RMCH
REDUCING MATERNAL AND CHILD MORTALITY THROUGH STRENGTHENING PRIMARY HEALTH CARE

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Audience: National, Provincial and District Departments of Health, Civil Society Organisations and other stakeholders interested in strengthening Clinic Committees and other community accountability mechanisms.

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Purpose of Document: This policy brief advocates for increased support from government to operationalise and strengthen Clinic Committees as accountability mechanisms to contribute to the health of mothers and babies.

Maximising the Potential of Clinic Committees as Community Structures to Promote Maternal, Neonatal and Child Health

Summary: *Clinic Committees are significant community governance structures with the potential to improve Maternal, Neonatal and Child Health (MNCH). This policy brief highlights key research on the functional limitations within Clinic Committees that hinder joint dialogue and action between the community and health care providers. Based on these research findings and observations in the field, this policy brief makes recommendations on addressing identified limitations within the broader health system, towards improving MNCH.*

KEY MESSAGES

Based on the research and data collected, as well as taking into account the decentralisation of the health system, the following key recommendations are put forward and are aimed at the different levels of government, to strengthen the functioning and potential value of Clinic Committees (CCs):

- **National government:**
- There needs to be stronger **leadership to operationalise national policy, legislation and strategy** to oversee and ensure the effective functioning of CCs, including a commitment to provide adequate financial support. It is further suggested that the latest 'Ideal Clinic' model about to be implemented (Ms Jeanette Hunter at UCT National Colloquium on Health Committees, 2014) include functional CCs as a measurement indicator.
- **Provincial government:**
- **Review and refine existing Clinic Committees policy and legislation**: The National Health Act (NHA) 2003 provides guidance for the development of policy and legislation at Provincial level and for Departments of Health (DoH) to ensure that all health facilities have functional Clinic Committees. In Provinces that have already developed policy/legislation, these need to be implemented accordingly. In some cases, where policy/legislation are incomplete or insufficient, Provinces need to urgently develop and refine policies and legislation on CCs. It is believed that developing legislation is preferable to policies as it provides stronger promise of enforcement.
- **District level:**
- **Prioritise training for CCs:** Effective training on the roles and functions of committees targeted at CC members (including health workers) should be given priority. Ongoing capacity building and mentoring should also be integrated into a training programme for CCs. Ensuring health workers (facility based and outreach) are included in this training will contribute to ensuring that CCs develop relationships at health facility level and therefore promote access, transparency and accountability.

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- **Provide Resources:** such as IEC material aimed at information and awareness-raising of the functioning and roles of CCs and to promote vigilance over election processes. This should include information aimed at the community as well as at health workers to raise awareness of the mandate of CCs. CCs also require access to basic infrastructure such as telephones, computers, internet and a meeting space to support their effective functioning, this could be provided at facility level. Providing refreshments at CC meetings was also found to motivate CC representatives and was met with appreciation.

- **At all government levels:**

- **On-going and effective monitoring:** is of utmost importance to ensure the status and progress of CCs is effectively managed. Designated officials should be in place at each tier of government to oversee the functionality of health governance structures including CCs.
- **Link CCs to relevant stakeholders to strengthen their social and political capital**: CCs would benefit by being connected to relevant government structures, civil society organisations and multi-stakeholder forums focussing on the social determinants of health. The strengthening of sub-district and district health forums is of particular importance so different CCs can be brought together to problem solve and share experience and resources together with other important stakeholders in the health system.
- **Commit to financing operating costs of CCs**: CCs need to be reimbursed for operating costs if they are to function effectively, in line with the NHA. Realistic costing and sufficient budget allocation for CCs needs to be included in overall budgeting exercises, filtering down from National to provincial, district and sub-district levels. It is recommended that CCs be financed not only for attending meetings but also to enable them to undertake monitoring and outreach activities to maximise their health promotion potential.

INTRODUCTION

Despite government and other stakeholders' commitment[1] to reducing mortality and morbidity amongst mothers and children, maternal and child mortality remains unacceptably high: one in 322 South African women does not survive pregnancy or childbirth, and one in 25 babies die before his or her first birthday[2]. Many of these deaths can be prevented through evidence-based, cost effective health interventions. Research attributes these statistics to two major challenges:

1. Limited or delayed uptake of essential MNCH services, especially by population groups that are historically disadvantaged, and
2. Limited capacity and motivation of health workers to adhere to national protocols and standards

(CARMMA, 2012)

Community participation is internationally recognised for its potential in realising good health outcomes. Community based structures such as Clinic Committees (CCs)[3], are important mechanisms to realise community participation and effective governance of the health system. This level of participation is critical to ensure accountability and access to quality health services, and encourage service uptake by communities.[4] CCs have the potential to contribute significantly to the health of mothers and their children and also reduce high mortality rates.

[1] In response to the current challenges, the South African government with key stakeholders formulated and agreed to a Negotiated Service Delivery Agreement (NSDA) which was signed in 2010, identifying reductions in maternal and child mortality as key strategic outcomes for the South African health sector

[2] The Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) in South Africa, UNFPA Report

[3] The term Clinic Committees (CCs) is used in this document however this also includes Community Health Centre Committees (CHCCs). The terms are used interchangeably and refer to the community governance structure that is attached to either a clinic or a community health centre.

[4] In addition, a set of supportive strategies, including the national Maternal, Neonatal, Child and Women's Health (MNCHW) Strategy for 2012 – 2016, the re-engineering of Primary Health Care (PHC) approach and the Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA), have all been developed. All these strategies, while focussing on direct health interventions, also highlight the importance of the inclusion and active participation of communities working in partnership with health workers and the health system, to improve maternal and child health outcomes.

A *Clinic Committee (CC)* is a formal, legislated structure intended to enable the community to participate in the health system. Their aim is to monitor and oversee the health system and to facilitate problem-solving dialogue on health challenges together with service providers and users. The focus of this policy brief is to highlight their (CCs) potential, and the issues that undermine this potential, to significantly contribute to maternal and child well-being.

Black Sash conducted a situational analysis on the functioning of CCs and their roles in contributing positively to MNCH outcomes. The analysis was conducted in two health Districts chosen because they have some of the highest maternal and child mortality rates in South Africa: in the Eastern Cape (OR Tambo) and in KwaZulu-Natal (uMgungundlovu). It highlighted the key challenges compromising the functionality and effectiveness of CCs. The policy recommendations in this brief are based on these findings, and aims to contribute to CCs potential to facilitate improved maternal and child health in communities (Bunce and Phillips, 2014).

1. THE LEGISLATIVE FRAMEWORK IN SOUTH AFRICA REGARDING COMMUNITY-BASED HEALTH GOVERNANCE STRUCTURES

Mechanisms for accountability and community participation in the health system to improve outcomes for MNCH *are* in place. Good governance is highlighted as a fundamental component of South African health care with the National Health Act No. 61 of 2003, making provision for formally constituted, community-based governance structures at various levels within the healthcare delivery system. As highlighted by Padarath (2008), governance structures in the form of clinic committees, hospital boards and district health councils - in line with national policy - are intended to give expression to the principle of community participation at a local and district level. These structures are intended to act as a link between communities and the health system, and to provide a conduit for the health needs and aspirations of the communities represented at local, district, provincial and national levels.

South African policy and legislative documents[5] include *The White Paper on Transformation of the Health System* which refers to the need for communities to participate in the planning and provision of services (Department of Health, 1997), and sets out the importance of people being given the opportunity to actively participate in the planning and provision of their health services, providing a number of methods for this to take place. These include ensuring that women and children, and vulnerable and under-served groups, participate in initiatives, and the development of simple community based information systems which would facilitate the identification of locally determined needs and the monitoring of related achievements.

2. THE CURRENT SITUATION: THE UNDER-UTILISATION OF CLINIC COMMITTEES AS CHANGE AGENTS

CCs are currently too weak to maximise their potential contribution to community participation processes. The National Primary Health Care Facilities Survey (NPHCFS), which was conducted in 2003, found that a clinic committee or community health centre committee existed in three out of five facilities in the country and that this figure had remained static since 2000. To date very little has changed.

CCs are recognised as being optimally positioned as governance structures to address *both* demand and supply side health issues. They have particularly potent potential in addressing demand side barriers as they can reach community members who are not coming to health facilities; if their composition is reflective of the catchment population demographic. The situational analysis conducted by Bunce et al (2014) highlighted several key constraints that undermine the effective functioning of CCs, including:

[5] A variety of policy documents give expression to the necessity of community participation, and its implementation in South Africa. Policies are framed by the 1978 *Declaration of Alma-Ata*, which proclaims peoples' right and duty to be active participants in their healthcare planning and implementation (WHO,1978) and later further reiterated in the *Ottawa Charter for Health Promotion,* highlighting the importance of community action towards better health.

- **Confusion around Role and Responsibilities of CCs**

CC representatives, communities, facility staff, other Department of Health officials, civil society organisations and other multi-stakeholder forums do not clearly understand the roles and responsibilities of CCs. Committee members themselves, expressed confusion about their roles and reported being involved in menial tasks involved in the day-to-day running of the health facilities, such as fetching water and providing security, thereby making them in affect unpaid service providers. This undermines their potential to enhance meaningful community participation in health systems.

- **Inadequate Training and Low Levels of Literacy**

Neither district had developed a formal training programme or resources for contracting out the training of CCs. Neither provincial policy, stipulates who is responsible for training and funding the training for these committees. The result is that CC representatives in OR Tambo did not receive any training. In uMgungundlovu CC representatives reported that while some members had received an induction, they felt that it had been insufficient in enabling them to function effectively. Further challenges include low literacy and numeracy levels among CC members which made knowledge transfer of complex and technical policy issues challenging.

- **Lack of District DoH Reporting, Monitoring and Evaluation of the Functionality of CCs**

The monitoring and evaluation mechanisms currently in place are inadequate to track the performance and functionality of CCs and are often limited to checking only the existence of meeting minutes (the content of these meetings is not emphasised). There is a general lack of reporting regarding which committees exist, their composition and whether they are functional. At the *provincial* level, no reports on the status of CCs were available for review.

Limited and insufficient interactions with sub-district managers, district managers, district portfolio councillors of health or MECs of health, were expressed and some officials at sub-district and district levels were perceived as gatekeepers, controlling further access. Due to limited understanding of the reporting system, committee members were therefore unable to navigate reporting channels to higher levels of the district or to the provincial health structure.

- **Tension of Navigating both Upward and Downward Accountability**

There is serious tension with regards to whom the CC is accountable to: the community or the health system. According to the NHA, committees are accountable at all times to the community. But according to policy directives they also need to be accountable to the health system, specifically to the MEC of health. They are also required to submit quarterly reports to the 'district portfolio councillor for health' (Eastern Cape CC/CHCC Policy, 2009).

This tension plays out in the advocacy role of the committees. They are meant to advocate in the best interests of the communities they serve, while at the same time being expected to advocate for the interests of the clinic or community health centre at district, province and with the public at large. The default seems to lean towards the health facility and *not* the community which is concerning and requires remedy.

- **Lack of Stipends and Incentives to Participate**

CCs are currently operating as unfunded entities and representatives (often from poor households) have to pay for transport and other running costs of the committee. This impacts on the general functioning and sustainability of the committees, and compromises the resolution of health challenges experienced. The lack of funding, incentives and support is particularly evident in the poor levels of attendance at important committee meetings as members are unable to cover costs such as transport and other logistics required. Due to high unemployment levels in South Africa, many members join with the expectation of the appointment leading to a paid job or eventually to a stipend, and then leave when this does not materialise.

Community Dialogue facilitated by Port St Johns CC in OR Tambo District of the Eastern Cape

Community Dialogue facilitated by Bruntville CC in uMgungundlovu District of KwaZulu-Natal

CONCLUSION:

Community participation is recognized as important in improving maternal and child health outcomes. Clinic committees are the vehicle through which such participation can take place, as they have the potential to be linkages between health providers and service users, thereby inclusively addressing supply and demand side barriers.

While CCs are theoretically vested with a powerful role in facilitating and effecting community participation in health issues, and for the purposes of this brief, specifically maternal and child health, in reality they are ineffectual governance structures, lacking agency to represent community health issues or to facilitate any joint problem-solving action between those demanding the necessary health services as well as those supplying them.

Policy Implications: As these governing structures are ideally positioned to directly influence community engagement on health issues, the policy recommendations motivate for varying levels of government support to activate and enhance the agency of these potentially powerful structures as significant contributors to maternal and child well-being in communities.

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