POPULAR PARTICIPATION IN PUBLIC HEALTH PROGRAMMES AT THE LOCAL LEVEL : AN EVALUATION OF THREE LOCAL HEALTH COMMITTEES IN THE SOUTH COAST AREA OF THE WESTERN CAPE PROVINCE.

BY

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DECLARATION

I declare that this Mini Dissertation Thesis is my own, unaided work. It is being submitted for the Degree of Master of Administration at the University of the Western Cape.

I testify that it has not been submitted for any other degree or at any other University, or institution of Higher Learning.

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ABSTRACT

The success of community participation or community involvement in health is not only dependent on adequate support for the process from the health services, but also on its implementation within an environment of political freedom, equality and the equitable distribution of resources. It is thus contended, that the forays by the apartheid South African state in the sphere of community participation in health in fact acted to mystify the inequity inherent in apartheid South African society. Through its promotion of a distorted form of community participation in health as a responsibility of individual communities and individuals, the 'participatory process' promoted was one in which communities were expected to improve their health status without the political, legal and economic power to enforce the necessary structural changes in the environments in which they existed.

This study traces the World Health Organisation's conception of community involvement in health, from the Alma Ata Declaration on Primary Health Care in 1978; the adoption of community involvement or community participation in health in its distorted form by the apartheid regime in South Africa through the 1977 Health Act; the refinement of this distorted concept in the early 1990s and its present application in the south coast area of the Western Cape province by this province's regional office of the Department of National Health and Population Development.

An investigation of the present day operationalisation of community

involvement in health was accomplished through an evaluation of three community health committees in the south coast area of the Western Cape province. The community health committee was the mechanism adopted by the Department of National Health and Population Development to promote community involvement in health. Focused interviews were used to elicit information on the community participation processes utilized in the establishment and functioning of the committees. Two of the three committees were established as a result of a directive issued by the Western Cape regional office of the Department of National Health and Population Development to the local authority health services under its jurisdiction. The third was initiated by concerned community members who then sought guidance from their local health service.

An evaluation of the responses of the participant committees indicate they received very little support from the health services; that they were generally not constituted by democratic means; that they have no decision making power as far as health development is concerned; and that they generally confined themselves to social marketing activities and the solving of individual community member problems. The study also attempts to provide recommendations on the way forward in the promotion of community participation in health as a social process of transformation.

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CHAPTER 1

INTRODUCTION

Community participation in health became a catch phrase in the international health arena after the 1978 conference on Primary Health Care in Alma Ata in the Soviet Union. Broadly speaking, this signalled an acceptance by the health establishment that the people at whom health services were directed, had to be a party to decisions relating to health service delivery and development. The issue which then faced health service renderers, was how far health service users were to be allowed to influence or direct health service delivery systems and health development.

This dissertation is an effort to analyse the issue by evaluating the manner in which the South African state, in the form of the Western Cape regional office of the Department of National Health and Population Development (DNHPD) sought to operationalise the community participation in health principle, namely, through the establishment of community health committees, a mechanism for popular participation in health advocated by the World Health Organisation (1991).

BACKGROUND TO THE PROBLEM

The National Party government's apartheid policies have resulted in a South African health service delivery system which is grossly inequitable and fragmented. The inequity in service delivery is aptly and easily demonstrated when one examines the apartheid government's health expenditure allocations to the four major population groupings in South Africa, namely, the Black, Coloured, Indian and White populations. In June 1989, the Minister of National Health and Population Development (South African Institute of Race Relations [SAIRR], 1990) announced that health expenditure in South Africa constituted almost 6% of the country's gross national product, and in the light of this, little or no increase in the health budget could be expected in the future. This decision was purportedly based on the fact that South Africa was in fact exceeding the World Health Organisation (WHO) norm of 5% of a country's gross national product as being acceptable for expenditure on health (Medical Research Council of South Africa [MRC], 1992).

Dorrington and McIntyre (SAIRR,1990) refute this as a simplistic explanation. It is their contention that the aggregation of health expenditure as a percentage of gross national product presents an inaccurate picture in the South African context because of the very high level of maldistribution of health care resources in the country.

The disparities in the allocation of expenditure between the various population groups in fact meant that the spending on health care for the Black population accounted for only 3% to 3,5% of the gross national product, (well below the norm determined by the WHO), while expenditure on Whites on the other hand, accounted for 13% to 14% of the gross national product. In addition, only 5% of the health budget was allocated to primary health care, this in a country with high infant mortality rates for the majority of the South African population as is indicated in table 1 below :

Table 1 : INFANT MORTALITY RATES (PER 1000 BIRTHS) IN SOUTH AFRICA 1981 - 1985.

	NATIONAL	10 MAJOR URBAN (a)	RURAL/PERI-URBAN
White	12.3	12.3	12.3
Indian	17.9	17.1	19.8
Coloured	51.9	25.9	66.0
African	94 - 124 (b)	38.6	100 - 135

(a) Excludes large peri-urban areas.

(b) Figure estimated using coloured urban-rural ratio as a basis (excludes Transkei, Bophuthatswana, Venda and Ciskei)

Source : MRC., 1992, p. 25.

This unequal allocation of resources is further compounded by the geopolitical fragmentation of the country into 'White' South Africa and

the 'independent' and 'self-governing national states'. This led to a situation where the apartheid health sector, consisting of fourteen health departments and numerous second and third tier authorities, was responsible for rendering health services to the South African population. A situation which made the efficient and effective provision of health services in South Africa very difficult (Pick, 1992).

The SAIRR (1991) provides the following profile of the living standards of South Africans : approximately 16,3 million South Africans live below the poverty line; some 2,3 million are malnourished; 31% of its labour force is unemployed or work in the informal sector; approximately 4 million homes, housing some two-thirds of the population are without electricity; the housing shortage stands at approximately 3,4 million units and it will cost approximately R16,46 billion to redress the backlog of water and sanitation to existing homes. Thus, for the majority of the South African population, the most basic survival needs have not been met.

In order for any meaningful change to be effected in this situation, the first step is the political enfranchisement of the majority of the country's population to ensure their legal and political right of equal access in the allocation of the nation's resources in all sectors, including the health sector. The profile noted above, is a direct result of the apartheid policies of South Africa's National Party apartheid government which, in the health

sector, resulted in a situation in which the majority of the country's population have been saddled with health services which were too far from where they live, of poor quality and limited range, not responsive to their client base, as well as operating from a victim blaming perspective, i.e. operating from the perspective that client populations are ultimately to blame for their ill health.

In light of the above, it goes without saying that simultaneously with the restructuring of South Africa's resource allocation system, should go the restructuring of the health services into a unified, integrated whole, with the reorientation of expenditure to primary health care services based on primary health care principles. This will enable the creation of a situation where the South African health service would be accountable, representative and responsive to the people it serves.

An essential input into the creation of this accountable, representative and responsive health service is the creation of an environment supportive of community participation processes in health service development (WHO, 1978, 1991; National Progressive Primary Health Care Network/ South African Health and Social Services Organisation [NPPHCN/SAHSSO], 1992). In addition to the prerequisite transformation of South Africa's political and economic structures, this process could be stimulated via the establishment of community based health committees composed of representatives of the formal health structures and the organs of civil

society in a particular community. It is envisaged that these community health committees will participate in the identification, formulation, implementation and evaluation of health service delivery structures and functions, and this participation will in turn, impact positively on the health status of communities by ensuring that health services deliver appropriate and quality health care.

In October 1992, the apartheid government (Subcommittee on Primary Health Care [SCPHC], 1992) proposed its strategy for dealing with community participation in health. This was in the form of a strategy document on primary health care (PHC) in South Africa. Perusal of this document indicates the existence of no less than six principles and one objective dealing specifically with the need to ensure the stimulation and support of community participation processes as an integral element of any government's PHC policy. In the South African document, these community participation PHC principles were set out as follows :

(I) Community members have the right and duty to participate in the planning and implementation of their health care both individually and collectively. Community involvement and participation are the cornerstones of PHC.

(ii) PHC and other health related services must be coordinated and managed at local level and with the participation of the community.

(iii) Local political, administrative and social patterns must determine how the planning, execution and control of PHC programmes at grassroots level can take place.

(iv) In determining the priorities for the rendering of health services, the felt and identified needs of the community must also receive consideration.

(v) Methods and techniques must be acceptable to those using them as well as to those on whom they will be applied.

(vi) Leadership from the community must be identified, recognised and involved (SCPHC,1992, p. 5).

With regard to the specific objective relating to community participation, it reads as follows, "To establish a mechanism for community involvement" (SCPHC, 1992, p. 8).

RATIONALE FOR THE STUDY

One way of evaluating the apartheid South African state's commitment to community participation as detailed in the PHC strategy document, is to evaluate its implementation efforts i.e. to evaluate the mechanism it has established for community participation or community involvement (as it was later called), in health service delivery and health service development. In the Western Cape province of South Africa this mechanism was called the community health committee. An evaluation of these structures will be attempted by examining the community participation processes supported by the health services in the establishment and maintenance of community health committees in three communities in the South Coast region of the Western Cape province of South Africa, namely the Concordia community in the Knysna municipality, the Parkdene community in the George municipality and the Sedgefield community in the municipality of the same name. These areas fall within the jurisdiction of the Western Cape regional office of the Department of National Health and Population Development (DNHPD), the first tier of the South African health service delivery system. The study will look at how

participation is presently encouraged by the health services and what power these committees have.

In April 1993, the Western Cape regional office of the DNHPD issued circular number 14 of 1993. This circular instructed the local authority health services under its jurisdiction to establish community health committees (DNHPD, Western Cape, 1993). The circular provided precise instructions to local health authorities on who should form part of these committees and the functions that the committees should perform. In essence then, the circular provides insight into the state health service vision of community participation in health. The circular itself will be dealt with in detail in chapter 3 as well as an analysis of the history of 'community participation' in health in South Africa under the apartheid regime.

METHODOLOGY OF THE STUDY

Initially, seven health committees were established by the Western Cape state health services through circular number 14. These seven committees were established between April 1993 and July 1993 and were to have been the focus of this study. These committees were however, also scattered throughout the Western Cape province, and owing to budgetary constraints it proved impossible for the researcher to include them in the study. By April 1994, however, some nineteen such committees had been established in one section of the Western Cape

province, namely the South Coast region. Requests to these committees for participation in this research yielded positive responses from three, namely, the local health committees of Concordia in the Knysna municipal area, Sedgefield in the municipality of the same name, and Parkdene in the George municipality. These committees thus provide the descriptive information on the processes presumed to presently guide community participation in health in these municipal areas in the Western Cape. By April 1994, two committees had been established within the Knysna municipality, one in the Sedgefield municipality and five in the George municipality (DNHPD, 1994a).

The evaluation of these three committees as mechanisms for community involvement in health (CIH) was conducted through focused interviews with members of the three health committees. These interviews were held in a group setting and a questionnaire guide, designed by the researcher was thus administered in a group setting. The questionnaire guide was used to elicit information on the following :

a. The reasons for the establishment of the health committee. This it was believed, would provide information on the representativeness and accountability of the committees.

b. How far the committees were in achieving what they had been established to do. This would provide insight into their decision making powers.

c. The manner in which the committees facilitated CIH processes in

their respective communities.

d. The resources available to these committees and from whence these resources were obtained.

e. The problems encountered by these committees in their efforts to achieve their goals.

The overall purpose of the questionnaire guide was thus to investigate the manner in which CIH had been operationalized through state initiated community health committees. During July 1994, one three hour interview was conducted with each of the three committees. The questionnaire guide contained open ended questions and was divided into three sections as follows :

a. Section A which dealt with how the committee was established and thus how representative it was of the community it was established to serve, and also, to determine to whom it was accountable.

b. Section B which dealt with the manner in which the committee facilitates community participation or community involvement in health (CIH).

c. Section C which dealt with the resources available to the committee.

The questionnaire guide was submitted to two medical doctors actively involved in facilitating community participatory processes in health development, for discussion and approval as an appropriate method of eliciting information about community participatory processes in health.

The invitations to the committees to participate in the study requested the presence of their chairpersons, secretaries and other interested executive members. No limit was placed on the number of committee members who wished to attend. The Concordia community health committee's delegation consisted of the chairperson, secretary and one other committee member. Their entire committee consists of seven persons.The Sedgefield health committee was represented by its chairperson, secretary and the Sedgefield clinic representative (i.e. the local clinic) on the committee. In all, this committee contains twenty-three members. The Parkdene health and community association (i.e. the name of the health committee) was represented by a seven person delegation consisting of its chairperson and secretary, both of whom are also in the employ of the Cape Provincial Administration's health department, the clinic sister attached to the Parkdene clinic and four members of the Parkdene community who are voluntary workers in self-help groups operating within the geographical boundaries of Parkdene.

The interviews were conducted in the form of a group discussion - the focused interview - using the questionnaire guide (See chapter 4 for questions and responses). The responses were recorded by the researcher and a volunteer scribe not associated with any of the three committees. During the course of the interviews, the responses given by the committee members were reflected back to the respondents in an attempt to ensure that their responses were being accurately recorded.

The subjective bias contained in this method is not lost on the researcher and it is recognised that the results cannot be indiscriminately generalised, since although a group of people were involved, it is still considered to be one interview. However, the strength of this method lies in the fact that it allows the researcher to understand the process by which the respondents arrive at their particular opinions and, should any answers be unclear, the researcher is able to probe further by asking respondents to explain what they mean (Nachmias and Nachmias, 1992). The method thus allows participants considerable leeway in expressing their opinions while still focusing on their experiences of the situations under investigation. A further weakness is the fact that the responses of members of the three communities who do not serve on their respective health committees were not included in the study. The inclusion of their responses would have provided valuable input into the manner in which community members view these committees. It is thus important that the responses of the participants be reflected in this study (See chapter 4 for participant responses) because they provide an interesting description of the activities and processes engaged in by state initiated committees and thus a descriptive account by committees members of their experience of CIH.

SIGNIFICANCE OF THE STUDY

An investigation into the operationalisation of community participation by the state and local authority health structures is essential because South Africa's first democratically elected government will still be working to a large extent with the same health service staff employed by the apartheid public health sector authorities. In addition, community participation or community involvement in health will be a process enthusiastically encouraged and politically supported by the African National Congress (ANC) led government in a democratic South Africa. It is thus important that we assess the ability of the health services to facilitate and encourage CIH.

This assessment is an attempt on the one hand, to inform the necessary and appropriate training and reorientation of staff, not only at grassroots level, but also at the senior and middle health service management level and, on the other, to analyse its present operationalisation so that CIH can take its rightful place as a social process for transformation and not merely be considered as another medical intervention. This is necessary, because unlike in the past, formal public sector health service staff will be accountable to the entire South African population and not only to the white minority for the services they provide. In order that both the coverage and quality of health care at the local level be of the optimum standard, it is important that those staffing the public sector health services be orientated towards the development of partnerships in health

service delivery and health development with communities, and that these partnerships be supported by the necessary resources. This is of immediate importance considering that a recent report (DNHPD, 1994b) indicates that the participatory processes presently encouraged by the state health services with respect to CIH are distortions of CIH processes.

CIH needs to be of a transformative rather than an instrumental nature. We need to determine whether communities are seen as recipients of health services or transformers of their own situations. The former approach militates, as Wisner (1988) notes, against group formation and self-organisation processes which are sometimes the only means by which people, especially the poor can mobilize around their demands for equitable and appropriate health services and health development. As far as South Africa in general, and the Western Cape province in particular are concerned, little research has been carried out on the community participatory processes currently encouraged by the public sector health service delivery system.

CHAPTER 2

THE PRIMARY HEALTH CARE APPROACH : THE WORLD HEALTH ORGANISATION'S MODEL

In order to explore the concept of community participation in health it is necessary to examine the social history of the concept. This in itself is an area of research still relatively neglected by proponents of the concept (Sanders and Carver, 1985; Navarro, 1986; Morgan, 1993). Debate on the subject exploded onto the international health scene in September 1978 when delegations of the 134 governments and representatives from 67 United Nations organisations, specialised agencies and non-government organisations making up the WHO and the United Nations Childrens' Fund (UNICEF) issued the Alma Ata Declaration on Primary Health Care (PHC). This declaration heralded a shift in emphasis from the hospital-centred, urban based, curative health service delivery system (which, with all its attendant problems, was regarded as the panacea for reducing disease in underdeveloped countries) to a comprehensive, multi-sectoral approach to health service delivery through decentralized health centres providing preventative, curative and rehabilitative services which would be accessible, acceptable and affordable to its users.

The success of this approach was predicated on the principle of full participation by health services users (which were presumed to be the communities living in the catchment areas of community health

centres/clinics) in the planning and implementation of their health care. The international health establishment cited the following as important factors facilitating their move towards the adoption of the PHC strategy :

i. The failure of the hospital-centred, urban based health service delivery system to reach the bulk of the population in the underdeveloped countries and the recognition that malnutrition, a major complication in many diseases was not going to be 'cured' by medical intervention because its roots lay in poverty.

ii. The inability of the vertical health programmes of the 1950s and 1960s to eradicate endemic diseases like schistosomiasis, tuberculosis, measles, gastroenteritis, malaria, trachoma and leprosy; the failure of national family planning programmes to lower birth rates and hence reduce population growth, and the partial rejection of population growth as the determining factor limiting economic growth and accelerating the consumption of the world's finite resources in the underdeveloped world.

iii. Changing health and development theories viz, growing sceptism with the modernisation theories which stressed the redirection of resources away from non-productive consumption sectors like health and education, towards economic growth. According to this perspective, once economic growth was assured, resources would automatically become available to what are considered to be non-productive sectors (for example, health and education), through a 'trickle down' effect. In countries like Brazil however, which showed

rapid economic growth, this did not necessarily occur. Navarro quoting from a study which dealing with the 'trickle down' effect in Brazil found not only a decline in state benefits and services used by individuals, but also a decline in,

> ... the percentage of state health expenditure from 4.6% of total state expenditure in 1977 to 2.4% in 1979 (as well as) a redistribution of income from the working class and peasantry towards the bourgeoisie (Navarro, 1986, p. 214).

This process was not however, uniform. Costa Rica for example, reflected both high rates of growth as well as the ability to redistribute the benefits amongst the poor (Morgan, 1993). It was, this inconclusive picture, according to Walt and Vaughn (1981), provided by the modernisation theories, which led to the formulation of a basic needs approach. This perspective proposed that development should be measured by the access of people to the basics needed to sustain life, for example, adequate food, shelter, drinking water, clothing and health care.

iv. The unprecedented improvements in the health status of the Chinese and Cuban populations. The international health establishment was especially enthusiastic about the Chinese barefoot doctor programme and the way in which lay health workers interacted with communities in the provision of basic preventative, curative and rehabilitative health services. Thus was born the concept of community participation in PHC. (Walt and

Vaughan, 1981; Mull, 1990).

Navarro (1986) summed up the world health situation prior to Alma Ata as follows,

> The year that the Declaration document was published (i.e. 1978), the following situation existed ... in the less developed countries approximately 11 million children under five years of age die every year of hunger, malnutrition and infectious diseases. To put the number of preventable deaths in another way, the equivalent of 20 nuclear bombs explode every year in the world of underdevelopment without making a sound (Navarro ,1986, p. 212).

What is noticeable about these factors, is the fact that they are divorced from developments in the economic and political spheres in the countries concerned. Very little is found in establishment health and development literature of the political conflicts which arose out of the differential access people have to economic power - a differential access which generally condemns people to a state of endemic disease and ill health. Health status in the underdeveloped world is looked at in isolation, it is divorced from the political, ideological and economic contexts in which it occurs. With regard to the Chinese and Cuban experience, what the international health establishment chose to a large extent to ignore, was the profound political transformation that had occurred in both societies. Sanders et al. (1985) show that the relative successes of China and Cuba in community participation in health, were largely the result of the redirection by these governments of previously private resources to national social

development programmes.

The success of China's Patriotic Health Campaigns of the 1950s, with its eradication of pests like rats, flies, mosquitoes and bed bugs, were simultaneously accompanied by improvements in the nutritional intake of the population, their improved and increased access to housing (which resulted in the reduction of airborne infectious diseases like whooping cough, diphtheria, measles and tuberculosis), as well as improved water supplies and sanitation (which resulted in reductions in cholera, gastroenteritis and poliomyelitis). These large scale development programmes were in large measure made possible by the government of the Peoples Republic of China reclaiming and redistributing privately owned agriculture and revenues from cash production to the Chinese population (Sanders et al., 1985). This viewpoint was echoed by Morgan (1993) as follows :

> ... the success of China's barefoot doctor programme prompted international experts to think about how a similar model might be applied globally, yet few experts analysed China's health successes in the context of other political developments occurring simultaneously in China. By looking only at the history of multilaterally sponsored health and participation programmes independent of local political context, the international agencies overlooked the relationship between politics and health (Morgan, 1993, p. 64).

Heggenhougen (1984) also supports political, social and economic transformation as an imperative in the support for PHC :

> The concern of any government advocating PHC should be with

> making changes to improve the total situation of communities. Such improvements are quite often the consequences of basic changes in the social and economic situation of particular population groups, and are related to issues of social justice, equal access to available resources and just return for ones labour (Heggenhougen,1984, p. 217).

Thus cautions Heggenhougen (1984), although the governments of many underdeveloped countries espouse the rhetoric of PHC and community participation, few have put into place the social, economic and political policies and programmes necessary to enable people to increase control over their environments.This inability to redirect adequate resources to PHC is however, considered by Mull (1990), to be the result of the way in which government bureaucracies in underdeveloped countries are structured. By this he means that sanitation, housing, water supply and electricity supply, for example - all the essentials for movement towards an optimum health status for populations - are not under the control of health departments. Mull (1990) appears to miss the point in this respect. It is not only that health departments or ministries do not administer these social development programmes, but rather that the resources themselves are not distributed to suit the social development needs of the majority of a particular country's population. The reason for this being, the manner in which national economies are organised, namely, in the pursuit of profit. Thus, comprehensive PHC, because of its financial cost, is not considered to be economically feasible. Citing a study by Chabot, Mull (1990) writes that PHC costs ten dollars per person to set up and two dollars per person per year to maintain. This he says, is not possible in underdeveloped

countries which are generally only able to spend one dollar per person per year on health. Thus what Mull (1990) fails to consider with any seriousness, are the economic and political forces militating against increasing social service expenditure.

This kind of analysis does not then attend to the root causes of the situation faced by populations in the underdeveloped world, viz., the effects of the world recession of the 1980s and how the massive rising debt interest of these countries (a result of capital accumulation as the driving force in capitalist society) was used by the International Monetary Fund for example, as a basis for introducing structural adjustment policies which were directed at the cutting of resources for social development programmes and their redirection towards the so-called productive sectors in order to secure the renegotiation of further loan agreements (Navarro, 1986; Morgan, 1993; Price, 1994).

Nowhere in its entire discourse on PHC and community participation in health does the WHO openly advocate for the transformation and fundamental restructuring of societies in underdeveloped countries so that, all people may enjoy the highest attainable standard of living, a fundamental right of all (WHO, 1978). What the WHO does promote rather, is that the PHC service is the most important intervention for the attainment of health in the Third World. This, according to Navarro (1986), is in itself a political and ideological position and means that health is not

perceived to be the outcome of politically determined structural, economic and social changes, but rather the result of technical interventions by the health sector, interventions which do not undermine the prevailing status quo (like for example, the pursuit of profit).

This is evidenced by the fact that the WHO had by 1984, provided a series of eight documents which it regarded as guidelines to be utilized by its member countries in the development, implementation and evaluation of their national PHC strategies (WHO, 1984). Although this general format is offered for its so called ability to be adapted to varying national situations, this also implies that the community participation envisaged is one which does not present any serious challenge to the inequalities inherent in societies whose economies are profit orientated. The capitalist state, through its governments would determine strategies, define their implementation and get communities to assist in the process. Morgan (1993) puts this position succinctly when she states, " National level health programmes are designed to modify and improve health status in ways which support domestic political priorities and don't challenge the political status quo " (Morgan, 1993, p. 161).

The international health establishment appears to subscribe to a social administration approach to the analysis of health and health development. This approach is, according to Doyal (1982), based on the following propositions :

a. That market forces cannot be held accountable for the whole scale provision of social services such as health, education and welfare. This is the task of the state. In the case of health, it is the outcome of medical intervention.

b. that not everybody in society has the ability to compete equally and effectively, owing to this, when they become ill or destitute, it is the duty of the state to care for the welfare of all its citizens, the ill and destitute included, at a price that the society can afford. Thus says Doyal :

> The basic mode of analysis is an empirical one, concerned only to a limited extent with the problem of how to minimise environmental threats to health, and to a much greater extent with the problem of how to provide people with more medical care, within the limits of an 'acceptable' level of public expenditure. Thus questions are typically posed in the following manner : 'What share of the national cake can go on medical care, and what proportion of that should be spent on the old as opposed to the mentally ill?' (Doyal,1982, p.14).

While there is an acceptance that economic, political and social factors can have a detrimental effect on the health of people, the ill health that exists is considered normal, a necessary evil about which nothing can really be done, and which is a small price to pay for the economic growth generally considered to be the desired social goal. Within this context, PHC and CIH are considered to be interventions which will assist in their quest for this goal. It is thus contended, that with respect to CIH, at best what the international health establishment proposed be adopted from

village/community health worker and barefoot doctor programmes, were the activities of these workers focused on the provision of simple treatments for a few diseases. This is evidenced by the manner in which the WHO defines CIH :

> Community participation is 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. With its aim of increasing personal and social responsibility for health and, at the same time, contributing to development, community participation is one of the principle strengths and supports of primary health care (WHO,1981, p. 33).

It is thus viewed as an instrumental process. People should learn how to treat simple diseases and manage meagre resources, not question why they are susceptible to some ailments while other groups are not, and why they have few resources and others have so much more.

The concept community also appears to be defined in terms of an aggregation of individuals and families living together within some sort of geographical boundary. The process of participation envisaged by the WHO (1981) then, assumes that people control their health once they have assumed 'responsibility' for it. The corollary for this is that they are then also responsible for their ill health because they have not taken 'responsibility' for it. The definition makes no mention of access to political and economic power. The WHO (1981) document does talk about power, but strips it of its meaning by reducing the problems faced in this respect

to interdisciplinary rivalries at the local level, which they believe, can be changed by reorientating local health staff to the PHC approach and by engendering a team spirit between staff and the communities they serve.

The WHO (1981) similarly glosses over the impact of the overall political and economic context and organisation of authority in society by saying that even in autocratic countries they have found that small projects,

> ... under voluntary auspices could make (a) real contribution to development. These will be high-risk endeavours and many may not succeed, but the few that do will be inspiring indeed. (They go on to suggest that),(t)here should also be some kind of network of contacts and exchanges of experience between such small voluntary projects (and that) while this approach ignores the overall health system, in certain exceptional circumstances it can be advantageous to work at the periphery and avoid the influence of a bad system. In this way, new forces for the transformation and reorientation of the system can be encouraged (WHO, 1981, p. 35).

This proposal becomes a damming indictment of the WHO (1991) position when one considers the price that village health promoters of the Chimaltenango development programme in Guatemala for example, had to pay for their efforts to promote community involvement in self-help activities in the early 1980s. In this particular case, eleven of the forty-nine village health workers in the programme as well as a number of their family members were murdered. The reason being, not because of their involvement in any revolutionary struggle, but due to the fact that they were beginning to effect real changes to their situations, were becoming more independent and self-reliant, thus seeming to threaten the existing

power structure (Heggenhougen, 1984).

This discourse should however, not be construed as an attack on the potential of PHC as an important aspect of much broader socio-political and economic interventions for dealing with health problems in the underdeveloped world. The movement of health facilities to the people and the provision of comprehensive care is a necessary but not sufficient in and by itself to improve the health status of many people. What is criticized is the ideological use of the approach - its use in treating symptoms and providing ideological acceptance for the maintenance of inequitable status quos. What the Alma Ata Declaration on Primary Health Care (1978) does, is list various technical interventions both inside and outside the health sector which are presumed by themselves to ensure health status improvement. This is according to Navarro, " ... misleading, since the effectiveness of these interventions depends on how (they) are related within a structure and a set of power relations that give them meaning and importance " (Navarro, 1986, p. 228). Avoidance of the recognition of these structures and power relations is thus seen as the main weakness of the approach, and it was in this ahistorical, empirical context that the WHO and multilateral international agencies like UNICEF, the World Bank and the International Monetary Fund developed their principle of community participation in health and development programmes.

WHAT IS COMMUNITY PARTICIPATION?

Participation is, " ... the most commonly-used slogan in contemporary debates about control over administration by people " (Hill, 1976, p. 208). The issue of groups of people expressing the need for increased self-government is nothing new. Since the last decades of the nineteenth century, with the shift from decision making through collegial structures, to decision making in individual bureaux in Europe, the problem of how to control public administration has been hotly debated. This debate has generally been concerned with creating mechanisms to prevent public administration from impacting negatively on democratic norms. In other words, the debate has been about ways to control administrations and make them more accountable within a particular socio-political environment.

Popular participation comes in various forms in societies. Boulle(1992) identifies the following categories:

(i) Manipulation : In this instance, participation is usually exercised by nominated bodies with functions and very little or no decision making power. " It occurs when public involvement in decision making is rudimentary, qualified and designed by power-holders to 'educate' or 'cure' the participants " (Boulle, 1992, pp.16-17).

(ii) Consultation : Here participants are provided with a platform on which they are free to make representations and recommendations. However, those to whom they are making the representations and

recommendations, are under no obligation to ensure that what was recommended is enforced.

(iii) Co-optation : Participants are party to the decision making process, but this very decision making process is constructed in such a way that what ever influence they have is limited and will not prevail if those in whose favour the decision making process has been structured, decide that the proposal will interfere with the status quo.

(iv) Partnership : This implies equality in the decision making process. The participants are able to negotiate on equal terms and engage in consensual decision making.

(v) Delegation : Here authority is provided to people and/or organisations to implement programmes or to formulate policy with or without the provision of a framework for operations.

There is little scope to argue that contemporary public administration in liberal democratic capitalist societies is more efficient in catering for the public interest than feudal or patrimonial administrations. With regard to popular participation, the task before one is of finding those instances where the potential to appropriate the administrative apparatus for sectional interests exists and, to prevent this from occurring. But, how viable is the political theory of pluralism? Although acknowledging that we live in a class based society, advocates of pluralism state that the nature of the conflict has changed substantially from the naked subjugation and

exploitation witnessed in the nineteenth century. Individuals have more rights as citizens and thus formally, equal access to a wider range of opportunities than previously. Secondly, power is more evenly diffused throughout democratic societies. It is true that some technicians eventually go on to become company directors, but how often does this occur? Finally, how many contemporary workers have ended up as capitalists based on the accumulation of wages? Although capitalists are not seen to be flogging workers on the production line, the underlying situation is not so different from the nineteenth century. The social relations of production are still inherently unequal. Thus the content of the relation has not changed, merely its form, which now appears as 'equal right'.

This relation is more so exposed within the South African context, where the economic exploitation is redefined as racial discrimination. It is thus racial discrimination which is blamed - and to a great extent it did exacerbate the problem - but it should not be divorced from the exploitation emanating from the economic sphere. It is especially in a liberal democratic society where the rules, supposedly based on rational and technical knowledge must be continually re-examined to ensure that they do not promote some interest at the expense of the general interest.

In the South African context then, the system of racial discrimination as the basis for distributing social goods must be dismantled and equal

political rights for all must be secured. The State must then be 'watched' because of its dominance in the lives and affairs of its citizens in all countries, especially in the realm of social development issues to ensure that it does not unnecessarily 'favour' one set of interests over another. This 'favouritism' has repercussions for increased self-government because as Dennis notes, " ... the form and content of those activities which remain in the residential locality ... are progressively less locality-determined " (Dennis, in Hill 1976, p. 232). Hill echoing this goes on to say :

> It is recognition of the extent to which key local determinants of local situations are often well outside these localities, at national or even international level, that has frustrated many workers involved in the government or local authority sponsored community development projects (Hill, 1976, p. 232).

Unless factors such as these are taken into consideration, concepts such as community participation and community involvement will become empty catch phrases instead of real solutions.

Thus, recognising the difficulties community/citizen participation holds for officialdom and project planners involved in social development activities or programmes, why is it still supported by the very people whose jobs will be made more difficult by its implementation? Some of the reasons offered by health professionals of why community participation is considered advantageous are :

1. More can be accomplished if the majority of people can be involved in an organised way. ... There are not enough professional health workers and if lay people become involved there is hope of developing health care for all.
2. Services can be provided at lower cost if people can be persuaded to donate time, material resources and labour on a voluntary basis. As a result it will enable government to spread their limited resources evenly to initiate projects in different areas at the same time.
3. Participation leads to a sense of responsibility for the project. It is assumed that if people participate in the planning and implementation of a project, their pride and commitment will motivate them to maintain it - even when outside resources are withdrawn.
4. Participation ensures that a felt need is involved and therefore guarantees that projects are selected well : if people are prepared to invest effort it proves their commitment to the programme.
5. Participation provides self-reliance and freedom from dependence on professionals. Professional skills are scarce and expensive. In most developing countries professional education is not geared to local needs and their relatively high standard of living makes it unlikely that they would work in rural areas. ... Collective self-care can replace the need for expensive and not truly preventive treatment by a doctor. It is a move to de-mystify medicine.
6. The use of indigenous knowledge and expertise will be promoted by participation.
7. Participation can act as a catalyst for further development projects. If participation in one successful project fulfils a basic need, people will be keen to take on further projects. ... The enthusiasm will promote self-esteem, help overcome apathy and the cooperative efforts will build community unity.
8. Participation in efforts to bring about development can result in conscientization - a critical awareness of the historical, economical and political causes of poverty and underdevelopment ... This heightened awareness could encourage people to make stronger and more effective demands for a greater share in resources and power. It will also encourage people to form organisations, for example, residents who participate in a self-study project become aware of the links between ill-health, low wages and poor housing and subsequently form a tenants' action group. (van der Walt,1983, pp. 19-22).

Many of the reasons relating to why community participation is necessary noted above, appear to be individually orientated and cost conscious.

Only as a last resort is the lack of resources considered to be a problem over which local people have little control. Thus are political and economic environments rendered neutral.

The WHO (1991) offers the following as the advantages of participation:

a. Coverage

Participation extends the coverage of health and development programmes through the extension of the direct influence of these programmes over more people. Participation also attracts more public support and thus increases the number of beneficiaries served by programmes.

b. Efficiency

'Willing participation' reduces duplication and increases the coordination of resources thereby increasing the efficiency of programmes.

c. Effectiveness

Programmes will operate effectively because people interested in specific programme areas will pool their efforts and give these efforts the benefit of their local knowledge, skills and resources.

d. Equity

Equity will be promoted when people share responsibility and serve those at greatest risk.

e. Self-Reliance

Participation promotes confidence among the participants and thus increases their sense of control over issues that affect their lives.

As with many of the reasons provided by van der Walt (1983) above, one gets the sense from the WHO (1991) advantages, that community participation is a strategy for working in essentially inequitable ideological, economic and political relationships. As in the case of van der Walt (1983) community participation is largely viewed as having an instrumental role. Wisner (1988) puts this aptly as follows, " The model implied is of local organisations as conduits or delivery points ... Peoples participation is invoked as acceptance of the package, as recipients of the 'message' " (Wisner, 1988, p. 4). Both the WHO (1991) and van der Walt (1983) appear to gloss over the vital importance of political, ideological and economic power relations in communities and the nation state as a whole. Both appear to ignore the fact that communities are not mere aggregates of individuals and that even amongst the poorest people, who have the least power, there are divided interests. The importance of understanding the power relations in the smallest and poorest community lies in the fact that they generally are microcosms of the larger society and can be an effective gauge of what is occurring on the national level.

Health programmes operating in the manner described by Wisner (1988) are aimed at bringing about changes in the behaviour of individuals, the individual family, and/or the individual community. International agencies for example, sponsor individual projects in communities - the so-called pilots which rarely appear to move beyond this pilot phase to become national interlinking programmes. These non-sustainable projects then

fuel assumptions that the contemporary poor health conditions of the working class and peasantry are due to their lack of concern for their own health and their disinterest in health education practice. By concentrating at the level of the individual community, family or person, and their 'ability' to manage or not manage their everyday circumstances, health included, results in, " ... the expropriation of control over the nature and definition of health from patient and potential patient in the health sector " (Navarro, 1976, p. 447).

Popular participation conjures up images of voting in national and local government elections as well as mass meetings and demonstrations on already mooted plans or issues. What about participation in decision making on issues before they become foregone or almost foregone conclusions? This situation, according to Lungu (1987) can be remedied by the institution of statutory committees peopled by private citizens. In his discussion of the Zambian government's attempts to promote citizen participation in development administration through the creation of multi-purpose development committees, Lungu (1987, p. 7) talks about citizen participation, which he defines as the " ... activities of private citizens directed at affecting administrative decisions and output."

Established by statute, these development committees have direct representation on Ward Councils, the latter being local government bodies. In this way, it is assumed there is direct citizen participation in the

local government councils. The purpose of these committees is to mobilize citizen participation in economic development. Prior to its introduction according to Lungu (1987), there were no administrative structures which enabled this kind of the direct participation by citizens in decision making at local government level. In fact the only participation by citizens in government decision making on the attainment of Zambian political independence, was the national ballot box. The problems faced by these development committees concerned poor motivation on the part of the citizenry. This was partly ascribed to their reluctance to participate in government sponsored programmes, as well as the failure of these committees to reflect the priorities of the communities, which were not group but rather individual based priorities such as, " ... building brick houses, improving a family maize field or digging a pit latrine, (rather than) community projects like new inter-village roads, wells or building schools ... " (Lungu, 1987, p. 14).

This inability to reflect the concerns of the ordinary citizen, resulted from the fact that the initiators of development policy did not consult with the citizenry for whom these structures were created. " The creation of these institutions though well intended, did not enlist the contributions of ordinary citizens... The movement has been promoted by members of intellectual, often academic, levels of society supported by international consultants and donor agencies " (Lungu, 1987, p. 14). Although there was national support for, and political commitment to the system, there

was an inability to translate this political commitment to all levels in a practical manner. This coupled with the tendency of the village headmen who were invariably the chairpersons of these committees at village level, to decide on issues with their traditional advisers instead of through participatory decision making processes, resulted in sectional interests being satisfied at the expense of the collective. A final important impediment to the success of these committees as vehicles for citizen or community participation, was the lack of resources in the form of money and skills training available to them. This factor was of significance more in the rural, than the urban areas, which did not have that much need of development committees because they were already resourced by development and other agencies.

The Zambian development administration model attempts to reconcile local and national interest. Its failure appears to be more the result of an over ambitious strategy which did not sufficiently explore how it would and could be implemented. The Zambian community/citizen participation experiment, according to Lungu (1987), should not be viewed as a failure of the concept, but should rather act as an opportunity for further research so that the similar mistakes are not repeated in future endeavours of this nature.

Midgely (1986, p. 23) defines community participation as a concept that " ... connotes the direct involvement of ordinary people in local affairs. "

In unpacking this definition, one finds that it does not tell us much. 'Direct involvement' can mean different things to different people. It can mean the use of community members as a cheap supply of labour by asking them to volunteer their services or it can mean consultation on how to distribute insufficient resources. It can also mean allowing people to have their say without investing in them the power to ensure that what they say is in fact implemented.

The United Nations, defines community participation as, " The creation of opportunities to enable all members of a community and the larger society to actively contribute to and influence the development process and to share equitably in the fruits of the development " (Midgely, 1986, p. 24). Here too, what 'development' and hence the 'fruits of development' means, are not spelt out. What this means in the context of social development is left largely to the governments of countries and, the international health establishment appears generally sympathetic to the economic arguments put forward if lip service is paid to the concept. In looking at government sponsored community participation programmes in Costa Rica, Morgan notes,

> ... Looking at these terms (i.e. participation in health) as political symbols enables us to 'unwrap' them, to reveal their ideological foundations and their function in political strategizing and agenda setting. The political underpinnings of these symbols may not always be readily obvious, however, many, indeed most of the symbols that are politically significant are overtly nonpolitical (Morgan, 1993, pp. 6-7).

When one examines health programmes purported to be developed through community participatory processes, they appear to be issue based in the sense that they are focused on a specific health problem. In fact, it is suspect whether one should talk about community participation or whether one should rather talk about the participation of members of target groups i.e. groups to be considered more at risk of developing certain conditions than others.

WHO AND COMMUNITY INVOLVEMENT IN HEALTH (CIH)

In 1991, the WHO published a technical report dealing with community involvement in health development. This report was based on research by a WHO study group tasked with analysing the work done in CIH over the eleven years since Alma Ata. Their brief was to :

> ... analyse this experience, identify critical challenges to the achievement of community involvement and come up with conclusions and recommendations that would help the health services and health personnel of WHO's Member States to begin a systematic move from talk to action (WHO, 1991, p. 2).

The section which follows will look at selected issues on CIH as identified by the WHO (1991) study group, viz.

a. What constitutes participation?

b. The influence of the setting in which CIH occurs

c. Ways of interpreting CIH

d. Key elements in the implementation of CIH

e. Mechanisms facilitating CIH.

What Constitutes Participation?

Participation is generally seen in one of three ways : either as contribution, or as organisation, or as empowerment. Participation as contribution according to the WHO (1991), generally occurs in projects or programmes established by outside agencies. People are expected to participate through either materially contributing to, or by providing voluntary labour to the specific health programme or project. Participation as organisation is concerned with the development of organisational structures to facilitate participatory process. While agreeing that the creation of these structures are important, the WHO (1991) noted that it is more important to facilitate the representation of community interest. This, it is assumed, will ensure that appropriate organisational structures and mechanisms will be put in place. This of course presupposes that the structures are perceived as legitimate by those who are supposed to be represented thereby, as well as the nature of the representation envisaged. Participation as empowerment is, according to the WHO (1991), difficult to define and can range from developing skills in people to enabling them to manage programmes effectively and to take decisions and action they believe are essential to their development. Empowerment through community participation thus appears to be focused on individuals as separate community members, not as participants in groups with some or no power.

The Influence of the Setting in which CIH occurs.

According to WHO (1991), several factors are critical in ensuring the successful implementation of CIH as part of the Health For All strategy :

a. Political commitment to the principle

This is more than the issuing of CIH policy statements, documents and/or guidelines. CIH is evident when resources, technologies and power are transferred to communities.

b. The reorientation of the formal health sector

This implies the democratisation of health sector bureaucracies through the decentralisation of structures and power. This is obviously not sufficient. It is suggested that this reorientation of the health sector can only be attained if all societal institutions and not only health bureaucracies (as suggested by WHO [1991]) are democratised.

c. The existing economic situation in the country

The existing economic situation is considered to be an important determinant of the emphasis given by governments to health development. The 'health' of the economy is the factor which determines the quality and quantity of resources allocated to the health sector. What must be borne in mind here, is the goal(s) to which the economy is geared. If the prevailing ideology is that economic growth is the primary solution to social development and that this growth can be achieved via the accumulation of capital, then the emphasis will not be on social development, but on capital accumulation and hence this will be where the country's resources will be directed. The WHO (1991) treatise does not

consider this as an issue because it is based on the assumption that economic growth is inherently 'good' and will therefore not have a negative impact on social development.

d. The development of local organisations, structures and management skills.

The definition of development is not clear. What is discussed, is the setting in which CIH is implemented. This setting is described as "... rural/urban, capitalist/socialist, resource rich/resource poor " (WHO, 1991, p. 8). These settings are seen as discrete with their own particular factors which impact in their own isolated ways on the outcome of CIH.

Ways of Interpreting CIH.

WHO (1991) identify what they perceive to be two broad, yet distinct ways of interpreting CIH as part of the Health For All strategy. CIH is used to either :

(i) promote awareness and understanding of health and health problems; or

(ii) promote community access to health services through the provision of information about existing services and health projects.

The CIH strategy thus appears to be limited to information provision by health 'experts' to 'unknowledgeable' communities. At issue, here is thus the perspective from which the information is given. For example, if it is from the perspective that very little resources are available to health and people show 'responsibility' by accepting this position and allowing themselves to be directed whether subtly or not, by the health services in

how these resources should be handled, they would act in quite a different way than if they are informed that the lack of resources is the result of the manner in which the society they live in is organised, and that it is this organisation to which the scarcity of resources can largely be attributed.

Key Elements in the Implementation of CIH.

On reviewing the current practice where CIH is concerned, the WHO (1991) study group cited the following as the key elements in its implementation :

(i) The external agency promoting CIH

Whether it is a government or non-government agency, the issue according to the study group is a) the agency's understanding of CIH i.e. does the agency view it as a supporting mechanism for existing programmes or as an enabling process? b) The role of the agency in this process - does the agency direct, support or facilitate the CIH process?

(ii) The community level worker

This person is seen as integral to the process. He/she is charged with the responsibility for developing the process. The impression that one is left with is that without this one person CIH will not become a reality at the local level. This person is in fact, 'in charge' of the process. This is evident in the following, " ... CIH must be the **responsibility of somebody** (my emphasis) at the local level. CIH will not just materialise; ... The key person needs to be identified and then undergo a suitable period of training " (WHO, 1991, p. 14).

(iii) Group development

The study group advocates a move away from the term community. Their rationale, is that the term is usually used in the geographical sense and does not really take into account clearly identifiable criteria such as cultural values or socioeconomic status. The trend is towards the identification of discrete groups.

(iv) The educational process

Here the study group makes an interesting statement viz., " Participation is essentially an educational process and accordingly CIH must contain a strong educational element " (WHO, 1991, p. 14). The educational element can either be in the form of information to people about health projects and how to get involved in them, or from awareness by enabling them to understand the causes of their health problems. This will then act as a base from which local people will derive solutions acceptable to them.

Mechanisms for Facilitating CIH.

The WHO (1991) identifies what they consider to be important mechanisms for facilitating CIH. These are village health committees or similar bodies; community health workers or other people central to the establishment of linkages between health services and local people, traditional health knowledge and practice; health campaigns; discussions and local meetings; and finally, drama, dance, festivals, art and song which they describe as more innovative approaches.

Ahistorical empiricism pervades contemporary health sector literature dealing with community participation. Further evidence of this is provided by Paul (1988), in his review of community participation in World Bank projects organised around urban housing, health and irrigation schemes. He defines community participation as, " an active process by which beneficiary/client groups influence the direction and execution of a development project with a view to enhancing their well-being in terms of income, personal growth, self reliance or other values they cherish " (Paul, 1988, p. 2).

Paul (1988) qualifies his definition by noting that the context for participation is the development project/programme, and that within the context of the project/programme, beneficiaries whether they be individuals or groups of people can be made to participate in various ways. This could imply some sort of manipulation or coercion. Paul (1988) does not however elaborate on this point. He also notes that he uses the term 'community ' to qualify the term 'participation' because in these projects people would have to act together and not as individuals to determine solutions. In this definition then, a 'community' is defined in terms of interest in a particular issue by an undefined number of individuals.

In the World Bank development projects reviewed by Paul (1988), the objectives of community participation were : empowerment, building

beneficiary capacity, increasing project effectiveness, improving project efficiency and project cost sharing. The last three objectives are not necessarily community participation objectives - they are external donor objectives, which, whether or not identified by target groups as priorities, will be included in any World Bank programme. It is also important to note that the way effectiveness, efficiency and cost sharing are defined could differ radically between the two parties. The first two objectives - empowerment and building beneficiary capacity have not received any real prominence because, according to Paul (1988), of the Bank's inability to provide staff with operational guidelines in these areas. It is interesting to note that World Bank staff need to be trained to work in a cooperative and just manner with beneficiaries.

Interesting issues emerge when one evaluates the outcomes of the Bank's empowerment and capacity building objectives. Of the forty World Bank projects surveyed by Paul (1988) which planned to use one or other form of community participation as defined by the above mentioned objectives, only three had empowerment as an objective. Of the three, only in the Zambian Sites and Services project were Bank staff compelled to incorporate empowerment as an objective, because of the Zambian government's insistence - a result of their philosophy of strengthening local communities and institutions. The remaining Bank projects in El Salvador were likewise compelled to include empowerment objectives because its implementing agency, a non-governmental organisation had

as its goal, community empowerment.

In the case of beneficiary capacity building, it was the direct objective of seven of the 40 projects. In this instance, capacity building was defined as, improving knowledge and skills so that project beneficiaries could assume responsibility for the management of parts of the project. This is a laudable goal. However, skills alone are a necessary but not sufficient goal for the management of project segments. If as Paul(1988) earlier defines beneficiaries as the "poor", how then are they to access the financial resources which their governments supposedly do not have, or are not directing their way to maintain the projects? Access to resources requires that capacity building be strengthened by community action. One often wonders whether this type of community participation objective, capacity building in isolation through the acquisition of a narrow range of skills is not setting beneficiaries up for failure.

Capacity building among beneficiaries was also an indirect objective of five of the population and nutrition projects reviewed by Paul (1988). It is interesting to note that in these projects, community beneficiaries were women organised into mothers groups. In the case of the population projects, the purpose of these groups was firstly, to enable them to educate themselves about contraceptives and then to motivate potential users. Thereafter, they took on the additional tasks of contraception distribution, and in the case of the nutrition groups, nutrition education. In

the case of contraception, according to Paul (1988), these additional tasks arose as a consequence of the project's objectives and goals, namely, contraceptive demand mobilization. Here again, capacity building in this form does not appear to be a need identified by the beneficiaries, but rather one vital for the implementation of the project according to the guidelines laid down by the donor agency. These forays on the part of the World Bank into community participation leaves one wondering whether they are merely another agency caught up in the rhetoric of community participation and, owing to the prevailing ideology, use community participation to obtain extra pairs of hands for service delivery efforts.

From the review thus far, one is left with the sense that CIH is quickly degenerating into an empty concept. Of the World Bank projects noted above, as it would seem with the WHO (1991) report, nowhere is there any challenge to any status quo built on inequality. Community participation processes are not used to challenge the causes of poverty and the reasons why the citizens of underdeveloped countries are bereft of resources. Essentially what comes through is the reduction of what is primarily a dynamic political process to a description of activities and tasks that need to be performed by local people and health service personnel.

CHAPTER 3

COMMUNITY INVOLVEMENT IN HEALTH IN SOUTH AFRICA

The review in the previous chapter suggests that PHC and CIH as espoused by the international health establishment conveys a way of doing things and a set of values which legitimize the existing situation by several mechanisms. This ideology can readily be adopted by any government without posing a serious challenge to its shortcomings as was the case with the internationally ostracised apartheid regime. In summary, this perspective is as follows :

(i) Preventable diseases are seen as something that individuals suffer from, rather than the result of the way political, economic, social and ideological relations are organised in a society.

(ii) Knowledge of these illnesses is privatized.

(iii) The practice of providing health services and health education without dealing with the underlying causes for the situation legitimates the ideology that it is what the individual is not doing that is the cause of his/her ill health.

In the 1970s, the South African apartheid state was faced with increasing strike action on the part of the Black workforce and a rejection of its primary ideological apparatus namely, the Bantu education system, by Black pupils and their parents. The unemployment rate in this time of positive economic growth in South Africa (2,9%), stood at 30% - 34%

(Keet, 1991), and although it was claimed that Black wages had been rising steadily since 1975, this was not weighed up against the increasing cost of living. A survey conducted by Markinor, and market research house (de Beer, 1984), indicated that half the households in Soweto for example, lived below the absolute poverty line at this time.

The apartheid state's response to this situation, according to de Beer (1984), hinged on their implementation of the following :

a. The removal of 'surplus' Blacks from 'White' South Africa under the guise of 'independence' for the homelands and hence the withdrawal of citizenship from a large number of Black South Africans.

b. The provision of limited and hence highly regulated trade union rights to the Black urban workforce.

c. The creation of a Black middle class which would, it was assumed, stem the increasingly vocal demands of the Black majority for full political enfranchisement in their country, through political opposition from the banned South African liberation movements especially the ANC, Pan Africanist Congress and the South African Communist Party.

d. The extension of meaningless 'political' rights to certain sections of the Black population, namely the Coloureds and Indians, through a bogus tricameral parliamentary system.

e. The use of the South African Defence and Police Forces as well as

> the state intelligence services to quell any opposition by force where cooptation measures failed.

The success of this strategy in turn, depended on the apartheid government being seen to be improving the quality of life of the urban Black population. " This is the reason for the series of commissions of enquiry focusing on housing, education, (and) trade union rights. ... It is also why the state has attempted to draw up a blue-print for improving health services " (de Beer, 1984, p. 43). In 1977 Act number 63, the Health Act was promulgated.

The 1977 Health Act, according to de Beer (1978), was a matter of extreme urgency because of the changing health situation in the country. However, when one looks at the situation he was describing, it appeared to have been coded to suit the white electorate. This is evidenced by the following description of the health status offered by de Beer (1978) :

> With the industrialisation of the Republic of South Africa after World War II and the development of large urban communities, infectious diseases faded into the background and occupational hazards became more and more important. Rapid improvement in the standards of living brought the inevitable diseases of affluent societies in its wake and coronary heart disease assumed epidemic proportions. With the ageing of the population, the degenerative diseases such as chronic bronchitis, congestive heart disease, arthritic conditions, metabolic disorders such as diabetes, and cancer became more important (de Beer, 1978, p. 6).

This situation, together with the acceptance of executive and financial responsibility by the 'independent' homeland governments through their 'autonomous' health departments was considered an important

constitutional development in the view of the apartheid government which would provide the South African health team, with the opportunity to develop a health system in line with 'modern health thinking'. This was supposedly not previously a viable proposal, because the Republic of South Africa was considered to be composed of people at 'different stages of development'.

What this constitutional development in fact meant was that the South African state health sector had now divested itself of its responsibility for the provision of health care to the majority of its populations in the rural homeland areas and would thus only provide health care and health services to the Black urban population who were legally allowed to be in 'white' South Africa. According to de Beer, " Final proposals for Homeland consideration were produced in 1975 ... (these proposals), if fully implemented, would have involved relocating at least one million people" (de Beer, 1984, p. 51). One million people, the majority of whom were women, children and the aged - those in dire need of health care - of whom the South African state, had divested itself of responsibility for the provision of health services.

This contention is supported by the following :

(I) The four white provincial administrations account for 62,1% of the total health expenditure;

(ii) The DNHPD and the three 'own affairs' health departments account

for 18%;

(iii) The ten homelands, which cater for the health needs of 43% of the total South African population, account for 18,4% of the total health expenditure (MRC,1992).

It was this kind of constitutional chicanery which enabled the DNHPD, " ... to pronounce its commitment to primary health care while ensuring that the bulk of the funding remains in the white controlled provincial administrations " (MRC, 1992, p. 97).

The 1977 Health Act also displayed an interesting conception of community involvement in health. de Beer (1978, p. 47) contends that one of the aims of the Act is, " ... to involve the community in selective priority determination and in supplementary service rendering, (which) can take place either on an organised or an ad-hoc basis, with special recognition of the role of all responsible voluntary organisations. " The selective nature of community involvement is demonstrated by the way in which the concept is defined, namely, " ... in essence, it is an attitude of good neighbourliness ..." (de Beer, 1978, p. 47). This definition as well as the example provided to explain how community involvement was envisaged in practice, provides one with interesting insight into the perception of community involvement held by the government of the day.

The example provided by de Beer (1978), concerns the need for home care for the aged who are ill. Community involvement is perceived to be necessary if the local authority or provincial administration directed to provide the service is not able to do so. This labour shortage on the part of the health service would then be filled by people living in this community who volunteer to be trained in home care nursing for the aged. They will perform this function free of charge in the spirit of good neighbourliness. The only responsibility the health service will have is to fund their training and oversee its implementation.

Other examples offered by de Beer (1978) are the use of community members to track down contraceptive users who discontinue contraceptive use; to track down people who offer resistance to the government's national family planning programme and; the transportation of people to hospital if official ambulance services are not available or do not exist in a particular area. All these services are presumed to be offered free of charge in a spirit of good neighbourliness. A logical conclusion which could be drawn from this, is that the State need one day no longer provide these services and, in addition, in matters of prevention and rehabilitation, citizens would be responsible for their own health.

This assumption gains credibility when one examines section 2(1)(e)(I-iv) of the 1990 National Policy for Health Act. This Act legislated individual responsibility for health in South Africa as follows:

> All inhabitants of the Republic, if he is capable of doing so, shall be primarily responsible for his own and his family's physical, mental and social well-being, ... that such inhabitant shall pay the costs incidental to his medical treatment. ... that the provision of a comprehensive health service by the State and local authorities shall be directed in a responsible manner at the needs of the individual and those of society, but that the available financing sources, natural resources and manpower of the Republic shall be taken into account; that the private sector shall be encouraged to provide health services in the Republic, but that the provision of such services shall be in the public interest. (Republic of South Africa,1990).

The state's role would be the provision of a health service and financial assistance for indigent people, both of course, subject to financial considerations. The need to legislate individual responsibility for health must be seen against the backdrop of the political economy of health in the 1980s in South Africa. According to Price (1994), by the mid-1980s, the apartheid government was faced by a declining economy due to its inability to attract foreign investment and long term loans. Together with the increasing pressure from international anti-apartheid pressure groups, domestic political violence and militant trade union activity further retarded capital flow into the country. This forced the apartheid government to adopt strict monetary policies which manifested themselves at the ideological level in the health sector in the call for individual responsibility for health and self-care in health matters. This legislation of individual responsibility effectively nullifies any conception of health as a

fundamental human right. Health could be obtained, but at a price.

The 1990 National Health Policy Act also made provision for the establishment of three national bodies which were either responsible for investigating and recommending or 'considering' national health policy. In the final analysis, decision making was centralised in the office of the Minister of National Health and Population Development. These three bodies, were the Health Policy Council, the Administrators Health Council and the Health Matters Committee. The composition of these bodies was statutorily determined and, composed of representatives of various state, provincial and local authority health service renderers. Provision was not made for statutory representation from organisations outside of this sector. Provision was only made for 'consultation with', 'taking evidence from' or 'hearing representations by any persons, bodies or authorities in the case of the Health Matters Committee (Republic of South Africa, 1990). It is thus suggested that while the government centralised health policy development and planning on the one hand, it took the idea of the decentralisation of health care provision to the other extreme through its legislation of individual responsibility for health, namely by 'decentralizing' it to the level of the individual.

The Alma Ata Declaration of 1978 calls on governments to assume responsibility for the health of their populations through the acceleration of social and economic development. However, almost twenty years down

the line the situation in South Africa looks as follows : It's general government expenditure as a proportion of gross domestic product (GDP) is the third largest of that of middle income countries, at just under 35% according to 1989 figures (Roux 1992). Social service spending as a proportion of projected GDP according to the 1993/94 budget estimate of expenditure stands at 34.2% and thus remains very much the same (Department of Finance, 1993). Despite this high level of social service expenditure, the living standards of the majority of South Africa's disenfranchised citizens remains deplorable. An analysis of public sector spending provides one way of assessing this situation. However, we need to look not only at how the South African government has allocated the nation's resources in an aggregated form as designated per functional category in the budget, but also at the way in which the apartheid policy of National Party government has skewed social service expenditure in favour of the White minority at the expense of the Black majority.

The policy of separate development found its economic corollary in fiscal apartheid. Grounded in the assumption that each population group in South Africa was required to finance its own social service expenditure from its tax contribution but negating these groups any opportunity of competing as equals in any sphere, meant that the Black South African's share in government expenditure benefits had to be financed by a fixed amount. This according to Van der Berg (1992a) was accepted as normal and seen as a form of 'development aid' which would be discontinued

once these groups were able to finance their own expenditures. The market forces envisaged to provide the impetus for this development did not however materialize. In addition, the various political 'reforms' and subsequent policy changes, for example, the extension of trade union rights to Black workers, the abolition of influx control and job reservation and the provision of the ninety-nine year leaseholds on property for urban based Blacks in the late 1970's and early 1980's exposed contradictions in the apartheid ideology.

The South African government was thus faced by a crisis of legitimacy in both the political and economic sphere. As van der Berg (1992a, p.128) notes, " The continuing search for legitimacy in the political sphere would be made easier if the economic system were perceived to be just i.e. legitimate." The fiscal apartheid paradigm provided the perspective that Whites carried 77% of the tax burden and hence were entitled to a major share (56%) of government expenditure. However, if one considers that the African population comprises 71% of the population and only gains access to 28% of government expenditure while the White population comprises 17% of the population and had the advantage of 56% of government expenditure, then we see the cause of the apartheid fiscal crisis. This apartheid fiscal paradigm goes a long way in explaining how the majority of the population in a country whose allocation according to international standards, especially in the realm of social services is on par with countries in its income category still finds itself in the position of

extreme poverty.

It is thus worth while looking at the disparities in social service spending by the apartheid government. This is especially pertinent with regard to their attempts at the promotion of CIH, since it highlights their unwillingness to supply the basic requirements for life to the majority of its population. This will be attempted by looking very briefly at government spending on welfare, housing education and health. This should dispel once and for all the belief that the health status of any people can be improved by only inputs into, and the reorganisation of the health sector without consideration of events taking place in the political arena.

WELFARE EXPENDITURE

Although the welfare budget increased from R5,1 billion in 1991 to R10,5 billion in 1993, per capita spending on Whites (R200) was twice as much as on Blacks (R100). An example of the problems facing welfare recipients in South Africa is aptly demonstrated by the example of the government's National Nutrition and Social Development Programme launched in August 1991. By January 1992 only R15 million of the R220 million set aside in the poverty relief fund in August 1991 was spent. This in a country where, as was noted above, 1,6 million people are living below the poverty line and 2,3 million are malnourished (SAIRR,1991). Similarly, in 1992, as many as 25 000 Black pensioners throughout the country were severely disadvantaged by the provincial administrations'

withdrawal of old age pension payouts in what they described as an attempt to curb the misuse of pension funds. The manner in which the situation was handled by the authorities spoke volumes about their insensitivity to the needs of the Black aged population in the country (SAIRR,1993).

Black welfare recipients also experience the brunt of the system of racial discrimination. According to van der Berg (1992b), the eligibility criteria which determine access to welfare payments are biased against Blacks. This is especially the case with regard to old age pensions. Parity with regard to old age pensions was only implemented with the tabling of the 1993/94 budget. This must not however, be seen as typical of the apartheid government's commitment to the attainment of parity in social expenditure. van der Berg (1992a) indicates that this move occurred largely through economic as opposed to purely political commitment to social pension disparity reduction. The decline in the real value of White pensions together with the effects of inflation and the relatively marginalised political status of Whites receiving a government pension (they form a very small and hence politically powerless group) enabled the government, " ... (to) use reform by stealth (as) the route for moving towards parity in social pensions " (van der Berg, 1992a, p. 131).

The African National Congress contended that this parity could have been implemented in 1992, through the addition of a further R2 billion to the

budget. In the 1992/93 budget, the government allocated R165 million in order to advance its staggered programme to achieve parity. This according to the African National Congress was inadequate in light of the fact that outside of the ten homelands, expenditure on the White elderly consumed 91% of the welfare budget (SAIRR,1992). The importance of old age pensions in the Black community was demonstrated by research which reinforced the African National Congress' position. It was found that in KwaZulu alone, pensions constituted at least 32% of the income of households.

> In all studies, pensions competed with migrant remittances for first place as source of income ... pensions represent a substantial inter- generational transfer of income, from the older to the younger. It is likely that, with increased unemployment, the pension system also represents a transfer from the elderly to the unemployed (SAIRR, 1992, p. 303).

The reluctance with which the apartheid government set about eliminating disparities in social service expenditure is further evidenced by their attempts to pass the Social Assistance Bill, first published in February 1992. The Bill advocated the exclusion of citizens of the "independent homelands" from eligibility for pensions. It also provided that the director general of the Department of National Health and Population be given discretion over the payment of pensions and in effect removed the legal right of persons to a pension.

HOUSING EXPENDITURE

Estimates of South Africa's housing shortage, according to the SAIRR (1991), abound. The South African Housing Trust estimates it at 3,4 million units and includes any household not living in a conventional house. The Council for Scientific and Industrial Research estimate stands at 2 million and will mean an annual erection of 320 000 houses. The Urban Foundation's estimate stands at 1,2 million which means an annual erection of 174 000 houses, while the South African government estimates the housing shortage at 3,3 million housing units. In April 1991, the government reported that 40 464 houses had been built for Black families, of this, the private sector constructed 30 911, self-help schemes accounted for 7 897 and the government for 1 656 (SAIRR, 1991). It can thus be seen that the actual construction of dwellings accounted for only 23,25% of the lowest shortage estimate mentioned above.

With regard to the 1991/92 housing budget, the Minister of Finance stated that the R1,2 billion would be supplemented by a further R750 million provided by the Independent Development Trust over two years and other initiatives by housing authorities. This would provide 900 000 families with access to low cost housing. The SAIRR (1991) noted that this would provide for only half the need. In addition, owing to the fact that Independent Development Trust planned to provide housing for 500 000 families over the two year period, the government was obviously expecting the remaining 400 000 families to be accommodated by public authorities.

There has however, only been a marginal increase in the housing budget over the last four financial years and in fact a decrease in the 1993/94 financial year (see Table 2). This seems to verify the SAIRR's (1991) position.

Table 2 : Budgeted Expenditure on Housing 1989/90 - 1993/94

Financial Year	Rm	Proportion of Budget
1989/90	959	1,5%
1990/91	1208	1,6%
1991/92	1356	1,6%
1992/93	1653	1,6%
1993/94	1603 *	1,3% *

(Source : SAIRR 1992/93 survey; * Department of Finance 1993)

The 1992/93 expenditure was supplemented by R500 million from the sale of strategic oil reserves and a further R1,1 billion from the Independent Development Trust, the Development Bank of South Africa and the South African Housing Trust. This meant that expenditure increased by 41% over that allocated in 1991/92. However, Planact, a service organisation cautioned against the superficial acceptance of this increase by highlighting the fact that its analysis of previous housing budgets indicated that housing funds were largely spent on, " ... civil servant subsidies, subsidies for first time home buyers and bridging finance to Black local authorities " (SAIRR, 1992, p. 219).

EDUCATION EXPENDITURE

The aggregated expenditure on education in South Africa over the past four financial years is impressive (see Table 3).

Table 3 : State Expenditure on Education 1990/91 to 1993/93

Year	Rm	% of total Budget	Education as % of GDP
1990/91	17,3	20,9	6,4
1991/92	19,9	20,6	6,5
1992/93	24,3	20,7	7,3
1993/94	27,2	21,4	7,3

(Source : March 1993 Budget Review)

A different story emerges when the expenditure is disaggregated into allocations per population group. Per capita expenditure on White pupils was just over three times as much as that spent on Black pupils in both the 1990/91 and 1991/92 financial years. According to the South African Institute of Race Relations (1993), R1248.00 was spent on a Black child as opposed to R4448.00 on a White child in the 1992/93 financial year - these figures include capital expenditure, and only apply to Black children living outside the homelands. The situation inside the homelands is far worse. In the KwaZulu Department of Education for example, expenditure per Black pupil was R428.00.

The disparities become more glaring and the financial attempts to 'promote parity' on the apartheid government's behalf, more mediocre when one considers that the allocation of almost half of the education budget over the past four years, was spent on White school children (SAIRR,1993) who comprise only 9,6% (a liberal estimate based on 1990 population projections) of the 10,4 million children in South Africa between the age of 7 and 19 years. Reduction in educational disparities has thus not been significantly addressed. According to Moulder (1992) of the R6.7 billion available for education expenditure in 1987, R2.6 billion was spent on less than one million white pupils. The crisis in South African Black education is summed up aptly by Trotter,

> ... it is interesting to note that the percentage of total costs (based on 1985 data) referring to Coloureds [10,4%] does not differ significantly from their proportion of the population [10,5%] or their percentage composition of the total enrolments of the state educational institutions [9,8%]. The percentage of total costs attributable to Indians [5%] is slightly higher than their percentages either in the population [3,2%] or in total enrolments [3,1%]. Glaring disparities occur for Africans and Whites. With 68,1% of the population and 73,3% of enrolments, Africans incur only 35,2% of the social costs. However, 49,4% of the costs are incurred on behalf of Whites, who constitute 18,2% of the population and 13,9% of enrolments (SAIRR, 1992, p. 793).

HEALTH EXPENDITURE

The allocation of health expenditure increased from R6,5 billion to R11 billion during the period covering the 1989/90 to 1993/94 financial years (Department of Finance, 1993). The most recent figures available (1987)

indicate that per capita health expenditure on whites is 4,3 times that spent on Blacks (SAIRR,1991). In addition, the government's commitment to 'equalising' health expenditure must also be seen against the backdrop of its allocation to the homelands. According to the South African Institute of Race Relations 1990/91 survey, only 29% of the national health budget is allocated to the homelands which in fact house 44% of the Black South African population.

An investigation by the University of Witwatersrand's Centre for Health Policy Research (1989) into the admission policies of nine hospitals before the announcement of desegregation and six months thereafter revealed that only two hospitals had made significant progress in desegregating wards. These instances leave a lot to be desired when we have to consider whether the apartheid government made a serious attempt to redress past injustices in terms of either expenditure or what turns out to be policy with little or no commitment to its implementation. The introduction of value added tax also impacted negatively on access to health since it increased the costs of both medicines and medical aids. According to the Representative Association of Medical Aid Schemes (SAIRR, 1991) value added tax would mean the increase in fees payable by the average member by R180 per year. This implies that access by the majority of the population to medical aid schemes is fast disappearing if in fact it was ever a reality, since approximately only 5% of the Black population has access to medical aid schemes (SAIRR, 1992).

An even better indicator of the apartheid government's lack of real commitment to diminish the gap in health spending between Whites and Blacks is evidenced by it's spending on Primary Health Care (PHC). During the late 1980s and prior to 1994, only 5% of the health budget is allocated to PHC, this in a country where the infant mortality rate for Black children is 62 per thousand live births (and this is a conservative estimate), 58 per thousand for Coloured children, 17 per thousand for Indian children and 13 per thousand for White children. Thus for the majority of the population the infant mortality rate is still above the World Health Organisation's norm of 50 per thousand for developing countries (MRC,1992).

The 1991 debate on the health budget, according to McIntrye (1992), highlighted the government's intention to reduce health expenditure in that it proposed an increase of 8,9% on the previous budget. Given the fact that the consumer price of inflation stood at between 14% and 15%, this in effect meant a real decrease in the resources available for public health care. This together with the devolution of PHC services to local authorities and the Provincial Administrations implies a shifting of the State away from its responsibilities in the health arena :

> Other public health services will have to consider alternative sources of income. Ultimately, the burden for financing of health services will increasingly fall on individuals using these services. It is likely that these proposals will have a significantly adverse effect on access to health care for the majority of South Africans (McIntyre, 1992, p. 61).

This relinquishing of responsibility by the state is in line with its drive towards the increasing privatization of health care. 'Conventional' wisdom has it that individuals are willing and able to pay for care that benefits them directly. In the South African context however, an investigation by Frankish (McIntyre,1992) found that an increase in day hospital tariffs saw a significant decrease in patient attendance at essential health services such as treatment for hypertension, diabetes and asthma. Thus, essential PHC services are being denied to people.

According to the University of the Witwatersrand's Centre For Health Policy (1989), fee for service and the third party payment systems in fact contribute to the rapidly rising costs of health care. With regard to the first mentioned, the health professionals' and/or health care institutions' income depends directly on the number of services provided. This could lead to the oversupply of medical services, not in the context that they are unnecessary, but rather that they could be optional, this means that unnecessary costs could be incurred. Medical aid schemes (third party payment) are also prone to the accumulation of unnecessary costs. Neither the consumer nor the provider of health services tend to be concerned about who pays. Instances may also arise where medical aid scheme members who, having paid regularly, feel that they are entitled to utilize services in order to get value for money. In the long run however, their contributions increase and costs are passed onto the consumer.

South Africa is thus a prime example of the perspective that events in the health sector are determined not by an evolution of ideas and organisations within that sector, but by political factors in the society at large. The inequity in social service expenditure noted above is a reflection of the socio-political and economic inequity in South African society. de Beer (1984) sums up the South African situation aptly as follows, " ... access to political power (proved) to be the best medicine for the 'poor whites'. On their own, better health services could do little to improve the health of the (African) population " (de Beer, 1984, p. 36).

The apartheid government adopted the WHO definition of PHC in February 1989 (DNHPD,1991). Their implementation was immediately guided by the WHO escape mechanism (which supposedly put this international organisation above international and national politics) namely, that, " The strength of WHO's Member states lies in (their) capacity to work out global themes ... and apply them in their own country after appropriate adaptation " (WHO, 1981, p. 12). Although not a member state during the apartheid years, the National Party government in South Africa recognised the ideological function of PHC. As an official strategy, PHC could be used to create the illusion of health care provision to the Black disenfranchised population. In addition, the PHC strategy could also act as a means of countering the growing influence of the National Progressive Primary Health Care Network (NPPHCN). Established in 1987 the aim of the network was the promotion of a comprehensive

national PHC system and not the adoption of PHC as one part of an essentially hospital and medical based - tertiary orientated - health system. At this time the NPPHCN was the only organisation actively engaged in this work through its national infrastructure and outreach programmes in the remote regions of South Africa.

It is this 'appropriate adaptation' meaning the provision of health services within the apartheid paradigm, that underlies all the National Party government's health policy initiatives and hence poor implementation performance as far as the Black South African majority are concerned. This politically sanctioned inequity has had and still does have implications for the majority of South Africans.

> South Africa combines the worst health consequences of industrialisation and poverty - high incidence of heart disease and cancers mainly among whites, and endemic patterns of preventable diseases among the majority Black population. The lack of basic public health conditions, such as adequate housing, safe water and sanitation, are the major causes of ill health. The fact that these problems are largely exclusive to the bulk of the Black population is a consequence of apartheid policy. (MRC, 1992, p. 5).

According to Buch (1989), the apartheid government's response to PHC has been less than enthusiastic. The DNHPD has not been able to respond coherently in the preventative and promotive arena. In fact, they have not been able to develop for example, any successful national campaigns to promote the simple technologies like GOBIFFF or the oral rehydration solution. Similarly, it has been the same performance with respect to the use of appropriate technology. Even the availability of the

Ventilated Pit Latrine design has not been utilized for the improvement of sanitation because of the lack of materials and training for communities. In addition, the team approach advocated by PHC proponents will be hard put to find acceptance in South Africa, where the present approach is a professional hierarchical one, with doctors at the top and the devaluation of the parts played by nurses, community health workers and other support staff in the health arena. In addition to the unequal distribution of health care centres, a nursing shortage and disproportionate supply of doctors and hospital beds in urban areas means that access to health services are unequal - in fact, a large proportion of the population does not have access to such facilities and services at all (Buch, 1989; MRC, 1992).

We have thus far considered the apartheid government's conception of CIH in the late 1970s and the 1980s and we have also looked at its social service resource distribution strategies. The latter being important since the chapters thus far have indicated that without adequate resourcing, CIH is not able to impact in any significant way on the health status of populations. The question before us now is, how did the apartheid government conceptualise and operationalise CIH in the 1990s?

In May 1991, the DNHPD hosted a two day forum/workshop on community participation in health. This forum, it was claimed, was attended by delegates from various organisations (DNHPD, 1991). The DNHPD

however, neglected to identify the constituencies/organisations present, thus it is not possible to make a judgement on the representativeness of the forum. An assessment of the forum proceedings will provide an indication of how the apartheid state health services envisaged the implementation of the CIH principle.

Community participation was defined as, " The stage in the process of development where a community becomes involved to the point where they can select and act upon their own felt priorities, set realistic goals and take responsibility for their decisions " (DNHPD, 1991, p. 3). This definition assumes firstly, that communities do not already possess this ability, that their life experiences in apartheid South Africa which saw the rise of civic organisations and a strong trade union movement which articulated the needs and aspirations of a vast number of communities, were not able to engage in these processes. No evidence is supplied by the DNHPD to support their notion of 'inadequacy' in this regard. Secondly, community involvement is seen as a stage in the process of development. If this is the case, what stage(s) precede it and how does CIH, essentially a principle of health development become a stage? The assumption that disenfranchised communities are not ready to take decisions, is well in line with the paternalistic attitudes of the health services and a direct result of the apartheid ideology which sees the disenfranchised population as being at a lower or lesser 'stage of socio-cultural development'.

The less developed community idea is also implicit in what the forum deemed to be the key to the attainment of the community involvement stage, namely, " ... a process of empowerment of communities through the enhancement of people's own capacities to improve their own lives and to take control over their own destinies " (DNHPD, 1991, p. 3). Thus the improvement or enhancement of individual capacity - which is not defined in any part of the document - was considered sufficient for people to 'change' the social context in which they existed. Victim blaming is evident in this scenario since it can then also be assumed that it is the individual's lack of competencies that is the cause of his/her ill health, rather than their lack of access to political and economic power. This notion is supported by Rissel :

> While there is no specific research documenting an increase in a psychological state of empowerment leading to improvement in physical health, there is ample evidence that groups without power, who reported feeling powerless, experience worse health. However power is measured, those with more power are healthier (Rissel,1994, p. 43).

It is not suggested that the enhancement of personal competencies - what Rissel (1994) calls psychological empowerment - is not important. What is being stated is that this is only one facet of the solution. Unless the structural inequalities of power are addressed, the rhetoric of empowerment and in this context, CIH will serve mainly to entrench a fundamentally patronising and essentially victim blaming agenda, thereby successfully obscuring inequitable political and economic structures and processes. This is evident in the DNHPD (1991) forum report which

makes no mention of the inequities resulting from the apartheid policy. These assumptions on the part of the forum thus calls attention to the question of the representative nature of the forum/workshop. It is advanced that the analysis of CIH put forward by the forum was within a paradigm acceptable to the health services of the apartheid state.

These perceptions also have a bearing on what forum participants perceived to be realistic goals for CIH by communities. Their perception is indicated by the following needs identified by the forum as priorities :

(i) Changing the attitudes of health professionals.

(ii) The provision of basic services and improving the status of women. This it was proposed, would result in a change in the poverty status of a large number of people.

(iii) Obtaining the commitment of political leaders.

(iv) Identifying and mobilizing community role players

(v) The effective utilization of manpower.

These priority needs would be addressed in the following ways :

a. " Creating self reliance and responsibility with an emphasis on self-care" Here again we see the element of victim blaming - people were just not responsible enough and something has to be done to create this 'responsibility'. Self-care was defined as, " ... learned, goal-oriented activity of individuals ... (aimed) at placing the locus of control with the individual, the family and the community " (DNHPD, 1992, p. 1-2). What the individual learns is how to cope

with the symptoms of ill-health and be accepting of health care technologies and health services.

This is evidenced by the following quote from the DNHPD's Self-care policy document, " Self-care in developed countries includes areas such as childbirth education, child abuse, premature infants whereas in developing countries the accent lies in areas such as immunisation, oral rehydration, water supply management etc." (DNHPD, 1992, p. 2). The three primary self-care interventions are described as self-treatment, disease prevention and promotion of health. These interventions are deemed essential in coping and managing ill-health, taking the necessary steps to prevent ill-health and improving health capacity and quality of life. Here again, the economic, political and social realities of South African life for the majority of its population are ignored in its totality. The causes of ill-health are presumed to lie within the individual and hence should be managed by that individual.

b. " Using a democratic approach and by respecting and allowing people to make inputs. " One wonders what is meant by 'using a democratic approach' in the context of an apartheid ideology. Likewise the very phrasing of the second part of the statement which is concerned with giving people permission to make a contribution gives us a strong indication of the undemocratic ethos in operation.

c. " Carrying out a situational analysis in specific communities." If the health professionals present at the forum were not aware of the deteriorating health situation in South African communities, they never would be.

d. " Local authorities should identify the communities in need." This solution clearly exposes the nature of the CIH envisaged by the DNHPD. Even the WHO (1991) investigations into community participation interventions strongly advocate the importance of developing partnerships in such ventures.

e. "The strategy to be followed should be identified with the community. " This solution appears to have been discarded during the course of the forum's proceedings. As we will see later, the forum decided that a strategic marketing strategy was essential for ensuring community involvement in health.

f. " Working through existing structures in a community, e.g. schools, civic associations and care groups."

g. " Completing something once started. Stay with the community and carry out the necessary evaluations and changes. " Here again decisions have been taken as to when health services will involve and withdraw themselves and also what roles they will adopt in the CIH process.

h. " The challenge for professionals is to be able to facilitate, become part of the community but still remain relatively peripheral to the community. Facilitate without dictation (sic). " Health professionals

thus see themselves as the 'experts', it is they who will control the process, local people must be 'guided' to make the correct decisions.

i " Get knowledge across to the community in such a way that they discover it for themselves. Then they will use it. " Why this subterfuge? Do those controlling the process want to disguise the knowledge they wish to impart. Is it because they are aware that people may not be convinced that what they wish to impart is the whole story, that when communities start questioning the premises offered, and come to understand the causes of their situations, they would articulate resistance against the inequity contained in the system?

j. " Obtain enough people to manage the services : people with management training, strategic planning and research expertise." How will the management of an already deficient service improve it? It is not the management of the services per se which is the fundamental cause of the problem - although it has a major impact on the problem - but rather the exploitative nature of the system in which the service operates.

k. " Paying attention to new models for the allocation of funding and facilities." If as was noted above, the inequalities are entrenched in the system through apartheid legislation like that related to the creation of 'independent' homelands then very little will be achieved by 'paying attention' to funding models. What is needed is the

political transformation of the existing resource distribution system.

" Training should be more job-related and more sectors should be involved in the provision of training to all levels of health professionals. " Granted that re-training is necessary, this by itself will not change anything unless the socio-economic and political structures are transformed, and this was not envisaged as necessary by the forum.

(DNHPD, 1991, pp. 1 - 3).

As was noted above, the forum considered it imperative that a strategic marketing approach be used to implement CIH. In fact, they noted that it was :

> ... essential to use a strategic marketing approach in order to obtain the involvement of people in health. (This would be accomplished through the utilisation of the following mechanisms) :
> (I) Community oriented education, formal as well as informal.
> (ii) The maintaining of community participation as an ongoing process.
> (iii) A social marketing strategy.
> (iv) Community based distribution of certain medicine and contraceptive methods.
> (v) The commitment of professional councils like the Medical and Dental Council (DNHPD,1991, p. 5).

Here again, it is essential that we analyse each mechanism in order to gain clarity on how the DNHPD would implement the CIH principle. **Community based education** can be a convenient label for education for reform and/or education for conformity (Werner and Bower 1988). In the latter instance, the purpose of the education is to discourage

resistance to social change, to encourage people to 'fit in' and thus is aimed at maintaining the status quo. In a more subtle way, education for reform is concerned with changing individual behaviour through the implementation of what is considered incremental improvements and getting people to accept that certain social, political and economic relations are inevitable and cannot be changed. The improvements thus mask the inherently unjust nature of the system. When one peruses the above, community based education by apartheid health services can only adopt one of these two or a mixture of the conforming and reforming functions. It can never have a liberatory or transformatory function since this would mean its active opposition to the apartheid ideology.

With regard to **community participation**, and its maintenance as an ongoing process. It is not clear how it acts as a mechanism for CIH? Surely it is supposed to be one and the same. What it appears to signify, is rather the need by the apartheid health services for a credibility vehicle. By ensuring the implementation of some kind of participation in its delivery system, state health services can use this as evidence of its 'willingness' to accommodate disadvantaged groups.

The use of **social marketing** techniques gained increasing popularity in the DNHPD in the late 1980s as was evidenced by its creation of a Marketing section within its Health Promotion subdirectorate which in turn formed part of the PHC Directorate. The primary function of this marketing

section was the use of social marketing techniques to promote PHC. Social marketing is concerned with the use of media technology in the targeting of individuals such as 'mothers' for the use of oral rehydration solution and 'teenage girls' for the use of contraceptives for example. It thus focuses on products which exist independently of the situations in which people find themselves during their everyday lives.

Social marketing is provided as a solution in place of problem solving by communities. It is the big 'quick fix'. Wisner puts this aptly as follows :

> At a time when there are many other social and economic forces tending to fragment extended families, neighbourhoods, and 'self-help' groups, it is alarming that the force of electronic media should also (be used) to fragment. A 'process' orientation works against fragmentation, situating possible 'solutions' to 'problems' in the growing understanding of wider social relations ... Ministries that cut back expenditures on such participatory, empowering work because social marketing appears 'faster' or more 'cost effective' cut the tap-root of the newly sprouting 'community' at the increasingly fragmented and class-polarized grassroots (Wisner,1988, p. 5).

In addition to this fragmentation, implicit in the assumptions of social marketing is the notion that effective communications, which is essentially technical information or knowledge supplied in the form of a health message, improves health status. Thus failure to follow the 'message' - which is often ascribed to inadequate motivation on the part of the receiver - is the reason for the health problem. This approach also negates the importance of political and economic inequalities as effective barriers to improved health status and promotes the world view that :

> People just need to get the right message at the right time in the right way and any obstacle can be overcome ... In lieu of addressing these('obstacles'), social marketing concentrates on communicating messages to individuals liberated from their social context by the assumptions of the free market. ... (this approach) takes these influences (ie the political and economic inequalities in society) as sheer constraints, and not legitimate targets of social change ... (Buchanan, Reddy and Hossain, 1994, p. 53).

Community based distribution would require the re-scheduling of certain medicines in South Africa. It is interesting to see contraceptives being singled out for this treatment. One wonders how this is going to be thrust on communities whose children are dying in infancy as was noted in the infant mortality rates mentioned above. With regard to obtaining the **commitment of professional councils**, no attention is paid to the ramifications of CIH in this regard. How is commitment to be obtained from councils whose power bases are likely to be eroded by the involvement of interests other than their own. Support in all probability would be forthcoming since as we have noted thus far, the vision of CIH proposed by the DNHPD(1991) in no way threatens the status quo.

In 1993, the South African state in the form of the Subcommittee on Primary Health Care, a creation of the Health Matters Committee, proposed resolution SPG 1/1993 (SCPHC, 1993), which contained the proposed guidelines for the implementation of a number of objectives contained in its 1992 Strategy for Primary Health Care in South Africa, CIH being amongst them. Unlike the DNHPD (1991) forum proposals noted above, the implementation guidelines for the establishment of

community involvement mechanisms were more coherently set out. They were accepted by the apartheid government as is evidenced by the fact that the Western Cape regional office of the DNHPD issued a directive to the local authorities under its control to establish community health committees, the favoured mechanism for promoting CIH in the SCPHC (1993) guidelines.

Although the subcommittee acknowledged the importance of political rights and representation for all as an important issue which needed to be addressed, their rationale for doing so was based on the fact that the health services needed to keep pace with South Africa's move towards democracy. This leaves one with the impression that a perception existed that a fundamental change in the political structure of the country would not result in a fundamental transformation of the state health sector. How this would be allowed to occur is beyond comprehension.

In addition, recognising that CIH is an " ... organic process inextricably linked to the overall democratic process ...", the SCPHC (1993) ascribe the 'slowness' of the process to the unfamiliarity of communities to normal democratic processes and their lack of involvement in health care services. One can agree that communities were not involved in health service delivery, but no evidence was led by the subcommittee to substantiate the claim that communities are ignorant of democratic processes. It is in fact incredulous that the state health sector, organised

as it was, on the basis of race, and hence along undemocratic lines, could accuse communities in South Africa of not being familiar with 'normal democratic practices', something which it as a sector had not concerned itself with in the past.

Together with the central issue of democratic political representation for all, the proposed guidelines offered by the Sub Committee on PHC (SCPHC,1993) included the following :

a. " Clear mandates and authority to the local level to implement community based programmes without having to obtain permission and resources from the central and regional levels " (SCPHC,1993, p. 268).

b. The orientation of health workers towards, and the training of health workers for, CIH. The recognition that they have tended to be alienated from the communities whom they serve and the need to involve communities in the selection of those who are to serve them.

c. The development and implementation of structures to ensure the involvement of elected and knowledgeable community representatives in the planning of primary health care services.

d. Ensuring the availability of funds for implementing CIH principles and initiatives.

e. State support of the CIH initiatives facilitated by non-government organisations in the form of funding and other resources.

f. Participatory evaluation and monitoring of primary health care programmes in communities.

g. Ensuring that health facilities are sited and, health services provided according to community needs, and ensuring this through community involvement in projects from inception.

However, the fundamental nature of CIH as a process for promoting socio-political change was not acknowledged by the subcommittee. They still proposed selective interventions as essential mechanisms for the improvement of health status namely,

> health committees, self-help groups/care groups, use of older school children in communities with low literacy levels, clinic committees, health awareness campaigns, voluntary help from community members in the day to day running of services (SCPHC, 1993, p. 271).

The SCPHC (1993) does not even mention the importance of dealing with poverty and unemployment, the housing shortage and the many other socio-economic inequities faced by the majority of the South African population. Their concern is only with the health sector. No guidelines are given for example, with respect to the importance of intersectoral collaboration for CIH.

Participation is thus proposed within the context of the present inequitable situation in the country. It thus comes as no surprise that the Western Cape regional office of the DNHPD, the first tier in the implementation of

state health policy issued circular number 14 of 1993 on 5 April 1993, which directed all local authorities under its jurisdiction to establish community health committees. Point number one of the circular read as follows :

> The National Health Matters Committee **has decided** (my emphasis) that a community health committee be formed in every community and it is the responsibility of the Local Authority to establish such committees (DNHPD, Western Cape, 1993, p. 1).

Secondly, that those communities where committees had already been established for the construction of clinic facilities be persuaded to change into community health committees. Thirdly, that where hospital boards were in existence, that they be represented on these health committees. Finally, local authorities were given a deadline - 28 May 1993 - to either report on the establishment of the health committees or see that they are in the process of being established. These four points immediately indicate the lack of understanding by senior health management staff of the concept of CIH. They decided that these committees be formed and who should have direct representation on the committee.

The circular also defined the goals and functions of these community health committees as well as the guidelines for their establishment and, what the department considered the prerequisites for their successful operation.

A. **Goals of community health committees as defined by the Western Cape regional office of the DNHPD**

(I) To obtain community involvement and thus collective responsibility for health and health care.
(ii) To promote self-care, reduce dependency and promote community involvement.
(iii) To provide primary health care services based on community needs (DNHPD, Western Cape, 1993, p. 1).

B. **Functions of community health committees as defined by the Western Cape regional office of the DNHPD**

(I) The committee, in cooperation with the health system identify, analyse and prioritise health problems. In cooperation with the health system, committees will also develop, implement and evaluate action plans with regard to these health problems.
(ii) Identify and develop resources.
(iii) Promote community awareness about health and health care.
(iv) Serve as liaison and spokesperson between the community and the health system (DNHPD, Western Cape,1993, p. 1).

C. **Guidelines for the establishment of community health committees issued to local authority community health staff by the Western Cape regional office of the DNHPD**

(I) Health committees should not be too big and in order for it to be representative of communities should be composed of non-professional service users.

(ii) Health services should guard against health committees being taken over by interest groups who would use the committee for their own purpose.

D. **Prerequisites for the successful operation of community health committees as defined by the Western Cape regional office of the DNHPD**

(I) Health services should lend recognition to these committees and support their goals.

(ii) Community leaders should be identified and involved in these committees.

(iii) Health services should give the necessary attention to the needs of the committee in order that they be perceived as credible bodies.

(iv) Health programmes should be directed at real needs so that communities can have confidence in these committees and thus support these health programmes.

(v) The health system should provide logistical support to the community and ensure that the basic infrastructure is in place.

In addition to the fact that no where in the circular is the definition of 'community' to be found, the circular is extremely directive. It instructs the health services on who should serve on these committees, what the functions of the committees should be what goals they should strive for and what should act as indicators of successful committees. In fact, this circular operates on the assumption that participation via a committee which has no statutory power, will improve the health status of communities. The assumption that communities are the cause of their ill health comes through clearly. No consideration is given to the structural

constraints under which people live.

The non-professional user idea is an interesting one. How is this type of individual defined? Does it mean that people considered uneducated in the formal sense i.e. no secondary or tertiary level education are those who should serve on the committee? What if any, ulterior motive is at work here? This obvious direction of the goals and functions of these committees raises a number of questions, namely :

1 Can apartheid health services promote participation as a transformation process? Or rather, is their concern the maintenance of the status quo?

2 What kind of participation are they talking about?

3 What power will these committees have?

4 Can they change health service delivery systems?

5 Are these committees merely inputting into already formulated plans and health service strategies?

6 To what extent do communities develop their own plans of action or local programmes?

These concerns are echoed by the MRC (1992) who note with increasing alarm the abuse of the CIH concept by the apartheid South African government. The latter usually confuses its definition of community involvement in health with consultation. In this sense, the consultation engaged in by the government, is with groups of its choosing. These

sessions usually end up as a forum through which the government communicates its already decided upon objectives to selected groups. This will trend will be examined in the next chapter.

CHAPTER 4

EVALUATION

An empirical evaluation of the Western Cape regional office of the DNHPD's promotion of CIH is attempted by looking at what it has done through the local authority health services under its jurisdiction with regard to the establishment and operation of community health committees. As was noted in chapter 1, it is necessary to provide a relatively detailed account of the responses of the participant committees. The data obtained provides a rich description of the interactions between the health service renderers and the recipients of these services.

PARTICIPANT RESPONSES

The responses of each community health committee will be dealt with separately. Thereafter, the findings will be discussed.

CONCORDIA COMMUNITY HEALTH COMMITTEE

A. REPRESENTATIVENESS OF THE LOCAL COMMUNITY HEALTH COMMITTEES

1. **When was the health committee established?**

The committee was established in 1992. Committee members were however unsure of the month in which it was established.

2. **Why was the committee established?**

The present members of the committee saw that the local authority clinic

staff were not reaching those people in the community who required services, especially those requiring treatment for tuberculosis. They then approached the staff and offered to assist them with tuberculosis case finding.

3. **Who was involved in the decision to form the committee and how did you go about forming the committee?**

Seven members of the community decided to form the committee and approached the clinic for assistance in this regard.

4. **Who does the committee represent?**

The people living in the Concordia township

5. **How were the members of the committee chosen?**

Community members volunteered to stand for election after being approached by the seven individuals who first identified the need for the committee.

6. **To whom is the committee accountable?**

To the local authority clinic and the Concordia Civic Association.

7. **How does the committee report to its governing body ie to those to whom it is accountable?**

To the clinic through the minutes of committee meetings. Also to the local civic association at their monthly meetings.

8. **Who can attend the meetings of the committee?**

Any person resident in Concordia.

9. **How are those eligible to attend committee meetings informed thereof?**

Being a very small community of only approximately 200 hundred houses, people are informed by word of mouth.

10. **How does the committee involve the residents of the area in which it operates in its activities?**

The committee invites residents to get involved in the activities it organises by asking them to assist with organisational tasks relating to committee activities.

11. **Does the committee have a management structure?**

Yes, a chairperson and a secretary

12. **How are people selected or elected to this management structure?**

Individuals volunteered for the positions at the first meeting where the decision was made to form the committee.

13. **Has the local health service acted on any decisions taken by the committee which requires the former to provide resources to the committee?**

No. In 1993, the committee asked the clinic to recognise them as community health workers and to provide them with more intensive training and this has not been done. The committee identified a fixed clinic as a need. They are subject to a mobile clinic service which does not satisfy the needs of the community according to the committee

representatives. To date they have had no feedback on this request.

B. COMMUNITY HEALTH COMMITTEES AS FACILITATORS OF CIH.

1. **What does the committee consider its major functions to be?**

To assist the clinic personnel with tuberculosis case finding and encouraging those receiving treatment to continue doing so.

2. **How were the functions of the committee decided upon?**

The committee members are in constant contact with tuberculosis sufferers and they identified the need to motivate these people to attend the clinic for treatment. The clinic personnel identified the case holding function since many patients were defaulting before completing treatment.

3. **How were the health needs of the constituency served by the committee identified?**

As was noted above, the present committee members realized that sufferers of tuberculosis in their midst were not being reached by the local health service, hence their offer to assist them with tuberculosis case finding.

4. **What activities are the committee members presently involved in?**

They assist individual community members with their problems. For example, they arranged that a social worker visits the community on a monthly basis to meet with those requiring their services and who do not have money to visit the social work offices in the nearby town. The

committee is instrumental in running the local crèche and community members work free of charge at this crèche - in any event there is no money to pay them. The committee in fact obtained funding for its construction from a local business. The committee also arranges an annual sports day for the community.

5. **How did the committee decide on these activities/projects?**

The committee holds meetings with the community. The issues raised at these meetings are then acted upon by the committee in conjunction with the community.

6. **Are there any other organisations or structures in the community presently dealing with the health needs of the community?**

No. The committee is the only such community structure.

7. **In the light of your answer to question 6, why was this committee then still established?**

As can be noted from the answer given by the committee this question was posed to the Concordia health committee.

C. RESOURCES AVAILABLE TO THE COMMUNITY HEALTH COMMITTEES.

1. **Does the committee have access to any financial resources?**

No.

2. **If yes, approximately how much does it normally have access to, and how does the committee acquire this money?**

As can be noted from the answer to question 1. This question was not posed to the committee.

3. **To what is the money allocated, and how is this allocation normally decided upon?**

This question was also not posed to the Concordia committee.

4. **What manpower is normally available to the committee?**

The committee members do most of the organisational work and they request assistance from the community in participating in the activities that are so organised.

5. **What tasks/duties do :**

   a. **Committee members normally engage in and,**

   b. **Ordinary community people not part of the committee involve themselves in?**

Committee members assist the clinic in the identification of community members who are in need of treatment for tuberculosis or those who have defaulted from the treatment regimes, as well as any other activities which the clinic may assign to them. Community members assist the committee members with activities at their request.

6. **Generally speaking, when are most of the committee's duties performed? i.e. is committee work performed after people are finished with their daily jobs or during the course of the day?**

Committee members are unemployed so they are available throughout the day and at night when necessary.

7. **Do you as a committee, think that your members should be paid for the work they do?**

Yes, because there is large scale unemployment in the area and people are poor. In this way, more people will get involved in health activities. At present they feel demotivated because they are living in poverty.

8. **Have committee members or the people involved in the committee's activities received any kind of training for the tasks they are expected to perform?**

Yes, committee members were given health education programmes and taught to identify tuberculosis symptoms. Information on the signs and symptoms of diahorrea, AIDS and sexually transmitted diseases were also given by the clinic sisters. However, the first aid training which was much needed in Concordia, although requested by the committee has not been forthcoming from the health service.

9. **Has the committee experienced any difficulties over the past 12 months in the implementation of its programmes or activities?**

Yes, committee members are not recognised by the community for the

health related activities they perform. The committee believes that this could be remedied if the clinic issued them with certificates when they finish a training session.

10. **How does the committee think that these problems can be solved?**

Job creation projects need to be implemented. The committee expressed an interest in door-bed gardens as a way of supplementing their and the community's diet. They are each going to make one but report that at this stage, the community are not very interested. They hope by providing an example, others will follow.

PARKDENE HEALTH AND COMMUNITY ASSOCIATION

1. **When was the health committee established?**

The association was establishede in June 1993.

2. **Why was the committee established?**

The nurse in charge of the clinic received a directive from her superiors to establish a community health committee which she then did.

3. **Who was involved in the decision to form the committee and how did they go about forming the committee?**

Volunteer groups which already operated in Parkdene were approached by the clinic sister. She then approached groups and/or people whom she thought would be useful to have on a committee of this nature. A number of them were already involved in voluntary community work such as

running soup kitchens and geriatric groups in the community.

The clinic nurse organised a meeting between herself and these community groups. Approximately thirty people attended the meeting and the twelve people elected at this meeting formed the health committee.

4. **Who does the committee represent?**

The people living in the geographical boundaries of Parkdene as well as a nearby self-help housing scheme and informal settlement.

5. **How were the members of the committee chosen?**

the committee was chosen as was stated above, from the people who attended the meeting called by the clinic sister.

6. **To whom is the committee accountable?**

The committee reports to the Parkdene clinic and to the municipality under whose jurisdiction it falls through the nurse in charge of the Parkdene clinic.

7. **How does the committee report to its governing body i.e. to those to whom it is accountable?**

Through the minutes of committee meetings. These are taken by the nurse in charge of the clinic municipality's health department after every meeting.

8. **Who can attend meetings of the committee?**

Any person resident in the geographical boundaries of Parkdene, which includes a self-help housing scheme and informal settlement.

9. **How are those eligible to attend committee meetings informed thereof?**

Posters are put up in the community and at the clinic. Committee members inform one another by word of mouth. Committee meetings are usually held on a monthly basis.

10. **How does the committee involve the residents of the area in which it operates in its activities?**

Committee members form subcommittees which consist of community people who then work on the projects suggested by the committee. The committee also reported that recently community groups, particularly a high school student group have begun approaching them for assistance with the organisation of health awareness programmes, usually issues related to the national health days and weeks specified by the DNHPD through its national health calender.

11. **Does the committee have a management structure?**

Yes, a chairperson and a secretary.

12. **How are people selected or elected to this management structure?**

They were nominated and then elected by the thirty people who attended the first meeting.

13. **Has the local health service acted on any decisions taken by the committee which requires the former to provide resources to the committee?**

No.

B. COMMUNITY HEALTH COMMITTEES AS FACILITATORS OF CIH.

1. **What does the committee consider its major functions to be?**

The development of the individual, the family and the Parkdene community.

2. **How were the functions of the committee decided upon?**

The members present during the interview were not clear on how the committee arrived at this function. The secretary of the committee who is also a local community health worker in the employ of the Cape Provincial Administration felt strongly that this should be the function of the committee. However its functions do not seem to be a conscious decision on the part of all concerned.

3. **How were the health needs of the constituency served by the committee identified?**

With the exception of the squatter community where a door to door survey of needs was conducted by the committee and a profile of the camp was thus developed, the health needs of the rest of the community were identified through statistics obtained from the Parkdene clinic.

4. **What activities are the committee members presently engaged in?**

The committee is predominantly involved in awareness campaigns around the health days identified through the national health calender issued by the DNHPD's Western Cape regional office. The committee also attends to individual problems such as assisting people in obtaining grants from the local state welfare agency. The secretary of the committee is normally the one who works on these cases because she has more power in getting officials in these departments to assist her. She does this by using her position as an employee of the Provincial Administration and not her position as the secretary of the Parkdene committee. This position, according to her holds no water with welfare officials.

5. **How did the committee decide on these activities/projects?**

The individual problem solving forays conducted by the secretary are dictated by the demands of individual community members. The health awareness programmes centred on the health calender are a result of directives from the municipal health service to the committee.

6. **Are there any other organisations or structures in the community presently dealing with the health needs of the community?**

The Parkdene Civic Association and a local high school students club.

7. **In the light of your answer to question 6, why was this committee then still established?**

The civic association does not directly address health issues. Their specific focus is on housing matters or rather the lack of housing units for the inhabitants of Parkdene. The high school students club was formed after the Parkdene committee. The committee and the civic have worked together on community health issues in the past. In 1993, the committee approached the civic association about broken power lines which were a danger to the children in the community. The civic then suggested that the association join its ranks which it did. However, after the April 1994 national elections, the civic withdrew from this relationship. The committee members did not wish to discuss the reasons for the split.

C. RESOURCES AVAILABLE TO THE COMMUNITY HEALTH COMMITTEES

1. **Does the committee have access to any financial resources?**

No, and they cannot engage in fundraising activities in the community because of its high unemployment rate.

2. **If yes, approximately how much does it normally have access to and how does it acquire this money?**

Owing to fact that it answered the previous question in the negative, this question was not posed to the committee?

3. **To what is the money allocated and how is this allocation normally decided upon?**

As was the case with question two, this question was not posed to the committee.

4. **What manpower is normally available to the committee?**

The committee members provide the major source of organising manpower. They also coopt members of the community and encourage them to form sub-groups/sub-committees to plan and implement awareness programmes on national health days.

5. **What tasks/duties do :**

   a. **Committee members normally engage in and,**

   b. **Ordinary community people not part of the committee engage in?**

Committee members are involved in health needs identification, project/activity planning and implementation. They also deal with individual welfare problems. Ordinary community members generally carry out the instructions of the committee. Committee members are also involved in the running of soup kitchens in the area and assist the clinic with the dispensing of tuberculosis medication as well as any other tasks which need to be done.

6. **Generally speaking, when are most of the committee's duties performed? i.e. is committee work performed after people are finished with their day jobs or during the day?**

Mostly after working hours.

7. **Do you as committee, think that your members should be paid for the work they do?**

Yes, especially if the functions of the committee become more structured. It is important that there should be some kind of payment because there are a lot of unemployed people who are assisting the committee, but they are not fully committed because of their impoverished circumstances.

8. **Have committee members or the people involved in the committee's activities received any kind of training for the tasks they are expected to perform?**

No. But training is perceived as necessary, especially conflict resolution and communication skills. The committee felt that one of their most important needs was to be informed about the social welfare structures so that they could more easily assist people who need to navigate these bureaucratic and unfriendly channels.

9. **Has the committee experienced any difficulties over the past 12 months in the implementation of its programme or activities?**

Yes. There is a severe lack of financial resources. The unemployment rate is high in the community and many people are on the verge of poverty.

There are also many social problems and the committee has no authority where government departments such as welfare are concerned. There is also widespread misuse of social welfare grants in the community.

10. **How does the committee think that these problems can be solved?**

An authorised channel needs to be set up through which the committee can work and be taken seriously.

SEDGEFIELD HEALTH COMMITTEE

1. **When was the health committee established?**

The committee was established in April 1993.

2. **Why was the committee established?**

The present chairperson of the committee was approached by the chief professional nurse of the South Cape regional services council which provides clinic services in the Sedgefield area to establish a community health committee.

3. **Who was involved in the decision to form the committee and how did they go about forming the committee?**

The chief professional nurse approached the present chairperson who then contacted the twenty-three health, welfare and development organisations operating in the Sedgefield area whom she thought should be invited. These organisations were requested to send representatives to the meeting. The issue of establishing a health committee was tabled.

The meeting had no knowledge of what was expected of them and used the DNHPD, Western Cape's circular No. 14 of 1993, to determine the purpose and functions of such a committee. At the meeting, those present exchanged ideas on what they perceived to be the health problems facing the community and how the committee should get started. The committee was formed at this, the first meeting.

4. **Who does the committee represent?**

The organisations who presently attend the committee's meetings.

5. **How were the members of the committee chosen?**

Each organisation approached by the present chairperson sent a representative to the first meeting and these people then constituted the committee.

6. **To whom is the committee accountable?**

The chairperson answered, " I'm not sure, that is an interesting question."

7. **How does the committee report to its governing body i.e. to those to whom it is accountable?**

The committee does not have any formal reporting system outside of the verbal reports given during the course of meetings. It does not report to any one overarching body. The delegates present reports to their organisations.

8. **Who can attend the meetings of the committee?**

The representatives of those organisations serving on the committee.

9. **How are those eligible to attend committee meetings informed thereof?**

The committee members inform one another when a representative requires a meeting.

10. **How does the committee involve the residents of the area in which it operates in its activities?**

The committee members identify the community's needs and then decide on the course of action to be taken.

11. **Does the committee have a management structure?**

Yes, a chairperson and a secretary

12. **How are people selected or elected to this management structure?**

The secretary volunteered her services and the chairperson was elected by the committee.

13. **Has the local health service acted upon any decision taken by the committee which requires the former to provide resources to the committtee?**

No.

B. COMMUNITY HEALTH COMMITTEES AS FACILITATORS OF CIH.

1. **What does the committee consider its major functions to be?**

The upliftment of the community, meaning the upliftment of the 'Coloured' Smutsville community and the nearby Black squatter camp called 'Die Gatjie'.

2. **How were the functions of the committee decided upon?**

This was not a conscious decision made by the committee but is a perceived function resulting from the issues raised by committee members during the course of meetings.

3. **How were the health needs of the constituency served by the committee identified?**

The health needs are identified by committee members who are also the representatives of organisations operating in the area. Members of the committee are approached about, or come to hear about problems which they then table at committee meetings. The committee then decides upon the solutions to be implemented. One such problem concerned the disconnection by the municipality of the water supply to the squatter community. The squatter community moved onto serviced sites in the vicinity of Sedgefield but did not pay for their services. The municipality reacted by disconnecting their water supply. The assistant nurse who represents the clinic on the committee brought this to the committee's attention. The committee approached the municipality to reconnect the water in at least one tap. The committee paid the reconnection fee and the

squatter community agreed to pay the water account.

4. **What activities are the committee members presently involved in?**

The committee reacts to problems which arise in the community. For example, they had a case where a member of the community was not able to afford a coffin to bury a family member. The committee financed the wood and employed a community member to build the coffin. They were also instrumental in negotiating with the Knysna municipality for the provision of water to the nearby squatter community.

The committee is also busy trying to negotiate with the provincial administration for an ambulance to be stationed in the area because of the increasing number of trauma incidents in the Smutsville and Die Gatjie areas near Sedgefield. They have also arranged a carnival in the white residential area of Sedgefield in order to create awareness amongst local elderly whites that they too were eligible to use the local clinic and thus they need not go into the Knysna business district area, approximately ten kilometres away to use the public health service facilities. They also arranged a fashion show in the area to raise funds for the committee.

5. **How did the committee decide on these activities/projects?**

Committee members identify health issues and the committee then decides on how to deal with the problem.

6. **Are there any other organisations or structures in the community presently dealing with the health needs of the community?**

There are 23 organisations including churches which operate in the area and deal with health and social welfare issues.

7. **In the light of your answer to question 6, why was this committee then still established?**

Because the health services asked that the committee be established.

C. RESOURCES AVAILABLE TO THE COMMUNITY HEALTH COMMITTEES

1. **Does the committee have access to any financial resources?**

Yes

2. **If yes, approximately how much does it normally have access to and how does it acquire this money?**

The amount varies because the money is obtained by fundraising as was the case with the modelling show. The chairperson also donated an undisclosed amount to the committee.

3. **To what is the money allocated and how is this allocation normally decided upon?**

The money is used at the discretion of the committee and on issues emanating from the committee as was the case with the coffin material and labour purchase and the payment of the reconnection fee for the water supply to the squatter camp.

4. **What manpower is normally available to the committee?**

The committee members are concerned with the organisational functions and they use volunteers from the community to assist where necessary. The chairperson stated, however, that they required more people to assist with committee activities.

5. **What tasks/duties do :**

   a. **Committee members normally engage in and,**

   b. **Ordinary community people not part of the committee engage in?**

Committee members decide on the problems which need to be addressed and the way this will be achieved. The ordinary community member involve themselves in tasks at the request of the committee namely, assisting with the implementation of awareness programmes, attending them or donating time and/or money.

6. **Generally speaking, when are most of the committee's duties performed? ie is committee work performed after people are finished with their day jobs or during the day?**

During working hours since the organisation representatives are employed by health, welfare and development organisations working in the area.

7. **Do you as a committee, think that your members should be paid for the work they do?**

No. Community work must be done for the love of the community.

Payment will detract from the enthusiasm which people presently display.

8. **Have committee members or the people involved in the committee's activities received any kind of training for the tasks they are expected to perform?**

No training was given, but it is much needed, especially guidelines on how to function effectively. They also require skills in the handling of the aged and first aid.

9. **Has the committee experienced any difficulties over the past 12 months in the implementation of its programmes or activities?**

Yes, too few community members are involved in the committee's activities. Those who are presently involved are generally the same people and are getting tired of community work.

10. **How does the committee think that these problems can be solved?**

The community must become more involved in the activities of the committee.

DISCUSSION OF FINDINGS

No individual or organisation outside of the state health services in the form of the DNHPD office in the Western Cape province was consulted with regard to the decision to compile and issue the circular. In fact, only senior and middle level health management staff were a party to its

compilation. This was borne out by the following report submitted to the Western Cape regional office of the DNHPD by its principal medical officer in charge of the Health Promotion Training section :

> ... it must be said from the outset that it was irresponsible of ourselves to distribute a circular (No. 14 of 1993) instructing local authorities to establish such committees ... The overall concept is that these community health committees are a way in which communities can participate in their own health development process. But it is the health sector that has come up with the idea and has initiated the action. Why does the health sector want community health committees? At worst it's to look good and gain credibility at a time when credibility is at an all time low. I hope this is not why. At best and ideally, its because we in the health sector know we can't handle things on our own and need help. We also know that some of our programmes need community involvement and community action; something that a health committee could provide. (DNHPD, 1994b, p. 1).

This report is directly applicable to the above mentioned committees because the work to which the health official refers was that done with health committees established by the local authority health services in the South Coast and Karoo areas of the Western Cape province as a result of Circular No.14. Thus none of the communities in which these committees were envisaged operating and subsequently established, were consulted in any way on the issue of the formation of such structures, never mind how they would operate.

With respect to the representativeness of these committees, the participants' responses to the questionnaire guide, highlight a number of interesting points. The questions dealing with who, why and how the committees were established, provide us with a classic picture of the top-

down approach operating within the apartheid health sector. In the case of Parkdene and Sedgefield, the health services, not the communities living within the geographical boundaries of these areas proposed and engineered the establishment of these committees. This would then explain the lack of interest by the broader communities resident in these geographical areas. The turnout at the meeting organised to set up these committees, as in the case of Parkdene for example, resulted in an attendance of only thirty people and, these people were specifically asked to attend. In the case of Sedgefield, only the representatives of organisations chosen by one individual were in attendance and these people did not know what was expected of them and did not have to seek mandates from the welfare organisations who employed them, to be a party to the establishment of a community health committee.

Likewise, the question on accountability speaks volumes. In all three cases, the health services appear to receive priority - committees report to them and receive strong direction from them. Issues deemed outside of their ambit by the health services are left to the committees to decide whether or not they would deal with them. Sedgefield did not even bother to consider that they might be responsible to any agency or organisation.

It is thus contended that the kind of participation facilitated by state health services through these committees is one of manipulation. As Boulle (1992) noted, this kind of participation is concerned with creating an

illusion of partnership but where those in power have the ultimate say over what is implemented and how it is done. This will become more clear when we consider the functions and activities undertaken by these health committees. There thus appears to be a strong modicum of truth in the report by the DNHPD Western Cape regional official (1994b) which queried the reason for the establishment of these committees, and is further reinforced by the fact that none of the committees felt that the problems identified by or the decisions taken by them, received any serious consideration or action on the part of the health services. Not surprising also is that the mood with regard to this issue was one of powerlessness, of acceptance of the situation.

In addition, in the section dealing with the committee as a mechanism for facilitating CIH, we find that it is only in the case of the Concordia committee that decision making on the part of the committee with regard to its functions and activities were guided by community based as opposed to individual problem solving. However, even this committee is only able to find limited acceptance. This appears to be related to the fact that its committee members were in constant interaction with the community, especially its tuberculosis sufferers and it was the need to see that people received treatment which motivated their decision to establish a committee. In effect, these committees all seem to operate on the basis of 'good will'. No structures and plans for community involvement have been established and as can be noted from the above, no move has been

made to devise mechanisms for the formalisation of accountability to the community the committee seeks to, and believes it serves and represents. The closest any of these committees come to ensuring community accountability is through the calling of public meetings at the convenience of the committees.

Parkdene understood the need for a community health profile, but felt that it was sufficient to leave it at the stage of a door to door survey which would then be analysed by them in conjunction with the health services in the form of the local clinic and that this would guide the course of action they would adopt. This in effect, led to a concentration on awareness activities through the advertising of national health days and weeks as directed by the DNHPD's national health calender.

Both Parkdene and Sedgefield's committees were bodies which reacted to individual problems. Even with respect to this, they were, relatively speaking, powerless to act. This was evidenced by Parkdene's case by the committee member who could not use her position as health committee member to ensure that the problems of her individual clients received prompt attention. She had to resort to her formal role as employee of the Provincial Administration's health services. Similarly, with respect to Sedgefield, a negotiated settlement could not be reached regarding an adequate water supply to the informal settlement in their area of 'jurisdiction'. In fact, the fact that the Sedgefield committee was

content to leave the issue at the reconnection of one tap provides evidence of the relative lack of understanding of the fundamental requisites for health, one of which is an adequate supply of potable water.

Finally, the committees themselves replicated a top-down approach. They take the decisions and instruct members of the community who are willing to assist in what should be done. These committees also do not receive any kind of logistical or other support from the health services. They appear to have been established and left to their own devices. The danger in this is that should they dissolve, it will once again be put down to the community's inability to involve themselves in community problem solving and hence indicative of their irresponsibility in matters relating to their health. The committees are presently the instruments of the health services and, also it appears, other social welfare services. They act as buffers between service providers and local people since when the latter cannot get any progress from service agencies, they turn to the committees as individuals. By treating these people as individual cases only, the committees mystify the problems, thereby further preventing them from becoming true agents of community mobilization. Thus these committees aid in the mystification of what are essentially political decisions, namely, the conscious maldistribution of resources to certain groupings based on the colour of their skins and the ideological reinforcement of health as a privilege and not a fundamental right.

Thus, in conclusion and in answer to the questions posed on page 87, it is highly unlikely that the apartheid health services could ever promote CIH as a means to empowering people to transform their social situations. As long as self-care and CIH are linked entirely to some vague notion of 'individual responsibility for health' without the requisite economic and political support systems, state initiated health committees will remain little more than rubber stamps for health service projects and plans. The MRC (1992) was thus correct when it noted that :

> Community participation implies that communities are given a direct say in the shaping of the social systems affecting their lives and in controlling development interventions. Governments are seldom adept at accommodating this approach, and given South Africa's authoritarian bureaucratic history, genuine community participation is an alien concept to most (MRC, 1992, p. 53).

The final chapter will thus deal with a few recommendations on the way forward in the search for viable community involvement in health.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The following recommendations on the way forward are offered for further debate. They are set out below in no particular order of importance.

1. Reorientation of public sector health professionals and training of community health committees :

As was noted in the introduction, South Africa entered into an era of democracy for the first time in its history in 1994. However, it goes into this new era with generally the same individuals and groupings who implemented the apartheid policy of the National Party in the health and other government services. It is thus essential that a programme be implemented which will result in the reorientation of, in this case public sector health workers, whether in the professional or support services. As long as the very people who are tasked with creating the environments supportive of CIH do not understand that it is a social process and not a technical intervention, the health services will not be able to facilitate community participation in health service delivery and health development. Much in this regard can be learnt from the experiences of the non-government health sector. The Western Cape region of the NPPHCN, through its training centre for example, has been providing training programmes for community health committees since 1991 (NPPHCN, Western Cape, 1991). This is time consuming because these committees hold regular elections and hence the network is continually involved in the training of new committee members. It is thus worthwhile

to append the course outline of their health committee training programme (see Appendix A). It is also important to note that at the time of writing, the health services had not yet considered training for local health committee members. In fact, with the exception of occupational health nurses, state health services do not presently offer any training to people outside of the public health sector. Yet these health services are the ones which direct their service delivery arms in the local authorities to establish committees, for which no policy has been formulated in the field of training or otherwise. This could lend credence to the notion that the state health services are setting these committees up for failure.

Owing to the fact the NPPHCN is the only organisation in the Western Cape currently training community health committees, it is strongly advised that they be brought in to facilitate the process with the public health sector. In addition, because of its history as an organisation of health activists, the network will be in a strong position to work in transforming the vision and practices of the public health sector.

2. Fundamental political and economic transformation :

The April 1994 national and regional general elections in South Africa accorded political rights to the majority of the population for the first time in the country's history. This political transformation must however, also be accompanied by a redistribution of economic power. We noted above the economic conditions under which individual responsibility for health

was legislated in 1990. Similar conditions exist at the present time, (1994/5). The onset of the democratic South Africa has not yet seen a 'rush' of capital into the country. Thus, attention will then have to be paid to the reallocation of expenditure.

This topic requires that attention be paid to both capital and consumption expenditure. The focus here will be on the consumption and capital expenditure required to promote equity in the delivery of social services to the majority of the population. There is widespread agreement that disparities in social service expenditure must be reduced. This will of course necessitate a change in expenditure patterns. However, rather than focusing on the addition of massive amounts of new revenue, the change will have to occur within and between spending categories. The primary requirement is the move from the fiscal apartheid paradigm to the integrated society paradigm, a paradigm recognising that fiscal justice is concerned with directing expenditure to impact on the needs of the poor rather than at so-called population groups.

van der Berg (1992a;b;c) argues that parity at White levels in social service expenditure for the previously disenfranchised, within the constraint of the existing budget, is not a feasible option in post-apartheid South Africa. He offers the following reasons : South Africa's social service expenditure is not out of line in international terms in fact, it is similar to other middle - income countries, further increases can thus only

be effected at the expense of other public sector programmes. In addition, the existing tax ratio is nearly at its threshold level.

The only alternative then, is the restructuring of existing social service expenditure, its reallocation within the functional categories of the budget. What this in fact means, according to van der Berg (1992b), is that the expectations of the various groups - the previously disenfranchised as well as the Whites - will have to be adjusted downwards. Donaldson (1992) echoes this perspective but indicates that although constraints on existing expenditure inhibits redistribution, this is further compounded by the lack of adequate inputs. Here he is specifically referring to the need for competent human resources in the form of teachers, doctors, community workers as well as those who can produce the materials necessary for the delivery of services such as books, building materials and medical supplies.

Another option mooted as a means of reducing disparities in social service allocation is through the freeing of funds previously used to maintain apartheid institutions and ward off the phobia of the 'external communist' threat which will become available with the abolition of apartheid and thus South Africa no longer has a need to operate as a destabilising force as far as its neighbours are concerned. This 'post-apartheid dividend' together with the reallocation of existing government expenditure, would optimistically provide approximately 3% of the GDP

per year (in 1991 terms) for new or additional spending (Loots,1992, pp. 101-102).

Economists do not doubt that the post-apartheid dividend exists. The problem arises in quantifying it. Loots (1992) states that a saving of R3.75 billion per annum can be effected; Maasdorp (1992) suggests R8 billion per annum and Moulder (1992), R2.3 billion. van der Berg (1992c) however, does not believe that the 'post-apartheid' dividend is anywhere as large as that indicated above. With regard to administrative duplication, he states that of the approximately R4 billion spent on own affairs departments (a result of the bogus tricameral parliamentary system) and homeland administrations, most of the expenditure was allocated to the wage bill of doctors, nurses and teachers. Administrative costs amounted to about one percent of the GDP in 1985. Decentralisation incentives amounted to approximately R1 billion per annum. This expenditure can be stopped immediately for new industrialists and existing recipients can be informed of the withdrawal of the scheme over a set period of time. Various other apartheid structures like the Group Areas Board and the Free Settlement Areas Board incurs costs of approximately R1/2 billion per annum and this expenditure can also be withdrawn within a relatively short space of time. With regard to the 'peace dividend', spending on policing and justice cannot be decreased as yet owing to the high levels of violence in specific parts of the country. In any case, notes van der Berg (1992c) the South African police force is small by international

comparison.

In any event there are savings which although, not sufficient to effect parity at prevailing White social service expenditure patterns will, if targeted appropriately, impact visibly on the social service expenditure of historically disadvantaged groups. The opportunity costs of defence spending since the 1970's, for example, viz R75 billion at 1990 prices could have been used, "...to build 1,9 million fully serviced houses, far in excess of the Urban Foundation's backlog of approximately 1,2 million units" (van der Berg, 1992c, p. 81).

3. Health committee funding :

With regard to the status of health committees, it is essential that their rights be entrenched at the local government level if they are going to have any credibility or any power when it comes to resource distribution and allocation. Here again, democratically elected committees must be in a partnership with the health services when determining the necessary structures, powers and functions accorded them. If statutory recognition is not perceived to be a viable alternative, it is imperative that whatever funding is available for CIH is allocated in a meaningful fashion. The reason for this statement is borne out of another project which was initiated by the Western Cape regional office of the DNHPD. In 1993, it launched what was firstly called a clinic competition and later renamed the community participation project (DNHPD, Western Cape, 1993b). The

aims of this endeavour were threefold. Firstly, to motivate local authority clinical staff to involve themselves in health promotional activities in communities. Secondly, " To increase the involvement of local communities through active involvement in projects for instance aesthetic improvement of properties and (thirdly) improvement and development of existing and yet as undiscovered capabilities and talents " (DNHPD, Western Cape, 1993b). A total of R30 000 - R6000 each for the five clinics identified as the winners - was allocated to a project which is in essence part of the job of clinical personnel and the public works departments of municipalities and hence, for activities for which staff and local authorities were already being paid to perform. The competition was concerned with identifying what the health services decided constituted successful community participation.

The evaluation criteria was concerned with the extent to which community resources were utilized in the project, the extent to which they contributed to the funding of the project and the extent to which they were responsible for the physical labour required to execute the project. The prize money however, was not given to the communities, but went into the coffers of the local authority within whose jurisdiction the clinic fell. This is of course in accordance with South African government treasury instructions since the DNHPD is not authorized to provide this kind of financing directly to informal projects of this nature. Thus, here again, health services define the boundaries of participation with local communities, groups and/or

projects, and control the most important power source, namely, the distribution of the finances. This type of endeavour which is labelled as community participation in health in fact reinforces the perception that the South African health services are not yet capable of directing this process.

It is important to ask why R30 000 was allocated to a competition and no money was allocated to the strengthening and support of community health committees in the Western Cape? Is it as the principal medical officer referred to above, noted in his report (DNHPD 1994) that the DNHPD in general and the Western Cape regional office in particular, is above all else, seeking credibility? Hence some sort of statutory safeguards are needed to ensure that these committees are not merely show pieces for the health services with little or no power as is the situation at present.

4. Future areas of research :

It is also imperative that research be carried out on how health service personnel perceive CIH. This will inform the training so desperately needed in this area. Without a comprehensive understanding of PHC as an approach, and CIH in South Africa as a process of social transformation will not advance beyond the social marketing techniques and manipulation currently masquerading as community participation in the South African public health service sector.

Hence it is important as Morgan (1993) so rightly states :

> ... it is pointless to attempt to identify the extent of participation without first spelling out the political motivations and ideologies of those who design the programs and conduct the evaluations. Is there any point in measuring degrees of participation without specifying the ends it is to serve? By whose criteria will 'success' be judged? (Morgan, 1993, p. 5).

APPENDIX : A

NPPHCN Western Cape Region : Health Committee Training Course Outline :

A. Introductions

Expectations

Ground rules

B. Understanding Your Organisation

What is an organisation?

What are structures?

Structures of the NPPHCN

Structures of the training centre

Community structures

Project structures

Role of health committees and community health workers

Democratic ways of group functioning and decision making

C. Office Bearers

How do we decide what office bearers we need?

How do we choose office bearers?

Roles of the different office bearers

D. Reports

Why do we use reports?

Different kinds of reports

Who are reports for?

E. Team building

How to get to know one another

Why do we need to trust each other?

How to give feedback

How to receive feedback

F. Health

What is health?

Factors that prevent good health

Factors that contribute to good health

G. Primary Health Care (PHC)

What is PHC?

Elements of PHC

Pillars of PHC

Strategies of PHC

H. Community Development

What is community development?

Factors that promote community development

Factors that influence community development

How health relates to community development

I. Goal Setting and Planning

What is a vision?

What is a goal?

Planning action

Evaluation

J. Fundraising

What is fundraising?

Who does the fundraising?

What makes fundraising successful?

The Fundraising Act

Do you need a fundraising number?

Fundraising proposals

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