

# Improving Health Care Provider – Health Committee Working Relationships for Responsive, People-Centred Health Systems

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Preamble

“We stand at a critical moment in Earth's history, a time when humanity must choose its future. As the world becomes increasingly interdependent and fragile, the future at once holds great peril and great promise. To move forward we must recognize that in the midst of a magnificent diversity of cultures and life forms we are one human family and one Earth community with a common destiny. We must join together to bring forth a sustainable global society founded on respect for nature, universal human rights, economic justice, and a culture of peace. Towards this end, it is imperative that we, the peoples of Earth, declare our responsibility to one another, to the greater community of life, and to future generations.”

– The Earth Charter

## **Abstract**

As community-based governance structures in the service delivery of primary health care, health committees can promote the quality, accessibility and responsiveness of service delivery. More specifically, health committees provide a platform for community members to advocate for their health needs and meaningfully participate in decision-making, oversight and monitoring of service delivery. Hence, health committees provide a bottom-up strategy to realise the right to health and a people-centred health system. Previous research has found that Health Committees in the Cape Metropole of South Africa face similar challenges as their counterparts globally. In South Africa health committees' role and mandate often seem to be unclear and weak policy frameworks have resulted in wide variations in health committee functionality. Health care providers, particularly health facility managers, have been identified to play a key role in creating a supportive environment for health committees' genuine and effective participation. Particularly, health care providers' misunderstandings of health committees' roles and responsibilities as well as their lack of engagement with health committees can form barriers to health committee's functioning. A gap in understanding exists on the impact training of health care providers could have on health committees' meaningful participation. While many health committee members in the Cape Metropole of the Western Cape Province were already trained, health care providers had not been trained until May 2015. Present realist evaluation sought to describe and explore the immediate and short-term impact of this pilot training on health care providers' responsiveness towards health committees. Pre- and post-training questionnaires, direct observations and semi-structured interviews were employed as research methods. The training evaluation was enriched by participants' diverse professional positions and work environments as well as their various experiences and relationships with health committees. The study reveals that the training played a role in increasing health care providers' responsiveness towards health committees' roles and functions. Health care providers demonstrated understandings and intentions towards building effective working relationships with health committees. However, training is recommended to be followed up on and to be continuous to ensure intentions are translated into practice and to account for the dynamic nature of health facilities, health committees and the health system in which they reside. In this manner, health care providers can increasingly contribute to building sustainable relationships with health committees to promote meaningful and effective community participation, the strengthening of people-centred health systems and the progressive realisation of the right to health.

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Everyone else who has inspired and encouraged me with their wisdom and compassion along the way.

## **Acronyms and Abbreviations**

CMHF	Cape Metro Health Forum
HC	Health Committee
HCP	Health Care Provider
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDRC	International Development Research Centre
LN	The Learning Network for Health and Human Rights
NHA	The South African National Health Act
PHC	Primary Health Care
UN	United Nations
WHO	World Health Organisation

Preamble

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## **PART A: RESEARCH PROPOSAL**

Health Care Providers' Responsiveness to Health Committees in the Cape  
Metropole, South Africa: A Training Evaluation

Submitted: February 2015  
Approved: March 2015

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## 1. Literature review

*For the purposes of this thesis, this section has been moved to part B*

## 2. Operational Definitions

**Right to health** is “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (UN, 1966). This means that, besides aiming for people to have access to treatment and to be disease free, this right promotes health by tackling challenges in the social determinants of health (UN, 2000). Moreover, promotion, restoration and maintenance of the right to health in its entirety are essential to provide equitable, equal and non-discriminatory access to quality health services (Hunt & Backman, 2007).

**Right to participation** is raised by the Declaration of Alma-Ata (WHO, 1978) as people having “the right and duty to participate individually and collectively in the planning and implementation of their health care”, which “requires and promotes maximum community and individual self-reliance as well as their participation in the planning, organization, operation and control of primary health care”. Potts (2008) defines participation as “the active and informed participation of individuals, communities and populations” and views it as an inherent element of health systems and the realisation of the right to the highest attainable standard of health (Potts, 2008).

**Community participation** in health care is the active identification of common health needs by geographically defined groups of people ( Rifkin, Muller & Bichmann, 1988). This includes their involvement in decision-making and setting up mechanisms to meet the identified needs to thereby improve and achieve equity in health and health care provision ( Rifkin, Muller & Bichmann, 1988).

It is also argued that community participation is not a once off activity but a process that can result in different degrees of involvement and different roles and power of community members (Loewenson, 2000). According to EQUINET this process involves partnerships between different community members and health system actors and stakeholders from other sectors that are voluntary, genuine and guided by common vision and goals (Loewenson, 2000). Hence, community participation can serve as a vehicle to improve a patient-centred health system by forming platforms to voice and address (vulnerable) communities' specific needs and finding solutions to issues (Craig and Mayo, 1995).

**Health committees** can function as a platform of community participation (Loewenson, Machingura, Kaim, (TARSC), & Rusike, 2014). By providing such a platform, communities can be enabled to advocate for their needs and to participate in the decision-making and agenda-setting with health care providers (Meier, Pardue, & London, 2012). In South Africa, a health committee is affiliated with a health facility and represents the community in the catchment area of that specific facility (Parliament of South Africa, 2003). The National Health Act (2003) states that a health committee should consist of community members from the facility's catchment area, ward councillor(s) and facility manager(s) (Parliament of South Africa, 2003).

**Health systems** are made up of "all organisations, people and actions, whose primary intent is to promote, maintain and restore health" (WHO, 2007). The World Health Organisation (2007a) names six health system key functions: health service delivery, human resources, leadership and governance, information, financing, as well as medicines and technology. As people form the heart of the system by driving these key functions (Hunt and Backman, 2007), they can both impede and improve health system functioning.

**Health care providers** are referred to in this proposal as health care workers, health facility managers and any other providers of service delivery to the communities.

**Health care workers** are referred to as those who stand at the frontline of health service provision and have direct contact with the patients. These people include doctors, nurses as well as receptionists.

**Health facility managers** are referred to as the clinical, financial and/or administrative heads of the health facility. However, e.g. depending on the size of the facility, they do not necessarily require direct contact with patients.

**Training** is referred to in this proposal as the capacity building of health committee members or health care providers. Training entails learning through personal reflection upon human rights and ethical professionalism, the role of inter-personal (power) relationships, governance, and health committees to facilitate effective community participation in health care as well as the realisation of the right to health (Marshall and Mayers, 2015). To achieve this, adult learning and experiential learning theory underpin the principles of this training (Hansman, 2001; Kolb, 1984).

**Understanding** arises from the processing of (present) knowledge to a personal interpretation of the meaning, the applicability and importance of that knowledge. Knowledge can be either transformed or not transformed by experience (Kolb, 1984). Thus, understanding, as used in this proposal, is the result of processed knowledge that can be influenced by experience.

**Responsiveness** is referred to as the sum of both understandings, intentions to practices, and practices promoting community participation and health committee functioning. These understandings and practices can be a result of experiences with community participation and health

committees, availability of training on community participation as well as other, upstream factors, such as work pressure (De Silva, 2000).

### **3. Problem Statement and Rationale**

Meaningful participation of community members is important for improving leadership, governance and accountability in a people-centred health system (Potts, 2008). This requires the active and informed participation of community members in health service delivery oversight, monitoring and decision-making (Haricharan, 2011; Potts, 2008; Rifkin, Muller & Bichmann, 1988). Health committees can form a platform for the community and its vulnerable groups to be involved in an active and informed manner to advocate for their needs. In this way, these governance structures potentially strengthen the delivery of inclusive, equitable and accessible health services, ultimately facilitating the implementation of the right to health (London & Schneider, 2012). Thus, fulfilment of the right to participation can serve as an instrument to realise the right to health (Meier et al., 2012).

The South African National Health Act (NHA) acknowledges the role of health committees in the promotion of both rights (Parliament of South Africa, 2003). The NHA states that a health committee must be composed of community members, a ward councillor and a health facility manager. However, it leaves its roles and mandate to provincial policy legislation and action (Parliament of South Africa, 2003). Consequently, provincial policies are found to be in different stages of development, hence health committees are found to be at different levels of functioning (Boullé, Makhamandela, Goremucheche & Loewenson R, 2008; Haricharan, 2013; Padarath & Friedman, 2008). The Western Cape Province is the only province with no final and implemented policy framework on the guidelines and regulations for community participation and governance structures in health (Haricharan, 2013). Padarath and Friedman (2008) show that lack of clarity

about the roles and responsibilities of health committees as well as their lack of power and mandate can limit their effective integration within the health system.

Health care providers' understandings of health committees' roles and functions, their practices towards health committees' effective functioning as well as their attitudes towards patient rights might influence health committees' meaningful participation. For instance, Haricharan (2011) reports on an audit of health committees in the Cape Metro and identifies, amongst other key challenges, challenges connected to health care providers' involvement. These are related to a lack of mutual trust and engagement between providers and health committees, health care providers' understanding of the relationship between the right to health and participation, their understanding of health committees' role and mandate as well as power imbalances between the facility manager and health committees. Moreover, some health care providers' are reluctant to involve communities and find accountability challenging (London et al, 2012; Padarath and Friedman, 2008; Glattstein-young, 2010).

Thus, for health committees to effectively integrate in the health system, the presence of health committee responsive health facility staff appears to be just as essential as capable and skilled health committee members. Hence, in addition to health committee training, training of health care providers, i.e. health facility managers and health care workers, could be vital to the effective implementation and functioning of health committees. Under the auspices of the Learning Network for Health and Human Rights (LN) and in cooperation with the Cape Metropolitan Health Forum (CMHF), health committees in the Western Cape Province are being trained to build their capacity and functionality. In February 2015, the LN will also implement training of health care providers on health committees as a mechanism of community participation. The proposed research will address

the gap in understanding the impact health care provider training could have on community participation through health committees.

This protocol proposes an evaluation of the health care provider training pilot. It seeks to describe and explore health care providers' immediate responsiveness to health committees' meaningful participation. The arising study findings will inform the further development and evaluation of training by the Learning Network in the Western Cape. Research findings may also encourage decision-makers in other settings to implement the health care provider training. Ideally, it will inform and support the development and implementation of local, district, provincial and national health policy on health committees' roles and functions, their training and health care providers' training on health committees.

#### **4. Research Aim and Questions**

With the implementation of the adult learning, rights-based training, the LN hopes to actively promote a better understanding of the role, mandate and functions of health committees among health care providers and their involvement with health committees. The aim of this research is therefore to evaluate health care providers' initial responsiveness to health committees as a result of the health care provider training. The research question and sub-questions are:

To what extent does the LN training of health care providers in the Cape Metro district health system promote their responsiveness to health committees?

- What are health care providers' pre- and post- training understandings of health committees and their role?
- Do health care providers' intend to change their practice following the training and if so, how?

These descriptive and exploratory research questions will be answered through the evaluation of three pilot sites or cases. The study's flexible evaluation research design will adopt different qualitative methods. These methods include documentary review, direct observations, pre-and post-questionnaires, semi-structured interviews and a field note diary.

## **5. Research Methods**

### **5.1 Setting**

Five Western Cape- based civil society organizations and two universities in Cape Town (UCT and UWC) collaborate under the umbrella of the Learning Network for Health and Human Rights. The proposed research is part of the LN's project "Health System Governance: Community Participation as a key strategy for realising the Right to Health" (HREC ref:179/2007) which aims to advance the right to health through civil society engagement and community participation. For the development and implementation of the rights based health care provider pilot training, the LN has been working together with the CMHF to identify the challenges affecting working relationships between health care providers and health committees. Health care providers from City of Cape Town clinics in a variety of sub-districts of the Cape Town District Health System will be recruited to attend centralised training sessions facilitated by two Learning Network trainers.<sup>1</sup>

### **5.2 Training Purpose and Approach**

The purpose of the training, designed by Marshall and Mayers (The Learning Network, 2015), is to stimulate community ownership of the right to health. This is done by encouraging health care

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<sup>1</sup> The initial proposal was to recruit study participants from three facilities at which the training would be implemented. Due to the nature of the training and sub-district managers' concerns about the burden of the training and study on the service delivery of the individual facilities, the training set up and implementation approach was changed, hence the recruitment of study participants as well.

providers to promote community participation in health care decision-making through their active engagement with health committees. The training manual content is based on the Health Committee Training Manual (Learning Network, 2014) and the feedback and experiences of CMHF health committee members who participated in the training and worked towards increased community representation at the health facilities. Adult and experiential learning approaches (Hansman, 2001; Kolb, 1984) are adopted to explain and discuss health committee functions and roles, the right to health, other human rights, inter-personal (power) relationships as well as governance to promote effective community participation in health care. In line with the adult and experiential learning theories, trainers will use the manual as a guiding tool and take up a facilitating role to engage with and build on what the trainees already know; a process called scaffolding (Vygotsky, 1978).

The prompts, guides and cues provided by the trainer as well as group exercises and discussions connect the content of the training to existent knowledge and experiences of the adults and the contexts in which they reside (Hansman, 2001). In this manner, effective scaffolding can take place through inter-subjectivity, which entails that different perspectives of different stakeholders are brought forward in an interactive manner. Inter-subjectivity will be stimulated in group discussions and is facilitated by the sharing and negotiation of meanings and situational definitions, the building of knowledge and restructuring of problems (Gallimore & Tharp 1990; Diaz, 1990). Moreover, participants' experiences with and expectations of health committees are explored by means of the training. Subsequently, the group discussions allow for a common vision to be identified or created.

More specifically, through the training, light will be shed on the different levels of involvement of staff and managers with health committees, their knowledge on health committees' role and mandate and the structures or mechanisms that are in place or are missing to facilitate health committee functioning. Accordingly, the trainers engage with the participants to identify how to

collaborate and where each party can contribute to improve health committee functioning. Based on Kolb's (1984) action learning cycle, the facilitators will stimulate continuous reflective observation of concrete experiences (Figure 1). This is followed by the formation of abstract concepts from these observations and the active experimentation with these concepts in new situations. For instance, the training will encourage discussion on human rights legislation and (personal) health rights violations from a broad span of cases and reflect on the discussions that these cases and personal experiences have brought about. In this manner, participants' thinking about and generation of new ideas and concepts is stimulated and solutions or strategies for future practices are discussed. Favourably, the training induces independent thinking and cooperative learning within the facilities of participants that will continue beyond the training (Vygotsky, 1979; Kolb, 1984).

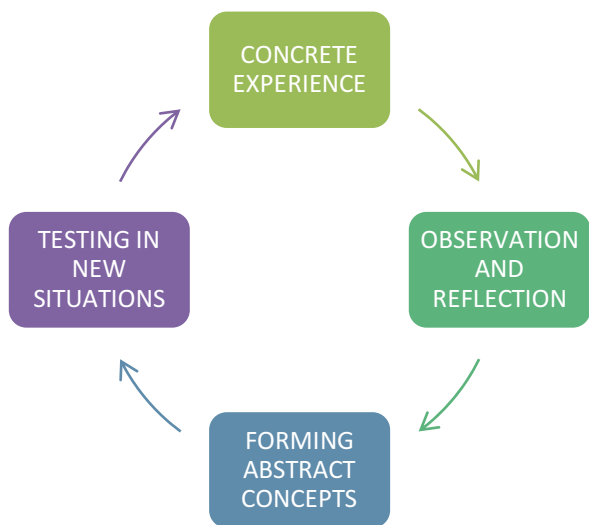


Figure 1: Kolb's Action Learning Cycle (adapted from Kolb, 1984)

### 5.2.1 Training Implementation

The training takes up the equivalent of one and a half training days: starting with one day of training followed by another half a day of training follow up, at least a month after the first day of training. Interim descriptive feedback will be given to the facilitators to be able to adjust the training to the participants' needs as well as for them to know what topics to focus on in the follow up session.

After the complete evaluation and when final improvements have been made, the training will potentially be rolled out through trainer-to-trainer development programmes in the sub-district services of the Cape Town Metro District Health System.<sup>2</sup>

### **5.3 Sampling**

For this study, health care providers will be recruited who vary in nature and extent of their relationships and experiences with health committees. However, the sub-district managers and facility managers control site access and determine the availability of managers, nurses and other staff to participate in the training, to which recruitment is therefore subject to. Hence, in cooperation with the LN, the trainers will engage with City Health Cape Town, sub-district managers and facility managers to buy-in their interest. For the purposes of this evaluation, the recruitment of study participants from at least two out of eight sub-districts will be pursued. This will allow for additional cases from which to draw information-rich, locally generated meaning of the concepts that the health care providers will be trained on (Babbie, 2007). Participants will be recruited until data saturation is reached or time for evaluation is restricted.

At least two different training groups will be evaluated, of which the sample size will differ per training group (approximately 10-20 participants). All health care providers who participate in the training and agree to participate in the study will be asked to fill in pre- and post-training questionnaires. For the interviews, this study will adopt purposive sampling (Babbie, 2007). The

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<sup>2</sup> The training was initially proposed to be two consecutive days to be divided up by the facility at which the training would be implemented. Accordingly, the training was planned to be improved and followed up on after the complete evaluation. However, due to the before mentioned changes in training set up and with the certainty of the training sessions being more dispersed over time, interim feedback became feasible and beneficial to both trainers and participants. An amendment was submitted to the Faculty of Health Sciences Human Research Ethics Committee and approved (as per 01/08/15, HREC REF: 2015/062) Eventually, the follow up training sessions did however not take place due to the low turnout and (project funding) time constraints.

study's aim is not to draw representative conclusions from the small, qualitatively investigated sample, but it strives to explore the possible variations in nature and extent of the immediate training outcomes (Lincoln & Guba, 1985). Therefore, a variety of health facility managers, nurses and other key stakeholders such as health promotion officers and health committee members will be asked to partake in the interviews. The latter stakeholders will only be approached for informed consent in cases where there has been interaction between the health facility and health committee after the training.

#### **5.4 Concepts and Theories**

The evaluation will primarily be guided by the learning themes and concepts covered in the training manual and the actual training. Based on these identified themes and concepts, changes in understanding and intended practices as a result of the adult learning-, rights-based training will be assessed (Vygotsky, 1978; Kolb, 1983; Hansman, 2001). The experiential and scaffolding learning processes themselves observed during the training will be evaluated based on Kolb's (1984) action learning circle (Figure 1).

Furthermore, the extent and nature to which health care providers' intentions to change practices stimulate the involvement and independence of health committees in the people-centred health system will be investigated. More specifically, the extent to which these intentions contribute to the four elements of primary health care delivery, planning, organization, operation and control as defined by the Alma Ata, will be investigated (WHO, 1978:VII). Extra attention will be paid to the before mentioned key challenges related to health care providers' nature and extent of engagement, as addressed by Haricharan (2011), to identify to which nature and extent the training can aid health committee's effective integration within the health system.

### 5.5 Data Collection Methods

The proposed study will adopt qualitative methodology in a flexible research design. This design is sensitive to the real-world dynamics of implementing a pilot training requiring participation of health care providers from different sub-districts in the Cape Metropole. It will also allow for responsiveness to the findings generated from earlier phases of data collection and ensures that study objectives are met. Moreover, the research questions and data collection methods will be continuously refined and can be changed as deemed appropriate.

By means of this research design, the “real-world” “hows” and “whats” of health care providers’ understandings, agendas and organisationally embedded (inter)actions during and after the training will be explored more in detail and interpreted in attempt to answer the research questions (Robson, 2002). Similar to the principles of adult learning theory and Vygotsky’s scaffolding framework that are adopted for the training (Kolb, 1984; Vygotsky, 1978; Hansman, 2001), this research design will be constructive. This means it supports the belief that knowledge arises from real-life experiences and is therefore obtained through interacting with people (Sale et al, 2002).

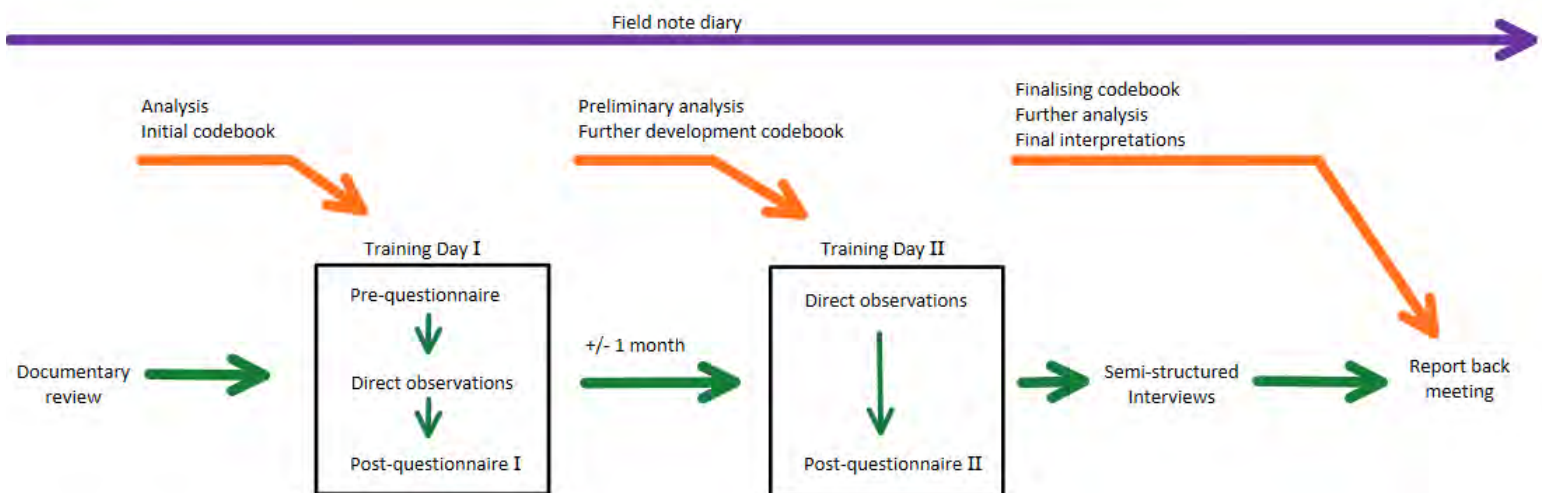


Figure 2: Overview of data collection process

### **5.5.1 Documentary Review**

The health care provider training manual (Marshall and Mayer, 2015) will be reviewed on the topics it discusses, from which concepts and themes will be derived to inform the questionnaires, the interviews and guide the study's data analysis. If meeting minutes of health committees affiliated with participating facility managers' facilities are available these will also be reviewed up to six months back in time. The review focus will then be on health care providers' involvement and interactions with the committee, e.g. health facility manager's attendance.<sup>3</sup> These minutes can play an important role in the triangulation of data as they can provide insight into the participants' previous natural responsiveness towards health committees.

### **5.5.2 Pre- and Post-questionnaires**

When participants have provided consent to do so, they will complete a pre-questionnaire just before the first training session starts (Appendix I). This will explore current understandings of health committees as well as stimulate reflections on previous and current practices towards health committees. A post-training questionnaire will be distributed directly after the training to assess the immediate training impact. It will be different from the pre-questionnaire in that it additionally asks for participants' opinion about the training and whether and how it would change their engagement with health committees (Appendix II). Based on the preliminary analysis of the first phase of data collection, the post-training questionnaire will be adapted and distributed approximately three to four months after the first day of training to assess the short-term impact of the training on health care providers' understandings and practices.

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<sup>3</sup> In the initially proposed evaluation of only three participating facilities it would have been feasible to look at all facilities' health committee's minutes. However, considering the diversity of participants attending the training as currently proposed, including nurses and officers, minutes will only be requested of the facilities of which (deputy) facility managers participated in the training.

Each questionnaire will take about 20 minutes to complete. The questionnaires will exist of primarily open-ended and a few multiple choice questions. These are based on the documentary review of the health care provider training manual and set up in conversation with the trainers to ensure agreement with their vision for the training. The total sample size for these questionnaires is expected to be small (approximately 30 people). Nevertheless, findings can describe the nature and extent to which the training changed participants' responsiveness to health committees (as a platform for community participation). These descriptions might identify responses and topics that could be given special attention to during the interviews.

### **5.5.3 Direct Observations**

Direct observations of the training sessions will inform the second post-questionnaires and the interviews. These observations contribute to the richness of the data by looking at the development of participants' understandings and ideas for future practices. This will possibly shed light on reasons why health facility managers and health care workers may or may not increase responsiveness to health committees as a result of the training. The observations will also help identify the nature of the training and interactions between participants from different facilities and sub-districts. While making these observations the researcher will not probe or pose any questions, allowing natural occurring data to be collected. In this manner, the observations can provide insights that go beyond participant's own meanings, definitions, descriptions of relationships, events and issues that are gathered from the questionnaires and interviews. In fact, it will help determine how interactional sequences occur, originate and are organisationally embedded (Silverman, 2013). In addition, health committee meetings will be attended where opportunities arise within the study's timeframe to observe the extent and nature of the direct impact health care providers' immediate change in responsiveness has on health committee functioning.

#### **5.5.4 Semi-structured Interviews**

Semi-structured interviews will be held to gain a deeper understanding of the emerging themes and phenomena arising from the preliminary analysis of observations, pre- and post-training questionnaires (Hennink, 2011). For this reason, interviews will only take place after the training and preliminary analysis of the first phase of data collection. These preliminary findings are used to inform, refine and adapt the open-ended, questions of the topic guide (Appendix V) in order to be relevant to the various working contexts and roles of the different participants. The open-ended questions will be formulated to leave sufficient room for variation in answers, probing based on preliminary findings and other questions that are stimulated by the interviewee's narratives (Cohen, 2006). The interviewee's responses to the second post-questionnaire completed before the interview can also inform additional probes.

Accordingly, the interviews will generate a more comprehensive understanding of the health care providers' experiences, personal changes as a result of the training and provide deeper insight into their definitions, meanings, and perceptions regarding the concept of meaningful community participation through health committees (Punch, 2005). The interviews will take up to an hour. Beforehand, the interview's purpose and duration will be discussed as well as confidentiality and consent for participation and audio recording reconfirmed.

#### **5.5.5 Report Back Meeting**

The discussions following the presentation of study findings during the report back meeting contribute to the data by means of respondent validation and follow up. Depending on participants' consent, these discussions will be recorded or notes will be taken.

### **5.5.6 Field Note Diary**

The field note diary will capture research details as well as general impressions and reflections on feelings and experiences of the researcher throughout the field work (Cottle, 1988). It will record all formal and informal communication, relationships, ideas (in attempt to discerning my own from those of others) and emerging interpretations. A field note diary will improve the audit trail and guide the triangulation of data by keeping track of rich data descriptions, decision-making, interpretations and interconnections made between data from different sources. The field note diary will thus be valuable during analysis and might reveal topics that otherwise would have remained unrevealed.

### **5.6 Data Analysis**

Due to the study's interpretive nature its flexible approach will be maintained throughout the analysis in order to prevent meaning to be lost. The codes and themes will therefore also be applied flexibly throughout the analysis and are subject to changes based on what is deemed appropriate with respect to the findings and the questions. I will use NVivo 10 to keep track of changes in my codebook and I will describe what and why I coded data segments in a certain way as well as whether the codes were derived deductively or inductively. Ultimately, the field note diary will facilitate the detailed description of the various stages of analysis.

Based on the conceptual frameworks and theories chosen for evaluation as introduced in *section 6.4* (page number), initial categories, concepts and themes will be identified. These will be used to guide the thematic analysis of the data. The themes discussed in the manual will inform the questionnaires as well as guide the interviews. The initial codebook is based on these manual themes as well as the themes, categories and concepts arising from the frameworks and theories. The codebook will be expanded based on the inductive analysis of further data collected and will be used to guide

subsequent deductive analysis based on the theories and concepts. Finally, the codes and meanings will be refined and the codebook collapsed.

Throughout the analysis key themes, concepts, ideas, contexts, meanings and patterns will continuously be described, decontextualised, interpreted, contextualised, reinterpreted and reflected on in order to answer the research question. As analysis will take place from the first point in data collection, reflections and reinterpretations of all analyses and interpretations as a whole will take place after all the data has been collected and analysed. The constant process of relating to the data, taking emotional and intellectual distance and reinterpretation will also help to reflect on my role and understandings in shaping the research process and generating findings.

The triangulation of all cases and sources will help understanding management at the facility and – perhaps to a lesser extent - sub-district level and its organisationally embedded need and obligation to address issues, involvement and partnerships (Sacks, 2004). Herein, it is important to both look at the mundanity of occurrences as well as the extreme cases and surprises (ibid), leading to a better understanding of the relationships, power balances, attitudes and practices of health care providers affecting their responsiveness to health committees.

## **6. Rigour**

When it is perceived necessary, questionnaires, informed consent and information sheets will be translated. This will be done by a translator who is an expert in the language and dialect as well as familiar to the local meaning and cultural connotations in order to convey “conceptual equivalence” (Mangen, 1999). Transcriptions of voice records, field notes and other data will be managed in NVivo. This software also helps to link the data to memos, hyperlinks and annotations for

immediate insight into related data, literature, reflections, decision-making and emerging interpretations.

A limitation to rigour is that I am not involved in the recruitment of study sites. The sites will be determined by where the Learning Network and trainers decide to pilot the study. Moreover, the fact that I am the only researcher responsible for this study's data collection and analysis can be a consequence to rigour as working in a team of researchers would be more rigorous. Team members can hold each other accountable for their ways of collecting data, their research tools, perspectives on the data, meanings of code categories, themes and interpretations. Nevertheless, I will be asking my peers and supervisors for second opinion and feedback on these aspects.

During the evaluation of the pilot training, dependability and repeatability will be increased by carefully documenting field decisions, method procedures, changes in questionnaires or topic guides and other fieldwork details in my field note diary (Lincoln and Guba, 1985). Furthermore, rigour will be persuaded by means of the flexible approach to data collection. Preliminary analysis of the data informs the rest of the data collection as well as it allows for review and reformulation of the research question and sub questions to ensure objectives are still being met. Confirmability will be enhanced through an audit trail existing of a field note diary and memoing journal in which thought processes, emerging interpretations and decisions during data collection, analysis and the write up of findings are kept track of.

I am a Dutch female and have a background in Biomedical Sciences and Science Communication. Although I do not have a background in Social Sciences, I might make observations that may be left unnoticed or seem common to other social scientists. In my field note diary, I will carefully review my interactions with the participants and the sites. These thick descriptions of interactions, relationships, thoughts and physical context will increase the applicability of the research (Lincoln

and Guba, 1985). Furthermore, the identification of essential context elements improves the reader to assess the usefulness of the findings for decision-makers in other settings.

My own and participants prior expectations are a threat to rigour. While observing the trainings, I will put my expectations aside to the best of my ability and avoid making assumptions while interacting with and relating to the training participants. I will be guiding and probing participants through relevant conversations that will help answer my research question. Altogether, this will result in a rich record on how health care providers are pursuing their goals and managing institutional tasks. However, my mere presence might influence the data.

I will increase credibility by interpreting data according to what is really collected and by elaborating on the expectations and surprises in findings. There will also be a report back meeting, in which respondents validate the draft transcriptions and findings at the end of the evaluation period to ensure the credibility of my interpretations and the findings. This will also provide the research participants with the opportunity to give feedback on partaking in the research itself.

All data will be gathered from health care providers at several different health facilities and these different sources facilitate the triangulation of findings. Moreover, qualitative data is primarily gathered by using three different methods; observations, documentary analysis and interviews which will be triangulated while analysing and interpreting to gain a deeper understanding of the many specifics that characterise the context (Lincoln and Guba, 1985). These methods will be performed until data saturation is reached or until the maximum time allocated for data collection is reached (three months).

## **7. Ethics**

### **7.1 Permission**

The overarching project “Health System Governance: Community Participation as a key strategy for realising the Right to Health” has already received approval (HREC ref# 179/2007). This research proposal will be sent in to the Faculty of Health Sciences Human Research Ethics Committee of the University of Cape Town for expedited review.

Buy-in of the sub-district managers’ and health facility managers’ interest in the training and evaluation will take place through visitations or monthly facility manager meetings. Access to pilot the training at health facilities of the Cape Metro has already been requested from the provincial Department of Health and City of Cape Town. The proposed evaluation will be submitted for review by the Western Cape Health Research Committee and City of Cape Town after it has been ethically approved by the Faculty of Health Sciences Human Research Ethics Committee. The Faculty of Health Sciences Human Research Ethics Committee will be notified of the specific study sites once permission from province, City of Cape Town and the facilities is granted. The Committee will also be made aware of any emerging need for an additional data collection method, type of analysis or study population and the ethical considerations around those.

Lastly, access to health committee meeting minutes will be requested from the health committee chair persons who will be contacted via the trainers of the LN’s Health Committee Training.

### **7.2 Risks and Benefits to the Participants**

The discussions flowing from the trainings may trigger the reliving of traumatic memories, problematic relationships or other issues experienced with (managing) service delivery, such as racism, abuse or violence. Although the risk and the need for psycho-social support are expected to

be minimal to none, participants will be encouraged to indicate when they require support. For these purposes, the LN's trainers can then be contacted.

The descriptive findings arisen from the study participants' contributions to the questionnaires will be used by the trainers to tailor the participants' follow up training and hence will be of benefit to the participants themselves. However, Research participation will not generate any further direct personal benefits. Participants will not be granted any incentives other than reimbursement for transport costs to the University to Cape Town or to any other location that is not one of the pilot sites. However, the training can be beneficial to the research participants as it is hoped to promote their understanding and practices of community participation through health committees.

Consequently, it can strengthen or improve the relationships between facilities and communities and thereby stimulate the promotion of the right to health through collaboration. Furthermore, the study findings will shed light on the potential impact of the training on health system functioning, create a better understanding of challenges in human rights based learning and how these challenges affect the extent and nature to which understanding will lead to intentions to improve practices towards health committees. This will pinpoint the aspects to include or improve on in the further implementation of the training and follow up.

### **7.3 Data Safety and Confidentiality**

Site characteristics will be used to distinguish the sites, nevertheless geographical locations will not be disclosed in the report or dissemination of the research findings to protect the anonymity of the sites. The participants will only be identifiable to me and everything participants tell me will be kept confidential. This encompasses that personal responses will not be linked to the individual at any stage of their participation nor will they be disseminated as such. I will ensure this by changing participants' names, the names of the places they work or any other trace of participants' identities in

all communications of the study findings and sharing of databases. Participants will be allocated an identity number after signing the informed consent to prevent identification and this number will be maintained as a reference for follow up during further data collection and analyses. Confidentiality of participants' participation in the group sessions of the actual training and during respondent validation in the report back meeting cannot be promised. However, participants will be urged to keep all information shared during the training sessions and report back meeting confidential.

To ensure safe data storage, hard copies of the questionnaires as well as field notes will be stored in securely locked cabinets. Audio records of training sessions, interviews and report back meetings as well as transcriptions of digital records, field notes and all other data will be saved and backed up securely on two different, multiple password protected computers; one home computer and one at UCT. Audio records and hard copies of questionnaires as well as field notes will be destroyed after two years to completely eliminate possible identification of study participants.

#### **7.4 Data Sharing**

The data will not be shared with anyone outside of the research team, comprising me, my supervisors and any researchers I may employ. The main supervisor has an appointment as a paid-on-claim UCT staff member and had previously an honorary appointment. Thus, while she has a Cardiff University affiliation, she is as much part of the UCT team as the other staff involved.

We do place the data on the LN project Vula website, a closed online platform to which only LN researchers have access. The data will only be uploaded once it is completely anonymised. All the LN researchers have agreed to this arrangement. Researchers from institutions outside South Africa will not have access to the data.

As data sharing with the trainers may raise anonymity issues, (interim) findings will be shared instead to be able to safeguard anonymity by providing an overview of the participants' breadth of answers

without linking it to any particular details that enable identification of the individual, their position and employment area.

### **7.5 Resource Requirements**

The study's Information Sheet and Consent Form (Appendix III and IV) of the study will be pre-distributed to all staff at the participating pilot sites. This is to provide ample time to the potential participants to decide whether or not to participate in the evaluation. Furthermore, the study will be introduced during staff or monthly facility meetings; this will provide the staff and managers the opportunity to raise questions and concerns.

The researcher will not be intrusive of the daily activities at the facilities. However, research participation does most likely require meetings during working hours, which can be both on week or weekend days. The time required from the potential study participants at the pilot sites is the attendance of a health facility meeting in which the training and evaluation are introduced (1 hour). If they have provided their informed consent, the study requests their participation in the training for a total duration of 2 days (this includes the completion of pre- and post-training questionnaires), the second post-training questionnaire (30 minutes), some of the trainees' participation in the semi-structured interviews (preferably 1 hour, but determined by the health care providers' availability) and possible participation in the report back meeting (up to 1 hour).

Trainings will be facility-based and data collection will mainly take place at the health facility. If there is no suitable space available at the facility for the time scheduled, interviews can be held at the Faculty of Health Sciences of the University of Cape Town.

## **7.6 Informed Consent**

Written consent will be obtained from participating sites (to approach staff, attend meetings, etc.), facility managers and health care workers. Participants will be volunteers of minimum 18 years of age who will have signed the informed consent. The information sheet and a copy of the signed consent form (Appendix III and IV) will be given to all participants.

Participants' permission to audio record the training sessions, interview and report-back meeting will be requested. In case participants do not agree to the interview or report-back meeting being audio-recorded, participants will be asked if they are happy with notes being taken instead. As any other method of data collection, the interviews will only start if participants provide informed consent. The report-back meeting will only contribute to the data when informed consent is provided to either audio-record or take notes of the meeting.

I will be reflexive of the influence of power dynamics on informed consent and I will prevent or address possible coercion of training participants taking part in this research by those involved with the recruitment of workshop participants, e.g. facility managers or trainers, as well as by myself. However, I will do to the best of my ability to prevent coercion through conducting the study recruitment by myself. Participants will be reminded that their participation is voluntary, of their ability to withdraw at any point without penalty and their ability to choose not to answer questions with which they feel uncomfortable.

## **8. Expected Outcomes**

This study addresses the gap in literature on the impact health care provider training could have on health committees' effective functioning. It also builds on the existing literature addressing health committees' challenges to meaningfully participate from a health care providers' perspective. At best,

findings might indicate that adult learning-, rights-based training can promote health care providers' responsiveness and thereby potentially facilitate health committee functioning as a platform for community participation in health care. Ultimately, this evaluation might describe the training's contribution to comprehensive realisation of the right to health in the South African District health system.

It is likely that the different facilities in different sub-districts will yield different outcomes of understandings and intended practices. For instance, health facilities with a well-functioning health committee are expected to gain new insights to improve practices, but are likely to be already quite responsive. Similarly, facilities with worse-functioning health committees might gain more benefit from the training in terms of their responsiveness. Furthermore, different enabling and impeding factors, whether context-specific or training-related, might be identified. These factors can potentially influence health care providers' eventual responsiveness, effective integration of health committees in the people-centred health system as well as inform future training and research.

### **8.1 Limitations**

Due to restricted time and financial resources, any inferences about the longer term changes in health care providers' responsiveness and health committee functioning as a result of the training cannot be made given the short time allocated for the evaluation of each facility (three months or less). An ethnographic design would have tracked the process from intentions to change practice to the actual actions promoting community participation and right to health in their broader definition and over a longer period of time. This interim evaluation solely looks at the potential immediate effect of adult learning-, rights-based training on health committees as a structure of community participation and not at other structures or mechanisms of community participation.

## 9. Knowledge Utilisation and Dissemination

The findings generated from this research will be reported to the LN, CMHF as well as the International Development Research Centre (IDRC) and the European Union (EU), who provide financial support to this project and its umbrella project. Furthermore, the findings will be directly presented and discussed with the research participants in the report back meeting. The findings will also be disseminated through publication of a peer-reviewed article (e.g. BMC International Health and Human Rights) and presentations at conferences (such as PHASA). A plain language report on the immediate changes as a result of the training will be drawn up and distributed as a poster in each participating facility. The research findings will be utilized by the LN and trainers to improve on health care provider training practices and inform further evaluation. The LN will also publish the generated knowledge on their website and distribute it via other networks that they are part of. At best, health departments and health facilities may decide to support implementation of the training programme on a larger scale.

## 10. Timeline

- While in South Africa
- While in the Netherlands

Activities	December 2014			January 2015				February 2015			March 2015		
Literature Review*													
Proposal final edits													
Presentation at LN Exco meeting													
Proposal review by Pat Mayers													
Proposal review by Jill Olivier													
Submissions for expedited review by HREC													
Submissions to province/City of Cape Town													
Preparation for fieldwork													

Activities	April 2015			May 2015			June 2015			July 2015		
Literature Review*	■	■	■	■	■	■	■	■	■	■	■	■
Fieldwork**			■	■	■	■	■	■	■	■	■	■
Data analysis/interpretation				■	■	■	■	■	■	■	■	■
Manuscript							■	■	■	■	■	■
Submission of thesis												■
LN Exco presentation												■

\* This entails keeping track of new publications and making sure the literature review is up to date throughout the process, in particular while awaiting approvals.

\*\* Timeframe for fieldwork is dependent on all research approvals to be specified and subject to training dates at facilities and health care providers' availability.

## 11. Budget

The budget plan depicted in the table below will be proposed to the Learning Network. It includes research costs for transport of both parties where required, stationary as well as administration costs to schedule meetings and data collection. The budget plan excludes budget allocated to audio recorders and NVivo 10, because these are already in possession. Furthermore, I will transcribe the interviews.

*Table: Budget proposal*

Item	Cost (ZAR)
Transport	3000
- Researcher (at 3 ZAR/km)	
- Participant (when required)	
Stationary	900
- Refreshments for participants (meetings, interviews)	
- Pens and paper	
- Prints and photocopies (informed consent, information sheet, questionnaires)	

Administration	300
- Telephone (100 ZAR x 3 months)	
- SMS reminders	
Knowledge dissemination	300
- Means of dissemination/communication (incl. report at report back meeting)	
<b>Total</b>	<b>4500</b>

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## **PART B: LITERATURE REVIEW**

Community Participation and the Right to Health  
in People-Centred Health Systems

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## **Introduction**

In this section, literature is reviewed on the role of community-based governance structures in the implementation of the right to health and participation in order to promote and strengthen people-centred health systems. Moreover, the role of community participation and health committees as community-based governance structures in the delivery of primary health care, both in international and South African health systems, will be discussed. Furthermore, the influence of interactions and relationships between the community (i.e. patients and the public) and health care providers through health committees will be examined. At last, this review will assess training strategies for health care providers to promote community engagement or health committee functioning in people-centred health systems and the right to health.

A literature search was undertaken using the Web of Knowledge, Scopus and PubMed databases focusing on human rights and people-centred health care, in a global and local context, but with particular focus on Southern Africa. The review also includes background and methodological books or readers published in English. The literature search of empirical evidence was limited to articles published in English between 2008 and 2015. Keywords used were: right to health, human rights, community participation, health (care) workers or providers or professionals, facility (or clinic) managers, (adult learning/ rights-based) training, health committees (and other similar terms such as clinic committees) and service delivery/needs responsiveness.

### **1. The Right to Health and People-centred Health Systems**

The right to health was first recognized by the World Health Organisation's Constitution in 1946 (WHO, 1946). Thereafter, the International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN, 1966) and the Declaration of Alma Alta (WHO, 1978) further specified the right to health as: "the right of everyone to the enjoyment of the highest attainable standard of physical and

mental health. State Parties have the obligation to respect, protect and fulfil this positive right through active promotion of its implementation” (WHO, 1978). The General Comment 14 is the United Nations’ interpretation of the meaning of the right to health as a human rights law. In this document advice is provided on the implementation of the right to health. For instance, it is highlighted that the State’s obligations to promote the right to health can be achieved through health policy formulation, and the implementation of health programmes or legal instruments (UN, 2000). These processes are all interconnected with and dependent on the health system. Like any human right, the right to health is indivisible, interdependent and interrelated with other civil, cultural, economic, political and social rights that focuses on human dignity and freedom. Particularly, it is recognised that the right to health will only be fulfilled when other underlying determinants and rights such as the right to adequate sanitation and nutrition are realised too (UN, 2000). Together these rights are legally guaranteed and highly promoted by the international human rights law (UN, 2000). As health programmes impact both human rights and health, these programmes need to adopt “complementary and indivisible approaches to advance human well-being” to achieve the right to health (Mann et al., 1999).

It is of key importance for health system functioning to adopt a human rights based approach that is focussed on intentionally driven policies that promote equitable, equal and non-discriminatory access to health services (Hunt and Backman, 2007). Although the State’s capability to formulate policies, set up health programmes and legal frameworks is essential for adopting a human rights based approach, the facilities, services and goods additionally need to be in place to lead a complete realisation of the right to health and eventually access to health care for all (UN, 2000). These organisations of structures and commodities together with the people and their actions form the health system (WHO, 2007a). Depending on the health system’s character and values, it may or may not adopt a rights based approach to achieve its goals.

The defining goal of any health system is to improve health by maintaining, promoting and restoring health (WHO, 2007b). The wider goal of a health system is to improve responsiveness, efficiency as well as social and financial protection (WHO, 2012). Health systems goals are facilitated through six key functions, or building blocks which are: health service delivery; human resources; leadership and governance; information; financing; medicines and technology (WHO, 2007a). These building blocks continuously interact with and influence one another through the actions of people who are at the core of the system (WHO, 2007a). Accordingly, a health system is not only made up of the resources, structures, organisations and technology, or hardware, but also the so called software elements that are people's values, norms, ideas, interests as well as their relationships (WHO, 2007a).

The compatibility of the software to work with the system's hardware at the local, organisational and national level affects the entire health system's functioning (WHO, 2012). As a result, change in health system functioning is ultimately shaped by the people operating at different levels and roles of health sector (Sheikh et al., 2014a). That is to say, different people and sectors (public and private) drive the maintenance, promotion and restoration of health and consequently the implementation of right to health. The latter structures have a direct and indirect influence on the functioning and ability of the health system to achieve its wider goals that are beyond the clinical setting (Sheikh et al., 2014b). For instance, from a health system's perspective, improvements of health system functioning can promote equity and respect for people's dignity and may show results directly by increased access to care and patient satisfaction (WHO, 2012). From a societal perspective, an implicit sense of equity and mutual respect while seeking health care can indirectly improve health system functioning (Hunt and Backman, 2007).

A people-centred approach focuses on health system functioning from both a health system's and societal perspective. In fact, such an approach shifts the focus from the disease to the person as a

whole (WHO, 2007c). It promotes collective-centred health care in which all people, i.e. both communities and those working in the system, contribute and benefit (ibid). Accordingly, a people-centred health system aims to empower the patients as well as their families, the communities and populations to promote their own well-being and needs (ibid). One of the ways in which communities can be empowered is by providing them with opportunities and skills to take part in advocacy and decision-making of health care (Laverack, 2009). This can enhance society's capacity to be actively involved in the improvement of their own health and their involvement in the tackling of challenges with the social determinants of health (ibid). Thus, a people-centred health system seems to account for the right to health's interdependent, indivisible and interrelated nature by actively embracing the importance of the upstream, social factors and rights that determine health. As Hunt and Backman (2007) point out "the right to health can help ensure that a health system is neither technocratic nor removed from those they are meant to serve" (Hunt and Backman, 2007). People are at the heart of the health system. Inter-sectoral as well as multi-level collaboration and action is essential to respect, protect and fulfil the right to health in the holistic, dynamic, people-centred health system. More specifically, community representation, empowerment and participation are inherent components to efficient and effective functioning of the people-centred health system and the realisation of the right to health (Craig and Mayo, 1995; WHO, 2012).

### **1.1 Limitations to a Rights Based Approach**

The idea of human rights being universal is often criticised (WHO, 2002). For instance, some critique is based on the language used, the Western ideology employed as well as on the context and time in which the Universal Declaration was formulated (Donnelly, 2007). Rights appear to be based on norms that are not always universally accepted (Preis, 1996). One could argue that what would be considered as appropriate implementation of rights is subject to the context of implementation.

Drawing on lessons from the HIV epidemic, De Cock et al., (2002) states that a human rights-based approach might not always be the most practical and applied framework for meeting public health and social justice goals, especially in poorly resourced regions, such as Africa. In line with this, Ferraz (2008) argues that a rights-based approach is perhaps too preferentially focused on individuals' rights and needs over the public good. Arguing from a neoliberal perspective, Mchangama (2009) further affirms the latter views by highlighting the lack of practicality of the rights based approach in a real world context. While Reubi (2011) echoes arguments made by other experts that action within a rights-based framework can draw resources away from interventions and can exacerbate inequalities.

Hunt and Backman (2007) argue that a health system risks becoming impersonal when experts dominate the use of the “top-down” approach to decision-making. They find that such an approach does not conform to a rights based and people-centred health care system. In a rights based, people-centred health system, patients and communities would namely raise concerns and needs as part of their direct involvement in health care decision-making and monitoring of health services (WHO, 2007b). However, the complexity of implementation thereof is amplified when dealing with the complex and holistic dynamics of a country's health system. Different health systems generate different health outcomes, because the challenges health systems face are dependent on their unique composition, place in society and priority given by the State (WHO, 2007a). However, independent of State intentions, people can function as both enablers and barriers to multilevel and inter-sectoral cooperation as well as the adoption of rights based approaches to health care in working together. After all, people are the drivers of the system and they maintain different relationships at different levels of decision-making. Thus, good governance is required to create a level of accountability and to share responsibilities between communities and the State to promote the right to health (WHO, 2012). Instead of implementing the right to health by means of a top-down approach, the next

section further explores a more rights based approach to its implementation: the employment of community participation as a bottom-up strategy to facilitate the right to health and people-centred health systems.

## **2. Participation and the Right to Health**

The Alma Ata Declaration addresses that participation can be claimed as a right in health care; “people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (WHO, 1978:VII). Moreover, it states that, in order for people to fulfil their right and duty to participate in the planning and implementation of their health, “maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care” must be promoted (WHO, 1978:VII). Additionally, the Ottawa Charter established the grounds for a new approach to public health that focusses on the sharing of responsibilities in order to promote the right to health (WHO 1986). The charter emphasises that “access to information, learning opportunities for health and funding support” are essential for active and informed community involvement. The bill would enhance community ownership and control of the right to health’s implementation at all levels of the health system (WHO, 1986). Furthermore, it is recognised that community participation platforms can serve as a vehicle to improve a patient-centred health system by raising and addressing (vulnerable) communities’ specific needs and finding solutions to issues (Craig and Mayo, 1995). The UN’s Moreover, the General Comment 14 describes community participation as a fundamental platform for effective healthy systems governance, not only at primary health care (PHC) or individual level, but at the organisational and national level as well (UN, 2000). Hence, community participation promotes autonomy of individuals and communities in society as encouraged by the human rights covenants (UN, 2000). Thus community participation is a key facilitator to attaining the highest

standard of health and strengthening health systems (Hunt and Backman, 2007; Potts, 2008b).

Finally, participation plays an important role in improving the key health system elements of governance and accountability in a people-centred health system (Potts, 2008b).

However, community participatory mechanisms are often mistakenly interpreted and used as extensions of human resources (Craig and Mayo, 1995). In such occasions, ownership for resource provision is established through skills generation and the reallocation of tasks and responsibilities (Potts, 2008b). This might be because health care providers lack the skills, are overworked, or lack compassion to involve the community in the planning and implementation of their service delivery (Franco, 2002). Furthermore, the nature and extent of patient-provider interactions could affect room for active participation and successful improvement of accountability within the health system (Baldwin-Ragaven, 1999).

### **3. The Right to Health and Community Participation in the South African Context**

Section 27(1 & 3) of the Constitution of the Republic of South Africa states that “every person has the right to access health care, including reproductive care” and not be refused emergency treatment” (Republic of South Africa, 1996). To achieve this, section 27(2) of the Constitution provides that the State takes reasonable legislative measures within its available resources. Any law that is passed under the Constitution must respect, protect and fulfil the right to access health care. However, this right (right to access health care) as the Constitution provides, does not comprehensively take into account underlying health determinants other than the right to access sufficient food and water as well as the right to social security mentioned in section 27(1). More recently, the South African government has signed and ratified the International covenant on social, economic and cultural rights (ICESCR) (UN, 2015). This means that these economic, social and cultural rights are acknowledged by the government and the State is now obliged to refrain from acts

that would undermine the treaty's objective. However, the government is not yet legally bound and cannot be held accountable to their implementation and progressive realisation of these rights at the international level.

The White Paper on the transformation of the health system in South Africa (1997) came out during South Africa's early democratic years and formed a new policy envisioning "healthcare for all".

Besides other objectives, this policy document aims to adopt the PHC approach by focusing on district implementation (Department of Health, 1997). The White Paper was drafted and legislated five years before the National Health Act (NHA) in 1998 (Hassim and Heywood, 2007). Thereafter other policy frameworks, such as the National Patient Rights Charter followed the same health reformative thinking. The National Patient Charter's rights were later acknowledged under the National Health Act (NHA) in 2003 (Parliament of South Africa: Act No. 61, 2003). The NHA aims to establish inter-sectoral cooperation and responsibility-sharing at national, provincial and district levels of the health system (ibid). Amidst other objectives, it hopes to achieve this through establishing an enquiry- and advocacy-spirited system encouraging participation (Hassim and Heywood, 2007; Parliament of South Africa, 2003).

The re-engineering of PHC, later accompanied by the Human Resources strategy for Health (Pillay and Barron, 2010), are now followed by the implementation of the National Health Insurance (NHI) green paper (Department of Health, 2011). This policy aims to "promote equity and efficiency, and to ensure that all South Africans have access to quality health care services regardless of their socioeconomic status". To achieve this, the policy focuses on community outreach and boosting the re-engineering of PHC by focusing on building district, school- and ward-based management systems and generating public-private health care partnerships (Department of Health, 2011). However, the National Health Insurance does not specifically state its approach to community

participation, except for allocating responsibilities to “primary health care agents”. These agents are supposed to identify health problems and behaviours and implement appropriate interventions for high-risk individuals and vulnerable groups (Department of Health, 2011). If any, it is not clear what roles community members play herein and there is no mention of community participation through health committees.

In South Africa, community participation ought to be structured through health committees. The NHA states that each clinic or community health centre or a group thereof must have a health committee and at least include a government councillor, a community member from the facility’s target area and the head of that facility (Parliament of South Africa, 2003). Although the NHA also recognises the importance of these community health agents, it does not elaborate on the functions and power of these health committees, ascribing this to provincial legislation (Pillay and Barron, 2010). This has led to countrywide policy differences and an unequal distribution of health committee implementation and success, as there are no clearly defined and allocated roles. In practice, committee members often lack the skills and health committees’ executed power is limited (Padarath and Friedman, 2008; Pillay and Barron, 2010). The Western Cape Province has yet to develop and implement a final policy framework on the guidelines and regulations for community participation and governance structures in health (Haricharan, 2013).

#### **4. Health Committees as a Platform for Community Participation**

Health committees are one of the interfaces through which community participation takes place. By formally linking health facilities with health committees, conversation between both communities and health care providers may be stimulated (Meier, Pardue, & London, 2012). Furthermore, needs for planning, implementation and education can be assessed through these structures (Meier, Pardue, & London, 2012).

Health committees could take on responsibilities of governance and co-management, generate resources, stimulate community outreach and advocacy, create health intelligence and mediate as a social leveller (McCoy, 2012). Community participation is stimulated through partnerships between frontline health workers and communities. When these partnerships are actively governed through health committees, health outcomes, quality and equitable access to care can improve (Boulle et al., 2008; Glattstein-young, 2010; Loewenson et al., 2004 McCoy et al., 2012).

McCoy et al. (2012) emphasise that all health committees function differently and are dependent on the complexity of health and societal factors influencing them in achieving their goals. For instance, according to the findings of a study conducted in the Cape Town metropolitan area, voluntary community participation is dependent on poverty and employment within the setting (Glattstein-young, 2010). It was also found that even when participation is incentivised it remains a challenge to retain community members (*ibid*). Furthermore, incentives might threaten a community participation agency's independence (*ibid*).

Furthermore, the health committees' role in improving equal access to health services can be impeded by a lack of clarity and allocation of health committee members' roles (Padarath and Friedman, 2008). Facility managers often do not understand the role and importance of health committees (Haricharan, 2011). Consequently, committees find themselves assisting in service delivery, delivering complaints without generating solutions and communicating issues at facility level to the community as opposed to the other way around (*ibid*). Facility managers tend to take ownership of the health committee and consequently limit mandate of the health committee (*ibid*).

Establishing good governance and clarity on roles and boundaries of health committee members is important when dealing with the heterogeneous and dynamic nature of health committees' composition and functions (Backman et al., 2008; Brinkerhoff & Bossert, 2013). Stakeholders

should therefore be stimulated to negotiate to invoke better power-relationships and equitable share of responsibilities. Inherently, power dynamics are influenced by the capacity and will of the state to make policies and implement them (Potts, 2008a). The state should create partnerships with non-state actors, such as health committees. In this manner accountability, oversight and responsibilities in decision-making about health service delivery can be shared and it can be avoided that communities are left feeling powerless and unrecognized (Potts, 2008a).

Haricharan (2011) studied the challenges that health committees face in the Cape Town Metropole. This research suggests that it is important to train health committee members on their responsibilities. In this manner, efficient partnerships within health committees as well as between the committees and State parties can be promoted. Moreover, it is expected that the empowerment of health committees may also create support from the environment to facilitate their active and informed community participation. Irrespective of health committees' empowerment, facility managers are identified as key stakeholders who influence health committee functioning. This confirms the need for service providers to actively listen to and engage with community participation platforms. Only then human rights dilemmas can be tackled and service delivery be adjusted to the community's needs (Cornwall, 2001). In agreement with London et al. (2012) and McCoy et al. (2012), it is valuable to further explore the role that health care providers, particularly health facility managers, play. In the following and last chapter of this review, more specific attention will be drawn to the extent to which these stakeholders affect the right to health and participation in the people-centred health system. Furthermore, it will look into the ways in which health care providers could be trained to create optimal freedom for the community to participate and for health committees to flourish.

## **5. The Role of Health Care Providers in Health Committee Functioning**

Active engagement between communities and health care providers is essential to promote the right to health. In order to facilitate this engagement it is of importance that health facility managers have a positive attitude towards community participation (Nathan, Braithwaite & Stephenson, 2013; Loewenson et al., 2014). In South Africa however, some health committees function as watchdogs and thereby delay work and decrease receptivity of facility managers to committees (Padarath & Friedman, 2008). Other committees function as an extension of services, assisting the health care providers where needed (Haricharan, 2011). Moreover, there is a misunderstanding of the active role both facility managers and health committees should play to facilitate community participation in health care (ibid). Firstly, facility managers can address issues they encounter in the services, as their job requires them to manage the facility and engage with patient's or health care worker's complaints. They are also in a position to assess in which ways the community can further create ownership of service delivery and take up responsibilities accordingly. In addition, through engagement with the facility users and workers, managers can promote the committee, stimulate interest and recruit committee members. Furthermore, facility managers can play an important role in networking and building relationships with non-governmental organisations (NGOs), the local government and lobby with policy makers to advocate for health committees' mandate, roles and functions.

In reality, these ways in which facility managers can stimulate health committee functioning are often restricted by their poor attendance at health committee meetings and little transparency on complaint processing (Haricharan, 2011). Padarath (2009) shows that the impact of health committees' advocacy for communities' needs is often diminished because of health care providers' unresponsiveness to the concept of community participation. Consequently, health committees end up solving problems between the facility and the community and do not generate solutions to deal

with daily health issues or issues raised by unsatisfied patients (ibid). Besides, health committees can appear invisible to facility staff and users (Glattstein-Young, 2010). It is essential for the facility manager to listen to their health committee's ideas and advice as well as to actively engage with them in decision-making. Only in this manner, the discrepancies between health services delivery and community needs, including the needs of vulnerable groups, can be tackled. Therefore, training of health care providers creates potential for health committee functioning to be improved. Ultimately, good working relationships between health care providers and health committees can thereby strengthen people-centred health systems and advance the right to health. However, there is a gap in empirical evidence on whether health care provider training could indeed have this impact. The next sections will provide a short exploration of the approach and content such training could adopt.

### **5.1 Training approach**

Health facility managers, health workers and committee members must take responsibility for their past and link human rights with their professional autonomy and accountability. According to Baldwin-Ragaven et al. (1999) this is required to shape their right to health promoting behaviour and to facilitate health system reform. Health professionals should be held accountable for their qualifications and be competent and proficient in their human rights knowledge, skills, attitudes and ethical practice. Baldwin-Ragaven et al. (1999) also argue that health workers should be trained in a continuous and interactive way. Through continuous training, better understanding of how to comprehensively act out the right to health is promoted and stimulated and opportunity is created to provide routine feedback on their practices (Baldwin-Ragaven et al., 1999). By means of the training, a deeper understanding will be gained on how the right to health is promoted by health care providers, the context in which they reside as well as their experienced struggles and adopted coping mechanisms. The training can focus on particular (human rights) cases through which learning is facilitated by building on previous knowledge and experiences (Vygotsky, 1978). When adopting

Kolb's (1984) action learning cycle, trainers facilitate continuous reflective observation of concrete experiences. This is then followed by the formation of abstract concepts from these observations and the active experimentation with these concepts in new situations. Individual reflection, reaction and response must precede any collective act to promote human rights and make these rights a respected and inseparable part of professionalism (Baldwin-Ragaven et al., 1999). This approach stimulates health facility managers to think about their visions and need for knowledge, skills or support and provides an opportunity to regain motivation. Moreover, positive motivation optimises training performance which subsequently can result in improved skills and knowledge that enhance job performance (Johnson & Beehr, 2014).

## **5.2 Training content**

Haricharan (2011) has suggested that in order to promote the right to health and participation, facility managers should first be trained on their understanding of health committee's role and functions as well as the concept of people-centred care. Similarly, Backman et al. (2008) have argued for the education of health care providers on their role as facilitators of community participation and in promoting democratic processes to elect committee members. Cornwall (2001) stresses the importance of skills such as responsibility and task sharing. Training can also play a role in providing insight into the cost-benefits of community participation (Parker, 1994). Active participation of the community can help facility managers identify reasons for resource wastage and help avoid this in the future. In the cases where facility managers offer health committees their resources it might also be useful for them to know how to train health committees on their managerial skills. This would improve a committee's key role in participation and stimulate their independence (Goodman, 2011). Haricharan (2011) recommends capacity building and skill development of facility managers aimed at power dynamic changes and the establishment of equal relationships. Moreover, facility managers

who are equipped with management and leadership skills will be able to inspire others and to make decisions towards a common vision (Gilson and Daire, 2014).

## **6. Conclusion**

Health committees carry potential to promote the quality, accessibility and needs-responsiveness of service delivery in people-centred health systems. Strictly speaking, health committees can function as a platform for community members to participate in decision-making processes regarding their health service needs. Thereby, they provide a bottom-up strategy to the realisation of the right to health in a people-centred health system. However, in South Africa health committees' role and mandate often seem to be unclear and weak policy frameworks have resulted in wide variations in health committee functionality. Health care providers, particularly health facility managers, are identified to play a key role in creating a supportive environment for health committees to function effectively. Health care providers' misunderstandings of health committees' roles and responsibilities as well as lack of engagement with health committees can thereby be a barrier to the communities' meaningful participation. This review identified a gap in evidence on the impact health care provider training could have on resolving these challenges to health committees' functioning. Literature shows that rights-based health care practices can be promoted by stimulating health care providers to reflect on their motivation and practices, subsequently learning from experiences and human rights case discussions. Such an experiential, rights-based training approach could be adopted to train health care providers on building mutually beneficial working relationships with health committees. Through promoting the right to health and community participation, health care provider training promises to have a positive impact on the accessibility, quality and needs-responsiveness of the health services delivered. Ultimately, this would strengthen people-centred health systems.

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# **PART C: JOURNAL MANUSCRIPT**

**BMC HEALTH SERVICES RESEARCH**

## **Health Care Providers' Responsiveness to Health Committees as a Platform of Community Participation: An Evaluation of Training in the Cape Metropole, South Africa**

Gimenne Zwama<sup>1</sup>

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**Abstract** (348 words)

**Background:** As community-based governance structures in the service delivery of primary health care, Health Committees can contribute to the responsiveness and people-centredness of health systems. Previous research has found that Health Committees in the Cape Metropole of South Africa face similar challenges as their counterparts globally. Lack of governmental, health facility managers' and other health care providers' recognition, understandings and accommodation of Health Committees can challenge their functioning. Thus far, health care providers had not been trained. This study evaluates health care providers' responsiveness towards Health Committees as a result of a recently introduced interactive, rights-based training on "Community Engagement for Quality Care".

**Methods:** Thirty-four health care providers, from all eight Cape Metropole health sub-districts participated in this evaluation. Training sessions of two separate groups were observed and participants completed pre- and post-training questionnaires. Three to four months after the training, semi-structured interviews were conducted with ten participants. A conceptual framework based on the interconnected concepts of people-centred health systems, community participation, and the right to health was used to evaluate health care providers' understandings and intentions towards health committees.

**Results:** Most health care providers indicated their understandings of Health Committees changed as a result of the training. Health Committees were perceived as more valuable and understood to be a key liaison body of communication between the community and the health care providers that can assist with and improve needs-responsiveness, quality and accessibility of health care. Post-training, health care providers expressed intentions to actively engage with the Health Committee and to ensure clear roles and responsibilities are set for all members and stakeholders involved. Differing

priorities of the department, sub-district and facility managers as well as Health Committee members' lack of commitment were perceived as barriers to health care providers' engagement with the Health Committee.

**Conclusion:** Training played a role in increasing health care providers' responsiveness towards Health Committees' roles and functions. However, to ensure health care providers' intentions are translated into practice, it is recommended that the training is followed up on in a continuous manner so to respond to the ever-changing dynamics and diversity of the relationships between Health Committees and health facilities.

### **Keywords**

Health Committees, health care providers, training, community participation, quality service delivery, primary health care, people-centred health systems, needs-responsiveness, South Africa, right to health.

### **Background**

With the global attention for people-centred health systems gathering momentum and World Health Organisation (WHO) publishing the global strategy on people-centred and integrative health services in 2015, it is increasingly emphasised that not just service users, but communities should also play an active and informed role in the maintenance, restoration and promotion of their own health [1][2][3][4]. Individual and collective participation at the community level can improve the delivery of primary health care (PHC) as acknowledged by the Alma-Ata Declaration [5]. Subsequently, it can promote the people-centredness and needs-responsiveness of health systems. These are characteristics of a health system in which everyone contributes and benefits [6] as well as where

health care services respond to people's perspectives of their needs and expectations in a holistic manner rather than focusing solely on disease and the diseased [3].

For people's participation to be effective and meaningful, communities' active and informed involvement is required in the evaluation of strategies, decision-making, prioritisation and implementation of the right to health [7] [8] [2]. The Alma-Ata Declaration builds on the right to health in PHC, adopting the WHO's definition of health as "the state of complete, physical, mental and social wellbeing, and not merely the absence of disease or infirmity" [9] [5]. Accordingly, both the Alma-Ata Declaration and the expert interpretations of the right to health in the General Comments no. 14 stretch the importance of tackling upstream social and economic health determinants in promoting PHC and the right to health respectively [5][7]. However, it is possible that curtailed focus on PHC and limited community input can constrain upstream, interdisciplinary, bottom-up and needs-responsive approaches to the delivery of quality and accessible PHC. Consequently, this can compromise the sustainable development of people-centred health systems and the progressive realisation of the right to health.

Health Committees (HCs) have been found to provide a bottom-up platform for community representatives to participate in health care decision-making, monitoring and oversight [10]. They can contribute to closing gaps in service delivery and promote quality care by advocating for community needs and keeping the health facilities accountable for the accessibility of the services offered [11]. By these means, HCs can facilitate the community's collective ownership of primary health care services [12] as well as promote the realisation of the right to health [13]. As HCs serve as community-based governance structures in the delivery of primary health services, they are inherently interdependent on the dynamics of the health system's social, economic and political contexts [1]. This requires us to look deeper into these contextual factors that challenge HC

functioning and the cross-cutting issues that affect HCs. George et al.'s narrative review confirms it is essential to look at the context in order to understand HCs' place and contribution to health systems strengthening [14] .

In South Africa, the importance of community participation is acknowledged in the National Health Act (NHA) which states that a HC must be composed of community members, a ward councillor and a health facility manager [15]. The Department of Health, however, delegates its role and mandate, as far as HCs are concerned, to provincial policy legislation and action. All provinces have legislation, draft legislation or guidelines, which differ substantially in the depth of descriptions and extent of inclusion of HCs roles and functions [16]. Accordingly, it was found that Provincial Departments of Health can fall short in their guidance, direction and training of HCs, thereby negatively impacting on HCs' effective functioning [17][18]. Consequently, the lack of clarity about health committees' roles and functions, as well as their lack of power and mandate, can limit their effective integration within the health system [19] [14], and result in a lack of uniformity in HC functioning [17] [12] [19] [20].

In the Western Cape Province, a discrepancy between policy and practice exists [16]. In comparison to other South African Provinces, the Western Cape had been behind on passing HC legislation [16], until they published a long awaited draft Bill on Health Facility Boards and Committees in 2015 [21]. Even though it recognises HCs as a community platform, it significantly reduces their active and integrative role in strategising, prioritising, decision-making and implementing health services according to community needs. In December 2015 cabinet approved the National Health Insurance (NHI) White Paper, whose purpose is to provide all South Africans "access to quality and affordable health care services based on their health needs irrespective of their socio-economic status" [22]. Once again, and indeed surprisingly, considering its purpose, the NHI white paper does not

acknowledge the full potential of HCs or community participation as continuous mechanisms to identify these health needs.

More specifically, there are insufficient national and provincial legal frameworks and mandate, hence a lack of clarity in HC roles and functions. This can potentially compromise HCs main role as an intermediary between the community and health services [14]. In many low-and middle income countries, nurses [23] and facility managers [12] lack capacity to work with HCs and require education on HCs roles and functions [14]. Studies have shown that in South Africa while some facility managers are aware of HC roles and functions and attended their meetings, others are completely unaware [24] [18][13]. As a result, health care providers (HCPs) can be reluctant to involve communities and find it challenging to be held accountable for their service delivery by the community [25][18][13]. In the Cape Metropole, HC-HCP working relationships have been found to be additionally challenged by power imbalances, lack of mutual trust and engagement as well as HCPs' lack of understanding of the relationship between the right to health and participation [12].

Thus, for HCs to effectively and sustainably integrate in people-centred health systems, HCPs need to provide an enabling, responsive environment to HCs genuine and effective participation.

However, there is a gap in evidence of the impact training of HCPs could have on HCs' effective and meaningful participation. While many HC members within the Cape Metropole have received training, HCPs had not been trained on community participation until May 2015.

This study aims to evaluate the immediate role of training on HCPs responsiveness to HCs as community-based governance structures in PHC service delivery. This paper reports the extent and nature to which HCPs' responsiveness changed in terms of their understandings and intentions to change practices towards HCs. After detailing HCPs' changes in responsiveness following the training, findings are discussed in relation to their (potential) contribution to the promotion of

community participation in the strengthening of people-centred health systems and advancement of the right to health. Furthermore, it sheds light on the contextual factors identified by HCPs as influencing translating their immediate responsiveness into practice.

## **Methods**

### *Training purpose, approach and implementation*

The Learning Network for Health and Human Rights (LN), a collaboration of civil society organisations and two universities in the Western Cape, aims to promote the right to health through community participation. As part of the activities to fulfil this purpose, the LN trained HCs across the Cape Metropole and identified key challenges affecting HCP-HC working relationships. In order to (re-)establish and strengthen HCPs' working relationships with HCs, a HCP training manual was developed and piloted.

The final version of the training manual titled "*Community Engagement for Quality Care*" consists of two main chapters called "Relationship Building" and "Health Committees and Governance" including eight appendices with additional readings [26]. In line with the NHA [15], the training manual aims to create health services that are responsive to community participation [26]. To facilitate this aim, the training manual is rights-based and in agreement with the national vision toward achieving a society committed to human rights values [22]. Accordingly, the training's vision is to establish accessible, equitable and quality care through developing an environment where communities participate and co-operate with HCPs in their own health.

The training adopts an experiential learning approach also known as the Kolb Cycle [27]. The trainers guide the participants through a reflective learning process that builds on previous experiences. This is stimulated through interactive group and case discussions as well as role plays.

These shed light on previous and current practices of engaging with, and involving the community. In this manner, tailored directions and encouragements can be made towards the community's participation in health care decision-making and their ownership of the right to health.

Initially, the training was intended to consist of two consecutive days of training. The first day would focus on the first part of the training manual ("Relationship Building") and the second day on the second part of the training manual ("Health Committees and Governance"). However, several sub-district managers expressed their worries about the burden it could place on the facilities when their employees are away from the services for two consecutive days. As a result, it was decided to decrease the training to one day followed up by another half a day at least a month after.

Subsequently, it was decided to focus the first session of the training on relationship building as well as HC's composition, roles and functions. The interim feedback arising from the preliminary analysis of questionnaires and observations was used to feed into and support the second, follow-up training session's agenda. Accordingly, this session was planned to discuss how to establish a common vision, host a HC meeting, manage conflict as well as it would explore issues of power and address other practical issues.

#### *Participant recruitment*

Health care providers from all (eight) City of Cape Town health sub-districts were purposively recruited for the training, contributing to the diversity of the study sample. These included senior professional nurses, professional nurses and clinic managers working at City of Cape Town clinics as well as environmental health practitioners, health promotion officers and programme co-ordinators working at sub-district level. Most sub-districts sent at least four participants to attend the training, of which two sub-districts send eight attendees each. However, one of the sub-districts was only

represented by two participants both positioned at sub-district level and another sub-district by two environmental health practitioners.

The first training was implemented in the Cape Metropole in May 2015. There was subsequent training two months later. Approximately six weeks after the first training sessions, follow-up sessions were planned in July and August. However, these were cancelled due to the low turnout and the small number intending to attend for the first and second group respectively. A total of 34 health care providers participated in both training and evaluation. Both training groups had one male attendee, both environmental health practitioners. With South Africa recognising 11 official languages, participants' native languages differed. Most study participants' first language was isiXhosa (n=12), followed by Afrikaans (n=9), English (n=7) and Sesotho (n=2). The training was conducted in English. The first training group's session (n=20) was facilitated by two expert educators from the University of Cape Town (UCT), one having extensive experience with the training and consultation of HCs, the other having years of clinical experience as a nurse and a lecturer. The latter facilitator was also the co-author of the training manual and the sole facilitator during the training of the second group (n=14).

#### *Study design and data collection*

This paper is based on a realist evaluation as described by Pawson and Tilley [28]. The purpose of this evaluation is to explore the possible variations in nature and extent of the immediate and short-term impact of HCPs' training on HCs. This is facilitated by the training participants' diversity in health care professions, experiences, local contexts and relationships with HCs. The data was collected between May and November 2015, and the study adopted a flexible research design making use of the following methods: pre- and post-training questionnaires, direct observations, semi-structured interviews and field note journaling.

Field notes were diarised from the moment preparations for training implementation started. Pre- and post-training qualitative questionnaires and a topic guide for semi-structured interviews were developed in concordance with the facilitators' vision for the training. Re-phrasing of a few questions in the pre-training questionnaires was done after preliminary analysis of the first groups' responses. The interview topic guide was adjusted after preliminary analysis of the questionnaires and additional probes related to questions arisen from questionnaire responses were included.

Written notes of the training observations were taken. These observations also provided 17.5 hours of audio recordings. Some parts of the recordings were transcribed in the cases where the written notes lacked context or clarity and they were considered relevant to the research questions. These fragments transcribed provided information around HCPs' understandings of HC roles and functions, engagement with HC members, intended practices and (expected) challenges related to HCs and community engagement or participation. The observations gave insight into the development of HCPs' responsiveness and contributed to the triangulation of data.

A total of 31 pre-training questionnaires consisting of mostly open-ended questions were distributed before the training (see Appendix I) to fifteen clinic managers, five senior professional nurses, four professional nurses, three environmental health practitioners, two health promotion officers and two programme officers. Four multiple choice questions supported by a few open-ended questions inquired about the current HC status and relationship at the facility or sub-district level.

Furthermore, participants were asked about their understandings of HC roles and benefits, the challenges in engaging and working with them as well as the ways in which the health facility can promote HC functioning.

The post-training questionnaires included four open-ended questions for specific evaluation of the training format and content. It also consisted of one multiple-choice question and 10 open-ended

questions mostly similar to the pre-questionnaires. Yet, in addition, it asked about their views of the role of the training in changing their understandings and practices towards HCs (see Appendix II). Post-training questionnaires were completed by 29 participants. Participants from the second group submitted their responses via email (n=12), resulting in missing data of two professional nurses.

Three to four months after the training, interviews were held with 10 purposively selected participants (six clinic managers, one senior professional nurse, one environmental health practitioner and two health promotion officers), based on their differences in sub-district and HC functioning (see Appendix V). Besides adding onto the triangulation of earlier collected data, interviews explored the role of the training on short-term HCPs' responsiveness and the impact thereof. Moreover, interviews contributed to the realist approach by providing deeper insight into facilitating and impeding contextual factors [28]: The societal and health system processes, dynamics and challenges that influence implementation of HCPs' responsiveness and their relationships with HCs interchangeably.

#### *Ethical permission*

This study was approved by the Faculty of Health Sciences' Human Research Ethics Committee of the University of Cape Town (FHS HREC, REF 2015/062, Appendix VI and VII) and by the Health Department of the City of Cape Town. City of Cape Town sub-district managers permitted the recruitment of training participants for the evaluation (Appendix VIII and VIII). Informed consent was obtained from all participants for the training to be observed (n=34), seventeen participants from the first training group (n = 20) agreed to complete the questionnaires and to be contacted for an interview. Of the second training group, everybody consented to participate (n=14) in all aspects of the research. All interviewees (n=10) gave verbal consent to be contacted for follow up questions.

### *Data analysis*

{NVivo 10} was used as a tool to manage all data. Questionnaire data was cleaned and anonymised in {Microsoft Excel} before import into {NVivo}. This also marked the start of the researcher's immersion in the data. Interviews were transcribed in {Nvivo} and any text that could lead to the identification of the interviewee was removed. This study adopted a thematic approach to analysis as described below.

Structural coding started with the preliminary analysis of questionnaires which consisted of data visualisation of responses through mind mapping. These mind maps guided the inductive coding of topics and categories into an initial codebook. This initial questionnaire codebook also guided the start of formation of the initial codebook for the observations, of which only the data relevant to the research question were coded. After this, being familiar with the breadth of the investigated matter and having mind mapped the relationships between categories, the codes were examined if they could possibly be fused into categories and sub-codes. The individual codebooks were refined and collapsed accordingly, which created small and simple codebooks with clear distinctions between the codes. Data was re-coded into meaningful units and the same was done for the remaining uncoded data, which slightly expanded the codebook again after which the meaningful units were collapsed into themes. Similarly, interviews were coded a while after initial coding of the questionnaires and observations, which provided the opportunity to have a freshened look at the coding of the entire dataset.

Ultimately this resulted in a common codebook of three categorising codes, which guided answering the research questions; understandings, practice and intentions to change practice. Six main defining codes provided specifics to the categorising codes, such as HC engagement, involvement, challenges

and issues, stakeholders, role of training in changing responsiveness, and strategies to promote HC functioning. Thirdly, the thematic and descriptive sub-codes to the main codes described the dimensions of the main and categorising codes. Moreover, data was classified and analysed based on representing pre- or post training understandings, intentions or practices as well as on the differences in participant attributes and HC relationships.

A similar codebook was used for every data type, with differences in sub-codes, thematic codes and in some cases additional main codes. In this thematic analysis, themes are similar to the interpretation of participants' statements to a general level, using experience distant concepts [29]. Generally, theme and sub-code names as well as their descriptions are kept as close as possible to how participants phrased them.

Data triangulation and integrative analysis of themes arisen from the different types of data guided the interpretations of the deeper meaning to the codes segments and themes respectively. After the entire analysis, thematic decisions were reflected upon as personal views of the themes could have changed. The collection of participants' different reflections, changes in understandings and intentions, their perceptions of the role of training herein as well as of the researcher's observations and field notes allowed for interpretive omniscience [29].

The conceptual framework is used to frame the interpretive analysis of themes in order to answer the research questions. It looks at the extent and nature to which HCPs' responsiveness to HCs as a result of the training can contribute to the three interconnected concepts of community participation, people-centred health systems and the right to health.

### *Dissemination*

Interim and post-training feedback was communicated with the training facilitators. Furthermore, the research findings will play a role in advocacy and will be disseminated widely to the training

participants, the funders (EU, IDRC), the LN, the Cape Metro Health Forum as well as the City of Cape Town and their sub-district managers. Key findings will be distributed as a poster across health facilities in the Cape Metropole. Finally, the findings are intended to be presented at departmental research meetings at the university and (inter)national conferences.

## **Findings**

### *HC presence, members and other stakeholders*

Of the 24 participants working at a clinic, 17 indicated to have a HC at their facility. All of these participants stated that the current composition of the HC consisted of community members and the facility manager. Only eight participants indicated that the facility's HC is functioning well (six clinic managers, one senior professional nurse and one professional nurse). Environmental health practitioners were also included as members of two of these well functioning HCs. Five participants stated that the local government councillor is part of their committee, of which four indicated their HC is functioning well.

After the training, participants (n=29) were asked what the health committee's composition as defined by the NHA should be like to which almost all responses included community members (27 vs. 15), ward councillors (27 vs. 10) and facility managers (25 vs. 7). All clinic managers and senior professional nurses included all of the before mentioned stakeholders. About a third of the respondents thought the HC composition, as stated by the NHA, should also include health care workers as HC members. This response was not related to the participant being a health care worker. Environmental health practitioners were perceived to be important members by a third of respondents as well. Reason for this was to address environmental health problems that influence community health, such as water and sanitation issues (environmental health practitioner no 2, clinic manager no. 4, 7). Some participants who currently have a HC or are working at sub-district level

also perceived it relevant to include receptionists and pharmacists as members of the HC (senior professional nurse no. 5, health promotion officer no. 1, 2)

Other recurrently mentioned community stakeholders were schools, security and social workers.

Some of the reasons for these were major social problems, drug abuse and violence in the community. More stakeholders mentioned were non-profit organisations, non-governmental organisations and churches in the area, to promote awareness of the HC and to ensure that health services are not unnecessarily duplicated. The latter stakeholders were already mentioned by participants who have or knew about a health committee including these stakeholders as members.

As a result of the training, training participants indicated to have learned about the HC members and stakeholders as well as the importance of all members' active involvement. Many participants specifically referred to not having known the ward councillor should be part of the HC. Additional stakeholders were understood to enhance communication and progress. An environmental health practitioner found it important to communicate with the HC about their composition: *"I should make it clear to others who might have different views why these stakeholders are needed. And then communicate that motivation to them. And then it will be up to me, or up to them, if I make an impact, I touch the heart and end up taking part"*. A clinic manager, without a HC, advised that the second in charge as well as everybody in facility should know about the HC members so to not ignore them. Clinic manager no.13 intended to advice the the sub-district's health promotion officer, the programme co-ordinator and non-governmental organisations to link with the HC to find out what the HC does in order to avoid the duplication of services. Two clinic managers (no.5, 14) resulted to have changed their practices as a result of the training, as they contacted the ward councillor regarding the HC. In the one case the clinic manager (no.5) wasn't able to get hold of him and in the other (no.14) the ward councillor is going to bring the clinic manager in contact with an active community member.

### *HC roles and functions*

From the pre-training questionnaire responses, health committees' were described as a link between the community and the facility, being "the voice of the community". HCs were thereby understood to play a role in the identification of health problems and subsequently address these to the facility. Furthermore, it was stated that health committees can benefit the facility by assisting with health promotional activities as well as informing the community on these activities and the services delivered at the facility. Participants indicated that these roles facilitate relationship building between the community and the facility, improve services and community health.

To a greater extent than before the training, all participants made specific reference to the importance of HCs functioning as a liaison body between the community and the facility to facilitate their two-way communication. Almost all participants pointed at HCs' role in health promotion and education was highlighted as beneficial for the health facility. Several participants explained that they could identify the source of outbreaks, mobilise the community to assist with campaigns, educate the community to prevent further spread and assist the health facility where needed. Hence, HCs can promote the fast response of the services (clinic manager no. 7). Other recurrently mentioned activities HC could assist with were outreaches and assisting nurses determining content of health talks at the clinic or presenting health talks themselves. They could do home visits for the purposes of explaining home remedies or recalls. HC participation in promotional activities was understood to facilitate meeting clinic targets. Health promotion officer no.1 said: *"there are programmes that are not functional in the facility without the presence of the health committees, for instance the Health and Safety Committee"*.

It was underlined by nurses (no. 3, 5), clinic managers (no.3,7,14), health promotion officer (no. 2) that HCs should inform the community of the challenges at the facility and two clinic managers (no.4,10) can lobby or assist with motivation for (expansion of) resources. HCs were also identified

by half of participants as being able to assist with a smoother operation of the health care facility in easing tensions with the community, e.g. where there are protests or rude clients or by helping with patient flow. Additionally, some participants said the HC can set up a helpdesk at the facility (clinic manager no.7, programme officer no.1), guide and fast track patients (clinic manager no. 3, programme officer no.1) as well as help management with the planning of transition of health services, e.g. in the case that a clinic is transformed to a Community Health Centre (clinic manager no.6). Moreover, HCs were commonly seen as beneficial to the facility in that they raise their awareness of community needs, they can receive complaints for them and advise the facility on how to deal with these. In turn, the community was understood to benefit from the HC by being given a platform for advocacy. Clinic manager no. 8 stated that the HC empowers the community to address and clarify their fears.

Most participants think that HCs' role can build trust. This role is understood to be facilitated by their interaction with both community and facility, their insight into both facility's and community's challenges, their ability to explain problems to the community as well as their closer relationship to them. Other reasons provided were that there will be more transparency on what is being done at the facility and the community will get a sense of belonging. Accordingly, a senior professional nurse said:

*"This [HCs] is a great idea. The government has been spoon feeding the community for a very long time. It is now the time that the society takes the responsibility, or ownership of their health and this change [implementation of HCs] would bring a tremendous improvement in our society because they do not feel left out."* – Senior Professional

Nurse no. 5

Overall, HC's participation in these roles was perceived to contribute to the improvement of service delivery.

*Participants' perceived changes in understandings about HCs*

Almost half of clinic managers said their perceptions about HC's roles and functions had not changed as a result of the training. Of these, clinic managers no. 2, 4 said they had always seen HCs as vital or valuable and one of them argued to have always considered HCs as integral. One of them explained:

*"The closure of [...] clinic is a classic example of what happens in the absence of a Health Committee. The community had no input in the closure of [said facility]. Should the clinic have had a functioning health committee, a collective grievance could have been lodged against the City of Cape Town Health Directorate." – Clinic Manager no. 5*

Another clinic manager (no. 10) said to have always understood HC's roles, *"it is just that some of the health committee members did not have a clue of what their roles and responsibilities were when they were still functioning."* Clinic manager no. 2 reasoned she did not change perceptions because she previously worked with a HC which clearly outlined their roles.

Most participants, however, indicated to have changed their perceptions as the training clarified HC's roles and functions. A senior professional nurse (no. 4) indicated that the training gave her a different perspective of the role of the health committee, which makes it now easier to set the boundaries. Environmental health practitioner no. 1 no longer viewed the HC as a threat to health care workers as the roles of the facility managers are not taken. A clinic manager (no. 9) wrote that the training "helps staff learn to know that health committee are not at the facilities to fight". Senior professional nurse no. 2 learned that some of the clinics work hand in hand with all HC stakeholders and address community problems in one platform which can decrease the number of meetings.

Another clinic manager (no. 10) said: *"I learnt that there are communities with good health committees that work in partnership with the facilities towards a common goal..."*

Some of the nurses have come to see the need of HCs being appreciated and clinic managers indicated to see them as more valuable or gained renewed insight into their importance. The training facilitated a better understanding of what HCs should do (clinic manager no. 13) and how to support HC functioning (clinic manager no. 15). Clinic manager no. 3 explained that HCs give a true background of what needs to be done and insight into how a community feels and thinks. Hence, “You cannot actually be without one” as was confirmed by one clinic manager (no. 5) who said HCs are needed in every facility and community. Professional nurse no. 1 said: *“The health committee and the health care providers should work together with the ultimate goal of providing quality health care to the community”*.

#### *HCPs working relationships and challenges with HCs*

Nearly a third of participants indicated that the facility is always engaging with the HC (six clinic managers, two senior professional nurse, one health promotion officer), both nurses with a HC say that the facility engages often (three clinic manager, one senior professional nurse). Four clinic managers and two environmental health practitioners reported to never engage with the HC. One environmental health practitioner sometimes engages with the HC, as do two clinic managers. One senior professional nurse’s facility rarely engages with the HC. All clinic managers have attended a HC meeting at least once before. Seven clinic managers, one senior professional nurse, two health promotion officers (a third of total participants) indicated they attend HC meetings each month. Ten participants (including all four professional nurses and two senior professional nurses) said that they had never attended a HC meeting.

Clinic managers indicated that current barriers to their engagement with HCs are related to their own ability to be available to the HC as well as their HC members’ level of commitment. HCPs’ unavailability was, in particular among clinic managers and nurses, commonly explained to be due to workload, having too many meetings and HC meeting times being held after hours. A clinic manager

(no. 5) perceives her unavailability after hours as a problem which needs to be addressed by replacing current HC members with members who are available during working hours. HC members' lack of commitment was repeatedly attributed to HC members having hidden agendas, being unavailable due to employment and not keeping set meetings. In a few cases, power struggles, attitudes, politics were indicated to be a barrier to personal engagement with the HC.

Other key challenges in working together with HCs were indicated to be misunderstanding, lack of mutual respect for one other's roles and responsibilities leading in to the crossing of boundaries and, consequently, mistrust. Conditions for trust building mentioned were having training or guidelines on clear roles and functions, being honest from the start and having a common vision. Furthermore, HCPs identified attitudes and HC's judgment as challenging to their relationships. No money for transport to meetings for both committee members as well as HCPs as well as volunteer recruitment were seen as challenges arising from a lack of funding; *"people don't want to volunteer their availability"* (clinic manager no.4).

*"...what came out for me also is, in the training, is how to motivate your community to take part. Not to just think of the money, but to think of something that, is an achieve - a stepping stone for them to maybe get into, uhm, to get a job. It is information that can go on their CVs at the end of the day. They gain experience, they gain knowledge, they meet new people." "...you can maybe get a job somewhere. However, the negative of that is, that people then sometimes expect to be placed in a position... But because of the high unemployment rate at the moment people don't want to work for free. So there, we also need to then get people to become creative with how they can raise funds, what can they do etcetera."* - (clinic manager no. 14)

Another clinic manager's (no. 1) perception was that health committees should be funded regardless of whether they focus solely on HIV/TB, which she observed as a priority that results in differences in funding allocation across sub-districts.

Health facilities were commonly understood to promote HC functioning by engaging all community stakeholders, communicating more often, meeting regularly (e.g. monthly as “each day brings its own challenges”, with an agenda and keeping minutes), involving them in health talks, outreaches and campaigns. Furthermore, by allowing the HC to present on their roles and functions (health promotion officer no. 2, clinic manager no. 11) and having a common goal HC’s functioning was perceived to be promoted. Power differences were recurrently understood to be resolved by understanding of and setting clear cut roles and responsibilities, by ensuring transparency, sharing power equally (e.g. by letting each member play an important role).

*Translating understandings and intentions into practice*

Five participants state that they would not engage differently as they are already dealing with community related issues, the HC is already functioning well or they have established a relationship in which there is awareness of boundaries. Other reasons for not being completely convinced of different personal engagement were the HC’s lack of visibility (senior professional nurse no. 6) in the participants’ current position and the need for time off work to engage with them (health promotion officer no. 1). In contrast, a program officer (no. 2) indicated that she would assist the facility managers on HC’s role, even though she is not working with HCs herself.

Nurses said they would consult the HC about ways to improve health talks, to provide more guidelines regarding HC functions and to involve them in the decision-making about the community. Clinic managers intend to actively participate in meetings more regularly, request for help in various work areas and to invite the ward councillor to assist in establishing the new committee. Another clinic manager (no. 12) said that because the training provided self development and created an understanding of what’s happening at other facilities she would improve her

relationship with other HC stakeholders. Other participants intend to start a helpdesk, encourage the active co-operation between all HC members and health care providers

Some participants perceived it relevant to train other stakeholders such as other facility members such as the second-in-charge and (sub-district) managers. A clinic manager, who recently moved up positions within the clinic, describes previous practices:

*“...with the previous manager.. she would just ask somebody to go sit in the health committee meeting, you know, nothing what you should be doing there, you're just sitting, then maybe sometimes you just play with your phone.[...] But if people are trained, I can also do what she was doing but knowing that that person knows exactly what she should be doing in the health committee.”* (Clinic Manager no. 8)

In a few cases, the training translated into changes in practices; but most intentions to change practices remained intentions for the duration of this evaluation. Some participants experienced that superiors limited participants' ability to implement their responsiveness. A clinic manager pointed at her manager questioning her training attendance, because she had so many other things to do. An environmental health practitioner (no. 2) said:

*“At the beginning I was told not to make myself clever. I explain situations to my manager saying he's going to get back to me as he's busy. ”So now I'm like waiting, I'm always waiting for somebody to tell me, okay, you must do that, you see.” “I don't think I can take initiative on this, because it's not part of my work. I think, they are busy now with other situations you see. Maybe...like, at the right time, it will be implemented as well in our district”* (Environmental health practitioner no. 2)

## **Discussion**

This section discusses the above reported findings in light of the conceptual framework that framed the interpretative analysis of these findings. The potential contribution of HCPs' responsiveness to

community participation through HCs to the people-centredness of health systems as well as the right to health will be examined.

Health Care Providers' increased perceived value of HCs' role in identifying and addressing community's needs to promote accessibility and quality of services, contributes to the comprehensiveness and responsiveness of people-centred care, two elements that are central to PHC and people-centred health systems respectively [5][3]. This is enhanced by enabling HCs to address complaints and sourcing of information on the background to the social determinants of health from the HC [5] [7]. Herein, HCPs demonstrated understanding of the importance of engaging with community members and other stakeholders in tackling environmental health, social and safety problems affecting the community's health. They have also indicated intentions towards the active involvement of the ward councillor, who was perceived to play an important supporting role in promoting the availability of health services as a key element of the right to health through the negotiations and lobbying for resource generation and mobilisation. This is favourable for the HC's effective participation and can also promote the right to health by reallocating resources that would otherwise be wasted [7]. This level of efficiency and responsiveness therefore contributes to holistic approach people-centred health care and the right of everyone to the complete state of social, mental and physical well-being [1][7].

HCPs increased understandings of HC roles have led to HCPs demonstrating intentions towards changes in practices providing HCs with the increased capacity to be actively involved in the implementation of primary health care service delivery. HCs are understood to play a role in health promotional activities and thereby the prevention and control of common diseases, as well as outbreaks and home visits to help with home remedies or promote continuity of care through recalls. These intended enabled actions are perceived to promote the Alma-Ata Declaration's

objectives for PHC [5] as well as meet people-centred health care coverage requirements of health systems [3].

The training can contribute to the promotion of the right to health as HCPs perceived HCs as a key body of communication between the community and the facility this contributes to the quality and accessibility of services as patients can be informed on the services or changes at the facility and provided appropriate guidance and referral before reaching the clinic. Furthermore, HCs are perceived to play a role in connecting patients and community members with other community forums or disease-specific support groups. HCPs were also responsive to HCs to supply food to patients taking medication, contributing to another objective of PHC and also promoting its quality [1] [7].

Hence, HCPs contribute to people-centred health care when the community is truly represented and participating, allow HCs to take control over their health and enable them an environment to engage with the health system as a whole [3] This includes participation and representation of the community in the setting of goals, making of decisions and solving of problems regarding the identified needs and expectations of the community [3]. The exact role HCs are enabled to play in the accountability of the services to policies and their mandate in decision-making regarding the services or strategies did not clearly surface from participants practices. Nonetheless, in the training this was discussed as a role of HCs. While HCPs were welcoming HCs advice, this might indicate that HCPs are still unresponsive to HCs as a form of accountability and oversight and provide them an active role in monitoring, strategy and planning of service delivery. It was also not evident what HCPs responsiveness is towards HCs as a mediator in violations of the right to health.

This study has also shed light on the possibility of the existence and ability of HCPs who are responsive of HCs and promote their functioning irrespective of the political or economic context.

This confirms that HCPs increased responsiveness can positively influence the crosscutting issues and contextual factors (as identified by George et al. [14]) that affect HC functioning, their contribution to responsive, people-centred health systems and the right to health. However, in the South African Eastern Cape for instance, after revitalising health promotion managers and health advisors' role to develop, establish and support HCs which improved relationships, these roles were only maintained in a few cases when the provincial Department of Health's priorities changed [17]. In addition to differing priorities, unresponsive superiors can also stand in the way of HCPs ability to engage with the HC. Thus, a legal framework recognising HCs' full capacity and some funding may be required for building sustainable working relationships between HCPs and HCs [3][30]. Therefore, it is important to underline and advocate for the critical role HCs relationships can play in the decision-making, planning and implementation of recent global, national and provincial developments and agendas, particularly with the Western Cape Draft Bill on Health Facility Boards and Committees [21] and the NHI White Paper [22] being opened for public comment before finalisation.

The training has provided the HCPs with an opportunity for professional development and has built on most of their skills that the WHO [4] identified as meeting the needs of the people, such as communication because of their expressed understandings and intentions towards its regularity and HCPs' intentions to actively engage. Others skills that were promoted as a result of the training were mutual collaboration and respect, empathy and responsiveness. The training facilitated mutual collaboration and respect as it increased understanding of HC roles, functions and the benefits for facilities. Empathy and responsiveness were promoted through the rights-based and case discussions, resulting in understandings and intentions towards creating an enabling environment in which genuine community participation is promoted and everyone's right to health is respected.

Skilled health care providers promote the quality of service delivery and thereby promote the right to health.

Overall, the training has shown to promote HCPs understandings and intentions towards HCs, even in the cases where HCPs already had a good relationship with the HC. Therefore, this study confirms the review evidence by George et al. [14], McCoy et al. [10] and Goodman et al. [11] that HCPs play a key role in promoting HC functioning. Furthermore, it meets the recommendations made by Haricharan [12] that the training of HCPs on HCs as a platform of meaningful participation has shown to be critical to building and strengthening working relationships with the community.

Thus, this study has narrowed the gap in evidence of the role of training in promoting HCPs responsiveness and the kind of supportive environment they are able to provide the HCs as subjected to the differences in and challenges of working contexts. Furthermore, this paper contributes to health systems research as the training builds HCPs responsiveness to HCs as hardware structures and thereby contribute to strengthening actor relationships within the health system at the meso, i.e. organisational and local, level. Building of HC member relationships can influence the policy process as interests of HCPs might have changed and can potentially play a role in lobbying for HCs meaningful participation at the sub-district or municipal level and thereby provide a HCPs' perspective on the value of HCs to the recent global, national and provincial agendas that impact the people-centredness and responsiveness of health systems.

#### *Suggestions for future training and research*

These training outcomes can be viewed as just small steps towards advancing sustainable HC functioning in the strengthening of needs-responsive, people-centred health systems. Especially, with respect to the permeable nature of HCs, the challenges they face, HCPs' challenges and the

ever-changing relationship dynamics between the facility and the community. Moreover, it must be ensured that HCPs intentions are realised and that the community genuinely participates in not only the provision but also for effective engagement in the development and planning of services. For these reasons, follow-up and continuity of training are important.

Moreover, additional research is needed to investigate the role of training on the long term responsiveness of HCPs in building working relationships with HCs and their functioning. Further analysis would be useful to map the broader, multi-level stakeholder relationships, such as the role of facility managers and sub-district manager, and other enabling or constraining factors directly or indirectly of influence to HCP-HC relationship building, maintenance and restoration.

#### *Limitations to training implementation and evaluation*

Of the ten participants from the first group who indicated to attend the follow up training only two participants attended. Both work at the sub-district level. The first groups' participants cancelled or did not attend the follow up for various reasons such as: submission of end of financial year reports, dealing with staff shortages because of illness, staff being away for winter school and having to attend other meetings. The second group's follow up session was cancelled due to a low confirmed number of attending participants. While most participants expressed interest and enthusiasm for the follow-up session, and even indicated to be disappointed that it did not take place, this lack of ability to follow-up on the first training session could illustrate that competing priorities are a challenge in committing to the full training programme as it was intended. It might also be a reflection of the practicalities of training implementation concerning the current priorities and policy context.

The challenges to training implementation had consequences for the rigour and comprehensiveness of the evaluation. The researcher's narrow knowledge about the studied sample and the data collection being part of a learning process are limitations to this evaluation. However, being an

“outsider” was also advantageous as to noticing the, perhaps, otherwise unnoticed observations and acquiring or confirming information that otherwise would have been overlooked or assumed because of its commonness. At times during the observations, language was a barrier while observing some of the small group discussions of isiXhosa speaking participants. Some Xhosa participants indicated that language was a barrier for them to express themselves fully the way they would have liked to in the interviews.

Even though pre-training and post-training questionnaires were perceived as lengthy and, at times, contained short or missing responses, the breadth and depth of questionnaire responses was generally good and consistent with what was observed during the training. One participant from the first group made a remark about the questionnaires having too many repetitive questions, which was inevitable with regards to study’s evaluation purpose. Two attribute-inquiring questions were improved on in their phrasing or ambiguity before distribution to the second group. The second group’s responses were overall richer in information as they had been given more time to answer the pre-training questionnaires and completed the post-training questionnaires at their own time as they were allowed online submission after the training took longer than expected. However, the latter resulted in completion up to two weeks after the training, which for few participants resulted in the measurement of retained rather than immediate responsiveness. Additionally, two professional nurses’ post-training questionnaires were lost to follow up.

Three participants from the first training group did not complete the questionnaires. These participants indicated that they were not completely aware of what the training was about and sometimes embodied reluctance to their active participation in the training. This might be a reflection of their relationship with the community, willingness to be trained on community engagement or their lack of satisfaction of the content and approach to the training. For instance,

one participant who completed the questionnaire mentioned that she didn't enjoy the style of teaching and the group work in contrary to all the other participants who particularly enjoyed the interactive nature of the training.

The study was constrained by time. Ideally, a longer evaluation period would have provided time for the rescheduling of follow-up sessions and implementation of the initially planned second post-training questionnaire which was to be distributed to determine the contribution of the second training sessions to HCPs responsiveness. Additionally, a longer study duration would have given insight into the longer term-impact of the training on HCPs responsiveness. Besides, it would have allowed time for interviews with professional nurses and an additional environmental health practitioner, whom were either hard to get hold of or unavailable due to the overburdening of clinics during the diarrhoea season. For the same reason, some clinic managers indicated to be too busy for an interview. There might also be a bias related to health care providers' availability for the training which may be a reflection of the workload or priorities of the clinic or sub-district. Finally, a longer study timeframe would have allowed the questionnaires to be validated beforehand.

Another study limitation to be considered is the sole inclusion of City of Cape Town clinics that used to be more health promotional, preventative and community-oriented. This makes them historically different from other health facilities in the Cape Metropole that were originally delivering curative services only. Some HCPs could therefore already be more responsive to the concept of community participation. City of Cape Town clinics are currently different from provincial governmental facilities in that they are run by nurses. Furthermore, they deliver mostly child and maternal health, family planning and to a certain extent adult TB/HIV services (depending on the clinic).

## **Conclusion**

The training played a role in increasing HCPs' responsiveness towards HCs' roles and functions as community participatory governance structures in the delivery of quality and accessible PHC. HCPs have thereby demonstrated understandings and intentions towards building effective working relationships with HCs to strengthen responsive, people-centred health systems that advance the right to health. However, training is recommended to be followed up on and to be continuous with regards to the differences in current working relationships, the ever-changing dynamics of HCs and health facilities as well as to ensure intentions are translated into practice. In this manner, HCPs can increasingly contribute to building sustainable relationships with HCs to promote communities' meaningful and effective participation, the strengthening of people-centred health systems and the progressive realisation of the right to health.

## **List of Abbreviations**

HC: Health Committee

HCP: Health Care Provider

LN: Learning Network for Health and Human Rights

NHA: National Health Act

PHC: Primary Health Care

WHO: World Health Organisation

## **Competing interests**

Non declared

### **Author's contributions**

The author is accountable for the development of the study design, data collection, management, analysis and write up of findings.

### **Author's information**

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## Appendix I: Pre-training Questionnaire

### An Evaluation of Health Care Provider Training on Health Committees as a Platform for Community Participation, Cape Town, South Africa

Thank you for filling in this questionnaire and for taking part in this study!

- Please complete the questionnaire below. This will take maximum 20 minutes.
- This questionnaire is anonymous. You do not have to write your name anywhere.
- You may skip questions that you do not feel comfortable with answering.
- If you do not understand a question, please ask me.

1. Gender:

2. Date of birth (dd/mm/yy):

3. Mother language:

4. At which facility are you working?

5. For how long have you been working at the facility?

6. What is your position at the health facility/your professional registration?

7. For how long have you been in this position?





8. Does your facility have a health committee?
  - a. Yes
  - b. No
  - c. I don't know
  
9. If yes, how long has there been a health committee connected to the facility?
  
  
10. Does your facility work together with the health committee?
  - a. Always
  - b. Often
  - c. Sometimes
  - d. Rarely
  - e. Never
  - f. I don't know

Please explain:

11. At the moment, who does the facility's health committee consist of?  
*You may circle as many as you like*
  - a. Health facility manager
  - b. Health care workers
  - c. All facility staff members (facility manager, health care workers, administrators, receptionists, pharmacists)
  - d. Community members
  - e. Mostly community members and a health facility manager
  - f. Local government councillor
  - g. I don't know
  - h. Other:





12. In your opinion, who do you think should be part of a health committee? Please explain why.

13. How often do you attend a health committee meeting?

- a. I have never been to a health committee meeting before
- b. Once every month
- c. Less than twice a year
- d. Between 2 and 6 times a year
- e. More than 6 times a year
- f. Other:

Please explain why:

14. As far as you know, what does the health committee currently do at/for the facility?





15. When were you last in contact with the health committee? Please explain why and what the outcome was.

16. Health committees' most important roles are to:

17. In my opinion, the health facility should do the following to promote the functioning of the health committee:





18. What are current barriers to your personal engagement with the health committee?  
Please explain why.
19. What do you think are the key challenges for both the facility and the health committee to work together? Please explain.
20. In what ways or situations do you think a health committee can be beneficial to the *health facility*?





21. In what ways or situations do you think a health committee can be beneficial to the *community*?

Is there anything else you would like to add about health committees and health care providers?

**Thank you for completing the questionnaire. The findings will be used for the evaluation of the training. You will be given a second questionnaire after today's training.**

If you have any questions or comments, you may contact me:

Gimenne Zwama  
Master of Public Health student  
Cell and Whatsapp: 083 695 9682  
Email: [gimenne@gmail.com](mailto:gimenne@gmail.com)



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## Appendix II: Post-training Questionnaire

### An Evaluation of Health Care Provider Training on Health Committees as a Platform for Community Participation, Cape Town, South Africa

Thank you for filling in this questionnaire and for taking part in this study!

- Please complete the questionnaire below. This will take about 15 minutes.
- This questionnaire is anonymous. You do not have to write your name anywhere.
- You may skip questions that you do not feel comfortable with answering.
- If you do not understand a question, please ask me.

---

1. If there's anything, what did you enjoy most about the training?

2. Did you learn something new? If yes, what? Please give examples.

3. What would you take home from today's training and why?

4. What would you add or change about the training and why?





5. According to National Health Act, what should a health committee be composed of?

*You may circle multiple answers*

- a. one or more local government councillors
- b. one or more members of the community served by the health facility
- c. the head of the clinic or health centre in question
- d. the health care workers (nurses and doctors)
- e. the pharmacist
- f. the receptionist
- g. the administrators
- h. Other:

6. Do you think that this health committee composition, as stated by the National Health Act, should be different? Please explain based on your experience.

7. I think health committees' most important roles are to:







11. How do you think the health committee is functioning at the moment? Please explain why.

12. What do you think are the key challenges for both the facility and the health committee to work together? Please explain.

13. In what way/situation do you think a health committee can be beneficial to the facility?





14. In what way/situation do you think a health committee can be beneficial to the community?

15. Based on your experience and what you have learnt in the training, do you think health committees could help build trust between the facility and the community? Why or why not?

16. What would you do to minimise power differences while working with the health committee?





Is there anything else you would like to add about health committees and health care providers?

**Thank you for completing the questionnaire. The findings will be used for the evaluation of the training. You will be given your next and final questionnaire in a month's time and if you agreed to, you may soon be contacted to plan an interview.**

If you have any questions or comments you may contact me:

Gimenne Zwama  
Master of Public Health student  
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Email: [gimenne@gmail.com](mailto:gimenne@gmail.com)



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## Appendix III: Information Sheet

### An Evaluation of Health Care Provider Training on Health Committees as a Platform for Community Participation, Cape Town, South Africa

**Student researcher:** Gimenne Zwama  
Email address: gimenne@gmail.com  
Telephone: 083 695 9682

**Principle Investigator:** Dr. Maria Stuttaford  
Email address: stuttafordm@cardiff.ac.uk

My name is Gimenne and I am a Master of Public Health student at the University of Cape Town. As part of my studies, I am evaluating the Learning Network's training that you will receive about health committees.

#### What is the Learning Network?

The Learning Network for Health and Human Rights (LN) is a collaboration between five Western Cape- based civil society organizations, two universities in Cape Town and one international university. The LN aims to promote the right to health through civil society engagement and community participation. Among other activities, the LN works together with the Cape Metro Health Forum to develop and implement training of health committees and health care providers on health committee's roles and functions. This training could help in the realisation of the right to health by improving community participation and working relationships.

#### Why am I being contacted?

I am contacting you to ask you to help with the evaluation. This is not a test of what you learnt. It is also not an evaluation of what you think of the trainers. I would like to talk to you about the training to hear if you learnt something from the training. If you did learn something, I would like to know what that was and how that is helpful or not. Also, I would like to find out whether you will do anything new or different because of the training.

#### What is the reason for the evaluation?

It is the policy of the national government that every health facility should have a health committee. I am keen to learn about your experiences of working with a health committee if your facility has one. In addition, I am interested to learn whether the training has influenced or will be influencing your work with the health committee. This evaluation may help improve the follow up session after the first day of training as well as further training initiatives.





### **What will I be asked to do?**

I am asking if you are happy with me to observe the training and take notes of what you have learned and of the discussions that have taken place during the training.

I will also ask you to complete three questionnaires. If you agree, you will be given a questionnaire to fill in before the start of the training, one after the training and the last one after the final training session in a few weeks' time. These will take about 20 minutes each and will all be completed at the place of training.

1. The first questionnaire is necessary to assess your previous and current practices towards health committees as well as your understanding of their roles and functions *before* the training.
2. The second is necessary to assess the *immediate impact* of the first day of training on your understandings of health committees. You will also be asked for your opinion about the training and how it can or will impact your work with health committees.
3. In a few weeks' time, the third questionnaire will assess the *short-term impact* of the training on your understanding and (intended) practices towards health committees.

If you agree, you may be invited for an interview for a maximum time of an hour. This interview is just to chat more in detail about your experiences and issues with the training and health committees in general as well as your suggestions and vision on future practices and training. If there is no suitable meeting room available at the facility for the time scheduled, interviews can be held at the Faculty of Health Sciences of the University of Cape Town.

### **What are the risks and benefits of my participation?**

To my knowledge and understanding there are no anticipated risks. If you do not want to answer any or some of the questions you do not have to. If after talking to me you are upset by something you can contact one of the trainers.

Fundiswa Kibido:      fundiswa.kibido@uct.ac.za  
021 406 6429 or 083 259 1026

Or Pat Mayers:        pat.mayers@uct.ac.za  
021 406 6464

I will not pay you to take part in the study but, if we need to meet away from your work place or place of training, I will give you money for transport. From this evaluation it will be possible to develop more and better training for you and other health care providers.





### **Will someone be able to find out if I took part in the study?**

Everything you tell me will be kept confidential. In all communications of the study findings I will change your name and your work place, but you will be identifiable to me. However, confidentiality of everything discussed during the training or in the report back meeting cannot be guaranteed. Nonetheless, participants of the training and report back meeting will be urged to not share information outside the group of training participants.

I am asking your permission to audio-record the training, the interview and report-back meeting. In case you do not agree for the training, interview or report-back meeting to be recorded, I will ask you if you are happy with notes being taken.

Hard copies of the questionnaires and notes will be stored in securely locked cabinets. Audio records of interviews and report back meetings as well as transcriptions of digital records, notes and all other data will be saved and backed up securely on two different, multiple password protected computers; one home computer and one at UCT. The hard copies of questionnaires and field notes as well as audio records will be destroyed after two years to completely eliminate possible identification.

### **What will happen to what I tell you?**

In between the training sessions, findings will be shared with the trainers to improve the follow up session following your first day of training and the training of other, future training groups. I will write a report about what I have learnt from everyone participating in the study. I will send you a summary of the report. I will write a paper for the University and this might get published in an academic journal. The findings might also be presented at a conference. A report back meeting will possibly be scheduled before the findings are made publicly available. In this meeting, I will share with you the knowledge that I got from the questionnaires and interviews. You can give any additional comments, your opinion and feedback on what I found. The research findings will then be shared in the form of my thesis and any other subsequent publications. The data will not be shared with anyone outside of the research team; comprising me, my supervisors and any researchers I may employ. The coded data can be made available for further research on an enclosed website which can only be accessed by other researchers of the South African Learning Network.

### **What if I decide not to take part?**

Your participation in this study is completely voluntary. You can choose to stop a questionnaire, interview or leave a discussion during the training or report back meeting at any time you wish. You do not have to give a reason for this. If you do not like to take part in this research you will not be treated any differently, nor will it affect your participation in the training. If you do choose to participate, your participation will not affect your job or job-related evaluations in any way.





**Who should I contact for more information or if I have a problem with the evaluation?**

Should you have any further questions about or problems with any part of the study at any given point, you can ask me:

Gimenne Zwama  
Master of Public Health candidate  
Cell and Whatsapp: 083 695 9682  
Email: [gimenne@gmail.com](mailto:gimenne@gmail.com)

Or for questions and concerns for the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee about your rights and welfare as a research participant you may contact:

Shuretta Thomas  
Administrator Faculty of Health Sciences' Human Research Ethics Committee (HREC)  
of the University of Cape Town  
Tel: 021 406 6338  
Email: [shuretta.thomas@uct.ac.za](mailto:shuretta.thomas@uct.ac.za)



## **Appendix IV: Consent Form**

### **An Evaluation of Health Care Provider Training on Health Committees as a Platform for Community Participation, Cape Town, South Africa**

Now that you have read the Information Sheet, I am asking if you are happy to participate in the research.

Please remember that:

- You do not have to participate in the research.
- You can choose to stop participating in the research at any time. You can choose to stop a questionnaire, interview or leave a discussion during the training or report back meeting at any time. You do not have to give a reason for this.
- If you decide not to participate in the study it will not affect your participation in the training or your employment.
- Interviews will be organised at a time and place that is good for you.
- The collected information will be shared with the trainers and other people from the research team and will be used for a report and a scientific article. Your name will not be recorded anywhere and not used in any of these communications.
- Anonymity and confidentiality in the discussions of the training and report back meeting cannot be guaranteed, but all participants will be urged to keep information confidential.

Do you have any questions you would like to ask me?

Please feel free to contact me for any additional information on this research:

Gimenne Zwama  
Master of Public Health student  
Cell and Whatsapp: 083 695 9682  
Email: gimenne@gmail.com

**If you would like to participate, please fill in the form on the next page.**

Please keep the Information Sheet and this page of the Consent Form for your records. If you decide to complete the next page, I will provide you with a (digital) photocopy of this.

I, \_\_\_\_\_(name) have read the information sheet and any questions I had have been explained to me. I confirm that I will participate in the training and understand what the study is about and what is expected of me.

- |   |                        |
|---|------------------------|
| I agree for the training to be observed             | Yes . . . . No . . . . |
| I agree for the training to be recorded             | Yes . . . . No . . . . |
| I agree to complete the questionnaires              | Yes . . . . No . . . . |
| I agree to be contacted for an individual interview | Yes . . . . No . . . . |
| I agree for the interview to be recorded            | Yes . . . . No . . . . |
| I would like to attend a report back meeting        | Yes . . . . No . . . . |
| I agree for the report back meeting to be recorded  | Yes . . . . No . . . . |
| I agree for written notes to be taken of:           |                        |
| The training  | Yes . . . . No . . . . |
| Informal conversations                              | Yes . . . . No . . . . |
| The interview                                       | Yes . . . . No . . . . |
| The report back meeting                             | Yes . . . . No . . . . |

**Participant:** \_\_\_\_\_  
(Signature)

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Researcher:** \_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_

## **Appendix V: Topic Guide for Semi-structured Interviews**

### **Guiding questions and probes**

**Now that you've had the training, how do you think the health committee should function to benefit your facility area?**

Probes: kinds of roles/activities within the community and at the facility, extent of participation to make a valuable contribution

**How would you describe the relationship between health care providers and health committee members (or community in the absence of a health committee) at your facility/in your facility area?**

Probes: facilitating/impeding factors

**How does the training help or hinder the development of the health committee and its successful functioning?**

Probes: in comparison to other trainings, (un)addressed challenges, what stood out most, changes in activities/engagement since training, source of pre-understandings

**What kind of structures would you put in place or what actions would you undertake to facilitate health committee functioning?**

Probes: formation of HC, (other) relevant stakeholders, to support HC needs, feasibility of intentions

**What would be your strategy to promote effective working relationships?**

Probes: trust, commitment, power differences, availability, communication

**What kind of further training or support would you want to enable health committees to effectively function in your facility/area?**

Probe: who should be trained on what (skills) and why?

### **Closing remarks**

- Thank you very much for your participation. Is there anything you would like to add?
- May I contact you for follow-up questions?
- When would you most likely be available for a potential report back meeting?

## Appendix VI: UCT Human Research Ethics Committee – Study Approval



**UNIVERSITY OF CAPE TOWN**  
**Faculty of Health Sciences**  
**Human Research Ethics Committee**



**Room E52-24 Old Main Building**  
**Groote Schuur Hospital**  
**Observatory 7925**  
**Telephone [021] 406 6492 • Facsimile [021] 406 6411**  
**Email: [Sumayah.ariefdien@uct.ac.za](mailto:Sumayah.ariefdien@uct.ac.za)**  
**Website: [www.health.uct.ac.za/fhs/research/humanethics/forms](http://www.health.uct.ac.za/fhs/research/humanethics/forms)**

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**03 March 2015**

**REC/REF: 062/2015**

**Dr M Stuttaford**  
School of Public Health & Family Medicine  
Falmouth Building  
FHS

**Dear Dr Stuttaford**

**Project Title: AN EVALUATION OF HEALTH CARE PROVIDER TRAINING: EXPLORING THE UNDERSTANDING OF HEALTH COMMITTEES, CAPE TOWN, SOUTH AFRICA (LINKED TO 179/2007) Masters candidate- Gimenne Zwama)**

Thank you for your response letter, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

**Approval is granted for one year until the 28 March 2016.**

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

***We acknowledge that the following student:- Gimenne Zwama is also involved in this project.***

Please note that the on-going ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the HREC REF in all your correspondence.**

Yours sincerely

**Signed**

**PROFESSOR M BLOCKMAN  
CHAIRPERSON, HSF HUMAN ETHICS**

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 312.10, 312.61 and 312.62.

## Appendix VII: UCT Human Research Ethics Committee – Approval of Amendment

 <b>UNIVERSITY OF CAPE TOWN</b> <small>WATERSKOPKAMPUS • KENNEDY • ROSSouw • KASTEL</small>		<b>FACULTY OF HEALTH SCIENCES</b> Human Research Ethics Committee	
<b>Form FHS006: Protocol Amendment</b>		<b>31 JUL 2015</b>	
<b>HREC office use only (FWA00001637: IRB00001938)</b>			
<input checked="" type="checkbox"/> Approved	<input checked="" type="checkbox"/> Type of review: Expedited	<input type="checkbox"/> Full committee	
This serves as notification that all changes and documentation described below are approved.			
Signature Chairperson of the HREC		<b>Signed</b>	
		Date	1/8/2015
<b>Note:</b> All major amendments should include a PI <b>Synopsis</b> justifying the changes for the amendment (please see notice dated 23 April 2012)			
Comments to PI from the HREC			

**Principal Investigator to complete the following:**

**1. Protocol information**

Date (when submitting this form)	24/06/2015	
HREC REF Number	2015/062	
Protocol title	An evaluation of health care provider training: exploring understandings of health committees, Cape Town, South Africa	
Protocol number (if applicable)		
Principal Investigator	Dr Maria Stuttaford	
Department / Office Internal Mail Address	StuttafordM@cardiff.ac.uk	
1.1 Is this a major or a minor amendment? (see <a href="#">FHS006hlp</a> ) Major (tick box) Minor (tick box)	<input type="checkbox"/> Major	<input checked="" type="checkbox"/> Minor
1.2 Does this protocol receive US Federal funding?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
1.3 If the amendment is a major amendment and receives US Federal Funding, does the amendment require full committee approval?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Appendix VIII: City of Cape Town Approval of Access to Sub-districts



CITY OF CAPE TOWN  
ISIXEKO SASEKAPA  
STAD KAAPSTAD

CITY HEALTH

Dr Hélène Visser  
Manager: Specialised Health

T: 021 400 3981 F: 021 421 4894 M: 083 298 8718  
E: [Helen.Visser@cape.gov.za](mailto:Helen.Visser@cape.gov.za)

2015-05-22

**Re: Research Request: An Evaluation of Health Care Provider Training on Health Committees as a Platform for Community Participation, Cape Town, South Africa (6490) (ID No: 10492)**

Dear Ms Zwama,

Your request has been approved to recruit staff as per your research proposal from the following Sub Districts:

**Mitchells Plain Sub District:**

Contact People

Mrs S Elloker (Sub District Manager)  
Tel: (021) 391-5012/ 084 222 1478  
Mrs N Nqana (Head: PHC & Programmes)  
Tel: (021) 391-0175/ 084 2221489

**Southern Sub District:**

Contact People

Mr M Cupido (Acting - Sub District Manager)  
Tel: (021) 710-8295/ 084 2200 145  
Mrs K Shuping (Acting Head: PHC & Programmes)  
Tel: (021) 710-9383

**Klipfontein Sub District:**

Contact People

Mr K Nkoko (Sub District Manager)  
Tel: (021) 630-1667/ 082 433 1332  
Mrs T Nojaholo (Head: PHC & Programmes)  
Tel: (021) 630-1626/ 084 220 0133

**Khayelitsha Sub District:**

Contact People

Dr V de Azevedo (Sub District Manager)  
Tel: (021) 360-1258/ 083 629 3344  
Mrs S Patel Abrahams (Head: PHC & Programmes)  
Tel: (021) 360-1153/ 084 405 8065

**Please note the following:**

1. Access to the clinics and staff must be arranged with the relevant Managers such that normal activities are not disrupted.
2. A copy of the final report must be sent to the City Health Head Office, P O Box 2815 Cape Town 8001, within 6 months of its completion and feedback must also be given to the clinics involved.
3. Your project has been given an ID Number (10492) Please use this in any future correspondence with us.
4. No monetary incentives to be paid on the City Health premises.

Thank you for your co-operation and please contact me if you require any further information or assistance.

CIVIC CENTRE    IZIKO LOLUNGU    BURGERSENTRUM  
HERTZOG BOULEVARD CAPE TOWN 8001    P O BOX 2815 CAPE TOWN 8000  
[www.cape.gov.za](http://www.cape.gov.za)

Making progress possible. Together.

Appendices

Yours sincerely

**Signed**

DR G H VISSER  
MANAGER: SPECIALISED HEALTH

cc. Mrs Elloker & Ms Nqana  
Mr Cupido & Mrs K Shuping  
Dr de Azevedo & Mrs Patel Abrahams  
Mr Nkoko & Mrs Nojaholo  
Dr Jennings

## Appendix VIII: City of Cape Town Approval of Extended Access to Sub-districts



CITY OF CAPE TOWN  
ISIXEKO SASEKAPA  
STAD KAAPSTAD

CITY HEALTH

Dr Hélène Visser  
Manager: Specialised Health

T: 021 480 3981 F: 021 421 4894 M: 083 298 8718  
E: [Helene.Visser@capetown.gov.za](mailto:Helene.Visser@capetown.gov.za)

2015-07-01

**Re: Research Request: An Evaluation of Health Care Provider Training on Health Committees as a Platform for Community Participation, Cape Town, South Africa (6490) (ID No: 10492b)**

Dear Ms Zwama,

Permission has been granted to extend research to the following additional sub-districts and will include health care staff (clinic managers, doctors, nurses, administrators). Training will be centralised for all sub-districts and first session will take place on 10 July 2015. This decision was made to decrease the expected burden on service delivery on the individual facilities due to staff being away for the training.

**Eastern Sub District:**

Contact People:

Dr P Nkurunziza (Sub District Manager)  
Tel: (021) 850-4315 / 084 800 0644  
Mrs T de Villiers (Head: PHC & Programmes)  
Tel: (021) 850-4312

**Tygerberg Sub District:**

Contact People:

Mrs M Alexander (Sub District Manager)  
Tel: (021) 938-8279 / 084 222 1471  
Mrs D Titus (Head: PHC & Programmes)  
Tel: (021) 938-8281 / 084 308 0596

**Western Sub District:**

Contact People:

Mrs G Sifanelo (Sub District Manager)  
Tel/Cell: (021) 514-4122 / 084 630 2903  
Mrs M Stanley (Head: PHC & Programmes)  
Tel/Cell: (021) 514-4124 / 072 329 6361

**Please note the following:**

1. All individual patient information obtained must be kept confidential.
2. Access to the clinics and its staff must be arranged with the relevant Managers such that normal activities are not disrupted.
3. A copy of the final report must be sent to the City Health Head Office, P O Box 2815 Cape Town 8001, within 6 months of its completion and feedback must also be given to the clinics involved.
4. Your project has been given an ID Number (10492b). Please use this in any future correspondence with us.

Thank you for your co-operation and please contact me if you require any further information or assistance.

CIVIC CENTRE IZIKO LOUJINTU BURGERSENTRUM  
HERTZOG ROULEVARD, CAPE TOWN 8001 P O BOX 2815, CAPE TOWN 8000  
[www.capetown.gov.za](http://www.capetown.gov.za)

**Making progress possible. Together.**

Yours sincerely

**Signed**

**DR G H VISSER**  
**MANAGER: SPECIALISED HEALTH**

cc. Dr Nkurunziza & Ms de Villiers  
Mrs Elloker & Ms Nqana  
Mr Cupido & Mrs K Shuping  
Dr de Azevedo & Mrs Patel Abrahams  
Mrs Alexander & Mrs Titus  
Mrs Sifanelo & Mrs Stanley  
Mr Nkoko & Mrs Nojaholo  
Dr Jennings  
Ms Caldwell

## Appendix X: Instructions for Authors – BMC Health Services Research

### BMC HEALTH SERVICES RESEARCH

#### Research articles

[Criteria](#) | [Submission process](#) | [Preparing main manuscript text](#) | [Preparing illustrations and figures](#) | [Preparing tables](#) | [Preparing additional files](#) | [Style and language](#)

Assistance with the process of manuscript preparation and submission is available from [BioMed Central customer support team](#). See '[About this journal](#)' for information about policies and the refereeing process. We also provide a collection of links to [useful tools](#) and resources for scientific authors on our page.

#### Criteria

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Research articles should report on original primary research, but may report on systematic reviews of published research provided they adhere to the appropriate reporting guidelines which are detailed in our [Editorial Policies](#). Please note that non-commissioned pooled analyses of selected published research will not be considered.

#### Submission process

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Manuscripts must be submitted by one of the authors of the manuscript, and should not be submitted by anyone on their behalf. The corresponding author takes responsibility for the article during submission and peer review.

Please note that *BMC Health Services Research* levies an article-processing charge on all accepted Research articles; if the corresponding author's institution is a [BioMed Central member](#) the cost of the article-processing charge may be covered by the membership (see [About](#) page for detail). Please note that the membership is only automatically recognised on submission if the corresponding author is based at the member institution.

To facilitate rapid publication and to minimize administrative costs, *BMC Health Services Research* prefers [online submission](#).

Files can be submitted as a batch, or one by one. The submission process can be interrupted at any time; when users return to the site, they can carry on where they left off.

See below for examples of [word processor](#) and [graphics file formats](#) that can be accepted for the main manuscript document by the online submission system. Additional files of any type, such as [movies](#), animations, or [original data files](#), can also be submitted as part of the manuscript. During submission you will be asked to provide a cover letter. Use this to explain why your manuscript should be published in the journal, to elaborate on any issues relating to our editorial policies in the '[About BMC Health Services Research](#)' page, and to declare any potential competing interests.

Assistance with the process of manuscript preparation and submission is available from [BioMed Central customer support team](#).

We also provide a collection of links to useful tools and resources for scientific authors on our [Useful Tools](#) page.

### File formats

The following word processor file formats are acceptable for the main manuscript document:

- Microsoft word (DOC, DOCX)
- Rich text format (RTF)
- Portable document format (PDF)
- TeX/LaTeX (use [BioMed Central's TeX template](#))
- DeVice Independent format (DVI)

TeX/LaTeX users: Please use [BioMed Central's TeX template](#) and BibTeX stylefile if you use TeX format. During the TeX submission process, please submit your TeX file as the main manuscript file and your bib/bbl file as a dependent file. Please also convert your TeX file into a PDF and submit this PDF as an additional file with the name 'Reference PDF'. This PDF will be used by internal staff as a reference point to check the layout of the article as the author intended. Please also note that all figures must be coded at the end of the TeX file and not inline.

If you have used another template for your manuscript, or if you do not wish to use BibTeX, then please submit your manuscript as a DVI file. We do not recommend converting to RTF.

For all TeX submissions, all relevant editable source must be submitted during the submission process. Failing to submit these source files will cause unnecessary delays in the publication procedures.

### Publishing Datasets

Through a special arrangement with [LabArchives](#), LLC, authors submitting manuscripts to BMC Health Services Research can obtain a [complimentary subscription to LabArchives](#) with an allotment of 100MB of storage. LabArchives is an Electronic Laboratory Notebook which will enable scientists to share and publish data files in situ; you can then link your paper to these data. Data files linked to published articles are assigned digital object identifiers (DOIs) and will remain available in perpetuity. Use of LabArchives or similar data publishing services does not replace preexisting data deposition requirements, such as for nucleic acid sequences, protein sequences and atomic coordinates.

Instructions on assigning DOIs to datasets, so they can be permanently linked to publications, can be found on the LabArchives website. Use of LabArchives' software has no influence on the editorial decision to accept or reject a manuscript.

Authors linking datasets to their publications should include an [Availability of supporting data](#) section in their manuscript and cite the dataset in their reference list.

## Preparing main manuscript text

---

General guidelines of the journal's style and language are given [below](#).

### Overview of manuscript sections for Research articles

Manuscripts for Research articles submitted to *BMC Health Services Research* should be divided into the following sections (in this order):

- [Title page](#)
- [Abstract](#)
- [Keywords](#)
- [Background](#)
- [Methods](#)
- [Results and discussion](#)
- [Conclusions](#)
- [List of abbreviations used](#) (if any)
- [Competing interests](#)
- [Authors' contributions](#)
- [Authors' information](#)
- [Acknowledgements](#)
- [Endnotes](#)
- [References](#)
- [Illustrations and figures](#) (if any)
- [Tables and captions](#)
- [Preparing additional files](#)

The **Accession Numbers** of any nucleic acid sequences, protein sequences or atomic coordinates cited in the manuscript should be provided, in square brackets and include the corresponding database name; for example, [EMBL:AB026295, EMBL:AC137000, DDBJ:AE000812, GenBank:U49845, PDB:1BFM, Swiss-Prot:Q96KQ7, PIR:S66116].

The databases for which we can provide direct links are: EMBL Nucleotide Sequence Database ([EMBL](#)), DNA Data Bank of Japan ([DDBJ](#)), GenBank at the NCBI ([GenBank](#)), Protein Data Bank ([PDB](#)), Protein Information Resource ([PIR](#)) and the Swiss-Prot Protein Database ([Swiss-Prot](#)).

For reporting standards please see the information in the [About](#) section.

### Title page

The title page should:

- provide the title of the article
- list the full names, institutional addresses and email addresses for all authors
- indicate the corresponding author

Please note:

- the title should include the study design, for example "A versus B in the treatment of C: a randomized controlled trial X is a risk factor for Y: a case control study"
- abbreviations within the title should be avoided
- if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the "acknowledgements" section in accordance with the instructions below. Please note that the individual names may not be included in the PubMed record at the time a published article is initially included in PubMed as it takes PubMed additional time to code this information.

### Abstract

The Abstract of the manuscript should not exceed 350 words and must be structured into separate sections: **Background**, the context and purpose of the study; **Methods**, how the study was performed and statistical tests used; **Results**, the main findings; **Conclusions**, brief summary and potential implications. Please minimize the use of abbreviations and do not cite references in the abstract. **Trial registration**, if your research article reports the results of a controlled health care intervention, please list your trial registry, along with the unique identifying number (e.g. **Trial registration**: Current Controlled Trials ISRCTN73824458). Please note that there should be no space between the letters and numbers of your trial registration number. We recommend manuscripts that report randomized controlled trials follow the [CONSORT extension for abstracts](#).

### Keywords

Three to ten keywords representing the main content of the article.

### Background

The Background section should be written in a way that is accessible to researchers without specialist knowledge in that area and must clearly state - and, if helpful, illustrate - the background to the research and its aims. Reports of clinical research should, where appropriate, include a summary of a search of the literature to indicate why this study was necessary and what it aimed to contribute to the field. The section should end with a brief statement of what is being reported in the article.

### Methods

The methods section should include the design of the study, the setting, the type of participants or materials involved, a clear description of all interventions and comparisons, and the type of analysis used, including a power calculation if appropriate. Generic drug names should generally be used. When proprietary brands are used in research, include the brand names in parentheses in the Methods section.

For studies involving human participants a statement detailing ethical approval and consent should be included in the methods section. For further details of the journal's editorial policies and ethical guidelines see '[About this journal](#)'.

For further details of the journal's data-release

policy, see the policy section in ['About this journal'](#).

### **Results and discussion**

The Results and discussion may be combined into a single section or presented separately. Results of statistical analysis should include, where appropriate, relative and absolute risks or risk reductions, and confidence intervals. The Results and discussion sections may also be broken into subsections with short, informative headings.

### **Conclusions**

This should state clearly the main conclusions of the research and give a clear explanation of their importance and relevance. Summary illustrations may be included.

### **List of abbreviations**

If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations can be provided, which should precede the competing interests and authors' contributions.

### **Competing interests**

A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organizations. Authors must disclose any financial competing interests; they should also reveal any non-financial competing interests that may cause them embarrassment were they to become public after the publication of the manuscript.

Authors are required to complete a declaration of competing interests. All competing interests that are declared will be listed at the end of published articles. Where an author gives no competing interests, the listing will read 'The author(s) declare that they have no competing interests'.

When completing your declaration, please consider the following questions:

#### *Financial competing interests*

- In the past three years have you received reimbursements, fees, funding, or salary from an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? Is such an organization financing this manuscript (including the article-processing charge)? If so, please specify.
- Do you hold any stocks or shares in an organization that may in any way gain or lose financially from the publication of this manuscript, either now or in the future? If so, please specify.
- Do you hold or are you currently applying for any patents relating to the content of the manuscript? Have you received reimbursements, fees, funding, or salary from an organization that holds or has applied for patents relating to the content of the manuscript? If so, please specify.
- Do you have any other financial competing interests? If so, please specify.

### *Non-financial competing interests*

Are there any non-financial competing interests (political, personal, religious, ideological, academic, intellectual, commercial or any other) to declare in relation to this manuscript? If so, please specify.

If you are unsure as to whether you, or one your co-authors, has a competing interest please discuss it with the editorial office.

### **Authors' contributions**

In order to give appropriate credit to each author of a paper, the individual contributions of authors to the manuscript should be specified in this section.

According to [ICMJE guidelines](#), An 'author' is generally considered to be someone who has made substantive intellectual contributions to a published study. To qualify as an author one should 1) have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; 2) have been involved in drafting the manuscript or revising it critically for important intellectual content; 3) have given final approval of the version to be published; and 4) agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. Acquisition of funding, collection of data, or general supervision of the research group, alone, does not justify authorship.

We suggest the following kind of format (please use initials to refer to each author's contribution):  
AB carried out the molecular genetic studies, participated in the sequence alignment and drafted the manuscript. JY carried out the immunoassays. MT participated in the sequence alignment. ES participated in the design of the study and performed the statistical analysis. FG conceived of the study, and participated in its design and coordination and helped to draft the manuscript. All authors read and approved the final manuscript.

All contributors who do not meet the criteria for authorship should be listed in an acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, a department chair who provided only general support, or those who contributed as part of a large collaboration group.

### **Authors' information**

You may choose to use this section to include any relevant information about the author(s) that may aid the reader's interpretation of the article, and understand the standpoint of the author(s). This may include details about the authors' qualifications, current positions they hold at institutions or societies, or any other relevant background information. Please refer to authors using their initials. Note this section should not be used to describe any competing interests.

### **Acknowledgements**

Please acknowledge anyone who contributed towards the article by making substantial contributions to conception, design, acquisition of data, or analysis and interpretation of data, or who was

involved in drafting the manuscript or revising it critically for important intellectual content, but who does not meet the criteria for authorship. Please also include the source(s) of funding for each author, and for the manuscript preparation. Authors must describe the role of the funding body, if any, in design, in the collection, analysis, and interpretation of data; in the writing of the manuscript; and in the decision to submit the manuscript for publication. Please also acknowledge anyone who contributed materials essential for the study. If a language editor has made significant revision of the manuscript, we recommend that you acknowledge the editor by name, where possible.

The role of a scientific (medical) writer must be included in the acknowledgements section, including their source(s) of funding. We suggest wording such as 'We thank Jane Doe who provided medical writing services on behalf of XYZ Pharmaceuticals Ltd.'

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Doe J. Title of subordinate document. In: The dictionary of substances and their effects. Royal Society of Chemistry. 1999. [http://www.rsc.org/dose/title of subordinate document](http://www.rsc.org/dose/title%20of%20subordinate%20document). Accessed 15 Jan 1999.

*Online database*

Healthwise Knowledgebase. US Pharmacopeia, Rockville. 1998. <http://www.healthwise.org>. Accessed 21 Sept 1998.

*Supplementary material/private homepage*

Doe J. Title of supplementary material. 2000. <http://www.privatehomepage.com>. Accessed 22 Feb 2000.

*University site*

Doe, J: Title of preprint. <http://www.uni-heidelberg.de/mydata.html> (1999). Accessed 25 Dec 1999.

*FTP site*

Doe, J: Trivial HTTP, RFC2169. <ftp://ftp.isi.edu/in-notes/rfc2169.txt> (1999). Accessed 12 Nov 1999.

*Organization site*

ISSN International Centre: The ISSN register. <http://www.issn.org> (2006). Accessed 20 Feb 2007.

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Zheng L-Y, Guo X-S, He B, Sun L-J, Peng Y, Dong S-S, et al. Genome data from sweet and grain sorghum (*Sorghum bicolor*). GigaScience Database. 2011. <http://dx.doi.org/10.5524/100012>.

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