The experiences of health committees of community participation in health information campaigns during the COVID-19 pandemic

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Acronyms

COVID-19 – Coronavirus Disease

HCs – Health Committees

PHM – People's Health Movement

WHO- World Health Organisation

Abstract

Background: During the COVID-19 pandemic, a need arose for information to be provided to communities in a way that is understandable, practical and suited to their context, in order to empower communities to mobilize and actively participate in prevention measures against COVID-19.The People's Health Movement (PHM) in South Africa generated information pamphlets meant for dissemination and training among vulnerable communities, in efforts to facilitate knowledge translation about non-pharmacological prevention behaviours in the fight against the pandemic. It was not clear what benefit health information delivered in this way would have on the agency of bodies such as health committees, in taking ownership of advocating for the implementation of non-pharmacological behaviours, though similar theories could be formed from the study of previous pandemics. This study aimed to explore the perceptions health committee members have regarding the potential impact of health information relating to COVID-19 non-pharmacological prevention behaviours, and the ability of these modalities to facilitate community participation and agency in health. **Methods:** A qualitative approach was taken, and health committee members from the Khayelitsha and Klipfontein health districts were invited to participate in two rounds of focus groups. Data was analysed through thematic analysis. Member checking with participants was done throughout both focus groups **Results:** Five overarching themes were identified, that showed that knowledge translation and sense-making of non-pharmocological behaviours detailed by the PHM information pamphlets were impacted by elements unrelated to the content and structure of the resources itself. **Discussion:** The study highlighted the important role of multi-modal and multi-player participation in empowering bodies such as health committees to foster the agency of their people, in making sense of health information. The study highlighted the need for congruent and equitable interventions and information dissemination, that is acutely aware of the challenges faced by health committees in related to health information itself. A neglect of these challenges proves to negate even the most accurate and evidence based health information resource, as was seen in the health committees perception of the PHM information pamphlets. Future research could serve to explore broader perceptions of community participation in health information campaigns, to further account for the unique challenges faced by communities

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Synopsis

During the COVID-19 pandemic, community engagement platforms like Health Committees (HCs) are a potentially vital link between policy makers and the community in fostering agency and active citizenry when it comes to improving community health behaviours (Strecker et al, 2012). This study aims to explore the perceptions of health committees on COVID-19 health information.

The study will make use of demographic surveys to collect biographical information from participants and will thereafter employ the use of focus groups to collect rich data on Health committees' perceptions. The nature of health committees' opinions over time will be recorded by means of follow-up focus groups, after they have been given a period to interact with the information pamphlets. It is hoped that the study will provide insight into the way in which health information, particularly regarding the prevention of COVID-19 is delivered, and how that impacts its effectiveness and acceptability by important community members.

1. Problem Statement and Rationale for the study

There are many different understandings of health committees in the current body of research. For the purposes of the study, health committees are understood as groups of people with a collective mandate and purpose, aiming to advocate for and assist in the enhancement of community health (Karuga et al, 2019). Health Committees are meant to be a key role player in facilitating the ability of communities to take ownership of their health, through the provision of health information (Muller, 2013), and this ownership by communities regarding decisions about health, is widely accepted as being a facilitator of overall improvements in health outcomes (Mulumba et al, 2018).

Legislation in the Western Cape, in South Africa defines Health Committees (HCs) as having a role in advocating for primary health services to be provided to their communities (Western Cape Health Facilities Boards and Committees Act, 2016). Importantly, health committees are meant to encourage community participation with regards to health through allowing community members a channel through which to express their concerns, and aid in having these concerns addressed (Botha, 2018).

Health committees are intended to form a vital link between government health officials, community members and healthcare facilities, and as part of their role, are mandated to ensure that the community is informed about pertinent health issues that concern them (Muller, 2013) There are many different understandings regarding the roles and powers of health committees, evident in the different levels of functioning of health committees across South Africa (Meier et al, 2012). In different provinces in South Africa, it is also clear that health committees do possess some agency in determining what role they will play to their facilities, dependent on the context and need of their community (Haricharan, 2012). Health committees will be defined as a state mandated structure affiliated with community health facilities aimed at facilitating community participation (National Health Act, 2003).

During the COVID-19 pandemic, a need has arisen for information to be provided to communities in a way that is understandable, practical and suited to their context, in order to empower communities to mobilize and actively participate in prevention measures against COVID-19. In some communities in the Western Cape, active health committees, in areas such as Manenberg and Khayelitsha, have been making concerted efforts to support communities as much as possible in raising awareness about COVID-19 and assisting with making sure members of the community understand and are able to carry out prevention measures. However, these efforts have often been curtailed by low support from government and lockdown restrictions which excluded these committee members from being able to work (Jeranji, 2020).

The People's Health Movement in South Africa (PHM-SA) have generated information pamphlets meant for dissemination and training among vulnerable communities, in efforts to facilitate knowledge translation about non-pharmacological prevention interventions to curb infections during the pandemic. The information pamphlets detail guidelines defining the different prevention measures meant to prevent COVID-19 infection such as social distancing and mask wearing, attempting to do so in a way that would be suited to the local context, delivering these messages with the use of clear language and carefully selected imagery.

The provision of this COVID-19 prevention information is intended to change the position of community members from disempowerment and vulnerability in the wake of the pandemic, to being empowered with tools (in the form of new knowledge) to be agents of their own good health. It is not known, however, whether the materials developed, is received, understood, and used by a body such as HCs in a way that could benefit their communities in this way. Community engagement platforms like HCs are a potentially vital link between policy makers and the community in fostering agency and active citizenry when it comes to improving community health behaviours (Strecker et al, 2012).

2. Research Question

What are the perceptions of health committee members of the likely effectiveness of the PHMSA information resources in influencing awareness of COVID-19 prevention protocols to communities, and what changes to these resources do they think should be made to better address the information needs in their communities?

3. Aims and Objectives

Aim:

To explore health committee members in the Khayelitsha and Klipfontein subdistricts' perceptions regarding the potential impact of the PHM COVID-19 information pamphlets in facilitating knowledge translation about non-pharmacological prevention behaviours in the communities they form part of and identify how the information resources could be improved.

Objectives:

1) Determine the opinions of the health committee members in the Khayelitsha and Klipfontein sub districts regarding PHM information pamphlets, particularly:

- Their opinion regarding how the information pamphlets succeed or fail to consider the socioeconomic context of the community they form part of, and that would need to make use of them.
- Comparisons of local understandings of the pandemic and non-pharmacological interventions with the way this information is provided in the pamphlets.
- Whether health committee members think that the PHM materials would succeed in raising awareness about prevention measures in their communities
- What improvements they think could be made to the materials

2) Determine how health committee members think community members will perceive the PHM materials, particularly:

- Whether they think community members will understand the PHM information pamphlets and be able to follow non-pharmacological prevention guidelines stipulated in the pamphlets.

4. Methodology

Study Design

The study will follow a qualitative research design. It will be an exploratory study, as not much is known on the topic of health committees' perception of educational material relating to COVID-19 non-pharmacological behaviors. This study requires a qualitative lens, as quantitative research would not be able to account for the complex nature of understanding the perceptions and opinions of health care committee members operating in a complex system. The decisions people make about health-related information is not straightforward and does not lend itself to concrete measurement (Bougeault et al, 2010).

The study will take the form of an exploratory case study, to best capture how the COVID-19 information pamphlets are viewed and understood by the community members participating in health committees in the selected areas. The case can be defined as the perspectives of health committees on an information source by the People's Health Movement of South Africa, detailing non-pharmacological prevention behaviors against COVID-19. A case study is the most appropriate method of exploration of this topic, to allow the researcher to explore the insights by a small group of people with specific knowledge (Ulin et al, 2005) – in this case, around community participation in health information campaigns. It allows for the questions of "what" and "how" to be answered in relation to the complexity of perceptions and opinions which may come to the fore in the responses of health committees to the educational COVID-19 information provided by the PHM. The study will make use of a short demographic survey provided to participants, followed by a focus group with a semi-structured topic guide to guide the discussion (Yin, 2009) The study will include two focus groups in the Klipfontein Subdistrict – one in the Gugulethu area, and one focus group in the Manenberg area; as well as two focus groups in the Khayelitsha area.

Focus groups will comprise approximately six to eight participants. There will be two focus groups conducted with each health committee, with a two to three-month period between the first focus group and the follow up focus group. Focus groups allow for respondents to share ideas and relate to one another's experiences of a topic (Ulin et al, 2005), and for the purposes of discovering more about possible adaptations or improvements health committees may suggest in respect to the information pamphlets presented to them, this type of platform will provide such an opportunity.

An initial round of focus groups will be held. At the start of each focus group, each participant will be provided with a demographic questionnaire to complete, which will collect demographic information about the participants partaking in the study (age, sex, employment, area of residence), and the participants' knowledge and experience of the COVID-19 pandemic. The purpose of this survey will allow for the

researcher to get to know the participants and better describe them during the analysis (Dobosh, 2017). The questionnaire will be used as we are aiming to study the diversity of opinion around the topic under study (Jansen, 2010) and the survey will be a representation of the different socio-economic, racial and cultural characteristics of the participants engaging in the focus groups.

Once each participant has completed a questionnaire, they will each be provided with a COVID-19 information pamphlet and will be given the opportunity to peruse the information pamphlet provided. The focus group will be guided by a semi–structured topic guide. The purpose of the focus group is to better understand the perceptions of each participant regarding the information pamphlets. The focus group will give the researchers the opportunity to better understand the perspectives of the health committees, and what has guided their perception of the COVID-19 information materials provided. In addition, after the initial round of focus groups, health committees will be provided with stock of the information pamphlets for use during their community education activities and will be informed that another focus group will occur where they will be able to provide further feedback on their experiences and perceptions of the information pamphlets once they have had the opportunity to make use of them in the communities.

Once the first round of focus groups has been conducted and analysed, the researcher will return to the sites after a period of one to two months, and a second round of focus groups will be conducted. It is important for the researcher to gain sufficient new learning from the participants to provide rich descriptions of themes arising pertaining to the information under study (Liamputtong, 2015). A second round of focus groups is also aimed at looking at any changes in understanding and opinion of the information materials that occur as the participants' experiences change during the pandemic, and as they have had the chance to make use of the pamphlets in their communities.

Characteristics of the study population

The population will be selected with the use of purposive sampling, as the study requires a specific group of individuals forming part of the population under study – health committee members operating as part of a committee for facilities in the Cape Metropolitan District – more specifically, facilities in the subdistricts of Khayelitsha and Klipfontein. The study population is health committee members in the areas of Manenberg, Gugulethu and two sites in Khayelitsha. The study will take place in community venues in these areas.

Gugulethu is a township in the Western Cape, situated on the Cape Flats (SA History, 2013). Its health facilities fall under the Klipfontein subdistrict. Gugulethu was established as a migrant worker township in 1958 (SA History, 2019). In Gugulethu, Health Committees have been active in trying to liaise with health

facilities to encourage prevention behaviors among community members (Jeranji, 2020). Manenberg is a predominantly Afrikaans area within the subdistrict of Klipfontein. It is a historically disadvantaged community established in 1966 under the Group Areas Act (SA History, 2019). Health forums in Manenberg appear to express experiences of disempowerment during the COVID-19 pandemic, and only really are empowered where managers of health facilities recognize their value (Jeranji, 2020). Khayelitsha – also the name of the subdistrict - is another large township in the Western Cape, situated south east of the Cape Town Metropole. (SA History, 2013). This township was established in 1983 as another form racial segregation of the historically "African" population of the Western Cape (SA History, 2019). This community's health forum- an umbrella body under which health committees in the sub-district are governed (National Health Act, 2003) - has, during the course of the pandemic, expressed public concern about their exclusion from intervention strategies in the community, and have often felt pushed aside when it came to the state's addressing of COVID-19 in their community, often reporting being left to use personal funds to disseminate prevention information in the community (Jeranji, 2020).

Health committees in these areas have been vocal about their view that health committees have and will continue to be a vital part of educating communities about prevention strategies when it comes to COVID-19 (Jeranji, 2020).

The population under study is defined as follows:
Community members are currently forming part of a health committee in the Klipfontein and Khayelitsha health sub-districts in the Cape Town Metropolitan district, with each health committee forming a single focus group. The level of functioning of the committee is not an inclusion criterion. Any participant fitting the above-mentioned criteria will be permitted to join the study, but is not in any way obligated to do so.

Recruitment and Enrolment

The researcher will approach health committees in the Klipfontein and Khayelitsha sub-districts, to gain their cooperation for participation in the study. An advertisement will be sent out to invite health committee members to the opportunity to participate in the study.
Written Informed consent will be obtained from all participants. Participants will each receive a document seeking their consent for participation in the study.
Participation will be entirely voluntary, and participants will be allowed to withdraw at any time during the study.

5. Data Collection and Analysis

Data collected will be produced from a single questionnaire provided to all participants, and two rounds of focus groups per health committee. Survey data will be collected by participants completing the questionnaire prior to the commencement of the first focus group. The services of a translator will be employed in focus groups where the language of the group is one the researcher is not sufficiently proficient in – namely IsiXhosa speaking groups – in order to ensure the accuracy of the transcriptions of these groups. It will be analysed and reported on through the use of descriptive statistics. Voice recordings from the focus group will be transcribed and analysed. The focus group interview data for each facility will undergo thematic content analysis, to determine the trends in the participants' responses. The researcher will analyse the data by manually documenting and themes that arise from the participants' responses.

Participants will be invited to receive feedback from the researcher regarding the findings from their group. This feedback will entail explaining the results of the study. This is to ensure that her interpretation correlates with the respective health committees' intended responses. This is important in order to ensure that the opinions of the participants were interpreted correctly. A final thematic analysis will be completed to draw commonalities in perceptions of the COVID 19 material.

6. Rigour

The principles of triangulation will be applied to the study. Multiple focus groups with different health committees in different areas and sub-districts will be approached to support the researcher's accurate interpretation of the participants' responses. Participants will be asked to verify the correctness of their responses during the focus groups as a form of member checking. This will ensure that the researcher's understanding of the participants' perceptions are reflected correctly, and that any discrepancies in understanding are accounted for in the reporting and discussion of the results. Finally, focus groups will be conducted more than once for each health committee. This way the findings of the study can be reinterpreted as new themes emerge, and rich data can be retrieved.

7. Ethical Considerations

The study will be strictly guided by the principles of the Helsinki Declaration (World Medical Association Declaration of Helsinki, 2001). The study will require participation from human participants, and therefore informed consent will be required. Participation in this study will be entirely voluntary and there is no foreseeable financial benefit attached to participation in the study, nor will the study serve to detriment participants financially, as every engagement will be done at the convenience of the health committees.

Participants will not be named in the study, in order to protect their anonymity. Researchers will not prejudice patients based in their responses to the study materials.

Informed Consent Process

Because the three official languages of the Western Cape include English, Afrikaans and IsiXhosa, informed consent documents will be translated and provided to each participant in their choice of English, Afrikaans or IsiXhosa. The researcher will explain the informed consent information sheet verbally to each participant. The researcher will seek the assistance of a translator to support the participants' accurate understanding of the contents of the consent document. Participants will be allowed to discuss the contents of the informed consent document with others to aid their understanding, and the researcher will ensure her availability to address any questions or concerns relating to their comprehension of the implications of their consent. Informed consent will be taken through the signing of a consent form by each participant, should they agree to participate in the study.

Privacy and Confidentiality

The researcher will attempt at all costs to protect privacy and confidentiality, through the use of pseudonyms in transcriptions and reporting. Focus groups will be held in communion with other members – either through a virtual platform or face-to-face, and thus participants will be made aware that they will be asked to share their opinions with other members of their committees and thus may elect to withdraw from the study at any point should they feel uncomfortable. Participants will be informed that it is not possible to guarantee confidentiality within the focus group, as other members will be hearing and responding to their opinions, however, participants will be asked not to share the contents of the discussion with people outside of the group.

Reimbursement for participation

Participants will not be reimbursed financially for participating in the study. All attempts will be made to prevent financial setbacks to participants (e.g. high transport costs), by ensuring that the researcher schedules participation in the study according to health committee members' availability, such as scheduling focus group meetings when members' are already at the health clinics their committee liaises with. Contributions towards participants' transport costs will be made where necessary, and refreshments will be served for participants attending the focus groups.

8. **Description of Risks and Benefits**

<u>Risks and potential discomforts</u>

Every effort will be made to protect the anonymity of participants. Because they hold standing within their community, and the political nature of the COVID-19 pandemic and the handling thereof by governments and interested parties, there exists potential risk of participants experiencing disagreements and tension amongst themselves or with community members. Nonetheless, the researcher will make every effort to report objectively and honestly on the response of the participants, to reflect their real perceptions and opinions. As health committee members may have experiences loss or trauma because of COVID-19 infections of community members, family or friends, discussion of this topic may highlight uncomfortable or traumatic feelings during the focus group. The researcher will thus ensure contingencies are in place to mitigate the occurrence of emotional distress as much as possible, by ensuring participants have access to counselling services should they require debriefing. The researcher will assist participants with referrals to Families South Africa's (FAMSA) Western Cape branch should they require counselling services.

In light of the COVID-19 pandemic, possible risk of infection will always exist when persons are asked to come together. Every effort will be made to mitigate the risk of an outbreak. The principles of social distancing will be observed at all times during contact with committee members, with strict requirements for mask wearing and social distancing to be observed by all members. Where possible, focus groups will be held on a virtual platform, to avoid unnecessary in person contact, however the technological requirements of each member of the committee will first be determined, to decide if a virtual platform will be possible. Where in person meeting is necessitated, the researcher will ensure that resources are available for appropriate hand washing and sanitising, in the community venue. The researcher will ensure that a venue is selected that allows for appropriate social distancing.

Potential benefits

This study holds potential benefits for the health committees involved, as well as for the community at large. This study will make use of information developed by the People's Health Movement of South Africa, which could be used by the health committees as a tool to further advocate for and educate community members on the use of non-pharmacological interventions to support the ongoing prevention of COVID-19 infection in the community, should the outcome of engagement be that the material has potential to benefit these communities' prevention outreach. Once refined with the input of health committees that come out of the study process, this research also holds potential benefits from the People's Health Movement, in that they would be able to refine their resource banks to be tailored to the communities it aims to advocate for.

Conflict of interest

The researcher declares no knowledge of any conflict of interest which could influence objectivity of the reporting in this study

9. Budget

The study will incur the following cost estimates:

Printing: R1500

General stationery: R250

Transport for participants: R2500

Total Venue hire: R2000

10. Timeline

Once approval has been received from the Research Ethics committee, data collection will commence and be completed within 6 - 8 weeks of ethics approval. Data analysis of the initial round of data collection will occur within 8 weeks. After approximately 4 - 6 weeks have passed, the second round of data collection will occur and will also be completed within 6- 8 weeks. Final data analysis and write up will occur and be completed within 10 – 12 weeks, after member checking and feedback to health committees has been completed (a period of 2-3 weeks).

11. Dissemination

The study report will be disseminated in a written summary to every health committee that participated. The researcher will return to the health committees and the report will be discussed with the use of a short power point presentation. The findings of the study will be presented to the People's Health Movement of South Africa organization. Finally, the study will be disseminated to the academic community at large through presentations and possible publications.

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Part B: Journal Manuscript

Targeted Journal: ***Health Promotion International***

Title: The experiences of health committees of community participation in health information campaigns during the COVID-19 pandemic

Summary

Community participation in health is well established as one of the core strategies of the WHO in the pursuit of sustainable health at local levels (WHO, 2002). Though community participation is a well-established field of research in health care, there is a gap in research regarding how communities participate in the development of health information campaigns. For instance, understanding how participation is activated through local community-based structures such as health committees, particularly during catastrophic health outbreaks, could be beneficial in facilitating optimised community participation and agency, particularly during pandemics. This study aimed to explore the perceptions health committee members have regarding the nature of community participation in the development of health information campaigns. A qualitative approach was taken, and health committee members from the Khayelitsha and Klipfontein health districts were invited to participate in two rounds of focus groups. Data was analysed through thematic analysis. Member checking with participants was done throughout both focus groups. The results suggested that health information campaigns may require more intentional engagement with community stakeholders to understand the information needs of the end users in the community when health information campaigns are developed. Involvement of HCs in the development of health information campaigns during the COVID-19 pandemic could have made substantial contributions to developing interventions that were contextualised, and that could address the barriers to adherence that were faced by their communities. Future health information campaigns should aim to actively engage HCs and participation to ensure these campaigns have a greater chance of successful implementation.

Key Words:

health committees, community participation, health information campaigns, COVID-19, pandemics, stakeholders

The experiences of health committees of community participation in health information campaigns during the COVID-19 pandemic

Introduction

In March 2020, the need for worldwide cooperation from all sectors of society in managing a pandemic and designing suitable health information campaigns came starkly into the spotlight, with the onslaught of the COVID-19 pandemic (Applebaum, 2020). The socio-economic challenges and lack of understanding of prevention behaviours, particularly in the working-class population, posed significant challenges to adherence to prevention measures issued by governments (Garba, 2020; Applebaum, 2020). Health information campaigns have the ability to empower communities to take responsibility for their own health and has been shown to have positive impacts on communities' ability to engage with the health system in a meaningful and effective way (Wabwire et al, 2015). It can be suggested that communities who are empowered in this way could develop agency during health emergencies (McCoy et al, 2012).

Pandemics and epidemics can be said to expose deficiencies in health systems, particularly at the level of the end user. There is evidence that communicable diseases disproportionately affect persons in developing countries (Hotez, 2020). This is due to the significant economic impact communicable diseases can have on societies, as well as the inability of fragile and under-resourced health systems to cope with the demand of an epidemic (Hotez, 2020). The COVID-19 pandemic exposed many health systems' inefficiencies in effectively communicating essential health information in a time of crisis, and starkly portrayed the impact external factors, such as political convictions, agendas of different stakeholders and administrative challenges have on effective delivery of health information (Applebaum, 2020). Woskie & Fallah (2019) advise that the engagement of communities in platforms of active participation are essential to building trust and fostering adherence, as providing education and information alone is simply not enough. It can be said that community participation is a key component in ensuring the trust and adherence of communities to health information.

Community participation in health is well established as one of the core strategies of the WHO in the pursuit of sustainable health at local levels (WHO, 2002). In the development of health information interventions, it ensures that the needs of the community are at the centre of the interventions. It allows for higher likelihoods that interventions will be responsive to the information needs of the community and increase the potential for the effectiveness of such interventions (Wabwire et al, 2015). However, it can be argued that well-constructed health information campaigns could still prove ineffective due to a number of factors, despite the theorised positive impacts of rigorous community participation in the development of local level health promotion interventions. Different actors in the health system also appear to perceive

increases in awareness and understanding of prevention measures differently, when the health system is put through a pandemic or epidemic, as was noted by Ling et al (2017) in their study of the Ebola outbreak in West Africa. In the study, it is evident that, while actors at the level of government, prioritised raising awareness and surveillance as important health activities, while local level actors, such as community leaders, perceived the empowerment of communities and their participation as a priority activity during the Ebola epidemic (Ling, et al, 2017).

Users of a health system tend to be more effectively reached when they receive health information from sources that they have built trusted relationships with (Rivera-Serrano, 2022). In a cross-sectional study done by Coroiu et al, (2020), trust was shown to be a global issue that inhibited the adherence of people in different countries to COVID-19 prevention behaviours. When persons did not understand or believe the messaging delivered by their governments, and did not trust the government, they felt more hesitant to adhere to the recommended health behaviours (Coroiu at al, 2020). Woskie & Fallah (2019) found that issues of distrust in the health system had the potential to derail well-constructed interventions, through underuse of health services and alternative health seeking by communities. A factor such as trust relationships between different stakeholders in a health system have the ability to facilitate or inhibit the effects of health promotion interventions.

Inconsistent and varied application of health information interventions by stakeholders at different levels of the health system creates a barrier to trust and adherence (Gialama & Paploukas, 2020). Non-governmental organisations (NGOs) have the potential to improve community participation in health information campaigns when their input is well integrated and sustained over time, as was seen by some studies during the Ebola epidemic (Ling et al, 2017). Studies conducted on the Ebola epidemic point to the benefits of community participation in the health campaigns during the epidemics and pandemics when trust relationships were intentionally fostered. For example, research on community participation during the Ebola epidemic showed that communities were more amenable to health information pertaining to interventions, when an intensive focus was placed on transparent and intentional communication from and between stakeholders engaging with communities and individuals (Bedford et al, 2017).

Though community participation is a well-established field of research in health care, there is a gap in research regarding how communities participate in the development of health information campaigns. For instance, understanding how participation is activated through local community-based structures such as health committees, particularly during catastrophic health outbreaks, could be beneficial in facilitating optimised community participation and agency, particularly during pandemics.

Health committees (HCs) can be defined as state mandated structures affiliated with community health facilities, aimed at facilitating community participation (National Health Act, 2003). In South Africa, provinces are required to provide for the establishment of HCs at all primary health care facilities, as a means to foster community participation in decisions and activities relating to health (National Health Act, 2003) Importantly, HCs are meant to provide a core link between the communities they service and the governance structures formulating and implementing health policies and interventions (Botha, 2018; Boulle et al, 2008), though it can be said that their roles are defined differently across the country. In the Western Cape, HCs have the function advocating for the provision of primary health services in their communities (Western Cape Health Facilities Boards and Committees Act, 2016). The committees should play an important role in supporting the communities they are part of to realise their right to health, and raise awareness about policies, services and information put forward by their health facilities (Western Cape Health Facilities Boards and Committees Act, 2016).

Community engagement platforms like HCs are a potentially vital link between health services and the community in fostering agency and active citizenry when it comes to improving community health behaviours (Strecker et al, 2012). Community participation through platforms such as HCs is a positive determiner of end users of the health system realising their right to health (Mulumba et al, 2018). This is because in its practice, it provides legitimate platforms through which users of the health system are able to engage actively with the health system to access healthcare and achieve good health (Mulumba et al, 2018). In order for communities to access the health system at different levels in an effective way, communities must have a good understanding of the system itself (Boulle et al, 2008), and it has been theorised that HCs have a vital role in supporting that (Mulumba et al, 2018).

In the Department of Health's White Paper on Health Transformation[1], it is detailed that HCs possess, as part of their mandate and purpose from government, the need to facilitate community participation in health (Department of Health, 1997). In line with the paper, HCs need to be empowered to take an active part in the design, implementation and review of prevention information meant to assist community members to make sense of prevention behaviours, in a way that fits their context and fosters agency. This is however hindered by the weak framing of HCs in the National Health Act (2004), posing a challenge to the formulation of defined functions of HCs at a local level. Despite HCs having positive potential to foster participation of communities in the understanding and implementation of policies at a primary healthcare level (Western Cape Health Facilities Boards and Committees Act, 2016); socio-economic, political and support barriers have historically hindered the effectiveness of health committees (Mulumba et al, 2018).

1 In South Africa, a White paper is a broad explanation of a policy framework, before that policy is introduced into law

Boulle et al (2008), found, through their work with HCs and community health facilities, that socio-economic factors often curtail the pursuit of good health.

Health promotion activities by various stakeholders and governance structures in the health system, are important for the delivery of health information for behaviour change (Wabwire et al, 2015). However, failure to involve members of the community in actively developing and implementing such initiatives, lends itself to a greater risk of failure, and lower adherence or acceptance of favourable health behaviours (Wabwire et al, 2015).

Civil society organizations such as The People's Health Movement in South Africa (PHM-SA) have been prominent actors in attempting to foster agency among organizations such as HCs. In 2020 PHM-SA decided to produce evidence-based pamphlets on non-pharmacological prevention behaviours as part of their health information campaigns for communities, in efforts to facilitate knowledge translation about these behaviours.

Because HCs are important role players in ensuring that the community is informed about pertinent health issues that concern them (Muller, 2013), it is important to understand their experiences of health information campaigns during the pandemic. The study aimed to explore HC members in the Khayelitsha and Klipfontein sub-districts' perceptions and experiences of health information campaigns and their perceptions of the nature of community participation in health information campaigns during the COVID-19 pandemic.

In some communities in the Western Cape, active HCs, in areas such as Manenberg and Khayelitsha, made concerted efforts to support communities as much as possible in raising awareness about COVID-19 and assisting with making sure members of the community understood and were able to carry out prevention measures. These non-pharmacological prevention measures included mask wearing, sanitising and handwashing protocols; social distancing, self-isolation and quarantine methods as well as guidelines pertaining to the safe disposal of infectious waste in the home. However, these efforts were hindered by low support from government and lockdown restrictions which excluded these committee members from being able to work (Jeranji, 2020).

Methodology

Study Design

A qualitative research design methodology was followed with focus groups as data collection method. This study required a qualitative lens, in order to attempt to account for the complex nature of understanding the perceptions and opinions of health committee members operating in a multifaceted system. The decisions people make about health-related information is not straightforward and does not lend itself to binary measurement (Bougeault et al, 2010). The study was an exploratory study design, as not much was known on the topic of health committees' perception of health promotion material relating to COVID-19 non-pharmacological behaviors. A flexible study design allowed for the evolution of the study to take place. Information was collated from participants and themes began to emerge. The aim of the study was to explore health committee members in the Khayelitsha and Klipfontein subdistricts' perceptions regarding the potential impact of the PHM COVID-19 information pamphlets in facilitating knowledge translation about non-pharmacological prevention behaviours in the communities they form part of and identify how the information resources could be improved.

The focus of study changed throughout the research process. This is because initial responses and discussions by HC members showed a greater focus on wider themes relating to community participation in health information campaigns, as opposed to the material under study at the start of the research process.

The health promotion material used to facilitate discussion detailed guidelines; attempting to do so in a way that would be suited to the local context, delivering these messages with the use of clear language and carefully selected imagery. While the initial focus of the study centered around HCs' perceptions specifically of the PHM health information material, it became clear that the material stimulated a broader discussion amongst participants. The study therefore made use of PHM health information resources as a tool to raise discussion amongst health committee members, to explore their experiences around health information campaigns during the COVID-19 campaigns, and how they viewed their – and the communities' - level of participation in the development of such campaigns.

Two health committees were chosen purposefully because they had been active in prevention efforts. Members of different HCs in the Manenberg and Khayelitsha communities were approached to participate in the study. Two focus groups were conducted with each health committee, with a two to three-month period between the first focus group and the follow up focus group. A total of four focus groups were conducted so that initial themes could be identified as they developed and could then be further explored through a second round of focus groups after initial coding and analysis of responses. Focus groups allowed for respondents to share ideas and relate to one another's experiences of a topic (Ulin et al, 2005), and for

the purposes of discovering more about possible adaptations or improvements health committees may suggest in respect to the information pamphlets presented to them, this type of platform provided such an opportunity. Focus groups comprised approximately six to eight participants.

At the start of each focus group, each participant was provided with a demographic questionnaire to complete, which served to collect demographic information about the participants in the study (age, sex, employment, area of residence), and the participants' knowledge and experience of the COVID-19 pandemic. The purpose of this survey was to allow for the researcher to get to know the participants and better describe them during the analysis (Dobosh, 2017).

The focus group discussion was guided by a semi–structured topic guide and emerging themes were drawn during the focus groups that framed the discussion. After the initial round of focus groups, health committees were informed that a second focus group would occur where they would able to provide further reflection on their experiences and perceptions of information campaigns and their participation therein over a period of time. Two rounds of groups were done with each site, as it was important for the researcher to gain sufficient understanding of the health committees' learning over a time period, during the pandemic, and to provide rich descriptions of themes arising pertaining to the information under study (Liamputtong, 2015).

Primary data collected was produced from two rounds of focus groups per health committee. Focus groups were tape recorded, with informed consent from each participant at every group. The services of a translator was used in focus groups where IsiXhosa[2] was the language of the group as the researcher was not sufficiently proficient in IsiXhosa to ensure that the responses of group members were recorded correctly. In addition to this, the assistance of a translator ensured that information was not lost when the participants responded, and that the participants were afforded the chance to understand questions and comments as accurately as possible when they were posed by the researcher.

The data were analysed and reported on through the identification and description of salient themes. IsiXhosa data were transcribed verbatim, and subsequently translated by an appointed independent translator. Voice recordings from the focus group were transcribed and analysed. The focus group interview data for each facility underwent coding and thematic content analysis, to determine the common notable trends in the participants' responses. The researcher analysed the data manually through the documentation of notable themes in the responses received from the participants.

2 IsiXhosa is one of South Africa's eleven official languages, and is a prominent language spoken in the Western Cape

Characteristics of the study population

The population was selected with the use of purposive sampling, as the study required a specific group of individuals forming part of the population under study – health committee members operating as part of a committee for facilities in the Cape Metropolitan District in Cape Town, South Africa – more specifically, facilities operating in the areas of Manenberg and Khayelitsha.

Manenberg is a predominantly Afrikaans-speaking area within the subdistrict of Klipfontein in Cape Town, South Africa. It is a historically disadvantaged community established in 1966 under the Group Areas Act (SA History, 2019). This Act geographically defined South Africans by racial groupings, through strategic segregation of residential and business area (SA History, 2019). Health committees in Manenberg express experiences of disempowerment during the COVID-19 pandemic and are only really empowered where managers of health facilities recognize their value (Jeranji, 2020). Khayelitsha – also the name of the subdistrict - is another large township in the Western Cape, situated south east of the Cape Town Metropole. (SA History, 2013). This township was established in 1983 as another form racial segregation of the historically "African" population of the Western Cape (SA History, 2019). This community's health forum, an umbrella body under which health committees in the sub-district are governed (National Health Act, 2003), has, during the course of the pandemic, expressed public concern about their exclusion from intervention strategies in the community. They reported feeling pushed aside when it came to the state's addressing of COVID-19 in their community, often reporting being left to use personal funds to disseminate prevention information in the community (Jeranji, 2020).

HCs in these areas have been vocal about their view that health committees have and will continue to be a vital part of educating communities about prevention strategies when it comes to COVID-19 (Jeranji, 2020).

HC members currently forming part of a HC in the Manenberg and Khayalitsha communities in the Cape Town Metropolitan district were approached to participate in the study. Each health committee forming a single focus group. The level of functioning of the committee was not an inclusion criterion. Any participant fitting the above-mentioned criteria was permitted to join the study but was not in any way obligated to do so.

Rigour

In order to improve the rigour of the study, the researcher performed member checking throughout each focus group, to ensure she understood the members of the group correctly. This was done through an ongoing invitation to participants during the groups to verify that their responses were recorded correctly during and after each focus group This was important in order to ensure that the opinions of the

participants were interpreted to reflect their voices in the data. Once this took place for each health committee group, data from both sets of committees was collated and a final thematic analysis was completed in order to draw commonalities in the perceptions of the groups.

Multiple sources of data (multiple focus groups with different health committees in different areas and sub-districts) were drawn upon to support the researcher in being thorough in her interpretation of the participants' responses. This ensured that the researcher's understanding of the participants' perceptions were reflected well, and that any discrepancies in understanding could be accounted for in the reporting and discussion of the results. Finally, focus groups were conducted more than once for each health committee to achieve data saturation.

Ethical Considerations

Informed consent was obtained guided by the principles of the Helsinki Declaration (World Medical Association Declaration of Helsinki, 2001). Participation in this study was entirely voluntary and there was no financial benefit attached to participation in the study, nor did it serve to detriment participants financially, as every engagement was done at the convenience of the health committees. Participants were counselled during the consent process, that anonymity within the group could not be guaranteed, as participants were known to each other and could identify each other during the group. Focus groups were held in communion with other members, and thus participants were made aware that they would be asked to share their opinions with other members of their committees and thus may elect to withdraw from the study at any point should they feel uncomfortable.

Informed consent documents were provided to each participant in the language of their choice. The researcher explained informed consent information sheet verbally to each participant. The researcher sought the assistance of a translator to support the participants' accurate understanding of the contents of the consent document. Participants were allowed to discuss the contents of the informed consent document with others to aid their understanding, and the researcher remained available to address any questions or concerns relating to their comprehension of the implications of their consent. Informed consent was taken through the signing of a consent form by each participant.

Results

Five overarching themes were identified. The results suggested that health information campaigns may require more intentional engagement with community stakeholders to understand the information needs of the end users in the community when health information campaigns are developed. Socio-economic factors and trust were shown to be significant influences hindering community participation in health information campaigns. The focus groups revealed complex considerations they felt required greater understanding if stakeholders were to ensure that information campaigns achieved their intended purpose of sense-making and adherence to non-pharmacological prevention interventions - particularly during public health emergencies.

System Responsiveness

HC members felt that the health system – particularly in respect to the governance branch of the health system - had not been responsive to their needs. They felt that they were left to understand non-pharmacological interventions on their own. Government took a top down approach and information about non-pharmacological interventions were not freely available until NGOs became involved – was not a collaborative effort in helping communities to understand this health information.

"So it was only the power leveraged from the Department of Health; they push one way information, so if you had any questions regarding that , your opinion was not known." - Health committee member, Manenberg

"...in an informal settlement, some of the regulations cannot be applied because it's crowded and there are open sewers with no water and no toilets, and this definitely doesn't help. I can definitely say this." - Khayelitsha Health Committee Member

HCs cited failures in the government's ability to provide HCs and their communities with health information during the pandemic as a reason for engaging with non-governmental bodies instead.

"I understand that the government has failed in providing information about COVID, doesn't know how to prevent it and has not given us the means to prevent Covid" - Khayelitsha Health Committee member.

Health committees largely agreed that they found little joy in their interactions with government, and cited a lack of governmental support in driving health information campaigns around the pandemic. HCs perceived that this disempowered them and the community, and hindered access to health information

campaigns. Health committee members found it difficult to receive information quickly and appropriately from government – they were not accessible or responsive.

"We would have been able to do more, if the government in the first place had not excluded us. They excluded us around what they were doing around the COVID-19." - Health committee member, Manenberg

"Okay, I don't know if I'm blaming anyone or I don't blame anyone, but if we can go back to last year February when there was one person who tested positive. They didn't do anything. The people who are in control of the country did absolutely nothing, to the point that you didn't know if you had to be scared of this thing or don't have to be scared of this thing." - Health committee member, Khayelitsha

Access to health information from NGOs

Resources from NGOs also had an impact on participation. NGOs played an important role in providing resources to Health Committees, particularly regarding issues such as non-pharmacological behaviours and vaccinations. Some HC members perceived these information pathways as more valuable resources in the provision of COVID-19 information, than health information tools received by government. HCs felt that external bodies played a crucial role in filling the gaps left by government interventions.

"....to an engagement session by MSF (Médecins sans frontières). We attended, I think it was, a 3-day session where they were giving information about Covid. In that session, people were wearing gloves, masks, you couldn't even see, and then we attended that session. It was an eye-opener. Then we started to say, no, we can't fold [our] arms. Let's work together, assist where we can, you know." - Health committee member, Khayelitsha.

Agency

HCs sought out information and resources for communities, from various stakeholders. They reported that empowered communities – including the health committees themselves, were able to participate more in health information and promotion activities when they had agency; and health committee members cited that focusing their efforts on providing the community with information and resources fostered agency and subsequent adherence. Health Committees focused their efforts on empowering communities to take ownership of their health, which had a positive impact on adherence to prevention measures and overall understanding of health information related to COVID-19.

"We went and we seeked [sic] out People's Health Movement and we said, " Look", there's this new virus, do you have information about it, can you train us about it, so that we can in turn train our members, about this virus and in turn train our community members about it, about the preventative measure, right?" - Manenberg Health committee member.

"…in addition MSF [Medicine Sans Frontiers, Doctors Without Borders] and PHM were key stakeholders which played a role of a vehicle to take_us where we wanted to be." - Manenberg Health Committee member.

As community members and HCs learnt about the positive impacts of prevention behaviours, through seeing their effectiveness, feedback loops were created where HCs were able to relay non-pharmacological and vaccination information with more conviction i.e. they believed it because it worked. Additionally, health committees found that when they acquired information from these external bodies, they felt empowered to participate in knowledge translation and to be advocates for the community. Health committees created their own feedback loops during the pandemic by discussing what they had learnt through workshops and engagements, with their community, and continued to seek information from groups such as PHM.

"And we could explain to people how it works, how it [the virus]works with your body and what's the effect it has on your body you know because we had been trained about that." - Manenberg Health committee member.

Trust

Health committee members cited a general feeling by many community members that those aiding them stood to gain and that their aide was not in the interest of the community. Issues of racial stereotypes also came to light when health committees discussed community adherence factors – many community members lacked trust in bodies of authority (especially government structures) due to historical perceptions of race relations fostered by experiences of the Apartheid Regime. One HC reflects how racial stereotypes stemming from historical segregation laws that existed in South Africa during this period, overshadowed the importance of how adherence measures were received due to trust relationships not being established. Thus negating potential effects the accuracy of prevention materials would have on adherence.

" ....there has always been this rift between the coloured and the blacks, you know....not for all of us, but for some. Because of, you know, how some of our parents were raised...were raised with this..." - Manenberg Health Committee member.

"*I'm talking from the coloureds....The president is a black man! Ooo hulle is almal skelm, daai jong lieg* [they are all dishonest, that man is lying]*" - Manenberg Health Committee member.*

Health committees reported on their own and the community at large's historic experiences of non-delivery from government being another barrier to trust, which resulted in a breakdown of trust. Communities' difficulty with *accepting* non-pharmacological prevention measures, despite these being delivered in understandable ways by different stakeholders.

Health committees reflected on the complex trust relationships they had with the government throughout the pandemic, and how this impacted their motivation to advocate for non-pharmacological prevention measures. They had great trust in the president, despite a lack of trust with various government departments, and this positively influenced acceptance of prevention measures.

"...but in my household, when that man was gonna speak at eight o clock, dan moet amal daar wies [then everyone must be there]*. Because the president is...and that is what we have tried to explain to the community. When the country is in a crisis then the president is the commander in chief." - Health committee member, Manenberg.*

HCs reported that they felt communities had difficulty adhering to prevention behaviours stipulated in health information campaigns. At both sites HC members indicated that they felt that lack of involvement in the development and implementation of health information campaigns undermined their ability to be effective in conveying messages about the importance of non-pharmacological prevention behaviours.

"I think everybody has been saying that the health department did not play their part. In assisting us as health committee members.....We were just thrown out there with a letter and..you are the health committee and there you go. So, we practically had to find ourselves, we had to do research [sic]."- Manenberg Health Committee member.

So, the communities, the majority of the people within the communities, as much as you will be bringing these tools that would help them, but they will still want to know who is developing these tools and who are you. - Khayelitsha Health Committee member.

Health committees expressed improvements in trust relationships with government – departments appeared more accessible and responsive to the communities' resource and information needs over time. When stakeholders demonstrated transparency with community members and Health committee members, trust was built with these parties which had a positive impact on buy-in and adherence

"The reason I trust Government is because of their vaccination programme, the president was the first person to take the vaccine. They have taken on collaborative approach whereby communities are given a platform to engage and advise. They acknowledge the challenges they face in the health sector and the challenges of implementation in communities. They present the information gathered by role-players evenly and the challenges they face" - Khayelitsha Health Committee member.

"…now there is some changes this time around there is exchange of emails daily, we get updates in changes and we even get invitations now and then." - Khayelitsha Health Committee member.

External factors affecting adherence and participation

HCs tried to drive the importance of non-pharmacological prevention behaviours to communities. However, they reported that external factors made following of these behaviours difficult or not possible and also undermined their participation in health information campaigns.
Both health committees cited socio-economic factors had a significant impact on the community during the pandemic, so much so that understanding and complying to non-pharmacological behaviour was largely de-prioritised.

"...concern is that we are under a pandemic and we are doing our level best to assist, but there is still a gap........They (the government) sort of rush into these… Say okay, you must all do this and all stay at home, and now you must all get vaccinated, with no real practical plan. - Khayelitsha Health Committee member.

Despite the barriers to participation, HCs cited different approaches to health information campaigns improved participation and ownership of non-pharmacological behaviours by HC members and the community members they served. It appeared that presenting health information in a variety of ways

improved adherence to non-pharmacological behaviours. The HC members felt that different approaches to delivering prevention information proved more beneficial than traditional methods (e.g. pamphlets) alone. Social media and technological methods of information dissemination proved of particular importance when targeting younger persons. HCs found that workshops improved their participation in understanding and teaching others about health information. In particular, experiential learning was also cited as playing an important role, though consistent follow through of interventions proved problematic for HCs .

"Well, people have individual Whatsapp groups as well, so when people receive something from the chatroom that they [are] on, they would obviously feed that information, share that with the health committee platforms...Ja, so they also, we also went there [where] for a presentation that they did, the doctors. So that was also interesting. And that is where [HC member] said that after that meeting with NACOSA, [Networking HIV and AIDs Community of South Africa – a civil society organisation] she send a email to the health department, and so it came about that there was an engagement between..uh..Klipfontein and the health department around engagement and communication" - Health Committee member, Manenberg

Challenges with misinformation was a important factor which HCs felt hindered community participation and adherence. Conflicting information and fake news led to HCs being unsure of which sources of information were legitimate. They reflected on how fear – created by misinformation and preconceived ideas, caused non-adherence to prevention behaviours for example, the use of quarantine facilities and seeking health attention:

"You know, then, they decided other countries were in lockdown already happened...we knew..I assume you knew, it was gonna come our way. So there wasn't that information beforehand. So then, when it came to us, then people were already saying "gan man, dies nonsens....die ding issie waarheidie [go man, this is nonsense..this thing is not the truth] *this thing isn't real, this COVID thing isn't real. And then the other issue was...so then there was a issue going around, the government is getting money for every dead COVID person"-Manenberg health committee member*.

"we thought if it is COVID we too scared to go to hospital. Because we heard everybody dies that goes into hospital." - Manenberg health committee member.

Health committee members also found that shortly after lockdown levels were relaxed, prevention behaviours quickly dissipated – despite all interventions to ensure health education. HCs noted that community members did not always possess insight regarding 'why' prevention behaviours were important

and identified a gap in prevention activities not focusing on facilitating understanding. They suggested that sustained interventions would have facilitated improved adherence and buy in from community members.

The HC members felt that information did not acknowledge their context enough, reporting that external factors would influence how adherent people could be to the information contained in pamphlets and other prevention activities .The health committees discussed the need for information to contextually appropriate, tailored to the challenges experienced in their own community.

"...in an informal settlement, some of the regulations cannot be applied because it's crowded and there are open sewers with no water and no toilets, and this definitely doesn't help. I can definitely say this." - Khayelitsha Health Committee Member.

Discussion

The study set out to explore how HCs perceived health information campaigns and community participation during the COVID-19 pandemic. It sought an understanding of what HCs felt influenced community participation in health information campaigns. The study highlighted the complexity created by a multitude of factors affecting how communities were able to understand, adhere to and participate in health information campaigns surrounding non-pharmacological behaviours during the COVID-19 pandemic. The study also found that health information from government did not facilitate community participation and was therefore perceived not sufficiently effective. HCs reported complex trust relationships with government, and reflected how this influenced their participation in health information campaigns. NGO involvement was reported to have a positive impact on HC's participation, through strengthened access to health information.

The focus group discussions reflected that factors such as socio-economic determinants hindered adherence to health information campaigns. Studies conducted on the Ebola outbreak and other recent pandemics reflect similar challenges in the empowerment of key community members for community participation in health information campaigns that were meant to facilitate health literacy and adherence (Woskie & Fallah, 2019).

Health committees during the study cited a multitude of factors had varying impacts on adherence to non-pharmacological behaviours during the COVID-19 pandemic. These included factors unrelated to health information campaigns; socio-economic factors, inconsistent or short-lived interventions, multimodal health

information interventions and the circulation of preconceived or misinformation about the pandemic all had impacts on the perceptions of health information campaigns by committees and their community. In a study of cancer prevention media campaigns, Katz et al (2015) saw health information campaigns around this topic have greater success in the form of local media information campaigns, as this was accessible to most parts of communities. Additionally, media campaigns that contained contextually appropriate messaging, and took the values of the community into account, proved more successful (Katz et al, 2015). Bedford et al (2017) found that health information campaigns during the Ebola epidemic, that made use of multiple platforms and modalities, served to increase social mobilization at a community level. Parallels can be drawn between what was found by Bedford et al (2017) and this study. The results of this study showed that when different approaches were utilised during health information campaigns, HCs perceived that adherence improved and these campaigns proved more successful. They cited an improvement in the success of their own health promotion activities with their communities when they were invited to workshops and sessions with stakeholders. Similarly, this study echoes what was found by Katz et al (2015), in that different media modalities, as well as contextually appropriate information that had communities' specific challenges in mind, was considered important for HC members during the COVID-19 pandemic. It was found that, a lack of consideration of the context of the community limited the impact of health information campaigns attempting to aid awareness of COVID-19 prevention behaviours.

Health information campaigns are understood to effect positive change in a health system's function for the community, as a systematic and goal driven course of action to improve health. The HCs in this study had valuable input regarding how the context of their communities should be considered when implementing health information campaigns. This finding has potential to add value when considerations are made for future courses of intervention to improve health literacy and adherence during health emergencies, as well as for strengthening of the health system and its policies. Learnings from studies into the Ebola epidemic reinforce the idea that key community members want to be, and should be active participants in health information interventions (Bedford et al, 2017).

Access to health information from external non-governmental stakeholders proved to be important. Health committees felt that NGO stakeholders had a positive impact on health information access, HCs viewed the government as largely having a negative impact on health information access, and thus on the perceived legitimacy of health information campaigns by HCs and their communities. HCs felt that NGOs facilitated improved access to health information during the pandemic, and cited not only information but also access to resources which would otherwise not be available to them. HCs found that NGOs were a facilitator of health information access and community participation during the pandemic. This sentiment is shared by

Van Pletzen et al (2013) in their study of partnerships of NGOs with communities to facilitate primary health care activities. Broadly, strong partnerships with NGOs in the primary health care setting have the potential to foster active participation responding to the health needs of communities (Van Pletzen et al, 2013). In the same vein, HCs in this study reported a great desire to be involved in the formulation of health information campaigns and reported perceiving greater transparency and involvement of communities by NGOs such as PHM, when it came to formulating ways of disseminating information about COVID-19 to communities.

In contrast, their experience of government intervention and health information campaigns was of a top down nature, impeding access to information due to their perceived removed approach to community participation. It is well understood that governments need to prioritise community participation in health interventions (Boulle et al, 2008), and HCs are viewed as an important mechanism within which to do so (Mulumba et al, 2018). NGOs can be said to fulfil a much needed role in augmenting health interventions and empowering bodies such as HCs (Van Pletzen et al, 2013), provided they are able to provide early and sustained support (Bedford et al, 2017). This study noted that NGOs played a vital role in facilitating the involvement if HCs in health information activities during COVID-19. To this end, however, it could be suggested that existing issues of trust in governmental bodies due to their lack of involvement of HCs in health intervention development, were further perpetuated by reliance of community bodies such as HCs on NGOs. A study by Scott et al, (2017) found that parallel systems – operating separately from governance structures, could form a barrier to collective action. Van Pletzen at al (2013) also cites the need for strong government, community and private sector partnerships to inform policy formation and implementation. This study provided insights into how improvements in the governments' ability to facilitate access of health information to communities through increased engagement with health committees. This suggests that increased community participation in health information campaigns improves community adherence to interventions like these.

HCs are intended as a vehicle to improve the responsiveness of the health system to the needs of the community it services (Mulumba et al, 2018). This study showed that members of each HC understood this as their core function, and were galvanised to improve health literacy for their people during the COVID-19 pandemic. However, the slow response of the government to their information needs, informed an apathetic response to the pandemic by communities. Information received from HCs during the study suggest that their historical experience of an unresponsive health system, as well the perceived lack of transparency by stakeholders when sharing information during the pandemic, impacted their trust

relationships. How responsive the health system is to the needs of the community it services, is an important indicator of the level of community participation in health activities. (Khan et al, 2021).

Wabwire et al (2015) state that, when community participation in health campaigns is encouraged, feedback loops are created whereby this involvement causes improved buy in towards health behaviours. In this study, HCs created their own feedback loops of important learnings they had when engaging with key stakeholders and attempted to translate this knowledge to their communities to improve their buy in to non-pharmacological prevention behaviours. Feedback loops were strengthened when evidence showed community members the effectiveness of behaviours they were taught about, and this correlates with Khan et al's (2021) findings that evidence based feedback facilitates the ability of communities to make informed decisions about their own health.

It can be said that the legitimacy of key stakeholders such as HCs in a health system can be elevated or undermined by their ability to be the link between the state and communities, as it influences the trust relationships that communities have with stakeholders (Scott et al, 2017). This study revealed that HCs perceived a history of non-delivery, as well as the racial prejudices rampant in communities, had a significant impact on the trust relationships with health information provided through campaigns by government and NGOs. It can be said that trust relationships in all forms have an impact on social cohesion, participation and motivation to cooperate with the health system (Okello & Gilson, 2015). Okello & Gilson (2015) found this in their study of health care workers' trust relationships in their health facilities. Rivera-Serrano (2021) reports in an interview with a public health specialist, that 'trusted voices' in community health interventions play an important role in overcoming the historic mistrust that is found globally in communities, which has been fostered by failing and unresponsive health interventions over time (Rivera-Serrano, 2021). This is alluded to in this study, whereby HCs cited how the president of the country became known as a 'trusted' voice, through persistent communication and collaborative efforts noted on the part of government during later stages of the pandemic.

Health information activities that are made for the people, by the people, have a greater chance of success (Khan et al, 2021).The study showed that active community participation when engaging in systematic courses of action for health, has the potential to improve the health system's ability to respond to the information and access needs of the community it services, particularly in health crises where a coordinated, rapid response from the system is required to safeguard the health of people (Applebaum, 2020).

Study Limitations

The study was limited by a lack of methods triangulation, and future studies on this subject could include additional data collection methods such as field observation of communities' engagement with health information campaigns, in order to improve the rigour of the study.

The timeline and completion of the study was affected by the availability of the participants to participate in the focus group, but also by the COVID-19 restrictions, particularly at the start of the study. Virtual focus group meetings would not have been possible for each HC member due to high data costs and challenges with connectivity during periods of power outages, which would have impacted their responses. Thus, research timelines were amended to ensure that meetings took place at appropriate times allowed by the amendment of lockdown restrictions.

The objectivity of the translator was a suspected limitation in the isiXhosa speaking group, as she was a member of the committee. Due to resource and time constraints, an independent translator for the focus groups was not obtained. To attempt to address this, the informal translator was briefed regarding providing the participants responses verbatim as much as possible. Additionally, in order to minimise the effect of a conflict of interest during the groups, during the transcription and analysis stage; the services of an independent translator was used to translate the recorded responses provided by the participants. The approach to exploration centered around the options and perceptions of HC members who form a link between policy and communities (Botha, 2018), in an attempt to gain insight into the ability of health information campaigns to facilitate knowledge translation in the community. The study's focus on HCs to represent community perception provides limitations to depth of understanding of community participation in health information campaigns during pandemics, which could be a potential focus for further research in this regard.

Conclusion

Exploration of HCs' perceptions across South Africa has the potential to allow for a greater diversity of opinion to formulate richer data sets and provide insights into perceptions across diverse contexts within the South African This study highlighted the need for congruent and equitable interventions and information dissemination, that is acutely aware of the challenges faced by health committees in relation to health information itself. A neglect of these challenges proves to negate even the most accurate and evidence based health information resource. Key stakeholders such as HCs are valuable contributors in the development of health information campaigns, particularly in health emergencies, as they have an acute

awareness of the needs of their communities. Involvement of HCs in the development of health information campaigns during the COVID-19 pandemic could have made substantial contributions to developing interventions that were contextualised, and that could address the barriers to adherence that were faced by their communities. Future health information campaigns should aim to actively engage HCs and participation to ensure these campaigns have a greater chance of successful implementation.

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Part C: Appendices

Addendum 1: Focus Group Code Book

Theme	Code name	Definition	Reasons to include it
Multiple Factors affecting compliance	**Perceived external factors affecting compliance**	Non-pharmacological behaviours are often not followed, because of external factors that make following of non-pharmacological difficult or not possible in communities such as Khayelitsha and Manenberg. Rules such as wearing masks, sanitising and social distancing were met with resistance by community members because of factors still prevalent after COVID waves – socio-economic factors, co-morbid conditions.	Community participation is a crucial part of ensuring that health interventions work. Involving the communities in the health system allows for improved sustainability and effectiveness of services (Meier et al, 2012). Therefore, issues with compliance to non-pharmacological behaviours could be related to a lack of community participation in the processes of developing COVID-19 related education material .
	Multimodal approaches to prevention activities improves compliance	The Health committee members felt that different approaches to delivering prevention information proved more beneficial than traditional methods (e.g. pamphlets) alone. Social media and technological methods of information dissemination proved of particular importance	

		when targeting younger persons. Workshops/experiential learning was also cited as playing an important, though consistent follow through of interventions proved probelmatic for HCs (" they must have follow up groups!")	
	Misinformation reduces compliance	Health committees report feeling "left in the dark during the pandemic" Conflicting information and fake news led to people unsure of which sources of information were legitimate	
	Fear	Health committees reflected on how fear – created by misinformation and preconceived ideas, caused non-compliance to prevention behaviours e.g. use of quarantine facilities and seeking health attention: "we thought if it is COVID we too scared to go to hospital. Because we heard everybody dies that goes into hospital."	
	"The why" is	Hcs found that shortly	

	missing re: health information (prevention behaviours)	after lockdown levels were relaxed, prevention behaviours quickly dissipated – despite all interventions to ensure health education. Hcs noted that community members did not always possess insight regarding 'why' prevention behaviours were important and identified a gap in prevention activities not focusing on facilitating understanding	
Access	**External resources aided access and compliance**	NGOs and external organisations played an important role in providing resources to Health Committees, particularly regarding issues such as non-pharmacological behaviours and vaccinations. Some Health committee members perceived these information pathways as more valuable resources in the provision of COVID-19 information Health committees felt that external bodies played a crucial role in filling the gaps left by government	Community Health Care workers possess unique insights into the workings of their community (Katebak et al, 2018); therefore it appeared that they were able to use this knowledge to seek out information appropriate to their context – this led to collaboration with the relevant NGOs Access – including access to information – is an important part of improving community members' utilisation of the health system resources for better outcomes (Ali, 2014).

		interventions "in addition MSF and PHM were key stakeholders which played a role of a vehicle to take us where we wanted to be."	
	Information empowers health committees and people	Health committees created their own feedback loops during the pandemic, and sought information from groups such as PHM independently, this helped with dissemination of information contained in PHM pamphlet. Collaboration from NGOs on teaching about non-pharmacological behaviours was important. What became more prominent towards the end stages of the height of the pandemic was the government's role in assisting communities with interventions and information, particularly surrounding vaccination information, which was a positive relationship change since the start of the pandemic	
	Lack of access to	Health committee	

	resources	members found it difficult to receive information quickly and appropriately from government – not accessible or responsive	
	Access to information empowers people	Health committees felt that they would have had a positive experience had they had access to the PHM pamphlets throughout the pandemic."And we could explain to people how it works, how it works with your body and what's the effect it has on your body you know because we had been trained about that."	
System responsiveness	**Health committees responsive to community's needs**	Health committee feel that the health system has not been responsive to their needs, and that they were left to understand non-pharmacological behaviours on their own – government took a top down approach and information about non-pharmacological behaviours were not freely available until external aid became involved – was not a	Though still a developing field, Responsiveness has been shown to be substantively relevant to the improvement of health outcomes in a health system (Khan et al, 2021). It is evident here that a lack of responsiveness from the health system could have impacted the participants' general consensus that their needs were not met regarding the need to understand non-pharmacological behaviours,

		collaborative effort in helping communities to understand this health information.	and as a result the above themes of a culture of poor compliance may have arisen in reaction to resources presented to them. Community participation and consultation is important in ensuring the effectiveness of health response measures implemented into a health system
	Government slow to respond/retroactive (lack of government)	Despite the information contained in the resource being understandable, community members do not trust government or external sources; health committee members cite a general feeling by many community members that those aiding them stand to gain and that their aide is not with the interest of the community. Compliance or community participation is thus often influenced by what community members feel they could gain as opposed to the potential benefit of a resource or measure of assistance. “ So, you will have those people within the community that will be like, as much as it’s going to help them, but still they want you to make sure you give them something, because they say with what I’m giving you, you	

		will go and get money elsewhere."	
	Knowledge gained from experience	As community members and Hcs learnt about the positive impacts of prevention behaviours, vaccination etc through seeing their effectiveness, feedback loops were created where Hcs were able to relay non-pharmacological and vaccination information with more conviction i.e. they believed it because it worked. " And even today I can even encourage people to get vaccinated or whatsoever because we must look after our own bodies before we can go out and spread the word."	
	Lack of continuity of prevention activities	Health committees commented on the fact that prevention activities created by external parties, though effective, were not sustained for long enough, and though they felt they learnt a great deal from these parties, were not always equipped to continue these	

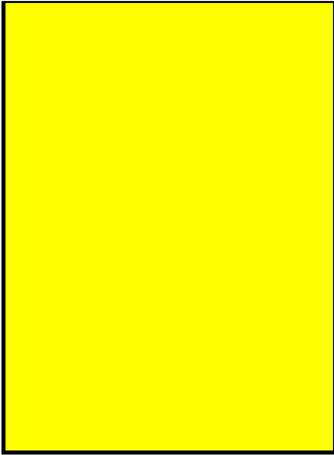
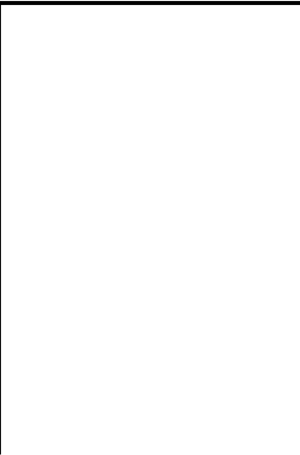
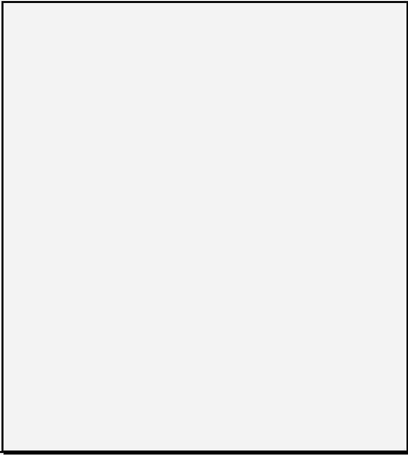
		interventions without their asisstance – financial and otherwise. “This time around we have no MSF, they left as they only partnered for 6 months and they are done.”	
	Contextually appropriate knowledge is key	The health committee members felt that the information did not acknowledge their context enough, citing that external factors would influence how compliant people could be to the information contained in pamphlets and other prevention activities The health committees discussed the need for information to contextually appropriate, tailored to the challenges experienced in their own community. Discussed how, sometimes information provided from external sources, though seeking to be of value, has little use due to the provider’s unfamiliarity with the current context of the community. Collaboration with	

		committee members would be a pertinent way in ensuring that information for COVID that was developed, took into consideration the community's current challenges to ensure compliance to health behaviours	
Access	**Lack of access to resources**	Health committee members found it difficult to receive information quickly and appropriately from government – not accessible or responsive	Access – including access to information – is an important part of improving community members' utilisation of the health system resources for better outcomes (Ali, 2014).
	Access to information empowers people	Health committees felt that they would have had a positive experience had they had access to the PHM pamphlets throughout the pandemic."And we could explain to people how it works, how it works with your body and what's the effect it has on your body you know because we had been trained about that."	
Trust	**Racial biases impacting trust relationship**	Issues of prejudice came to light when health committees discussed community	When individuals possess trust in a person, facility or institution, they are positively influenced and motivated to

		compliance factors – many community members lacked trust in bodies of authority (especially government structures) due to historical perceptions of race relations. This impacted how compliance measures were perceived negatively, and thus negated any potential effects the accuracy of prevention materials would have on compliance. “I’m talking from the coloureds....The president is a black man! Ooo hulle is almal skelm, daai jong lieg, en nou gese dit”	act (Okello & Gilson, 2015). Therefore, it is important to understand which trust relationships influenced the actions and perceptions of Health Committees as it pertains to non-pharmacological prevention measures, and at a later stage, vaccination information
	No confidence: historically “let down” - lack of trust in the government	Health committees reported on their own and the community at large’s historic experiences of non-delivery from government, which resulted in a breakdown of trust. Communities’ difficulty with accepting non-pharmacological prevention measures, despite these being delivered in	

		understandable ways by different stakeholders	
	Belief in the president – Health committees trust in prevention behaviours	Health committees reflected on the complex trust relationships they had with the government throughout the pandemic, and how this impacted their motivation to advocate for non-pharmacological prevention measures. They had great trust in the president, despite a lack of trust with various government departments, and this positively influenced acceptance of prevention measures.	
	Improved relationships between government and Health committees	Health committees unanimously expressed improvements in trust relationships with government – departments appeared more accessible and responsive to the communities' resource and information needs. "now there is some changes this time around there is exchange of emails daily, we get updates in changes and we even get invitations now and	

		then.”	
	Transparency builds trust	When stakeholders demonstrated transparency with community members and Health committee members, trust was built with these parties which had a positive impact on buy-in and compliance	
Agency	Health committees as agents of community health	Health committees sought out information and resources for communities, from various stakeholders“Look”, there’s this new virus, do you have information about it, can you train us about it, so that we can in turn train our members, about this virus and in turn train our community members about it, about the preventative measure, right?	Burgess & Campbell (2015) assert that challenging settings lend themselves to a lack of freedom and choice in the decision making of people in those settings about their own lives. Similarly, understanding what contributed to a building of agency in harsh socioeconomic settings such as those under study, would aid the researcher to understand the success and/or failure of standardised and widely accepted non-pharmacological prevention information, and later, vaccination information
	Empowered communities have agency	Health Committees focused their efforts on empowering communities to take ownership of their health, which had a positive impact on compliance to prevention measures	

		and overall understanding of health information related to COVID-19. “They have taken on collaborative approach whereby communities are given a platform to engage and advise”	

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Addendum 2: People's Health Movement information pamphlet on non-pharmacological prevention strategies for COVID-19

COVID-19 – How can we practice social distancing?

Why must we practice social distancing?

COVID-19 an infectious disease caused by a virus which makes people sick. When an infected person coughs or sneezes, they release tiny droplets of fluid containing virus particles into the air. Other people can become infected by breathing in these droplets if they are standing within a few meters from the infected person. Social distancing is important to stop infection from one person to another.

What is Social Distancing?

Social distancing means we need to practice physical distancing. Even if we are not ill, we need to keep a certain distance apart from other people in public places to reduce the spread of infection. The recommended distance is about 3 steps (or 2 meters) away from others. So, when you go out to get groceries, water, to the clinic, or pharmacy, do your best to stay about 3 steps away from other people.

During the lockdown, we need to remain at home, only going out if absolutely necessary (to get groceries or medication). Distancing also means staying at least two seats away from other passengers when making use of public transport (e.g. taxis and busses), and only travelling when you really need to. You can protect others by limiting your time out in public and contact with other people.

But if you and your family are not ill, and have been remaining at home as instructed by the lockdown, you should continue to live together as you would normally as a family. **It is okay to share hugs and close contact with those in your home.** Physical distancing does not mean we lose human connections.

Do I need to wear a mask?

If you are not sick, you do not need to wear a mask inside your house. You must wear a mask if you go out, especially to crowded spaces like shops or clinic. Wearing a mask helps prevent infection transmission - this means that people who have the infection without knowing it will not spread the infection to others.

What type of mask?

You can make your own mask out of cloth. It should have three layers. I must cover your nose and mouth. You must not touch the front of the mask while you wear it. After wearing it, you should wash it with soap and iron it to reuse it.

Do I need to wear gloves?

You do not need to wear gloves. It is better to make sure you wash your hands carefully (for 20 seconds using soap and water) and to avoid touching your face. Gloves can become contaminated and give you a false sense that you are protected. If that happens, you can end up spreading infection.

What is Quarantine?

Quarantine is when someone has had contact with a person who has COVID-19 and must stay apart from other people in case they develop COVID-19 to avoid infecting others.

What is Self-isolation?

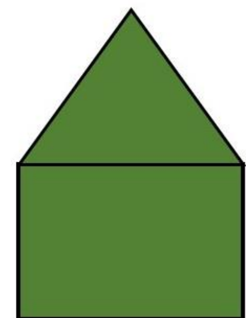
Self-isolation is when you have COVID-19 or you have symptoms which you think are COVID-19 and you stay apart from other people to avoid infecting others.

Where will people be quarantined or isolated?

If you are tested and found to have COVID-19 or if you are traced because you are a contact of someone with COVID-19, you will be asked stay apart from others – i.e. to be isolated or quarantined. The health worker will assess if you can do that at home. That is called Home Quarantine or Home Isolation. If you cannot stay apart at home, there will be quarantine and isolation accommodation set up where you should move to in order to stay separate from others. The accommodation will be safe with toilets, a place to wash and meals so you stay apart from other people to avoid infecting others.

What does it mean to Home Quarantine?

This means that you must stay at home. You will be asked to home quarantine when you are not showing symptoms but have been in close contact with someone with COVID-19. This is to stop the spread of COVID-19. Close contact means face to face contact closer than 1 meter or contact with someone in a confined / small space) for more than 15 minutes. A healthcare worker might contact you if you have been in close contact with a COVID-19 patient and ask you to quarantine for 14 days. You will not be tested during this time, unless you start showing symptoms during these 10 days. While you are in home quarantine,



Stay at Your Home

- You should not leave your home. Send others (friends or relatives) for groceries or medication, if necessary, and wear a mask when retrieving your groceries from them.
- Monitor yourself for symptoms. If you have symptoms, you must immediately contact your **health care provider or the hotline at 021 928 4102.**

Do I need to wear a mask during home quarantine?

- If you are not sick, you do not need to wear a mask inside your house. Wearing a mask helps prevent infection transmission, this means that people who have the infection without knowing it will not spread the infection to others.

Wash your hands often with soap and water

What if I need to quarantine at home and I live with other people?

- Organise a separate room for yourself
- If there is no room available, contact your health care provider or the provincial hotline (021 928 4102). While you are waiting, try to keep 2m (3 steps) away from the other people in your home.
- Wear your reusable mask at home.
- Make sure you wash your hands for 20 secs using soap and water often. Avoid touching your face.
- If you don't have soap and water use hand sanitizer instead (at least 60% alcohol content)

Kitchen / Cooking Area:

- Wear your reusable mask at home when cooking
- Wipe the surfaces thoroughly after use
- Use your own eating utensils and wash these after use
- Remember to wash your hands for 20 secs with soap and water or use hand sanitizer. Avoid touching your face.

Wipe surfaces after you use them

Bathroom and Toilet Usage:

When disinfecting surfaces, make use of a 1 in 6 solution of bleach (6 teaspoons of bleach with 1 litre (4 cups) of water.)

What if I have young children that live with me?

- As much as possible try and adhere to the guidelines above to maintain distance. We understand that following the directions above may be difficult with young children
- Explain to your children that you are staying home to protect other people, and practise hygiene methods with them as much as possible.

What if I am breastfeeding?

It is still important to continue to breastfeed your baby.

- Wear your cloth mask at all times when breastfeeding
- Wash your hands thoroughly for 20 seconds with soap and water before holding your baby
- **Do not touch your mask or face –** if you touch your mask: stop breastfeeding, replace / wash and dry your mask and wash your hands before you begin again
- **If you are feeling unwell:** try and express milk for your baby as much as possible, instead of breastfeeding

What symptoms should I look for during my quarantine?

- Fever

- Cough
- Shortness of breath
- Sore throat
- Sore muscles
- Other flu like symptoms

If you develop any of the above symptoms, contact your healthcare provider or the hotline at 021928 4102.

How long do I need to stay in my home in quarantine?

10 days

- After 10 days if you show no symptoms you can interact normally with people in your household
- You may go and get groceries and essentials. Wear your cloth mask and stay 3 steps (2m) away from other people. Wash your hands for 20 secs with soap and water or use hand sanitizer. Avoid touching your face.
- Your cloth mask must be washed regularly with soap and water. Hang in the sun to dry

Addendum 3: Informed consent information sheet

Good day, thank you for reading this and agreeing to speak with me.
My name is Carryn James. I am a Master's student in Public Health at the University of Cape Town. As part of my degree, I am doing a thesis about health committees and their opinions of COVID-19 information pamphlets made by the People's Health Movement of South Africa (PHMSA)
As you may know, there have been a set of rules laid out by the national government that are meant to prevent the spread of COVID-19 in communities, and these have been implemented at the start of the National Lockdown in March 2020. I am inviting you to participate in this study because you form part of your community health committee.
I will take you through this information sheet, so that you can decide if you would like to participate.

The purpose of the study

The study is being conducted to find out more about health committees' opinions about COVID-19 prevention information (such as mask wearing, social distancing and hand washing) that was made to raise awareness in communities about how to prevent the spread of COVID-19. As you may be aware, community health groups like Health Committees are a very important link between facilities and the community. Therefore, your opinions of such materials is important to make decisions about how COVID-19 safety information is delivered in an effective way to the community.

What are the goals of this study?

1) To determine the opinions of the health committee members in the Khayelitsha and Klipfontein sub districts regarding PHM information pamphlets
2) To determine how health committee members think community members will understand and receive the PHM materials

What will you have to do during this study?

If you agree to participate in the study, you will be asked to read through the information pamphlets made by the People's Health Movement of South Africa. These pamphlets are about ways to prevent the spread of COVID-19. You will also be asked to fill out a short survey. Then, the researcher will contact you to be a part of a group discussion with other members of your health committee. You will be asked to discuss different questions with your fellow health committee members and will be asked questions by the researcher, as part of the group.
All information you provide in the survey will be kept strictly confidential and your identity will not be made public in the report. Responses recorded in the discussions will also not include your identity when written in the report.

What are the benefits of the study?

This study does not offer any money for your participation. The findings of the study have the potential to benefit your health committee, as changes will be made to the information pamphlets according to the opinions of the health committees to be appropriate for roll out in the

community, and we hope that they can be used by health committees as a tool to educate and empower their communities.

Are there any risks associated with the study?

While every effort will be made to protect your identity, your fellow committee members who are participating in the study will be aware of your opinions in the group, as you will be of theirs.

As the discussion takes place in a small group setting, the researcher will take every effort to minimize the risk of COVID-19 infection. A spacious venue in the community will be selected and the researcher will ensure the venue allows for social distancing and sanitising. We will ask you please to wear your mask throughout the discussion, and if you do not have a mask, one will be provided to you.

Do I have to participate in the study?

No, you are under no obligation to participate in the study, and you may withdraw your participation at any time.

Who are the researchers?

Carryn James
Jmscar006@myuct.ac.za
0617595447
Researcher, Masters Student, UCT

Dr Hanne Haricharan, PhD
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(021) 4066524
Research Supervisor, UCT

Addendum 4: Informed consent form

SIGNATURE PAGE

The perceptions of health committee members of PHMSA COVID-19 prevention information

If you have read this consent form, or had it read and explained to you, and you understand the information, and you voluntarily agree to join the study, please sign your name or make your mark below.

I ____ confirm that the purpose, risk and benefits of participating in the study have been explained to me.

Participant

___________________________________ ___________________

(signature) (Date)

Witness

___________________________________ ___________________

(name and surname) (Signature)

Addendum 5: Demographic Survey Questions

1. Biographical Information

Age:	Level of Education
Gender:	Role in the Health Committee:
Location:	Employment:

2. Have you been infected with COVID-19 before?

Yes No Not sure

3. Has anyone in your family been infected with COVID-19 before?

Yes No Not sure

4. Currently, do you have a place where you can find information about COVID-19 and the prevention of infection?

Yes No Not Sure

Addendum 6: Focus Group Discussion Guide

Note: This initial focus group guide may be adapted to consider the responses from the demographic survey, once these have been received and analyzed

- **Introduction**
  - Researcher introduces herself to members of the group and thanks them for agreeing to participate
  - Inform group members that the discussion will last approximately 60 – 90 minutes
  - Explain purpose of the discussion and why participants were selected to be a part of the study
  - Go through ground rules for the discussion
  - Get consent from each participant (participants to sign consent for participation in the focus group)
  - Ask each member of the focus group to introduce themselves and will be provided the platform to ask any questions they may have

- **Composition and functioning of health committee during COVID-19**
  - Round robin – participants to briefly talk about their health committee and their role in the committee
  - Ask participants about how the COVID-19 pandemic impacted the functioning of the committee – what roles did they undertake in the community during the pandemic?

- **General feedback after survey completion and pamphlet review**
  - Ask participants to talk about their initial impressions and understandings after completing the survey
  - Ask participants to talk about their initial impressions and understandings after reading through the PHM information pamphlets

- **Health committee opinions about the PHM information pamphlets on COVID-19 prevention**
  - Do you think the PHM pamphlets are considerate of the community context in how the information is laid out? Why or why not?
  - How does the community interpret/understand the prevention rules for COVID-19? How is this different or the same as what is said in the pamphlets?

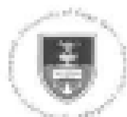
- Talk about how the group thinks these pamphlets could be used in the community – if not, explain why they would not be useful
- Talk about how the group would improve the PHM pamphlets

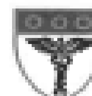
- **<u>Health committee opinions about how the PHM material will be received by the community</u>**
  - Talk about how the group thinks the community will understand the PHM information pamphlets
  - Talk about whether the group thinks the use of the PHM materials in the community will help community members to understand and follow non-pharmacological prevention guidelines. Why/why not?

- **<u>Final thoughts from the group</u>**
  - Round robin – allow group members to share any other closing thoughts about the PHM pamphlets and potential impacts it may have if used in the community
  - Questions and closing comments

Thank you very much for your participation in the group today, feel free to contact me if you have any further comments or questions after the group has ended.

Addendum 7: Human Research Ethics Council Approval





UNIVERSITY OF CAPE TOWN
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Human Research Ethics Committee

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Website: www.health.uct.ac.za/fhs/research/humanethics/forms

05 July 2021

HREC REF: 352/2021

Dr H Haricharan
Public Health & Family Medicine
FHS
Email: Hanne.harichan@uct.ac.za
Student: Jmscar006@myuct.ac.za

Dear Dr Haricharan

PROJECT TITLE: THE PERCEPTIONS OF HEALTH COMMITTEE MEMBERS OF PHMSA COVID-19 PREVENTION INFORMATION-MASTER'S CANDIDATE-MISS CARRYN JAMES

Thank you for your response letter, addressing the issues raised by the Faculty of Health Sciences Human Research Ethics Committee.

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

This approval is subject to strict adherence to the HREC recommendations regarding research involving human participants during COVID -19, dated 17 March 2020 & 06 July 2020.

Approval is granted for one year until the 30 July 2022.

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.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: Miss Carryn James will also be involved in this study.

Please quote the HREC REF 352/2021 in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.