Promoting partnership between Communities and Frontline Health Workers: Strengthening Community Health Committees in South Africa.

A Participatory Reflection and Action Project
REPORT

Community Development Unit,
Nelson Mandela Metropolitan University
South Africa
with the Regional network for equity in health in east and southern Africa (EQUINET)

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. This report has been produced within the capacity building programme on participatory research and action (PRA) for people centred health systems following training by TARSC and IHRDC in EQUINET. It is part of a growing mentored network of PRA work and experience in east and southern Africa, aimed at strengthening people centred health systems and people's empowerment in health.

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Executive Summary

The Community Development Unit, Nelson Mandela Metropolitan University with support from The Regional Network for Equity in Health in East and Southern Africa (EQUINET) and IDRC Canada, initiated a process to strengthen the relationship between the Community Liaison Officers and health advisors (as representative of the frontline health workers) working within Nelson Mandela Bay Municipality and the Community Health Committees of Sub-district B (Uitenhage and Despatch). The purpose was to strengthen the relationship between these frontline health workers and the community, through the formalised structures of the community health committees.

This work was implemented as part of a multi-country programme exploring different dimensions of participatory approaches to people centred health systems in east and southern Africa, through Training and Research Support Centre (TARSC) and Ifakara Tanzania in the Regional network for equity in health in east and southern Africa (EQUINET).

The process included participatory workshops with twenty-four health workers which aimed to increase their understanding of Community Health Committees (CHCs) and participatory techniques, so as to be able to support the CHCs more effectively in future. The Community Development Unit then worked with two of these health workers to plan and conduct a three-day Participatory Reflection and Action (PRA) workshop with thirty representatives from Community Health Committees and key stakeholders in Sub-district B, intended to strengthen community participation and deepen an understanding of the roles and responsibilities of community health committees.

Both qualitative and quantitative findings were recorded. The quantitative findings were drawn from pre- and post- test questionnaires which were intended to be conducted with both groups. The pre-test questionnaires demonstrated that both health workers and communities acknowledged the important role that community health committees could play in the health system. Community members however were more knowledgeable of the members of the community health committees and their meeting practice. Health workers were more aware of the potential influence and role that CHCs might be able to play in the health system.

The process with health workers was thwarted in that the Health Promotion department received instructions during this time from Provincial Health Department to focus their efforts entirely on fighting tuberculosis, and to suspend their other work. This severely limited the process as it was the intention to work with the health workers to deepen their knowledge and understanding of PRA by actively working with the CHCs in planning and implementing PRA processes in their sub-districts. Three health workers from sub-district B were however willing and keen to continue the PRA process which was progressing.

Qualitative findings were recorded from the discussions and activities within the workshops which aimed to develop an understanding of local communities, identifying needs, prioritising these, identifying problems and planning subsequent actions to take on as community health committees.

The workshops provided an opportunity for health workers to discuss the roles and responsibilities of Community Health Committees and to recognise that these structures are sorely under-resourced. They recognised that as health workers they provided limited support for Community Health Committees. The community workshop provided an opportunity for community members to network together and to discuss issues of common interest. Mapping of neighbourhoods surrounding the health facilities provided an important opportunity for exploring the similarities and differences in the challenges and resources available to the local

communities. There was an acknowledgement from community members that seldom is an opportunity provided for community members to discuss together in an in-depth way the problems affecting their communities. Community members became more aware of their commonalities, particularly those negatively affecting their communities, such as alcohol abuse, gangsterism and crime, teenage pregnancy. The health workers of sub-district B invested much energy into the process and expressed their eagerness to pursue PRA further and to work more closely to promote the CHCs.

The post-test survey with community members was of particular interest in that instead of increasing knowledge and awareness of CHC members, the community became aware of the important role and function that these committees play, and after the workshop the post test revealed that community members were less sure that members had been elected, that they knew all members of the CHC, and that CHC members properly understood and were trained for their roles.

The post-test questionnaire with health workers was conducted seven months after the initial workshops, and without support from CDU. The questionnaires indicated more awareness of the CHCs, their potential and limitations. Some of the responses to the statements were difficult to understand and warranted further discussion. Given the time constraints and the working instructions, it was not possible to discuss further. This is a limitation for this study and presents an opportunity for further investigation in future.

For the members of the Community Development Unit, it was agreed that this should be the start of a process. The staff agreed that PRA was a most useful method of working with communities. The starting point where communities know their needs best and are able to articulate these, and develop this further together to understand community dynamics and problems is a most empowering process. We recognised however that ongoing work within the community with both health workers and community members needs to be done to ensure sustainability of the process.

1. Background

Increasingly since the health reforms initiated by the Alma Ata Declaration, policy makers have included elements of community participation within the policies and legislated frameworks for health in numerous participating countries. From these countries, their community participation processes, and the studies that have been conducted, there are numerous lessons to be learned about community participation in health (Baez and Barron 2006). There are a range of documented formalised community health structures, be they health centre committees in Tanzania, village health committees and health centre committees in Zimbabwe, neighbourhood health committees and health centre committees in Zambia or community health committees in South Africa. They are all intended to serve a similar purpose: providing an opportunity for community members to participate, interact and partner with the health services to promote health within local communities. The intention is to further elevate participation to the level of the district, where increased authority and management of health services is located. Communities would then have the opportunity to become instrumental in directing health services.

The Zambian experience has been well documented. (Macwan'gi & Ngwengwe, 2004; Ngulube et al., 2004; Ngulube et al.,2005). Ngulube *et al.* (2004) administered semi-structured questionnaires, interviews, focus group discussions and workshops in Zambia in their research on governance and participatory mechanisms and structures in the health system. Their findings indicate that at the local clinic level, Neighbourhood Health Committees (NHCs) have been well supported by the community. Roles and functions of the NHC have been clearly defined and are understood. NHC members have been formally trained, a weekly radio programme supports this training and members graduate as 'community mobilisers.' The results of their efforts have been promising. There have been positive changes noted, especially with increased community participation in health promotion and specifically with the uptake of water purification.

Lessons can also be learned from studies conducted in Zimbabwe. Loewenson et al., (2004) conducted a case-control study, conducting interviews and focus group discussions at eight sites in Zimbabwe assessing the impact of Health Centre Committees (HCC's) on health system performance and health resource allocation. A few important findings were indicated in this study. Firstly, HCC's are associated with improved health outcomes. Loewenson *et al.* (2004) were able to indicate that there were more staff, higher budget allocations, more Expanded Programmes of Immunization (EPI) campaigns and better availability of drugs at health facilities with HCC's. Secondly, there were improved primary health care (PHC) services at the facilities. Lastly, there was a better understanding of community needs, especially those for environmental health and service quality, and a perception that there was an active response to these needs.

In South Africa, formalised structures for promoting a partnership in health between communities and health workers are recognised as an important step towards realising community participation in health, an essential ingredient towards a model of comprehensive primary health care. Community Health Committees (CHCs) are proposed as a statutory structure at each health facility to develop this partnership. An outline of their intention and purpose is contained within the South African National Health Act 61 of 2003 and within the White Paper on the Transformation of Health in South Africa (Republic of South Africa 1995).

CHCs comprise an elected body of people who serve as representatives of the community at the local health facility. Included in their membership are the head of the health facility and the local government councillor. They are intended to serve an important function in

ensuring that the broad health needs of the local community are addressed. Their aim is to involve communities in the planning and provision of health services, promoting public accountability and encouraging communities to take greater responsibility for health promotion. In essence, they are established to serve as the dynamic liaison between the community and the clinic and to foster co-operative governance. Representation is intended to be tiered toward representation at the sub-district, district and ultimately provincial level.

Currently Community Health Committees are not functioning as effectively as they could be within Nelson Mandela Bay Municipality (NMBM). A report about one area of the municipality, sub-district B, compiled by the Community Development Unit for the Municipal Health Directorate in June 2005 indicated that the area met the legislated requirement of having committees with community members, with eleven committees involving local health volunteers, but that these were poorly functioning and served limited purpose (NMMU, 2006). Frequently the health committee members were selected by health facility staff without the involvement and knowledge of the local community. It would appear that the CHC members are rarely provided with skills or resources to adequately manage this task. Health facility staff were also seldom included within the structure, and ward councillors were mostly absent.

A subsequent audit of CHCs conducted in Nelson Mandela Bay Municipality by the clinic supervisors in March 2006 indicated that more than 50% were not operational (Bala, 2006). At that time, of the 49 potential CHCs at fixed facilities, 24 had CHCs which were described by health personnel as “operational”; seven were described as of “limited functioning” or “barely functioning”; and 18 had no committee at all. (Bala, 2006). This means that just over 50% of the clinics did not have active community representation and participation through the CHCs. The health needs and opinions of the communities served by these facilities were, therefore, not being properly represented and thus not adequately addressed. At the meeting of health facility supervisors, the health promotion programme manager was encouraged to improve the situation and actively establish and promote CHCs in the district.

Five Community Liaison Officers (CLOs), employed by the Health Department, responsible to the Health Promotion Manager (District Department of Health), were tasked to establish, support and develop CHCs. Until the appointment of the Health Promotion Manager for the District however, this function was neglected. The CLOs claimed in a meeting with the staff of the Community Development Unit that they were regarded by the health department to be a viable conduit for input from the local community and were expected to assist with the numerous campaigns that the Health Department implements. They expressed their frustration at not having their independent programmes. The appointment of a Health Promotion Manager allows the work of the CLOs to become more focussed and enhances the opportunity to promote CHCs.

This participatory process was carried out within Nelson Mandela Bay Municipality (NMBM) which comprises the three towns of Port Elizabeth, Despatch and Uitenhage, in the Eastern Cape Province in South Africa (See Figure 1). NMBM constitutes a health district, divided into three geographically distinct sub-districts. Each of these areas consists of an approximately equal population. Within NMBM, two health departments operate: the Municipal Directorate of Health, responsible for delivering primary health care (as a delegated responsibility from the Provincial Department of Health) to 42 health facilities; and the Provincial Department of Health, which manages eleven health facilities within NMBM. A policy of functional integration and understanding of collaboration directs their current operations. The current arrangement between the Province and the Municipality is, however, currently under review, with the possibility that responsibility for all personal health care may revert to the Province in the future.

Figure 1: Map of Eastern Cape: Nelson Mandela Bay Municipality spans Port Elizabeth, Despatch and Uitenhage

According to the NMBM Integrated Development Plan (2007), there are 1,3 million people resident within the municipality. The population is 52% female, and 37% are youth below the age of 20. Functional illiteracy of the adult population is at 8,5 %. According to the integrated development plan for the area "The situation analysis of Nelson Mandela Bay indicates high levels of poverty and unemployment. 44% of the economically active population is unemployed and 38% of the total households is (sic) indigent." (NMBM, 2007: 130). The prevalence of HIV among pregnant women is 34,5%.

Prior to the commencement of this programme, the Community Development Unit had been working within sub-district B and had established a good relationship with the CLO and a health advisor. In 2006 a process was initiated to improve representation and accountability of the CHCs within the local community and to this end a number of workshops had been facilitated. The CLO and health advisors were being supported by the Community Development Unit to continue this process; and had been reasonably effective in providing for more representative structures and for some ward councillor involvement.

The work reported within this report was implemented by the Community Development Unit with the local municipal and provincial health departments, through the Health Promotion Programme which included the Community Liaison Officers. The process sought to promote and build on these existing relationships to better understand and address the problem of poorly functioning CHCs. It aimed to build the capacity of the CLOs to strengthen CHC functioning, and through a participatory action research process, to

- Enhance the confidence and capacity of Community Liaison Officers in their role of promoting and supporting effective CHCs throughout NMBM.
- Support a pilot CHC to understand its roles and responsibilities; understand the local community needs, and address a prioritised aspect of community needs.

It was intended that the CHC would be supported in this process to engage in a participatory way with the community to ensure that all voices are heard, in particular those of more vulnerable groupings such women, children, the elderly, people living with disabilities and adolescents. It was hoped that with increased communication, cooperation would be improved and that further steps towards and effective partnership and cooperative governance could be taken.

From this pilot work it was intended that all involved: the CDU team, the local and provincial health departments, CLOs and the CHC members would build skills and understanding, new knowledge and capacities to strengthen CHCs in the NMB district. The intervention in one area was intended to provide new knowledge and learning and skills to inform efforts to improve the functioning of the CHCs more widely and to share regionally on strengthening community participation in health.

The process was implemented as part of a multi-country programme exploring different dimensions of participatory approaches to people-centred health systems in east and southern Africa, through Training and Research Support Centre (TARSC) and Ifakara Health Research Development Centre, Tanzania, in the Regional Network for Equity in Health in East and Southern Africa (EQUINET). Two staff members of the Community Development Unit attended the EQUINET training workshop in participatory methodology in Bagamoya, Tanzania in February 2007. The workshop aimed to develop an understanding of Participatory, Reflection and Action (PRA) methods. The workshop promoted an experiential understanding of participatory methods and tools, and provided time and opportunity for participants to consider the application of PRA within the context of their work. It allowed for application for funding to implement PRA techniques within the context of our work within the theme of Promoting Partnerships between Frontline Health Workers and Local Communities. Follow up mentoring was given by TARSC and the network of health professionals working with PRA to the application of the approach to a specific area of work. This report is the outcome of that process which the Community Development Unit implemented.

The process was carried out by staff of the Community Development Unit (CDU), Nelson Mandela Metropolitan University, supported financially by IDRC Canada and technically by Training and Research Support Centre. CDU works to promote the voice of the community, particularly in relation to public health matters within the Eastern Cape Province, South Africa. Three staff members worked together in the planning and implementation of the process: Nomgcobo Makhamandela, Rhoda Goremucheche and Thérèse Boulle. The work was mentored, peer reviewed and technically edited by Rene Loewenson TARSC and Aaron Muhinda HEPS-Uganda provided peer review input.

2. Methods: The Participatory Reflection and Action Process

2.1 The design of the process

A PRA process was designed to address the aims outlined above. Following discussion with the Health Promotion Managers of the two health departments and with the CLOs, it was intended that the process would include:

- Implementing a pre-test baseline questionnaire to both health workers and community members on the functioning of the CHCs. This same test would be repeated at the end of the intervention to assess perceived change.
- Planning with and training representatives from District Health Promotion team in particular the CLOs on using participatory methods to explore the purpose, role and functioning of the CHCs and to plan an intervention for a selected pilot CHC.
- Negotiate with the local CHCs towards the implementation of a participatory process, involving them in the selection of the pilot CHC.

- Implement, together with the CLOs, a participatory workshop with a selected CHC and stakeholders on the roles and functions of CHCs.
- Follow-up to support the CLOs to communicate the understanding of CHC roles within the department and the community and to support the selected CHC to identify and address the health needs of the community in the Local Integrated Development Plan.
- Evaluation of the process through a post- intervention survey and review of the process and lessons learned for wider scale up including with the community and with the department of health at a quarterly Health Forum

The process included both qualitative and quantitative methods. The qualitative process included the use of PRA techniques within a series of workshops with health workers initially, and then with the local community and their support health workers. It was hoped that by initiating the process with the health workers, they would be sufficiently equipped to be involved together with the Community Development Unit staff in planning and implementing the subsequent process with the community, and thus ensure sustainability of the process.

We used the PRA approach and tools to promote the voice of the community, with consideration for those most vulnerable; and to provide for a cyclical process of needs identification, prioritization, problem identification and development of action plans to address problems and needs, to implement those actions and then reflect on the process and the changed needs after intervention.

2.2 Implementing the design and changes made

In the preparation for the work an introductory meeting was held with the Acting Director of the Municipal Health Department to obtain consent and buy-in to the PRA process with CHCs and health workers. Three meetings and discussions were held with the two Health Promotion managers working within NMB to explain the work and solicit their support, important as the CLOs fall directly under their authority. Both were enthusiastic and participated in the planning of the process and workshops. A meeting was also held with the local government Constituency Office as a start of a process to inform local ward councillors of the PRA process with CHCs and of their role in supporting CHCs within their wards. Ward councillors have an important role to play in linking CHCs with the processes of local government, and potential to access funds and support for programmes of the CHC.

The workshops for frontline health workers were expanded. Whilst CDU had initially planned to work with the CLOs, the Health Promotion Managers advised that the workshops could be extended to include the health advisors in the district. This increased the number of frontline health workers from five to twenty-four, which meant an expanded team and more supportive network of health workers. Two workshops were conducted with Community Liaison Officers and Health Advisors. The workshops intended to draw on their experience of working with communities and CHCs, to identify some of the gaps that exist in their functioning and to work out action plans to address these. Whilst CDU had hoped to host one two-day workshop with CLOs, because of the distances within the district, and the complications that transport arrangements seem to provoke, two separate one-day workshops were held within the sub-districts in NMBM for CLOs and Health Advisors.

Sub-district B was selected by the Health Promotion Programme as our area of operation, given the prior work CDU had conducted in the sub-district and its readiness to move forward. Two preparatory meetings were held with CHC members, community stakeholders and health workers in Sub-district B to develop and understanding of PRA and the purpose

of holding a PRA workshop for CHCs. It was hoped that a good understanding of the process would be gained and that there would be support for the workshop.

It was at these meetings that the idea of supporting a single CHC was rejected by the stakeholders. Community members clearly articulated the need for all CHCs to send at least two representatives to the workshop so that all CHCs within the sub-district could benefit from the process. They also identified key community stakeholders who would serve to broaden representation, hold CHCs accountable and market CHCs within the local communities.

A three-day workshop was thus held with 30 CHC members, community stakeholders and health workers in Sub-district B. It served to develop a common understanding of the community, identifying the local needs and problems, and exploring ways to address these. It was hoped that CHC members and community stakeholders would develop a common understanding of their local community, would feel confident in their roles as CHC members and would assertively take up this responsibility. PRA tools included extensive community mapping, identification of problems and needs and prioritisation of these. The Stepping Stones activity was used to demonstrate the inter-related nature of communities and health services, whilst the Human Sculpture provided a visual understanding of the broader Health system within which communities and local health facilities are operating. Action plans with clear time frames were developed for implementation after the workshop.

A follow-up meeting was held to report of progress, evaluate the process and plan for further action. A graphic design artist was also involved to convey a message for the marketing of CHCs, and for this to be translated into a poster which would be distributed and displayed at local health facilities, libraries and other public venues.

Throughout the process, staff of the Community Development Unit reviewed each step, and integrated the feedback from stakeholders within NMB to shape the PRA process. Two changes were thus made that reinforced and did not detract from the aims or approach:

i. The Health Promotion Managers were keen to extend the PRA workshops with CLOs to include the local Health Advisors. Health Advisors work to support health promotion at a local level, interact directly with the community and report to the CLOs. Thus the workshop for two days with five CLOs was extended to include the health advisors and two one-day workshops held with CLOs and Health Advisors for the three subdistricts of NMBM. Twenty four health workers participated in this process.
ii. The preparatory meetings and discussions with the community stakeholders and CHC members in sub-district B revealed the concern that the process be more inclusive with all CHCs in the sub-district participating. This was responded to and stakeholder groups identified from the religious sector, youth, women's organisations, ward committees, community based organisations and NGOs such as the Treatment Action Committee.

We also experienced challenges. Some processes were interrupted, disrupting the PRA process. During the intervention, the Provincial Department of Health announced that with NMBM having one of the highest TB prevalence rates in the country, all Health Promotion managers should focus their efforts on reducing TB. Despite our efforts to convince the District Health Promotion managers of the longer term and wider gain of the work with CHCs, including for TB control, they suspended the efforts of the CLOs and Health Advisors to support and strengthen CHCs, and turned their attention to TB. They agreed to revert to the PRA process in 2008. This had implications for gathering the health worker groups together plan and implement the community workshops, and to conduct the post-test questionnaire. We were however able to agree that the CLO and three health advisors from sub-district B would continue with the process, which would directly benefit that sub-district.

Whilst we did not conduct post-test questionnaires with the health workers, we none-the-less made telephonic contact with eight health workers and interviewed them on their progress with the CHCs.

3. Implementing the process and findings

3.1 The baseline assessment

A pre- and post test questionnaire was administered to health workers and community members to measure their levels of understanding and perceptions of CHCs and to monitor any changes that the implementation of the process might bring about. Baseline data on personal knowledge and understanding of local health committees was collected and any subsequent change in their knowledge and understanding could thus be monitored. The questionnaire comprised 13 statements to which the participants were asked to consider their response and either agree, disagree or indicate that they did not know (See statements in Table 1).

Table 1: Pre – test questionnaire results with health workers and community members

	Health workers N = 24		**Community members N= 27**	
Statement in Pre-test Questionnaire	**% Agreeing**	**% Dis-agreeing**	**% Agreeing**	**% Dis-agreeing**
1. The local clinic has a Clinic/Community Health Committee.	87.5	8.3	100	0
2. I know all members of the CHC.	25	75.0	70.4	25.9
3. Community members were elected to their positions on the CHC.	54.6	41.7	77.8	22.2
4. The CHC is important to bring community views to the clinic health workers.	100	0	85.2	11.1
5. The CHC and health staff meet regularly to discuss issues affecting health.	50.0	45.8	63.0	33.3
6. The CHC can influence health plans in our area.	95.8	0	88.9	11.1
7. Communities should influence the way health budgets are spent in our areas.	70.8	25.0	55.6	40.7
8. Communities' actions in health in this area are known and appreciated by health workers.	66.7	33.3	63.0	33.3
9. The Health Services should report back to the communities on the health services they provide.	79.2	16.7	88.9	3.7
10. The community members in the CHC understand their roles.	25.0	75.0	81.5	11.1
11. The community members in the CHC are trained for their roles.	12.5	83.3	70.4	25.9
12. The community members in the CHC discuss issues regularly with the community.	16.7	79.2	63.0	33.3
13. The ward committee of local government has no link at present to the CHC.	33.3	45.3	40.7	51.9

Note: The balance on 100% is made up of "don't know" responses

The pre-test questionnaire was administered to twenty-four health workers and thirty community members. Table 1 shows the results for the two groups separately.

The results indicate that the existence of CHCs was widely acknowledged, as was their importance in bringing community views to health workers. In the latter case their importance was acknowledged more by health workers than community members. There was reasonable consensus that the CHC could influence health plans in the local area, again with health workers having a more positive view than the community members on this and on whether communities should influence the way health budgets are spent. The communities had higher levels of agreement than health workers on whether community members in the CHC are elected, known to the community, understand their roles, are trained for their roles, and discuss issues regularly with the community. In general, health worker agreement with these statements was very low. This indicates a lower level of perception of community involvement by health workers.

The views between health workers and community members were more similar in respect of whether community actions in health are known and appreciated by health workers (67% and 63% respectively agreed), and whether health services should report back to the communities on the health services they provide (79% and 89% agreed); and whether the ward committee has no link to the CHC (45% and 52% disagreed).

3.2 The participatory process on community needs and the CHC

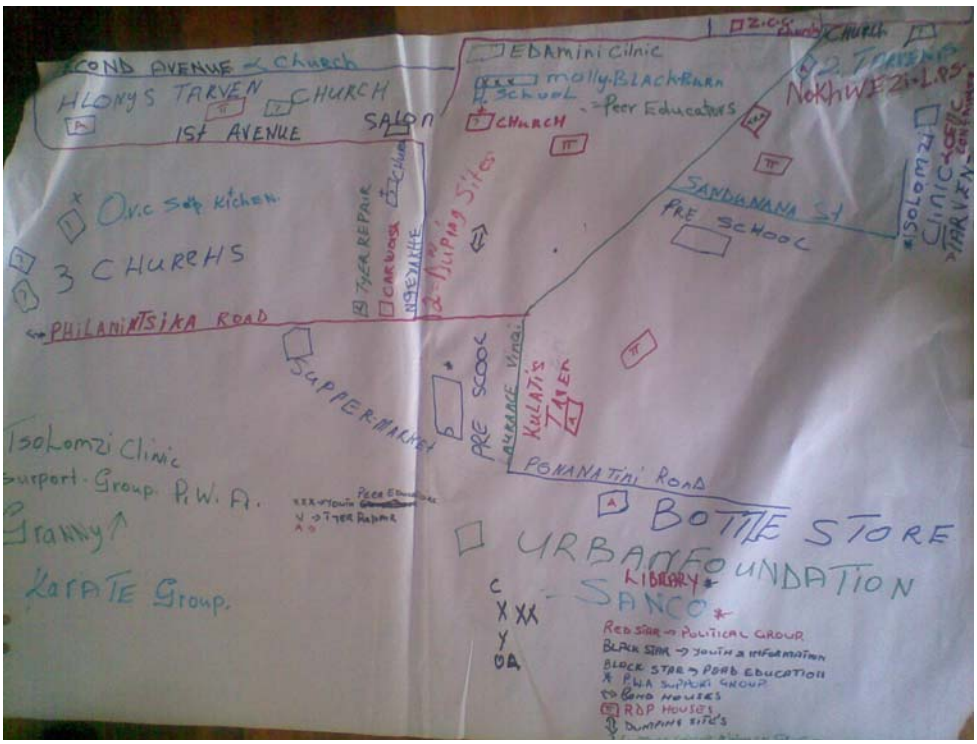
Two meetings were held with CHC members and stakeholders of sub-district B to prepare for a PRA workshop. The meetings were well attended by both representatives from the eleven CHCs in sub-district B, community stakeholders representing youth organisations, the faith based organisations, disabled people and the TAC, as well as health workers. The meetings were important in developing an understanding the process to be followed and to ensure that the appropriate people attended the workshop. Representatives understood their responsibilities and were serious about the workshop and transferring skills to others who could not attend. Having community representatives from various stakeholders provided for diversity and the useful addition of being able to hold CHCs accountable. It was during these meetings that the community members insisted on representation from all eleven health facilities.

A PRA workshop with CHC members and community stakeholders was held in late November 2007, attended by 30 community members representing the 11 CHCs in sub-district B, and the remainder from various community stakeholder groups, including faith based organisations, youth groups, community based organisations, disabled people, and women's groups. One follow up workshop was held for community and health workers from Sub-district B to monitor progress, evaluate the process and plan for further action.

Two health worker workshops were conducted with the intention of providing skills in PRA so that the health workers could assist in the planning and implementation of the community workshops. However with the length of the workshop reduced to one day, it was only possible to provide an introduction to PRA, practice some tools and touch on the roles and functions of CHCs.

The PRA process with CHC members and community stakeholders started with **social mapping**, to develop an understanding of the local communities around the health facilities in sub-district B. Participants grouped according to their local facilities and analysed their local communities by means of community maps. The selected sub-district has fairly distinctive geographic divisions making it relatively easy to divide participants according to their more localised areas. The community mapping was enthusiastically implemented, and more time requested for to consider and plot all aspect of the environment. It was a very

thorough process with participants detailing the infrastructure of the area with all community features such as schools, spaza shops, churches, sports fields, libraries, clinics, surgeries, driving schools, car washes, funeral parlours, community gardens bottle stores and taverns. The process was slow as participants shared levels of detail with one another.



Community map of the Kwanobuhle area Source: T Boulle. 2007

Community participants then identified social groupings and their distribution within their local areas, inserting these on coloured cardboard squares onto the maps. Common groups were identified such as local HIV support groups, groups coordinating soup kitchens, Community Policing Forums, shack-dwellers. Amongst the most common community groups was the identification of criminal gangs which are involved in buying and selling of drugs. Participants were surprised that gangsters and drug lords were such a common feature across all the maps. They shared stories of the operations of these gangs and their ability to terrorise neighbourhoods. Another problem group for the community were the money lenders or loan sharks who have become very powerful in communities as they have become very wealthy and extort repayment from indigent clients most of whom are in receipt of welfare grants.

Using their maps further, the participants identified people and groups within their communities who hold power. They identified the 'drug lords' as holding much power and influence in their local communities as they had become very wealthy. They identified the church as having potential power since most residents attended church and were part of the church structures eg the Women's Union and choirs. There was a feeling that the Church could do more to utilise that power. The groups also identified the most vulnerable groups within communities, those whose voice is not heard via the community health committee and at the clinics. These were the poorest people living in the informal settlements, elderly people, and people living with disabilities.

Understanding Health: In plenary, and using picture codes, the groups identified the factors affecting health and the broad requirements for health:

- Poverty was the most common feature identified as negatively impacting on health
- It was also broadly noted that education about healthy lifestyles was required to develop an understanding about health and that communities were instrumental in assuming responsibility for health in partnership with local health services and local government.

"Health is much more than tablets. It's about lifestyle and environment."
*(*Community health committee member)

Identification of health problems through mapping process.
Source: T Boulle. 2007

The groups identified the health problems in their areas and their local health needs, using their maps a base from which to launch the discussion. The areas around taverns and gang lands posed the most concern for public health hazards, with alcohol and drug abuse reported to be rife, leading to domestic violence, many rapes, knife attacks, assaults and murder. A pastor at the workshop explained, for example, how the previous night he had been called out to a group of families where three seventeen-year old youth, who had been taking drugs, were involved in a fight and had been killed after an argument over the spoils of robbery.

There were concerns too about illegal dumping in some of the areas. In some areas once a community member started to dump on a site, others would follow and soon a dump site had been started. Because these were not legal, they were not cleared. They posed health hazards due to spread of disease and as children were at risk of having their feet cut.

The following health problems were identified:

- Houses selling cheap alcohol: *'mshovalale'* (a locally made brew which is seemingly toxic and makes drinkers very aggressive) ; alcohol and drug abuse
- Illegal dumping
- Violence, including a high crime rate, theft and robbery, domestic violence and rape
- Teenage pregnancy
- TB and HIV
- Poverty, unemployment, school drop out and overcrowding, particularly in shacks
- No ambulances for emergencies

Explaining health problems in the PRA meetings
Source: T Boulle. 2007

In a ranking activity the groups identified their most pressing health needs as the **abuse of alcohol, teenage pregnancy, poverty and unemployment, HIV and AIDS and TB.**

"Health is a basic human right. We need to involve people in their own health. Clinics must be in the communities, close to the people. Communities must own their clinics. Communities must know that they are part of ownership of the clinics."

Community member, TAC member

The process then continued towards the development of an **understanding of the health systems** within which the Community health Committees and community stakeholders are operating. A human sculpture using a common concern of elderly people as the focus was used for this. This revealed that those health workers seen to be closest to the people, ie those at the clinic, were not decision makers; and that the decision makers in the district and provincial and national health management were probably unaware of the problems being experienced at the local clinic level, with poor access to this group by the community and local health workers. Participants expressed concern about services at a local level, especially in relation to the long queues which patients had to endure at all the health facilities. This had ramifications for safety as patients had to leave home in the dark and there was report of attacks on people on their way to the health facilities.

Changing the scenario to one in which the patient would feel more supported was understood to require the support of the whole system, although it was recognised that there was probably much to be done at the local level to improve services for patients. One feature of the more ideal situation was reducing the distance between patients, local health services and provincial and national health roleplayers. There was a growing understanding that the CHCs provided an avenue and opportunity for channelling concerns about health issues to decision makers.

Working together to improve health: Improving the system called for a better understanding of the role that communities could meaningfully play in the health system. In

the PRA process a 'Stepping Stones' activity using TB as a guide health problem demonstrated clearly that it was necessary for health workers and the local community to work together. Participants identified all the requirements for TB to be improved within communities, and put these down on the ground in an analogy as stepping stones towards their goal of crossing a river. It was further recognised that other stakeholders were also required to assist eg Department of Agriculture for assistance with food gardens, and Department of Labour for employment related problems.

Some of the identified stepping stones are listed below:

- The family must be involved and work together with DOT supporters.
- Food parcels need to be provided to the very poor TB patients.
- The clients must be advised about a balanced diet and change of behaviour.
- We need to establish food gardens.
- We must help the people to stop buying this cheap beer.
- TB clients must be taught about the importance of taking TB treatment regularly, and taught about the disadvantages of defaulting which can result in MDR and XDR TB.
- The community must assist and inform the clinics when the people is not drinking their pills.

Stepping Stones exercise with community members
Source: T Boulle 2007

In plenary the group then moved on to **identify the various groups and stakeholders within the community** with which they could work. They did this visually with a stakeholder mapping diagram. The diagram identified groups that the CHC worked with and those groups that it should in the future aim to work with. Churches, community policing forums, the local civic association and sports bodies were identified as opportunities for strengthening relationships.

Key stakeholders identified by participants included:

- Nursing staff. "*We need to nurture a good relationship with Nursing staff at the clinics"* (CHC member)

- Government – Provincial and local government, Strategic planning dept, ward councillors, Portfolio Health and Environment, Education, Social Development. "*We need to try to make this a multi-sectoral initiative"*. (Member of faith-based organisation)
- Community – churches, community based organisations (CBOs), non government organisations (NGOs), Traditional healers and surgeons, traditional leaders (less in Uitenhage), schools, principals and sports people.
- Special Programmes Unit and the Constituency Office are important targets. Councillors have become involved with CHCs in Uitenhage.
- The Business community, although not currently involved with CHCs, has potential to involve businesses, especially given their involvement in HIV initiatives.

The stakeholders identified at the health worker workshops were not dissimilar from those identified by the community, and included local government councillors, the Community Policing Forum, teachers, social workers, youth, traditional healers, churches and business people.

Community health committees were identified as a useful conduit for community concerns to be raised within the health systems, Community members emphasised that CHCs had an important role to play in bridging the gap between communities and the health services.

- *"They assist communities to identify needs that can then be addressed in partnership with the health services."* (Community Health Committee member, Clinic)
- *"They promote an active partnership with the health services."* (Community Health Committee member, Health Centre)
- *"They provide us with the potential to reach the most vulnerable groups in our communities"* (Community Health Committee member, clinic)
- *"They can identify projects that communities can work on and work to alleviating poverty."* (Youth group member)
- "*They act to link, as a liaison between the clinic and community. It reports everything from community to clinic, both good and bad. Will bring complaints about members of the clinic staff*" (Health Advisor, sub-district B)
- " *They are informed and involved in clinic activities eg campaigns and outbreaks, and are the first to know of problems in the community"* (Health Advisor, sub-district C)

They also observed that more needed to be done to strengthen their voice. They thus developed action plans to take the process further and to ensure that they could support one another.

The health workers also identified that CHCs were not operating effectively and tried to identify some of the reasons for this. One of the important reasons related to the lack of prioritisation by the Department of Health of community participation, and therefore lack of support for CHCs. The lack of guidelines for CHCs also posed a major challenge as there is no direction and guidance on roles and responsibilities for CHCs. Health workers observed that "*We don't know their role and they don't know their role".* The role confusion was raised in a number of ways, ie that

- Some of the CHC members want stipends but they are different from health volunteers, except that their roles and functions have become confused now, with health volunteers serving on the CHC.
- While some were noted to want management functions like supervision of staff, others were noted to only discuss complaints, or help with clinic duties, like cleaners.

The CHCs members were felt not to be visible or known in some places, with no regular meetings held. While in some sites CHC members were perceived to feel that they own the clinics, in others CHCs were seen to lack of involvement within the health institutions.

A further concern was raised about the lack of cooperation with the structures of local government. Working together with the local government councillor and the ward committee structure was seen to be imperative to the success of the CHC. It is through the local government structures that many of the broader health challenges could be addressed.

"CHCs do not receive sufficient support from ward councillors and ward committees. Without the support of the local government councillors, our efforts are fruitless."

(Community Liaison Officer, sub-district A)

3.3 Developing community action plans

Community members and health workers grouped according to their health facilities and wards, and drew up action plans for their way forward. These were largely practical plans aimed at drawing in other members of their organisations and committees to report back, and to establish similar PRA processes to involve other members in their area. The health workers pledged their support for the process and agreed to follow up the CHCs, monitoring that their plans were being implemented. All groups were keen to implement a mapping process which would highlight for their organisations the problems to be tackled.

The action plans emerging from community level included steps such as

- Report back meetings to community members, organisations within the community, councillors and the sisters at the clinics
- Implementing the mapping exercise with the community and stakeholders to identify and prioritise health problems .
- Conduct community awareness campaigns on health issues and on the CHCs.

In one area the two major problems identified were teenage pregnancy and the illegal brew, 'mshovalale', and plans were made to conduct door-to-door campaigns, educational campaigns and to improve access to contraception services for teenagers.

Whilst not anticipated in the original proposal, a meeting was held with the local constituency office that proved useful in establishing a link with the local government councillors and being able to convey to their administrative and political support staff the importance of local government involvement. This local government support was most effective when the health worker made contact with the local government councillor and there was agreement to work together. There were very varied levels of involvement by the ward councillors, and there seemed to be little possibility of changing support if a councillor was not interested or motivated.

A poster was commissioned to convey key messages in a poster, particularly to communicate and market the existence of the CHC at each health facility and the need for the CHC to represent the voice of the community. The draft poster was commented on by the community.

3.4 The PRA process with the health workers

While health workers were involved in the process with communities, in the meetings they held on their own as CLOs and Health Advisors further attention was given to identifying and addressing the needs of the CHCs. There were clearly discrepancies in the levels of support that CLOs and Health Advisors were providing for the CHCs, but those who were not providing any support to CHCs were keen to get them established and learn from others at the workshop. The health worker workshop served to improve levels of understanding of the nature of CHCs and the roles they might effectively serve.

Health Promotion. The health workers discussed in groups the role that they could positively play in promoting and supporting community health committees, noting that they have a role in imparting health information, but that CHCs are hampered by poor

representation by some stakeholders, including traditional health practitioners who have been approached to be involved.

"Health Promotion has that mandate to disseminate information, that means people need to know about the services that the dept has for them eg mother and child, TB, HIV and AIDS. All of these are there to render services, our role is to inform people about these services. It would be easier for us if we could make use of these community members to communicate to community. We can give them information about the department. Our role is to create the environment to speak about these things."

(Health Promotion Manager, NMB Municipal Health Department)

They agreed that monthly dialogue was needed with the CHC members to discuss their roles and support, and that health workers could co-ordinate amongst themselves to provide this support. It was noted that health workers input is needed for institutions to release members to take part in CHCs and that information needed to be given to the nurses in charge on the programme for their support.

"Existing CHC members need to be consulted. Consult with them, inform them about the workshop so that processes are transparent and they are included. They can assist in identification of community stakeholders. We need to increase community representation"

(Health Advisor, sub-district A)

The roles of the CHCs were raised and discussed by the CLOs and Health Advisors, adding their ideas to the guidelines for CHCs being drawn up by the Eastern Cape Health Department. Their ideas are shown in Box 1 below.

Box 1: Roles of CHCs suggested in the PRA workshop

- Promote community participation
- Identify health related problems in the community for purposes of planning
- Ensure linkages with the ward health desk
- Encourage communities to initiate development project projects
- To be actively involved in the planning and implementation of health campaigns
- Ensure participation in governance structures at sub district, district and provincial level
- Develop mechanisms of monitoring and evaluating implementation of health policies
- Assist the department in ensuring security and safety of clinic premises and staff
- ensure that good quality of care is maintained at all times
- Ensure adherence of the facility to departmental opening and closing times
- Assist in monitoring that drugs and other clinic materials are available at all times
- Assist in ensuring the maintenance of clinic buildings and grounds.
- Strengthen ownership and support of the clinic amongst local communities
- Ensure patients' rights are up held and that "Batho Pele" principles are practiced.
- Raise funds on behalf of the clinic

The health workers drew up plans of action for the future. The Health Promotion Manager planned a process of supervision and support to ensure continuity and sustainability for the programme. The activities are shown in Table 2 below. The process of intervention would be monitored and reviewed to assess the learning from a change process around the CHCs, to inform wider approaches on these mechanisms for community involvement.

Table 2: Activities planned by health workers

CLOs and Health Advisors	
Core Tasks	Activities
Conduct an audit of CHC at local facilities	Identify who serves on CHC, numbers, governance structure, community involvement, reporting to / communication with community and facility staff, involvement of councillor and ward committees, relationship with facility staff
Disseminate information on CHCs	Meeting with sister-in-charge to provide feedback Meeting with current CHCs to provide feedback, ensure transparency and provide support
Involve stakeholders	Identify local stakeholders Meet with local ward councillors and ward committees Meet with relevant stakeholders to provide information towards community ownership of CHC
Health Promotion Managers	
Report to sub-district managers and facility manager meetings on Health Advisor and CLO roles and functions; and CHC operations	

By the end of both health worker workshops, CLOs and Health advisors were keen to work with communities to strengthen CHCs. Generally there was agreement that an audit of the current levels of functioning of the CHCs needed to be conducted; current CHC members and health facility staff needed to be engaged within the process; community stakeholders and ward councillors needed to be consulted to increase levels of participation. The Monitoring Programme from the Health Promotion Managers was also developed so as to ensure sustainability of the programme.

Recommendations were also made to the district health department from these meetings, which were submitted to the health departments in Nelson Mandela Bay. These included that:

- The guidelines for Community Health Committee functioning need to be finalised and distributed, including the composition of their membership.
- Specific key performance areas for supporting CHC functioning need to be added to job descriptions of health workers.
- An audit of CHCs needs to be done within NMBMM, understanding membership, criteria for selection, involvement of ward councillors and committee, communication with health services, communication with community.
- A comprehensive plan for strengthening of CHC functioning and implementation of CHCs in the district needs to be designed. This plan, including induction and training programmes, is needed to establish and maintain effective CHC functioning.
- The health department and Constituency Office need to work together to elicit support from local government councillors and ward committees for CHCs. This requires political buy-in and assistance from the Portfolio Councillor for Health and Environment.

3.5 Follow-up workshop for community health committees and stakeholders

A follow-up workshop for the CHC members and community stakeholders was held in February 2008 to monitor and evaluate progress from the initial workshop, identify learning and plan ongoing work.

The CHCs presented work that they had implemented over the prior period. This included across the different CHCs collectively:

- Communication with school teachers, churches, the municipality and the police to explain the importance of having their representative within the CHC; and involvement of new CHC members from these key structures
- Establishment of an office for the CHC at a local school to provide a point for communities to visit of they have problems to discuss;
- Promotion of messages on prevention of ill health and encouragement of dialogue on issues such as drug abuse and violence and sexual abuse; and promotion of incentives to encourage youth uptake of Sexual and reproductive health services;
- Dissemination of information to communities on how the health services work and explanations from clinic staff on how referral and complaints can be tactfully handled so that the CHC and the clinic staff can work well together.
- Action on specific identified priority health problems , with specific community level actions to encourage TB patients to get treatment and for their family members to go for TB testing; joint action with ward councillors to remove the illegal alcohol brew *mshovalale*, engagement with the municipality about illegal dumping, with a clean up of the dump site and community monitoring of the continued policy of no dumping;

"High teenage pregnancy is one of our biggest problems that we identified in the previous work shop. We wanted to lower the rates so we sought a way to motivate young women and girls to stick to their contraceptives. One way was to give them a bag and lip gloss each time they came for contraceptives. We got these donated by a local company. We understand that this may not at all solve the problem of HIV infection and other infections but we have to accept the reality of premarital sex and try and prevent unwanted pregnancies as best as we can."

(Community Health Committee, sub-district B)

"We approached the Municipality about the illegal dumping. They agreed to clean the dump site and the community has been warned about the consequences of dumping there. Now it's the community members who are monitoring that site. They are very determined that no-one should dump there again. That was a really big achievement for us."

(Community Health Committee, sub-district B)

The participants clearly articulated the learning from the process to date. The major learning was on the critical importance of knowledge of health systems within communities, knowledge of community conditions by health workers, and strengthened communication between communities and health workers. From the community side, the improved knowledge of health systems and how they work, such as the hierarchies from nurse to sister in charge and upwards made it clearer how requests or complaints from the CHC would progress. A deepened appreciation for the involvement and consultation of all groups within the community in health matters was observed, as was the need for constant communication to maintain a relationship with all relevant stakeholders, to encourage joint work, to ensure that the community is able to approach health services with their problems and for the CHC to work hand in hand with the community, patients and clinic staff. It was also noted that it is difficult it is to get some stake holders on board, like our Ward Councillor, calling for new strategies to get their buy in.

"We have drawn up a database to help us know who does what and where within our community so that we can help people who approach us for help by telling them exactly where to go. For example where to get help with soup kitchens, government grants, birth registrations or HIV and AIDS Support Groups. We believer this will strengthen the work we do because we are drawing in a wider range of stakeholders as we learnt at our last workshop."

(Community Health Committee, sub-district B)

The review raised two aspects that indicated promising conditions for sustainability: the CHCs were optimistic about their work, even where they had faced difficulties in reaching and getting support from people like ward councillors. They also did not see that they needed significant outside resources to continue the work, having the resources mainly within their communities.

"We already have the human resources within us. We have skills here that we are not using so we need to be involved extensively and utilise what we already have. "

CHC member

What they did express a need for was skills training in areas such as Home Based care to better support community processes, and an information centre to provide an accessible point to access health promotion resources. There was a clearer perception of the role and work to be done by CHCs, with a call for continuing links between CDU, CHCs and the Department of Health to monitor and review the work and ensure their effectiveness. The problem of involvement of councillors was discussed with options raised for how to better engage them through Council meetings and through the Portfolio Councillor for Health. It was also felt that a seminar bringing together CHCs and all stakeholders could engage those difficult to reach so that all sides can openly discuss how their work affects each other and how their relationships can be improved.

4. Review of and reflection on the intervention

This participatory action research and intervention was carried out to better understand the processes for involvement of communities in health, and to learn lessons to inform wider health practice. In this section we review the learning and knowledge derived from the process.

4.1 Repeat of the questionnaire

The baseline questionnaire was repeated with the same group of community members at a follow up review meeting to assess how far the participatory process had changed reported perceptions and practices. It was completed by 30 Community members. The health workers did not attend the follow up review meeting due to their deployment towards TB-related activities. CDU arranged that the questionnaires would be conducted by the CLOs and Health Advisors at a meeting of the health promotion programme. This however did not materialise.

The Post-test questionnaire was conducted after seven months with 16 health workers, all of whom had participated in the pre test questionnaire.

Table 3 shows the findings of the post test responses, compared with the pre test results of the community members and health workers.

Some responses remained relatively similar. For the communities, there were similarities in pre and post test responses in the report of the presence of a CHC, the importance of the CHC in bringing community views to the clinic health workers, the need for health workers to give feedback to communities, the perception of whether communities should influence health budgets, the extent to which community actions are known and appreciated by health workers, on dialogue with health workers and the extent to which CHC members discuss issues with the community.

Table 3: Pre–and post-test questionnaire results with health workers and community members

	Health workers		Community members	
Statement in Questionnaire	**Pre test N=24**	**Post test N=16**	**Pre test N=27**	**Post test N=30**
	% Agreeing	**% Agreeing**	**% Agreeing**	**% Agreeing**
1. The local clinic has a Clinic/Community Health Committee.	87.5	87.5	100	93.3
2. I know all members of the CHC.	25	62.5	70.4	60.0
3. Community members were elected to their positions on the CHC.	54.6	56.3	77.8	53.3
4. The CHC is important to bring community views to the clinic health workers.	100	68.8	85.2	83.3
5. The CHC and health staff meet regularly to discuss issues affecting health.	50.0	43.8	63.0	66.6
6. The CHC can influence health plans in our area.	95.8	62.5	88.9	83.3
7. Communities should influence the way health budgets are spent in our areas.	70.8	43.8	55.6	56.7
8. Communities' actions in health in this area are known and appreciated by health workers.	66.7	62.5	63.0	66.6
9. The Health Services should report back to the communities on the health services they provide.	79.2	68.8	88.9	93.3
10. The community members in the CHC understand their roles.	25.0	25.0	81.5	66.7
11. The community members in the CHC are trained for their roles.	12.5	6.3	70.4	53.3
12. The community members in the CHC discuss issues regularly with the community.	16.7	18.8	63.0	63.3
13. The ward committee of local government has no link at present to the CHC.	33.3	31.3	40.7	53.3

For the health workers, there were similarities in pre and post test responses in the report of the presence of a CHC, whether the members to the CHC are elected, the perception of whether communities actions in health are appreciated, whether CHC members understand their roles, the extent to which CHC members discuss issues with the community and the links between the ward committee and the CHC.

In some areas perceptions had become more positive. For health workers there were perceived improvements in knowledge of the members of the CHC, while for communities, there were perceived improvements in the link to the ward committee. However in a number of areas perceptions had changed towards more negative perceptions: Health workers had more negative perceptions of the regularity of CHC meetings, of the CHC influence on health plans, of whether CHC members should influence health budgets, how well CHC members report back to communities and whether the members are adequately trained for their roles.

For community members there was shift to a less positive perception after the intervention on community knowledge of the CHC members, on whether CHC members were elected to their positions, or whether CHC members understand or are trained for their roles.

The community views in the *post* test were generally closer to those held by health workers in the *pre* test, and in the post test community members and health workers seemed to have more closely aligned views, although still with substantial differences in some areas (such as understanding of and training for roles by the CHCs, and regularity of meetings with communities, where the health workers held substantially more negative views.

The results seem to indicate that as insight was gained into the roles of CHCs, community members and health workers came to see some of the flaws in the current situation. The intervention had not proceeded for sufficient time to overcome these shortfalls.

Hence while some areas that were easy to change showed dramatic increases, such as health workers knowing CHC members, there was also less confidence after the process amongst health workers that the CHC members were adequately clear about or trained for their roles, this perhaps informing a more conservative perception about whether they should have any influence on health budgets. The growth in awareness around what CHCs *should or could* do appeared to make both groups somewhat less positive about what they were currently doing.

These results need to be discussed with the health workers and CHCs, as part of the dialogue on future interventions, and on the communication between and expectations of health workers and communities. In addition to such pre and post test questionnaires, future processes could also include indicators of progress towards desired changes in the functioning of CHCs, that can be collectively reviewed by the groups themselves and used as a basis for shared strategic planning.

4.2 Reflection on the role of the PRA process

The feedback from the community and health workers suggest that this intervention was the start of a process that requires further follow up by CDU for it to have deeper impact.

At the outset of the process, very few of the committees had elected community representatives. Most committees were composed of community health volunteers selected to the CHC by the health facility staff to meet the legislated requirement.

The process itself generated change. In sub-district B, CDU began the process of working with the CLO and health advisors to implement an election procedure for CHCs, and to include the participation of the local government councillors. By the time of the community workshop, most CHC members were elected. Their participation in the PRA workshops enabled them to better understand the purpose of CHCs, the role of CHC members and how to hold participatory workshops with community members so that their views could be heard. It also enabled participants to hold CHCs accountable. The PRA process provided CHC members and stakeholders with confidence to return to their CHCs and community organisations to act and make changes to situations identified as being problematic. This confidence was borne of a thorough process, and one which the participants could claim as their own.

A very good working relationship was established with the CLO and a health advisor within sub-district B. They became very motivated to establish and nurture CHCs, despite instructions to defer other work while the focus was switched to reduce TB within the district. Such motivation signals that this is an area where health workers can derive job satisfaction, and where some support can enhance existing for motivation. They

commented that the CHCs provided an opportunity to the Health Promotion Programme to have an area of influence that was uniquely

The PRA process with the community members was inclusive and actively encouraged participation. Whilst some participants were fairly quiet in the plenary of the workshop, within the groups, they were more interactive. The tools proved to be creative and enjoyable which further increased participation. In the community workshop, the mapping proved a most valuable tool. It provided for layers of information. By the end of the workshop, the maps were full of information which was useful to community members in understanding their communities; and would be useful to convey the information to health facility staff. There was a recognition that much knowledge and experience was held within community members that is not necessarily available to health facility staff and that this information should be shared.

Of particular interest was the way in which the health workers embraced the PRA tools, especially in sub-district B. They became engrossed within the workshop working with community members to map closely the community around the health facilities. They were eager to learn more about PRA and to try to implement more participatory tools within their work. The CLO and health advisors agreed to assist in supporting the CHCs and monitoring that progress was being made; and that action plans were implemented.

It was interesting too that the questionnaires showed a fall in some perceptions of the positive performance of the CHCs. Increased knowledge and insight into CHCs and the role that they could play, appears to have made participants more sceptical of their current performance and capacities, and closer in their perception to the health workers initial views. The results suggest that the measures included in this process represent a start of a programme of work with CHC members and the local community stakeholders to strengthen the training, capabilities and functioning of the CHCs. Part of this work involves networking people within the community and with local health services. There was a positive sharing of knowledge and information in all the workshops, particularly in the community workshop where more time could be allocated for discussion. The value of a forum where community members can share information was noted, as was the use of tools that enable full participation of all role players: facilitators and participants.

4.3 Lessons learned and next steps

This relatively small intervention has demonstrated that with support and encouragement health workers can take forward a process of supporting CHC members. It has indicated that community members are keen to participate in health matters. They have a wealth of knowledge and information, particularly about the communities in which they live, which they are willing to share.

PRA approaches have proved a useful way of working with community members to elicit their knowledge and of developing more in-depth understanding, insight and knowledge of local communities amongst other stakeholders. PRA tools have been useful to promote communities' understanding of the integral role they are required to play in promoting health, and within the health system. This understanding made communities clearer on the possibilities of CHCs as a means of meaningful participation, and both communities and health workers clearer on the shortfalls in current practice.

CHCs present a real option for communities to work together in an organised way with the local health services. Their membership is drawn from organisations and groupings within the community from whence much information could be gained on the conditions within those communities. They also provide ready and legitimate entries into those communities. Whilst it appears that the link with the health services via the Health

Promotion Programmes has been strengthened, there is still much work to be done, specifically in training the health workers further to understand and implement PRA in their daily work. The link with the local government councillors appears to be driven by their individual interest and passion.

This was however the start of a process that needs to be sustained. Community members need positive support from health workers to develop their role and actions. Health workers too require ongoing support to be motivated, particularly where this type of work receives little formal support.

In the process, as facilitators, we also learned some lessons:

- PRA approaches need to be structured, but they also call for flexibility. We needed to be responsive to community demands that we abandon plans to work with a single pilot CHC and be inclusive of as many CHC members as possible from the district.
- Community stakeholders are key to monitoring and holding community structures to account. In the community workshop, the stakeholders became more vigilant about whether the CHCs were playing certain roles and if not, demanded to understand the reasons for not playing these roles.
- Factors beyond the control of local facilitators can have significant impact on the process. The instruction for health workers to concentrate their efforts solely on TB, and relinquish their participation in the work on CHCs, despite our rigorous arguments, was hard to accept. Responding to these circumstances is itself a process of reflection and action: The problem led us to work more closely with the health workers within the sub-district, to spend more time with them and strengthen communication and learning with this group to a greater degree than had we been together in a larger group.
- PRA demands that the facilitators work as a team. It is invaluable to plan, implement and facilitate as a team. It serves to promote much discussion and debate within the team. It also requires that a lot of thought and reflection is put into the process in order to feel prepared for a variety of eventualities.

"*It felt as though a voyage of discovery was started. On the voyage many problems were uncovered, and this can only be the start. We now have to tackle those problems so that our voyage can reach its destination of improved communities and better health.*"

Community member, Sub-district B

The community workshop participants Source: T Boulle 2007

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

The Community Development Unit forms part of the Nelson Mandela Metropolitan University. It is a service provider – offering training and capacity building to NGOs and Community Based Organisations throughout the Eastern Cape. A major focus of work for the unit is on health and the promotion of community participation in health.

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