Submission to the National Department of Health on the Draft Policy for Health Governance Structures

Introduction: This is a joint submission from the Health Systems Trust and the Learning Network on Health and Human Rights, a network of civil societies and universities.

Our experience relates to work we have done with health committees. Our submission therefore only relates to health committees. We have limited knowledge of how other health governance structures function and therefore refrain from commenting on the content of the policy in relation to these.

We acknowledge the National Department of Health's Draft Policy as a very important step in providing a legal framework for health governance structures, and specifically for health committees. We commend the department for taking this step. We feel that a policy is crucial for creating sustainable, functional and meaningful structures for community participation and addressing some of the challenges facing both these structures and the health system.

The following comments are divided into comments on the process of creating the policy and comments on its content:

Comments on the process

While we do appreciate the opportunity to make comments on the policy, we are concerned about certain aspects of the process.

1. The time frame:
    The time frame for comments has been too short. We feel that it is important to give sufficient attention to the policy and to consult broadly enough to ensure that community organisations and structures are heard and their input taken into consideration.

2. Broad consultation:
    Consultation with current health governance structures, civil society and other stakeholders: We are uncertain about how widely this draft policy has been circulated and to what extent health governance structures such as health committees have been consulted. We firmly believe that a policy on community participation should have input from community participation structures. It is also recommended that this draft policy is discussed at the National Health Council so as to ensure that MECs are aware of it and can promote it within their provinces.

3. Clarification:
    Finally, we believe there is a need to clarify how the two draft policy papers sent out for comments relate to each other. Is the 'Establishment of clinics and community health centre committees' an SOP to the policy or a separate policy? In addition, we are uncertain about whether there are pages missing in this document on establishing committees as it begins with 9.2. Moreover, the policy refers to an annexure that is not available in the document.

We would appreciate clarification on this point. We would also like to know what the timeline is for the policy and what plans there are for implementation.

In light of the above concerns, we would like to suggest the following:

1. that the NDoH seek broader consultation on this policy, especially with already existing health governance structures – if this is not already happening – and,
2. that it extends the deadline for comments.

Comments on the content

Due to the limited time allocated for comments, the comments below are our broad comments based on an initial reading and discussion of the documents. They are not exhaustive and – as stated – we feel that more time is needed to consult and think through the content of the Draft Policy. The issues we have identified thus far are:

1. The scope and force of the policy:

    Clarity is needed on the scope and force of the policy. Specifically, how does it relate to the National Health Act (2003), section 42 (3) which states that provincial legislation must stipulate role and function of health committees? Will the NDoH policy only be put in place in provinces that do not have existing policy on the role and function of health committees; does it replace existing policy in provinces which have formulated their own policies on the role of health committees? (such as those in Kwazulu-Natal, the Eastern Cape, the Free State, and Mpumalanga). Furthermore, how does it relate to legislation on other health governance structures, such as provincial policies on District Health Councils, Facility Boards Act etc?

    Finally, there is concern about how existing committees will be affected by this policy and clarification is needed on this.

2. Separate sections for the different governance structures:

    We believe that more consideration should be given into the purpose of having one policy for several health governance structures as these structures are constituted differently. Health committee members are appointed by the MEC after being democratically elected, while members of facility boards and district health councils are appointed. Though health committees and hospital boards may share similar roles, the role of district health councils is very different to that of health committees and hospital boards. We suggest having separate sections in the policy for health committees, hospital boards and district health councils.

3. Tiered health governance system:
   We would like the NDoH to consider a tiered health governance system where representatives from local tiers are represented at district, provincial and national levels. We believe it is worth considering how a tiered system could facilitate involvement in national policy issues and generally make for a more coherent health governance system.

4. Definitions of key concepts:
   We believe there is a need to define or expand the definition of concepts such as meaningful community participation, oversight, accountability, governance, participatory democracy. We are concerned about some of the policy's wording. An important example of how the wording and definitions can impact on the meaning of the policy is set out in the section that discusses the objective of health governance structures as being to 'assist the institutional management in meeting the greater burden of responsibility'. Our concern is that a governance structure should provide governance rather than 'assist' the facility management. We are aware that health committees exist in a context of power differentials and currently many health committees do not provide governance and are not part of decision-making, but rather take direction from facility managers. We are concerned that this objective reinforces the notion of health committees as structures that act under the instruction of the facility management rather than guiding management structures and ensuring community input. We find it important to stress that all financial matters must be aligned to the Public Finance Management Act.

5. Section 6. "Principles underpinning accountability and community involvement":
   Firstly, we would like to suggest that section 9 "Legal and Policy Prescripts" should precede this section. We also propose that this section is moved to the beginning of the policy and that the principles should be broader. We prefer the use of the term 'community participation' rather than 'community involvement' as we believe that health governance structures are about participation, which we understand entailing being part of a decision-making process and sharing power. We believe that these principles should refer both to local policies/charters such as the patients' rights charter and the Negotiated Service Delivery Agreement as well as principles listed in international commitments such as principles underpinning Primary Health Care in the Alma Ata Declaration, the right to health and the right to participation as stated in the International Covenant on Social, Economic and Cultural Rights, principles listed in the Rio Declaration on Social Determinants of Health and in the Millennium Development Goals. Lastly, we struggle to understand how 6.1 on individual responsibility to health relates to principles underpinning community participation and accountability. Similarly do we wish to state that we do not understand the appropriateness and relevance in Sect 5. Of quoting a document form 1983 [Organs of People's Power], where-as recently we have the Ouadgadougou declaration on PHC 2008, the Rio declaration and our own

Core Norms and Standards for Health which are all equally explicit regarding the potential strength and power of Community Leadership, Ownership and Governance.

6. Powers and functions of governance structures:
We note and acknowledge that health committees are identified as a 'structure of governance' (in section 1). We agree with conceptualising health committees as governance structures. However, we think there is a need to elaborate on how we understand and define a governance structure. We agree that a governance structure is "required at all times to be accountable to the communities served." We think there is a need to expand on what accountability means. In our opinion accountability entails accounting for the provision of quality of health care services, monitoring and evaluating these as well as having a role in resolving complaints. On that note, we propose that the fifth bullet point under section 7.6 be changed to include community representatives being part of resolving complaints as appropriate as opposed to monitoring the resolution of complaints. We also believe there is a need to expand on governance structures as 'providing governance'. We would like to suggest a definition of governance that includes: providing guidance, leadership, strategic direction, being involved in the planning of health services. A governance structure, importantly, should be part of a decision-making process and have power to influence/make decisions. With regard to governance, we would find it useful to delineate what is meant with 'governance' as opposed to 'management.' This may be useful in defining the roles of governance structures and the roles of management teams.

7. Roles and responsibilities:
We think that more work is needed on defining roles and responsibilities of health governance structures. In particular, we find the fundraising role to be contentious and problematic. While health committees could potentially assist facilities already engaged in fundraising, we do not think that it should be a core responsibility of health committees. On a similar note, we do not see health committees as structures responsible for sponsorships. The whole section: 7.5 is potentially contentious, some of the points closely emulate managerial functions and responsibilities. The role of governance should focus on the HRM Strategy rather than HRM functions. We suggest that the role of the facility management in terms of the governance structures should be included in this policy.

8. Communication, reporting and linkage between structures
If communities are to participate effectively in health governance it is important that their views be considered and the trends in the problems they raise not only be considered by the MEC for health as set out in this policy, but also at a variety of different levels in the health system. For example representatives from health committees or even from sub-district health fora should be able to provide feedback to and raise issues with the district health council, the provincial consultative health fora, the provincial health councils or even the National Health Council. We reiterate that it is

important to consider how structures such as the National Health Council, provincial health councils, district health councils, facility boards, consultative forums on health and health committees relate to each other. We also would like more clarity on reporting and communication lines.

9. Section 8 "Challenges facing governance structures":
Section 8 is of great concern to us. We fully agree that the issues raised such as transport, lack of budgets, lack of telephone and ensuring that committee members get time off for meetings during working hours are crucial challenges. There is sufficient evidence that these impact negatively on the functioning and sustainability of committees. However, the policy does not address these challenges.
We would like to suggest replacing this section with a section that stipulates how these challenges are going to be addressed. This could be covered in a section titled *support for health committees and* should include information about how logistic support will be provided for health committees to ensure that these become functional committees. Financial support to cover running cost of the committee, reimbursement for transport and other expenses should also be stipulated. It is also worth considering whether committee members should receive a stipend or being reimbursed for time taken of work to attend meetings. The policy should discuss how and who will provide this logistical and financial support for health committees to be able to function effectively as structures for community participation in health.

10. Training and orientation, section 7.11:
We note that the NDoH acknowledges the importance of training and orientation of members of governance structures. We agree that this is of utmost importance, especially for health committee members who often come from 'marginalised' communities and have limited formal education. However, we believe that the policy should stipulate whose responsibility training is and how it will be funded. We also find it important to stipulate that appropriate induction, on-going capacity building, learning experiences and training should be aimed at strengthening existing capacity and building capacity of the governance structure and individual members to meaningfully fulfil their roles of providing governance and having an oversight function, as this will strengthen community ownership in the health system.

11. Election and composition of health committees:
We think that there is a need to carefully consider how health committees should be elected. In other words should there be 'open' election or should health committees be composed by certain sector representatives. This is a contentious and problematic issue. We recognize that sectorial election has advantages such as helping groups coming together and solidify community engagement. However, consideration needs to be given to the rationale behind the composition suggested in 9.3. We appreciate that some groups have been selected because they represent particular vulnerable/marginalised groups or because their co-operation with the health services is needed. However, there are other marginalised groups that are not represented – such

as refugees and sexual minorities (the LGBTG 'community'). There may be vulnerable groups that are not represented by community organisations and would not be represented at the committee due to sectorial representation.

Thus, we think it would be worth considering outlining principles for composition rather than pre-designated sector representations. These principles could relate to broad/fair representation of sectors present in the local area, based on principles such as diversity and striving for representation of vulnerable and marginalised groups. We would also like to suggest not limiting the size of health committees, but rather let size and composition be determined by local context.

12. <u>Social mobilisation to elect and nominate committee members:</u>
    The nomination process (section 9.4): We acknowledge that the facility management teams have the responsibility of organising a public meeting to facilitate the nomination process and to inform relevant stakeholders. However, our experience in the Eastern Cape suggests that it is important to engage in a social mobilisation process prior to public meetings to ensure participation. We would therefore like to suggest that the organising committee should be responsible for social mobilisation.

13. <u>Facility managers and ward councillors' role and participation:</u>
    There is a need to consider how to support/ensure participation by facility managers and ward councillors. The facility managers' attendance is crucial to the functioning if health committee. The ward councillors' participation opens the opportunity for reporting into the District Health Council and the sharing of community knowledge on health issues.

<u>Closing remarks</u>

In concluding, we would like to reiterate that this draft policy is a very important step in providing a framework for functional community participation. However, given the complexities of such a policy we propose that sufficient time is given for consultation with community structures and health governance structures to ensure a carefully considered sound policy based on buy-in from relevant stakeholders. We look forward to further engagement on the policy.