hours of operation (strong)
QUALITY

Health facilities, goods & services:

- scientifically & medically appropriate;
- and of good quality.
Fund-raising or seeking funds outside the health sector (new medical equipment, new facility – Rotary)

- Improved security
- Renovations
POTENTIAL
ACCOUNTABILITY

- Connection to Sub-district Directors & MEC for Health
- Ensure service delivery to a certain standard ("keep the balance and people on their toes")
- FM fulfils obligations to community
- Monitor Clinic stats (improvement)
“Expertise” of HC members
- Police – volunteer in trauma victims unit
- Affiliation with wards councillors & municipalities
- Hospital Boards
- Homeless Shelters
- Community Housing projects
- Schools & Youth
BARRIERS & FACILITY FACTORS OF EFFECTIVE COMMUNITY PARTICIPATION VIA HEALTH COMMITTEES
Facility Managers

- **Active/Functional HC:** FM always present, high levels of respect for community, FM actively seeks HC assistance, views HC involvement extending beyond “complaints”

- **Barely Functional HC:** Manager sometimes present, chooses not to involve HC in most decision-making, manager feared, low levels of respect for community

- **Non-functional HC:** Manager unable to cope, HC ultimately collapsed without staff input, some questions arising about respect for community
Active/Functional HC: Difficulty accessing other HC members

Non-functional HC: Extreme difficulty accessing members of past HCs;
NO CONSENSUS: HC ROLES & FUNCTIONS

- FM – more than complaints & compliments?
- Service Providers – helping hand
- HC members – helping hand (soup kitchen, health promotion, clinic information), dissemination of information, increasing accountability, whatever possible
Provincial & City Health:
- strict chain of command
- No guidelines for HC involvement in decision-making or needs assessment
- Division of services (City & Province)
- Guidelines developed: Ways of operating
- Problem – Sub-districts sometimes operational → prevents dissemination to HCs
Proximity to clinic
Availability (elderly, unemployed)
Use of public health services (chronic)
Community “elites” (expertise)

Lack of remuneration?
VISIBILITY OF HC

- Name Tags
- Photo in Clinic / Day Hospital
- Use of the media
- Presence in facility
- Contact with service providers
SUMMARY

- ?
THANK YOU 😊