Part 0: Preamble

University of Cape Town

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University of Cape Town

Training clinic health committees: a vehicle for improving community participation in health

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Cape Town, 2017

DECLARATION

MPH (Health systems) Mini-Dissertation

I, ***Nkandu Chikonde**,* Student No. **CHKNKA005**, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Signature: Signed by candidate

Date: 10/08/2017

DEDICATION

This study is dedicated to my loving and caring parents, Dorothy Katebe-Chikonde and James Mwewa Chikonde whose encouragement, strength and investment towards my education has been invaluable in every way.

Abstract

Objectives: In South Africa, and globally, community participation has become a key feature in the health system. In order for meaningful participation to occur within the health system several mechanisms have been identified as critical and this includes formation of health committees (HCs) at health facility level. Previous research indicates that health committees are imperative in both actualizing community participation and realisation of right to health. However, few studies have been undertaken to understand the impact training health committees has on community participation and right to health. This study sought to evaluate the impact training clinic health committees in community participation, health and human rights has on participation and right to health. The training been evaluated was led by Learning Network on Health and Human Rights and targeted four clinics in Cape Town Metropole of Western Cape, South Africa. The Learning Network is a grouping of five civil society organisations (CSOs) in Western Cape, South Africa at four universities which was launched in 2008 after the recognition of a gap in documented knowledge that CSOs had on health and human rights. The study explored health committees' changes in knowledge, perceived competencies, documented member's understanding of roles and HCs sustainability as well as the trainings impact on relationship between HCs and health service providers.

Methods: The study was a multiple case study with multiple qualitative methods for data collection. Narrative data was collected through twelve in-depth interviews with health committee members, one facility manager, two focus group discussions and three physical observations across four health facilities. Health facilities were purposively selected from

a list of health facilities trained by the Learning Network in 2014. Inclusion criteria also included English speaking health facilities and those in close proximity to each other.

Results: The study revealed that training HCs contributed to improved competencies, awareness and knowledge of community participation and the right to health. After the training, HC members were perceived to be more aware and responsive to their roles and responsibilities at the health facility. It was also noted that the training aided improved HCs perspectives on sustainability and roles, improved interpersonal skills and self-esteem. Conversely, the study revealed that despite the training improving participation and right to health, power imbalances between HC members and facility staff/managers who hold authority has a bearing on when and how participation occurs.

Conclusion: The study demonstrates that training health committees contributed to improving the levels of community participation such as planning, consultation and advise [Arnstein, Rifkin and Loewenson] in the realisation of right to health. It is recommended for wider community participation that trainings of such magnitude are conducted together with facility managers/staff.

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Part A: Protocol

1. INTRODUCTION

2. Problem Identification

The importance of community participation as a component of the primary health care was stated in the Alma Ata declaration (WHO, 1978). As a result many governments, including the South African have taken steps to include community participation in the provision of health care. It is evident that community participation potentially contributes to the realisation of the right to health in various ways including allowing for closer monitoring of the health system (SJR, 2005). However, there is a growing concern worldwide that the health system has not fully embraced the core values enshrined by the Alma Ata regarding community participation and therefore not entirely contributing to the overall development of health systems (Hixon, 2008).

In South Africa, the involvement of communities in various aspects of planning and provision of health services has been outlined in the White Paper for the Transformation of the Health System by the Department of Health (DOH, 1997). The White Paper encourages the establishment of mechanisms to improve accountability between the public and health providers (ibid). Likewise, the National Health Act of 2003 (section 42) sets out the establishment of Health Committees (HC), hospital boards and district health councils as mechanisms of decentralizing the management at health facility level (Department of Health, 2004). The National Health Department (2013) draft policy for health governance structures includes health committees as a major governing mechanism concerned with planning, oversight and accountability (Department of Health, 2013; Haricharan, 2014).

Despite the plethora of policy legislation and documents related to community participation that exists within the South African public health sector, there is little mention on the role of Health Committees (HCs) and their formation (Padarath and Friedman, 2008; Meier et.

al, 2012). Research links empowering communities in one sector as having benefits for the wider community empowerment (Lynch et al., 2013). However, there is little research on the role that training[1] has on Health Committees (HCs) in contributing towards the bolstering of community participation for the realisation of the right to health as well as for wider community empowerment. South Africa is currently re-engineering its primary health care system, and it is unclear how this will affect community participation (Haricharan, 2014) and what the role of training of health committees is in this process. Previous studies also show that despite the potential impact, community participation through HCs in South Africa has been problematic and in some cases ineffective and limited (Glattstein-Young, 2010; Haricharan, 2014). The proposed research aims to evaluate the training of Health Committees by the Learning Network[2] on Health and Human Rights as a mechanism of improving community participation in the health system. A rights based approach is used to frame the study.

3. Conceptual Framework

In this study, a conceptual framework using the right to health and community/citizen participation will be adopted. There are many ways of conceptualizing participation which ranges from non-participation to forms of participation where citizens are part of the decision making process (Haricharan, 2014). This study will make use of ideas from the work of Arnstein (1969), Rifkin (1988) and Loewenson (2000) who all write on the role of

[1] Training refers to the building of capacity among Health Committee members in effective communication, leadership and power relations, health and human rights. This is aimed at helping to clarify and develop an understanding of Health Committee member's roles and improving their ability to participate.

[2] The Learning Network is a grouping of five civil society organisations (CSOs) in Western Cape, South Africa and four universities which was launched in 2008 after the recognition of a gap in documented knowledge that CSOs had on health and human rights.

participation in the health system.

According to Arnstein's *A ladder of Participation* (1969), participation is defined as citizen power with a ladder that represents different forms of participation with eight steps suggesting an increase in participants power (Figure 1). The first two steps on the ladder consists 'non-participation' which are manipulation and therapy. The third and fourth steps include informing, consultation and placation and these are considered to allow some voicing of opinions form the community. However, these steps are not considered to fully embrace the opinions of individuals because the powerful may not heed to concerns raised (Arnstein, 1969). In the final three steps, Arnstein specifies that 'genuine participation' is where partnership is formed and power holders agree or are forced by counter power to share planning and decision making responsibilities. This also entails the delegation of power and allowing of citizen control over plans and decision making processes (Arnstein, 1969). Arnstein's model has been adopted and implemented widely, for example, the United Kingdom Community Group on Health for All (1991) (Figure 2).

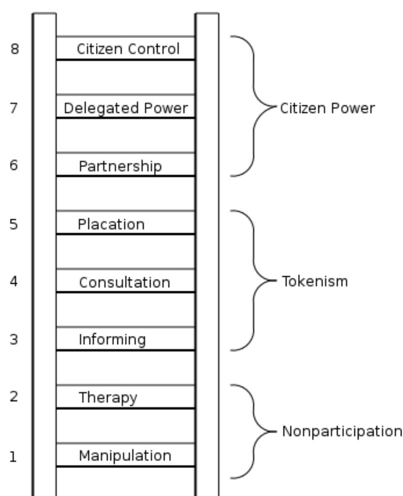

Figure 1: Sherry Arnstein*, A Ladder of Participation (1969)*

Loewenson's (2000) exploration of participation in health systems was influenced by concepts of levels and forms of participation developed by the Community Participation Group of the United Kingdom for All Network (1991) and highlighted the degree of control between community and health system. Loewenson (2000:21) argues that participation in health systems should be viewed as a process that is "involving genuine and voluntary partnerships between different stakeholders from communities, health services and other sectors on shared involvement in, contribution to, ownership of, control over, responsibility, benefit from agreed values, goals, plans, resources and actions around health". Furthermore, Loewenson (2000) adds that participation occurs as a process in the health systems rather than a one-off activity. It is further argued that participation within the health system can be realized through community engagement in health promotion, policy priority and standard setting, allocation of resources and monitoring of quality of care. At all these levels of the health process, participation plays a crucial role, and assessing these roles can help to understand the degree of control between communities and health system in decision making and over resources (Loewenson, 2000). This supports the claim that participation can range from low to high degree according to how the different level targets are met.

Degree	Community Participation	Example
High	Has control	Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Has delegated power	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept.
	Plans jointly	Organisation presents tentative plan subject to change and open to change from those affected. Expect to change plan at least slightly and perhaps more, subsequently.
	Advises	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Is consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.
	Receives information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
Low	None	Community told nothing

Figure 2: Source: Community Participation for health for all. London, Community Participation Group of the United Kingdom for All Network, 1991.

Another author, Rifkin mentions that participation can occur as a result of several factors that can be considered to exist on a continuum. Rifkin et al (1988), developed a continuum of participation which can be viewed on two spectra (narrow at one end and wide on the other). The continuum disaggregated into five components or indicators is used to analyse whether participation is wide or narrow with respect to each other. The suggested indicators are: needs assessment, leadership, and organisation of the programme, management of the programme and resource mobilization. This way of understanding community participation enables an easy linkage of the different aspect that may infer the actual role of participation within the health system. The view by Rifkin et al (1988) is similar to the ideas addressed by Loewenson (2000) that participation can be measured against the varying participatory roles that individuals play within different components of the health system. In addition, Rifkin et al (1988), indicates that the levels of participation depend on the 1) information sharing, 2) mobilizing of communities, 3) collaboration and 5) empowerment of community members. These can be rated and scored. This approach views empowerment

as the ultimate level for facilitating meaningful participation. It is argued empowerment creates opportunities for those without power to gain knowledge, skills and confidence to take decisions that affect their own lives (Rifkin & Pridmore, 2001).

All the three authors place an emphasis on communities sharing power with the health managers as a way of achieving optimum participation. These ideas will be considered together to create a framework for understanding how training health committees may impact on levels of participation at the health facility level.

In this study the right to the highest attainable standard of health (also referred to as "right to health") is conceptualized using the right to health framework as outlined by the International Covenant on Economic, Social and Cultural Rights ICESCR (ICESCR, 2000). According to the ICESCR the right to the highest attainable standard of health refers to the right to access health and its underlying determinants. In this study, right to health will be evaluated with principles outlined in General Comment 14 (GC), Article 12 of ICESCR which points out the importance of participation in health related decision making at community, national and international levels. General Comments are authoritative interpretations of individual human rights or of the legal nature of human rights obligations. They provide orientation for the practical implementation of human rights and form a set of criteria for evaluating the progress of states in their implementation of these rights. General Comment 14 (GC) points out four criteria crucial in measuring the realisation of the right to health; acceptability, accessibility, availability and quality of care. These four criteria were utilized to conceptualise the right to health in this study. Availability in this context refers to ensuring that health services are available in sufficient quantity provided by the State party. While accessibility relates to ensuring that health facilities, goods and services are accessible to everyone without discrimination, within the

jurisdiction of the State party. This means having four overlapping dimensions, namely non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility (right to seek, receive and impart information and ideas concerning health issues). Acceptability is defined as ensuring that health facilities are respectful of medical ethics and are culturally appropriate. Finally, quality of care outlines the need for health to be scientifically and medically appropriate and of good quality as such making sure that there is skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation (ICESCR, 2000).

1.3 Research Question

What role does the Learning Networks training of Health Committees in Health and Human Rights play in community participation and the realisation of the right to health in Western Cape?

1.4 Objectives of the Study

Aim

The proposed research aims to evaluate the Learning Networks training of Health Committees in Health and Human Rights as a mechanism of improving participation and how this impacts on realising the right to health in Western Cape, Cape Metropole Clinics.

Specific Objectives

i. To understand the short-term impact of the HCs training on the knowledge levels and competencies among the participating HC members.

ii. To document narratives on the changes in perception among Health Committee members on their roles and sustainability of the HCs.

iii. To understand the success and challenges in the interaction between the HC members and health facility managers/health personnel in the delivery of quality health care.

1.5 Purpose and Relevance of the Study

The proposed research is a descriptive multiple case study that seeks to document if the Learning Networks training of health committees in Health and Human Rights relates to community participation and the realisation of the right to health in the context of Western Cape, Cape Metropolitan Area, South Africa.

2.0 RESEARCH JUSTIFICATION

2.1 Health Systems, Right to Health and Participation

Health inequalities are widening globally (Kruk and Freedman, 2007). In response, several interventions targeted at building and strengthening health systems have been proposed by government's worldwide (Adam et. al, 2012). The World Health Organisation defines a health system as "consisting of all organisations, people and actions whose primary intent is to promote, restore or maintain health". Its overall goals are "improving health and health equity in ways that are responsive, financially fair, and make the best or most efficient use of available resources" (WHO, 2007). While this definition may seem complex, one way of looking at the components of the health system is through the WHO "Framework for Action" which describes six clearly defined health system building blocks that together constitute a system. These building blocks are: service delivery, health workforce, information, medical technologies, financing and leadership/governance. The building blocks assume that the effective functioning of these blocks will lead to improved health outcomes, responsiveness, social and financial risk protection and improved efficiency. However, this framework does not explain the relationships that may exist between the building blocks, but regards them to

be independent components that ought to function for the health system. The health system should not be seen as monolithic since it has a dynamic level of interactions, synergies and shifting sub-systems (ibid).

The building blocks approach to the health system help to establish that people are at the centre of the health system and not just mediators and beneficiaries, but actors in driving the functioning of the system (Savigny, 2009). Recently this has led to participation by individuals, civil society movements, and claim holders aimed at influencing health workers, managers and policy-makers' and duty bearers attitudes in realizing the right to health (WHO 2007; WHO 2008; Potts, 2009).

Active involvement and participation of people and groups is viewed as a constructive step towards improving the ideals of realising the right to health. The Declaration of the Alma-Ata is largely credited for bringing participation to the fore of health systems internationally (WHO, 1978). The Alma-Ata Declaration states that Primary Health Care should be "the essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at all stages of their development in the spirit of self-reliance and self-determination" (WHO, 1978). The Declaration relays crucial narratives related to the function of the health system in providing primary health care such as acceptable provision of health care, accessibility of services to individuals and families in the community, full participation of the community and affordability and maintenance of the primary health care system. The implication of such a declaration is the awareness that health services can be claimed as rights by individuals and community. The Ottawa Charter on Health Promotion built on Alma Ata and reiterates community action towards better health as necessary on the

basis that individuals and groups have the right and duty to engage in health care planning and implementation (WHO, 1986).

2.2 Participation and health committees

Participation in health first came to the fore internationally in the Declaration of Alma-Ata (WHO, 1978). It had global impact. For example, it cited the successful community work led by Sidney and Emily Kark in South Africa during their work with health centers in Pholela and Lamontville in the 1940s where community health associations were formed. Even at the time, these community health associations contributed positively to the functioning of the health system (Kark, 1952). This was also during the time that 'people-centered' and 'participatory' forms of development were gaining prominence in the majority of countries in the world (Chamber 1983; Kahssay and Oakley 1999). Participation manifests itself in different forms and despite some studies showing contribution to efficiency (McCoy, 2011) and cost-effectiveness, there remains little robust evidence of the impact on health outcomes (McCoy, 2011).

While there may be many forms of participation, such as through community-based organisations or non-governmental organisations, a mechanism that is appearing more recently in numerous health policies globally (Kamuzora, 2013) is that of health facility committees/health committees. This structure is placed as a strategy for health systems strengthening and health improvement (McCoy, 2011). An example of where these committees have emerged can be found in Tanzania. In fact, the formation of health committees or boards involving community representatives has emerged as an important dimension to health care planning and decision making within the decentralized district health care system across Tanzania (Kamuzora, 2013). Health committees have been

identified as a useful health governance structure, a building block of health systems, and have been recognised as a vehicle through which community participation can be achieved in primary health care facilities (Loewenson 2000a; Padarath 2008). Cleary and Gilson (2013) refer to the use of such an accountability mechanism in the form of a health committee as a means of 'external accountability'. As opposed to 'bureaucratic accountability', which is concerned with the different levels of the health system, 'external accountability' tools seek to regulate answerability between the health system and community (Cleary and Gilson, 2013).

As such, HC committees are a critical part of the accountability process in health and do contribute to needs analysis, planning, implementation and education of primary health care in the area (Padarath and Friedman, 2008). The involvement in these activities encourages participation in the provision of health care especially in a decentralized health care system such as that envisioned for South Africa (ibid).

There is a formal provision in the South African National Health Act of 2003 for community-based governance structures at various levels of the health care delivery system. Clinic committees, hospital boards and district health councils in the South African context stand for the expression of community participation at a local and district level. The Act further outlines roles and responsibilities of the committees (Department of Health, 2013). There is clear evidence that health committees can improve external accountability/community participation (Cleary and Gilson, 2013). Nevertheless, the extent to which health committees can participate in health services is determined by how empowered to participate its members are (Baum and Kahssay, 1999). Glattstein-Young (2010), in her study recommends a rights-based approach training that aims at meeting the deficiencies in participation among HCs in Cape Metropolitan.

2.3 Training of Health Committees

Several studies in South Africa suggest that health committees are not functioning optimally (Boulle et al., 2008; Padarath and Friedman, 2008; Haricharan, 2014). Numerous factors are believed to be responsible for this. The factors include, but are not limited to, "lack of political commitment, limited resources, limited capacity and skills, attitudes of health workers, lack of clarity of the role and mandate of committees, limited co-operation from health services, and lack of support" (Haricharan, 2014). It can be to argued that these factors are linked to a lack of 'external accountability' (Cleary and Gilson, 2013), 'citizen participation' (Arnstein, 1969; Loewenson, 2000) and can be largely remedied through training of health committees as a way of improving participation and accountability. As in an example from Zimbabwe, Loewenson (2000) suggests that training of HC committees (HCs) plays a crucial role in contributing to the improved level of participation. If HCs are equipped with information on planning, management and health information, they are more likely to meaningfully contribute to improved health outcomes (ibid). A study in Uganda (Bjorkman and Svensson, 2009) suggests that training HCs accelerates the optimal function of the health system. A study in Zambia, Ngulube et al. (2004) concludes that training HCs helps to clarify roles and responsibilities at the health facility/clinic level and helps to clear misunderstandings. Finally, McCoy (2011) in a review of the literature for evidence on health facility committees (in low-and middle-income countries) suggests that training HCs can be an emancipatory process that the health system can use to drive community participation (ibid).

2.4 Legislative and policy Context

South Africa put in place legislative and executive measures to realize the benefits of community participation (Meyer, Pardue and London, 2012). These measures were introduced to deal with the divisive health system that existed during apartheid. In 1948, the Nationalist Party assumed power and further entrenched fragmentation of health care when the Bantustans were created, each with its own health department. The Bantustans (and their government departments) acted separately from each other, like quasi-independent powers. By the end of the apartheid era, the South African health system was highly divisive with 14 separate health departments in South Africa (including one from structures reporting to each of the three parliaments), health services were focused on the hospital sector, and primary level services were underdeveloped (Coovadia et al.,2009). When apartheid came to an end, the health system reform moved towards a decentralized district health system (DOH, 1997; Haricharan, 2014). Decentralization was suggested by the ANC government through the 1994 Reconstruction and Development Programme (RDP) in order to bridge the socioeconomic divide left in the wake of apartheid policies (Coovadia et al., 2009). The change to a more decentralized district heath system was based on different factors including the principles of Primary Health Care, emphasizing participatory systems for comprehensive care in accordance with international consensus stated in the Declaration of Alma-Ata as opposed to a divisive system that existed in the apartheid era (ibid; Meier et al., 2012).

In 1997, the White Paper on Transformation of the Health System reiterated South Africa's commitment to improve community participation with an emphasis on "fostering community participation across the health sector" (DOH, 1997) and established practical mechanisms to improve linkages between community and the health services system (Meier et al., 2012). Later, the National Health Act 61 of 2003 (DOH, 2004), formalized the

establishment of health committees, hospital boards and district health councils and mentioned that each clinic/community health centre or cluster of these should have a health committee consisting of one or more local councillor(s), the head(s) of the health facility/facilities, and one or more members of the community in the area served by the health facility/facilities (ibid).

The Act also stipulates that the roles and functioning of HCs should be developed by the respective provincial governments (DOH, 2004). In 2008, as a response, the Western Cape provincial government developed a draft policy for health governance/community participation, but the same has never been implemented (Western Cape Draft Policy, 2008). In 2011/2012, a decision was made not to implement the Draft Policy, but to rather amend the Facility Boards Act to give legislative effect to health committees (ibid). Further, it is important to mention that the introduction of the National Health Insurance (NHI) may affect community participation although the extent to which this may happen is still unknown. Additionally, a strategic planning framework, "2020 The Future of Health Care in Western Cape" which reaffirms community participation is currently under discussion. The policy environment in South Africa and specifically the Western Cape Province certainly demonstrates a commitment towards aligning health services in a pro-participation approach. The Western Cape Province parliament enacted the Western Cape Health Facility Boards and Committees Act 4 of 2016 to outline guidelines for the establishment, functions and procedures of boards established for hospitals and committees established for primary health care facilities.[3]

[3] The Act was enacted in 2016 after data collection was already conducted on the study

2.5 Research gap

Evidently there is a lack of research about training[4] of Health Committees as it impacts community participation and the right to health. This study is well positioned to offer an understanding of the role that training has on the level of participation exhibited by Health Committees (HCs) and impact on the right to health. This study also goes further to understand the perceptions health committee members and facility manager on the interplay between participation and the health system.

3.0 OPERATIONAL DEFINITIONS

Health system: According to the World Health Organisation the Health System "consists of organisations, people and actions whose primary intent is to promote, restore or maintain health". This definition enables people to be at the centre of health care and emphasizes the importance of participation (WHO, 2007).

Community: In the context of this study, community refers to individuals living in a defined geographic area who access services by the same health facility and who are represented by a specific Community Health Committee (Western Cape Department of Health, 2007).

Participation: Participation has been defined by EQUINET (2000) as "involving genuine and voluntary partnership between different stakeholders from communities, health services and other sectors based on shared involvement in, contribution to, overlap of, control over, responsibility for and benefit from agreed values, goals, plans, resources and actions around health" (EQUINET/TARSC, 2000).

[4] Training refers to the building of capacity among Health Committee members in effective communication, leader and power, health and human rights. This is aimed at helping to clarify and develop an understanding of Health Committee member's roles and improving their ability to participate.

Community Participation: "Community participation is a process where 'community members' engage with health officials in matters related to health and health services, and where that includes involvement in setting the agenda, identifying problems, planning and implementing solutions, taking part in decisions, having an oversight function that entails monitoring and evaluation, and ensuring an accountable health system." (Haricharan, 2012).

Right to health: In the current study, this is used as "the right to the highest attainable standard of health". According to General Comment 14, the right to health is not to be understood as the right to be "healthy"; the right to health contains both freedoms and entitlements. These entitlements include the right of access to health care and the right to its underlying determinants, including adequate sanitation, nutrition, education, housing, healthy occupational and environmental conditions as well as access to health-related education and information (General Comment No 14, ICESCR, 2000).

4.0 METHODS

This study will adopt a flexible research design (Robson, 2002) to address the research question, its purpose and the guiding questions. The study will adopt multiple case study qualitative methods for exploring the interaction between HCs and the health system/health personnel. These methods will help to make the inquiry into the 'what's and how's' and will seek to get some new insights into the functions of health committees (ibid). Additionally, the study will be investigating a real life setting (health committee members in Cape Town), looking at HC members and their 'real life' involvement with health service provision. The design will allow for the in-depth exploration of reported changes in HC roles and participation at their health facilities and any changes in knowledge and competencies that may have impacted on the participation and the perceptions of HC sustainability. Using the multiple data sources and collection methods will help in ensuring

improved rigor, triangulation and accuracy of data collected (Hennink et. al, 2011) in order to meet the stated objectives of the investigation. In addition, this study is framed as a health policy and systems research and therefore combines methodologies that are supportive of this approach.

4.1 Study Setting

4.1.1 Choice of Study Site

The study will be conducted with health facilities that have functional health committees that have undergone training for HCs with the Learning Network (LN). All these facilities will be selected from within Cape Town, the Metropolitan area of Western Cape Province of South Africa. This study will be conducted under the auspices of the Learning Network for Health and Human Rights (LN). The LN is a grouping of five CSOs in Western Cape, South Africa and four universities (Stuttaford et al., 2014). The LN was launched in 2008 after the recognition of a gap in documented knowledge that CSOs had on health and human rights (London et al., 2012). The network has since engaged with CSOs in conceptualizing the right to health (Stuttaford et al., 2014). As a result of the collective action and recognition of the knowledge gap in health rights (ibid; London et al., 2012), the LN has been training Health Committees in Western Cape as a way of improving community participation to enable the realisation of the right to health. This study will form an evaluation of understanding the role of such training of HC members and how it affects participation and the realisation of the right to health.

4.1.2 Population

The study will mainly focus on the following central groups that relate to the work of Health Committees (HCs) in the Western Cape, as follows: Health Committee members, key

informants and service providers/facility managers/health personnel at the respective health facilities.

Health committee members: these are different individuals from the community selected by community members and health facility staff in a given process such as elections and nominations to be on the committee at their designated health facility.

Health providers/facility managers: this category is for the individuals that are responsible for providing health services at the health facilities where the health committees will be selected to be part of this study. These individuals will include but not be limited to facility managers, nurses, doctors, social workers and other allied health professionals.

There are a total of eight sub-districts in the Cape Metropole of Western Cape South Africa with health facilities in each of the sub-districts that have trained HCs. Using a purposive sampling procedures to identify the four HCs two from the Afrikaans/English speaking facilities in Klipfontein and West-sub-districts.

4.2 Research Design

This study will use qualitative data collection methods to explore and understand the role of training HC members on community participation. The use of a qualitative design will help to achieve an in-depth understanding of this study (Hennink et al., 2011). This study will collect data on the relationship between training of health committees and the realization of the right to health.

4.3 Sampling Strategy

The study will use a purposive sampling procedure. Key stakeholder interviews will be conducted with partners involved in the Learning Network project including the Cape Metro Health Forum, LN trainers and CSOs. This study will include four health facilities/Health

Committees that have successfully completed the LN training on Health and Human Rights. Health Committees that are not English/Afrikaans speaking will not be included in this study. At each of the health facility, five in-depth individual interviews will be conducted with HC members, one focus group discussion (FGD) with HC, one individual interview with the facility manager and other community stakeholders deemed relevant to the study. The sample population for each of the facility is illustrated in the table below:

Targeted sample	
Key stakeholders from Cape Metro Health Forum, HC trainers	6 in-depth interviews
Health Committees	5 in-depth individual interviews. 1 focus group discussion (FGD).
Facility manager	1 facility individual interview at each health facility.

4.4 Data collection Methods

Research question	**Data collection methods**
Has there been a change in the health committee's capacity to participate (through improved knowledge and competencies in effective health committees, leadership etc.)?	• In-depth interviews • Focus group discussions (FGDs) • Observation of training and participants • Researcher field work journal writing

How has the training impacted on the perception of sustainability and participation of Health Committees among Health Committee members?	• In-depth interviews • Focus group discussion
Has there been any change in the participation interaction between HCs and health personnel?	• In-depth interviews • Focus group discussion • Participant observation • Researcher journal writing

As indicated in the table above, data will be collected using in-depth interviews, key stakeholder interviews, HC focus group discussions (FGDs), participant observation and journal writing. The in-depth interviews will be conducted among all sampled HC members. In addition, interviews will also be conducted with key stakeholders in this case, the Cape Metro Health Forum Executives and facility staff.

4.5 Justification for Data Collection Methods

4.5.1 Individual in-depth interviews

Individual in-depth interviews are recommended to explore social occurrences (Lofland & Lofland; 1995, Patton, 2002). This method emphasizes the use of verbal communication and is often efficient and effective bringing out a participant's attitudes, as well as perceptions or expectations concerning a particular issue (Lofland and Lofland, 1995). The objective of using this method will be to elicit deeply rooted attitudes, perceptions and experiences especially from the HC members. In-depth interviews will be conducted individually with HC members, facility managers and key informants. Most of the data coming from the HC members will be compared with data from the facility manager/service providers or heath

personnel. Additional questions will be asked during these interviews and although there is an interview guide (see appendix), the interviews will be flexible and seek to elicit in-depth narratives.

4.5.2 Group discussion

Focus group discussion (FGDs) with the HCs will help to address a new dimension to the data by adding a new dimension of group thoughts and opinions (Robson, 2002). Group interviews can help to provide checks and balances for the participants and can help identify extreme views focusing on the most important topics in the community (ibid). These discussions will be helpful for this study to find some differences of opinion seeking to understand the outliers. The researcher will ensure that these interviews establish group rules and do not take more than 1 hour and 30 minutes.

4.5.3 Researcher Journal

Journals are vital in highlighting thoughts, feelings and reflections and help to triangulate data from different sources on behaviour (Hyldegard, 2009). They also tend to improve rigour in qualitative research (Clayton and Thorne, 2000). The researcher will keep a journal to record experiences during the study from all sources of data (whether informal or formal).

4.6 Data Management

All interviews and discussions will be recorded apart from the conversations that will be informal. The audio records will be transferred onto the researcher's computer and stored in folder protected by password. The researcher will store the notes from the field including the journal in a secure place only accessible to him.

4.7 Data Analysis and interpretation

A thematic approach will be adopted in analysing interviews, observations and notes. This process will also be aided by the conceptual framework by understanding the finding that can fit in the categories/themes of participation and non-participation according to (Arnstein, 1969; Loewenson, 2000; Potts, 2009). A conceptual framework helps to provide a language for making interpretations (Gilson, 2011). A coding system will be developed based on the research questions and this will cater for the initial categorization of the text. Interviews will be transcribed to produce transcripts of narrative text for thematic analysis. Translation will also be done if necessary. Descriptive or open codes will be developed through identifying theme, coding, recoding and classification by examining regularities, convergences, divergences in the data. Data will be summarized and synthesized to retain as much as will be possible in terms of phrases and expressions of respondents (Kamuzora, 2013). Some of the key themes as mentioned above will be gathered deductively based on some of the key categories in the Arnstein (1969) ladder of participation. There will also be provision for flexibility to identify the inductively emerging themes and patterns in the text.

4.8 Ethical Considerations

The *Belmont Report,* as part of the World Medical Association Declaration of Helsinki (1964) on ethical principles for research, identifies three core principles for the ethical conduct of research which will be applied to ensure appropriate ethical consideration on this study (Hennink et. al, 2011). These areas are justice, beneficence and respect of persons. This study will ensure that all these are met by; explaining to the study participants what the study is about and the benefits this may have on their community, their health committee and ultimately their health facility such as improved understanding of role of training and possible influence of future HC policy.

The study participants will also sign informed consent when they agree to be part of the study; participants under 18 years of age will be excluded from the study. The study will be conducted with minimal risk for the participants while ensuring that there is absolute anonymity through protecting the information that will be gathered through the study under an encrypted and password locked laptop folder or cabinet. In addition, the study will use pseudo-names as a standard in order to protect the names of the study respondents. During focus groups however, the interviewer will ensure confidentiality but it will not be guaranteed among the other group participants.

The research will also enable research validation by allowing participants to check the findings during a community report back meeting to provide feedback where necessary. The research participants will not be given any financial or material reward for their participation in the study.

This study is part of a larger study by the Learning Network which has already been approved by the UCT Ethics committee in 2007 (Ref: 179/2007).

4.9 Limitations

Limited study sample size based because of the time frame and budget is likely to be a limitation. In addition, language may be a factor as most of the communities on the study may be Afrikaans and isiXhosa speaking which the researcher is not well versed in. Other limitations foreseen in the study include logistical issues related to time and financial resources. Lack of time might not allow the participants to share all that they would want to share and thus may affect the amount of rigor in the data collected. The study will only provide a short-term understanding of the impact of the training but it would be important for a follow-up study to establish the continued impact of the training on the participants to

understand the long-term impact(s).

4.9.1 Risks and Benefits

The benefits of the study are not at an individual level. It is anticipated that the results will inform the development of training for HCs which may in the longer terms influence the development of policy and practice related to community participation. The study is not likely to pose any risks to the welfare of the participants, however, should there be any emotional/psychological distress resulting from it, a referral system for support will be employed through the already existing community health structures that are part of the Learning Network.

The study may be taking up some of the space and time at the health facility for the interviews on group discussion to be conducted. Space will be booked in consultation with facility staff so as not to impact on service provision. Health service providers might be interviewed during normal working hours, however this will be done in such a way as to ensure no negative impact on service provision. All the necessary material for the research will be provided by the researcher and therefore the health facilities do not have to provide any equipment or material.

5.0 RIGOUR

In order to ensure rigour the researcher will constantly review the question/topic guides to be aligned with the research objectives. With the permission granted, there will be a comprehensive recording of data using audio-recorders and detailed transcription of the individual interviews and focus group discussions thereafter. Where possible, the transcriptions will be compared to each other in order to clear any inconsistencies. In addition, the data will be collected from different data sources (HC members, facility

members) and using different data collection methods (in-depth interviews, Focus Group Discussions, journal experiences and reflections) (Olshansky, 2006; Golafshani, 2003).

6.0 ANTICIPATED GAINS IN KNOWLEDGE

The findings will help to build on the body of literature which is aiming at clarifying the roles that training of health committee plays in improving community participation and the realisation of the right to health. In addition, the findings will help to clarify changes in competencies and knowledge among health committees. Furthermore, the study will also delve into understanding the relationship between health committees and the utilization of health care by the community members.

7.0 KNOWLEDGE TRANSLATION

The findings of the research will be shared with the different stakeholders as part of the dissemination. The research will produce a one-page summary with the recommendations for the study. This will be shared through the LN communication channels which includes a public website and mailing list including CSOs. The summary will also be shared through various listserv' (e.g. EQUINET). A poster depicting key findings will be displayed at each participating health facility/health committee. A presentation will be made to the LN which includes CSOs and health committee members. Findings of the evaluation will also form part of a report to the IDRC.

8.0 TIMELINE

The data will be collected within 8 weeks from the time the final ethics approval from both University of Cape Town's (UCT) Health Research Ethics Committee (HREC) and the Department of Health (DOH) is acquired and the data analysis, interpretation and writing will be done within 10-12 weeks thereafter.

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Part B: Structured Literature Review

Training clinic health committees: a vehicle for improving community participation in health

INTRODUCTION

This section presents literature reviewed on the role of training health committees and how it affects community participation and realisation of the right to health. The literature delves into understanding the international framework of participation in health systems and explores existing policies supporting community participation in South Africa. The literature search included a systematic review of data from several manuscripts including UN and WHO online catalogues, UCT library catalogues and other online databases such as Web of Knowledge, Science Direct, PubMed, World Cart and Google Scholar. As part of the search, the following key terms were used; health committee, clinic health committee, village health committee, health facility committee, clinic committees, training, community participation, health rights and right to health. The literature includes English language literature published since 2009 and key texts before this period are also included in the review because of their critical importance to the topic. It includes published articles from peer-reviewed journals, published or unpublished reports, conference presentations and post-graduate dissertations.

SUMMARY AND INTERPRETATION OF LITERATURE

Origins of Community Participation in Primary Health Care

Primary Health Care (PHC) was accepted as the official approach to protect and promote the health for all people by member states at the WHO Alma Ata Conference in 1978 (WHO 1978). The International Convention on Economic Social and Cultural Rights (ICESCR), appeals that State Parties should recognize the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health. The covenant further outlines that in order for the State Parties to achieve the full realisation of this right, necessary steps need to be taken (ICESCR, 2000).

Rifkin (2014) points out that the importance of community participation entered the global health policy arena at the point of accepting the Alma Ata Declaration (Rifkin, 2014; WHO, 1978). The Declaration enforces the recognition of health as a human right, that inequalities in current health status are 'politically', socially and economically 'unacceptable' and that critical health care must be 'accessible to all individuals and families in the community through their [peoples] full participation' (Rifkin 2014; WHO 1978). The declaration points out that people have the 'right' and 'duty' to get involved or participate individually and collectively in planning implementation of health care (WHO 1978). Additionally, the responsibility of State Parties in promoting health has been embedded in the PHC declaration, isolating the importance of providing adequate health and social justice to fulfil, promote and respect the right to health for all (WHO, 1978).

In a review of the literature by Cleary et al (2013), it is mentioned that the Alma Ata Declaration provided an initial view of how conceptualization of services at the first level of care should be organized, delivered and managed within decentralized health systems (Clearly, 2013). In this conceptualization, decision-space-i.e. decision making authority over planning, budgeting, managing and monitoring of activities (ibid) would be transferred from the national level to the local level [decentralized]. The Declaration underlined the importance of involving citizens in health care priority setting (ibid). It is strongly argued that increased "decision-space" at lower levels of the health system, together with citizen involvement in priority setting, [might] enhances the responsiveness of the health system. Cleary et al (2013) further argue that appropriate decision making space needs to be complemented by governance approaches that enable and sustain responsiveness, by promoting systematic learning and accountability.

Health Systems, Right to Health and Participation

Despite global efforts to strike a balance in promotion of access to health for all (Sheikh 2014), health inequalities have been widening (Kruk and Freedman 2007) over time. In response, several interventions targeted at building and strengthening health systems have been proposed (Adam et al 2012). The World Health Organisation defines a health system as consisting of "all organisations, people and actions whose primary intent is to promote, restore or maintain health" (WHO 2007). Its overall goals are "improving health and health equity in ways that are responsive, financially fair, and make the best, or most efficient use of available resources". (WHO, 2007). While this definition may seem complex, one way of looking at the components of the health system is through the WHO "Framework for Action" which describes six clearly defined health system building blocks that together constitute a system. According to the framework these building blocks are: service delivery, health workforce, information, medical technologies, financing and leadership/governance. The building blocks assume that the effective functioning of these blocks will lead to improved health outcomes, responsiveness, social and financial risk protection and improved efficiency. However, this framework does not explain the relationships that may exist between the building blocks, but regards them to be independent components that function within the health system. It has, however, been argued that the health system should not be seen as monolithic when it has a dynamic level of interactions, synergies and shifting sub-systems (WHO 2007).

In fact, some of the literature argues for the importance of having people at the centre of the health system (Savigny, 2009; Sheikh, 2014; Rifkin, 2014). It has been put forward that people are not just mediators and beneficiaries but actors in driving the functioning of the system (Savigny, 2009). Recently this has meant participation as individuals, CSOs, and claim holders, and also as key factors influencing health workers, managers and policy-makers and individuals claiming their right to health (WHO 2007; WHO 2008) through participating in

perceived or apparent aspects of the health system. The closing statement at the Third Global Symposium on Health Systems Research in Cape Town on 3rd October, 2014 further reiterated the need for the health system to adopt a more participatory approach in which communities have a stronger voice in, not only defining their emerging health needs, but also in planning and monitoring health (Health Systems Research, 2014). Active involvement and participation of people and groups is viewed as a constructive step towards improving the ideals of preserving the right to health. This approach is encouraged by the Declaration of Alma-Ata which states that Primary Health Care should have "the essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at all stages of their development in the spirit of self-reliance and self-determination" (WHO 1978: 1). The Declaration raises some crucial points related to the function of the health system in providing primary health care such as acceptable provision of health care, accessibility of services to individuals and families in the community, full participation of community and affordability and maintenance of the health care. The Ottawa charter on health promotion built on Alma Ata, reiterates community action towards better health as necessary on the basis that individuals and groups have the right and duty to engage in health care planning and implementation (WHO, 1986). The highest attainable standard of health is clarified in General Comment 14 (GC) of Article 12 of the International Convention on Economic Social and Cultural Rights (ICESCR, 2000). General Comments are authoritative interpretations of individual human rights or of the legal nature of human rights obligations. General Comments provide orientation for the practical implementation of human rights and form a set of criteria for evaluating the progress of states in their implementation of these rights. Critical imperatives for progressive realisation are outlined in this article with recognition that certain rights cannot be fully attained in the short

term. The ICESCR General Comment 14 (Article 12) points out that the state must show deliberate and tangible actions that demonstrate commitment to its obligations under the convention (Glattstein-Young, 2010; ICESCR, 2000). Further, GC 14 outlines four criteria by which progressive realisation of the right to health can be measured these are; availability, accessibility, acceptability and quality of care. Availability in this context refers to ensuring that health services are available in sufficient quantity within the State party. While accessibility relates to ensuring that health facilities, good and services are accessible to everyone without discrimination, within the jurisdiction of the State party having four overlapping dimensions of non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility (right to seek, receive and impart information and ideas concerning health issues). Acceptability defined as ensuring that health facilities are respectful of medical ethics and culturally appropriate. Finally, quality of care outlines the need for health to be scientifically and medically appropriate and of good quality as such making sure that there is skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation (Glattstein-Young, 2010).

Potts (2008a) adds that the right to the highest attainable standard of health empowers rights-holders (people) to demand accountability at national, regional and international levels (Potts, 2008a; 2008b). As such, participation is linked to social accountability, by providing mechanisms through which community members can get involved in health care such as public hearings and mass social audits (Potts, 2008a; 2008b). The Treatment Action Campaign (TAC) with a history of rights-based, patient driven HIV/AIDS activism in South Africa provides a good example of citizen mass mobilisation. TAC has been at the centre of mobilising citizens to demand health care for people living with HIV/AIDS since the end of the apartheid era in South Africa (Mbali, 2005). Health committees are an example of platforms which allow the

process of participation to take place, led by community members who are the right-holders. Right-holders are entitled to have access to effective accountability and remedy. (Potts, 2008a; 2008b).

Conceptualization of community participation in health

Defining community participation in health has been contested (Rifkin, 2013). However, Morgan (2001) acknowledged two main perspectives—utilitarian and empowerment models (Rifkin 2013; Morgan 2001) as helpful in understanding community participation. Between the two approaches, the utilitarian approach was particularly criticized for viewing participation as a 'technocratic' solution to a 'political' problem (Cooke and Kothari 2001). Further to that, Rifkin (1996) argued that failure of community participation was largely due to unrealistic expectations, resulting from viewing participation as an intervention rather than a social process. Conversely, the empowerment model which seeks to advance the agency of individuals and communities has also proven hard to implement (Michener, 1998). Key literature points out that the empowerment model has been criticized for unrealistically assuming abilities of poor and marginalized communities and overlooking the broader social and political realities (Rifkin, 2013; Carpenter 2007; Brett 2003).

Other authors have gone on to try and pinpoint the role of community participation in health by defining components that define meaningful participation. Different literature entries, in fact argue that community participation ranges from low or non-existence (where community is told nothing), to high, 'active and informed' participation where the community has control over decisions and agenda setting (Loewenson, 2000a; Potts, 2009). In this literature review, conceptualization and understanding of community participation will be done by mainly focusing on the work by Loewenson (2000), Arnstein (1969), and Rifkin (1988) on community participation.

Loewenson argues that participation in health systems should be viewed as a process that is "involving genuine and voluntary partnerships between different stakeholders from communities, health services and other sectors on shared involvement in, contribution to, ownership of, control over, responsibility, benefit from agreed values, goals, plans, resources

and actions around health (EQUINET/TARSC)". Loewenson (1999) adds that participation occurs as a process in the health systems rather than a one-off activity. Furthermore, it is pointed out that participation within the health system can be realized through community engagement on health promotion, information exchange, policy priority and standard setting, mobilization of resources, allocation of resources and monitoring of quality of care. At all these levels of the health process, participation plays a crucial role, and assessing these roles can help to understand the degree of control of communities in health system decision making including over resources (Loewenson, 2000). The ideas of Loewenson (2000) on the degree of control by the community on the health system are mainly influenced by concepts on levels and forms of participation by the Community Participation Group of the United Kingdom for All Network (1991) as illustrated in the figure 1 below.

Degree	Community participation	Example
High	Has control	Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help each step to accomplish goals.
	Has delegated power	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept.
	Plans jointly	Organisation presents tentative plan subject to change and open to change from those affected. Expect to change plan at least slightly and perhaps more subsequently.
	Advises	Organisation presents a plan and invites questions. Prepare to modify plan only if absolutely necessary.

	Is consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be accepted.
	Receives information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
Low	None (no community participation)	Community told nothing.

Figure 1: *Source: Community Participation for health for all. London, community Participation Group of the United Kingdom for All Network, 1991.*

Another author, Rifkin (1988), mentions that participation can occur as a result of several factors on a continuum. Rifkin et al (1988), previously developed a continuum of participation which can be viewed on two spectra (narrow at one end and wide on the other). The continuum disaggregated into five components or indicators is used to analyse whether participation is achieved (wide) or not adequately achieved (narrow) in respect to each other. The suggested indicators are: needs assessment, leadership, and organisation of the programme, management of the programme and resource mobilization as indicated in figure 2 below. This way of understanding community participation enables an easy linkage of the different aspects that may define the actual role of participation within the health system. The view of Rifkin et al (1988) is similar to the ideas addressed by Loewenson (2000) in that participation can be measured against the varying participatory roles that individuals play within different components of the health system. In addition, Rifkin et al (1988), indicated that the levels of participation depend on the 1) information sharing, 2) mobilizing of communities, 3)

collaboration and 4) empowerment of community members. These can be rated and scored. This is in the light of viewing empowerment as the ultimate level or rating in order to facilitate meaningful participation, they argue that this creates opportunities for those without power to gain knowledge, skills and confidence to take decisions that affect their own lives (Rifkin & Pridmore, 2001).

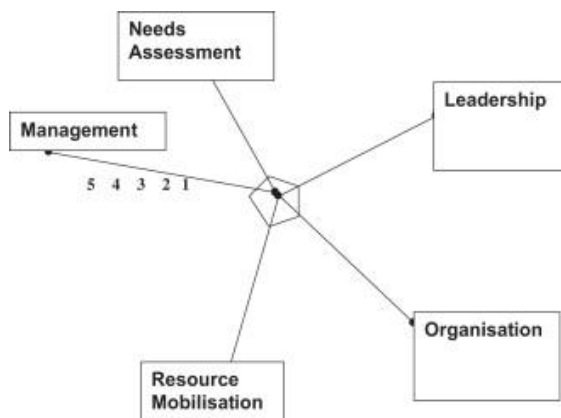

Figure 2: A spider-gram for assessing participation (Rifkin et al 1988)

Another key author who expands on participation is Arnstein. According to Arnstein's *A ladder of Participation* (1969), participation is defined as citizen power with a ladder that represents different forms of participation with eight steps suggesting an increase in participants' power. Similar to the ideas also confirmed by the United Kingdom Community Group on Health for All (1991), the first two steps on the ladder are labelled as 'non-participation' which are therapy and manipulation. The third until fourth steps include informing, consultation and placation these are considered to allow some voicing of opinions form the community. In the final three steps, Arnstein specifies that 'genuine participation' is where partnership is formed and power holders agree to share planning and decision making responsibilities. In addition, this also entails delegation of power as a prerequisite for the rest of the steps to occur and as well as allowing citizens to have control over some plans and decision making processes (Arnstein, 1969).

Community participation and health committees

Participation in health first came to the fore internationally in the Declaration of the Alma-Ata (WHO, 1978). It had global impact. For example, the successful community work orientated by Sidney and Emily Kark in South Africa during their work with health centers in Pholela and Lamontville in the 1940s where community health associations were formed. These community health associations at the time contributed positively to the health system (Kark, 1952). This was also during the time that 'people-centered' and 'participatory' forms of development were gaining prominence in the majority world countries (Chamber 1983; Kahssay and Oakley 1999). Participation manifests in different forms and despite some studies showing contribution to efficiency (McCoy, 2011) and cost-effectiveness, there remains little robust evidence of their impact on health outcomes (McCoy, 2011).

While there may be many forms of participation such as; through community-based organisation or non-governmental organisation, a mechanism that is appearing more recently in numerous health policies globally (Kamuzora, 2013) is that of health facility committees. The Literature infers that the clinic health committee structure is a formal strategy for health systems strengthening and health improvement (McCoy, 2011). There are several countries where these committees have emerged. In Tanzania for example, the formation of health committees or boards involving community representatives form an important part of health care planning and decision making within the decentralized district health care system, these committees have been instituted through the Local Government Urban Authorities Act of 1982 and Local Government District Authorities (Loewenson et al, 2014; Kamuzora, 2013). Similarly, India has laid down guidelines that guide specifics of community participation through village health committees (Colvin et al, 2010). Another example of formalized health committees is Zimbabwe where the National Health Strategy 2009-2013 even proposed investment in activities for health committees (Loewenson et al, 2014). In Uganda, the health

committees are recognised for supporting community outreach work, including patient follow-up at the grassroots level, mobilization of people to use services and support communication with the public (Loewenson et al, 2014). In Malawi, the health committees are considered a conduit for grievances in relation to performance of the health service while health action committees mobilize communities to participate in development projects at the health centre. For Zambia, Neighbourhood Health Committees (NHCs) were established through the National Health Service Act of 1995 to link the community and the health institutions. However, the National Health Act of 2005 dissolved the boards but health committees continue to exist informally despite their legal mandate being repealed (GoZ, 1996; Ngulube et al., 2004; TARSC; UNZA, 2011).

Health committees have been identified as a useful health governance structure and recognised as a vehicle through which community participation can be achieved in primary health care facilities (Loewenson 2000a; Padarath and Friedman 2008). The right to the highest attainable standard of health empowers rights-holders to demand accountability at national, regional and international levels (Potts, 2008a). Participation is linked to social accountability, by providing mechanisms through which community members can get involved in health care such as public hearings and mass social audits (Potts 2008b). Health committees are a platform which allows the process of participation through accountability to take place and led by community members who are the right-holders. Right-holders are entitled to have access to effective accountability (Potts, 2008a).

Community participation and Primary Health Care in South Africa

Legislative and policy context

South Africa has developed evolving legislative and executive measures to realize the benefits of community participation (Meyer, Pardue and London, 2012). The health system reform post-apartheid has been aimed at moving towards a decentralized district health system (DOH, 1997; Haricharan, 2014). Decentralization was suggested by the ANC government through the 1994 Reconstruction and Development Programme (RDP) in order to bridge the socioeconomic divide left in the wake of apartheid policies (Coovadia et al., 2009). The reason for shifting to a more decentralized district heath system was based on different factors including the principles of Primary Health Care, which places emphasis on a participatory systems for comprehensive care in accordance with international consensus stated in the Declaration of Alma-Ata (ibid; Meier et al., 2012).

In 1997, the White Paper on Transformation of the Health System reiterated South Africa's commitment to improve community participation with an emphasis on "fostering community participation across the health sector" (DOH, 1997) and establish practical mechanisms to improve linkages between community and health services system (Meier et al., 2012). Later, the National Health Act 61 of 2003 (DOH, 2004), formalized the establishment of health committees, hospital boards and district health councils and mentioned that each clinic/community health centre or a cluster of these should have a health committee consisting of one or more local councillor(s), the head(s) of the health facility/facilities, and one or more members of the community in the area served by the health facility/facilities (ibid). The Act also stipulates that the roles and functioning of HCs should be developed by respective provincial governments (DOH, 2004).

In 2008, as a response, the Western Cape provincial government developed a draft policy for health governance/community participation but it was never implemented (Western Cape

Draft Policy, 2008). In 2011/12 a decision was made not to implement the draft policy, but to rather amend the facility boards Act to give legislative effect to health committees (ibid). The policy environment in South Africa and specifically Western Cape Province certainly demonstrates a commitment towards aligning health services in a pro-participation approach. The Western Cape Province parliament enacted the Western Cape Health Facility Boards and Committees Act 4 of 2016 to provide for the establishment, functions and procedures of boards established for hospitals and committees established for primary health care facilities.[5]

Health Committees in South Africa

In South Africa, according to Padarath and Friedman (2008), clinic health committees should be seen as a critical part of the accountability process in health and are defined as; "part of the governance structures of the health facility and participate in needs analysis, planning, implementation and education of primary health care in the area". This is a starting point for encouraging participation in the provision of health care especially in a decentralized health care system such as that envisioned for South Africa (Padarath & Friedman, 2008). The idea of participation appears largely in a policy paper called the White Paper on Transformation of the Health System by Department of Health (DOH, 1997), which points out that active participation is a crucial in achieving the goal of implementing a primary health care based approach (DOH, 1997).

According to Haricharan (2014), she states that "the White Paper conceives that participation entails that communities are involved in 'various aspects of the *planning and provision* of health services' (DOH, 1997). It also emphasizes the importance of establishing mechanisms to improve accountability as well as promote dialogue and feedback between the public and health providers".

[5] The Act was enacted in 2016 after data collection was already conducted on the study

Community participation was formally recognised in South Africa as part of the health system reform post-apartheid in the National Health Act 61 of 2003 (DOH, 2004; Haricharan, 2014; Meier et al, 2012). The National Health Act presented provincial governments with the responsibility of establishing the specific roles and functions of health committees (Meier et al, 2012). In a review of policy framework for community participation in Western Cape Province of South Africa, Meier et al (2012), makes a note that, the presence of highly discriminatory governmental health services during the apartheid era led CSOs to develop health services independent of the government (ibid). The same author's further point out that through the development of Health Committees (HCs), civil society representatives monitored health in their respective regions and acted as a link between the community and health institutions, encouraging improved services as a part of national advocacy to enable equity in the South African health system.

The Western Cape community participation context

After the enactment of the National Health Act of 2003, South Africa's Western Cape policy makers started outlining provincial frameworks for community participation, with the roles and responsibilities of health committees formally proposed for the first time in 2008 in the draft policy framework for community participation/governance structures for health (Western Cape DOH, 2008), although it was never implemented (Haricharan, 2014; Meyer et al, 2012; DOH, 2013). The draft echoed the structures of the NHA, it also defined and described how each clinic in the province could develop a HC, composed of community members, ward councillor and the health facility manager (Western Cape Draft Policy, 2008; Meier, 2012). The NHA requires that the provincial governments must develop their legislation to stipulate the functioning and roles of health committees (DOH, 2004). It is important to note that the Western Cape Health Facility Boards and Committees Act was eventually promulgated in July, 2016 a period after which this study had been completed.

As described by Haricharan (2014) and Meier et al (2012) in their respective review of the Western Cape policy framework on community participation, at the moment, within the Greater Cape Town Metropole, community participation at the clinics and health centre is a three-tiered system. The first tier in constitutes the health committee. The second comprises eight sub-district health fora comprising representatives of all health committees in that sub-district. The final/third tier is composed of the Cape Metro Health Forum, made up by member of the eight sub-district health fora (DOH, 1997).

Training of Health Committees

Although the extent is not fully established, key literature illustrates that training health committees play a crucial role in contributing towards improved level of participation and realisation of the right to health (Loewenson, 2000). As pointed out by both Loewenson (2000) and Rifkin (2014) health committees empowered with information through training on planning, management, health information are more likely to actively engage with the provision of health care and improve health outcomes. Similarly, communities that lack the language, information, cohesion, organizational structures and capacities for effectively engaging in health structures can become disempowered and distrustful in the process (Loewenson, 2000b; Morgan, 2001).

For example, in Kenya, the Ministry of Health and Aga Khan Health Services (AKHS) jointly implemented an intervention consisting local communities forming dispensary health committees. The committee members were trained and progress was monitored during the pre and post-intervention period. Although this study did not have a control, the training was perceived to have an impact on HCs perceptions on participation. Health utilization and revenue generation increased in all clinics; weekend outreach services for the most distant villages were initiated; medicines became more readily available and village health workers were efforts were strengthened (Sohani, 2005).

In addition, a randomized control study in Uganda that measured and described the impact of community monitoring of public primary health care providers found that training of health committees had an impact on the level of community participation and improves health outcomes (Bjorkman & Svensson, 2009). Bjorkman and Svensson (2009) argued that training health committees can quicken the attainment of the right to health and improve community participation through empowering community members to act based on information about the function of the health care system.

More literature reveals that training of health committees on the right to health can make significant contributions towards improving the role that health committees play in community participation and enhance the process of creating more accountability in delivering health services (Institute of Rural Research and Development, 2010).

Conversely, it has been pointed out by some studies that failure on the part of the relevant health authority or CSOs to train and capacitate community members can lead to less than ideal community participation (National Progressive Primary Health Care Network, 1996).

It is further emphasized that building some form of capacity among the health committee members can be a vital step in ensuring improved levels of participation. McCoy (2011 argues that through empowerment, health committees have the potential to be emancipatory (McCoy, 2011). This is further cemented by Ngulube et al (2004) in a study conducted with health committee members in Zambia, who state that fear of dealing with *educated people* [emphasis added] can be a significant barrier for the health committee members to participate at the health facility level. It further adds that lack of training or simply some capacity can lead to unclear understanding of committee member's roles and responsibilities and this may be the most enduring problem faced by the health system governance structure (Ngulube et al 2004).

IDENTIFICATION OF GAPS OR NEEDS FOR FURTHER RESEARCH

A study by Glattstein-Young (2010) indicates that some health committees in the greater Cape Town area were able to advance right to health and improve service delivery. She suggests in her study that benefits of community participation were greater for ‘stronger’ health committees. However, there is lack of robust research that is hinged in providing evidence for links between training of health committees and impact it has on community participation (Rifkin, 2014). The literature review reveals that existence of health committees in different countries around the world is meant to support the delivery of quality health care but previous research has not been conducted in Cape Metropole, or globally to examine the role training HCs plays on community participation and the influence it has on the health system reform in order to promote right to health. Based on the literature review, the effectiveness of HCs on community participation and how they compare with other participatory approaches was not clearly established. There was lack of evidence to establish how HCs’ as means of community participation compared with other participatory approaches such as community mobilisation and social audits. This study sought to understand the role training health committee members plays on community participation and realisation of the right to health.

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TITLE PAGE

Title: Training clinic health committees: a vehicle for improving community participation in health

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Training clinic health committees: a vehicle for improving community participation in health

Abstract

Objectives: In South Africa, and globally, community participation has become a key feature in the health system. In order for meaningful participation to occur within the health system several mechanisms have been identified as critical and this includes formation of health committees (HCs) at health facility level. Previous research indicates that health committees are imperative in both actualizing community participation and realisation of right to health. However, few studies have been undertaken to understand the impact training health committees has on community participation and right to health. This study sought to evaluate the impact training clinic health committees in community participation, health and human rights has on participation and right to health. The training been evaluated was led by Learning Network on Health and Human Rights and targeted four clinics in Cape Town Metropole of Western Cape, South Africa. The Learning Network is a grouping of five civil society organisations (CSOs) in Western Cape, South Africa at four universities which was launched in 2008 after the recognition of a gap in documented knowledge that CSOs had on health and human rights. The study explored health committees' changes in knowledge, perceived competencies, documented member's understanding of roles and HCs sustainability as well as the trainings impact on relationship between HCs and health service providers.

Methods: The study was a multiple case study with multiple qualitative methods for data collection. Narrative data was collected through twelve in-depth interviews with health committee members, one facility manager, two focus group discussions and three physical observations across four health facilities. Health facilities were purposively selected from a list of health facilities trained by the Learning Network in 2014. Inclusion criteria also included English speaking health facilities and those in close proximity to each other.

Results: The study revealed that training HCs contributed to improved competencies, awareness and knowledge of community participation and the right to health. After the training, HC members were perceived to be more aware and responsive to their roles and responsibilities at the health facility. It was also noted that the training aided improved HCs perspectives on sustainability and roles, improved interpersonal skills and self-esteem. Conversely, the study revealed that despite the training improving participation and right to health, power imbalances between HC members and facility staff/managers who hold authority has a bearing on when and how participation occurs.

Conclusion: The study demonstrates that training health committees contributed to improving the levels of community participation such as planning, consultation and advise [Arnstein, Rifkin and Loewenson] in the realisation of right to health. It is recommended for wider community participation that training of such magnitude is conducted together with facility managers/staff.

International framework

Health systems research has long placed importance on participation [1]. The right to health in health systems re-engineering has also grown in prominence [2] and forms a core principle of health governance [3]. The right to the highest attainable standard of health was first outlined in the World Health Organization's (WHO) constitution of 1946 and has been reaffirmed in international human rights law through the bill of rights [4] and recurred in the Declaration of Alma-Ata [5].

The highest attainable standard of health is clarified in General Comment 14 of Article 12 of the International Convention on Economic Social and Cultural Rights (ICESCR) [3]. General Comments (GC) are United Nations authoritative interpretations of individual human rights or of the legal nature of human rights obligations. The General Comments provide orientation for

the practical implementation of human rights and form a set of criteria for evaluating the progress of states in their implementation of these rights. Critical imperatives for progressive realisation of the right to health are outlined in this GC with recognition that certain rights cannot be fully attained. The ICESCR, GC 14 (Article 12) points out that States Parties must show deliberate and tangible actions that demonstrate commitment to its obligations under the convention [3]. Further, the GC 14 points out that right to health is not just about health but should include "underlying determinants of health such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health". GC 14 also clarifies four critical principles by which progressive realisation of the right to health can be measured and these are; availability, accessibility, acceptability and quality of care. The general comment further elaborates that the population's participation in all health-related decision-making is important at all levels; community, national and international [3]. Participation in health first came to the fore internationally through the United Nations (UN) Declaration of Alma-Ata [5] adopted in 1978 which defines primary health care as "essential health care, based on practical, scientifically sound and socially accepted methods…accessible to individuals and families in their community through their full participation" [5]

Potts links participation to social accountability because it provides mechanisms through which community members can get involved in health care such as public hearings and mass social audits [6, 7]. Health committees are a platform that allows the process of participation to take place and to be led by community members who are the right-holders. Right-holders are entitled to have access to effective accountability [6, 7].

Health Committees as a form of community participation

Sidney and Emily Kark's [8] work in South Africa is one of the first documented examples of community participation. It documents the work that was done during their work with health centers in Pholela and Lamontville in the 1940s where community health associations were formed. These community health associations at the time contributed positively to the health system [8,9,10]. While there may be many forms of participation such as; through community-based organizations or non-governmental organizations, a mechanism that is appearing more prominently in recent health policies globally [11] is that of clinic health committees. McCoy [12] infers that clinic health committee structures are a strategy for health systems strengthening and health improvement [12]. For example, in Tanzania, health committees are a part of planning and decision-making as part of a decentralized district health care system instituted through the local government authorities [11, 12]. Similarly, India has established village health committees to support the provision of health services at health facility level while Zimbabwe, through the 2009-13 National Health Strategy, proposed investments in activities for health committees as a way of affirming the importance of community participation in realisation of the right to health [13]. Another example is in Uganda where health committees support outreach work, make patient follow-ups, and mobilize communities to access services and link health facilities with people. In Malawi and Zambia, health committees are considered as conduits for grievances and a link between community and health service providers respectively [14, 15, 16,17].

Loewenson [18] and Rifkin [1] point out that health committees empowered with information through training on planning, management, health information are more likely to actively engage with the health system through scrutinizing the provision of health care in order to improve health outcomes. Although the extent is not fully established, research illustrates that training health committees play a crucial role in contributing towards improved levels of

participation and realisation of the right to health [18]. Furthermore, communities that lack the language, information, cohesion, organizational structures and capacities for effectively engaging in health structures can become disempowered and distrustful in the process [19,20]. The aim of this paper was to evaluate the impact that training health committee members had on improving community participation as well as understanding how this contributed to the realisation of the right to health. The paper outlines the study context and barriers in participation. It utilizes a human rights framework to evaluate the role of the training.

South Africa legal framework

The right to health is outlined in the South African constitution (Section 27) [21]. It provides for the right to health of access to health services, social security, sufficient food and water. The constitution also provides for children with the right to basic nutrition, shelter, social services and health care services [21]. South Africa ratified the ICESCR in 2015 [22] and in addition the South African national constitution makes provisions for courts and tribunals to consider international law when interpreting the Bill of Rights [21,22]. Participation was first established in the White Paper on Transformation of the Health System [23], which points out that active participation is crucial in achieving the goal of implementing a primary health care based approach [24,25]. According to the White Paper, "participation entails that communities are involved in 'various aspects of the *planning and provision* of health services" [23]. It also emphasizes the importance of establishing mechanisms to improve accountability as well as promote dialogue and feedback between the public and health providers" [23:8].

Later, community participation was formally recognised in South Africa as part of the health system reform post-apartheid in the National Health Act 61 of 2003 [26]. The National Health Act (NHA) presented provincial governments with the responsibility of establishing the specific roles and functions of health committees [27]. Padarath and Friedman point out that clinic health committees are a critical part of participation in health and that they should be

considered as part of the governance structures of the health facility [28]. They further reiterate that HCs should be able to take part in needs analysis, planning, implementation and education of primary health care in their respective areas [28]. This is regarded as a starting point for encouraging participation in the provision of health care especially in a decentralized health care system such as that envisioned for South Africa [28].The policy and legislative context sets out a vision for HCs but the varied implementation of participation and forms of HCs is evidence of the contestation.

After the enactment of the National Health Act of 2003, South Africa's Western Cape Province, where this study was conducted, started outlining a provincial framework for community participation, with the roles and responsibilities of health committees formally proposed for the first time in 2008 in the draft policy framework for community participation/governance structures for health [29], although it was never implemented [24]. The draft policy echoed the guidelines in the NHA and structure for clinic health committee stipulated in the NHA, it also defined and described how each clinic in the province could develop a HC, composed of community members, ward councillor and the health facility manager [27,29]. In 2016, the Western Cape heath facility boards and committees Act was promulgated, but since this happened after the completion of fieldwork, it had no bearing on the training or research. Therefore, this research did not delve further into the contents of the Act.

Within the Greater Cape Town Metropole of Western Cape, community participation at the clinics and health centre is a three-tiered system. The first tier constitutes clinic health committees (also referred to as health committees in this paper) [24]. The second tier comprises eight sub-districts with representatives of all health committees in that sub-district [24]. The third tier is composed of the Cape Metro Health Forum, an umbrella body of all health committees, consisting of members of the eight sub-district health fora [24].

Research on Health Committes' barriers

Literature outlines several barriers that health committees are faced with. There is documented lack of interest from the community to be part of the HC and this affects the legitimacy of most committees and has a bearing on representation and consequently the sustainability of the committee's roles in the community [18]. Another barrier is risk of 'provider' bias and lack of community ownership, most health committee meetings take place at health facilities which may add influence from facility staff/managers [18]. In addition, committee meetings are generally irregular, poorly attended and face difficulty in retaining members due to lack of incentives and resources. Overworked health staff at clinic level often lack the time to provide oversight and support to HCs. The lack of oversight and support was identified as a key barrier to HCs level of participation. Health committees undertaking clinic responsibilities and unpaid roles at the clinic is regarded to undermine their ability to effectively oversee the performance of services in addition to lack of commitment from health care workers to HC meetings. Finally, limited or lack of cooperation with local government officials and facility managers also hinders HC ability to function effectively [15, 17,18].

Research on HCs and training

There is need for training health committees in participation and the right to health in order to have a positive impact on the health system [30]. Health committees empowered with information through training on planning, management, health information are more likely to actively engage with the provision of health care and improve health outcomes [1,31]. Similarly, communities that lack the language, information, cohesion, organizational structures and capacities for effectively engaging in health structures can become disempowered and distrustful in the process [20,32]. In a study in Kenya, HC training was found to lead to an increase in health utilization and revenue generation [33]. In Uganda, training has had an impact on improving community participation leading to improved health outcomes [34]. It

has been noted that training HCs can quicken the attainment of the right to health and improve community participation through empowering community members to act based on information about the function of the health care system [34].

Failure on the part of the relevant health authority or civil society organisations to train and capacitate community members can lead to less than ideal community participation [35]. It is further emphasized that building some form of capacity among the HC members can be a vital step in ensuring improved levels of participation. Through empowerment, HCs have the potential to be emancipatory [12]. Furthermore, lack of training or simply some capacity can lead to unclear understanding of committee members' roles and responsibilities and this may be the most enduring problem faced by governance of the health system [15]. The literature reveals that existence of health committees in different countries around the world is meant to support the delivery of quality health care but there is lack of research in the Cape Town Metropole, South Africa, or globally to examine the role training HCs plays on community participation and the influence it has on the health system in order to promote right to health [1]. This study sought to understand the training's impact on health committees' participation and its subsequent impact on the right to health.

Theoretical and Conceptual framework

In order to evaluate the impact of training health committees in health and human rights and community participation, a human rights based conceptual framework was utilized. The evaluation was for a training programme led by the Learning Network on Health and Human Rights. The training took place over three days and aimed at making sure that community members understand the legislation governing health in order to participate in strengthening the health system, exercise effective community participation and to recognise the right of community members to participate in their own health and the health of their communities. Furthermore, the training examined core functions of health committees in developing

partnerships with health facilities and the local governance structures responsible for delivering quality, health services. The training was conducted with four clinics in Cape Metropole of Western Cape, South Africa.

The theoretical framework for this study views participation as consisting of four principles of the right to health of availability, accessibility, acceptability and quality of care. Community participation in health is a contested concept [36] and has been defined differently by several authors. For the purpose of this study community participation, will be understood according to Loewenson [16:3] as "involving genuine and voluntary partnerships between different stakeholders from communities, health services and other sectors on shared involvement in, contribution to, ownership of, control over, responsibility, benefit from agreed values, goals, plans, resources and actions around health". A more broad view on participation has been discussed by Morgan [20] who identified utilitarian and empowerment models of participation [20, 36]. Among other critics, it is pointed out that neither of the two most widely used notions of participation call for it to be initiated entirely by community members [37]. Further, Rifkin [38] argued that the failure of community participation was largely due to unrealistic expectations, resulting from viewing participation as an intervention rather than a social process dealing with health problems created by poverty and inequality [38]. The empowerment model, which seeks to advance the agency of individuals and communities has also proven hard to implement [39] with this model being criticized for unrealistically assuming abilities of poor and marginalized communities and overlooking the broader social and political realities but justifying the role of training HCs to assist in advancing individuals' agency[36, 40, 41].

Attempts have been made to pin point the role of community participation in health by defining components that make-up 'meaningful' participation. Community participation ranges from

low or non-existent (where the community is not engaged), to high, ‘active and informed’ participation where the community has control over decisions and agenda setting [6,16].

The conceptual framework used in this research is based on a critical review of key literature and draws mainly on the definitions and concepts outlined by Arnstein [42], Rifkin [43] and Loewenson [16] on community participation. Meanwhile, the right to health is conceptulised according to the ICESCR [3] which outlines four guiding principles to understanding right to health; availability, accessibility, acceptability and quality of care.

Arnstein in her monograph *A ladder of Citizen Participation* [42], defines participation as citizen power on a ladder that represents different forms of participation with eight steps suggesting an increase in participants’ power. Arnstein specifies that ‘genuine participation’ is where partnership is formed and power holders agree to share planning and decision making responsibilities. This also entails the delegation of power and allowing of citizen control over plans and decision making processes [42]. Secondly, Rifkin et al [43], developed a continuum of participation which has two spectra (narrow at one end and wide on the other). The continuum desegregated into five components/indicators is used to analyse whether participation is comparatively wide or narrow. The suggested indicators on the continuum are: needs assessment, leadership, and organisation of the programme, management of the programme and resource mobilization [43]. The narrow end of the continuum indicates non-participation while the wide end indicates high level of participation. Rifkin et al [43] points out that in order to attain the highest level of community participation the following needs to take place; information sharing, mobilizing of communities, collaboration and empowerment of community members. This understanding of participation stresses the importance of empowerment [43]. Lastly, Loewenson [16, 44] argues that participation in health should be viewed as a process in the health systems rather than a one-off activity. She points out that the process should involve “genuine and voluntary partnerships between different

stakeholders from communities, health services and other sectors on shared involvement in, contribution to, ownership of, control over, responsibility, benefit from agreed values, goals, plans, resources and actions around health". It is further argued in her paper that participation within the health system can be realized through community engagement on health promotion, policy priority and standard setting, allocation of resources and monitoring of quality of care [16].

In this study the right to the highest attainable standard of health (also referred to as "right to health") is understood using the rights framework as outlined by the ICESCR [3]. According to the ICESCR, [3] the right to the highest attainable standard of health refers to the right to access health and underlying determinants. The ICESCR GC 14 points out four principles crucial in the realisation of the right of health; acceptability, accessibility, availability and quality of care. These four principles were utilized to conceptualise right to health in this study. Availability in this context refers to ensuring that health services are available in sufficient quantity. While accessibility relates to ensuring that health facilities, good and services are accessible to everyone without discrimination, having four overlapping dimensions of non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility (right to seek, receive and impart information and ideas concerning health issues). Acceptability is defined as ensuring that health facilities are respectful of medical ethics and are culturally appropriate. Finally, quality of care outlines the need for health care to be scientifically and medically appropriate and of good quality for example making sure that there is skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation [3].

Study purpose

This research explored the impact of the Learning Network training of health committees on community participation in the context of ongoing health systems re-engineering and promotion of the realisation of right to health. More specifically, the study sought to understand the impact training of HCs had on knowledge and competencies; perception on sustainability and interaction with health personnel. The findings are intended to contribute to the body of literature on the impact training HCs has on community participation and realisation of right to health.

Methods

The study adopted a multiple case study with multiple qualitative methods [45] to evaluate the impact of the Learning Networks training of Health Committees in Health and Human Rights on community participation and the realisation of the right to health in four health committees of Cape Town Metropole in the Western Cape, South Africa. The LN is a grouping of five CSOs in Western Cape, South Africa and four universities [46]. The LN was launched in 2008 after the recognition of a gap in documented knowledge that CSOs had on health and human rights [46]. The network has since engaged with CSOs in conceptualizing the right to health [46].

Data collection methods used to evaluate the impact of the training included in-depth interviews, focus group discussions and participant observation at the clinics through attending meetings. This was a descriptive multiple case study that sought to document the role of the Learning Networks (LN) training of health committees in Western Cape, South Africa. The intention of the training was to equip health committees with an understanding of legislation on health and human rights to enable their participation in strengthening the health system, recognition of their right to participate and exploration of core functions of health committees.

The training content was predominantly structured based on the contents of the South African National Health Act [26] and National Draft Policy on Health Governance Structures [29]. The training took place in 2014 (October-November) and the data was collected between December 2014 and April 2015 before the Health Facility Boards and Committees Act 4 of 2016 was promulgated by parliament in Western Cape.

Study Population

The study was conducted with health committees that had attended the health committee training organized by the Learning Network for Health and Human Rights (LN). The health facilities were selected from within the Cape Town Metropolitan area of Western Cape Province of South Africa. The study mainly focused on the following core groups that relate to the work of health committees (HCs) in the Western Cape, as follows; health committee members and health providers/facility managers/health personnel at respective health facilities.

Study Setting

The study was conducted with HCs from four health facility locations within Cape Metropole (Cape Town, South Africa). The facilities and their setting are described below (Figure 1):

Site	Description
1. Health Facility One (HF1)	Found in one of the poorest suburbs, to the south east of Cape Town. This clinic is managed by City Health and it has a full-time facility manager.
2. Health Facility Two (HF2)	Situated in a highly populated suburb, it is characterized by low-income and a history of high gang related violence. The clinic is managed by City Health and has a full-time facility manager.
3. Health Facility Three (HF3)	Situated in a partially informal, large and fast-growing township. The clinic is one of the three provincial government clinics in the area and has a full-time time facility manager.
4. Health Facility Four (HF4)	Situated in a coastal town and managed by the City of Cape Town, characterized by high turnover of managers. It is serving a less densely populated community.

Figure: 1*: List of health facilities*

Data collection and Sampling

Data was collected through 12 in-depth interviews, participant observations and 2 focus group discussions. The in-depth interviews and focus group discussions were conducted among all sampled committee members from the four health facilities. Observation notes were taken in the journal by the researcher. With consent, the interviews were audio recorded. The in-depth interviews were conducted using a topic guide developed with aid of the conceptual framework and contents of the learning networks training. Flexibility, allowed for probing topics that appeared during the interviews.

Data Analysis and interpretation

A thematic approach was adopted in collecting data and analysing interviews, focus group discussion and observation notes. Interviews were transcribed to produce transcripts of narrative text for thematic analysis. Data was analysed inductively and deductively using the conceptual framework that helped to understand and make the initial codebook for the findings that fitted in the key terms/categories/themes of community participation and right to health [42,43,16].

A coding system was developed based on what role the training of health committees in health and human rights played in community participation and the realisation of the right to health. Descriptive or open codes were developed through inductive analysis and used to identify themes, coding, recoding and classification by examining regularities, convergences, divergences in the data. The codes were thoroughly compared to the study purpose and research question to help shape into key categories of improved knowledge and competencies, perceptions on roles and sustainability of HCs and relationships between HCs and health facility staff/managers. Data was thereafter summarized and synthesized to retain as much as possible in terms of phrases and expressions of respondents [11] that correspond to key

categories reflecting the impact of training HCs on participation and on the realisation of the right to health.

Ethical Considerations

Ethical clearance was obtained from the ethics committee at the University of Cape Town Human Research Ethics Committee (HREC) reference number 634/2014 and permission was obtained from the Western Cape Department of Health. Written consent was obtained from all study participants. Participation in the study was on a voluntary basis and participants were free to withdraw at any time without penalty. Anonymity, giving pseudonyms to the participants and keeping transcripts in secure folders locked by passwords only accessible to the researcher was guaranteed for confidentiality. However, confidentiality for the focus group discussions could not be guaranteed. This was also explained and made clear to the participants.

Results

Training impact on knowledge and competencies of HCs

The research found different examples of how the respondents benefited from the training on health and human rights and the impact it had on individuals' and groups' capacity to participate at health facility level. Assertiveness was identified as a major skill gained among other skills such as leadership, confidence and critical thinking as a result of attending the training.

> *"The training was informative and it made us assertive and that is why we pushed for a health committee; there was no functional health committee at the other clinic. Because of the training, we knew exactly how to go about it [claiming to have a functional health committee] until this point"*— ***Health***

Committee Member, Health Facility 1 (Focus Group Discussion)

The health committee members who attended the training explained that they felt more confident about themselves after attending the training. They pointed out that their self-esteem improved after the training and that this 'empowerment' led to improved participation because they were certain of their involvement.

It was revealed during the research that the training encouraged participants to work closely with fellow health committee members in having a united 'voice'. It was said that the training helped them to realise the importance of speaking with one 'voice' and on behalf of others (including the community members) who could not approach health facility staff with complaints about services.

> *"Whoever has a problem, there is a box and patients can place their complaints which the health committee is in charge of reviewing"*-**Health Facility member (Health Facility 3)**

Furthermore, respondents expressed unity in dealing with challenges they face with health service providers whose behaviour they felt was not according to their expected standards as made clear during their training.

> *"We, as the committee, should be the voice of the voiceless, but the people are so used to being mistreated they take it as a given and don't see the health committee as an avenue that they can use to be treated with dignity and respect."*-**Health Committee Member (Health Facility 1)**

The health committee members that were interviewed reiterated the importance of the training in taking the responsibility to speak on behalf of other people within their communities as noted in the narrative below.

> *"She [one of the HC members] is the voice of the people that cannot talk due to the status in the community. She speaks for all of them this auntie…you*

can tell she's trained"— ***Health Committee Member, Health Facility 1 (Focus Group Discussion)***

As is clear from the quote above, speaking with one 'voice' was a common theme of expressing unity among the health committee members. They emphasized the importance of working together as key in building levels of participation at the health facility.

Training impact on roles and sustainability and levels of participation for HCs

The learning networks training resulted in participants embracing a form of participation consistent with the higher level of participation outlined in the conceptual framework described above by Arnstein [42], Rifkin [43], and Loewenson [16]. Participants in this study identified several aspects which confirms what the above authors conceptualize in their narrative of community participation such as involvement in planning and providing advice.

Involvement in activities at the health facility

It was said by the health committee members that the health committees training on human rights aided their clarification on involvement in activities at health facilities. Before the training, community participation was viewed by health committee members to be more about service delivery and less about accountability. As a result, before the training, the health committees were involved in various activities at the health facility such as cleaning at the health centre which can be considered to be a limited form of participation according to the conceptual framework. It was also heard that before the training, health committees adopted the role of caring for those that are neglected by the community as their way of participating in the health system. In all four health facilities in this research, heath committees sought clarity from their facility managers on whether they should be more involved in health promotion activities such as immunization, HIV awareness and community outreach activities after attending the training. The study revealed that involvement in activities was a major way

in which health committee members received recognition. As noted from the health committee members in the interview below, it was illustrated that the training eased duties sharing on activities between HCs and health facility staff.

> *"It is now easy to share tasks [activities]. That is why we work with the TB [tuberculosis] sister, not the whole clinic just the TB sister and, for instance, there's a child that doesn't come for immunization and they give us a referral slip to give to the mother and then the mother must come to the clinic with the child perhaps neglected to come the day they were supposed to come"*—**Health Committee Member (Health Facility 1)**

Participation through consultation

After attending the training, HC members expressed improved recognition of a need for them to be involved in decision making at the clinic compared to the period before they were trained. Consultation in the activities related to the health facilities was consistently demonstrated among health committees who were part of the research. As a result of the training, it was pointed out that some HC members disclosed being consulted on various decisions at health facility level and this was a result of having more awareness of clinic activities and their right to be part of decision making and agenda setting emanating from the training.

> *"After the training, we asked to be consulted and I have now been asked to join the nurses meetings, but that is just to express views if I have something"*—**Health Committee member (Health Facility 4)**

At one of the health facilities, the health committee chairperson explained that she is free to attend meetings with clinic staff at the health facility. It was further mentioned that the feeling of empowerment to freely express herself was a result of feeling confident enough due to the participation in the training.

> *"No decisions are made without me in any of the facilities, I have now been*

asked to join the nurses meetings…just to express if I have anything to say"—**Health Committee member (Health Facility 2)**

Before the training, heath committee members explained that they did not attend all meetings at the health facilities, but only gave their brief contribution on selected issues. This form of contribution was still considered by them (health committee members) as a way of participating, because they made their views heard. However, after the training, the health committee reported active involvement in meetings. With improvement in knowledge and awareness of roles and responsibilities, HC members reported being more confident to provide advise during meetings.

Participation through playing an advisory role

At health facility 1, a clear distinction between the role of the health committee and the staff was made through facility level guidelines. It was demonstrated during the study that health committees took up more of an advisory role after their training. Although the HCs did not have a role to play in most of the decisions made at the health facility, they provided their input through giving their thoughts and in that way helped influence decision making at the health facility level.

"Whenever they need advice [health facility staff], we are there to help; if they want to know what is going on in the community they ask us."—***Health Facility Manager (Health Facility3)***

When one of the members of the above mentioned health committee was asked if they contributed to the decision making process after the training, they lamented that they only gave opinions and ideas. This is stressed in the statement below.

"No, you can only give your opinion. Although the training helped us to know our role, you can only give your ideas during these meetings. That's all."—***Health Committee Member (Health Facility 3)***

In terms of services provided at the health facilities health committees mentioned that they could influence the decision on what services should be considered appropriate and culturally sensitive in their respective communities. At one of the health facilities, the facility manager gave an account of how the health committee would influence the decisions made around the kind of services made available to the community. The facility manager at this clinic expressed awareness of the expectation from the community on their role to influence decisions or provide advice on the services that can be made available better at their facility.

> *"We may decide Termination of Pregnancy as a service due to growth of people needing Termination of Pregnancy; but then the community can come and approach us to say we don't want Termination of Pregnancy, but instead we want the strengthening of Family Planning"*—***Health Facility Manager (Health Facility 3)***

At one health facility, the committee played an advisory role on the procurement procedures. Additionally, the health committee was given a responsibility to identify community members who could be employed on a part-time basis to help in building an extension for the clinic. When the secretary to this health committee was asked about this development, she responded with enthusiasm as she stressed:

> *"Truly speaking, we are getting closer [pause] in playing an advisory role, yesterday we had an opportunity to meet [give our advice] with this company that is an extending our pharmacy"*—***Health Committee Member (Health Facility 3)***

The HC at the abovementioned facility expressed confidence in building on their levels of participation due to the impact of the training in affirming their role at the clinic. The same health committee gave an account of providing advice during departmental meetings.

> *"We are part of each and every meeting as much as the department has its own plan on how to do the extension, but we feel that we are much more involved, we make decisions is terms of community participating in the development, in terms of people getting jobs even though not long term, but being labourers participating in this development"—**Health Committee Member (Health Facility 3)***

Participation through planning

Compared to the period before the training, there was evidence of community members taking part in planning through analysing tentative plans made by the health facility staff. The planning process at health facilities included making decisions on the budget, allocation of resources and administration related issues. Although this did not happen in all the health facilities, HF1 a health committee member recounted how they were part of the planning process.

> *"Yes, sometimes we can be part of the planning, but this because the health committee got its own space and the clinic got its own space. We can't just go, we need to hear from them; when we go to the meetings we hear from what they need [and] what they come up with so that we could also make our contribution"—**Health Committee Member (Health Facility 1)***

The researcher heard that the HC members in HF1 became more accommodating to work with staff at their health facility after they attended the training. It was further pointed out that the training did equip them with skills useful in planning and budgeting. They (HF1) noted that the training assisted in putting them on the same thought pattern with health facility staff.

Participation through delegated duties

Accounts of delegated duties were not prominent in the study, but one example in which delegated duties was verified was through health committees committing to ensuring the health facility had individuals that can perform duties when required.

> *"The management is supposed to attend their [health committee] meetings, in that way there's a two way communication; if she's [sister-in-charge] having a time share or she needs people to go out in her area, she can ask for the assistance and it will be given to her"—**Health Committee Member (Health Facility 4)***

Participation through Citizen Control

There was an isolated case in which a health committee demonstrated the highest form of participation through control over decisions at health facility level after receiving the LNs training. At HF3, the health committee was involved in identifying a problem and made all key decisions in dealing with the challenge. The clinic initially had a break-in and without a budget allocation from the Department of Health or health facility, the health committee decided to be part of the solution by approaching the department of health and asking that their clinic is made more secure. The interviewees pointed out that this level of vigilance was not experienced before attending the training.

> *"It was a decision we had to take at that level to say we want to have security 24 hours and we want to have a system where people will be searched when they are entering the premises. I don't think we would have been this serious if it was not for the training"—**Health Committee Member (Health Facility 3)***

Impact of training on interaction between HCs and health personnel

Good relationships

Members of all four health committees expressed the importance of a good relationship with the facility managers and staff at the clinic after attending the training. It was pointed out on several occasions that the training helped to improve the relationship with health personnel especially the facility manager. One key issue that was pointed out as helpful in improving the relationship was increased level of involvement of facility managers. In one health facility, health committee members reported having an accommodating facility manager.

> *"This manager is perfect, there is no problems with her, she's really top-notch, I don't have a problem so far"-**Health Committee Member, Health Facility 1 (Focus Group Discussion)***

Having a good relationship with the facility managers assisted in providing more transparent conversations between the health facility and the health committees.

> *"We can speak about anything, we can ask them advice and they can ask us advice and whatever, but we are there to help each other. That is what community work is all about to help each other and to see to everything that needs to be done"— **Health Committee Member, Health Facility 1 (Focus Group Discussion)***

The facility manager who was interviewed on the study was quick to mention that one of the reasons for the good relationship was the keenness by HCs and facility staff to collectively keep communities updated and maintaining cultural sensitivity and relevance.

At one of the health facilities, it was mentioned that after training, the relationship had improved because of good communication and clarification of roles and responsibilities. In addition, the improved relationship seemed to affect the level of engagement between health committee and facility manager.

> *"So after the training we had a good relationship, before we were just coming in, seeing floors that are not swept and complaining in front of the patients. Now after the training we had ways of approaching things, when we see something wrong we just don't shout on the spot, but we find ways of how to engage and we have to go to the facility manager"—**Health Committee Member (Health Facility 3)***

In another case, good relationship with the clinic staff meant that the health committee was available to participate in any activities that the facility required. Overall, good relationships existed in the health facilities, which all four health committees attributed to the impact of the training.

> *"We now have a very good relationship with the clinic, so whenever they need us for anything, they know they can call us and whenever we need them we can also call on them" – **Health Committee Member, Health Facility 1 (Focus Group Discussion)***

Poor relationships

It is imperative to take note that despite observing and hearing participants recounting good relationships with facility staff and managers after the training, there was an account of a poor relationship affecting one health committee's level of participation. Participants at the facility recounted lack of commitment from the facility manager to work with health committee.

> *"There was no relationship because the facility manager, she wasn't receptive of the idea of having a health committee, she was not welcoming of a health committee"- **Health Committee Member, Health Facility 2 (Focus Group Discussion)***

It was not clear what led to the facility manager's lack of support for HC but during the discussion it was discovered that the named facility frequently changed facility managers which led to lack of consistence.

Training impact on enablers and inhibitors of community participation

Facility manager understanding of roles

Although the facility manager who was interviewed did not attend the LN training at the time the research was conducted, he pointed out that health committee members exhibited a good understanding of their roles after they attended the training. It was pointed out that after the training, HC members demonstrated an adeptness to participate. The manager expressed clear awareness of roles and expectations of health committee members due to an information session he had with the HC after their training. The awareness of these roles by the manager seemed to spur motivation among the health committee members to fully participate.

> *"You could say, (I) am more a coordinator. My role is of coordination and it is supposed to be community driven and I am an ex-officio and am just there to advice or facilitating. The health committee has been well informed on their role and now they share with us [facility staff]"*—***Facility Manager (Health Facility 3)***

Improved communication

Communication was cited as a major area of improvement after attending the training. It was pointed out that having adequate knowledge about processes was not good enough to improve participation and that for HCs to be effective; members needed to communicate properly.

> *"Overall, it is how they communicate, how to make effective communication in those meetings, The training was important in helping with this and it makes it easier now"*—***Health Committee Member (Health Facility 3)***

Some of the health committees expressed concern that before the LN training they did not know what communication channels they were required to follow when communicating with staff and colleagues at their clinic. They indicated that lack of awareness of the processes contributed to their low level of participation. However, they were quick to point out that the

training assisted in their awareness of the organisation structure, the hierarchies and the appropriate channels of communication.

> *"Before, I found to be a health committee member challenging, because you find that when you are a health committee member there are many things you are involved in; you must know a lot of things in your facility like the organigram, who is who, which channels you must make/use of/for communication. The training helped to bring clarity"—**Health Committee Member (Health Facility 1)***

Role of the training on Right to Health

Availability

There was improved awareness of making health services more available and in sufficient quantity after attending the training. HCs explained how they got involved in ensuring that patients were receiving adequate amounts of health services.

> *"The people come here [to the clinic] month after month and they get the same service available for them. They [community members] are happy, because they have services for them when they need them."-* ***Health committee member (Health Facility 1)***

Accessibility

It was pointed out that after the training, health committee members were able to identify key challenges in accessing health facilities. One of the committees mentioned during a group discussion that they play an important role in ensuring non-discrimination of marginalized groups such as the elderly, children and the disabled at their health facility. It was further noted that HCs assist the elderly and children to access health services especially in facilities were long queues are prevalent.

"Sometimes people stand in the queues for medication, like the chronically ill patients; if we see it's an elderly persons or children with disabilities at the clinic then we always help and tell them what to do"- ***Health committee group discussion (Health Facility 1)***

It was further noted that HC members were more aware of the importance of information accessibility (providing information about health services available at the facility). As a result of the training, they were more confident to provide referrals to those accessing services.

"They can talk to us if someone needs help and we refer them, I know my area and everyone has their own area they can refer them to"- ***Health committee member (Health Facility 2)***

Acceptability

Health committee members reported that after the training, they became more aware of the need to support the respect for human rights and dignity of their community members accessing health services.

"They've got rights, rights to be treated fairly, right to be treated with dignity and respect and right to be cared for" ***Health committee member (Health Facility 4).***

In some instances, HC members outlined how the training assisted them in identifying key elements crucial to ensuring that health care services are acceptable. In the statement below, a member of a health committee points out the need to be respectful of medical ethics in delivering health services to the community.

*"When you go to the day hospital you have the right to be treated without discrimination. You have the right to get medicine from the hospital. We make sure they can't refuse to help you at any centre"-****Health committee member (Health Facility 4)***

Quality of care

Study findings did not fully point out ways in which health committees affected the delivery of scientifically and medically appropriate health services. However, the study points out some key efforts by HCs aimed at ensuring that staff personnel provided quality health services. After the training, HCs reported increased involvement in providing feedback to health service providers by being in charge of the suggestion box.

> *"I think the suggestion box- before we used to have tension. The facility manager demanded to keep the key and the HC member comes in only once in a week, but after the training we had a way of sitting down and saying for us to access the information in the suggestion box"*- ***Health committee member-(Health Facility 2)***

Discussion

The study provides a perspective on the role that training health committees plays in improving community participation and realisation of the right to health in Cape Town. The findings of the study are consistent with arguments framed by Arnstein [42], Rifkin [43] and Loewenson [16] that participation is influenced at various levels and among other factors includes relationships, information sharing, agenda setting, decision making and mobilization of resources. The study provides some evidence of some key contributions training health committees has on community participation and realisation of the right to health.

Further, the study revealed the importance of training health committees in 'empowering' members and improving their knowledge levels and competencies in order to meaningfully participate at health facility level. The study demonstrates the importance of improving interpersonal skills and self-esteem among health committee members in order to strengthen participation. Apart from providing insight into evaluating the impact that training health committees has on community participation and realisation of the right to health, this study

elucidates the role of the training on improving health committee members' preparedness to respond to participatory roles.

Involvement in activities at the health facility

All four health committees reported improved involvement in activities at health facilities as the major form of participation and realisation of the right to health after attending training. Involvement in continuous activities at health facility is consistent with Loewenson, who argues that participation in the health system should be a continuous process of engagement rather than a one-off activity [16]. Loewenson also adds that participation should be based on 'genuine' and 'voluntary partnerships'. Findings from this study point out that health committees do get involved in activities such as health promotion and information exchange. Although involvement in activities is a good step in ensuring that community participation is achieved, more is required for the community to 'have control' which is the ultimate goal of participation [16]. According to Loewenson, 'having control' which refers to deciding on what needs to be done and making key decisions in the process is the highest form of community participation [16]. Considering this definition of control, all four health committees were unable to demonstrate control over the health facility decision making process apart from one example where the health committee initiated the decision on securing the clinic after a break-in that happened at the clinic.

Information sharing

Loewenson [18] and Rifkin [1] point out that health committees empowered with information through training on planning, management, and health information are more likely to actively engage with the health system. Rifkin and Pridmore [47], also add that in order to facilitate meaningful participation, opportunities need to be created for those without power to gain knowledge, skills and confidence to take decisions that affect their lives [47]. The findings on

the study align with these principles by revealing the importance of sharing information with health committees. One element the study revealed is that health committee members grew in confidence after benefiting from information about their role and gaining knowledge on the health system, during the training. The growth in confidence could help HC members address power and authority imbalances between themselves as health facility staff and facility managers. All four health committee conclusively indicated that sharing information alone with health committees is not enough but should be complemented with other elements such as allocation of resources to put any plans into action. The importance of combining information sharing with other forms of empowerment was also highlighted by Rifkin [43] in her literature. She suggests that information sharing should at least be combined with mobilizing communities, collaboration and empowerment of community members to act [43].

Information sharing is a crucial step in ensuring that citizens become aware of their environment, but does not guarantee their contribution or control of situations. Bjorkman and Svensson [34] argue that training health committees can quicken attainment of the right to health and improve community participation through empowering community members to act based on information about the function of the health care system [34]. As shown in this study information sharing alone is not enough but should be paired with consistent empowerment of individuals within a social context. Rifkin [43] actually argues that participation should not be viewed as an intervention but rather as a social process dealing with health problems created by poverty and inequality. This is to establish that sharing information is a foundation for creating strong participation linkages but should not be a 'once-off' occurrence as pointed out by Loewenson [16] and Rifkin [43] but should be an integrated part of social interactions [16]. These arguments link well with the findings of this study as it perceives community participation to be an ongoing process that is or can be influenced by numerous factors and the interaction between these factors rather than a one off activity. The findings on this study have

confirmed previous study findings that sharing information is not the end of the process but the means to an end in community participation.

Allocation of resources and monitoring of quality care

Despite attending the training, the extent to which all four health committees exhibited levels of participation and realisation of the right to health seemed to be enhanced by the availability of resources and monitoring of health care provision in these sites. All the four health committees had individuals playing participatory roles. Although all the health committees referred to involvement in monitoring the delivery of health services, they were limited in their extent to contribute towards monitoring. One of the major challenges cited was the lack of resources (specifically funds) to aid transport for health committee members who live far from health facilities. It was understood, that the Department of Health in Western Cape previously allocated some funds to health committees, but with the absence of such funds, committee operations faced challenges in spreading their reach.

Relationship between the health committee and facility managers influencing participation

A consistently emerging theme from the study points to the importance of the training in creating or strengthening a good relationship between health committees and facility managers. In one facility, the manager had keen interest in working closely with the community. One of the reasons given by the manager at this clinic for such keenness was the importance of keeping communities updated, maintaining cultural sensitivity and being relevant to their needs. It was pointed out by the facility manager that the community was important in making some of the decisions on the kind of services that should be provided at the clinic. Health committees' roles and responsibilities were displayed in the clinic administrator's office at HF3, attesting to the importance of both 'parties' having awareness of roles as stressed by the training. Members are not just mediators and beneficiaries, but actors in driving the functioning of the health

system [48] and they should, therefore, be at the centre of the health system [49]. One other critical imperative to note in the relationship between HCs and facility managers is the power and authority imbalance. Findings seem to affirm the notion that facility mangers hold more power and authority in decision-making and agenda setting therefore interfering with some of the efforts by HC members.

Right to health

Training of health committees contributes to realisation of the right to health and to secure greater availability, accessibility, acceptability and eventually quality of care. Irrespective of location, HCs demonstrated a heightened level of interaction with facility staff to ensure that healthcare standards were not compromised. Of important note is the involvement of HC members in the collation of complaints and suggestions received through the suggestion box. This task featured consistently in all four clinics and HC members understood the critical role it played in maintaining non-discriminatory and medically sound services. All four clinics appreciated the efforts made by HCs to make health accessible. It was later reported that pilot trainings for health care providers were later conducted in May 2015, with a focus on immediate and short-term impact on health care providers' responsiveness towards health committees [50].

Study Limitations and Challenges

The major challenge of the study was related to logistics and inadequate funding for the study. The inadequacy led the researcher to leaving the field early. As a way of overcoming the challenge, the study sites were selected based on their close proximity to each other in order to minimize costs related to travel. Other challenges included difficulty in arranging meetings with health committee members who were either busy with full-time work or lived far from the clinic and required transport. In addition, due to the constraint in time and busy schedules,

only one facility manager was available for the interview out of a total of four facility managers. The findings on this study offers insight into evaluating the impact that training health committees has on community participation and realisation of the right to health. It also casts some light on the role of training on improving health committee members' preparedness to respond to participatory roles. The study used a purposive sample to identify four health committees, two from each of the predominantly Afrikaans/English speaking facilities in Klipfontein and West-sub-districts. Health committees that were not English/Afrikaans speaking were not included in this study because the researcher was not familiar with other languages and did not have enough resources to facilitate translation.

Conclusions

The study findings indicate similarities with ideas brought forward by Arnstein, Rifkin and Loewenson on forms and levels of community participation and the right to health according to ICESCR [16,42,43]. Based on the study findings, it was demonstrated that training health committees contributes to improving the levels of participation such as consultation and getting the health committees to provide advice to health facility staff. In addition, the study indicates that the training helps to improve HC members' individual and collective knowledge and perceived competencies in participation and right to health issues. The research further established that the training introduced new dimensions of the roles and responsibilities of health committee members. The training also had an impact on improving interpersonal skills, individual confidence and self-esteem among HC members. It was not clear from the study the extent to which training health committee members will sustain efforts of participation and right to health at health facility level. However, there seems to be enough evidence to indicate that training can positively impact HCs preparedness to respond to participatory roles and responsibilities as well as contribute towards community participation and right to health. The

training managed to clarify HCs' roles and responsibilities to the HC members, but in order to foster adequate levels of participation and realisation of right to health, there is need to consider having similar trainings for facility managers and staff[6]. Finally, it would be crucial for the Learning Network to think about having refresher courses to keep the Health Committees abreast with changes in policies and strategies around community participation.

[6] It must be noted that a training for health facility managers led by the Learning Network took place in 2015, but this was after the field work for this study was completed and therefore the study did not make reference to it.

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Part D: Appendices

APPENDIX 1: GUIDE FOR JOURNAL

Manuscript Submission Guidelines

Journal of Health Services Research & Policy

CONTACT INFORMATION

Any correspondence, queries or additional requests for information on the Manuscript Submission process should be sent to the Editorial Office as follows:

Christine Rivett-Carnac

Editorial Administrator, *Journal of Health Services Research & Policy*

Department of Health Services Research & Policy

London School Hygiene and Tropical Medicine,

15-17 Tavistock Place, London WC1H 9SH, UK

Tel: +44 (0)20 7927 2107, Fax: +44 (0)20 7927 2701

Email: Christine.Rivett-Carnac@lshtm.ac.uk

8. Manuscript style

8.1 File types

Text files must be saved in .doc or .rtf format. Other suitable formats include .tif for photographic images, .xls for graphs produced in Excel, and .eps for other line drawings.

8.2 Journal Style

Title page

The first page should contain the full title of the manuscript, 3 keywords, the author(s) name(s) and affiliation(s), and the name, postal and email addresses of the author for correspondence, as well as a full list of declarations.

The title should be concise and informative, accurately indicating the content of the article.

Abstract

Original research and Review articles should include a structured abstract (objectives, methods, results, conclusions). Essays and Perspectives should include an unstructured abstract.

Tables and Boxes

Tables and Boxes should be out with the text. Tables must be prepared using the Table feature of the word processor. Tables should not duplicate information given in the text, should be numbered in the order in which they are mentioned in the text, and should be given a brief title.

Figures

Figures should be out with the text. All figures should be numbered in the order in which they are mentioned in the text. All figures must be accompanied by a figure legend. If figures are supplied in separate files, the figure legends must all be listed at the end of the main text file.

Line drawings should be produced electronically and clearly labelled using a sans serif font such as Arial. Graphs may be supplied as Excel spreadsheets (one per sheet). Other line drawings should be supplied in a suitable vector graphic file format (e.g. .eps)

All photographic images should be submitted in camera-ready form (i.e. with all extraneous areas removed), and where necessary, magnification should be shown using a scale marker. Photographic images must be supplied at high resolution, preferably 600 dpi. Images supplied at less than 300 dpi are unsuitable for print and will delay publication. The preferred file format is .tif.

Abbreviations

Symbols and abbreviations should be those currently in use. Authors should not create new abbreviations and acronyms. The RSM's book Units, Symbols and Abbreviations provides lists of approved abbreviations.

Units

All measurements should be expressed in SI units.

Statistics

If preparing statistical data for publication, please read the statistical guidelines (section 8.8).

8.3 Reference Style

Only essential references should be included. Authors are responsible for verifying them against the original source material. SAGE uses the Vancouver referencing system (http://www.uk.sagepub.com/repository/binaries/pdf/SAGE_Vancouver_reference_style.pdf): references should be identified in the text by superscript Arabic numerals after any punctuation, and numbered and listed at the end of the paper in the order in which they are first cited in the text. Automatic numbering should be avoided. References should include the names and initials of up to three authors. If there are more than three authors, only the first three should be named, followed by et al. Publications for which no author is apparent may be attributed to the organization from which they originate. Simply omit the name of the author for anonymous

journal articles – avoid using ’Anonymous’. Punctuation in references should be kept to a minimum, as shown in the following examples:

5. Handy CB. *Understanding organisations*. 3rd edn. London: Penguin, 1985
6. Hart E. Ghost in the machine. *Health Serv J* 1991;**101**:20–1

8.4 Manuscript Preparation

The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point.

8.4.1 Your Title, Keywords and Abstracts: Helping readers find your article online

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE’s Journal Author Gateway Guidelines on How to Help Readers Find Your Article Online.

8.4.2 Corresponding Author Contact details

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

8.4.3 Guidelines for submitting artwork, figures and other graphics

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE’s Manuscript Submission Guidelines.

Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

8.4.4 Guidelines for submitting supplemental files

This journal is able to host approved supplemental materials online, alongside the full-text of articles. Supplemental files will be subjected to peer-review alongside the article. For more information please refer to SAGE's Guidelines for Authors on Supplemental Files.

8.4.5 English Language Editing services

Non-English speaking authors who would like to refine their use of language in their manuscripts might consider using a professional editing service. Visit English Language Editing Services on our Journal Author Gateway for further information.

APPENDIX 2: Information Sheet

Greetings. Thank you for sparing the time to speak with me.

My name is Nkandu Chikonde and I am a Masters student from the University Of Cape Town (UCT). As part of my Master's degree in Public Health, I am doing a study about the role of training community health committees on improving community participation in the delivery of health services. I am inviting you to be part of this study.

I will go through this information sheet with you, so that you may know more about the study before you decide to participate.

The purpose of the study

The study is being done in order to evaluate the impact of the training of health committees on the right to health. You may be aware of the efforts in South Africa to improve health governance by introducing legislation and structures that improve community participation. The extent to which these efforts have been successful has not been fully established and this study will seek to understand how community health committees (HCs) can become effective and contribute towards an improved health system.

What do I hope to achieve from this study?

- To evaluate the impact of training on Health Committee members knowledge levels and competencies.
- To understand the change in perception on roles and sustainability of Community Health Committees among Health Committee members.
- To evaluate the relationship between Health Committee members and health service providers and their interaction with the health facility.

What research methods will be used?

If you agree to be part of this study, I would ask you to complete the consent form that is attached. I would then conduct an interview for about an hour with you to get some detailed information about the role of training community health committees in improving community participation and the right to health. Occasionally I would be gathering information based on my observation of the health committee training and interaction of health committee members with the heath facility personnel/staff.

The information you will give me will be confidential and will be recorded in a manner that protects your identity. No participant names will appear in this study. All the information collected will be put together to write a report for my dissertation.

What are the benefits of the study?

You will not receive money or material rewards by participating in the study. However, we anticipate that the findings from this study will provide information that can be used to improve the relationship between communities and health services.

What are the harms/risks to you by participating?

There are no anticipated harms/risks to you as a participant. However, if you encounter any problems during the study, let me know as soon as possible, through the contact details I have provided below.

Do I have to take part in this study?

No. You can decide to stop being part of the study at any time. Just tell me and there will nothing wrong with that. Also note that you will not be treated any different because you decided to stop being part of the study.

Consent to participate:

Please read the consent form and if you are willing to take part in the study as a participant, we will ask you to sign it as an agreement to participate. Thank you.

Contacts:

Nkandu Chikonde	Mobile: +27 (78) 925 9932
(Researcher- Masters Student, UCT)	Email: nkanduchikonde@gmail.com
Maria Stuttaford, PhD	stuttafordm@cardiff.ac.uk
(Research Supervisor)	
Hanne Haricharan	hanne.haricharan@uct.ac.za
(Research Supervisor)	

Further questions about your rights or welfare in the study may be directed to the Health Research Ethics Committee on the following details:

University of Cape Town, Faculty of Health Sciences

Room E52-24 Old Main Building

Groote Schuur Hospital

Observatory 7925

Telephone (021) 406 6338

Email: shuretta.thomas@uct.ac.za

APPENDIX 3: Consent form

Focus group consent form

I agree to participate in a research study by *Nkandu Chikonde* from the University of Cape Town. The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily. I understand that I will not be paid for my participation. I may withdraw from and discontinue participation at any time without penalty.

I give permission for my interview with *Nkandu Chikonde* to be audio-recorded (please tick). Yes □ No □

I understand that my name will not be used in any report that is published.

I understand that the discussion will be kept *strictly confidential* and the other Health Committee members in the group will be asked to keep what we talk about private, but this cannot be assured.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box :)

I agree to quotation/publication of extracts from my interview □

I do not agree to quotation/publication of extracts from my interview □

I have read and understood the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

I have been given a copy of the consent form.

Participant's signature:

____Date ______________

Participant's name:

____Time ___________ __

(Capital letters only)

Investigator's signature: ______________________________Date ______________

Investigator's name: NKANDU CHIKONDE Time

____

(Capital letters only)

Individual interview consent form

I agree to participate in a research study by *Nkandu Chikonde* from the University of Cape Town. The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily. I understand that I will not be paid for my participation. I may withdraw from and discontinue participation at any time without penalty.

I give permission for my interview with *Nkandu Chikonde* to be audio-recorded (please tick). Yes □ No □

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box :)

I agree to quotation/publication of extracts from my interview □

I do not agree to quotation/publication of extracts from my interview □

I have read and understood the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

I have been given a copy of the consent form.

Participant's signature:

____Date_______________

Participant's name:

____Time ____________

(Capital letters only)

Investigator's signature:

____Date______________

Investigator's name: NKANDU CHIKONDE **Time______________**

(Capital letters only)

APPENDIX 4: Interview guides

A. In-depth interviews: Key stakeholders/informants

Introduction

- Thank the participant for taking part in the research.
- Introduce self to the participant and mention that the interview will last 1 hour.
- Explain purpose of the interview and ask for consent (signing).
- Ask the participant to say something about themself.

Perception about the training of Health Committees

- Respondents general thought on whether the training is relevant or not. Is it effective and at what level?
- Thoughts on the trainings value addition of towards HC participation/ does the training make any changes in community participation? Any improvement examples that can be mentioned? Changes in their own and their Health Committees participation or attempts to participate differently.

Perception on the roles and sustainability of Health Committees

- What do you consider to be the role of HCs? Is this what is happening at your health facility? Please give reasons? How does this link to the training by the Learning Network?
- What are your views on the sustainability of HCs at the facility? What can be done to improve or ensure sustainability? Do you think the LN training has influenced this?

Community participation

- What do the HC members do? Activities (planning, implementation, monitoring, control activities)?

- How would you describe the relationship/interaction between the HCs members and facility managers/staff/service providers? Does it signify freedom to exchange ideas and plans?

Access to health committees

- Setting up of meetings with facilities and other key informants
- Contact details for the HCs and key informants
- Access to health facilities and communities by the researcher

Thank you for taking part in the interview. The findings will be put together as soon as possible. Would you be available for follow up question if necessary?

B. In-depth interviews: Health Committee members/Health Service providers

Introduction

- Thank the participant for taking part in the research.
- Introduce self to the participant and mention that the interview will last 1 hour.
- Explain purpose of the interview and signing of consent.
- Ask the participant to say something about themself.

Description of the Health Committee

- Composition of the HC. Who are the members of the HC?
- How long has the HC been actively existing at the health facility?

Knowledge levels and competencies gained from the training

- Examples of newly acquired information/how different are it from the knowledge before?
- Understanding of effective HCs/ what is it? Understanding of leadership, community participation in health systems, democracy health and human rights?
- What activities have HC members engaged in before and after the training?
- Examples of change in skill set to participate.

Understanding of roles and the sustainability of HCs

- What do you view as the purpose/role of the HC? Has this changes since the training?
- Has the HC ever been involved in planning, implementation, budgeting or monitoring of health services/activities/programmes? If yes, how has this been happening?
- Have you been involved since training/are you attempting/planning to get more involved? Why? Why not?
- Do you think the HC should continue playing this role? Why or not?

- Do you think the role of HCs is sustainable? Why? How has the training influenced this?

Community participation and ownership

- What is the frequency of interaction/contact between HC members and health providers? What has been the purpose of the interaction?
- Has there been any changes in the level of interaction in the past three months? What could this change be attributed towards?
- How often do the HC members meet and who attends these meetings? Are there any minutes available for the meetings?
- How would you describe the relationship with the service providers/HC members? Reason for the description? Has there been any changes since the training?

Factors influencing the participation of HCs in health activities at the facility

- Who sets the agenda at the facility? Who makes decisions? How are decisions made? What is discussed at HC meeting?
- How do you feel about how you set the agenda/make decisions at the facility with staff/facility manager? Why this response?
- How do facility managers/staff feel about involvement of HCs?

Enablers of community participation and the right to health

- What sorts of things make the HC operate the way it does?
- What are some examples of what your HC has done at the health facility?
- What are the activities that the HC is busy with/working on? What is the level of influence on decisions at the health facility?

Conclusion

Thank you for your participation, do you have any questions for me about what we discussed or the way forward after the study?

C. Focus Group Discussion (FGDs)

Introduction

- Thank the group for taking part in the research.
- Introduce self to the group and mention that the interview will last 1 hour.
- Explain purpose of the group interview and deal with some basic ground rules.
- Get consent (signing).
- Ask the participant to say something about themselves.

Knowledge levels and competencies gained from the training

- Examples of newly acquired information/how different are it from the knowledge before?
- Understanding of effective HCs/ what is it? Understanding of leadership, community participation in health systems, democracy health and human rights?
- What activities have HC members engaged in after the training?
- Examples of change in skill set to participate.

Understanding of roles and the sustainability of HCs

- What do you view as the purpose/role of the HC?
- Has the HC ever been involved in planning, implementation, budgeting or monitoring of health services/activities/programmes? If yes, how has this been happening?
- Do you think the HC should continue playing this role? Why or not?
- Do you think the role of HCs is sustainable? Why?

Community participation and ownership

- What is the frequency of interaction/contact between HC members and health providers? What has been the purpose of the interaction?

- Has there been any changes in the level of interaction in the past three months? What could this change be attributed towards?
- How often do the HC members meet and who attends these meetings? Are there any minutes available for the meetings?
- How would you describe the relationship with the service providers/HC members? Reason for the description?

Factors influencing the participation of HCs in health activities at the facility

- Is there a mechanism for facility managers to deliberately include HCs in agenda setting/decision making.
- How do HCs feel about participation levels at the facility by staff/facility manager? Why this response?
- How do facility managers/staff feel about involvement of HCs?

Enablers of community participation and the right to health

- What sorts of things make the HC operate the way it does?
- What are some examples of what your HC has done at the health facility?
- What are the activities that the HC is busy with/working on? What is the level of influence on decisions at the health facility?

Thank you for taking part in the study, please do not hesitate to let me know if you have any questions.

APPENDIX 5: UCT ETHICAL APPROVAL

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

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

29 August 2014

HREC REF: 634/2014

Dr M Stuttaford
Public Health & Family Medicine
Falmouth Building

Dear Dr Stuttaford

PROJECT TITLE: EXPLORING THE ROLE OF THE LEARNING NETWORKS TRAINING OF HEALTH COMMITTEES IN HEALTH AND HUMAN RIGHTS ON COMMUNITY PARTICIPATION AND THE REALIZATION OF THE RIGHT TO HEALTH IN WESTERN CAPE? (Master's candidate-N Chikonde) sub-study linked to 179/2007

Thank you for submitting your sub-study to the Faculty of Health Sciences Human Research Ethics Committee for review.

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

Approval is granted for one year until the 30th August 2015.

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)

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

We acknowledge that the MPH student, Nkandu Chikonde will also be available in this study.

Please quote the HREC reference no in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS
Federal Wide Assurance Number: FWA00001637.

HREC 634/2014

APPENDIX 6: CITY OF CAPE TOWN ETHICAL APPROVAL

CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

CITY HEALTH

Dr Hélène Visser
Manager: Specialised Health

T: 021 400 3981 **F:** 021 421 4894 **M:** 083 298 8718
E: Helene.Visser@capetown.gov.za

2014-12-09

Re: Research Request: Exploring the role of the Learning Networks training of Health Committees in Health and Human Rights on community participation and the realization of the right to health in Western Cape? (ID NO: 10462b)

Dear Nkandu Chikonde,

This is an amended letter as per your request to swop Silvertown Clinic to Manenberg Clinic.

Your research has been approved for recruitment from the City Health facilities mentioned below. However, these Health Committees may not have been fully functional/ participated in the Learning Networks training and it may not be possible to recruit to the full sample size of 40.

Mitchells Plain Sub District: Contact People	**Eastridge Clinic** Mrs S Elloker (Sub District Manager) Tel: (021) 391-5012/ 084 222 1478 Mrs N Nqana (Head: PHC & Programmes) Tel: (021) 391-0175/ 084 2221489
Southern Sub District: Contact People	**Strandfontein Clinic** Mr M Cupido (Acting: Sub District Manager) Tel: (021) 710-8295/ 084 2200 145 Mrs B van Niekerk (Head: PHC & Programmes) Tel: (021) 710-9383/ 082 821 7361
Klipfontein Sub District: Contact People	**Manenberg Clinic** Mr K Nkoko (Sub District Manager) Tel: (021) 630-1667/ 082 433 1332 Mrs T Nojaholo (Head: PHC & Programmes) Tel: (021) 630-1626/ 084 220 0133

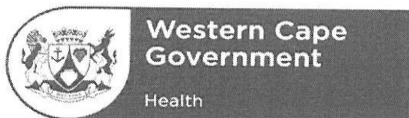
Please note the following:

1. All individual patient information obtained must be kept confidential.
2. Access to the clinics and its patients must be arranged with the relevant Managers such that normal activities are not disrupted.
3. A copy of the final report must be sent to the City Health Head Office, P O Box 2815 Cape Town 8001, within 6 months of its completion and feedback must also be given to the clinics involved.
4. Your project has been given an ID Number (10462b). Please use this in any future correspondence with us.
5. No monetary incentives to be paid to clients on the City Health premises.

CIVIC CENTRE IZIKO LOLUNTU BURGERSENTRUM
HERTZOG BOULEVARD CAPE TOWN 8001 P O BOX 2815 CAPE TOWN 8000
www.capetown.gov.za

Making progress possible. Together.

APPENDIX 7: DEPARTMENT OF HEALTH EHICAL APPROVAL-WESTERN CAPE GOVERNMENT



STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE WC_2014RP19_980
ENQUIRIES: Ms Charlene Roderick

University of Cape Town
Faculty of Health Sciences
Anzio Road
Observatory
Cape Town
7935

For attention: **Mr Nkandu Chikonde, Dr Maria Stuffaford and Ms Hanne Haricharan**

Re: EXPLORING THE ROLE OF THE LEARNING NETWORKS TRAINING OF HEALTH COMMITTEES IN HEALTH AND HUMAN RIGHTS ON COMMUNITY PARTICIPATION AND THE REALIZATION OF THE RIGHT TO HEALTH IN WESTERN CAPE?

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Albow Gardens CHC	**L van Wyk**	**Contact No. 021 514 6512**
Gugulethu CHC	**L Makamba**	**Contact No. 021 637 1280**
Hanover Park CHC	**G van der Westhuizen**	**Contact No. 021 692 1240**
Heideveld CHC	**A Eksteen**	**Contact No. 021 638 3202**
Nolungile CHC	**G Viana**	**Contact No. 021 387 3230**
Khayelitsha Site B CHC	**D Binza**	**Contact No. 021 360 5208**
Woodstock CHC	**E Vosloo**	**Contact No. 021 460 9189**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR J EVANS
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 18/12/2016

CC	**K GRAMMER**	**DIRECTOR: SOUTHERN / WESTERN**
CC	**A HAWKRIDGE**	**DIRECTOR: KHAYELITSHA / EASTERN**
CC	**P OLCKERS**	**DIRECTOR: MITCHELLS PLAIN / KLIPFONTEIN**

APPENDIX 8: SAMPLING PROCEDURE

Study participants attributes			
Clinic	Gender	Position	Attributes
Site A	Female	Chair	Was elected as chairperson in 2014 but has been a HC member for over 10 years and acting a health care worker at the facility
	Female	Member	Used to be a very active HC member but after suffering a stroke could not be as active but actively participating now(again)
	Female	Member	Member of the HC for 5 years, serving at the clinic and partly employed with an NGO to help with community mobilization for awareness campaigns and research at certain times.
	Female	Member	Joined the HC in 2014
	Female	Member	Joined the HC in 2014
	Female	Member	Joined the HC in 2014
	Female	Member	Joined the HC in 2014
Site C	Male	Chairperson	Chairperson of the health committee since been elected in 2010 and active member of the health forum. Has a good understanding of the health issues in the community and comes from a social worker background before joining and service on the HC.
	Female	Committee secretary	Previously a member of the Treatment Action Campaign community mobilization team, was identified to become part of the HC and later elected to be secretary. Also serving as an active member of the HF.
	Male	Member	Over 10 years of working on community and health related issues with other organisations and currently building a livelihood community youth project focusing on young people from churches and HIV. Also employed by a local business to help with community liaison.
	Female	Member	A member of the PopART research as a community mobilization contact. New on the HC, only joined in 2014.
	Male	Facility manager	Has been at the facility for the past 3 years and was trained as a Nurse and later in Management. He is not working as a nurse but managing the facility. Having previously managed another health facility, he has a long relationship of understanding and helping to coordinate health committees (HCs).
Site B	Female	Chairperson	Serving a HC member for 8 years and active in community mobilization.

	Female	Secretary	Member of the HC since 2010, has keen interest in furthering studies especially after the LN training. Wants to study human resource.
	Female	Member	Works as a health care worker at the nearby day hospital with HIV and TB patients. Active as a health HC member for 4 years.
Site D	Female	Chairperson	Has been on the HC for 20 years and participated actively at the health centre and community. Owns a crèche within the community.
	Female	Member	Has been a member for 15 years and previously served as secretary for the HC.
	Female	Member	Has been an active member for 20 years at both the facility and in the community

APPENDIX 9: INITIAL CODE BOOK/FRAMEWORK

Name	Code	Definition	Example	When to use it
Has control	Control	Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help each step to accomplish goals.	Health committee member have been involved setting the agenda, execution and given a degree of power to make key decisions	When there has been a clear indication of the health committee/member having a degree of control over events at the health facility.
Has delegated power	Delegate	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept.	Evidence of clear guidelines at the health facility providing the health committee with specific decisions that they can make.	When the guidelines are available, practical and understood by the health committee members.
Plans jointly	Plans	Organisation presents tentative plan subject to change and open to change from those affected. Expect to change plan at least slightly and perhaps more subsequently.	Health facility has evidence of collaborative decisions.	When the health committee has been a part of changing or altering plans at the health facility.
Advises	Advises	Organisation presents a plan and invites questions. Prepare to modify plan only if absolutely necessary.	Health committee provides frequent views/opinions.	When there is evidence of health committees been accorded an opportunity at the health facility to ask questions about plans provided and when this results in

				modification of decisions.
Is consulted	Consult	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be accepted.	Health committee informed of plans in order to 'tick' boxes of having laid out ideas to community members	When there is evidence of community member getting informed about plans before they are concluded in order to make a final decision.
Receives information	Infor	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.	Health committees informed about decision and they comply.	When there is evidence of health facility convening a meeting to inform the health committee of decision(s) made with an expectation of compliance.
None (no community participation)	None	Community told nothing.	No information is provided to the health committee about activities/decisions at the health facility.	When there is no information about decisions circulating to the health committee.

Appendix 9 was adopted from Loewenson, R. (2000) *Participation and accountability in Health Systems: The missing factor in equity?* Zimbabwe: TARSC.