

# **Implementing community participation through policy reform: A study of the Western Cape's Draft Policy Framework for Community Participation**

Benjamin Mason Meier, Caitlin Pardue and Leslie London

This study examines the political, historical, and legal context for the development and implementation of the Draft Policy Framework for Community Participation in Health in the Western Cape Province of South Africa (Draft Policy). Through national and provincial legislative analysis and a series of in-depth interviews with key stakeholders, the researchers analyze key facilitating and inhibiting factors for the adoption and implementation of the Draft Policy, drawing out implications for participation policy in public health law reform and concluding that attempts to promote participation must adequately address the underlying factors crucial to achieving effective participation. Based upon these underlying factors, this article proposes that policies seeking to institutionalize community participation should ensure policy formalization, community representation, administrative support, and capacity building. Given the public health importance of structured and effective policies for community participation, and the normative importance of participation in realizing a rights-based approach to health, this analysis informs researchers on the challenges to institutionalizing participation in health systems policy and provides practitioners with a research base to frame future policy reforms.

Community participation is crucial to realizing a rights-based approach to health, yet many health systems have not enacted policies to enable the institutions necessary for effective participation. With participation both a human right in itself and instrumental to the realization of other rights, this case study investigates the challenges to developing health policy for community participation in the Western Cape province of South Africa. Although the Western Cape has taken evolving steps to institutionalize participatory frameworks through community health committees, these committees remain informal under the District Health System and have struggled to promote community participation without formal recognition under law. In an effort to overcome these challenges, stakeholders have sought to formalize the structures of participatory institutions through the development of a Draft Policy Framework for Community Participation in Health (Draft Policy). This experience of developing policy to meet the needs of the community and increase community participation within a health system undergoing enormous post-apartheid transformation presents an insightful case study of policy reform to institutionalize participation, addressing the complex realities of the participation process and highlighting limitations in the development and implementation of rights-based health policy.

To understand the relationship between policy frameworks and community participation in health, this study analyzes the process of structuring community participation in the development of the Draft Policy. In addressing the policy landscape in which these reforms were developed, this article reviews evolving policy efforts to provide for community participation in health systems, examining the prospective benefits of participation in local health systems and the policy efforts advanced in South Africa to ensure these benefits. With the Draft Policy as a frame of analysis, the researchers conducted documentary policy analysis and semi-structured interviews with key informants on the development of this participation policy. Moving beyond the specific and unique circumstances of the experience in the Western Cape, this analysis seeks to map the paths through which community participation is structured, functions, and relates to other sectors of society and to develop more generalizable factors for future research on effective community participation policy in the health system. By focusing on those thematic factors likely to facilitate or inhibit health reform, this study outlines best practices in developing policy to realize meaningful community participation and advance progressive realization of the right to health.

## **I. BACKGROUND – THE IMPORTANCE AND EVOLUTION OF PARTICIPATION POLICY IN SOUTH AFRICA**

It is widely recognized that there have been enormous strides in restructuring health services in South Africa since the end of the apartheid era. Moving away from the discriminatory, racist, and iniquitous system that pervaded the apartheid government, the new health service is premised on a vision of an integrated, comprehensive health system that promotes equal access for all South Africans to the conditions and services necessary for disease prevention and health promotion (Department of Health 1997; Ntsaluba and Pillay 1998). Many of these changes were only possible with extensive investments in policy development—often through highly consultative processes that reflect both the inclusive tradition of the anti-apartheid movement as well as the legal imperatives in South Africa’s Bill of Rights—to foster increased citizen participation in

decision making at all levels (du Plessis and Corder 1994). Operationalizing the growing social scientific consensus that increased participation in the health system leads to increased health benefits, key South African legislation has signaled continuing support for community involvement in decision making.

Amidst this evolving policy framework, efforts have been made to codify community participation in health systems, recognizing community participation as integral to realizing South Africa's constitutional commitment to the right to health. Beginning with the National Health Act (Department of Health 2004) and in the Department of Health's Patients' Rights Charter (Department of Health 2007), both intended to facilitate greater health care decision making for users of health services (McIntyre and Gilson 2002), community participation in health was structured in the Western Cape through Health Committees (HCs) within the District Health System (DHS) (Department of Health 2004). With these HCs existing only on an ad hoc basis, the Draft Policy was developed in the Western Cape in an attempt to formalize the roles and responsibilities of participatory institutions through the Cape Metro Health Forum (CMHF). However, despite this intent to structure policy to facilitate the health benefits of community participation, these institutions have struggled to promote participation without formal recognition under law (Glattstein-Young 2010).

### **A. Community Participation in Health Systems**

Community participation in the health system has come to be seen as a key component of any rights-based health policy. An instrumental aspect of the human right to health—and an independent human right, an intrinsic end unto itself—such participation allows for sustainable health services that more effectively address local needs (Potts 2008). With international consensus that participation is a principal component of primary health care, a rights-based consensus concretized in the Declaration of Alma-Ata (International Conference on Primary Health Care 1978), community advocates have sought to translate this international health and human rights consensus into domestic policy. If mechanisms for participation within the health system are structured through the development of appropriate institutions, it is thought that community participation has the potential to increase awareness of specific community health issues, disseminate knowledge and health education, and increase accountability of health care providers and policy makers – with participation policy helping to realize a rights-based approach to health (Yamin 2009).

Operating at an individual level, participation leads to an increased sense of personal responsibility and self-determination, decreasing isolation by fostering relationships between health care providers and the community and yielding broader effects on individual beliefs about government (Soss 1999). With increased public participation, individuals gain greater autonomy to assess their health needs, collaborate with others, and evaluate the reform of health care programs (Dujardin 2004). Further, when communication is opened between the health system and individuals, these individual community members may be more inclined to learn about health issues specific to their environment, using this education to improve their lifestyle choices and overall wellbeing (Zakus and Lysack 1998; Levendal et al. 1997; Atkinson et al. 2010). This kind of involvement is highly dependent on building positive relationships, two-way interactions, and effective communications within the community and across health care providers. When the

relationship between health care providers and patients is based on mutual respect and trust, it is found to change the dynamic from a submissive patient passively receiving care to a citizen who is actively engaged within the system, improving health outcomes.

At the community level, participation facilitates greater policy responsiveness to community needs (Green and Frankish 1994), contributing to the system's efficiency and effectiveness by providing feedback and securing involvement in decision making (Brownlea 1987). When communities are well informed and educated on health issues, their active participation in a transparent system can serve to hold service providers and government officials accountable for their actions (Laverack and Labonte 2000). Through this public deliberation, community members can create avenues to exert influence on decision makers and hold providers accountable for ensuring that funds are allocated equitably and efficiently and for safeguarding that health staff and patients continue to interact in respectful and constructive ways (Dujardin 2004; Pérez et al. 2009). As a result of such participatory priority setting, the health system becomes more tailored to the specific community's health needs and thus more likely to improve health for all.

Providing democratic legitimacy to the health system, community participation has recently become a focal point of civil society and a linchpin of health governance. Creating a public sphere for persuasive dialogue in the health system, such collective deliberation is seen to improve both community development and health system management, resulting in more reasoned, informed, and public-oriented decisions (Habermas 1984). Yet despite widespread theoretical consensus on the benefits of community participation in the health system, there remains little understanding of the policies necessary to facilitate community involvement. While studies of community participation structures in the health system have been undertaken in the United States (Morone and Kilbreth 2003), Canada (Charles and DeMaio 1993), and Great Britain (Abelson et al. 2003), there is comparatively far less understanding of how such policies have been developed outside the West, especially in Sub-Saharan Africa (Walt and Gilson 1994). In this process of translating theory to policy, South Africa provides a paradigmatic case study of the struggles in creating structures that would assure the benefits of community participation.

## **B. South African Policy Reforms to Realize Participation**

South Africa has developed executive and legislative measures to realize these benefits of community participation in the health system, establishing HC participation structures to promote community involvement in health services and reflect fundamental values of the New South Africa (Boulle et al. 2008). With roots in the anti-apartheid struggle and the Mass Democratic Movement's engagement with the health sector, the struggle for freedom became intertwined with the assertion of a human right to health for all (London 2004). In the presence of highly discriminatory governmental health services during the apartheid era, civil society organized to develop health services independent of the government (Baldwin-Ragaven, de Gruchy and London 1999). During the 1980s and early 1990s, the National Progressive Primary Health Care Network (NPPHCN), funded primarily by the European Union and the Kaiser Family Foundation, established a training college outside the state system to train community HCs. In this context, the local HCs monitored health in their respective regions and acted as

liaisons between the community and health services institutions, advocating for improved services as a part of national advocacy to facilitate equity in the health system.

In the aftermath of the apartheid regime, the new democratic government under the African National Congress (ANC) strove to include community participation at various levels of policy making (ANC 1994a). During this period, the ANC brought together “municipal authorities, unions, civics, parties, business groups, and other stakeholders into loosely corporatist bargaining structures” (Heller 2001: 143). Yet the promise of involving the community and promoting local governance went unfulfilled in the ensuing years, driven by: (1) governmental embrace of neoliberal orthodoxy, focused on “streamlining management systems, cutting costs, and emphasizing administrative performance rather than mobilizing participation, training ordinary citizens, and engaging in sustained consultation, much less deliberation,” (2) growing governmental reliance on private sector consultants, and (3) increased preference for outsourcing, privatization, and public-private partnerships (Ibid: 146). Where civic movements had been largely based in oppositional politics and antagonistic protests against the apartheid government, these tactics limited cooperative engagement with the newly democratic government (Madlingozi 2007). Attempting to cultivate constructive community engagement, significant tensions between civil society and the state began to emerge when government officials, many of whom had previously engaged in civil society activism, appeared reluctant to support civil society participation in state decisions (Habib and Taylor 1999).

Against these larger struggles, efforts to develop structures for participation in health took shape as early as the implementation of the 1994 Reconstruction and Development Programme (RDP). Bridging the deep socioeconomic divide left in the wake of apartheid policies, the RDP recommended fundamentally changing the South African health system to a District Health System based on the principles of Primary Health Care, which emphasized participatory systems for comprehensive care and underlying determinants of health in accordance with international consensus codified in the Declaration of Alma-Ata (Coovadia et al. 2009). As a reflection of the ANC Health Plan, this new system was intended to allow greater local control over health policy, explicitly recognizing an emphasis on “*community participation and empowerment*, intersectoral collaboration and cost-effective care, as well as an integration of preventive, promotive, curative and rehabilitation services” (ANC 1994b: 45, emphasis added). Creating a new socio-economic policy framework, the RDP served as an inspirational framework to guide South Africa’s transformation by addressing the vast inequalities created by apartheid; yet despite these efforts to reform the apartheid health system based on a framework of decentralization, equity, and community participation (Levendal et al. 1997), programmatic efforts to foster a “people-driven” movement were not operationalized, as practical avenues for local civic involvement were significantly limited because of undefined responsibilities and inadequate infrastructure to facilitate participation (Blumenfeld 2003; Adelzadeh and Padayachee 1994).

Clarifying and extending the RDP to the health system, the 1997 White Paper on Transformation of the Health System in South Africa (White Paper) emphasized South Africa’s continuing commitment to community participation, seeking “to foster community participation across the health sector” and establishing practical mechanisms to improve communication between the community and health services system (Department of Health 1997). Although it remains unclear to what extent the White Paper contributed to promoting community participation in

health (McIntyre and Gilson 2002), this emphasis on improving communication between government systems and the community would find support in the 1997 Public Sector code – referred to as the Batho Pele (“people first”) Principles. Proclaiming that access to public services is a right of all citizens and that communities should participate in the planning of public services to improve and optimize service delivery, Batho Pele outlines eight principles necessary to structure communications:

[insert Table 1 about here]

To make explicit the elements of the White Paper and Batho Pele, framing government responsibilities for open communication between health service providers and citizens, the 2000 Patients’ Rights Charter created a common standard of rights to assure that all people have access to health care. In proclaiming the rights of patients, the Charter balances the rights of patients with their responsibilities, providing that patients participate actively in the health system and that they play an important role in decisions regarding their own health and wellness:

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision making on matters affecting one’s health (Department of Health 2007).

These rights and responsibilities for individual participation would shape the implementation of community participation through the District Health System.

### **C. Participation through the District Health System**

The development and institutionalization of a decentralized District Health System (DHS) as the basis for a transformed post-apartheid health service has been at the core of policy reforms to bring together the multitude of disaggregated apartheid-era health systems and “ensure that emphasis is placed on health and not just on medical care” (McLauren 1995). Facilitating participation by focusing health care decision making at the district (rather than national) level, a DHS would increase communication between providers and citizens and give communities greater opportunity to contribute to these decisions, with the 1995 Policy for the Development of the District Health System outlining that:

Each health district will have smaller Community Areas, sub-units of the district, which could be served by a clinic, by a Community Health Centre, a number of satellite clinics, by a District Hospital, or by a combination of such facilities. The users of these facilities should be an integral part of the health services, and not merely be seen as the passive recipients of services. In order for this to happen, the users need to be organised into a structure which will relate to the health system, and it is suggested that the structure be the *Community Health Committee* (Department of Health 1995: 3, emphasis added).

With structures for community participation central to the future implementation of the DHS, participation was viewed as a means for primary health care to be delivered in a more equitable and efficient way across a defined geographic district (Hall, Hayes and McCoy 2002), bringing

together all organizations and individuals providing health care—whether governmental, social security, non-governmental, private, or traditional—and securing the partnership of individuals, communities, and health care providers necessary to improve health.

Developed over almost a decade of negotiation among competing constituencies, the National Health Act of 2003 consolidates much of the earlier health policy development on the DHS and outlines in broad terms the governance structures for community participation (Department of Health 2004). Under Section 5 of the National Health Act, each health district shall establish a District Health Council (DHC), consisting of a member of the metropolitan or district municipal council (who serves as the chairperson), a representative of the Executive Council (the provincial-level cabinet), a member of the council of each local municipality, and not more than five additional persons appointed by the Executive Council. As a means to promote cooperative governance, the DHC is intended to assure coordination of planning, budgeting, and provisioning and monitoring of all health services. Creating a formal structure for community participation under Section 6, the National Health Act requires that every health facility be linked with a Community Health Committee (HC), consisting of community-elected representatives (e.g., a health facility manager or a local ward councillor) (Department of Health 2004). Table 2 outlines the institutional landscape of Health Councils and the functions of organizations and individuals as described in the National Health Act.

[insert Table 2 about here]

Notwithstanding the legislative framework of the National Health Act in defining the structure of DHCs and conceptualizing the roles and powers of HCs, the National Health Act delegated to provincial governments to provide legislation for the functioning of DHCs, management of these councils, and detailed budget and performance targets for services in the health district. Because the National Health Act has not given specific mandate for the establishment of HCs, comparatively less articulated than the mandate for DHCs, this national legislation has not been implemented for HCs in most of the nine provinces (Paradath and Friedman 2008). Through the national policy conceptualization of HCs, it is clear that South Africa has acknowledged the importance of participation in the health system; however, this commitment has not translated into tangible policy results at the provincial level – with a 2003 survey finding that HCs were established in only 60% of Primary Health Care facilities in the country (Reagon et al. 2004) and a 2006 study concluding that many established HCs were ineffective and poorly functioning, with HCs members reporting that their opinions were neither valued nor considered within the health service system (Nelson Mandela Bay Metropolitan University 2006).

#### **D. The District Health System in South Africa’s Western Province**

In South Africa’s Western Province, policy makers began outlining provincial frameworks for community participation after the implementation of the 2003 National Health Act, with the roles and responsibilities of HCs formally proposed in the 2008 Draft Policy. The Draft Policy defines and describes how each clinic in the province develop an HC—composed of community members, the ward councilor, and the health facilities manager—with the HC facilitating conflict resolution and community representation as a liaison between the clinic, the community, and the government. Through local conflict resolution, complaints and concerns within the

community are to be addressed by the clinic's HC, where such concerns would be discussed with clinic staff and resolved directly at the clinic level. In community representation, HCs are expected to meet with health managers (government officials and hospital representatives) in each sub district to discuss common issues and successful strategies for health promotion. Translated into health policy, representatives from each of the sub districts then meet as the Cape Metro Health Forum (CMHF), which further engages with civil society and government officials in policy reform efforts. This tiered system of resolution and representation through the Draft Policy (diagrammed in figure 1 below) provides institutional avenues that seek to make the benefits of community participation a reality for health policy in the Western Cape Province.

[insert Figure 1 about here]

Although this Draft Policy has been developed, it remains a draft document that has not been formally promulgated by Western Cape legislation in accordance with the NHA, creating uncertainty in the CMHF's role and authority within the health system (CMHF 2009).

### **E. The Cape Metro Health Forum**

Within the Western Cape, the CMHF emerged from anti-apartheid struggles in the health sector and was first established in the 1995 Provincial Health Plan as an interim consultative forum for community participation pending formal legislation. As detailed in Table 3, the CMHF forms the current structure for community participation – with members and functions designated under the Cape Metro Health Forum Executive (CMHF Executive), the Sub-District Health Fora, and the Community Health Committees (HCs).

[insert Table 3 here]

Evolving outside the umbrella of the DHS, the consolidated CMHF encompasses a single health district with 8 Sub-District Health Fora and is intended to include all HCs linked to clinics in the Metro (with 86 committees as of 2010). Representing the entire district, the CMHF Executive comprises an elected Chairperson, representatives from each of the eight sub-districts, and ex-officio members nominated by the Metro DHS and City Health, functioning together to coordinate the Sub-District Health Fora, create strategies for optimal community participation structures, and evaluate the effectiveness of the HCs. At the sub-district level, where health disparities lead to sub-district-specific health priorities (Groenewald et al., 2010), Sub-District Health Fora serve as a platform for sharing concerns and problem solving strategies among members in the sub-district, including a representative from each HC within the sub-district, a representative from each district hospital board, ex-officio managers nominated by the Metro DHS and City Health, and representatives from relevant civil society organizations. Closest to communities themselves, the HC's primary role is to serve as a liaison between the community and the clinic staff, with committee members intended to simultaneously provide governance to the clinic and work directly with the community. Under this representative structure for community participation, HCs consist of the local ward councillor, 3-8 community members, and the head of the health facility – organized under a chairperson elected from the HC.

Although these CMHF structures are outlined as part of the Western Cape Provincial Health Plan of 1995, the National Health Act of 2003 does not include a CMHF-like structure, and it is thought that the CMHF will soon be replaced by a District Health Council pursuant to recently-approved provincial legislation. In order for the government to continue to recognize community participation as part of the DHS, members of the CMHF have called for legislative implementation of the Draft Policy to institutionalize community representation.

## **F. The Western Cape's Draft Policy Framework for Community Participation**

Using the CMHF as a model, the Draft Policy seeks to formalize community participation structures within the Western Cape DHS. Providing a standardized framework for the establishment, appointment, and functioning of these structures, the Draft Policy proposes a decentralized participation structure, modeled after the DHS structure in order to create a network of communication from local clinic committees to the CMHF and to the health system. Much of the impetus behind the Draft Policy stemmed from a need to legitimize HCs within in the health system, to ensure that the needs, concerns, and complaints of the individual patients and the community are properly addressed, and to foster community support for policies and programs. Through the CMHF, the ability of the health system to improve participation within the district is therefore built upon an existing network accepted as a legitimate structure by all actors involved in the health system. In codifying the Draft Policy, it is thought that HCs, Sub-District Health Fora, and the CMHF would find greater authority for implementing community participation through the following principles and objectives:

### **2.3 Guiding Principles**

- i) to observe the PHC principles as articulated in the Alma Ata declaration and the NHA of 2003;
- ii) to strengthen governance of service delivery structures and facilities through effective participation of civil society;
- iii) to work in partnership with other stakeholders to improve the quality of care at all levels of the health system;
- iv) to involve communities in health service delivery and health promotion activities;
- v) to establish mechanisms to improve public accountability and promote dialogue and feedback between the public and all relevant stakeholders;
- vi) to build a responsive organization within legal and political frameworks guided by the constitution and various pieces of legislation;
- vii) to involve communities in various aspects of the planning and provision of health services; and
- viii) to encourage communities to take greater responsibilities to their own health promotion and care.

### **2.5 Specific Objectives:**

The strategic objective will be achieved through the follow specific objectives:

- i) to establish functional district health councils in 100% of the health districts in the Western Cape;

- ii) to establish functional hospital boards at 100% district hospitals in the Western Cape;
- iii) to establish functional clinic/community health centre committees to achieve 100% coverage of all PHC facilities in the Western Cape;
- iv) to establish functional sub-district health fora in 100% of the designated health sub-districts in the Western Cape.

As stakeholders lobby for this Draft Policy, legislators in the Western Cape have recently promulgated legislative reforms to authorize District Health Councils – a structure that may duplicate some or all of the functions of the CMHF. Addressing community concerns within the health system, this District Health Council structure may create separate fora to consult with relevant groups and facilitate communication between local communities and government officials. Should this occur through the District Health Council, it is unclear what will become of the CMHF and its structures for community participation.

## **II. METHODS**

To understand the relationship between policy frameworks and realization of community participation in health, this study seeks to document and analyze the structures of community participation in the development of the Draft Policy. Focusing on those thematic factors that facilitate or inhibit health reform, this study highlights best practices in developing policy that realizes rights-based community participation.

With this Draft Policy as a frame of analysis, the researchers conducted a detailed case study analysis of the evolution of the policy landscape for community participation in the health system in the Western Cape province of South Africa. Complementing this documentary policy analysis, the researchers conducted semi-structured interviews with a snowball sample of eight key informants – government representatives, HC members, and community advocates known to have considerable knowledge of the District Health System in the Western Cape, the community participation structures in the health system, and/or the development of the Draft Policy. Moving beyond the specific and unique circumstances of the experience in the Western Cape, this analysis seeks to develop wider and more generalizable factors for future research on effective community participation policy in health systems (Gerring 2004).

The semi-structured interview methodology is ideal for assessing the process of health policy reform. Given the impracticability of experimental or statistical methods of analysis, this method allows researchers to explore different avenues of inquiry as themes surface during interviews (Mack et al. 2005). Such semi-structured interviews facilitated an open-ended dialogue between interviewer and informant, providing unique data for understanding the political and social environment surrounding the development of the Draft Policy. Employing a topic guide for each interview, a single interviewer pursued key questions and topics with each informant, with the full research team continually revising and adapting the topic guide as themes emerged, allowing for the iterative development of more detailed questions for subsequent interviews and further analysis.

To select potential interview subjects, the researchers first identified the major participatory structures in the Western Cape, and from this, selected members of relevant governmental, community, and advocacy institutions during the time of the development of the Draft Policy. Contacting individuals who were directly involved in the policy drafting process, those who could provide first-hand accounts of the specific events in the evolution of the Draft Policy, snowball sampling allowed an expansion from these preliminary individuals to a range of stakeholders representing a wide variety of informant perspectives and experiences (Miles and Huberman 1984). Selected in consultation with individuals who were knowledgeable about Western Cape health policy, twelve potential informants ultimately were identified, of which eight were able to be interviewed by the researchers.

These eight semi-structured interviews focused on the role of the informant in the creation of the Draft Policy, community participation debates that surfaced during this drafting process, obstacles to policy implementation and strategies employed to overcome these obstacles, and expected changes in community participation and public health. These individual narratives were complemented by a review of collected documentation from meetings, reports, and charters; participant observation of HC and CMHF Executive meetings; and dialogue between government officials and community members at a September 2010 NGO forum sponsored by the South African NGO Coalition (SANGOCO).

From transcriptions of the informant interviews and analysis of supplemental documents and observations, a narrative account of the policy making process was created. Through thematic analysis of these case study data—examining recurring topics, beliefs, and patterns (Aronson 1994)—the researchers identified and analyzed major themes in the policymaking process.

### **III. ANALYSIS – DEVELOPING COMMUNITY PARTICIPATION POLICY**

Creating policy that effectively implements rights-based community participation has long faced challenges in defining and addressing the complex realities of the participation process (Morgan 2001). To achieve meaningful community participation through policy that leads to progressive realization of the right to health, it is necessary to analyze the paths through which community participation is structured, functions, and relates to other sectors of society (Mandan 1987). In the Western Cape, policymakers question whether HCs provide an accurate reflection of community needs, resources, and values in order to build partnerships within the health system for increased community participation. Where political and social structures may undercut community participation for the common good, reinforcing existing social structures and inequalities, these participatory structures must be explicitly addressed in policy development (Jonas 1978).

In order for community leaders to be seen as authoritative spokespeople in the eyes of the community and the health system, providing a foundation for realizing the health benefits of participation, the method of selection, representation, and participation must be perceived as creating political legitimacy and procedural justice. For example, the benefits of meaningful participation cannot be accomplished if minority and disadvantaged groups are not accurately represented in institutions or do not have substantial authority within the health system (Zakus

and Lysack 1998). In defining the process by which representatives are elected, appointed, or assigned to HCs, the operational aspects of community participation must be understood before rights-based health outcomes are realized (Potts 2008), as the form of selection of community members—by direct election from the entire community, election from specified interest groups, or appointment from local government—is crucial to the programmatic success of any participatory institution (Parkinson 2004). Beyond the selection process, determining who is a legitimate representative of the community requires that selected individuals possess sufficient knowledge of the health system and dedicated commitment to the institution. Representation creates a series of opportunity costs that many community members cannot afford, including lost pay, travel costs, and training difficulties (Zakus and Lysack 1998), costs that may limit participation only to community elites who may not be seen as legitimate spokespeople for the community at large. Even when those traditionally left out of the health system are able to find ways to participate, the political and social environment may create an environment in which representation is not accessible (Frankish et al. 2002). Therefore, policy makers must come to understand who is included in the definition of the community and who could potentially be excluded through the implementation of community participation policy.

Given these imperatives for—yet limitations to—HC participation through the CMHF, this research identifies five structural obstacles to community participation in the Western Cape:

1. *There is organizational uncertainty as to what the role of CMHF is or should be.* The CMHF lacks clearly defined authorities within the new DHS, as the CMHF's informal consultative origins are incommensurate to the formal institutional arrangements that currently structure engagement between the health system and the community.
2. *There is complexity in identifying, selecting, or electing those who truly represent the community.* Without processes for determining community representation, it is often difficult to determine if representatives are participating in the best interests of the people for whom they claim to speak, denying legitimacy to HC structures.
3. *There is little governmental support for community participation.* There is not an institutionalized structure to build HC capacity to engage with the health system.
4. *There is a lack of administrative training for HC members.* Once a committee member, there is little substantive training or administrative support to carry out required community representation functions.
5. *There is unclear policy support for institutions of community participation.* In the policy efforts to implement a DHS, and now in efforts to establish District Health Councils, leadership is lacking to institutionalize community participation in government decision making.

From this analysis, it becomes clear that provincial policy holds a crucial role in overcoming these obstacles, facilitating or inhibiting the development of representative institutions conducive to community participation.

### **A. Organizational Uncertainty**

When the CMHF was formed in 1995, it was during a time of major restructuring of the health system in the Western Cape. At the national level, the Department of Health was seeking to bring together fourteen autonomous health authorities; at the local level, the City of Cape Town alone had twenty-seven distinct authorities providing health services. In this restructuring, the new Provincial Health Department sought to implement national policy by merging various health authorities under the mantle of one DHS. As a forum to discuss these structural reforms with affected groups, the CMHF served an essential, albeit informal, role in bringing together health officials and community members to collaborate and coordinate during the provincial implementation of the national Policy for the Development of the District Health System. With the Western Cape having since moved to formalize other institutional arrangements in the health system, the CMHF's informal structures cannot effectively structure health system participation without clearly defined responsibilities.

Since the Western Cape has begun to put in place formal institutions for DHS oversight, the CMHF has not been able to collaborate adequately in a process in which it has no legislative standing or defined mandate within the DHS. This uncertainty in its formal authority greatly inhibits the CMHF's ability to participate within sophisticated institutional arrangements and rigid lines of authority. As noted by a key stakeholder, "provincial treasury, national treasury, national acts around finance determine how our budgets get formulated – a consultative body can't really be involved in all of these processes." Given these institutional limitations to community participation under informal arrangements, CMHF representatives expressed significant alienation from the health system highlighting how a lack of defined authority leaves the CMHF without any formalized basis to engage with the DHS.

To alleviate this organizational uncertainty, the Draft Policy was sought as a means to formalize the CMHF pursuant to provincial legislation. With no other institution responsible for community participation, compounded by a concern that the DHS has neglected the community involvement principles central to the National Health Act, stakeholders emphasized the continuing need for HCs, arguing that "it raises a concern of how seriously we take our very own policies as a government and how seriously we are in the implementation of our policies and guidelines." With adoption of legislation to create a District Health Council, there is growing concern that the continued existence of the CMHF will be superseded where it is not institutionalized under law, with stakeholders lamenting how CMHF's exclusion from the District Health Council might significantly weaken or eliminate a role for community participation in the health services system:

It depends on what it is that government wants to achieve with [the District Health Council]. Because if you want true participation, I'm not sure the District Health Council on its own and the committees in their current capacity is sufficiently going to do that. If you really want people governing and people having a say,

then the structure doesn't create that. The structure creates a kind of opportunity of engagement, but it's really dependent on the way we actually do it and the way we engage with it.

As such, many community members fear that the District Health Council will not adequately allow for community participation, increasing their efforts to secure adoption of the Draft Policy as a means to formalize the CMHF as a basis for engagement within the DHS.

## **B. Community Representation**

Not fully addressed in the Draft Policy, there remains complexity in identifying, selecting, or electing community representatives to the HCs. As this problem was identified by a key stakeholder:

It's a highly politicized process. In my own opinion, it's not necessarily the right people who come forward to represent their communities...The people who get elected in my personal estimation, are the wrong people who get elected for the wrong reasons, for the wrong things. And it's not of their own doing or their own making, but it's the motivation for stepping forward and being a community participator. What inherent skills and things does that person bring to the party?

Several stakeholders noted that the lack of clearly defined processes for representation creates an environment in which community representatives do not have a clear understanding of the communities for whom they claim to speak in these institutional structures. Emblematic of the limitations to true representation, elections for HC members are frequently forgone in place of direct appointment from the committee chair. In such situations in which these members are not elected or selected by standard procedures, engagement with the HC may serve only for personal benefit, with community representation reinforcing existing bases of social capital and reflecting nothing more than personal opinion. Rather than representing their communities, it is believed that several community representatives were motivated strongly by self-interest, volunteering to participate in these health committees merely to gain the qualifications necessary to seek future employment and leaving the committee once employed and nominating as a replacement a family member or friend without any additional confirmation. With such processes undercutting efforts to achieve community participation, a stakeholder criticized:

You know you're speaking on behalf of a community of people. You have the responsibility and an obligation to that community...and often I find that we are dealing with personalities and I sometimes think, "Who are the voices behind these people and do they even understand those voices?" So how do they actually communicate those needs and don't paper it with their own personal issues?

These non-standard selection processes, allowing personal motives to play a role in joining committees, present potentially serious obstacles to community representation, denying HCs the impartiality, public spirit, and effective conflict resolution structures necessary for community participation.

### **C. Institutional Support**

As the government seeks to engage with these community representatives, there is not a clear vision of how the DHS can institutionally support community engagement to promote meaningful participation in the health system. Reflecting on the relationship between the DHS and HCs, one Department of Health official noted:

We've restructured the structure, but now we're kind of working out the mechanics of the structure and how the DHS engages and how it works in practice. And part of that has to deal with the community and having a voice closer to management and informing processes. There hasn't been a lot of energy into really grappling with that.

While the main government entity responsible for the provision of health services, the provincial Department of Health has not traditionally had the authority for raising community capacity for participation. The Department has been restructured to meet the objectives of the District Health System, emphasizing primary health care and rights-based community participation; however, the Departmental leadership come primarily from medical backgrounds, and stakeholders within the Department noted the enduring limitations of this medicalized workforce:

The Department at the moment is doctor heavy and comes with the thinking around the way doctors operate and the medical model. So there's not necessarily – the ideology is not developmental. It's not rights-based. With that kind of culture, I don't know if we are the right people to do it, even if we had some obligation to support them [community representatives].

As a result of this organizational culture, it was believed—both inside and outside the Department of Health—that many of the Department staff continue to question whether the Department has the obligation or ability to engage in capacity building to support community representatives. Without institutional support to enable representatives, a stakeholder questioned: “Are we going to wait for health committees to somehow organically develop this capacity or do we actually invest in looking into how to increase capacity in health committees?”

Even with the Draft Policy, there remains ambiguity over how the Department could communicate effectively with its constituents, give voice to community representatives, and relate institutionally to community participation structures. As a stakeholder warned, “the whole idea of putting the structure in place was to bring the services closer to people, to have the decision-making processes closer to where the action is happening... We are going to fall short if we just put the structure in place and we don't actually stay true to the idea.” As stakeholders seek support for the Draft Policy, it is clear that legislation is only the first step, with institutional support programs necessary to build the capacity of community representatives to participate in the health system.

### **D. Administrative Training**

Beyond building capacity for community participation, HC members often noted the need for administrative training – as defined by communities themselves, but including, at a minimum, basic computer skills, administrative committee procedures, prevailing health issues, DHS bureaucratic functions, and HC participation responsibilities. With this member training only just begun, one of the trainers reflected on how the training impacted the role of the community representatives in the health system:

The interesting thing for me was that when we were doing this training that people's eyes opened. "Yeah that makes sense." And it was heartening to see that people did understand what's happening to them, why they were getting sick. Because a lot of the training was around what makes you sick, what makes you better – understand primary health care first before you can understand your role in the primary health care system. People did want to know. People are smarter than people expect. They can work some things out because they are survivors.

Confirming the findings of an earlier study conducted by The Learning Network for Health & Human Rights at the University of Cape Town (Haricharan 2010), the most common concern of HC members was greater training in community representation and more understanding of HC roles and responsibilities.

Yet some members of the Department of Health were critical of the trainings they had conducted, with a Department representative reflecting that "there was a big drive in 2008 [for training], contracted by the Department... From my side, very little return for their investment." In this stakeholder's opinion, community representatives lack the administrative rigor necessary to benefit from training, with this Department representative criticizing attendees for failures in "respecting people's time, contacting [Department members], keeping informed, making sure they arrive at the right time, constituting a proper meeting, taking proper meeting procedure...all of that is missing from this process." While HC members regretted that unavoidable issues such as access to transportation and prior commitments had restricted training attendance, limiting the benefits of these previous trainings, these community representatives nevertheless emphasized the importance and success of these trainings.

These opposing perspectives on the value of training (between the Department and community representatives) can be explained by the divergent ways in which the two groups define training success. Because the Department is a large governmental institution that is evaluated on the basis of achieving measurable targets within a limited budget, cost-benefit analysis defines its success or failure, whereas community members and trainers may gauge success on factors not amenable to quantifiable measures such as individual empowerment or community participation. Further, with this administrative training thought to provide a demonstrable impact only once a threshold number of representatives have been trained, the Department would need to scale-up training to reach this tipping point and see a significant correlation between representative training and community participation.

## **E. Policy Implementation**

As the Western Cape Province seeks to implement the DHS, it has concentrated on three strategic objectives – addressing the backlog of service provision inherited from apartheid, reconfiguring the balance of resources spent at tertiary level in relation to that spent at primary (district) level, and setting up functioning districts and DHS management teams, principally a collaboration of the Provincial and City health services. However, in reforming policy, less attention has been paid to establishing effective institutions for community participation at the local level. Because the CMHF has been drawn into trying to influence national legislation, it has not focused on building effective HCs, which would require investment in: how to mobilize communities to select representatives, how to ensure that HCs meet regularly, how to engage health services management, and how to interface communities with management at the local clinic level. While the DHS is being put into place, the absence of investment in community participation has not changed the way in which communities participate in the system. The health system has been reorganized so that management can be brought closer to communities and that communities can have a voice in policy, but without support in engaging communities through HCs under new DHS, many question the lack of focus on effective community participation in health system management, with many of the original government officials feeling “stuck” in the old system and operating as if no change has taken place. Where government managers continue to neglect community voices, there is a need for effective and engaged leadership who have a clear understanding of what kind of community participation is required and how that participation can be realized in a way that allows community representatives to find themselves more active members in the health policy process.

To realize this vision, the Department of Health promulgated new legislation in December 2010 to institutionalize a District Health Council to address community concerns pursuant to the National Health Act of 2003 (Department of Health 2010). This Western Cape District Health Council Bill defines the DHC as including:

- (a) a Chairperson, as a member of the metropolitan or district municipal council in the specific health district, nominated by the relevant council;
- (b) a person appointed as a representative of the Provincial Minister;
- (c) a member of the council of each local municipality within the health district, nominated by the members of the relevant council; and
- (d) not more than five other persons, appointed by the Provincial Minister after consultation with the municipal council of the metro or district municipality.

Without formal community representation under this new policy, the DHC intends to elicit community participation through its authority to “consult with or receive representations from any individuals, organizations, or institutions on any matter regarding health or health services” and to “ensure that appropriate and comprehensive information is disseminated to the local communities on the health services in the health district” (Department of Health 2010). With this new Bill never explicitly requiring formal structures for community participation in this advisory role, stakeholders expect that the establishment of this DHC will lead to the dissolution of the CMHF, bringing an end to efforts in the Western Cape to foster community participation in the health system.

Adding to this uncertainty in structures for community participation, the Department of Health has not adequately communicated to community representatives what future effect the DHCs will have on existing participatory structures, with members of the HCs and CMHF unaware of the likely impact on their respective roles. As the Department of Health reviews the previous structures in place as it prepares to align itself with the new DHCs, government officials fret the prospective loss of the CMHF, explaining:

This is going to be a challenge. Because we've legitimised these structures, because we interact with them, because we give them funding. And once a District Health Council comes into being, [the CMHF and sub district foras] have the perception they are legitimate. But they are actually not legally legitimate in terms of the structure. It's going to call all of this into question. And there are going to be some serious—I can just already see the dynamics that are going to fly around the issue.

With the District Health Councils not yet implemented, this review will be critical in identifying gaps relating to the role community participation will have in the health system.

In the absence of legislative authorization of their own operations, the CMHF and HCs have evolved over time to serve a quasi-official role for community participation in the health system, and yet their future is unclear without formal institutionalization. As seen in the institutional experience of the CMHF, the goals, expectations, and methods of community participation must be clearly defined and formally established to ensure a positive working relationship between the local government and community representatives. And even where such participation is institutionalized, such representation alone will not ensure the benefits of community participation. In order to avoid these implementation problems through the DHC, specifically defined objectives and responsibilities must be outlined in a transparent and interactive way, with significant community input, to create mutually-accepted, effective, and legitimate institutions to represent the community's needs. Through a transparent, just, and carefully defined policy, this new institution can develop a process by which the community's specific roles are clearly defined, in which each representative is perceived as a valid representative of the community, in which capacity is built for engagement with the health system, and in which the DHC appropriately addresses the community's concerns and values.

## **CONCLUSION**

With community participation vital to realizing South Africa's commitment to the human right to health, it is crucial that policies address the processes by which participation is established, formalized, and maintained within the health system. Because of the shortcomings in community participation, exemplified by role of HCs in the CMHF, many have come to undervalue the relationship between the government and the community since the hopeful beginnings of community participation in the birth of the New South Africa. While the Western Cape has taken evolving steps to institutionalize these participatory frameworks, with the development of the Draft Policy and most recently with the legislative approval of DHCs, these transitions may

signal the decline, demise, or complete reconfiguration of existing structures for community participation, leaving the HCs without direction moving into the future.

From the Western Cape experience, many lessons emerge in the context of policy development for community participation in the health system. To assure the success of institutions for community participation, this research finds that there must be clearly defined roles and functions of community representatives, codified in legislation, that specifically outline how communities engage with government through effective and accountable channels for participation. To facilitate this rights-based participation in the health system, ongoing training and policy support must be established to enable communities to communicate with government officials. Without legislative authority that articulates participatory structures, community participation is likely to fall into uncertainty, inefficiency, and ultimately dissolution.

There are abundant benefits of community participation, but these benefits have the potential to be lost in a system in which community participation is exclusively dependent on power structures, political will, and informal institutions. Without further research to establish clear and precise roles for participatory institutions, paired with extensive training and capacity building for representatives, community participation will not be able to achieve its full potential in the health system.

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