RMCH
REDUCING MATERNAL AND CHILD MORTALITY THROUGH STRENGTHENING PRIMARY HEALTH CARE

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Black Sash RMCH Literature Review: Situational Analysis

Strengthening Public Accountability Mechanisms to Improve Maternal and Child Health Services

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Acronyms

CC	Clinic Committee
CDU	Community Development Unit, Nelson Mandela Metropolitan University
CLOS	Community Liaison Officers
CHC	Community Health Committee
DHC	Dispensary Health Committee
EC	Eastern Cape
HCC	Health Centre Committees
KZN	Kwa-Zulu Natal
NHA	National Health Act
NHC	Neighbourhood Health Committees
PHC	Primary Health Care
PRA	Participatory Action and Reflection
RMCH	Reducing Maternal and Child Mortality through Strengthening Primary Health Care Project
RMCH	Reproductive, Maternal and Child Health
TB	Tuberculosis
UCT	University of Cape Town

Community Health Committees

Background

Since the advent of the Alma Ata Declaration a number of reforms have been implemented in signatory countries to include community participation as a founding principle in health policies and legislative frameworks. The South African National Health Act (NHA) 61 of 2003 and the White Paper on the Transformation of Health in South Africa, provides the legal basis for Clinic/ Community Health Committees (CCs/CHCs) and outlines their intended purpose. The NHA further emphasises that Provincial legislation must provide for the establishment of CCs/CHCs and outline their functions. These health committees must at the very least include the following:

(a) one or more local government councillors;
(b) one or more members of the community served by the health facility; and
(c) the head of the clinic or health centre in question.

(NHA 61 of 2003, Chapter 6, Section 42).

CCs/CHCs are known by several names across the continent but all serve a similar purpose of strengthening the relationship and partnership between health workers and the community and providing a space for community participation in health. Community participation is meant to be further elevated to the District level where increased management of health services is located. A tiered system of representation is envisioned whereby the voice of ordinary citizens moves from the local to the Sub-District, District and ultimately Provincial levels. This is intended to allow communities to become instrumental in influencing their health services and promote public accountability. CCs'/CHC's are acknowledged as a crucial component of a comprehensive primary health care model (Boulle et al., 2008).

"These structures offer the opportunity for a very tangible democracy in which ordinary people can participate and make a difference. They provide an opportunity for the voice of the most marginalised to be heard, for a dynamic process toward the progressive realisation of the right to health; and for radical transformation that can start at the local level but which defines the essence of a democracy" (Boulle, 2013).

Evidence on Clinic / Community Health Committees: South African Experience

CCs Evidence of success:

According to an HST study conducted by Padarath & Friedman (2008), CCs have played an instrumental role in improving health outcomes, ensuring greater efficiency and effectiveness in healthcare, and in ensuring equitable outcomes and extended coverage of services. The

report also reported on the success of an EC CC in securing emergency medical transport for patients in the catchment area of their clinic. This CC was also successful in ensuring a more consistent supply of medication at the clinic. In KZN, a CC was able to negotiate with their local chief for land to be used to construct accommodation for the facility nurses (Padarath & Friedman, 2008).

Factors facilitating the effective functioning of CCs

- Explicit political support in order to champion the issues raised by the CC
- Support from health facility staff: enabled through highlighting the value of the participation from these CCs. Lack of support and co-operation often occurs due to the perception of clinics staff being policed by governance structures. The report also highlighted that the support from health facility staff is important for the effectiveness of the CC and without this support the CC is limited from developing into a structure playing an effective role in the governance of the health facility.

Factors impeding the effectiveness of CCs

- Lack of stipends: It was reported that committee members fail to attend meetings as a result of the travelling costs; this was also found to be one of the reasons why some facilities do not even have CCs.
- Lack of local councillor representation on the CC
- Roles and responsibilities not being clearing defined and understood and as a result the activities of the CC was found to be mostly confined to problem solving between the community and the health facility
- Lack of provincial guidelines

Evidence from Nelson Mandela Bay, Eastern Cape

A CDU Experiment with Participatory Reflection and Action Methods, 2007

Health Committees have been active in Nelson Mandela Bay Metropolitan area since 1996, however it was only in 2009 that Provincial policy was promulgated in the Eastern Cape to formalise their establishment and functioning. A project was implemented in 2007/08 by the Community Development Unit (CDU), Nelson Mandela Metropolitan University with assistance from The Regional Network for Equity in Health in East and Southern Africa (EQUINET) and IDRC Canada, which aimed to strengthen the relationship between frontline health workers and CHCs. The CDU worked closely with both the municipal and provincial health departments which included the Community Liaison Officers (CLOs). The project sought to strengthen the capacity of the CLOs to improve the functioning of the CHCs,

ensure they understand their roles and responsibilities and understand and prioritise local health needs. The project focused on one pilot CHC with the intension of building the capacity of the CLOs and the municipal and provincial departments of health to roll out the participatory tools to other CHCs in the Nelson Mandela Bay district.

The project was part of a regional programme which supports participatory approaches to community centred health systems in East and Southern Africa. The pilot project explored whether Participatory Action and Reflection (PRA) facilitation techniques could strengthen community participation and contribute to a more comprehensive understanding of the roles and responsibilities of CHCs. The project concluded that PRA was a very useful tool to strengthen the work of CHCs (Boulle, 2008).

At the commencement of the project it was found that although the Nelson Mandela Bay Municipality, Sub-District had established CHCs these were functioning poorly. Many of these CHCs were not elected democratically and representatives had rather been selected by the facility manager. CHC representatives had not been furnished with the necessary training or resources to meet their responsibilities. Moreover very seldom were facility staff included in CHCs and ward councillors were almost entirely absent (NMMU, 2006).

An audit of CHCs in Nelson Mandela Bay Municipality conducted by clinic supervisors in March 2006 revealed that 50% were non-operational in that they did not have any active community participation and representation. This means that the health priorities of communities were not being adequately represented or addressed by the CHCs (Bala, 2006). To address these shortcomings the recently appointed Health Promotion Manager at the District Department of Health together with the CLOs which reported to the manager were tasked with establishing and supporting the CHCs. It is important to note that before the appointment of the Health Promotion Manager there was no one at district level who was responsible for making sure the CHCs were functioning (Boulle, 2008). In several districts across the country, including OR Tambo where the Black Sash RMCH project is being implemented, this function continues to be vacant with no clear responsibility allocated to promote CHCs.

Methodology: The Participatory Reflection and Action Process

The project included the following:

- A baseline review using a pre-test questionnaire with health workers and community members eliciting views on the functioning of CHCs, which was repeated at the end of the intervention to measure progress.

- Training representatives from the District Health Promotion Team with emphasis on the CLOs to use participatory methods to explore the role, functions and purpose of CHCs as well as planning interventions to be implemented with the pilot CHC.
- Facilitating with the support of CLOs participatory workshops with the pilot CHC and community stakeholders to explore roles and functions of committees.
- Supporting the CLOs to follow up with the department and the community to share the understanding of CHC roles. Supporting the CHC to identify and address the health priorities of the community within the Local Integrated Development Plan process.

PRA techniques were used within a number of workshops held first with health workers and subsequently with the CHC members and local community stakeholders along with their supporting health workers. The PRA approach is said to be effective in harnessing the voice of the community and especially the voice of the marginalised who might struggle to be heard in other spaces.

Social Mapping: was one of the PRA techniques used whereby CHC members and community stakeholders grouped together according to their local geographical areas to map out and analyse their local communities and facilities by drawing community maps. The community mapping was received enthusiastically by participants and was a brilliant tool for stimulating conversation around resource access and barriers and other important issues. Participants would then identify a range of different social groupings and map out their distribution such as soup kitchens, Policing Forums, local HIV support groups, shack dwellers, criminal gangs and loan sharks. Participants would then identify which of these groups hold power and which are vulnerable and the nature of their influence, as well as an emphasis on their voice within the CHCs.

The maps were used as a basis to then launch discussions around health problems and health needs and whether these were localised in specific areas. The various health needs could then be further prioritised through a ranking exercise. This process then developed into a discussion around understanding the health systems within which CHCs and other stakeholders are operating in. Key reflections to come out of these discussions included important insights such as “that those health workers seen to be closest to the people i.e. those at the clinic, were not decision makers; and that the decision makers at district and provincial and national health management were probably unaware of the problems being experienced at the local clinic level... there was a growing understanding that the CHCs provided an avenue and opportunity for channelling concerns about health issues to decision makers” (Boulle, 2008: 14).

Stepping Stone Activities were used to understand what role communities and other key stakeholders could play in improving the health system. This PRA technique took one key health issue e.g. Tuberculosis (TB), and then unpacked the various steps that were required to successfully combat this health issue. The steps would be laid out as symbolic 'stepping stones' along their journey to crossing their figurative river. These interventions (stepping stones) including activities such as establishing food gardens, promoting healthy diet and behaviour, education around importance of taking TB medication etc. The next step would be to identify the various groups who could contribute to realising these goals through a mapping diagram e.g. NGOs, various government departments, business community, churches, schools, traditional leaders etc.

Key Lessons from CDU Experience

Unexpected Impacts of Political Pressures: The CDU's experience illustrated the significant impact that broader political pressures can have on one's work with CHCs and the importance of having political champions within the Department of Health to support the work. The CDU's work was undermined by broader political processes outside of their control especially the instructions from the Provincial Department of Health that all Health Promotion Managers should focus their energies entirely on fighting TB. The result was that the Health Promotion Managers suspended the CLOs' efforts to support the CHCs and rather attend to the TB crisis.

PRA Techniques as Inclusive and Powerful Tools: This case study illustrates how PRA techniques are very effective in stimulating broad participation of community members. PRA can be used as a technique to generate an understanding of the role of CHCs among stakeholders. It can also be used as a tool by CHCs and health workers to engage the broader community and give them voice in prioritising health needs as well as coming up with solutions and action plans to address these needs. PRA tools are also useful in assisting community understanding of how integral their role is in contributing to health promotion in their community and the potential of CHCs as the embodiment of meaningful community participation.

Community Participation is Essential to the Success of CHCs: One of the key reasons identified for the failure of the CHCs was that community participation was not prioritised. This relates both to the token level of community participation in CHCs as well as the lack of consultation between CHCs and the local community which results in a lack of support for and ownership of CHCs and in extension the local health system. The participation of community stakeholders is also essential in holding the CHCs to account. Once community

members are aware of the roles and responsibilities of the CHC they become more vigilant in monitoring them and demand they play their roles adequately.

The Roles and Responsibilities of CHCs are poorly Understood: It was clear from the engagements that neither the community, CHC members nor health officials were very clear on the roles and responsibilities of CHCs. Some of the examples that illustrated the confusion of roles included: the demand for stipends illustrating a confusion between the role of CHC members in comparison with health volunteers; the expectation of assuming management functions at facility level; the request for CHC members to be involved in clinic duties such as cleaning; and the primary focus on handling complaints versus problem solving (Boulle et al., 2008).

UCT programme to support and strengthen the committees in Nelson Mandela Bay

Following the 2009 Eastern Cape *'Policy on the Establishment and Functioning of Clinic and Community Health Centre Committees'* a number of CHCs were set up and trained in the Nelson Mandela Bay Metro. Boulle (2013) who was involved in this project comments that "It was an ambitious project but was thorough and through a social mobilisation process, nomination and election process 49 committees were established, and thereafter 500 committee members were trained". However two years later when Boulle became involved in a UCT programme to strengthen the CHCs they found that the committees she had left so enthusiastic and vibrant were struggling. Many of the CHCs had lost more than half of their members, 46% of them were not meeting regularly and the committee members expressed their despondency with the health system (Boulle, 2013).

Key Factors Undermining Clinic Committee Functionality

Health Function Centralised under the Province: Previously both the Provincial Department of Health (managing eleven health facilities) and the Municipal Directorate of Health (delegated responsibility for PHC to 42 health facilities) were operating within the metropolitan area. However in mid 2012 the Province took over this function which has caused serious upheavals and resulted in a shift of priority away from the CHCs with no support being provided or forums convened.

No Programme Person or Portfolio responsible for CHCs: The shift of power to the province also meant that there was no clearly outlined responsibility for CHCs.

Reporting and Tiered Representation System: Although the reporting procedures are clearly outlined in the policy document whereby Sub-District and District forums provide the vehicle for CHC committees to take their concerns and suggestions- these forums have not been championed by the Department of Health.

Uncooperative Facility Managers thwart CHC Progress: Facility Managers were integral to the effective functioning of CHCs however it was found that only half of the managers actually attended meetings. Moreover, **"**in only two instances did the facility managers provide reports to the committee. In the absence of the facility manager – much of the purpose of the committees is lost – for how is the committee able to hold the health services to account without a report from the manager?" (Boulle, 2013).

CHCs Felt Powerless to Demand Change: The CHCs reported feeling like they were being ignored as although they brought the concerns and complaints of the community to the facility they could see no recourse being taken to address these challenges. This is perhaps due to the failure of the tiered system of representation resulting in the CHCs having no way to escalate their complaints.

One-sided Relationship between CHCs & Facilities: CHCs expressed frustration with the fact that they championed the concerns of the facility e.g. lack of staff and stockouts creating difficult working environments, however they never received any feedback or acknowledgement with the concerns they brought to the facility.

Lack of Local Ward Councillors Participation in CHCs: In spite of the NHA, which requires their participation, they are simply not participating and championing these forums which mean the tiered system of representation is failing.

Progress Made

Facility Manager Reports: They were able to insist that the Facility Managers provide the committees with reports by educating them on this requirement and including it as an item on sample agendas.

Reviving the Sub-district and District Forums: With much work they have been able to revive the Sub-District forums which are being convened again, and continue to press for the District forums.

Key Lessons from UCT Experience

Importance of Political Champions: "Our work is with the committees: They are our target but we realise that we cannot make progress without the inclusion of the services: the facility managers, staff, health promoters Sub-District and District management. We are also trying to work with the councillors – this has proved more challenging" (Boulle, 2013). It is integral to also target these stakeholders for workshops and training opportunities to ensure they sustain the efforts to strengthen CHCs.

Importance of emphasising and learning from failures: There is a tendency to try to only report on the successes; however the introduction of presenting case studies of failures at

the Sub-District forums has proved to be an excellent learning opportunity among different CHCs.

CHCs require Constant Mentoring and Support to be Successful: Revitalising the failing CHCs has required constant mentoring by the UCT team who attend meetings, provide technical support and run refresher trainings on roles and responsibilities. A lot of energy also goes into working with and mobilising health officials.

PRA techniques have also proved invaluable as tools: to work with CHCs and community stakeholders.

Importance of Forums to bring CHCs together: Sub-District forums and other collaborative opportunities add much value to the work of CHCs so they may collectively address challenges and seek effective solutions. UCT has also initiated a successful exchange learning programme with CHCs in Cape Town.

Success of a Collaborative Approach versus Adversarial Approach: "We have seen the results of an adversarial approach. It has been shown to be of little use. Currently, we have one committee, in fact the committee that showed some of the most promise during the training that adopted a very adversarial approach with staff because of the bad attitudes of some of the staff members towards the patients. It has been a very rocky road. The committee was dismissed from the clinic by the staff (even though they did not have the authority to do so) and it has taken more than a year of meetings and a conflict resolution process to get the committee back to the facility" (Boulle, 2013).

Dangers of Forming a Social Compact between the Community and Health Services: Although as mentioned above an adversarial approach has been seen to be corrosive, one still needs to employ caution as a relationship of collaboration with the public sector can also lead to perverse incentives. As Boulle (2013) emphasises we need to be cognisant of the danger of "legitimising poor service delivery. This is an issue that health committees need to guard against. So becoming too close to the facility staff and listening to all their woes has inherent dangers. The committee needs at all times to represent the interests of the community" (Boulle, 2013).

Importance of Advocacy Interventions to navigate the contested space between public and community power: CHCs are entities that sit at the intersection between the public and community sphere, both which have different and often opposing agendas for engaging in a social compact. Advocacy can be an essential component in navigating this balance in any one community and it is here where the Black Sash can play a significant role (Boulle, 2013).

Evidence from Clinic Committees in Cape Town, Western Cape

Research done by Haricharan (n.d) on CCs in Cape Town found that the contributions of health committees were limited to supporting and assisting health services, as opposed to the participatory role these health committees are meant to hold. Health committees have the potential to positively impact health and health care services; however the effectiveness and functioning of these CCs are being undermined by a number of factors serving as barriers limiting their efficiency. The research highlighted that the following factors could enhance the functioning of CCs, resulting in improved health and health care services:

Co-operation and participation from ward councillors: who serve as a link between the committee and health authorities. Ward councillors are able to provide the political will to ensure meaningful community participation. Two of the case studies on CCs in Cape Town had representation on the committee from the ward councillor. These health committees therefore had the opportunity to discuss health matters as a political issue as they were able to raise issues around the shortages of doctors with the Sub-District, but they also had support from the ward councillor who approached the MEC for Health; regarding this matter. The ward councillor services as a link to the political system and without this political will, CCs might face frustrations resulting from a lack of access to the political level.

Co-operation from facility manager: In order for a health committee to fulfil its role as a liaison between the facility and the community, participation and cooperation from the health facility manager is crucial. Without support from the facility manager these health committees will be unable to fulfil their mandate.

CC engagement with the community: In order for the community to show interest in the health committee they need to be aware of what the CC/CHCC is doing. A lack of interest from the community also makes it difficult to recruit members and to create a sustainable and representative health committee.

Community CC membership is representative of the community: For the CC to serve as a link between the community and the health facility, the committee needs to not only be representative of the community but also representative of different parts of the community. The effectiveness and functioning of CCs is immensely enhanced by the participation of young people, as opposed to the committee only consisting entirely of elder members.

Haricharan (n.d) found the following factors to be negatively impacting on health committees:

- **Lack of basic material resources and funding:** The lack of basic resources such as telephone, fax, computers and stationary as well as not having access to office

space and equipment and administrative costs for the committee and for committee projects; affects the sustainability of these health committees. Out of pocket costs and being forced to carry the cost of participation by using their own phone and paying for their own transport, places an undue burden on committee members and often results in members leaving the health committee.

- **CC struggling with sustainability and functionality:** which is evident in irregular CC meetings, cancelled meetings, poor attendance at meetings and difficulties retaining members. The difficulties of finding a place to meet as well the lack of financial support, also affects the sustainability of health committees and results in these CCs/CHCCs falling apart.
- **Committee members lack of clarity on their role and function:** It was found that health committee members would only attend meetings when there is an emergency or crisis, and one or two committee members would be left to carry on the committee, whereas it was felt that during the time when there is no crisis or emergency; the committee should be working together to see what they could be doing and where they could be most effective. The research also stated that this lack of commitment from members might be due to their lack of uncertainty regarding their role and function. The research conducted with CCs in Cape Town found that committee members are often not aware of what their role and functions are and they have no knowledge on what they are supposed to be doing as a CC. This results in them engaging in what is often viewed as voluntary work, and they also don't know where the boundary between their work and that of the clinic staff and management exists. This lack of clarity regarding their functioning leaves the health committee powerless and confused about their role and mandate. This uncertainty of roles is one of the reasons for the poor functioning of CC, and this lack of clarity with regards to their functionality also affects the sustainability and functionality of the committee as representatives might opt to leave the CC/CHCC.

Evidence on Community Health Committees: African Experience

Evidence on Health Unit Management Committees in Uganda

A randomised case-control study by Bjorkman and Svensson (2009) of a project which sought to strengthen community monitoring of rural PHC facilities provides very interesting evidence on how HUMs can achieve positive health outcomes. The study was conducted over nine rural districts in Uganda and compared health outcomes between communities where the intervention was implemented and those without the intervention.

The intervention involved a local NGO which facilitated community meetings where the staff of facilities and community members could discuss the challenges and status of health service delivery. A pre-intervention survey was conducted after which a report card was generated for each facility which was used as a point of discussion in the meetings. The first meetings were held with community members where they identified key challenges and then developed action plans which they could implement together with service providers to address challenges. Information on health rights and entitlements were provided to enrich the discussions. Special attention was focused on ensuring broad participation especially by marginalised groups such as youth and women by forming small discussion groups.

Meetings were also held with facility staff where the pre-intervention data and the challenges identified by the community were discussed. After this a 'interface meeting' was facilitated between community representatives and facility staff where they discussed the action plan for improvements and unpacked respective rights and responsibilities of all stakeholders. The outcome of this meeting was the development of a jointly owned action plan and a 'community contract' which outlined how the community would monitor the agreement was being honoured. After six months a follow up community meeting and interface meeting were held and surveys were conducted to measure the impact of the intervention.

The community monitoring intervention was jointly implemented by the HUMC, local councils and ordinary community members. The successful multi-stakeholder approach to monitoring renders important lessons for the Black Sash proposed community scorecard intervention which would employ a similar multi-stakeholder approach.

The health outcomes in those facilities where the intervention was implemented were impressive. Access and utilisation of health services was 20% higher in those facilities including antenatal care, family planning and infant deliveries. In the intervention group a 35% reduction in the probability of infant death was found in comparison to the control group. There were measurably better process and output indicators in the intervention facilities e.g. staff absenteeism was less, waiting times were lower, facilities were cleaner and patients were more likely to report clinic equipment shortages. There was active community monitoring in the intervention sites which was illustrated by community members being better informed about the roles and responsibilities of HUMCs and more active discussions of the performance of health staff in the local council meetings held within the intervention communities.

The study further illustrated the efficacy of community monitoring by comparing treatment intensity across districts, it was clear that there was a positive correlation between community monitoring, health utilisation and health outcome indicators. However there could

be a number of other variables which influenced this which were not taken into account (Bjorkman & Svensson, 2009).

Another Study on Uganda's experience with Health Unit Management Committees

The health unit management committee is a channel through which community participation in health system governance is enabled (Konde-Lule, n.d). However, a study conducted in Uganda by Konde-Lule (n.d), found that public health centre management committees are not performing the role of community participation in the governance of their health centres as effectively as they are meant to. The efforts of these management committees are undermined and they are not able to effectively participate in health governance due to a lack of training on roles and responsibilities, no guidance and support, funding gaps, public ignorance of the existence of the management committee, and limited management experience and technical skills (Konde-Lule, n.d).

The management committee is a means through which the public can channel the views for improving health service delivery in their communities (Konde-Lule, n.d). However, in Uganda it was found the community was not aware of these management committee structures and this public ignorance means that the community and facility beneficiaries cannot submit complaints and suggestions through this channel (Konde-Lule, n.d).

It was also reported that the efforts of the committee were undermined as the committee did not have any representation from individual(s) with any technical knowledge in the medical profession and as a result they have been facing severe challenges. During research conducted in Uganda it was reported if the facility manager is the only member of the committee with the knowledge on health and medical issues, it would be easy for the facility manager to dominate and control the committee. This would results in the oversight roles of the committee being easily compromised. For the effective functioning of health committees' technical skills are also needed in the areas of finance and management (Konde-Lule, n.d). Further enabling factors enhancing the effectiveness of these committees involved identify individuals for selection on the health committee who would be willing to offer voluntary service and who have a diversity of skills to offer for the good functioning of the health committee, it was also reported that regular training should be provided for health committee members at least once a year (Konde-Lule, n.d).

Zimbabwean Experience with Health Centre Committees

A study conducted by Loewenson et al., (2004) provides valuable insights into the impact of Health Centre Committees (HCCs) on the performance of the health system and resource allocation. The study was a case-control study conducted over eight sites in Zimbabwe. The

study found a positive correlation between HCCs and improved health outcomes which included the following:

- Better staff
- Stronger links between communities and health workers
- Higher budget allocations
- Increased availability of drugs
- Significantly higher likelihood of health service use
    - Greater use of antenatal care
- Better community health indicators (health practices, health knowledge and use of health services)
- HCC initiated community outreach projects such as:
    - Building waiting mothers' shelters
    - Building water tanks and toilets
    - Raising extra resources for health

Evidence of what Health Centre Committees were able to achieve in Zimbabwe

The research study by Loewenson et al., (2004) identified three case studies within which HCC were able to achieve significant and successful outcomes. These were as follows:

- The HCC in Goromonzi played an instrumental role in dealing with the lack of water supply experienced at their clinic as well as in improving sanitation and community health education. It was also found that in wards where there were no health committees communities reported that problems were not being dealt with.
- In Gunde the HCC was involved in the procurement of a water tank for the health centre. Before this issue was taken up and resolved by the HCC, the water tank at the clinic was leaking and needed to be replaced to have adequate water stored as the lack of water was affecting the activities of the clinic. The nurse at the clinic informed the HCC that the health authorities were supply water tanks but these needed to be applied for. The HCC at Gunde was successful in their request for a water tank and they have also played an instrumental role in mobilising the community to provide labour for ensuring the installation of the water tank.
- The Gweru HCC was successful in the construction of a waiting mothers' shelter at the health facility. As there are no facilities at the clinic for pregnant women to stay, an increase in home deliveries was reported. The HCC then took on the construction of a waiting mothers' shelter for expectant mothers as one of their projects. The HCC was assisted by the ward councillor who consulted with the rural district council. The HCC was also instrumental in identifying a donor who would fund this project. This

HCC was successful however the project was stalled as the donor pulled out, due to delays in completion of project documents.

Although the HCCs evidently contributed positively to improved health outcomes, Loewenson et al., (2004) also emphasised a number of limitations to the influence of HCCs including:

- Little or no direct influence over core health budgets or over clinic management
- HCCs were not able to hold service providers to account due to their poor knowledge of health resources, staffing levels or budget processes
- Several members of the community were unaware of HCCs or their roles in health,
- Vulnerable and poor groups had difficulty attending HCC meetings and were often overlooked.
- The clinic committees are elected community representatives of the local health facility its membership includes the head of the health facility, the local government councillor, and community members who are serviced by the health facility.
- CCs ensure that the broad health needs of the local community are addressed – a useful conduit for community concerns to be raised within the health systems – bridging the gap between communities and the health services
- The aim of the CCs is to involve communities in the planning and provision of health services

Zambian Experience with Neighbourhood Health Committees

Zambian experience with Neighbourhood Health Committees (NHCs) provides a good case study of well functioning committees. Ngulabe et al. (2004) found that NHC representatives had been provided with formal training which was further maintained through a weekly community radio programme which graduates participants as 'community mobilisers'. The roles and responsibilities of NHCs appear to be well understood and clearly defined. A number of positive outcomes are believed to be associated with the NHCs, including improved community contributions to health promotion and including the increased uptake of water purification.

Kenyan Experience with Dispensary Health Committees (DHC)

Kenya is a country with scarce resources and faces many challenges in managing health services in way that ensures that the poorest have access to healthcare (Sohani, 2005). A model of healthcare delivery was developed and tested by Kenya. This model of healthcare involved the community in order to establish good governance at dispensaries managed by staff of the Ministry of Health. Community members were elected and served as

representatives on the Dispensary Health Committee (DHC). The main function of the DHC is to govern the health and development activities at the dispensary level. The model was based on the premise that one of the most fundamental ways of improving the quality of basic healthcare is to make the dispensary and outreach staff accountable to the communities they serve. Through this model, people from the community ar**e able to take charge of the way** in which health services are offered (Sohani, 2005).

What this model was able to achieve:

Through this model, the community was able to participate in the planning and managing of healthcare activities, and help safeguard against the misuse and appropriation of scarce resources (Sohani, 2005). Following the establishment of the DHC an improvement in the access to health care for the poorest was evident, as well and improvement in the quality of services offered by the dispensary. Additional improvements following this model included a regular and sufficient supply of essential drugs due to the improved management of available resources (Sohani, 2005).

Enabling factors enhancing the effectiveness of the DHCs

Democratic election of DHC representatives: When representative for the DHC were democratically elected by the community they were found to be more accountable to the community who elected them, and they were able to command respect and support from the community. This model of incorporating DHCs as part of establishing good governance with regards to healthcare was successful as it involved the community and in this way was able to receive community support. Also, the members of the DHC were representative of the whole community and not only the powerful and better connected groups (Sohani, 2005).

Effective leadership: DHCs with effective leadership were found to be particularly effective in being able to reach the right balance sharing power with the nurse in charge and motivating the members of the DHC to actively get involved in taking charge of health care activities at the community level (Sohani, 2005).

Barriers to the success of this model:

Conflicts between the clinic staff (dispensary nurses) and the DHC: progress was hampered due to conflicts related to nurses being reluctant to giving up control and the DHC members were often not confident enough to challenge their authority. Training should therefore be done with the clinic staff in addition with the DHC members. Training needs to be done with clinic staff so that they can be made aware of how the DHC could assist them in managing the dispensary (Sohani, 2005).

Political interference: Due to the success of this model the dispensary was able to accumulate funds in its bank account as a result of the efficient management of resources. A local councillor had intentions of gaining access to these resources and therefore had an influential role in members leaving the DHC and replacing them with individuals who would be more likely to adhere to his commands (Sohani, 2005).

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