CLINIC COMMITTEES AND THEIR PERCEIVED ROLES IN GOVERNANCE AND COMMUNITY PARTICIPATION IN THE CITY OF JOHANNESBURG

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DECLARATION

I **Chimwemwe Dhlamini** declare that this research report is my original work. It is being submitted for the degree of Master of Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University. I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong. I confirm that the work submitted for assessment for the above degree is my own unaided work, except where I have explicitly indicated otherwise.

I have read the sections on referencing and plagiarism in the Wits Plagiarism Policy, and I have followed the required conventions in referencing the thoughts and ideas of others. I understand that the University of the Witwatersrand may take disciplinary action against me, including suspension or permanent expulsion, if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: 

Date: 12 August 2024

DEDICATION

The report is dedicated to my children, Tina and Tendai.

Thank you for allowing me time away from you for the research and write-up of this report.

This work is the fruit of countless sacrifices.

Thank you for making me see this adventure through to the end.

ABSTRACT

Background

The United Nations Sustainable Development Goals (SDGs) underscore the importance of health system governance, and the engagement and participation of communities. In South Africa, the National Health Act emphasises community participation and makes provision for the establishment of health facility committees to act as a link between communities and the health system.

Study aim

Explore the perceived roles of clinic committees in community participation and health governance in a selection of wards in the City of Johannesburg (CoJ).

Methods

This was an exploratory qualitative study of clinic committees in six wards in the CoJ, with equal representation of provincial (n=3) and local government (n=3) clinics. Following informed consent, in-depth interviews were conducted at each of the six clinics with clinic committee members and the primary health care (PHC) facility manager. The semi-structured interview scheduled focused on the establishment, composition, functioning and the knowledge, motivation and experience of clinic committee members, relationships between and among different stakeholders, perceptions on the clinic committee roles in community participation, and health governance. Thematic analysis was used.

Results

Eighteen in-depth interviews were conducted with 12 clinic committee members and six PHC-facility managers. At the time of the study in 2021, all six selected clinics had an established clinic committee, the number of members ranged from two to eight, and consisted mostly of middle-aged women.

The interviews revealed a political, but standard and uniform clinic committee selection process. Some of the clinic committee members reported that they had neither received formal appointment letters, nor formal induction and training.

The study participants reported that each clinic had a functional clinic committee, demonstrated by monthly meetings, a venue for holding the meetings, discussion of or feedback on

substantive issues related to patients, staff and/or the clinic, and keeping of minutes. Nevertheless, the clinic committee functioning was influenced by the relationships between the clinic committee members, and the PHC clinic managers and/or staff.

The perspectives on the clinic committee's role in community participation highlighted the committee as the dual voice of the community and PHC facility manager, serving as a resource or mediator, and providing feedback to the community. The clinic committees' role in health governance was mediated by their knowledge and relative power in relation to the PHC facility manager. The committee's governance role was seen as assisting with the smooth running of the clinic, information sharing, the management of patient complaints, and sourcing sponsorship. However, the lack of a stipend and benefits for clinic committee members, and resource constraints emerged as major challenges.

Conclusion

Investment in clinic committees, combined with a multi-prong approach to address the challenges identified, will enable these structures to fulfil the envisaged community participation and governance roles.

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ABBREVIATIONS AND ACRONYMS

CC	Clinic Committee
CCM	Clinic Committee Member
CHCC	Community Health Centre Committee
CoJ	City of Johannesburg
COVID 19	Corona Virus Disease 19
DHS	District-based Health System
DHC	District Health Council
DoH	Department of Health
DRC	District Research Committee
ECD	Early Childhood Development
ESA	East and Southern Africa
FM	Facility Manager
HCC	Health Centre Committees
HREC	Human Research Ethics Committee
MPH	Master of Public Health
MEC	Member of Executive Committee
NDoH	National Department of Health
NHI	National Health Insurance
NHRD	National Health Research Database
PHC	Primary Health Care
PHC-FMs	Primary Health Care-Facility Managers
SDG	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

1.1 Background

Universal Health Coverage (UHC) is a key target of the Sustainable Development Goals (SDGs), in recognition of its importance to achieving the SDG goal on health and well-being (United Nations, 2019). UHC embodies the goals of equity in access to health care, the provision of a comprehensive range of quality health services, and financial risk protection (WHO, 2016). The 2019 Political Declaration following the United Nations (UN) high-level meeting on UHC, underscores the importance of health system governance, and the engagement and participation of communities (United Nations, 2019). Primary health care (PHC) is the cornerstone of UHC (United Nations, 2019). The 2018 Astana Declaration on PHC reiterated the participation and empowerment of individuals, families, and communities as a key element of the PHC approach (WHO, 2018)

In concert with global developments, South Africa's goal of UHC is enunciated through the proposed National Health Insurance (NHI) system (NDoH, 2017b). PHC is the foundation of the health system and is enshrined in the National Health Act 61 of 2003 (Republic of South Africa, 2004). PHC is also emphasised in the proposed NHI system (NDoH, 2017b). The National Health Act both underscores the importance of community participation, and the role of communities in health systems governance (Republic of South Africa, 2004). Section 42 of the National Health Act provides for the establishment of committees at PHC facilities, which consist of clinics and community health centres (Republic of South Africa, 2004). The Act envisages these community-based structures to facilitate community participation in the planning, delivery, organisation and evaluation of health services, and to play an oversight role (Levendal et al., 2014).

There is a paucity of studies in the City of Johannesburg (CoJ) that focuses on clinic committees and their role in community participation and in health governance. The aim of this Master of Public Health (MPH) research study was to explore clinic committees and their perceived roles in community participation and in governance in a selection of wards in the COJ. It was envisaged that the findings of this study would assist health managers to enhance the contribution of the clinic committees in community participation and improved health system governance at the PHC level.

This chapter provides the context of, and background to, the study and contains a brief literature review of research studies that focused on clinic committees, health governance and community participation. Section 1.2 provides a definition of the various terms used in the research report, followed by section 1.3 that focuses on the global and South African context of clinic committees, health governance and community participation. The concluding sections in the chapter present the problem statement, study rationale, research question, the aim, and study objectives.

1.2 Definition of Terms

Community	"Community is a group of people whose members share social, political, economic, cultural and health characteristics, and who live within the same geographical area" (World Health Organization, 1978:49).
Community participation	"The process by which individuals and families assume responsibility for their own health and welfare and for those of the community and develop the capacity to contribute to their and the community's development. It includes involvement in the planning, and implementation of health services" (World Health Organization, 1978:50).
Clinic Committee	"A structure mandated by the National Health Act that serves as a mechanism for community participation and is an interface between the health services and communities" (Haricharan et al., 2014:2).
Health governance	"The process of directing health system resources, performance and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable and responsive to the

	needs of the people" (Levendal et al., 2014:81).
Health governance structures	"Health governance structures refer to clinic committees (CC), community health centre committees (CHCC), hospital boards (HBs) and district health councils (DHCs)" (Levendal et al., 2014:82)
Ward	"A local government demarcation of a municipal area into manageable, politically affiliated units" (Campbell, 2011).

1.3 Studies on Clinic Committees, Health Governance and Community Participation

1.3.1 Global context

Both health governance and community participation were enunciated in the groundbreaking 1978 Alma Ata Declaration on PHC (World Health Organization, 1978). These concepts are also central to the achievement of the SDGs, of which UHC is a key target (United Nations., 2019). Notwithstanding differences in definitions and interpretations, there is global consensus on the importance of both health governance and community participation in improving the performance of the health care system (Gaudrault et al., 2015), and ultimately population health outcomes (Bath and Wakerman, 2015). Community participation and governance facilitate and enhance people-centredness (WHO, 1978) and responsiveness in service delivery, itself a goal of health systems (WHO, 2015).

In Africa, the 1987 Bamako Initiative served as a strategy for improving access to quality and affordable PHC, with community or public participation as one of its main tenets (Pangu, 1997). Health ministries in Africa endorsed the Bamako initiative, which led to the emergence of community-based structures as a mechanism for community participation (Gaudrault et al., 2017). These community-based structures have different names in different countries, such as village committees, clinical committees, community health committees, or health facility management committees (Gaudrault et al., 2017). Regardless of the name, these committees are formal

structures that exist to facilitate community participation in health service delivery and enhance oversight and improve accountability (Esau et al., 2020).

Several studies have explored the roles and functions of these community-based structures, their benefits, and advantages, as well as the barriers or constraints faced. In Kenya, a 2005 research study found that the gaps to effective participation of clinic committees were caused by lack of training of health care providers (Sohani, 2005). In 2011, another Kenyan study found that clinic committees are structures that have defined roles to bridge the gap in service delivery and to ensure accountability for quality and accessibility of health services (Goodman et al., 2011). A 2012 multi-country study in Zimbabwe, Kenya, Uganda and Peru, found that clinic committees positively contribute towards health outcomes (McCoy et al., 2012), while another study found that the clinic committee can improve monitoring, accountability, and service delivery (Flores, 2016).

A 2011 Tanzanian study found that members were demotivated due to the lack of incentives which negatively affected the functioning of the clinic committees (Macha and Borghi, 2011). There were also potential provider bias because all the PHC clinic managers led the meetings, thus limiting the discussion or representation of community issues (Macha and Borghi, 2011).

A 2014 comprehensive review of health centre committees in 16 countries in east and southern Africa (ESA), including South Africa found heterogeneity of community-based structures in terms of composition, roles and functions (Loewenson et al., 2014). Nonetheless, there was expressed health policy support for these structures to ensure social participation and accountability at the PHC level of the health system (Loewenson et al., 2014). In general, the review found that the roles of these community-based structures included oversight, monitoring and reporting on adherence to the provision of PHC services and the extent to which the community's complaints were addressed (Loewenson et al., 2014).

However, the review found that in the majority of countries, there was a lack of enabling legislation on these structures. This legislative vacuum served as a barrier to their formal recognition by health managers and health professionals, exacerbated by the top down decision-making approach of

many PHC facility managers (Loewenson et al., 2014). There were also gaps in the guidelines on the authority, role, functioning, and resourcing of these committees (Loewenson et al., 2014). Consequently, the clinic committees faced constraints such as limited resources and little or no support from the PHC clinic managers (Loewenson et al., 2014). Similarly, a 2015 Tanzanian study found that the factors that influenced the performance of the health committees included administrative practices of the district health managers, supervision, training, and public awareness (Maluka and Bukagile, 2016).

The 2014 ESA review found that the clinic committees do not always represent the larger community as the members could be the most influential people who do not necessarily represent disadvantaged or marginalised groups (Loewenson et al., 2014). The exclusion of marginalised groups was also found in a 2017 study in West and Central Africa, which happened through the individualised and non-systematic character of clinic committees, the domination by certain powerful individuals, and an insufficient or lack of a collective approach to the management of issues (Lodenstein et al., 2017).

A 2016 study in Nigeria found that community health committees have the potential to respond to the needs and values of the community (Abimbola et al., 2016). However, there were different modes of the functioning of the community health committees, influenced by existing social, cultural and religious structures (Abimbola et al., 2016). Furthermore, power asymmetries, limited capacity, and unclear guidelines on accountability made it difficult for these structures to improve health facility performance, and/or quality of health care (Abimbola et al., 2016). Similarly, a 2020 Kenyan study found that the clinic committees had minimal participation in governance because they were primarily involved in health promotion interventions (Haricharan et al., 2021b), while a 2017 study in West and Central Africa highlighted the importance of clear definitions of the powers of clinic committees in ensuring accountability (Lodenstein et al., 2017).

1.3.2 South African context

In South Africa, the Constitution as the supreme law of the country, places an obligation on local government to encourage the involvement of communities and community organisations

(Republic of South Africa, 1996). The 1997 White Paper for the Transformation of the South African health system underscores the importance of PHC and community involvement in the planning and provision of health service delivery (Department of Health, 1997). This principle of community participation is enshrined in the National Health Act 61 of 2003 (Levendal et al., 2014). Section 42 of the National Health Act makes provision for the community-based structures, such as clinic committees and hospital boards (Republic of South, 2004). The National Health Act also enables the provincial health departments to formulate more specific policies and/or guidelines on the roles of clinic committees (Haricharan, 2015).

In light of the importance of community participation and health governance, there is an increasing scholarly focus on the advantages of clinic committees, the reality of policy implementation (Haricharan, 2013), factors influencing the functionality or functioning of clinic committees (Levendal et al., 2014), the influence of power on participation in health policy and practice (Haricharan, 2019), and strategies to improve community participation (Mulumba et al., 2018, Chikonde, 2017),

Clinic committees could be a vehicle for community participation in advancing the right to health (Glattstein-Young, 2010). Other studies have highlighted the advantages of these community-based structures, such as ownership of the services rendered by health facilities (Haricharan, 2012), improved service utilisation and access to health care for poor people, user satisfaction, as well as enhanced performance of health workers (Esau et al., 2020).

Notwithstanding an enabling National Health Act, there are variations across the nine provinces on the policies and/or guidelines regarding clinic committee (Haricharan, 2015). A Western Cape study found that the provincial legislation was restrictive and limits the roles of clinic committees in decision making, strategy formulation and service prioritisation (Provincial Government of the Western Cape, 2016). Some researchers have argued that the provincial legislation was unlikely to lead to effective and meaningful community participation as the roles of clinic committees were narrowly defined (Meier et al., 2012). Furthermore, the lack of or unclear roles and functions of the clinic committees and their decision making powers had the potential for negative effects within the health system (Boulle, 2013, Meier et al., 2012, Padarath and Friedman, 2008). The

differences in policies and/or guidelines were found to influence PHC facility managers and nurses to work with the clinic committees and to gain knowledge about the clinic committee's roles and functions (George et al., 2015). Importantly, inconsistencies or gaps between policy and practice can compromise the role of clinic committees as a link between the community and the health facility (McCoy et al., 2012, George et al., 2015).

Several studies in Eastern Cape, Free State, KwaZulu-Natal, and the Western Cape provinces have found that a combination of factors influence the effective functioning of clinic committees, as well as their accountability to communities (McCoy et al., 2012, George et al., 2015). These factors include the composition of clinic committees, the lack of transparency on member election, poor adherence to existing policy guidelines, unclear linkages to the broader governance structures or other government sectors; lack of or insufficient awareness of health care providers; and inadequate financial and technical input (Padarath and Friedman, 2008; Boulle, 2007; Cleary et al., 2013; Levendal et al., 2014 and Esau et al., 2020). In addition, untrained clinic committee members, together with power imbalances and lack of mutual trust between health providers and clinic committees adversely affected community participation and the right to health (Zwama, 2016). Another study found that the prejudices of health providers towards the clinic committee members mitigated against community participation, often resulting in poor quality services (George et al., 2015).

A 2016 Cape Town study found that clinic committee members had limited decision-making powers, they lacked clarity on their roles, they had limited skills, and also experienced negative attitudes from the PHC facility managers and ward councilors, as well as lack of support and recognition and limited resources (Haricharan et al., 2021b). The participation of communities was also limited (Haricharan et al., 2021b). However, the training of both clinic committees and health care providers has the potential to improve community participation as was found in a study in Mpumalanga province, South Africa (Esau et al., 2020). The study found that the clinic committees had no capacity to fulfill the governance role (Esau et al., 2020). However, through training, both the clinic committees and the health providers learnt that clinic committees played an important role in linking the community and the clinic. In addition, it was found that the clinic committees improved health service delivery to communities, and the health-care providers expressed

willingness to engage with these clinic committees (Zwama et al., 2019). The study also underscored the role of health care providers in ensuring the effective functioning of the clinic committees (Zwama et al., 2019).

1.4 Problem Statement and Study Rationale

Good governance is of vital importance because of the proposed NHI system in South Africa with PHC as its foundation. There is also consensus on the importance of community participation in improving the performance of the health system (Gaudrault et al., 2015), and ultimately population health outcomes. However, the main problem is that there is limited information on clinic committees and their perceived roles in governance and community participation in the City of Johannesburg (CoJ). The CoJ is of strategic importance as it generates 16 percent of South Africa's gross domestic product, and it is the financial capital of South Africa, with almost three-quarters of corporate headquarters located in the city (CoJ, 2018). In addition, the majority of studies on clinic committees have been conducted in the Western Cape and there is a dearth of studies in the CoJ.

Hence, it was envisaged that the MPH study would provide insights into the roles of clinic committees in health governance and community participation, and how these committees exercise those roles in the CoJ. The findings could assist health managers to enhance clinic committees' contribution to community participation and improved health system governance at the PHC level.

1.5 Research Question

What are the perceived roles of clinic committees in governance and community participation in a selection of wards in the City of Johannesburg?

1.6 Aim and Objectives

The overall aim of the study was to explore the perceived roles of clinic committees in governance and community participation in a selection of wards in the City of Johannesburg.

The specific objectives of the study were to:

1. Describe the characteristics of clinic committees in a selection of wards in the City of Johannesburg.
2. Explore the perceptions of clinic committee members and PHC facility managers on the functioning of clinic committees.
3. Explore the perceptions of clinic committee members and PHC facility managers on the roles and responsibilities of clinic committees in relation to:
    a. Community participation
    b. Health governance

1.7 Outline of the Research Report

Chapter 1: This chapter has highlighted the background to, and context of my MPH study on clinic committees and their perceived roles in governance and community participation in the City of Johannesburg, including a review of the literature relevant to the study objectives. The problem statement, study rationale, aims and objectives were also outlined.

Chapter 2: This chapter describes the methodology of the MPH study.

Chapters 3: Presents the detailed study findings.

Chapter 4: This chapter provides an integrated discussion of the study findings.

Chapter 5: This chapter concludes the research report, and makes key recommendations based on the study findings, including suggested areas for future research.

CHAPTER 2: METHODOLOGY

2.1 Introduction

This chapter describes the approach and the methods used in the study to meet the objectives. Section 2.2. describes the study design and Section 2.3 describes the study setting. Section 2.4 presents the population of interest while Section 2.5 outlines the study sample. Section 2.6 presents the recruitment of participants in the study whilst Section 2.7 describes the development of the data collection instruments. Section 2.8 outlines the pilot study. Section 2.9 outlines the actual data collection. Section 2.10 describes data processing and analysis. Section 2.11 presents the study limitations and mitigation. The concluding Section 2.12 describes the ethical considerations and researcher reflexivity.

2.2 Study Design

This was an exploratory qualitative study of clinic committees in six wards in the City of Johannesburg. In an exploratory qualitative study, the researcher is able to explore complex social phenomena through the views and experiences of the participants (Baxter and Jack, 2008), namely community participation and health system governance in the case of this MPH study. Participants were able to explain their experiences and views in detail because of the close collaboration that was developed between the participants and the researcher (Baxter and Jack, 2008). The research process involves in-depth questioning of participants, with data typically collected in the participant's setting (in this case the selected clinics), inductive analysis of data, combined with deductive analysis linked to the study questions, in order to generate themes that enable the researcher to interpret and ascribe meaning to the data (Creswell et al., 2007).

Qualitative research is used to gain in-depth and nuanced knowledge of the underlying reasons, perspectives, and motivations of study participants regarding a social issue (Creswell et al., 2007). Therefore, an exploratory qualitative study design was appropriate for the present MPH study, as the researcher explored and gained an in-depth understanding of the perceived roles of clinic committees in governance and community participation in a selection of wards in the City of Johannesburg.

2.3 Study Setting

The MPH study was conducted in six, purposively selected wards in the City of Johannesburg. Johannesburg is the provincial capital of Gauteng and covers an area of 1,645km^2. Johannesburg also known as Jozi, Joburg, or Egoli is a vibrant and culturally rich city with a population of approximately 5 million people (StatsSa, 2022). It is South Africa's biggest metro by population size, and prides itself as the economic and financial hub of the country (StatsSa, 2022).

The six wards were selected to ensure that there was an equal representation of local government (n=3) and provincial clinics (n=3). The local clinics were selected in wards 69 (Clinic 4-region B), 56 (Clinic 3-region F) and 67 (Clinic 5-region F) and the provincial clinics were selected in wards 36 (Clinic 2-region D), 91 (Clinic 1-region E) and 52 (Clinic 6-region D).

The available budget, geographical proximity, and logistical issues were additional considerations for the selection of the six wards.

2.4 Population of Interest

The population of interest consisted of the clinic committee members of the six PHC clinics and the managers of these clinics.

With regard to the clinic committee members, the researcher was interested in the chair of the clinic committee, the secretary, the treasurer, and an ordinary member. The inclusion criteria for the clinic committee members were membership of the clinic committee for at least one year. This was to ensure that the individual had relevant knowledge of the clinic committee, and its roles in community participation and governance.

Similarly, the inclusion criteria for the PHC facility managers were those individuals that had been working in the clinic for at least one year and were in permanent positions or acting positions.

2.5 Study Sample

The key factor in the qualitative research method is to determine the nature of the population of interest (Sargeant, 2012). In the present study, participants were purposively selected. Purposive

sampling is a technique that researchers use to select participants who have rich information so that they are able to provide in-depth information about a subject that is significant to an inquiry (Sargeant, 2012). At each of the selected clinics, the following people were eligible and invited for interviews:

1. PHC facility managers (n=6).
2. Four committee members from each clinic, including the chairperson, the secretary, the treasurer, and an ordinary member (n=4), provided that these individuals met the eligibility criteria. Hence, 24 clinic committee members (n=24) were eligible for interviews.

2.6 Recruitment of the Participants

Once ethics approval was obtained, the researcher visited each of the selected clinics. At each clinic, the researcher contacted the relevant PHC facility manager to explain the study, obtain buy-in, and arrange for a suitable date and time for the interview. The researcher also requested the PHC facility manager for the contact details of the clinic committee members. Once obtained, the researcher contacted each of the clinic committee members, explained the study, and established their availability and willingness to participate in the study.

2.7 Development of Data Collection Instruments

The researcher developed an information sheet (Annexure 1) to explain the purpose of the study, as well as consent for participation and audio-recording the interviews (Annexures 2A and 2B), and semi-structured interview guide that drew on the relevant literature on community participation and health governance.

The interview guides were tailored for clinic committee members (Annexure 3A) and for PHC facility or acting managers (Annexure 3B). The interviews explored the establishment of the clinic committee, composition of the committee, the functioning of clinic committees, knowledge, motivation and experience, community relationships, participation, and feedback, and their role in health governance.

2.8 Pilot Study

Prior to data collection, the interview guides were piloted with one clinic committee member and one PHC facility manager from a ward that was not part of the main study. The purpose of the pilot was to check the clarity of questions, ascertain the ability of clinic committee members to respond to the questions in English, and determine the length of time to complete the interview. The pilot testing revealed that no adjustments were necessary, as all the questions were clear, and no translation was needed.

2.9 Data Collection

After the initial meetings with the PHC facility managers from respective clinics, the researcher met with the individual participants depending on their availability. The researcher explained the written purpose of the study, issues of confidentiality, consent, benefits, and risks of participation. The researcher explained that participation in the study was voluntary, and they had the right to refuse to participate in the study. There would be no direct benefits to anyone who participated in the interviews. Similarly, there would be no negative consequences for individuals who did not want to be interviewed. The participants were also given an opportunity to ask questions.

All eligible study participants were given an information sheet (Annexure 1) and reminded of the voluntary nature of the study. After obtaining informed consent (Annexures 2A and 2B), the researcher conducted face-to-face interviews with these individuals using a semi-structured interview guide tailored for clinic committee members (Annexure 3A) and for PHC facility managers (Annexure 3B). The interviews were conducted in English. The interviews took place between October 2021 to January 2022.

The researcher took primary responsibility for conducting the interviews between October 2021 to January 2022, and scheduled the interviews during working hours at times convenient to the study participants to ensure that there was no disruption to the daily routines. All the interviews were conducted in a quiet, private area (usually the boardrooms) to ensure confidentiality. Interviews were audio-recorded with informed consent to make it easier for the interviewer to capture the information discussed during the interviews. The researcher also took detailed field-notes.

The interviews took an average of 40 minutes, but the time varied depending on the responses of the participants.

2.10 Data Processing and Analysis

2.10.1 Data management

Prior to coding and data analysis, the researcher transcribed each audio recording verbatim, and checked for any typographical errors. In order to protect the data, only the researcher and the supervisors had access to the transcribed data, stored on a password-protected computer. The data were de-identified by assigning pseudonyms such as *"Clinic 1_CCM 1"* to the clinic committee members and *"Clinic 1_FM 1"* to the facility manager and no reference is made to the name of the clinic thereby ensuring confidentiality and anonymity. The recorded audio data, transcripts and the consent forms will be destroyed two years after publication or six years if not published.

2.10.2 Data analysis

Thematic analysis was conducted whereby the researcher familiarised herself with the data from all the transcripts to understand data prior to coding and get a meaning from it (Sargeant, 2012). The researcher ensured that rigour and trustworthiness were taken into consideration.

2.11 Ensuring Rigour and Trustworthiness

Rigour is a quality assurance mechanism that ensures that standard procedures are applied in the design, conduct, and reporting of the study (Cypress, 2017). In this study, rigour was ensured by maintaining fidelity to the protocol, as well as a clear study design, customised data collection tools, and proper study execution.

Trustworthiness refers to the degree of trust that readers must have in the study results (Cypress, 2017). In order to ascertain trustworthiness, the researcher made use of the following criteria on credibility, confirmability, meaning in context, recurrent patterning, data saturation and transferability (Morse et al., 2002). In order to ensure consistency, credibility and dependability of the data, the researcher's supervisors and the researcher coded three similar transcripts from

different groups of participants (PHC facility manager and clinic committee member) independently. All the transcripts were read carefully to identify codes and possible themes. The researcher and supervisors met to discuss any coding discrepancies until an agreement was reached. A comprehensive codebook was compiled once the themes emerged. The researcher used the codebook to code and analyse the remainder of the interviews. The responses from the participants were compared and contrasted, highlighting differences and similarities in and among participants. Another meeting was held to reach agreement on the themes and sub-themes that emerged from the data. This process was used as a proxy for the validity of the themes that emerged from the data.

Confirmability was ensured by taking detailed field notes during data collection. The researcher also maintained self-awareness of her role in the process. In addition, the researcher ensured verbatim transcription of the interviews from the voice recording (Cypress 2017).

2.12 Study Limitations and Mitigation

Potential refusal to take part in the study would negatively influence the study sample. The researcher minimized this by explaining the study to the participants and building a good rapport with them.

Furthermore, social desirability bias is a potential limitation when conducting face-to-face interviews. This was minimised by careful structuring of questions, not asking leading questions, and by putting the study participants at ease during the interviewing process.

Due to time and resource constraints, the study was conducted in six selected wards in the City of Johannesburg. Therefore, the findings are not representative of the entire City. Nonetheless, the researcher obtained rich insights on the participants' perspectives on community participation and health governance.

The MPH study was conducted during the COVID-19 pandemic, and this was a limitation. Although the researcher reassured study participants of preventive measures that would be taken, some of the participants were reluctant to participate in the interviews. The views of those who did

not participate in the study may be different, even though data saturation was reached after the analysis of 10 interviews as the same themes emerged.

2.13 Ethical Considerations and Researcher Reflexivity

This research project was approved by the Human Research Ethics Committee (HREC) (Medical) of the University of the Witwatersrand, Johannesburg (reference number M210358). Further permission to conduct the study was obtained from the Gauteng Provincial Department of Health, as well as the City of Johannesburg (CoJ)'s health department, with National Health Research Database (NHRD), reference number GP_202105_025, and District Research Committee (DRC), reference number 2021-05-005.

The researcher complied with the Singapore Declaration on Research Integrity, and ensured that all ethical guidelines were complied with, namely detailed information, voluntary participation, informed consent, anonymity and confidentiality of information (Resnik and Shamoo, 2011). The participants were not reimbursed for their participation. Each participant was given a small, non-monetary gift consisting of a mask and a bar of soap upon completion of the interview as a token of appreciation. However, they were unaware of this at the start of the interview, to ensure that there was no coercion.

A potential pitfall for any researcher is subjectivity in the research process, including pre-conceived ideas and prior assumptions about the subject and/or participants (Palaganas et al., 2017). As a researcher, I practised reflexivity, namely the process of consciously examining my own point of view and how it could impact my research. I did a trial run with one of my supervisors to ensure that I conducted the interviews in an unbiased manner. During data collection, I ensured that the interviews were scheduled on separate days for the clinic committee members and the PHC facility managers, and in a private space. I made the respondents feel comfortable prior to conducting the interviews, and I let the participants respond to the questions without interruption. I ensured that my voice and body language were non-judgmental.

During the analysis (see above), I immersed myself in the data, and I reflected on the perspectives of the study participants without any preconceived notions. The process of independent coding

together with the two supervisors and the iterative process of joint discussion and reflection helped to minimise any potential bias and misinterpretation.

CHAPTER 3: RESULTS

3.1 Introduction

This chapter presents the study findings. Section 3.2 summarises the characteristics of the study participants, while Section 3.3 describes the establishment and functioning of the clinic committees. Section 3.4 explores in detail the themes and sub-themes that emerged from the study.

3.2 Characteristics of Study Participants

The final number of study participants was 18, of whom 12 were clinic committee members (CCMs) and six were PHC facility managers (PHC-FMs). The major reason for not reaching the target number of participants from the clinic committees was the COVID-19 pandemic, which restricted the willingness and/or the ability of CCMs to participate in the study. Other reasons included the death of some CCMs, inactive committee members, and/or no contact details for members, making it impossible to reach them. However, the researcher was able to interview all the PHC-FMs at all the six clinics.

As can be seen from the table, the PHC-FMs from the six clinics were professional nurses, two thirds were women (4/6), the average age of the PHC facility manager was 47 years, and they had been in the respective clinic committees for more than two years (Table 1).

The majority of CCMs were females and their ages ranged from 41 and 80 years. Apart from the ward councilor who was an elected politician, the majority of CCMs had a matric certificate, while a few had a degree as the highest qualification. Their professional backgrounds included banking, teaching, business, and communications (Table 1). The CCMs had at least one year's experience of serving as clinic committee members.

Table 1: Background characteristics of study participants

Clinic code	Type of clinic	FM characteristics		Number of CCMs interviewed	Characteristics of CCMs			
		Gender	Age		Gender		Age	Experience and/or expertise of CCMs interviewed
					M	F		
1	Provincial	Female	50	1	-	1	60	CCM 1 • Fundraiser of CC • Hair stylist
2	Provincial	Female	49	3	1	-	56	CCM 2 • Secretary/acting chairperson in CC • Degree in communications • Extensive experience in public relations, financial advisor, board member of Early Childhood Development (ECD)
					-	1	49	CCM 3 • Treasurer of CC • Marketing management • Drop out student in Psychology
					-	1	48	CCM 4 • Deputy secretary of CC • Former health promoter • First Aid
3	Local	Female	48	2	1	-	80	CCM 5 • Chairperson of CC • Ward councilor
					-	1	68	CCM 6 • Secretary of CC
4	Local	Female	45	2	-	1	64	CCM 7 • Chairperson of CC • Retired bank manager

Clinic code	Type of clinic	FM characteristics		Number of CCMs interviewed	Characteristics of CCMs			
		Gender	Age		Gender		Age	Experience and/or expertise of CCMs interviewed
					M	F		
					-	1	46	CCM 8 • Secretary of CC • Extensive training in counselling and mentorship • Retired financial manager in the bank
5	Local	Male	47	2	-	1	60	CCM 9 • Ordinary member of CC • Retired community development worker
					-	1	43	CCM 10 • Secretary of CC • Retired in banking
6	Provincial	Male	45	2	-	1	41	CCM 11 • Ordinary member of CC • Community activist/leader, traditional circumcision, advisor of ward councilor, retired teacher
					1	-	51	CCM 12 • Secretary of CC • Community activist/leader • Artist (singer, dancer) • Teaches the community in gardening

3.3 Establishment and Selection of the Clinic Committees

At all selected clinics, the clinic committees were in existence, with the reported period since establishment ranging from five to 27 years (Table 2).

Table 2: Estimated year of establishment of clinic committees

Clinic code	Type of clinic	Estimated year of establishment of CCs	Number of CCMs
1	Provincial	2015/2016	3
2	Provincial	More than 20 years ago	8
3	Local	Many years ago (CCMs reported that prior to 2016 they served for three terms and elections were done every year)	8
4	Local	1994	2
5	Local	2020	5
6	Provincial	2016	4

The selection of the clinic committees is presented under four themes: *the selection process*; *appointment letters*; *motivation*; and *induction and training of clinic committee members.*

3.3.1 The selection process

The participants reported a similar process at five clinics (clinic 1, clinic 3, clinic 4, clinic 5 and clinic 6), with slight variations in the advertisement mechanisms used to select clinic committee members. At clinic 2, participants reported that the ward councilor organised a meeting and explained the roles of clinic committees. The community members, facility managers, ward councilor and MEC played different roles during the selection process of CCMs.

In general, the selection was a district-oriented process, with the latter advertising the posts in the newspapers, on the radio, and/or sending or delivering application forms and pamphlets to the clinics. Several PHC facility managers reported placing these advertisements strategically at clinics so that they were visible to community members. The prospective candidates would then complete the application forms and submit them to the PHC facility managers of the respective clinics, who in return would submit the forms to the district office. The district office would submit the applications to the MECs office. Thereafter, clinic committee members were called in at the relevant clinic to start working, each in a portfolio that they were capable of.

The following quotations reflect these processes:

> *"Normally the process starts at the district whereby they advertise for that purpose. They bring the forms and the information leaflets to the clinic. We put the posters strategically in places where they will be seen* [by community members] *and the interested candidates will come and fill in the forms and submit to the district."* (Clinic 1_FM 1)

> *"We heard about the advertisement on the radio and on newspapers and then we came to the clinic, and we filled in the forms and then put them in the box and after some time, they called us. We gave ourselves portfolios according to our skills."* (Clinic 6_CCM 12)

At clinic 4, one CCM contradicted the process that was reported by the facility manager. According to her, the community members were the ones who elected her, but she followed the other processes of filling forms and receiving an appointment letter from the MECs office. The MEC approved and signed the application forms and successful candidates received appointment/acceptance letters.

> *"Well, the elections are done by the community, it is not done by the clinic or the health department, I by chance went to a community meeting and I was elected. I came to the clinic, filled in some forms and I was given the appointment letter by the MEC Office of the Health Department."* (Clinic 4_CCM 7)

At clinic 2, both the facility manager and CCMs reported a slightly different process where the ward councilor organised community meetings to explain the clinic committee and its roles. This was then followed by similar processes as reported in the five clinics. However, at this clinic the ward councilor nominated an additional four members to be part of the clinic committee in addition to the ones appointed by the MEC.

> *"The ward councilor called in a meeting with community members and nomination takes place. There is an advertisement requesting the community members to apply for the position to be a member of a CC. The forms are submitted at the MECs office. The MEC issues letters of appointment to the newly appointed members. I am not sure how they select them at the provincial office. After receiving the appointment letters from the*

MEC office, we appoint people in different portfolios as long as they have capacity." (Clinic 2_FM 2)

"So, there is a community meeting organized by a ward councilor. He explains everything about the roles of the committee members. People are encouraged to frequently check on the notice board for vacancy as a CC member. Those interested send their names either to the PHC facility manager or to the current chairperson of the CC. Then we receive acceptance letters, and we are then invited to come to the clinic." (Clinic 2_CCM 4)

However, the facility manager at clinic 2 indicated that she did not know the details of the selection process at the provincial office.

3.3.2 Appointment letters

The interviews revealed a problem of appointment letters: some CCMs reported that they started serving at the clinic without receiving formal appointment letters from the MEC office. This view was also expressed by Clinic 3 facility manager who reported that the clinic committee members had not yet received their appointment letters. She indicated that she briefed the CCMs about their functions and advised them to continue working.

"However, they have not received their appointment letters. I have informed the clinic committee members that they can continue volunteering. I have briefed them on the functions." (Clinic 3_FM 3)

3.3.3 The stated motivations of clinic committee members

Some CCMs stated that they volunteered to represent their communities, driven by a passion for people and servitude towards communities and to the disadvantaged.

"Our appointment to these positions was literally done by us. We had a meeting with the PHC facility manager, and we voted [to assist] *on a voluntary basis. We looked at each other's profile, lifestyle and availability and decided on roles to play."* (Clinic 5_CCM 9)

"I have passion to work for and help people in my community. I feel that people need awareness on their health issues, and I have to be in the forefront to help people." (Clinic 6_CCM 11)

"I come from a background whereby you see there are a lot of disadvantaged people. There are different things that I can do in order to reach out to the disadvantaged." (Clinic 5_CCM 10)

However, the possibility of an income was the motivation for some CCMs who expected to be paid for sacrificing their time and service.

"We are volunteers, and we sacrifice for the sake of the community in many things such as our time, money for transport to the clinic. We use our own data for communication, buy food from our pockets. It is really challenging from our side since we are not employed." (Clinic 5_CCM 9)

"The issue of not getting a stipend is a big deal. We know that we are volunteers, but we need just a small amount as a sign of appreciation. We sometimes need money for transport, lunch when we attend these meetings, money for data or airtime when we are communicating with each other as clinic committee members." (Clinic 6_CCM 12)

3.3.4 Induction and training of clinic committee members

At four of the six clinics, the participants reported that the CCMs received formal induction and/or orientation. In clinic 2, the Department of Health officials had cancelled training and induction on more than one occasion, leading to the PHC facility manager doing orientation and training.

"We did not [have training or is it induction?] but it was planned twice if not thrice. We have been waiting for somebody from the Department of Health to give us an induction. So, our PHC facility manager gave us orientation." (Clinic 2_CCM 2)

Similarly, the facility manager at clinic 3 decided to do orientation for the CCMs.

"*I have briefed them on the functions and have been told that they are supposed to go for orientation. The clinic cannot function without the clinic committee; it is ideal for the clinic to have it."* (Clinic 3_FM 3)

3.4 Functioning of the Clinic Committees

3.4.1 Frequency, chairing, and venue for clinic committee meetings

Five out of the six clinics reported that they held monthly meetings. At clinic 1, the CCMs indicated that they ensured that their monthly meetings were scheduled according to the availability of the facility manager.

However, there were some inconsistencies at clinic 4 where the PHC facility manager reported that they met every two months whilst the clinic committee members reported that they met every month. All the participants except for clinic 3 reported that their clinics had a venue for the meetings and that minutes of the meetings were kept. At clinic 3 participants reported that the clinic committee members used any room available for meetings since the clinic did not have a boardroom.

The participants also reported that the chairpersons of the clinic committees convened the meetings. However, in clinic 6, one participant reported that if the chairperson was not available, any other member of the committee convened the meeting.

In general, the participants were of the view that the clinic committee members were committed as they attended meetings and would communicate if they would be absent from the meetings:

> *"From my point of view, there wasn't any particular problem because the members of the committee were aware that we met monthly, and they were required to be present. If they could not be present, they would send their apologies in advance."* (Clinic 3_CCM 5)

In addition to meetings, the clinic committee members and the facility managers reported that they communicated using WhatsApp messages, telephone calls or SMS messages.

3.4.2 Issues discussed during clinic committee meetings

The participants reported that several issues were discussed, and feedback given during the clinic committee meetings. These can be grouped into *facility-related issues*, *patient-related issues*, and *staff-related issues*.

With regards to *facility-related issues,* these included discussions about the running of the clinic and its performance, operational plans such as open days and outreach programmes, clinic infrastructure projects, financial matters, statistics of health conditions, cleanliness of the clinic, infection control, waste management, human and material resources, as well as security and safety measures of the clinic.

> *"The discussion is based on the basic running of the clinic. Of late our main focus has been on Corona* [the COVID-19 pandemic], *and other health issues such as HIV/AIDS, TB. So, on 1st of December, we will have HIV/AIDS Awareness Day."* (Clinic 5_ CCM 10)

> *"We discuss six key priorities of cleanliness of the clinic, staff attitude, infection control, waste management, availability of medication and complaints."* (Clinic 6_FM 6)

> *"We discuss about the cleanliness of the clinic, if things are not going ok in the clinic, they will tell us about what happened when we were not around because the clinic opens 24 hours."* (Clinic 1_CCM 1)

Patient-related issues included customer and patient care matters such as patient treatment, complaints raised by the community members and patients, discussion about how to resolve them, compliments, suggestions, and community needs such as introduction of additional services.

> *"Community needs thus if the community wants more services for example if there are services that are not available, and the community is in dire need of them."* (Clinic 4_FM 4)

> *"We handle complaints, check whether our patients are taken care of, and are happy and get medication on time."* (Clinic 2_CCM 2)

The participants reported that *staff-related issues* were also discussed, including shortages of staff, code of conduct, statutes guiding them, statistical data, staff attitudes, performance of staff, and challenges with staff.

"We discuss the performance of staff. Shortage of staff, some departments are short-staffed, especially in maternity ward. I think a lot of staff members have reached pension age. Some of the staff ladies are pregnant and are supposed to go on maternity leave. Staff go to lunch at the same time. This affects people because they have to wait for their services." (Clinic 2_CCM 2)

"*In our meetings we discuss so many things such as code of conduct, statutes that are guiding us and statistical data that includes targets, for example immunisations to under-five children."* (Clinic 4_FM 4)

3.4.3 Relationships between CCMs and PHC facility staff

Although there were no reported tensions among the CCMs at each of the six clinics, the interviews revealed ambivalent relationships between the clinic committee members, and the PHC clinic managers and/or staff.

Across the six clinics, the relationships between the CCM and PHC facility managers and/or staff ranged from harmonious and supportive (clinics 2, 3, 5 and 6), to strained, tense and/or outright abusive (clinics 1 and 4).

At clinics 2, 3, 5 and 6, both the CCMs and the facility manager reported mutually supportive and professional relationships. Although there are occasional disagreements, these are resolved in an amicable manner.

"Our relationship is an open one, it's a fair one. We are not here to police them. We are here to enhance their effort and responsibility. There is teamwork and not antagonistic. I think we get along very well with her the way we deal with issues. There is honesty and integrity amongst us." (Clinic 2_CCM 2)

"The relationship is good, they are supportive, and they are involved in clinic activities. For example, it was sometime on Sunday when the car hit the wall, I was called from home. When I came to the facility, I found that the members of the CC were already here." (Clinic 2_FM 2)

"Very beautiful and we are here for serving a purpose. The PHC facility manager is one of the most sociable people that you can find on earth. He teaches you and we learn from each other. He is open to ideas and there is a good collaboration between us and the PHC facility manager." (Clinic 5_CCM 10)

"It is a professional relationship; it is good although sometimes there can be some frictions because we are people with different personalities and also our way of thinking is different, but we are able to sort out our differences and work towards the same goal." (Clinic 5_FM 5)

However, at clinic 2, despite the harmonious relationship between the CCMs and the PHC-FM, the clinic staff members were reportedly not aware of the existence of the clinic committee.

"The clinic staff does not understand our role at the clinic." (Clinic 2_CCM 3)

"The clinic staff do not know us as a result they don't welcome us when we are at the clinic." (Clinic 2_CCM 4)

At clinic 4, both the clinic committee member and the PHC facility manager reported strained relationships.

"At one stage there was a complete [relationship] *breakdown between the PHC facility manager and the clinic committee in 2018, 2017, because the staff went on strike."* (Clinic 4_CCM 7)

"[The relationship is] *not that good, we are trying to build it."* (Clinic 4_FM 4)

In addition, the CCMs at clinic 4 reported that they faced challenges from clinic staff who regarded them as threats, or who felt intimidated by committee members.

"Unfortunately, the clinic committee was seen as a threat. We had a lot of challenges with the staff hence we brought in the stakeholders from the community like community radio station, the clergy, youth desk, to assist us because we were not getting anywhere." (Clinic 4_CCM 7)

In some instances, there were tense relationships because of the expectations of the CCMs. For example, at clinic 5, the participants reported that clinic committee members received preferential treatment and they were not expected to wait in a queue.

> *"As CC members you are identified by wearing a badge in so doing you get the first preference. You don't stand in the queue as others."* (Clinic 5_CCM 10)

In contrast, at clinic 4, the clinic committee members reported that they were treated as "ordinary people" by queueing like everyone else.

> *"As the clinic committee member when you come to the clinic, you have to queue just like all other patients. You have to go through the same procedure, which is fine, I didn't have a problem with that but then I saw first-hand how the community people are being treated as I said, I waited for 4 hours here. And when I brought it up, I was just told, it's how it is."* (Clinic 4_CCM 7)

At clinic 1, the PHC-FM was of the opinion that the relationship is strained because of perverse incentives of members who join the clinic committee in order to get tenders or other benefits as CCMs.

> *"Some of the clinic committee members joined because they thought that was the only way to get tenders from the government."* (Clinic 1_FM 1)

At two clinics (1 and 4), participants reported physical assault, in one instance with the perpetrator being the staff (clinic 4), and in the other instance, the community members (clinic 1).

> *"There was a male nurse who attacked a lady who came to the clinic with her child. When I intervened, the clinic staff were supporting him, and the situation was really bad. We actually put our lives at risk so many times."* (Clinic 4_CCM 7)

> *"Most of the times we serve them with fear, thinking that they are going to beat or assault us. All these actions are because they do not understand how the clinic functions, their expectations from the clinic."* (Clinic 1_FM 1)

3.5. Roles, Responsibilities, Community Participation and Governance

Three overlapping themes emerged from the in-depth interviews: *community participation, voice, and feedback*; *governance, knowledge,* and *power*; and *navigating resource constraints and resistance* (Table 3).

Table 3: Study themes and sub-themes

Theme	Sub-themes
Community participation, voice, and feedback	• Clinic committee as resource or mediator • Voice of community and PHC facility manager • Feedback to community
Governance, knowledge, and power	• Smooth running of clinic • Visibility and availability of CCMs • Information sharing vs decision-making • Management or resolution of complaints • Variations in CC involvement
Navigating resource constraints	• Lack of stipend and benefits • Inadequate clinic infrastructure or amenities

3.5.1 Theme 1: Community participation, voice, and feedback

This theme highlights the multiple and at times contrasting perspectives of the CCMs and the PHC-FM on community participation.

(a) Clinic committee as resource or mediator

The CCMs were of the opinion that their role was to ensure that the clinics are user-friendly and that the clinic goals of the provision of quality care are achieved.

> *"I realised that as a community, when you enter at the clinic, you don't know exactly where to go, what to do, at some point you don't know where to report what. As a clinic committee we are standing in the gap. So being at the clinic I am making sure that the clinic is user-friendly."* (Clinic 2_CCM 3)

Both the CCMs and the FMs were of the opinion that the CCs served as a resource for the community by disseminating health and clinic-related information. The CCs engaged in health promotion activities, and they ensured that communities are aware of the norms and standards for healthcare establishments.

> *"We discuss six key priorities: cleanliness of the clinic, staff attitude, infection control, waste management, availability of medication and complaints… people need awareness*

*on their health issues, and I have to be in the fore-front to help people." (*Clinic 6_CCM 11)

"We organise and invite the community to attend open days such as breast cancer awareness month, smokers' day, TB Day, World AIDS day, Down's syndrome day, Smart Heart Day and other educational campaigns." (Clinic 5_CCM 9)

In some instances, the clinic committee served as a liaison and mediator between the facility manager and the community, and this was mostly done through meetings, forums, open days, suggestion boxes, and other community awareness activities.

The CC put posters informing the community if there are some challenges that affect the services at the clinic. They assist in solving problems that are raised by the community through the suggestion box." (Clinic 3_FM 3)

"The CC becomes a link between the community and the clinic and that is very important to me because they are in the community all the time. They attend community meetings as they have all the information." (Clinic 5_FM 5)

"The clinic committee links the clinic and the community. The CC conveys information to the community about all that is happening at the clinic be it construction and so on." (Clinic 6_CCM 12)

The CCMs reported that they served as mediators in the resolution of conflict between the clinic, staff, and the community.

"If a person is fighting here at the clinic, you must go and visit that person and explain what happened, why they are fighting with the staff in the clinic so that the clinic mustn't be closed. We have to mediate between the clinic and the community." (Clinic 1_CCM 1)

"If there are issues that are raised by the community or the clinic, the CC acts as a go-between the two parties. There was conflict…. people were against the PHC facility manager because of a vacancy that was at the clinic. People were supposed to repair the roof and they thought the PHC facility manager was the one hiring. So, clinic committee members called for the meeting and talked to the community that the PHC

facility manager was not the one hiring and that the contractor was the one hiring people." (Clinic 6_CCM 12)

(b) Voice

The clinic committee was seen as a voice or mouthpiece of the community as they would present community challenges to the facility managers.

"A mouthpiece for the community for example, the PHC facility manager wouldn't know challenges that the community is faced with. The facility manager can't be everywhere at once." (Clinic 2_CCM 4)

"The voice of the community, you are there to voice our opinions on behalf of the community. Because not everybody can come out and say we are having problems of this nature. …… you get a better understanding of health issues." (Clinic 5_CCM 10)

The participants reported that the clinic committee was able to voice community complaints with other stakeholders such as the municipality officials.

"It's an outside voice that is not restricted. We had the privilege of approaching the city of Johannesburg and informing them about problems that they were not aware of." (Clinic 3_CCM 6)

Similarly, some participants believed that the CC represented the facility managers during community meetings, served as a support to the facility manager and would at times assist staff in getting answers from the community.

"CC would be able to assist the staff in getting answers from the members of the community that use the facility who may not be prepared to talk with the staff." (Clinic 3_CCM 5)

"They are able to attend community meetings that I am unable to attend because of work duties. They are in the community every day, they identify the needs, the problems in the community they live in." (Clinic 5_FM 5)

The CCs were members of the same community served by the clinic, most participants were of the view that community members cooperated and listened to them due to familiarity and association with them. The following quotes reflect this:

"The community can easily listen to the clinic committee because they talk to people that they are familiar with." (Clinic 4_FM 4)

"If there are issues that are raised by the community or the clinic, sometimes the community feels much easier to communicate with the clinic committee because its members are the people they always associate with." (Clinic 6_CCM 12)

"The community members cooperate more when issues are addressed by the CC because its people they live with." (Clinic 2_FM 2)

(c) Feedback to community

In addition to being the voice of the community, the CCs reported that they provided feedback to their communities on matters affecting their clinics such as renovations and service delivery. In one clinic, a CC member mentioned that the community was given an opportunity to submit quotations for construction or renovation projects. This feedback and engagement with the community would often be done through talks at radio stations, community meetings, and other platforms such as the clergy, youth desk, and political parties.

The participants stated that:

"The councilor calls for a public meeting and gives us an opportunity to talk about the clinic on health and social development. For example, last time they were repairing the clinic in the dental section, and we informed the community about renovations. So, the community is informed that the dental services will no longer be offered as the renovations are under way and they need to go to other clinics." (Clinic 6_CCM 11)

"It was so easy because we have our radio station so we would go on the radio and talk about the services rendered by the clinic. We would also inform the other stakeholders such as the clergy, youth desk, political parties about the clinic and these stakeholders would give feedback to the community. Also, if there were community meetings, we would attend and always the clinic comes up and then we would give feedback in the meetings." (Clinic 4_CCM 7)

In addition, the ward councillors would ensure that they create space in their meetings for the CC to engage with and inform the community and to give feedback.

3.5.2 Theme 2: Governance, knowledge, and power

This theme focuses on the perspectives of both the clinic committee members and the facility managers on the notion of governance, and whether the clinic committee has the knowledge and/or power to provide oversight (governance) of the clinic and its facility manager.

The following sub-themes emerged from this theme thus Smooth running of clinic, Visibility and availability of CCMs, Information sharing vs decision-making, Management or resolution of complaints and Variations in CC involvement.

Participants highlighted that for the CC to be effective, its members needed to be knowledgeable and be able to compile their own reports to ensure objectivity.

(a) Smooth running of the clinic

According to the participants, the CCs ensured that service delivery was aligned to the PHC norms and standards. The CCMs said that they ensured that the clinics had enough resources to serve the communities and reported that they monitored services through the records that were kept by the PHC facility manager.

> *"We make sure that the clinic has enough resources in order to provide services to the community. There must be enough medication, enough staff with good attitude towards people."* (Clinic 6_CCM 12)

> *"We have the programme of the clinic. We check reports from the PHC facility manager regarding the challenges of the clinic, come up with solutions, and advise where we can."* (Clinic 2_CCM 3)

> *"We are here to oversee that the clinic is delivering services to the public and if everything is normal during the day. For example, is the clinic open, are people coming in and out, are people being attended to? We have to ensure that people are accessing services and if they are not, we need to know why not."* (Clinic 5_CCM 9)

(b) Visibility and availability of the CCMs

Although one participant reported that the staff disliked the clinic committee members as "watchdogs", participants highlighted the positive impact of the CCMs visibility and availability at the clinic.

> *"I am always here going round and seeing that people get care all the time, getting their medicine; they get what they want all the time. That is why am here every day."* (Clinic 1_CCM 1)

> *"The clinic committee was very visible to see what was happening especially the turnaround time, we were at the clinic practically every day. We would come and sit here and observe and just by us being here things would happen."* (Clinic 4_CCM 7)

> *"Our constant visibility and availability are important and provide assistance where possible if the clinic is facing challenges."* (Clinic 5_CCM 10)

(c) Information sharing vs decision-making

Some participants indicated that the clinic committees provided a space for learning and sharing of information. This in turn helped to equip the CCs with knowledge and skills.

> *"We learn from the health professionals and get empowered with information. We develop skills, management skills, social skills and we get to understand health issues better than an ordinary community member who is not involved in the clinic committee. We get to know what is happening in the health facilities."* (Clinic 2_CCM 2)

The interviews revealed mixed views on the involvement of clinic committee members in decision-making. The majority of the clinic committee members mentioned that their suggestions or contributions were not considered at management level. In one clinic, the participants reported that their inputs were not considered despite pleading with the PHC facility manager to be involved in decision-making.

> *"We would give our inputs, but they were not considered. So basically, our involvement was zero on numerous occasions. We humbled ourselves and came to them and asked them and pleaded with them to involve us, but they refused."* (Clinic 4_CCM 7)

At another clinic, a clinic committee member highlighted the potential benefits of involving them in strategic planning.

> *"Our inputs are not that noticeable because we are only doing it during the meetings. When the management goes on strategic planning, they must invite us so that our contribution should be official and have an impact."* (Clinic 2_CCM 2)

Some facility managers reported that they involved the clinic committee members in decision-making in certain areas, such as organizing events e.g. open days.

> *"We would involve them in planning if there were projects they would be involved. Making projections as to where they want the clinic to be in future. Involve them in the running of the clinic. We also had an agreement at some point that they should be coming to the clinic and just take a walk around the clinic and speak to patients."* (Clinic1_FM 1)

However, the PHC facility managers indicated that CC members were excluded from decision-making on strategic issues (e.g., on staffing) and/or clinical matters, but were seen as important in operational decision-making.

> *"It depends on what type of decisions one wants from them. So, they wouldn't be involved in clinical issues but matters like if there is no running water in the facility and it's affecting the service then they would be involved. They would be involved because they could inform the community quicker than I could. They would be in contact with the Councillor who forms part of the CC and effect change."* (Clinic 3_FM 3)

> *"There are issues like staffing; I do not involve the clinic committee. I just inform them about it because I do not hire staff. I involve them in planning of Open days, sourcing sponsorship. If the clinic committee members want additional services to be provided on weekends."* (Clinic 4_FM 4)

> *"The other time we decided as CC members that medication should be made available to patients even if they miss their appointment dates. It is a matter of the patients giving reasons for missing the appointment."* (Clinic 5_CCM 10)

(d)Management or resolution of complaints

The management and/or resolution of complaints was mentioned frequently as an important element of governance. Every week, the facility manager and the CCMs jointly opened the suggestion boxes and addressed the issues at hand. At times, the clinic would introduce a service or conduct an in-service training to address the complaints that were raised. If there was no specific complaint, they grouped complaints and addressed them according to the six ministerial quality of care priorities. They followed the complaints management process where the complainant would fill in the complaint form, and this would be followed by a clinic acknowledgement letter and a target of addressing the complaints within 25 working days.

> *"The clinic committee members check in the box every week. If there are complaints, the PHC facility manager is notified and calls in for a meeting whereby the CC members and the parties involved in the matter [complainant and the staff member] attend the meeting."* (Clinic 5_CCM 10)

> *"Of course, the clinic has a suggestion box that was opened jointly by the member of the committee and the PHC facility manager."* (Clinic 3_CCM 5)

> *"If there is no specific person involved, we group complaints according to the six priorities that I mentioned earlier on. And we structure a service in order to address the complaints raised. If we have a specific person mentioned or singled out, then we follow the complaints management procedure whereby a person is given a formal form to complete, raise the complaint, call in the person accused, you get each side of the story, you organize a redress then an outcome. We also organize in-service training programs to all staff in order to address issues."* (Clinic 6_FM 6)

> *"We do have a process of complaints, we do have complaints forms where they write their complaints, and we acknowledge their complaints. Then we plan with the complainant the date to redress the complaint …… if the complainant is happy then we close the case. If its verbally maybe they come to the office to complain we ask them to write it down and if they can't write, we assist with the writing of the complaint then we immediately write the acknowledgement letter. The complaint is resolved within 25 working days."* (Clinic 2_FM 2)

However, the interviews also revealed the contestations about community or patient suggestions and the resolution of complaints. In one clinic, the keys of the suggestion box were lost, and people's written complaints went missing.

> *"Sometimes people go direct to the PHC facility manager's office, or they put those complaints in the suggestion box. However, it is not functional at the moment as there are no keys. I have so far received complaints through SMS."* (Clinic 2_CCM 1)

Some complaints were missing from the suggestion box and as a result, people resorted to sending their complaints through SMS messages to the clinic committee members.

> *"There is a complaints box that we set up…. there was an incident whereby a gentleman gave me the original complaint and he put the copy in the complaints box. When I came back, I asked about the complaint it was missing. So, the problem is how many other complaints have been put aside. And we ask, can we please have the keys of the box so that nobody can take the complaints out of the box. It wasn't done."* (Clinic 4_CCM 7)

(e) Variations in clinic committee involvement

Across the six clinics, the level of involvement of clinic committee members in governance differed. In some instances, the participants were of the opinion that they had no role to play in the governance of the clinic as it was a responsibility of the Department of Health.

> *"The clinic committee actually does not have a role in the governance of the clinic. The governance of the clinic is essentially done by the Department of Health in Johannesburg."* (Clinic 3_CCM 6)

Other participants were of the opinion that their role was to sort out problems in the community, or to participate in meetings with stakeholders.

> *"We are called by the PHC facility manager and sort out problems raised by the community……if there is a project, firstly they consult us the CC so that we can tell the community that they mustn't see people busy at the clinic otherwise they will think that there is something wrong. The community needs to know what is happening at the clinic."* (Clinic 1_CCM 1)

> *"Ok, each and every time when the PHC facility manager, his colleagues, other stakeholders from D.I.D* [Department of Infrastructure Development]. *and ANOVA*

[non-governmental organisation], *when there is a meeting, they invite us. So, they do take our opinions."* (Clinic 6_CCM 11)

Clinic committee members also seem to play an important role in sourcing sponsorship, in some instances to deal with lack of resources, or for events such as open days.

"We speak to people around the community, business people in the community who can donate chairs." (Clinic 2_CCM 2)

"We are working together with the health promoter. Together we select suitable days for events and organize the events. We even look for sponsors who can assist in providing food in order to have a successful event." (Clinic 2_CCM 3)

"I involve the CC in planning of open days, sourcing sponsorship." (Clinic 4_FM 4)

3.5.3 Theme 3: Navigating resource constraints

This theme highlights the resource constraints at both personal and organisational levels that the clinic committees have to navigate.

(a) Lack of stipend or benefits

The lack of a stipend is a thorny issue and was raised by the majority of clinic committee members and PHC facility managers. The majority of CC members were of the opinion that receiving a stipend would help them to meet financial needs, as the majority were unemployed. Furthermore, their families had expectations that they would receive an income as the CCMs were at the clinic the whole day. They were also of the opinion that a stipend would demonstrate appreciation for their contribution as volunteers.

"The problem is that we are not getting paid that is why we don't see all the CC members. They are looking for piece jobs in order to financially sustain themselves especially January is a difficult month." (Clinic 1_CCM 1)

"The issue of not getting a stipend is a big deal. We know that we are volunteers but we need just a small amount as a sign of appreciation…..in that case, a stipend would go a long way." (Clinic 6_CCM 12)

"If a person spends their whole day at the clinic, their family expects them to bring something……. It becomes challenging because your family says you can't be dedicated to something you don't get anything in return." (Clinic 2_CCM 4)

The participants reported that the lack of the stipend was exacerbated by the lack of transport, and benefits such as food, and airtime. The CCMs noted that they sacrificed their money for transport to the clinic and money to buy food and airtime for communication with each other on issues about the community.

"We are volunteers, and we sacrifice for the sake of the community in many things such as our time, money for transport to the clinic. We use our own data for communication, buy food from our pockets. It is really challenging from our side since we are not employed." (Clinic 5_CCM 9)

"We sometimes need money for transport, lunch when we attend these meetings, money for data or airtime when we are communicating with each other as clinic committee members." (Clinic 6_CCM 12)

"As nominated members, we need to be given something in return in the form of a stipend. The money will help us with basic things such as transportation to the clinic, food for lunch at the clinic. This will make us to be more committed." (Clinic 5_CCM 10)

Some clinic committee members also raised the lack of a uniform or a name badge, and one was of the opinion that a name badge would help with the easy identification of the clinic committee. However, the interviews revealed that a name badge was also seen as a way of enabling preferential treatment for CCMs.

"The advantages are that as CC members you are identified by wearing a badge in so doing you get the first preference. You don't stand in the queue as others." (Clinic 5_CCM 10)

Some PHC facility managers were also of the opinion that a name tag might assist the clinic committee members.

"[They need] *working resources such as a badge or a name tag as a form of identity. Having a form of identity is advantageous because people will know that they belong to*

a certain structure. Even if they are given uniforms that will distinguish them from ordinary civilians." (Clinic 6_FM 6)

(b) Inadequate clinic infrastructure or amenities

The interviews revealed that clinic committees also had to navigate poor clinic infrastructure such as broken walls or lack of chairs.

"There are things that need to be fixed. There is a huge crack on the wall and that's a major structural defect. The issue has been reported to the PHC facility manager and she has escalated the matter to the Department of Infrastructure Development (DID)." (Clinic 2_CCM 2).

"We go round the clinic and see if there are any pipes that are leaking or any breakages if the ceiling is falling, then we fill in the form and we submit the report to the maintenance office." (Clinic 6_CCM 12)

"*The clinic committee should have resources such as stationery in order for them to serve the purpose. They come and use clinic resources such as computers to type the reports."* (Clinic 6_FM 6)

In addition to inadequate infrastructure, the lack of chairs was an issue of concern as this meant that the patients did not have anywhere to sit whenever they were at the clinic.

"There are no chairs, most of them are broken." (Clinic 2_CCM 2)

Water shortages were an issue of concern in some clinics. The clinic committee members were responsible for informing the community about the water shortages.

"If there is no running water in the facility and it's affecting the service then they would be involved. They would be involved because they could inform the community quicker than I could." (Clinic 3_FM 3)

"I tell them if there is no water in the clinic." (Clinic 4_FM 4)

CHAPTER 4: DISCUSSION

4.1 Introduction

Using an exploratory qualitative design, this study set out to obtain the perspectives of clinic committee members and PHC facility managers on community participation and governance in a selection of clinics in the City of Johannesburg. The study is important as community participation plays an important role in the discourse on Universal Health Coverage (UHC) (Raman and Kabir, 2016) that are at the centre of health care reforms in South Africa.

The key findings that emerged from this study are shown in Table 4 and discussed further below in line with the study objectives (Chapter 1) and the relevant literature.

Table 4: Summary of key study findings

• At the time of the study, all six selected clinics had an *established clinic committee*. • The interviews revealed *a standard and uniform clinic committee selection process*, albeit largely political. However, some of the clinic committee members reported that they had neither received formal appointment letters, nor formal induction and training.
• The *number* of clinic committee members ranged from *two to eight* and consisted mostly of middle-aged women. All the clinic committee members reportedly had completed matric, while some members had diplomas or degrees. • Although participants reported that they were motivated to serve on the committee to *represent or serve communities*, the *possibility of an income* also emerged as a motivator.
• At each of the selected PHC clinics, participants reported *a functional clinic committee*, demonstrated by monthly meetings, a venue for holding the meetings, discussion of or feedback on substantive issues related to patients, staff and/or the clinic, and keeping of minutes kept. • However, the clinic committee functioning was influenced by the *relationships* between the clinic committee members, and the PHC clinic managers and/or staff, which ranged from harmonious and supportive (clinics 2, 3, 5 and 6), to strained, tense and/or outright abusive (clinics 1 and 4).

• The participant perspectives on the *clinic committee's role in community participation* centred on the committee as the dual voice of the community and PHC facility manager, serving as a resource or mediator, and providing feedback to the community.
• Notwithstanding variations across the six clinics, the interviews revealed that the clinic *committees' role in health governance was mediated by their knowledge and relative power* in relation to the PHC facility manager. The committee's governance role was seen as assisting with the smooth running of the clinic, information sharing, the management of patient complaints, and sourcing sponsorship for open days.
• The navigation of resource constraints was a thread that ran through the interviews, notably the lack of a stipend and benefits for clinic committee members, and inadequate clinic infrastructure or amenities.

In this chapter, the key results are discussed in line with the study objectives and the relevant literature.

4.2 Selection of Clinic Committees

Across the six clinics, the interviews revealed that there was a standard and a uniform process of selection of clinic committee members, consisting of adverts, application at the PHC clinic, involvement of the ward councilor, and submission of the applications to the district office, and then to the office of the Member of the Executive Council (MEC) for Health. The final appointments of clinic committee members are made by the MEC in line with relevant legislation. Although this uniform selection process is commendable, the appointment of clinic committee members is largely a political process. This could result in appointments of those individuals who are influential or politically connected, rather than people who represent the needs of the communities served by the clinics. The negative influence of political appointments has been found in the 2014 ESA review of community structures (Loewenson et al., 2014), and a 2017 study of health facility committees in West and Central Africa (Lodenstein et al., 2017). However, other scholars have argued that the assumption that lay members of health service committees represent patient or community interests is not always correct, because some represent the interests of health professionals or managers (Hogg and Williamson, 2001).

At the time of the study, some of the clinic committee members indicated that they did not receive formal appointment letters signed by the MEC. In addition, some did not receive

induction into their roles and functions. The pocket handbook for members of PHC governance structures recommends that all newly appointed clinic committee members should undergo induction and training in order to gain knowledge and skills to fulfill their roles in clinic committees thereby strengthening the governance structures (NDoH, 2017a). Although the COVID-19 pandemic presented difficulties of in-person training, the lack of induction of clinic committees could reflect the lack of prioritisation of clinic committees. While the reported motivations of clinic committee members included a passion for community service and helping the disadvantaged, the absence of formal appointment letters and lack of induction or training could affect the ability of clinic committees to fulfil their roles and responsibilities as envisaged in the National Health Act.

4.3 Characteristics of Clinic Committees

This study found that the number of clinic committee members ranged from two to eight. One of the six clinics only had two clinic committee members, while another had three members. Although the National Health Act 61 of 2003 does not specify the number of clinic committee members required (NDoH, 2004), the small number raises questions about the ability of these small clinic committees to represent the interests or needs of the surrounding community and to fulfil their community participation and governance roles.

The study findings are similar to those of a Cape Town study which highlighted the constraints of clinic committees with very small numbers for a combination of reasons, including lack of incentives, poor attendance, and lack of support from communities (Haricharan et al., 2021b). Similarly, a 2018 comparative case study of two municipalities in South Africa (Nelson Mandela Bay) and in Uganda (Kibonga and Kyankwanzi) found that the capacity of clinic committees influenced their efficiency and responsiveness (Mulumba et al., 2018). A 2022 narrative review also found that the lack of capacity (both numbers and skills) of PHC health committees in South Africa impeded their functioning (Hove et al., 2022). The implications of my study findings are that both the PHC facility managers and the district health managers should ensure that there are sufficient numbers of clinic committee members, both to comply with the criteria for ideal clinic status and to enhance committee functioning.

The study found that the majority of clinic committee members were middle-aged women, suggesting that men and young people were less involved in the clinic committees. The reason for the dominance of women could be because they use more health care services than men as

has been shown by other studies (Bertakis et al., 2000), and because of women's sexual and reproductive health service needs (Haricharan et al., 2021b). A 2008 South African study also found that women dominated the health facility governance structures in all provinces (Padarath and Friedman, 2008). However, another South African study that explored the relationship between gender and community participation found a gender bias in health focus areas, and that gender equality and gender relations amongst health committees were misunderstood and unaddressed (Austin, 2017).

The limited involvement of young people in clinic committees is of concern, as South Africa has a demographically young population, that presents a huge opportunity for socio-economic transformation (African Union, 2019). The involvement of the youth could be an opportunity to empower young people with knowledge and skills, expose them to networks, enhance their chances of possible employment, and prevent harmful health behaviours. Hence, the implications of the study findings is the need for concerted efforts in the City of Johannesburg to ensure the involvement of men and young people in clinic committees, given the benefits of such diversity (Loewenson et al., 2014). However, diversity training would need to accompany the establishment of more inclusive clinic committees.

At each of the selected clinics, the clinic committee members reportedly had matric, which means that they were literate and had completed school. Some clinic committee members also had post-school qualifications including degrees. The education and broad range of skills of clinic committee members are encouraging, as a 2016 Tanzanian study found that educated people were not willing to volunteer for these positions (Bukagile and Maluka, 2016). However, the high education levels of clinic committee members in the CoJ raise concerns about their ability to identify with or understand the needs of the broader community, especially vulnerable groups, or those with limited education.

4.4 Functioning of clinic committees

Encouragingly, the study found that each of the selected PHC clinics had a functional committee, and this was demonstrated by monthly meetings, a venue for the meetings, discussion of or feedback on a range of issues, and the keeping of minutes. However, in one clinic, the members reported that meetings were scheduled depending on the availability of the PHC facility manager. The PHC facility manager is an ex officio member of the clinic committee, hence the availability of the manager would affect meetings at all clinics. In the

case of this clinic, the specific mention of the PHC manager's availability might point to a potential challenge. The Ideal Clinic Manual states that the PHC facility manager should ensure that there is a functional clinic committee, as this is one of the criteria for achieving compliance standards (NDoH, 2020). Regular meetings is also one of the indicators to assess the functionality of clinic committees (Gaudrault et al., 2017) and to enhance their effectiveness (Levendal et al., 2014).

This study found that clinic committee members discussed or received feedback on various matters including facility, patient, and staff-related issues. These findings were similar to what Haricharan and colleagues found in a Cape Town study (Haricharan et al., 2021b). The pocket handbook for members of PHC governance structures recommends that issues discussed during the meetings should be specific and that decisions and action plans should be clearly recorded (NDoH, 2017a).

At four of the six studied clinics, the committee members reported that they had harmonious relationships with the PHC facility managers and that they were able to resolve differences in an amicable and professional manner. This is encouraging as other studies have found that good relationships between clinic committees and PHC facility manager enable the provision of resources to fulfil the roles and responsibilities of clinic committees (Haricharan et al., 2021b) and to improve the community's access to health care services (Nxumalo et al., 2013). Notwithstanding these harmonious relationships at the four clinics, the clinic staff of one clinic was reportedly not aware of the existence of the clinic committee. This points to the need for the clinic committee to build relationships beyond the PHC facility manager.

In two clinics, the committee members reported dysfunctional relationships with the PHC facility managers and/or clinic staff, which had degenerated into incidents of physical assault. Although other studies in South Africa have reported on power imbalances and lack of mutual trust between health providers and clinic committees (Zwama, 2016, Haricharan, 2019), and the prejudices of health providers towards the clinic committee members (George et al., 2015), no published studies on violent interactions between these structures and clinic staff could be found. A 2020 study in Burundi reported on the tensions between clinic committees and health facility staff, especially after training, and recommended that more attention needs to be paid

to the socio-economic and cultural contexts (Falisse and Ntakarutimana, 2020). Such severe conflicts could impact negatively on access and utilisation of health care services, and the trust in the health care system (Yaro et al., 2023). The study findings suggest that intervention by the district health management team is needed at these two clinics to determine the root cause of the conflict, and to put in place remedial measures to resolve the conflict, rebuild trust and ensure constructive engagement between the clinic committees and the PHC clinic managers and staff.

4.5 Perspectives on community participation

One of the key objectives of this study was to explore the perceptions of clinic committee members and PHC facility managers on the roles and responsibilities of clinic committees in relation to community participation. The study participants were of the opinion that the clinic committee is the dual voice of the community and PHC facility manager, they serve as a resource or mediator, and they provide feedback to the community.

At face value, it appears that the roles of the clinic committees in community participation are aligned with the pocket handbook for members of PHC governance structures, which states that: "*Clinic committees are the protectors of the vision and mission of the provincial health system, the district health system, and their clinics. They have a responsibility always to act in the best interests of the clinic and its stakeholders, in particular the patients and the community"* (NDoH, 2017a). However, there are inherent tensions in the notion of the clinic committee being the voice of both the community and the PHC facility manager. Firstly, being a dual voice requires cordial and respectful relations between the clinic committee and the PHC facility managers. In this study, two of the six clinics reported tense and conflictual relationships, while the clinic staff did not know about the committee at one of the four clinics which reported harmonious relations. These problematic relations combined with the small number of clinic committee members at three of the clinics, suggest that community participation was sub-optimal at these clinics. This was also found in the 2022 narrative review by Hove and colleagues, namely that the implementation of effective and meaningful participation remained a challenge, despite an enabling policy environment (Hove et al., 2022).

Secondly, the WHO Declaration of Alma Ata envisaged community participation as a broader process that includes individual and family responsible for health, capacity for community

development, and involvement in the planning, and implementation of health services (WHO, 1978). Others have argued that community participation is a catalyst for change in the community (Tierney et al., 2018). Although the clinic committees fulfil important liaison roles between the clinic and the surrounding communities, the activities appear to focus primarily on health service provision, rather broader health or community development endeavours. Furthermore, the quotes in the previous chapter suggest that community members were passive recipients of health services, who "cooperated with and/or listened" to the clinic committee members, rather than play an active role in their own health and/or development.

As community participation plays an important role in people-centeredness, health system responsiveness, and addressing the social determinants of health (Zwama et al., 2019), the study findings suggest that a holistic approach is needed to ensure that the clinic committees in the CoJ are able to fulfil their developmental roles.

4.6 Perspectives on health governance

This study also set out to explore the perspectives on the health governance role of clinic committees. The study found that there were mixed views, and that the committee's governance role was seen as assisting with the smooth running of the clinic, information sharing, the management of patient complaints, and sourcing sponsorship. The clinic committee members felt that their suggestions and contributions were not considered at a strategic or management level. The study found that the clinic committees' role in health governance was mediated by their knowledge and relative power in relation to the PHC facility manager. Some clinic committee members reported that the governance role was not their responsibility but that of the Department of Health, suggesting a lack of awareness about this important aspect.

The contestations about the clinic committee's role in governance and the power imbalances were also found in other studies in Zambia (Macwan'gi and Ngwengwe, 2004), Nigeria (Abimbola et al., 2016), and South Africa (Haricharan et al., 2021a). In contrast, a study found that the involvement of clinic committee members in decision-making resulted in improved relations between the community and the clinic staff (Maluka and Bukagile, 2016).

4.7 Navigating resource constraints

A thread that ran through the interviews was the resource constraints. Clinic committee members were challenged at both personal (lack of a stipend) and organisational levels. Some of the members indicated that the possibility of a stipend was a motivator for applying and joining the clinic committee. They indicated that they used money from their own pockets for food, transport and airtime/data. Across the six clinics, the PHC facility managers highlighted the lack of a stipend for clinic committee members as a constraint. Similarly, in a Mpumalanga study, the clinic committee members reported that a possible stipend was a motivator for people to join or leave the clinic committees (Esau et al., 2020). They further found that lack of funding negatively impacted the functionality, stability and sustainability of clinic committees (Esau et al., 2020). A Tanzanian study found that financial incentives enhanced the performance of the clinic committee (Maluka and Bukagile, 2016). South Africa has a high unemployment rate, and it is unfair to expect community members to volunteer their time, without any compensation. Furthermore, members of hospital boards receive a stipend, suggesting a lack of prioritisation of clinic committees. Hence, the policy on the stipend for clinic committees should be reviewed to ensure that they are treated in the same manner as hospital board members.

At organisational level, the clinic committee members had to navigate poor clinic infrastructure (broken walls, lack of chairs) and the lack of dedicated resources to enable them to fulfill their role. Clinic committee members reporting fund-raising to organise events as well as buying chairs. The review of health facility structures in East and Southern African countries also found that clinic committee members were involved in mobilising resources in order to ensure that health facilities were functional (Loewenson et al., 2014). A Tanzania's study found that clinic committee members formed village banks, in order to meet their economic needs and they managed these village banks through monitoring their finances (Macha and Borghi, 2011).

This MPH study did not explore resource utilisation at each of the clinics or confirm the reported lack of resources. Further research on these aspects should be done. Nonetheless, primary health care is the stated foundation of the South African health system and is the form of the proposed reforms of the National Health Insurance (NHI) system. In light of the reported resource constraints, there should be investment in clinic committees to ensure that the infrastructure is upgraded and/or maintained. For example, there should be consideration of a

dedicated line item in the budget of districts to ensure that clinic committees are able to fulfil their community participation and governance roles.

4.8 Conclusion

Notwithstanding the existence of clinic committees at the study clinics in the CoJ, and the positive roles that they play, insufficient diversity of committees, tense or conflictual relationships, insufficient awareness, induction or training, and resource constraints mitigate against the full realisation of community participation and/or health governance by these structures. The recommendations that flow from these study findings are shown in the final chapter of the research report.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study set out to explore the perspectives of clinic committee members and PHC facility managers on community participation and governance in a selection of clinics in the City of Johannesburg. The recommendations that flow from this study are shown in Table 5, together with the actors responsible for implementation, and elaborated below.

Table 5 Study recommendations

Recommendation	Department of Health (provincial, district)	PHC Facility Manager	Clinic Committee
1. Ensure appointment of sufficient number and diversity of clinic committee members	**X**	**X**	
2. Induction and training of clinic committee members	**X**	**X**	
3. Training of PHC managers and staff on rationale, roles, and responsibilities of clinic committees	**X**		
4. Facilitate and ensure engagement, communication and relationship building between clinic committees and PHC clinic staff	**X**	**X**	**X**
5. Review policies on clinic committees, including payment of stipend	**X**		
6. Advocate for investment in, and additional resources for, PHC clinics	**X**	**X**	

5.2 Appointment of clinic committee members

The PHC facility managers and district health managers should ensure that there are sufficient numbers of committee members, and that there is diversity in terms of gender, age, education, and other criteria are appointed. The district health office could develop guidelines on the desired composition of clinic committees, together with awareness raising and/or diversity training sessions. Once the clinic committee members are appointed, the PHC facility manager and the district office should ensure that every committee member has a formal letter of appointment.

5.3 Induction and training of clinic committee members

PHC facility managers and district health managers should ensure that all newly recruited clinic committee members attend an induction and orientation meeting. During the induction process, the clinic committee members should be oriented on the district health system, the primary health care (PHC) approach, relevant legislation and policies on clinic committees, and their envisaged roles regarding community participation and health governance. The training should also include interpersonal relations, teamwork, and the management of conflict. However, training should not be a once off event. Consideration should be given to annual workshops or capacity building sessions to engage with clinic committees, build relations with surrounding communities, raise awareness of new health policies or developments, get input and suggestions on health system improvements, broader community development, and addressing the social determinants of health. These annual events could also be used to share good community participation and governance practices and develop solutions for similar challenges faced by clinic committees.

5.4 Training of PHC managers and staff

The experience in other countries (Falisse and Ntakarutimana, 2020), and in the Western Cape Province of South Africa (Zwama et al., 2019) has shown that there are benefits of training health care providers on the reasons for, and role of clinic committees that go beyond compliance with the ideal clinic manual. The district and provincial health management should ensure relevant training for clinic managers and staff, which could draw on existing clinic committee training programmes in the country, as well as the pocket handbook (NDoH, 2017a). Training for clinic staff should also include interpersonal relations, teamwork, and management of conflict.

5.5 Engagement, communication, and relationship building

Given the fraught relationships at two of the clinics, the district managers should facilitate a series of team-building workshops across the CoJ, to improve relationships between the clinic committees and the relevant PHC facility managers. This will prevent the perception of victimisation or targeting of these two clinics.

The district managers should ensure formal introductions of new clinic committee members to the relevant PHC managers. These managers in turn should introduce the clinic committee members to the clinic staff. The initial introductions will create a foundation in developing

strong relationships with the clinic staff, which may foster positive attitudes towards each other, resulting in strong relationships with the communities. Furthermore, the PHC manager could put the names and photos of clinic committee members on the notice board, so that they are known both to staff and to the community at large.

5.6 Review policies on clinic committees

The Gauteng Department of Health should review the policies on clinic committees, which fall within the ambit of the provincial MEC. As indicated, hospital board members receive a stipend, which is budgeted for by the relevant hospital. Similarly, the budget of each clinic could include a line item for the payment of stipend of clinic committees. The criteria for receipt of stipend could consider the socio-economic circumstances of each clinic committee member.

5.7 Advocate for investment in and additional resources for PHC clinics

As was highlighted by the study findings, the participation and governance role of clinic committees is hampered by insufficient or lack of resources, namely a dedicated budget for clinic committees, infrastructure, and other essentials. Although fundraising could be encouraged, it is government's responsibility to ensure that PHC services are financed appropriately. The districts and individual clinics may require technical assistance to do the costing and prepare a detailed budget and motivation for the resources needed to provide health services according to norms and standards.

5.3 Areas for future research

This was a small qualitative study that explored the perspectives of clinic committee members and PHC facility managers on community participation and governance in six clinics of the CoJ. The findings of the study could be used to design a survey to quantify community participation and governance at all PHC clinics in the CoJ.

Other possible research studies are listed below:

- Developing indicators of the functioning and performance of clinic committees
- Strategies for achieving meaningful community participation at PHC level.
- The association between resource availability and the ability of clinic committees to fulfil their mandates of community participation and health governance.

- The impact of training of both clinic committees and PHC facility managers on interpersonal relationships and clinic performance.
- The perceptions of communities on the clinic committees in governance and community participation in the City of Johannesburg.

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ANNEXURE 1: PARTICIPANT INFORMATION SHEET

Clinic Committees and their perceived roles in Governance and Community Participation in the City of Johannesburg

Good day,
My name is Chimwemwe Dhlamini. I am a Master of Public Health student from the School of Public Health at the University of the Witwatersrand in Johannesburg. I am conducting research which seeks to explore the role of clinic committees in Governance and Community Participation (i.e. their involvement in planning, decision-making, and implementation of PHC health services) in the City of Johannesburg. I would be most grateful if you would agree to participate in this study. The interview will take around 40 minutes of your time.

The questions are not a test, so there is no right or wrong answers. Your opinions and experiences are important. My role as an interviewer is to listen and to understand your point of view, but not to pass judgment. You may refuse to answer any questions that you do not feel comfortable answering. You may also say that you do not know the answer to a question.

Confidentiality

The information that you give in the interview will be kept confidential. Only the research team will know who has been interviewed. All interviewees will be assigned a code and these codes will be used on the transcribed interviews. Your name will not be revealed in any written data or report resulting from the study.

The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up as the health chapter, which will form part of the overall provincial case study.

Consent

The University of the Witwatersrand Human Research Ethics Committee (Medical) has provided ethical approval for the study. We have also obtained permission from the provincial and local government health authorities. You will need to provide informed consent to participate in the study. If you are willing to give your consent and take part, I will appreciate your participation and the information that you are willing to provide.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the interviews. Similarly, there will be no negative consequences for individuals who do not want to be interviewed. We will not compensate any participant for taking part in the study. During the interview, you have the right to decline to answer any questions that make you feel uncomfortable or to stop the interview at any time. However, I would appreciate it if you do share your thoughts and feelings about the questions I will be asking you.

Recording the interview

I would like to request your permission to audio-record the interview because I cannot write down all your answers quickly enough and might miss some important things that you will say in response to some of the questions that you will be asked if I do not record them. The voice-recordings and notes will remain confidential and your identity will not be disclosed.

The recorded interviews will be transcribed and transcripts of interviews will bear the code and not the name of the interviewee. These voice-recordings and transcripts will be kept on a password-protected computer. As per national requirements, the voice-recordings will be destroyed two years after the publication of the research findings.

Contact details

I will be happy to answer any question you have about this study. The contact details for the HREC Chair/ Administrator for participants should you wish to direct queries, concerns or complaints regarding the ethical activities surrounding the study are **Professor Clem Penny** Tel **011 717 2301**, or **Ms. Z Ndlovu** Administrative Officer **011 717 2700/1234/1252**; or **zanele.ndlovu@wits.ac.za**. If you have questions about the research, you may also contact me as the Principal Researcher or the Research Supervisors:

MPH candidate	**Supervisor**	**Co- Supervisor**
Chimwemwe Dhlamini Impilo Child Protection and Adoption services Cell: 078 731 0650 Email: chimsydhl@yahoo.com	**Dr Prudence Ditlopo** Centre for Health Policy School of Public Health University of the Witwatersrand, Johannesburg Phone: +27 11-717 3433 Email: prudence.ditlopo@wits.ac.za	**Professor Laetitia Rispel** South African Research Chair School of Public Health University of the Witwatersrand, Johannesburg Phone: +27 11-717 2043 Email:laetitia.rispel@wits.ac.za

ANNEXURE 2A: CONSENT FORM FOR CLINIC COMMITTEE MEMBERS AND PHC CLINIC MANAGERS/ACTING PHC FACILITY MANAGERS

Clinic Committees and their perceived roles in Governance and Community Participation in the City of Johannesburg

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I agree to participate in the study entitled: **Clinic Committees and their perceived roles in Governance and Community Participation in the City of Johannesburg.**

The goals, methods and the purpose of the study have been explained to me and I have been given the opportunity to ask questions. I understand that the study will involve participating in an in-depth interview. I understand that I have the right to refuse participation in the study.

I agree to participate in the study on condition that:

1. I can withdraw from the study at any time voluntarily and that no adverse consequences will follow on the withdrawal from the study.
2. I reserve the right not to answer any/or all questions posed in the study.
3. The Provincial Department of Health has approved the study.
4. The Human Research Ethics Committee at the University of the Witwatersrand has approved the study protocol and procedures.
5. My name will not appear anywhere on this interview guide. All results will be treated with confidentiality.
6. The Researcher is committed to treating participants with respect and privacy throughout the study.

PARTICIPANT

Signature/Initial **Date and Time**

RESEARCHER

Printed Name	**Signature**	**Date and Time**

ANNEXURE 2B: CONSENT FORM FOR AUDIO-RECORDING

Clinic Committees and their perceived roles in Governance and Community Participation in the City of Johannesburg

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I have been given the information sheet on the study entitled: **Clinic Committees and their perceived roles in governance and community participation in the city of Johannesburg.** I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that I can decide whether or not the interview should be recorded and that there will be no consequences for me if I do not want the discussion to be recorded. I understand that information from the voice recordings will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the discussion is voice recorded, the voice recording will be destroyed two years after the publication of the findings.

I understand that I can ask the person interviewing me to stop the voice recording and to stop the interview altogether, at any time.

I consent voluntarily for the researcher to record the interview **(please tick)**. Yes ☐ No ☐

Participant

Signature/Initial:

Date:

Researcher

Signature:

Date:

ANNEXURE 3A: INTERVIEW GUIDE FOR CLINIC COMMITTEE MEMBERS

Clinic Committees and their perceived roles in Governance and Community Participation in City of Johannesburg

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1. **Date of Interview:**
2. **Category of Participant**
    a. Participant code number:
    Chairperson/Secretary/Treasurer/Ordinary member
    b. Type of PHC facility:
    Local=**001**
    Provincial=**002**
    c. Location (ward)=
3. **Opening hours:**
4. **Result codes:**
    01= Completed, **02=**Respondent not available, **03=**Respondent refused,
    04= Partially completed, **05=** Other

NB:
-Circle all that apply
-Write information required on the space provided

CHARACTERISTICS OF CLINIC COMMITTEES

1. Could you tell me about the clinic committee at this facility (probe when established, how many members, gender, age, skills/experience)?
2. How are decisions made about the chairperson of the committee? What about other members of the clinic committee?

FUNCTIONING OF THE CLINIC COMMITTEES

3. Did you as a clinic committee member receive induction or orientation when you started?
4. How often does the clinic committee meet?
5. Who convenes the meetings?
6. Who attends these meetings?
7. Where do the meetings happen?
8. Are the meetings attended by the PHC facility manager?
9. What are the items that are discussed in the meeting? Do you ask for reports on the performance of the clinic?

10. Are there any minutes? (record-keeping)
11. How would you describe the relationship between the clinic committee members and the PHC facility manager?

PERCEPTIONS OF CLINIC COMMITTEES ON ROLES AND RESPONSIBILITIES

12. What motivates you to serve on this clinic committee?
13. What do you know about primary health care? Or the district health system?
14. What do you consider as the most important role of the clinic committee (probe community participation or governance)?
15. In your opinion, what are some of the advantages or benefits of the clinic committee?
16. What are some of the difficulties that you experience as a clinic committee member?
17. What do you think could be done to overcome these difficulties?

THE ROLE OF THE CLINIC COMMITTEE IN COMMUNITY PARTICPATION AND GOVERNANCE

18. How would you describe the relationship between the clinic committee and the surrounding community? Are there any activities that you embark on to link the PHC facility and the community? Please tell me about these activities
19. What do you do to provide feedback on the clinic to the community?
20. What do you do to link the PHC facility manager and community members?
21. What role does the clinic committee play in ensuring the participation of the community in the clinic or in health?
22. What do you think is your role in ensuring the smooth running of activities (governance) at PHC facility level?
23. To what extent are you involved in decision making at the PHC facility level (probe tell me how you are asked for your inputs on health service delivery at the PHC facility and how often)?
24. How do you resolve complaints or issues raised by the community?
25. Is there anything you would like to say?

Thank you for your time in participating in the study

ANNEXURE 3B: INTERVIEW GUIDE FOR PHC CLINIC MANAGERS/ACTING PHC FACILITY MANAGERS

Clinic Committees and their perceived roles in Governance and Community Participation in City of Johannesburg

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1. **Date of Interview**
2. **Category of Participant**
   a. Participant code number:
      PHC facility manager/Acting PHC facility manager
   b. Type of PHC facility:
      Local=**001**
      Provincial=**002**
   c. Location (ward)=
3. **Opening hours:**
4. **Result codes:**
   01= Completed, **02=**Respondent not available, **03=**Respondent refused,
   04= Partially completed, **05=** Other

NB:
-Circle all that apply
-Write information required on the space provided

CHARACTERISTICS OF CLINIC COMMITTEES

1. Could you tell me about the clinic committee at this facility (when established, how many members, gender, age, skills/experiences)?
2. Could you tell me how the members of this clinic committee were decided on (probe election, appointment)?

FUNCTIONING OF THE CLINIC COMMITTEES

3. How often does the clinic committee meet?
4. Who convenes the meetings?
5. Who attends these meetings?
6. Where do the meetings happen?
7. What are the items that are discussed in the meeting?
8. Are there any minutes? (record-keeping)
9. How would you describe your relationship with the committee members?

PERCEPTIONS OF ROLES AND RESPONSIBILITIES OF CLINIC COMMITTEES

10. What do you consider as the most important role of the clinic committee (probe community participation or governance)?
11. What are some of the advantages or benefits of clinic committees?
12. What are some of the difficulties that clinic committee members experience?
13. What do you think could be done to overcome these difficulties?

ROLE OF THE CLINIC COMMITTEE IN COMMUNITY PARTICIPATION AND GOVERNANCE

14. How would you describe the relationship between the clinic committee and the surrounding community?
15. Please tell me what feedback you provide to the clinic committee?
16. What role does the clinic committee play in ensuring the participation of the community in the clinic or in health?
17. How do you involve the clinic committee in decision-making at this clinic (probe can you tell me how you ask the clinic committee members for their inputs on health service delivery, how often?)
18. How do you resolve complaints or issues raised by the community?
19. Is there anything that you would like to say?

Thank you for participating in the study

ANNEXURE 4: HUMAN RESEARCH ETHICS COMMITTEE APPROVAL

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Dr Chimwemwe Dhlamini

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M210358

NAME: (Principal Investigator)	Dr Chimwemwe Dhlamini
DEPARTMENT:	School of Public Health Johannesburg Health District Alexandra CHC, Mofolo CHC, Rosettenville Clinic, Westbury Clinic, Yeoville Clinic and Zola CHC
PROJECT TITLE:	Clinic Committees and their perceived roles in Governance and community participation in the City of Johannesburg
DATE CONSIDERED:	26/03/2021
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Prudence Ditlopo and Prof Laetitia Rispel
APPROVED BY:	CB Penny Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	05/08/2021

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions.Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **March** and will therefore be due in the month of **March** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

11 August 2021
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE 5: PROVINCIAL HEALTH RESEARCH COMMITTEE APPROVAL

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Joburg
a world class African city

Research Committee of
Johannesburg Health District

Enquiries: Ms. Busisiwe Sikhosana
Tel: 011 694 3909
Email :Busisiwe.Sikhosana@gauteng.gov.za
Hillbrow CHC: Administration Building,
Cnr Smith Str. & Klein Street
Private Bag X21, Johannesburg,
South Africa, 2017

30th June 2021

6 Wexford Court, 122 Albert Street, Rosettenville

Rosettenville

Johannesburg
2190

Email: chimsydhl@yahoo.com

Dear: Ms Chimwemwe Dhlamini

TITLE: ***Clinic Committees and their perceived roles in Governance and Community participation in the City of Johannesburg***

DRC Ref: 2021-05-005

NHRD Ref no: GP_202105_025

OFFICIAL APPROVAL

The Johannesburg Health District Research Committee (DRC) has reviewed your application. This letter serves as approval to access the Districts Health facilities (mentioned below) for the above research.

The following conditions must be observed:

- The facilities in which the research will be conducted are: ALEXANDRA CHC, MOFOLO CHC, ROSETTENVILLE CLINIC, WESTBURY CLINIC, YEOVILLE CLINIC, ZOLA CHC
- These facilities will be visited from: 30/06/2021 to 30/06/2022
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit an annual progress report to the District Research Committee.

- Your supervisor and University of The Witwatersrand will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.
- You will liaise with the manager/s before initiating the study.

Contact	Sub District	Sub District Manager/ Area Manager	Contact No.	Cell phone
X	ABCEF	Ms Lombuso Matlala	011 440 1259	082 307 0267
X	D	Ms Maria Mazibuko	011 674 1200	082 781 9919
	G	Mr Peter Mathole	011 213 9603	072 483 6839
	CoJ A	Ms Nelly Shongwe	011 237 8010	082 467 9276
	CoJ B	Ms Zanozuko Mbane	011 718 9656	082 551 5804
	CoJ C	Mr Tebogo Motsepe	011 761 0200	084 655 5420
	CoJ D	Ms Busi Phiri	011 986 0164	082 467 9316
	CoJ E	Mr Vusi Mazibuko	011 582 1504	082 464 9547
X	CoJ F	Mr M Monyamane	011 681 8130	082 467 9423
	CoJ G	Ms Olga Kruger	011 211 8936	083 286 0388

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above. Please feel free to contact us, if you have any further queries.

On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

Regards,

Prof S. Moosa
Chairperson: District Research Committee
Johannesburg Health District
Date: 30th June 2021

Mrs M.L Morewane
Chief Director
Johannesburg Health District
Date: 30/06/2021

Dr Baski Desai
Executive Director (Acting)
City of Johannesburg
Date: 22/07/2021

ANNEXURE 6: PLAGARISM DECLARATION

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Chimwemwe Dhlamini (Student number: 1893117) am a student registered for the degree of

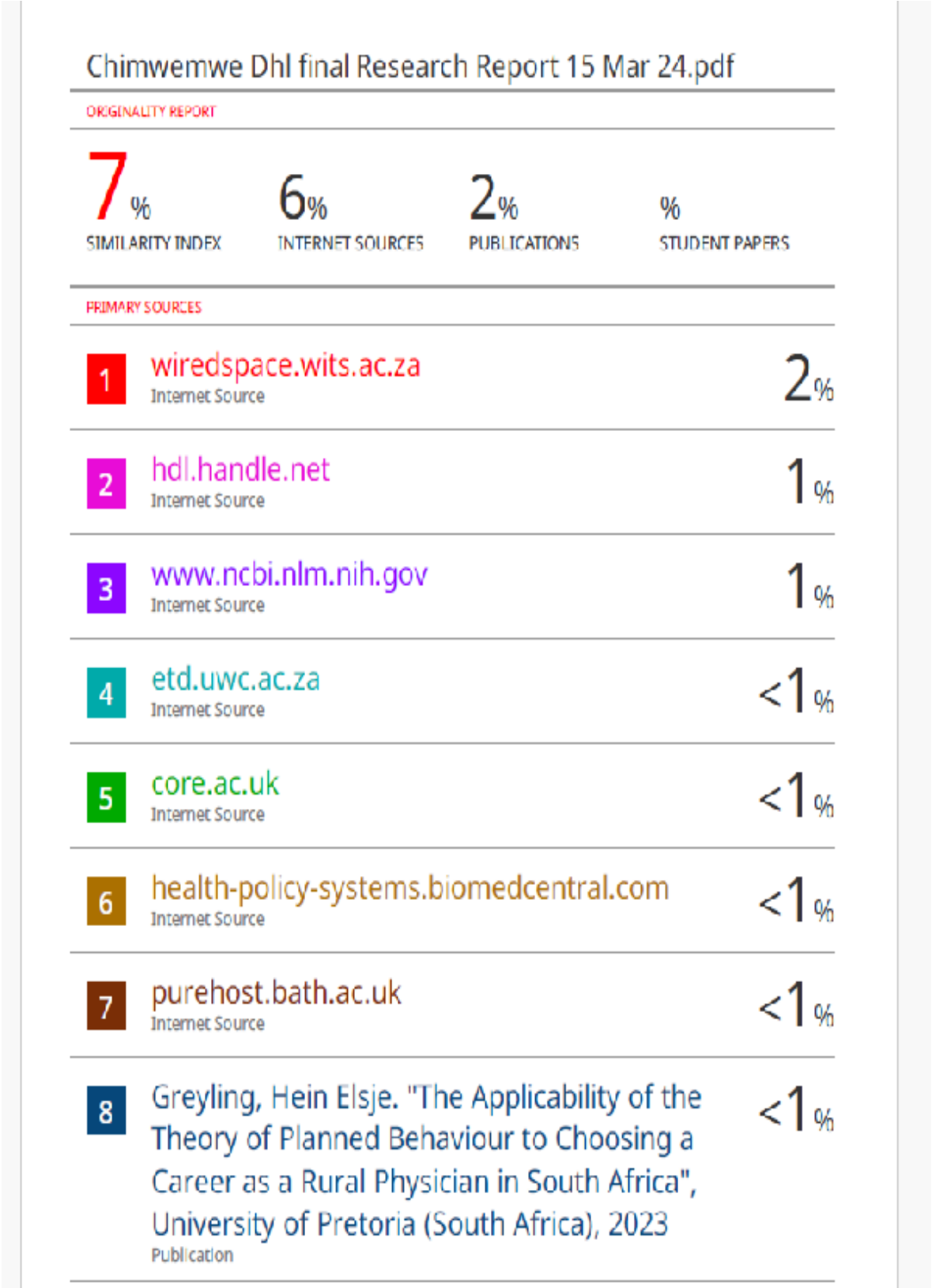
Master of Public Health in Health Systems and Policy in the academic year 2018.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature: _____ Date: 12 August 2024

ANNEXURE 7: PLAGARISM TURNITIN REPORT



Chimwemwe Dhl final Research Report 15 Mar 24.pdf

ORIGINALITY REPORT

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