

Draft Policy Guidelines on Clinic Committees

Introduction

Participation is a cornerstone in South Africa and in the country's health system reform. It is also an international human rights requirement linked to the right to health. The National Health Act (NHA) mandates clinic committees at all primary healthcare facilities and stipulates that these should be composed of the facility manager, a ward councilor and community members. It leaves it to provinces to promulgate legislation outlining the roles and functions of clinic committees, leading to a very uneven set of roles for health committees across South Africa. In addition, roles for clinic committees are, indirectly, prescribed in the Ideal Clinic Realisation and Management Programme and the National Complaints Guideline. While clinic committees are not mentioned in the NHI, amendments to the NHA resulting from the NHI outline a vision for community participation that is relevant to clinic committees.

The purpose of this national policy is to create a framework legislation for clinic committees based on an analysis of the international human rights framework, abovementioned national policies, provincial legislation as well as a draft national policy for health governance structures, which was written in 2013 but never implemented. Furthermore, a nationwide consultative process involving community clinic committee members helps ensure the policy reflects their perspectives. The goal is to develop a policy that aligns with existing frameworks while incorporating on-the-ground experience. This suggested national framework legislation should guide provincial policies, ensure that provincial policies align with national policies and that there is some consistency across provinces.

Background

The Alma-Ata Declaration, adopted in 1978, is a key document outlining the Primary Health Care approach. It talks about people's right and duty to 'participate individually and collectively in the planning and implementation of their health care'. This underscores that communities should not be passive recipients of care but active partners in shaping and delivering health services. The declaration promotes local ownership, asserting that health systems are more effective and sustainable when community voices are involved in decision-making. It links community participation with cooperation across sectors like education, agriculture, and housing, recognizing that health outcomes are influenced by broader social determinants. Another important aspect covered in the Alma-Ata Declaration, is that the declaration emphasises the communities' need to receive appropriate education to enable them to participate.

Furthermore, the right to health is both an international human right, stipulated in the International Covenant on Economic, Social and Cultural Rights, and a Constitutional right.

Participation – sometimes called community participation, social participation, citizen participation or public participation - is a basic human right. The right to participation is a right in itself and a right linked to the right to health as outlined in the International Covenant on Economic, Social, and Cultural Rights (ICESCR). General Comment no 14 (GC14) on the Right to Health is an expert interpretation and provides guidance on this right. In GC14, participation features as a central component to achieving the right to health and should occur at local, national and international levels. Participation is defined as involvement in decision-making regarding priority-setting, planning, implementing and evaluating strategies to achieve better health. It also involves influence in policy and accountability, including involvement in a national health strategy. In short, participation is understood as participation in health governance. Ensuring meaningful participation in health governance is part of States' human rights obligations. States that have signed the ICESCR are obliged to put in place mechanisms for participation. South Africa ratified the ICESCR in 2015 and hence should report on progress in realising the right to health, including participation. Furthermore, States' obligation extends to stewarding an entire health system, whether delivered through public or private services.

This policy is based on a Human Rights approach to participation. It acknowledges that there are many different forms of participation and that South African health committees constitute a specific form of community participation, as health committees are linked to the health services, or more specifically, to local clinics. The policy understands community participation in health to be about community participation in health governance; as a process where community members engage with health officials in matters related to health and health services, and where that includes involvement in identifying problems, needs, planning, implementation, oversights and monitoring of health service delivery and address social determinants of health (NOTE: Need to discuss whether we want to include SDH).

The Policy is also based on a Primary Health Care (PHC) Approach as outlined in the Alma-Ata and Astana Declarations. A PHC approach emphasises participation as an integral part of realising the right to health and highlights the importance of addressing underlying conditions for ill health, including Social Determinants of Health.

The policy also takes cognisance of the amendments to the NHA resulting from the National Health Insurance Act. The two provisions outline a conceptualisation of community participation “in the planning provision and evaluation of health services in the health district.”

Health committees became statutory bodies with the National Health Act of 2003 (no. 61 of 2003). Section 42 of the Health Act provides the regulatory framework for health committees in South Africa. It states that a health committee must be established for a clinic, a group of clinics, a community health centre or a group of clinics and/or community health centres. The Act furthermore states that the committee must include the head of the facility, one or more

local councillor(s), and one or more members of the community that is served by the facility. The National Health Act stipulates that the functioning of health committees must be prescribed in provincial legislation.

However, other national policies provide some details on health committees. The first is the Ideal Clinic Realisation and Management Programme, which is a Quality insurance programme that provides a number of points for a functional health committee, including a set of roles. The checklist below reflects these and other roles .

Below Policy Framework suggestion outlines all components for a well-functioning clinic committee. Research shows that well-functioning clinic committees have a direct positive impact on health outcomes in the communities they serve¹

Policy guidelines

1. Roles and Responsibilities

1.1 Community Participation and Representation

Clinic Committees shall:

- Identify and communicate the health needs and priorities of their communities.
- Assist communities in articulating their needs, concerns, and complaints to health authorities.
- Receive and discuss suggestions from community members with facility management.
- Organise regular engagement meetings, report-back meetings and communication sessions with the community.
- Invite facility managers to participate in clinic committee-led community engagement activities.
- Promote inclusivity by ensuring that marginalised populations—including people with disabilities, LGBTIQ+ communities, and refugees—have equitable access to quality healthcare.

¹ Esau, N., English, R. and Shung-King, M. (2020) ‘An assessment of a “training-of-trainers programme for clinic committees” in a South African district: a qualitative exploratory study’, *BMC Health Services Research*, 20(1101 (2020)), pp. 2–16. Available at: <https://doi.org/10.1186/s12913-020-05921-z>.

Haricharan, H.J., Stuttaford, M. and London, L. (2021) ‘Effective and meaningful participation or limited participation? A study of South African health committee legislation’, *Primary Health Care Research and Development*, 22(e28), p. 1. Available at: <https://doi.org/10.1017/S1463423621000323>.

Karuga, R. *et al.* (2022) ‘Participation in primary health care through community-level health committees in Sub-Saharan Africa: a qualitative synthesis’, *BMC Public Health*, 22(359), pp. 1–17. Available at: <https://doi.org/10.1186/s12889-022-12730-y>.

- Conduct structured induction and mentorship for new committee members during the final six months of each term.

1.2 Policy Engagement and Strategic Planning

Clinic Committees shall:

- Participate in discussions with facility management regarding local health indicators and service outcomes.
- Contribute to strategies aimed at addressing the Social Determinants of Health.
- Collaborate with other stakeholders in the health system, including provincial health structures, non-profit organisations (NPOs), community-based organisations (CBOs), and non-governmental organisations (NGOs).
- Hold quarterly public meetings in collaboration with the ward councillor.
- Jointly plan with facility management to set service delivery priorities and align facility budgets with community needs.
- Engage in the provincial health budgeting process through District and Provincial Health Committees to advocate for community-specific allocations.
- Review and provide input on provincial health budget implementation on a quarterly basis.
- Ensure that the governance and management of the facility adhere to human rights principles.

1.3 Service Delivery Oversight

Clinic Committees shall:

- Identify service delivery challenges and collaborate with facility management to address them.
- Participate in planning interventions that respond to community needs.
- Implement and evaluate patient satisfaction surveys and community scorecards, and address key findings in consultation with facility leadership.
- Initiate and support health awareness and education campaigns in collaboration with health staff and community stakeholders.
- Liaise with health governance structures, such as facility boards and district health councils, to strengthen coordination and service delivery.

1.4 Monitoring and Accountability

Clinic Committees shall:

- Monitor the performance and service standards of the facility through active engagement and data review.
- Receive regular reports from facility management on operations, progress, and challenges.
- Exercise the right to request and access necessary information to fulfill their governance and oversight roles.
- Conduct routine visits to monitor facility operations and the implementation of improvement measures.
- Ensure that at least one clinic committee member is present at the facility on a daily rotational basis to observe and report on service conditions.
- Be responsible for opening and reviewing the contents of the clinic's public complaints box in a transparent and accountable manner.

1.5 Financial Oversight

Clinic Committees shall:

- Review and monitor the facility's financial reports in relation to community needs and budget plans.
- Manage all monetary donations and financial contributions received by the Clinic Committee, ensuring transparent record-keeping and adherence to financial controls and accountability mechanisms.

1.6 Human Resources and Staff-Community Relations

Clinic Committees shall:

- Engage with facility management on human resource, including new staff and issues affecting service delivery and staff morale.
- Promote a respectful, collaborative environment between facility staff and the community, addressing any interpersonal or procedural concerns.

1.7 Complaints Management

Clinic Committees shall:

- Monitor the process and outcomes of complaint investigations to ensure timely and fair resolutions.
- Manage incoming suggestions and complaints from the public and address them in consultation with facility leadership.

2. Composition of Clinic Committees

2.1 Membership Structure

Clinic Committees shall be composed of the following members:

- The facility manager(s).
- A ward councillor.
- A minimum of six (6) to ten (10) community representatives, comprised as follows:
 - Six (6) to eight (8) members elected from the community.
 - Two (2) to three (3) members appointed by the Member of the Executive Council (MEC).
- A representative of the clinic's community health workers.

2.2 Community Representation

Community representatives must constitute **more than 50%** of the total membership of the Clinic Committee to ensure that the committee remains community-driven and accountable.

2.3 Diversity and Inclusion

The composition of Clinic Committees must reflect the **diversity** of the community they serve. Consideration must be given to ensuring representation across **age, gender, and race**. In addition, **marginalised groups** who face particular challenges in accessing quality healthcare—such as, but not limited to, **persons with disabilities, LGBTIQ+ communities, and refugees**—must either be directly represented on the committee or have their perspectives adequately voiced through designated representatives.

2.4 Support and Optional Members

It is recommended that a **designated health service staff member** be assigned to support the functioning of the Clinic Committee. In addition, provision may be made for the **optional inclusion** of other health workers, health sector representatives, or representatives of **organised labour**, where appropriate and agreed upon by the committee.

2.5 Public Participation in Meetings

Any member of the public may attend and participate in Clinic Committee meetings, provided that they **indicate their intention to attend in advance** and submit the issue they wish to address. While public attendees may contribute to discussions, they **shall not hold voting rights** in committee decision-making.

3. Clinic Committee Formation

3.1 Election of Community Representatives

A minimum of six (6) to eight (8) community representatives shall be elected to the Clinic Committee at an Annual General Meeting (AGM), held every three (3) years. Elections must be conducted by secret ballot.

In addition to the elected members, **the** Member of the Executive Council (MEC) may appoint two (2) to three (3) additional community representatives to serve on the Clinic Committee. These appointments shall be made from among candidates who have submitted their nominations through the process outlined below.

3.2 Candidate Nomination Process

All prospective candidates must comply with the following nomination criteria:

- Candidates must be endorsed in writing by at least two individuals who can attest to the candidate's qualifications.
- Each nomination must include:
 - A motivation letter;
 - A Curriculum Vitae (CV);
 - Two endorsement statements from individuals and/or organisations outlining the reasons for nomination and the candidate's past and/or future contributions to the community.
- The facility must extend invitations to registered organisations in the community to nominate and endorse representatives, accompanied by a motivation letter.
- The sitting Clinic Committee retains the right to verify all nominations for accuracy and completeness.
- A deadline for nomination submissions must be established and communicated at least 30 days prior to the AGM.
- A final, vetted list of all eligible candidates must be displayed publicly at the clinic and online, where possible, at least 14 days prior to the AGM.

Eligibility: Any South African citizen or legal foreign national residing within the clinic's catchment area and over the age of 18 is eligible to vote and to stand as a candidate in the election.

Compliance with the Protection of Personal Information Act (POPIA) or its successors must be observed throughout the nomination and election process.

3.3 Annual General Meeting (AGM) Procedures

The AGM is the formal platform for electing Clinic Committee representatives and must be conducted according to the following provisions:

- The **facility manager** is responsible for organising the AGM.
- The AGM must be advertised in the facility and through **local media**, with costs covered by the **Provincial Department of Health**.
- A **minimum public notice period of 30 days** must be observed before the AGM date.
- The AGM must be convened **within six (6) months prior to the end of the current committee's term**, and not less than three (3) months before the term expires.
- A **minimum of 20 community members** must be in attendance for the election to proceed.
- The **roles and responsibilities** of Clinic Committee members must be clearly introduced to all attendees.
- Each candidate must provide a verbal **motivation** during the AGM, explaining why they are standing for election and how they intend to serve the community.
- The **Provincial Department of Health** shall provide **transport allowances and refreshments** to enable broad community participation in the AGM.

3.4 Election Procedures

The election process shall be guided by the following procedures:

- Each AGM participant may vote for up to **eight (8)** community representatives.
- The **candidates receiving the highest number of votes** shall be declared elected.
- No candidate shall be elected unless they receive at least **50% of the total votes cast**.
- The **Independent Electoral Commission (IEC)** or an appointed **independent convener** shall oversee and facilitate the election process.

3.5 Dispute Resolution

Any **disputes, objections, or irregularities** related to the nomination or election process must be submitted in writing to the sitting clinic committee and facility manager within **seven (7) days** following the AGM, who will investigate and resolve the matter within **14 days** of the complaint being received.

3.6 Re-election and Term Limits

Clinic Committee members may serve for a **maximum of three consecutive terms**, subject to re-election. Members who have served two terms may only stand again after a full term has passed, unless otherwise approved by the MEC in exceptional circumstances.

3.7 Contingency Procedures

In the event that:

- There are insufficient eligible candidates;
- There is inadequate attendance at the AGM; or
- The community fails to elect candidates from those who present themselves,

The **sitting Clinic Committee** shall attempt to establish a new committee by **identifying suitable community members** who are willing and able to serve.

3.8 Final Appointment

Within **two (2) weeks** of the Clinic Committee being elected, the **MEC must officially appoint** the new committee.

4. Post-Election Governance and Operational Procedures

4.1 Convening the First Meeting

The **facility manager** shall convene the **first meeting** of the newly elected Clinic Committee within **one (1) month of the Annual General Meeting (AGM)**.

At this inaugural meeting, the Clinic Committee shall **elect the following office bearers**:

- Chairperson
- Secretary
- Treasurer

In the absence of either the chairperson or the secretary at any meeting, the Clinic Committee may elect an **acting chairperson or secretary** to serve for that particular meeting.

Only **elected community representatives** are eligible to be elected to office bearer positions.

4.2 Financial Oversight Structure

The **treasurer** shall be supported by a **finance team** consisting of **two (2) to three (3) elected committee members**. This team shall be responsible for:

- Overseeing the Clinic Committee's **budget and expenditure**.

- Presenting a **financial report** at each Clinic Committee meeting for review and discussion by the full committee.

4.3 Foundational Governance Documents

The first official task of the newly formed Clinic Committee shall be to:

- Develop a **Clinic Committee Constitution** and a **Code of Conduct (CoC)**; or
- Adopt or amend existing governance documents based on **national guidelines**.

Any **amendments** to the Constitution or Code of Conduct must be:

- Presented for acceptance at the **Annual General Meeting (AGM)**, and
- Submitted to the **Sub-District, District, and Provincial Health Forums** for official record and alignment.

4.4 Term of Office and Handover

The Clinic Committee shall serve a **term of three (3) years**.

Members may be **re-elected for up to Three (3) additional terms**.

During the **final six (6) months** of the term:

- Current committee members shall continue to serve alongside the **incoming Clinic Committee members**.
- This period shall be used for **handover, mentorship, and structured induction**, ensuring continuity and knowledge transfer.

5. Linkages to Other Health Governance Structures and Coordination

5.1 Multi-Level Governance Framework

In order to strengthen coordination, representation, and information-sharing across the health system, Clinic Committees shall be linked through a tiered structure of community health governance bodies, as outlined below:

5.1.1 Sub-District Health Committees

- All Clinic Committees within a sub-district shall collectively establish a **Sub-District Health Committee**.

- Each Clinic Committee shall nominate **two (2) representatives** to serve on the Sub-District Health Committee.
- The Sub-District Health Committee shall:
 - Convene **at least twice per year**, and
 - **Elect its own office bearers** from among its members.

5.1.2 District Health Committees

- All Sub-District Health Committees within a district shall establish a **District Health Committee**.
- Each Sub-District Health Committee shall nominate **two (2) representatives** to serve on the District Health Committee.
- The District Health Committee shall:
 - Convene **at least twice per year**, and
 - **Elect its own office bearers** from among its members.

5.1.3 Provincial Health Committees

- All District Health Committees within a province shall establish a **Provincial Health Committee**.
- Each District Health Committee shall nominate **two (2) representatives** to serve on the Provincial Health Committee.
- The Provincial Health Committee shall:
 - Convene **at least twice per year**, and
 - **Elect its own office bearers** from among its members.

5.1.4 National Health Committee

- All Provincial Health Committees shall form the **National Health Committee**.
- Each Provincial Health Committee shall nominate **two (2) representatives** to serve on the National Health Committee.
- The National Health Committee shall:
 - Convene **at least twice per year**, and
 - **Elect its own office bearers** from among its members.

5.2 Recognition and Legal Standing

All the above health governance structures—from Sub-District to National—shall be formally **recognized by the Provincial and National Departments of Health as legalized and institutionalized platforms for community participation in health governance.**

These structures represent **legitimate community voices** and play an essential role in:

- Health policy planning

- Implementation oversight
- Monitoring and evaluation at all levels of the health system

5.3 Purpose and Coordination Role

The purpose of these governance linkages is to:

- Facilitate mutual support and capacity building among community structures
- Enable experience-sharing and best practices
- Address community health issues across the sub-district, district, and provincial levels
- Liaise directly with sub-district and district health management teams

A **representative from the District Health Committee Forum** shall also sit on both the **District Health Council** and the **Provincial Health Council** to ensure continuity and coordination between governance and service delivery structures.

6. Training of Clinic Committee Members

6.1 Responsibility for Training

It is the responsibility of the **Provincial Department of Health** to ensure that all Clinic Committees receive comprehensive and timely training to effectively perform their mandated functions.

6.2 Timing of Training

- Training shall be conducted **within the first month** following the election of a new Clinic Committee.
- All **re-elected members** are also required to attend the training to ensure continued alignment with current roles, responsibilities, and governance practices.

6.3 Training Objectives

The primary objective of the training is to **build the capacity** of Clinic Committee members to:

- Fulfill the roles and responsibilities as defined in this policy.
- Ensure **functional and sustainable** committee operations.
- Understand and uphold principles of **accountability, participation, and equity** in health governance.

6.4 Training Methodology and Content

Training shall include the following components:

- **Peer-to-peer learning**, incorporating structured exchanges with experienced Clinic Committee members to promote practical knowledge transfer and mentorship.
- Provision of a **Training Manual** to each Clinic Committee member, which includes:
 - A clear description of their roles and responsibilities.
 - A **Code of Conduct booklet**.
 - A copy of relevant **legislation on community participation in health**, with **plain language explanations** of their rights and duties.

6.5 Ongoing Capacity Building

In addition to the initial induction training, the Provincial Department of Health shall ensure the provision of **refresher training sessions** at regular intervals to:

- Reinforce core concepts,
- Introduce policy or procedural updates, and
- Address any capacity gaps identified through monitoring and evaluation of committee performance.
- Encourage continued peer to peer learning

7. Support for Clinic Committees

7.1 Provision of Meeting and Work Space

To enable effective operation, the **health facility** must:

- Provide a **dedicated venue** for Clinic Committee meetings.
- Allocate **office space** for ongoing Clinic Committee work, including meetings with community members, planning activities, and administrative functions.

7.2 Secretariat and Administrative Support

To support the functionality of the Clinic Committee:

- The facility must provide **secretariat support**, including:
 - **Minute-taking** at meetings, and
 - **Basic financial administration**, unless the Clinic Committee has the **internal capacity** to perform these functions independently.

- Where feasible, the facility should **build the capacity of designated Clinic Committee members** to take on secretarial and financial tasks effectively.

7.3 Equipment and Communication Access

The facility must ensure that the Clinic Committee has access to the following resources:

- A **dedicated phone**,
 - A **computer**, and
 - A **printer**,
- for use in official Clinic Committee communication, documentation, and reporting.

7.4 Identification and Access Privileges

- All Clinic Committee members must be issued with a **facility identification (ID) card** to confirm their official status.
- The **Chairperson, Secretary, and Treasurer** shall be issued a **staff number**, allowing them access to:
 - **Internet and computer systems** necessary for committee-related functions,
 - While excluding access to **patient records and facility-sensitive information**.

8. Visibility of Clinic Committees

8.1 Public Display at Facilities

- All Clinic Committee members shall be displayed **visibly and uniformly across the province**, alongside facility staff, on a **standardised layout board** placed in a **public area** of each facility.
- The board shall include **photographs and the designated roles** of each Clinic Committee member.

8.2 Information Wall Display

- An **Information Wall**, located in the facility foyer, shall introduce all Clinic Committee members, including their **names and contact details**, to facilitate public engagement.

8.3 Online Visibility and Transparency

- All Clinic Committee members shall be presented on the **National Department of Health (NDoH) website**, under a dedicated **Clinic Committees webpage**.

- The web page must include:
 - Committee member **names and contact details**,
 - Linked **provincial and facility-level information**, and
 - Be **updated within one (1) month of any election or replacement** of committee members.

8.4 Daily Availability Notices

- The facility's public **notice board** shall indicate:
 - **Which Clinic Committee members are available** on that day for community engagement.

9. Financial Support for Clinic Committees

9.1 Monthly Stipend

- The **National Department of Health** shall provide a monthly **stipend of ZAR 2,500** to each Clinic Committee member, subject to the following conditions:
 - Stipends are contingent on **regular participation** in Clinic Committee meetings and Health Forum activities.
 - Members who miss **three (3) consecutive meetings or activities** without a valid written apology shall have their **stipend withdrawn**.
 - Any **unallocated stipend funds** shall be redirected to support **Clinic Committee community activities**.

9.2 Reimbursements and Operational Expenditures

The **Clinic Committee's financial team**, in accordance with its approved budget from the National Department of Health, shall manage the following:

- **Transport reimbursement** for attendance at:
 - Health Committee meetings
 - Other relevant meetings and forums
 - Training sessions
 - Official community activities
- **Airtime and data allowances** for communication and coordination.
- A dedicated **operational budget** to support the execution of roles and responsibilities as outlined in this policy, including:
 - **Stationery**,
 - **Educational materials**,
 - **Miscellaneous administrative costs**.
- A **refreshment budget** for Clinic Committee meetings (e.g., tea and coffee).

10. Frequency of Meetings

- The Clinic Committee shall convene **at least once per month**.
- A meeting shall be considered quorate when **at least half** of the committee members are present, **provided that the majority are community representatives**.
- **Online meetings** are permitted where necessary to ensure continuity of governance and participation.

11. Participation and Accountability of Facility Manager and Ward Councillor

11.1 Ward Councillor Attendance

- If the **ward councillor** is absent for **three (3) consecutive Clinic Committee meetings** without valid reason, the Clinic Committee may formally request **disciplinary action** through the **Sub-Council Chairperson** and the **facility manager**.
- The matter shall be addressed in accordance with the **Code of Conduct for Councillors** and relevant municipal procedures.

11.2 Facility Manager Attendance

- If the **facility manager or their designated representative** is absent for **three (3) consecutive Clinic Committee meetings** without valid reason, the Clinic Committee may submit a formal request for **disciplinary action** to the **Sub-District Health Manager**.
- Appropriate corrective action shall be taken by the relevant health management authority.