Theme: Health

Leslie London[1]

Mobilising Community Voice to address the Social Determinants of Health – Using Statutory Structures for Meaningful Participation in Health

Community participation is a key element of the primary health care approach which is, itself, central to the redesign of the South African health system promised by the National Health Insurance and its accompanying programme to re-engineer primary health care. Drawing on earlier policy documents[i], the National Health Act establishes structures for community participation in the form of health committees (HCs) to act as the interface between communities and the health services. This is, in itself, a significant expression of the commitment to enabling people's participation in decision-making contained in the South African Constitution.

However, while it described the composition of Health Committees broadly, the Act left the explicit roles and functions to provincial legislation. As a result, there is wide variation and inconsistency in the responsibilities, powers, and relationships of health committees across provinces, their institutional positioning and the extent to which they receive any support in their roles. As a result, the ability of community voice to influence health policy and service delivery is limited and not commensurate with the policy intent of the Constitution nor with the stated goals of the National Development Plan[ii].

Successive pieces of research[iii] have shown that HCs are the victims of a policy hiatus: There is inadequate support from the services, a lack of a clear mandate, a confusion of service and governance roles for participatory structures, lack of recognition of community efforts,

About this brief

This brief was commissioned by the Mandela Initiative to help inform a synthesis report on its work since the 2012 national conference, Strategies to Overcome Poverty and Inequality, organised by the University of Cape Town. The MI provides a multi-sectoral platform to investigate and develop strategies to overcome poverty and reduce inequality in South Africa. While the Nelson Mandela Foundation is a key partner, the Initiative has relied on collaborations between academics and researchers, government, business leaders, civil society, the church and unions.

The synthesis report serves as a framework for reporting on the work of the MI at a national gathering on 12 – 14 February 2018 at the University of Cape Town. The MI Think Tank has identified the objectives for the gathering as:
- to anchor the contributions of the MI within an analysis of the current South African political and economic context;
- to share the recommendations emanating from the MI-related work streams at a policy/strategic level to advance the goal of eliminating poverty and reducing inequality;
- to critically engage with the potential impact of the recommendations on eliminating structural poverty and inequality; and
- to discuss ways of promoting popular conversations and debate about what needs to be done to eliminate poverty and reduce inequality, beyond the MI.

The synthesis report aims to assist participants to prepare for the national gathering. The report drew on findings from the sectoral research projects of Think Tank members; the MI's Action Dialogues; a report on an MI Community of Practice workshop with research chairs from different universities to identify cross-cutting themes emerging from the MI's research programme; and the work programmes of others who have expressed an interest in contributing to the goals of the MI.

[1] School of Public Health and Family Medicine, University of Cape Town

inconsistency in whether and how community representatives are compensated financially. Further, a lack of investment in skills building of community members asked to serve on such committees, lack of guidance on how committees should be comprised and constituted, and no provision for articulation of how these structures, intended to be the voice of communities, might articulate with policy-making structures at all levels of the health system.

This means that services continue to have deal with a massive burden of disease that is not ameliorated by any meaningful opportunities for community participation to help address such challenges. Given the links between health and poverty, this represents the loss of a major opportunity to intervene to break such a cycle.

Our work with HCs began in 2009 when the umbrella body for HCs in the Cape Town municipal area, the Cape Metro Healthcare Forum (CMHF), joined a Learning Network for Health and Human Rights[iv] (LN) hosted by the Health and Human Rights programmes in the School of Public Health and Family Medicine at the University of Cape Town (UCT). The LN was established to share good practices and experiences aimed at advancing health and human rights. Through a grant from the EU to strengthen demand for quality primary health care, the LN undertook a multifaceted intervention to build the capacity of HCs in Cape Town and Port Elizabeth over a three-year period. Through a combination of training, policy advocacy, materials development and testing of instruments to support HCs, the evidence that HCs could be strengthened to be more effective governance structures at local level was confirmed. However, success of these interventions was dependent on a number of aspects: a) appropriate resource investments by government to meet its stated policy intent; b) willingness of key gatekeepers and policy-makers to recognise the ceding of power to community structures and to put this into regulations; c) receptiveness of health care providers to concepts of community participation that renegotiate power relationships between providers and communities.

Not all such elements existed in the two sites, nor were they consistent between municipalities or even within municipalities. For example, trained and empowered health committees were able to clearly articulate community needs but if providers were defensive or threatened, the enhanced community voice generated conflict between communities and services. In some cases, such conflict was generative, because it led to resolution processes that redefined relationships between services and their community as more equal – but only if appropriately managed. The lesson here is that meaningful community participation requires not only intent but effort and resources to make it work.

Additionally, the capacity building of HCs revealed that community structures were not only faced with service-linked challenges but were being called on to address social determinants of health such as crime, violence, child abuse, food insecurity and gender discrimination. These challenges cannot be solved within health facilities but require coordinated inter-sectoral action at multiple levels. While local clinics have little say over how resources are allocated to them by their district or provincial head office, local officials controlling social determinants of health have some limited power to mobilise resources needed.

Thus, the second phase of work with HCs has focused on building the capacity of HCs for leadership at community level, to draw officials, community-based organisations (CBOs), non-governmental organisations (NGOs) and communities together to find local solutions to the problems directly impacting on health; and, where systemic interventions are needed upstream, to mobilise collective action to effect policy or programme changes. Preliminary experience suggests that (a) local action can be successful in drawing in local resources existing in communities but previously unavailable to

address health needs (e.g. local CBOs and NGOs operating in the community); (b) building capacity through training has given local community members skills, confidence and access to networks which has enabled them to start local NPOs to address priority community challenges (e.g. children's day centres able to extend child protection to vulnerable populations, and achieve registration with social service authorities; (c) networking community structures with resources outside communities has expanded community capacity to address social determinants of health. Through these actions, greater involvement of officials from local authorities has been possible, as they have seen positive benefits of community agency helping them to address what appear to be intractable problems of poverty contributing to ill-health.

Over and above the immediate effects on health and social outcomes, the positive impacts amongst community members on self-esteem and the sense of agency achieved through training and subsequent implementation of action steps promises the possibilities of long-term strengthening of community systems, which will, in turn, enhance local capacity to address social determinants of health and to benefit from programmatic investments intended to achieve poverty reduction. This is still work in progress and will be evaluated over the next two years. However, we believe that rethinking the existing model of community development, to better draw on strengths and abilities that exist in communities in ways that neither rely for success on externally-driven resource inputs nor shift the burden onto poor communities, is a sustainable option for addressing many of the social determinants of health that characterise life in poverty.

Our recommendations:

1. Modest but coordinated inputs are needed to unlock the potential of communities to find local solutions that improve their social conditions. Some of the inputs are financial (in terms of covering the costs incurred by community members to organise at local level – e.g. travel reimbursements, cell phone time), but most are about building capacity (training).
2. Following through on training requires mentorship and 'holding hands' of trainees embarking on action to address challenges. This in turns requires personnel skills in understanding community work and responsive to community needs who understand processes of community entry and support.
3. Recognition of the lived knowledge and experience of community members and the importance of their contributions is critical to making community interventions work.
4. Health committees can play key roles in coordinating community level action. This requires HC members trained in leadership with clear mandates and supported to accomplish tasks both in the health facilities and also in the communities. There is an urgent need for national policy to clarify the role, scope, support and mandate of health committees so that they can play this critical role.

For more information on the Mandela Initiative:

[i] African National Congress. National Health Plan of 1991;
African National Congress - see the health sections of the Reconstruction and Development Programme (1994);
Department of Health. (1997). White Paper for the Transformation of the Health System in South Africa. Notice 667 OF 1997. Accessed on 13th May 2017 at http://www.gov.za/sites/www.gov.za/files/17910_gen667_0.pdf.

[ii] National Planning Commission. (2011). National Development Plan. Johannesburg: National Planning Commission

[iii] Meier MB, Pardue C, London L. (2012) Implementing community participation through legislative reform: a study of the policy framework for community participation in the Western Cape province of South Africa. BMC International Health and Human Rights 2012; 12(1):15.http://www.biomedcentral.com/1472-698X/12/15;
Glattstein-Young G. (2010). Community Health Committees as a Vehicle for Participation in Advancing the Right to Health. MPH Thesis, University of Cape Town, Cape Town;
Padarath A, Friedman I. (2008). The Status of Clinic Committees in Primary Level Public Health Sector Facilities in South Africa. Health Systems Trust: Durban:
Haricharan, HJ. (2012). Extending Participation: Challenges of Health Committees as Meaningful Structures for Community Participation. A Study of Health Committees in the Cape Town Metropole. At www.salearningnetwork.weebly.com

[iv] The Learning Network for Health and Human Rights (LN) comprised at the time Ikamva Labantu, The Women's Circle, Epilepsy South Africa (Western Cape), Women on Farms Project, University of Cape Town, University of the Western Cape and Ikahaya Labantu. All organisation except the Ikahaya Labantu remain involved in the LN currently.