DEVELOPMENT OF THE PUBLIC HEALTH MODEL OF COMMUNITY PARTICIPATION IN THE KWAZULU-NATAL PRIMARY HEALTH CARE SYSTEM

by

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A thesis submitted in fulfilment of the requirements for the awarding of a DOCTOR OF PHILOSOPHY Degree in Public Health at the School of Public Health in the Faculty of Community and Health Sciences, University of the Western Cape

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DECLARATION

I declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of the university or other institute of higher learning, except where due acknowledgement has been made in the text.

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ABSTRACT

Background
It is universally acknowledged that Primary Health Care (PHC) is the key approach for the delivery of health services in order to achieve the “Health for all” goal of the World Health Organization (Dhillon, 1994).

Introduction
The purpose of this study was to develop the public health model of community participation for the KwaZulu-Natal primary health care system. The model is intended to improve the understanding of community participation and to explore its potential value in strengthening the facilitation of health promotion in the health facilities.

Method
A qualitative multi-case study of community participation was conducted at district, sub-district, hospital, clinic and community levels of the KwaZulu-Natal’s PHC system. The study was implemented in three interrelated phases. During the first phase, the situational analysis of the existing systems, processes and challenges of community participation was conducted. Participatory methods were then employed, during the second phase, to engage PHC professionals in the identification of the inputs, systems and processes that could constitute the community participation model. The third phase of the study was dedicated to the implementation and evaluation of pilot health promotion projects to test the principles of community participation in health promotion. Four health promotion projects, namely (1) training of the clinic committee, (2) the anti-teenage pregnancy campaign, (3) diabetes awareness project and (4) the establishment of the patient support group, were piloted and evaluated in different sub-districts of KwaZulu-Natal. This study phase culminated in the drafting of the community participation model and guidelines for its implementation.

Findings
The situational analysis found that the hospital boards and clinic committees were major players for community engagement in most health facilities. Community consultations, information sharing, empowerment and outreach health services were found to be the main processes of community involvement. The stakeholders that worked with the health facilities in the planning and delivery of health services were mainly government departments, schools and to a limited extent, the NGO’s.
Community structures such as churches, prisons, CBO's and traditional health practitioners were not part of the routine health programmes of health facilities. Among the main challenges of community participation in the KwaZulu-Natal health system were inadequate understanding of community participation by health officials and by community representatives, lack of supportive systems, lack of interest by communities, inadequate resources and lack of incentives for participation. The pilot projects in this study were implemented in accordance with the core principles of community participation, namely inter-sectoral collaboration, consultation, empowerment of the community, community mobilization and participatory approaches. The evaluation of the implementation of the pilot projects during the third phase of the study showed that the combination of stakeholder involvement, empowerment and participatory approach added value to health promotion. The study identified stakeholders such as health professionals, NGO's, patient support groups and community organizations as the pillars of the ideal community participation model. The model supports processes of community participation such as community consultations, empowerment and mobilization of the communities to take care of their own health. It further illustrates how these processes can potentially improve health promotion.

Conclusion
The community participation model produced by this study, reflects the systems and processes of community participation in the KwaZulu-Natal health system. The findings from the implementation and evaluation of the pilot projects support the model's prediction that the effective implementation of community participation activities in collaboration with relevant provider and community stakeholders can strengthen the facilitation of health promotion projects by health professionals.
ABBREVIATIONS AND DEFINITION OF TERMS

ABBREVIATIONS

AIDS – Acquired Immunodeficiency Syndrome
CBO’s – Community Based Organizations
CDC - Communicable Diseases Control
CCG’s – Community Care Givers (formerly known as “Community Health Workers”)
CEO – Chief Executive Officer
DHC – District Health Council
DHIS – District Health Information System
DHMT – District Health Management Team
DM – District Manager
DTT – District Task Team (district level service delivery multi-sectoral committee)
EMS – Emergency Medical Services (formerly “Emergency Medical and Rescue Services”)
HIV – Human Immunodeficiency Virus
IAPP – International Association for Public Participation
IEC – Information, education and communication
IC – Intersectoral Committee
KZN – KwaZulu Natal
LTT – Local Task Team (municipal level service delivery multi-sectoral committee)
MEC - Member of the Executive Council (in the Provincial Legislature)
NGO – Non Governmental Organization
OECD – Organization for Economic Cooperation and Development
OSS – Operation Sukuma Sakhe (KwaZulu-Natal’s popular name for the Governmental Multi-Stakeholder Service Delivery Forum or multi-sectoral committee)

PHC – Primary Health Care

SA – South Africa

SGB – School Governing Body

STI – Sexually Transmitted Infections

TB - Tuberculosis

TBA’s – Traditional Birth Attendants

THP’s – Traditional Health Practitioners

WHO – World Health Organization

WTT – Ward Task Team (community level service delivery multi-sectoral committee)

**DEFINITION OF TERMS**

Community involvement – systems and methods used by service providers to engage communities in the planning, delivery and monitoring of community services.

Community participation - an educational and empowering process in which the people, in partnership with those who are able to assist them, identify the problems and the needs and increasingly assume responsibilities themselves to plan, manage, control and assess the collective actions that are proved necessary.

Community mobilization – efforts and methods used by service providers to encourage communities to implement activities and projects for self-help and self-care in order to ensure effectiveness, access and sustainability of services and interventions.

Inputs – resources, information or finance required to obtain a desired output.

Processes – actions, steps or approaches taken to achieve a particular end or objective.

Systems - a set of components which work together as part of a mechanism or network.

Ward - a designated geographical area or service delivery unit within the municipal area.
THESIS OVERVIEW

This thesis is organized into five chapters. Chapter 1, the introductory chapter, provides an overview of the background and problem statement in relation to community participation. It further describes the motivation for conducting the study. Chapter 2 reviews the literature on community participation and it focuses on the systems, processes and models of participation as discussed in other public health studies and literature. A review of the relevant literature was critically analysed to permit inclusion of only that information which directly related to this study. Chapter 3 introduces research questions and describes the study design as well as data collection methods used in this qualitative research. Chapter 4 presents and analyzes the findings of the study. Data is described in line with the study’s research questions and objectives. Chapter 5, the final chapter, interprets the findings and discusses their contribution to the answers for the study’s research questions. It further highlights the implications of the findings on the primary health care system. In this chapter, the researcher presents the community participation model and makes recommendations for the improvement of community participation in the KwaZulu-Natal primary health care system.
CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

It is universally acknowledged that Primary Health Care (PHC) is the key approach for the delivery of health services in order to achieve the “Health for all” goal of the World Health Organization (Dhillon, 1994). The concept of community participation in health became popular after the Declaration of Alma Ata in 1978 (WHO, 1978). One of the declaration’s four pillars of primary health care is community participation, which is defined as “the active involvement of people and the mobilization of societal forces for health development” (Dhillon, 1994). The other three pillars are political and societal commitment, inter-sectoral co-operation and systems support.

This thesis explored the extent to which community participation has been achieved in the KwaZulu-Natal primary health care system. The thesis also proposes a community participation model and guidelines for its implementation.

1.2 STATEMENT OF THE PROBLEM

As a developing country, South Africa is affected by high incidence of communicable illnesses such as HIV, AIDS and tuberculosis (Karim et al., 2009) and there is therefore broad consensus among public health practitioners that communities should be involved in the processes for managing their health conditions. Despite this consensus, however, several studies have identified shortcomings in the implementation of community participation in South Africa. These include inadequate understanding of participation, shortage of resources and high turnover of healthcare workforce (Ndhambi, 2012).

As Susan Rifkin points out, the inadequate understanding of community participation approaches is one of the most important barriers to the implementation of participatory initiatives and strategies (Rifkin, 2001). Negative attitudes and practices of health professionals have also been cited as constraints to community participation. For example, in a study of community participation in India, authors noted that health professionals were not recognizing certain community-based organizations (CBO’s) and were not involving all community organizations in the planning processes (Kyobutungi & Nayar, 2005).

In a study examining constraints to community participation, Westergaard identified the lack of a theoretical framework as one of the challenges which affected community participation.
in some health systems (Westergaard, 1986). This is the case in the KwaZulu-Natal health care system. The recent establishment of government-driven multi-sectoral committees for service delivery in KwaZulu-Natal is seen as an important step towards community participation (KwaZulu-Natal Department of Health, 2010). However, these committees operate at a political level, outside of the health care system. Although community participation in South Africa is formalized, the policy framework for community participation has been pioneered only by the Western Cape department of health (Meier et al., 2012).

In view of these challenges, this study was designed to assess the systems and processes which supported community participation in the KwaZulu-Natal PHC system. The study aimed to explore the extent to which community participation could be modelled in order to increase the understanding of the processes and approaches to community participation. This study will hopefully contribute to the effectiveness of community participation initiatives in KwaZulu-Natal and in the whole country.

1.3 MOTIVATION FOR CONDUCTING THE STUDY

The review of empirical literature suggests that there is some value of community participation in programmes development (NORAD, 2013). The experiences from the South African health system as well as from other parts of the world have demonstrated that community participation can make a useful contribution to health service delivery and development (Ndhambi, 2012). The transformation of health care services in a free South Africa post 1994 was in line with the new constitution and right to health care (National Health Act, 2003). The transformation addressed the need for equity in health service provision and improved the understanding of the user-perspective in the management of health. Representation of communities in consultative structures such as hospital boards and clinic committees in South Africa, became regulated (Loewenson et al., 2014).

Furthermore, the mobilization of communities and non-health sectors continues to contribute significantly to health promotion and development (Adeleye & Ofili, 2010). With the recognition by the World Health Organization that improved health status not only depended on disease control but also on the systems that delivered health care, there is growing interest among health managers in the importance of actively involving the beneficiaries of care in decisions about the provision of that care (Rifkin, 2014). Ongoing public health research is therefore needed to ensure that health systems are responsive to the social needs of the communities in line with the political ideals of the country (Preston et al., 2009). Strengthening health systems effectiveness is one of the four strategic pillars of South Africa’s National Department of Health (Department of Health, 2010). Community
participation, as an essential component of primary health care, is one of the interventions with the potential for improving the efficiency of the health system (Axelsson & Axelsson, 2009). Being a complex phenomenon, however, community participation has no standard definition and has no common approach (Rifkin, 2014).

Despite the emphasis on community participation by the World Health Organization (Dhillon, 1994) and by the South African National Department of Health (Meier et al., 2012), the review of literature showed that there was no framework or policy for community participation in the KwaZulu-Natal PHC system. Although there are consultative structures, in the form of hospital boards and clinic committees, the activities and contribution of these structures on health care, are not being monitored by the department and by the health facilities (Padarath & Friedman, 2008). The lack of prescribed guidelines for involving communities and for facilitating health education projects may lead to inconsistencies and variability in community participation practices in different health facilities (Westergaard, 1986). Due to the complex nature of community participation, there is a need to standardize the systems and processes that should be used by health professionals and by community representatives in ensuring sustainable community participation for the benefit of health care (MacQueen et al., 2001).

Community initiated development projects are often not reported in peer reviewed literature (Preston et al., 2009). Preston and co-researchers noted that academics and government departments were more likely to report only about the projects they have initiated. As a result of this, community perspectives on community participation were rarely captured.

Recognizing the need to understand the community perspectives of community participation, this study sought to investigate how communities themselves viewed and valued community participation in health service delivery.

This study was motivated by the need to improve the knowledge base about enabling systems and generalizable approaches to community participation. The study was needed to identify existing determinants of community participation and to design the framework and tools for supporting health promotion within the KwaZulu-Natal health context. Recognizing that much work had been done to understand community participation methods, this study used previous international models of community participation as reference for studying community participation in KwaZulu-Natal, and to demonstrate the potential effect of community involvement on health promotion. Such models include the pentagram model, Davidson’s wheel of participation, the IAPP’s, OECD’s, Martin’s, Alfred Health’s and Reddy’s partnership models. It is plausible to argue that the chances of achieving better results could be improved by a more detailed and systematic analysis of the context, and a better understanding of who the participating stakeholders are, and how the communities should be involved at different levels of primary health care. Through the piloting of health
promotion projects, this study sought to provide further evidence of the useful role of participatory approaches on health promotion.

1.4 PURPOSE OF THE STUDY

The purpose of this study was to develop a model of community participation for the KwaZulu-Natal primary health care system. The study examined the existing community participation initiatives, and explored their applicability in strengthening health promotion and in the design of the participation model for the KwaZulu-Natal primary health care system. It is believed that the model could be used to improve the understanding of community participation and to strengthen the implementation of the health promotion projects by the health officials.

1.5 RESEARCH QUESTIONS

The study addressed the following questions:

- What are the existing systems, processes and challenges of community participation in the KwaZulu-Natal primary health care system?
- How can the existing systems and processes be used to develop a model of community participation for the KwaZulu-Natal’s primary health care system?
- Can the existing systems and processes of community participation be used by the health professionals to strengthen their health promotion projects?

1.6 ASSUMPTIONS

For the purpose of this study, three assumptions were made. First, it was assumed that the data obtained from the study sub-districts was comparable to other sub-districts in the rest of the KwaZulu-Natal province. This assumption was based on the fact that all service delivery units were supervised centrally by the provincial health department, and that the PHC systems were therefore standardized and uniform throughout the province. The second assumption was that the responses gathered from the individual interviews with service providers and community representatives were truthful as their responses were self-reported. Thirdly, it was assumed that behaviours observed during the health promotion campaigns and during the pilot projects were typical and true for any given day, outside of the days observed.
CHAPTER 2
REVIEW OF THE LITERATURE

2.1 INTRODUCTION

Community participation is a complex phenomenon that has been extensively studied by many researchers and continues to be of great interest even today. The concept of community participation in health became popular after the Declaration of Alma Ata in 1978 (WHO, 1979). The Alma Ata Conference identified primary health care as the key to working towards Health for All. The World Health Organization identified four pillars on which action for “Health for all” must be based. One of these was community participation. The other three pillars are political and social commitment, inter-sectoral cooperation and systems support (Dhillon, 1994). It is believed that community participation can enable promotion of primary health care through advocacy, social support and empowerment.

Over years, the WHO member states have been grappling with the challenge of translating the principle of community participation into practice. Differences in understanding what or who is “community”, what is “participation” and how to implement and measure community participation have been debated for some time. Many people have argued that because the community is not homogeneous it is not easy to implement “community participation”. Despite differences in understanding it, community participation has become a prerequisite of many health programmes for health departments and health facilities (Rifkin, 1996).

In order to illustrate the progress and developments in the understanding of community participation, this chapter reviews literature and research on various aspects of this subject. There is broad consensus that communities should be involved in the systems and processes for improving their own health. Many researchers have focussed their efforts on measuring community participation and, to some extent, its short-term benefits. Because community participation is implemented alongside other health processes and interventions, it has been difficult to measure its effects on long-term health outcomes. There is also no single agreed concept of what participation is or should be and health programmes often develop without an explicit definition (Guareschi & Jovchelovisch, 2004).

A review of theoretical literature suggests, therefore, that a more practical approach to the analysis of participation is required to create an understanding of the conditions under which participatory approaches may strengthen the health system.
This chapter will review what is already known about community participation, in particular the participatory processes and their potential benefits for primary health care. The review will involve the assessment of the challenges that were identified during the implementation of community participation initiatives in other settings. Theoretical and operational frameworks of community participation which guided the conception of this study, are presented. These frameworks include some of the systems, processes and tools for encouraging the implementation and measurement of community participation.

2.2 WHAT IS COMMUNITY PARTICIPATION?

Community participation is a concept that has been accepted as essential for the provision of health care for the people (WHO, 2008). However, its meaning and understanding has changed and evolved over the years. In this section, the various descriptions of community participation are revisited and critically compared according to their scope, objectives, practicality and relevance to the South African health setting.

Rifkin and others have described the conceptual framework for community participation by defining the “community”. According to Rifkin, a community is a group of people living in the same geographical area and sharing defined basic values and/or same basic interest (Rifkin et al, 1988). People of common interest or needs therefore embark on initiatives to address their needs. Considering this, Rifkin et al suggested that community participation be understood as: “a social process whereby specific groups with shared needs and living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet their needs”. This perspective of community participation recognizes the right of communities to express their needs and to stand up to them. In South Africa, communities are well known for standing up for their rights and social change. Community participation should be understood and implemented in the spirit of meeting the needs of communities.

A well-known description of community participation is the one proclaimed by the 1978 Declaration of Alma-Ata. In this declaration, the World Health Organization identifies community participation as “the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop capacity to contribute to their community’s development” (WHO, 1978). This view of community participation implies the need, which is to transfer responsibility for health to individuals and communities. The biggest lesson from this definition is that communities are partly responsible for their health, and they should therefore participate in health care
programmes that affect their health. This requires that individuals and communities partner with their health facilities during the planning and provision of services.

Subsequent descriptions of community participation have contributed to the understanding of the systems and processes through which communities could participate in the health system. Participation in health essentially requires communities to be involved in health care activities and programmes. In his definition of community participation, Stoker unpacks the involvement of members of the public as “the taking part by community members in any of the processes of formulation, passage and implementation of public policies” (Stoker, 1997). According to this definition, communities are essential participants in decision making and implementation. The involvement of communities in policy formulation and implementation is a huge step towards the ownership of health care system by communities and is an ideal for public health systems of democratic states such as South Africa.

The important role of communities in decision making was also acknowledged by Gryboski et al., in their description of community participation as “a process that increases a community’s capacity to identify and solve problems” (Gryboski et al, 2005). When communities have this capacity, health service delivery may be more effective because solutions to health problems are based within the community’s social structures and context. The increasing number of complaints against hospitals in South Africa is an indication of the many structural and logistical problems that characterize the country’s public health system. The collective identification and addressing of health problems through community participation processes has a strong potential to strengthen the health system. It is important to note that community participation is a process and not necessarily a single activity or end-point (Rifkin, 1996). As a process, community participation often leads to some end-point or goal. In most cases, the expected end-point of community participation is co-ownership of health services or programmes by providers and by communities.

Co-ownership of health programmes is a step towards “power to the community”. The power perspective of community participation is well illustrated by Westergaard, in which she envisages community participation as the “collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from such control” (Westergaard, 1986). The importance of power and control over resources in health care cannot be over-emphasized. It is not surprising that the empowerment of communities is an integral part of all modern processes of community participation. Education and empowerment of communities with knowledge and skills is necessary to improve their power and role in the delivery of health care services. The central issues of control and power play a role in promoting sound health decisions and in
establishing self-help health programmes at community level. The historical experiences of the majority of South African communities resulted in unequal access to healthcare and inadequate empowerment.

Various studies of community participation as well as experiences from community participation projects in different countries have identified the potential value of partnership between health professionals and communities. Partnership is only possible if communities are empowered on health matters in order for them to be able to take decisions and to promote their health. According to Laleman & Annys (2000), communities may participate in one or more phases of the project. In this step-wise approach, participation may involve contribution of ideas, priorities, resources, time or decision making, implementation or evaluation. The advantage of this definition is the flexibility it offers and the fact that effective participation will depend on the availability of time, expertise and other resources. While contributing to the health care system, the communities in turn derive ownership, the ability to express themselves, to learn and to be empowered through the transfer of skills, abilities and knowledge.

In the South African context, where empowerment and partnership are essential vehicles for development, the most relevant definition of community participation is perhaps one that promotes rights and responsibilities of all the role players. Roy and Sharma define community participation as “an educational and empowering process in which the people, in partnership with those who are able to assist them, identify the problems and the needs and increasingly assume responsibilities themselves to plan, manage, control and assess the collective actions that are proved necessary” (Roy & Sharma, 1986).

Consumer and community involvement in the planning and delivery of health care is core to the original concept of primary health care, as defined in the Alma Ata Declaration 1: “Primary health care is essential health care based on practical, scientifically sound and acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO, 1978).

Community participation means that people should be knowledgeable about their own health problems and that they should identify the strategies for their solution and reduction, draw out plans of actions according to priority and available resources. The community may participate in planning and managing services and may make inputs into overall policies, strategies and workplan of the health programmes. Effective community participation requires strong national commitment with high degree of decentralization as well as
mobilization of resources (WHO, 1978). At local level, there should be actively participating institutions and multi-sectoral approach to service delivery.

2.3 COMMUNITY PARTICIPATION APPROACHES AND TECHNIQUES

Many studies have been conducted to understand the processes necessary for successful community participation. Draper et al., in their case study of community participation (Draper et al. 2010), assessed the participation activities and defined the community participation continuum for the health programmes. Using an evaluation tool, the researchers analyzed different ways in which communities were participating in the delivery of health-related interventions.

When assessing or analyzing the methods of community participation, some researchers have attempted to classify participation methods as “top-down”, “bottom-up” or “partnership” methods. Rifkin distinguishes between the “top-down” and “bottom-up” approach to community participation (Rifkin et al., 1988).

2.3.1 Top-down approach

Rifkin narrates that in the top-down approach, health planners or health professionals decide the health objectives and convince the people or communities to accept them (Moser, 1983). This usually yields lower degree of community participation. The top-down approach is first step towards community participation. This approach includes very little empowerment of communities, and as such it is regarded as low level participation. The top-down involvement of communities is a traditional approach whereby health professionals implement outreach health services at community level. A typical example of top-down approach is the use of outreach health teams, which may include the medical officer, nurse, social worker, community health worker etc. Through home visits or “mobile community points”, the outreach health teams are supposed to perform a wide range of activities such as health education, advice, screening, treatment and referrals.

According to Rifkin, this community participation approach is generally accepted as “inadequate”. As a result there are not many studies or projects which try to demonstrate its usefulness anymore. The top-down approach to community participation is still useful, however, if combined with other approaches to encourage participation by communities. For example, there is still a need for trained health workers to visit patients and citizens for screening, education and environmental assessments. During outreach health services,
health professionals should provide practical empowerment of communities with knowledge and skills for sustainable health promotion.

2.3.2 Bottom-up approach

The “bottom-up” initiatives of community participation resulted in the 1970’s after the failures of “top-down” approaches (Moser, 1983). As opposed to top-down approach, the bottom-up approach has a higher chance of participation. The bottom-up approach recognizes community participation as “the result of community people, essentially the poor, gaining information, access to resources and eventually control over their lives rather than being dominated by the authorities”.

In a study to assess participation in a community-based health planning and services (CHPS) in Ghana, Baatiema et al. found that the communities were empowered to take greater control over their health, sought to promote community-driven health care services, with technical support from the department of health (Baatiema et al., 2013). The CHPS strategy advocated for the planning and implementation of primary health care services with active participation of community leaders and members. The mobilization of community leadership, decision making systems and resources in this “bottom-up” approach improved resources allocation, the identification of health needs as well as leadership capacity at community level.

In theory, the bottom-up approach represents high degree of community participation, whereby communities identify their health needs and implement direct and indirect initiatives to improve their health status. However, the bottom-up approach can only be effective when the communities are highly empowered and motivated. The process of transferring health knowledge and skills for primary health care to the communities may take many years in a developing country. This approach therefore should be implemented in combination with top-down activities which should include professional support and guidance.

2.3.3 The Partnership approach

The partnership approach is an alternative to top-down and bottom-up approaches to community participation. In the partnership approach, governments and communities work together in planning and decision making (Reddy, 2002). The partnership approach requires that communities be involved in the planning, implementation, monitoring and evaluation of health services at all levels of care. In the South African health context, the mandatory presence of functional hospital boards and clinic committees for public health facilities is an important initiative for encouraging partnership between health facilities and communities.
The above overview of the methods and approaches to community participation, implies that community participation processes should further be analysed by focusing on specific questions such as “who are participating stakeholders?”, “where do they participate?”, “How do health professionals involve communities?”, “why do communities participate in health?”, “what participatory structures are in place to encourage community participation?” and “what challenges affect community participation?”. These are the questions that formed the basis of this study’s situational analysis of community participation in the KwaZulu-Natal primary health care system.

2.4 WHY IS COMMUNITY PARTICIPATION IMPORTANT?

Several field studies have demonstrated the beneficial effects of various community participation initiatives in different countries. Most of these studies were implemented in developing countries because of the high need for primary health care interventions in these countries. The WHO’s promotion of community participation was greatly influenced by the China example of ‘barefoot’ doctors in 1968 (Chatterjee, 1993). This programme consisted of part-time health workers which provided basic health services in rural areas. Apart from the transfer of skills, the programme is known for achieving good community mobilization for health.

Another example of a beneficial participatory campaign was the establishment and empowerment of ‘Neighbourhood Groups’ for women in India during the year 2005. This community participation programme was in response to the need to address the challenges of poverty and ill-health (Kyobutungi & Nayar, 2005). The assessment of these community mobilization structures identified their positive effect on disease control and health financing. The women support groups were involved in health information dissemination and drug distribution. The training of the support groups in health, e.g. cholera prevention, empowered them with knowledge and skills for disease management at community level. The group also managed a loan scheme to assist members to meet family healthcare expenses.

A related community participation study by Anja Welschhoff determined that the decentralization of health care decision making and services through community-level workers improved access to health services in India (Welschhoff, 2006). This study showed that the degree of community participation was associated with the extent of involvement and the degree of involvement in decision making processes. When more people were involved and when the level of their decision making was high, there was higher degree of participation. The involvement of communities in health also seemed to improve the responsiveness or effectiveness of the health care system. Through effective community
participation, the advocacy role of community structures is encouraged and this in turn encourages the health care system to respond to the expressed health needs of the community.

In a study of community participation in New Zealand, Neuwelt et al., developed a community participation toolkit for assessing and developing participation by different stakeholders in primary health care (Neuwelt et al., 2005). The Community Participation Toolkit contained a set of resources for organizational self-review as well as framework for community participation. The evaluation of the implementation of the toolkit showed improved confidence, commitment and leadership levels among the users and PHC stakeholders. The empowerment of stakeholders resulted in better understanding of community participation processes and 'buy-in' in the health care system.

There are many other potential benefits to community participation in primary health care. People belonging to the same entity and having a common perception of collective needs and priorities, and the ability to assume responsibilities for decisions made within the community can play an important role in promoting community participation. Community participation increases the understanding of the user-perspective in the management of health. It promotes and strengthens self-reliance in matters of delivery of health services. The members of the community, who are chosen by the community and are appropriately trained, act as frontline representatives and are more accessible and acceptable to the people (Hilderbrandt, 1996).

Because the indigenous knowledge and local resources are utilized, community participation can bring down the cost of health care (Roy and Sharma, 1986). In a study to compare and contrast the state-run and the community-run health post in Nepal, researchers found that community-financing, as opposed to state-financing, enhanced community engagement in health (Seperhi & Pettigrew, 1996). The study further showed that the benefits were higher under a community-financed health structure because community financing, as a tangible demonstration of community participation, improved service utilization. This project demonstrated how communities could take responsibility for their own health to a certain extent, and how community participation could reduce dependence and inefficiencies that characterized most health systems.

It is believed that health seeking behaviour is essential for early identification of illnesses and for decreasing morbidity. The positive effect of community participation on community empowerment and health-seeking behaviour can potentially influence several health outcomes in the community. Community involvement in health is a strategy for health development. It is a basic right, which all people should be able to enjoy. Community
involvement can be a means of making more resources available by drawing upon local knowledge and resources. The extension of coverage and lowering of health costs can make health services more cost-effective. In a community participation environment, the community is given the right to ensure that services are acceptable and responsive to the community priorities as opposed to medical needs as defined by health authorities (Sepehri and Pettigrew, 1996). Community involvement also reduces dependence and makes community members aware that they are active participants in development and public affairs in general.

2.5 CAN COMMUNITY PARTICIPATION STRENGTHEN HEALTH PROMOTION?

The analytical methods used in earlier studies place limitations on describing and understanding how community participation is related to health improvements. The studies described in the previous section view the effectiveness of community participation against desired healthcare end-points such as the following:

- Responsiveness to health needs
- Improvement in community’s knowledge
- Improved disease control
- Increased health care seeking behaviour
- Development of community’s self-help health projects

In a systematic review to examine the effectiveness of community participation on Maternal and Child Care programme, Marston and co-researchers (Marston et al., 2013) found that the community participation interventions increased the uptake of professional care during pregnancy, childbirth and after birth in Nepal, India and Kenya. The community participation intervention included the mobilization of communities to identify root problems of poor care-seeking behaviour, empowerment and mobilization of resources. The study also showed improvements in quality of care by traditional birth attendants and neonatal mortality was found to be lower in the intervention areas compared to the control group.

Through participatory approaches, the NGO, Society for Education, Action and Research in Community Health (SEARCH), worked with the community of Gadchiroli in the provision of primary care to neonates (Gryboski, et al., 2006). The project involved adult males and women’s groups in the village committee that was driving the project. By the project’s third year, new-born mortality had fallen by 60% in the intervention areas and there was significant reduction in various new-born and maternal illnesses. After ten years, these results were sustained, and the project proved to save lives and to influence new-born health
projects in India and other countries. Some studies, such as “Community participation in PHC: Lessons from tuberculosis treatment in South Africa” (Kironde & Kahirimbanyi, 2002), have also shown some value of community participation in improving health promotion effectiveness. Kironde and Kahirimbanyi found that participatory methods through Directly-Observed Treatment – Short Course (DOTS) strategy improved treatment adherence among tuberculosis patients in the Northern Cape.

Despite some advances in the study of the community participation, it is not always easy to assess the effectiveness of a community participation intervention on health care. This is because community participation interventions are implemented alongside other initiatives. When assessing the role of community participation therefore, the investigator should include in-depth analysis of the mechanisms and processes through which the intervention might produce change. The confounding factors in health care delivery, unfortunately, make it difficult to associate positive health change to a particular participatory intervention. The small number of high quality studies, and lack of information about why the interventions have succeeded or failed, prevents us from stating what makes participation intervention successful. Effectiveness studies on community participation are therefore still needed for further clarity in this area.

In an effort to bridge the evidence gap between community participation efforts and health outcomes, this study has applied participatory principles in the implementation and evaluation of pilot health promotion projects in the primary health care setting. Because health promotion is at the centre of PHC programmes, the effectiveness of health promotion projects can be regarded as an input for influencing the knowledge, attitudes and healthy behaviours of the community members.

2.6 LEVELS OF COMMUNITY PARTICIPATION

Assessing the scale of community participation is essential in understanding the extent to which community participation has been achieved by the health system. Among the best known frameworks for measuring community participation are the Arnsten’s ladder of participation and Aubel’s classification of community participation.

2.6.1 Arnstein’s ladder of participation

One of the attempts commonly used to determine the scale of participation by the public is the Arnstein’s ladder of participation (Arnstein, 1969). Arnstein views participation as a symbol of community power. The Arnstein ladder had eight levels as shown in Fig. 1.
Arnstein classifies participation using the eight-rug scale, where the lowest level indicates non-participation and the highest level represents highest participation. The Arnstein’s level of community participation can therefore be used as reference when assessing community participation. However, her classification lacks emphasis of the empowerment role by officials. In developing countries like South Africa, empowerment is an important strategy for involving communities and in improving their decision-making capacity. Arnstein’s definition of participation does not take into account the other initiatives through which communities can involve themselves. Using health as an example, certain communities do organize themselves to form self-help initiatives such as the nutrition programmes, patient support groups and other advocacy groups.

Despite the common lack of monitoring tools, especially for developing countries, the Arnstein framework provides a useful tool for assessing the degree of community participation. The challenge for any health authorities is to move up the ladder, finding new tools and techniques that promote active and genuine involvement, citizenship and empowerment rather than settling for the more passive processes of providing information and consultation (WHO, 2002).
Another useful approach for assessing the degree of community participation is the classification of participation according to “levels of participation”. In her paper presentation, the United Nations Children’s Fund (Unicef) consultant Judi Aubel identified four levels of community participation (Aubel, 2001):

- **Low level** (participation score=1), involvement of the community is minimal to none because the community lacks certain basic skills, the socio-political environment creates obstacles to participation, or communities are simply not given opportunities to participate.
- **Moderate level** (participation score=2), communities are aware of the health programs and issues; may assist in needs assessment, planning or implementing activities at the direction of the professional health workers; and may or may not be aware of program evaluation results. Decisions remain with the professional health workers.
- **High level** (participation score=3), community members are involved in all aspects of program management, advocate for their own needs, make decisions in partnership.

**Fig. 1:** Arnstein’s Ladder of Participation, (Arnstein, 1969)
with professional health workers, and are involved in project evaluation.

- Highest level (participation score=4), community members are directly involved in making decisions about all aspects of program management, resource allocation, and process and outcome evaluation. At this level, equity and inclusiveness are present in all areas of the program, including representative leadership.

The Aubel's assessment method clearly defines measurement criteria and is relatively easy to apply. Because it includes flexible process and outcome indicators, the Aubel’s classification method can be applied to many different types of health systems.

2.7 COMMUNITY PARTICIPATION MODELS

The community participation models described in this section fit Dr Soumya Swaroop’s description of a public health model (Soumya, 2015). A public health model, according to Dr Soumya, is a summarized description or illustration of organized measures to prevent disease or promote health. The model considers human factors, environment and interventions such as health promotion and it targets policies and approaches to address the health or social problem. The steps in the development of the model include problem analysis by addressing such questions as “who”, “what”, “when”, “where” and “how” do various systemic factors affect it. Dr Soumya Swaroop stresses that the public health model must be based on research findings from needs assessments, community surveys and that the programs must be implemented and evaluated rigorously to determine their effectiveness before they are adopted broadly.

In this section, the researcher presents some of the frameworks that have been proposed by other researchers and policy makers in their efforts to analyse community participation. In relation to this study, these frameworks provide informative guide on analysing the nature and processes of community participation in local health settings. For each of the model, the researcher has explored the potential applicability of the model framework for providing insights into the design and applicability of the community participation model in the primary health care system in KwaZulu-Natal. Each model presented in this section is critically reviewed to assess its relevance to local participation processes and its usefulness in the design of subsequent models.
2.7.1 The IAPP’s Spectrum of Public Participation

The participation framework that most clearly outlines the activities through which the communities can be involved in service delivery, is the one designed by the International Association for Public Participation (IAPP). The framework assists with the selection of the level of participation that defines the public’s role in any public participation process (IAPP, 2007). The spectrum, illustrated below, shows that different levels of participation are legitimate and depend on the goals, time frames, resources and levels of interest in the decision to be made. The spectrum is essentially a matrix identifying the various levels of participation. The levels include inform, consult, involve, collaborate and empower. Each level of participation is chosen based on the specific goal of the project and the promise being made to the public.
Even in the health care context, this spectrum provides a good foundation against which community participation can be modelled to support health projects. The spectrum, however, does not reflect the corresponding roles of the participating communities and does not
highlight the role of other stakeholders that work collaboratively or alongside the service providers and communities.

2.7.2 The OECD Participation Framework

To illustrate the relationship between the government and its citizens, the Organisation for Economic Cooperation and Development (OECD) developed an analytical framework for conducting comparative surveys and case studies on community participation (OECD, 2001). Recognizing the importance of partnership, the OECD released the publication “Citizens as Partners: Information, Consultation and Public Participation in Policy-making”.

As shown in figure 3 below, the OECD framework defines information as a one-way relationship through which the government produces and delivers information for use by citizens. Consultation is a two-way relationship in which citizens provide feedback to government. Government officials define issues for consultation and manage the process, and citizens are invited to contribute their views and opinions. Active participation is a relation based on partnership in which citizens actively engage in policy-making.

![OECD's Framework (OECD, 2001)](image)

The OECD framework is a simple model with a huge potential to guide community participation in health services. Because of the important role of consultation and information sharing in the health sector, this framework can increase the relationship and cooperation between health professionals and communities.

2.7.3 Martin’s Model

Pedro Martin (Martin, 2010) draws on Arnstein’s ladder of participation (figure 1) which classifies participation according to the level of power delegated to communities. Martin
compares and contrasts different understandings of participation across three related models Arnstein’s, IAPP’s and OECD’s models (Fig. 4).

Arnstein’s Ladder

- Citizen control
- Delegated power
- Partnership
- Placation
- Consultation
- Information
- Therapy
- Manipulation

IAPP Spectrum

- Empower
- Collaborate
- Involve
- Consult
- Inform

OECD Model

- Active participation
- Consultation
- Information

**Fig. 4:** Martin’s Model (Martin, 2010)

Martin argues that the question of power in community participation cannot be ignored. He believes that, unless power and control are transferred to communities, resources allocated to community participation could be lost without much impact or change resulting from them. This argument is true for developing countries like South Africa, where most communities still require empowerment on health knowledge and skills in order for them to contribute to health promotion.

2.7.4 Davidson’s Wheel of Participation

Since the Arnstein’s ladder of citizen participation was published in 1969, there has been several efforts by researchers and health planners to illustrate modes of achieving it. Many of these innovators acknowledged that it was almost impossible and inappropriate to aim for the top rung of the Arnstein’s ladder (Kummeling, 1999). In recognition of this, Scott Davidson had developed the wheel of participation for Scotland’s South Lanarkshire Council as a model to define and encourage levels of participation in planning and development.
(Davidson, 1998). The wheel draws on the ladders discussed above and distinguishes objectives related to information, consultation, participation and empowerment (Fig. 5).

**Fig. 5: Davidson’s Model (Davidson, 1998)**

The unique contribution of the Davidson’s model is the classification of the degrees of participation for each of the four involvement processes. For example, consultation can range from what he terms “limited consultation” to “genuine consultation”. Similarly, the empowerment of communities can achieve only “delegated control” or “entrusted control” in which empowered community members are able to take critical decisions on matters affecting their health. This classification of the degrees of participation can assist health professionals and managers to set objectives of their participation initiatives in line with their strategic plans and available resources.

2.7.5 The Pentagram Model

In their contribution to the assessment of the degree of community participation in health promotion programmes, Rifkin and colleagues (Rifkin *et al.*, 1988) also developed an assessment method, using a pentagram model. The pentagram method provides a tool for measuring and describing participation by means of a visual representation. The model allows for comparison of participation at different time periods of measurement. The
pentagram visualization is based on pre-identified process indicators for participation, specifically the following:

- Needs assessment
- Leadership
- Management
- Organization
- Resource mobilization

Fig. 6: Rifkin’s pentagram (Rifkin et al, 1988)

The arm for each process indicator is graded with time intervals such as ‘number of years’. After scoring the degree of participation for each indicator, the score points are joined using lines, as shown in the illustration above. The degree of participation is visually represented in the pentagram by the area within the lines joining the process indicators.

The advantage of the pentagram model is that it has fixed indicators of participation. As a result, this framework can be used to compare participation over different periods of time. All the five arms of the pentagram model are relevant and are represented in the structure of the KwaZulu-Natal PHC system.

2.7.6 The Partnership Model

In the partnership approach, governments and communities work together in planning and decision making with long-lasting results. These long-lasting outputs were identified by Narayana G Reddy in his book “Empowering Communities through Participatory Methods” (Reddy, 2002):
In the partnership model (figure 7), health professionals have the responsibility to empower communities on health issues in order for them to play a productive role in health development. Communities too, are expected to participate directly or indirectly at all levels of health service planning and health promotion. There are many activities and initiatives that represent partnership approach to community participation. In Reddy’s partnership approach, communities can be involved in the planning, implementation, monitoring and evaluation of health services at all levels of care. As a result, the communities derive long-lasting results such as ‘sustainability of participation’, ‘dignity to the community’ as well as ‘control over their own affairs’. In South Africa, the National Health Act (Act 61 of 2003) requires that communities be involved through consultative structures at various levels of health care delivery. The presence of functional hospital boards and clinic committees for public health facilities is an important initiative for encouraging partnership between health facilities and communities.

2.7.7 The Alfred Health Model

Apart from researchers, the policy makers can also design the community participation models based on their experiences and health settings. One such model was constructed by Alfred Health during their strategic planning for the 2006 – 2010 period (Alfred Health, 2006). The Alfred Health model of community participation is based on their theme: “working in partnership with our community, consumers and carers to improve our services”. The model typically comprises of five pillars, consultation, involvement, mobilization, empowerment and partnership (figure 8). The planners believe that these pillars represent participatory processes that are implemented by the organization at individual, programme and organization level:

![Diagram of the Alfred Health Model](image-url)
The Alfred Health model further describes the “measures of success” than can be used to evaluate the effectiveness of participation at various levels of service delivery. As an example, the measure of partnership is “participation in quality improvement activities and quality processes”. To evaluate mobilization efforts, the model proposes “availability of appropriate links and regular engagements with community organizations” as one of the indicators. Similarly, the Alfred Health plan suggests performance measures for consultations, involvement and empowerment. Having been designed by health managers, the Alfred Health model is more likely to be practical and relevant to the needs of primary health care. Ideally, the incorporation of the participation model and its performance indicators in the organization’s strategic plan is a useful initiative and a sign of commitment to the implementation of community participation. In this way, the organization lays the foundation for the monitoring and evaluation of participatory activities on specified intervals and at the end of the strategic period.
The lack of reference to inter-sectoral collaboration is a striking feature of all community participation models reviewed thus far. As opposed to looking at participation simply as a bilateral engagement between providers and communities, the United Nations Programme on HIV/AIDS (UNAIDS) recognized the importance of stakeholders in the health programme. The UNAIDS professionals believed that the starting point of good participatory practice was the identification of key stakeholders (UNAIDS, 2011). Although the stakeholders identified in the UNAIDS model (figure 9) are those relevant to the conduct of biomedical HIV

**Fig. 8:** Alfred Health Model (2006)

### 2.7.8 The UNAIDS's Stakeholder Model

The lack of reference to inter-sectoral collaboration is a striking feature of all community participation models reviewed thus far. As opposed to looking at participation simply as a bilateral engagement between providers and communities, the United Nations Programme on HIV/AIDS (UNAIDS) recognized the importance of stakeholders in the health programme. The UNAIDS professionals believed that the starting point of good participatory practice was the identification of key stakeholders (UNAIDS, 2011). Although the stakeholders identified in the UNAIDS model (figure 9) are those relevant to the conduct of biomedical HIV
prevention trials, these stakeholders are generally applicable to other health programmes and other health systems.

To illustrate the importance of broad and inclusive stakeholder engagement, the UNAIDS’s guidelines recommend that the programme implementers identify four types of stakeholders, namely global, national, broader and community stakeholders.

![Stakeholder Model](adapted from UNAIDS Guidelines, 2011)

Interestingly, the UNAIDS professionals acknowledge that the community is not a single entity that is easily identifiable in any population. Hence, they refer to “community stakeholders” rather than community. The reference to community stakeholders helps the health professionals to identify all relevant stakeholders such as CBO’s, schools, families etc. The UNAIDS model therefore provides a useful approach for encouraging broad participation and recognition of the contributory roles of all stakeholders in the programme. The model, however, does not distinguish between community stakeholders and the stakeholders that work as partners with health professionals. Such a distinction, if described, would mobilize stakeholders to recognize each other and to work together in the planning and pursuit of their common goals.
Understanding the political context of the country where programmes or projects are being implemented is essential in identifying opportunities for community participation (Choguili, 1996). The South Africa’s National Health Act (Act 61, 2003) recognizes the important role of community participation in health service delivery (National Health Act, 2003). In terms of the Act, the Republic must “establish a health system based on decentralized management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourages participation”. The National Health Act makes provision for the establishment of consultative forums at both national and provincial level. Clinics and community health centre committees are proposed as advisory and governance structures to strengthen the delivery of health services at community level. In January 2010, the Cabinet resolved to prioritize four broad categories of focus, namely increasing life expectancy, combating HIV and AIDS, improving tuberculosis management as well as the strengthening of the primary health system in order to improve effectiveness and to reduce costs of health care. These focus areas provide clear direction for the major policy shifts in health service delivery. Without full community participation, none of these four objectives can be realized in any health system.

In South Africa, community participation is the official approach that has been accepted as essential for the provision of health care for the people. The National Department of Health further outlined the “Ten Point Plan” that provides fresh hope for the realization of the four cabinet goals (Dept. of Health, 2010). The Ten Point Plan includes, among other things, “mass mobilization of communities for better health”. Mass mobilization of communities is one of the new inputs to the department’s strategic objectives. Although not yet fully described, community mobilization promises to encourage community participation as one of the pillars of primary health care.

The N’doro Palliative Care Project, situated in Soweto, was a project funded by the Development Cooperation Ireland, and also significantly supported by the government (Dinat et al., 2005). It was based in an academic government hospital and provided a free palliative care service. Linked to NGO’s, government and state services, as well as academic organizations, this project strived to bring role players together. To this end, the Soweto Care Givers Network was set up in 2001 and brought together many organizations that were involved in home-based care. The Soweto Care Givers Network and the N’doro project embarked on an empowerment approach rather than the utilitarian approach toward community participation. The Soweto Care Givers Network invited participation from existing community based organizations, government representatives and other stakeholders.
According to Dinat et al., this project sought to involve and empower the community in the many ways, such as health promotion, advocacy, inter-sectoral collaboration as well as dialogue with community groups.

Similar networks of community-based organizations have been established in South Africa. One such network is the Nkandla HIV/AIDS network in KwaZulu-Natal. Nkandla is a deeply rural area with low socio-economic status. Although there are many outreach services by the health department, such efforts are not enough to address health challenges which are mostly complicated by poverty, illiteracy and unemployment. Under these circumstances, adequate community participation is difficult for the communities. The HIV/AIDS network is funded by the department of health and has eight CBO's affiliated to it. The main activities of the network are home visits where health education, tracing of defaulters, home based care and referrals are implemented. It remains to be ascertained whether a network of organizations can be effective in facilitating community participation (Kahssay and Oakley, 1999).

Due to philosophically different models, South Africa has no standardized community participation model for health and community participation is neither an identifiable activity nor a fully integrated strategy of primary health care (Dinat et al., 2005).

2.9 COMMUNITY PARTICIPATION INITIATIVES AND APPROACHES IN KWAZULU-NATAL

The KwaZulu-Natal public health system is comprised of many public sector hospitals and primary health care clinics. The main community participation strategy is the use of hospital boards and clinic committees in the governance of health facilities. These structures provide liaison and communication platform between public health facilities and the local communities.

In January 2010, KwaZulu-Natal Department of Health issued a Policy for Primary Health Care Supervision. The purpose of the policy was to “address supervision of Primary Health Care service delivery rendered by the department of health within the province of KwaZulu-Natal, to support community participation and inter-sectoral collaboration in order to achieve improvement in the health status of the population of KwaZulu-Natal” (KwaZulu-Natal Dept. of Health, 2010).

Clearly, this new policy recognizes the role of community participation in primary health care and further attempts to incorporate elements of community participation in guiding primary health care supervisors on their role of supervising primary health care clinics. The policy is
a culmination of three workshops that were run in the province during the year 2008. A mix of district management members, PHC Supervisors, PHC service providers and hospital-based nurses participated in the project. The staff at district and provincial level was also consulted at subsequent provincial meetings. Apart from description of the existing PHC structure, principles and historical background, the policy in essence defines the supervisory roles of managers at provincial, district, sub-district, hospital and clinic level. In terms of the policy, the units requiring supervision at service level are:

- School health teams
- PHC clinics
- Mobile health clinics
- TB outreach and tracer teams
- HIV outreach and tracer teams
- Community Health facilitators
- Home Care and Non-Governmental Organizations funded by the Department to provide Community and Home Based Care
- CDC & Expanded Programme on Immunization Surveillance Teams
- Eye Care/Prevention of Blindness Programme Outreach and
- Mental Health Programme Outreach.

Although not mentioned in the above list of units to be supervised, clinic committees are also supervised by the institutional PHC manager. The PHC Supervision Policy requires that the hospital based PHC Supervisor ensures integration of the above-mentioned units in order to provide an integrated and comprehensive service to the community. The policy identifies the risks that still need to be addressed by the KwaZulu-Natal Department of Health and these include inadequate availability of resources for sustained community participation as well as inter-sectoral approach by government departments, private sector and community, especially at district and sub-district levels.

One of the expected outcomes of the PHC Supervision Policy is sustained community participation in health. To ensure community involvement and participation review, the PHC supervisor must enquire about issues related to community involvement and participation during each visit to the PHC clinic. The supervisor must encourage participation of clinic staff in clinic committees. The policy requires that the PHC supervisor should meet with each clinic committee twice a year to ensure that their concerns about services and health issues are heard. Concerns of the clinic committees must be brought to the attention of the district management (KwaZulu-Natal’s Policy on PHC Supervision, 2010). In terms of the
Supervision Policy, the PHC supervisor must also encourage the PHC professionals to plan and conduct specific community outreach activities on a regular basis.

In terms of this policy, the PHC supervisor must monitor, on a monthly basis, the communication of health information with communities, the management of challenges, social mobilization, and the mobilization of resources. The concerns of the community care givers (CCG’s) about families and community health issues must also be noted at every clinic visit and reported to the relevant authority or organization. The supervision policy proposes various indicators for measuring its implementation, namely PHC supervision rate, availability of transport for support and supervision, package of PHC services rendered by each facility, accessibility and acceptability of health care. As shown by its strong outreach and community component, the KZN supervision policy is a useful intervention for encouraging the involvement of communities in the health system.

The South Africa’s “War on Poverty Programme” project (South African Government, Poverty and inequality Report, 2009) is a well-known project for encouraging partnership between the government and communities. The “War on Poverty” programme (also known as the Flagship project) is implemented through governmental multi-stakeholder service delivery forums, which are the multi-sectoral committees at district, sub-district, and ward municipal levels. In order to encourage all stakeholders to work together, the KwaZulu-Natal version of the Flagship Programme is commonly referred to as “Operation Sukuma Sakhe” (“Let’s stand up and build”). This is a provincial effort to encourage all government departments, local leaders, and communities to work together in accelerating “measurable performance and accountable delivery of services” to the communities. The programme hopes to accelerate the achievement of the eleven target outputs for the government departments. The department of health is a major role player in the programme. The strength of the flagship framework is the collaboration of various service delivery departments whose efforts are directed at addressing the needs of communities holistically.

The flagship project does not have additional budget over and above the allocation to the different service delivery departments. Community profiling is a process through which officials collect household’s socio-economic data in various municipal wards in order to identify needs and to monitor community interventions. The multi-sectoral approach to community mobilization by the KwaZulu-Natal government strengthens the capacity and accountability of the health department as one of the providers of essential services.

As early as the 1977, the Latin American experiences of community participation in health portrayed the importance of inter-relationships between local health facilities and the community. It is important for service providers to have close partnerships with community
organizations as well as with private and other governmental organizations at local level (Hevia, 1977). The multi-sectoral service delivery forums in KwaZulu-Natal are a good example of such working relationship between government service providers and communities.

2.10 CHALLENGES OF COMMUNITY PARTICIPATION

Although public health literature shows community participation and its benefits in a positive light, it may have many challenges. Studying the challenges of community participation is useful in understanding why community participation interventions vary from one setting to the other, and why they sometimes fail to achieve desired health outcomes. Community participation in Ghana, for example was found to be hindered by lack of opportunity and capacity in the community (Kilewo & Frumence, 2005). The understanding of the challenges of community participation is helpful in planning and decision making by health managers and by community participation organizations.

Anja Welschhoff points towards several hurdles for successful community participation in the health sector (Welschhoff, 2006). First of all, lack of empowerment limits the ability of communities to make informed decisions and health choices. Lack of interest in participation activities was commonly ascribed to lack of incentives as well as poor responsiveness of the health system. Community participation can at times be an inefficient and time-consuming process. In many disadvantaged health systems, the cost of implementing community participation may limit its roll-out. Furthermore, there are fears among some health professionals and governments that uncontrolled empowerment of people may cause them to make risky health decisions or to reduce health seeking behaviour (Welschoff, 2006). In addition, the absence of basic life necessities in some areas where there is poverty and unemployment, shortage of health professionals, poor attitudes and inadequate health services makes community participation untenable.

In their study of community participation, Kyobutungi and Nayar noted that the attitudes and practices of health professionals were also a major constraint to community participation (Kyobutungi & Nayar, 2005). This study found that health professionals did not recognize the local community based organization (CBO) and they failed to involve it in the health planning processes. It was observed also that health professionals were doubting the potential value of community organizations in health promotion and development.

The majority of community participation studies include the assessment of challenges affecting the community participation interventions in specified health programmes. The
knowledge of common challenges to participation can be used to strengthen the design of the participation intervention (Welschoff, 2006). Most studies of community participation have focussed more on identifying the challenges of participation than on quantifying their impact. Whilst some community involvement programmes can prosper amidst several small challenges, one significant challenge can bring the programme to a halt. The future assessments of community participation challenges should therefore include the extent to which each challenge influences the effectiveness of the programme. One of the ways to do this is to weigh and prioritize the perceptions or experiences of participants in the health project.

2.11 THE THEORETICAL FRAMEWORK OF COMMUNITY PARTICIPATION

The lack of a theoretical framework is one of the challenges which affect community participation in some health systems (Westergaard, 1986). The review of the literature on community participation, however, has improved the researchers’ appreciation of the work that has been done and the knowledge that has been gathered in different sectors and contexts. When different models, perspectives and approaches to community participation are summarized, the following appear to be the common systems and methods for encouraging participation and development in the health system:

- There should be supportive participatory structures such as inter-sectoral committees, hospital boards, clinic committees and community advisory boards
- There should be ongoing partnership between service providers and communities
- Methods should be in place to involve communities in health. Such methods should include informing, consultation, collaboration and delegation
- The communities should be empowered with health promoting knowledge and skills
- Methods should be in place for communities to participate in health promotion and development. Such methods should include advocacy, self-help community projects and participation in advisory boards and committees
- The health system should have policy or processes for promoting shared responsibility for health by health professionals and by communities

Although the above processes and initiatives provide some framework for understanding community participation, the review of literature shows that more work is still needed to understand the relationship between community participation and health outcomes. A review of theoretical frameworks and models purported by Arnstein (1969) and Rifkin (1988) provides an excellent basis on which to build a framework for assessing the relationship
between community participation and health promotion. In his framework, Arnstein views consultation as the first step towards community participation and power (Arnstein, 1969). Rifkin (1988) offers a set of indicators for assessing community participation based on her definition of the concept. Such indicators include needs assessment and capacity building for the communities. Due to the limitations of earlier studies on describing the effect of community participation on health improvements, this study’s conceptual framework incorporates mobilization of communities and resources, in addition to consultation and empowerment, to explore the potential benefit of community participation in strengthening health promotion.

The conceptual framework which inspired this study is illustrated graphically in figure 10.
2.12 SUMMARY

Theories of community participation have received considerable attention by many researchers and policy makers. The principle of community participation is so well recognized in international health circles that no declaration about primary health care is made without it (WHO, 2006). Community participation is important for many reasons. People have much to contribute from their own knowledge and experiences to improve health conditions. Through empowerment, participation can increase skills and knowledge of local people thus providing opportunities to improve their lives. People’s involvement can increase resources to support health care. Through participation, the social learning process is created whereby professionals and local people learn from each other and build working partnerships for sustainable improvements. Community participation therefore reflects a commitment to social justice and promotion of democracy.

Much analysis of community participation is incomplete as a guide to governments and non-governmental organizations (NGO’s) in terms of the approach required to achieve success in community participation (Choguili, 1996). Various frameworks and models have been proposed for the understanding and measurement of community participation. The existing models of community participation, such as Arnstein’s ladder of citizen participation, Davidson’s wheel of participation, Martin’s model etc. have contributed to the understanding of the processes of community participation under different contexts and circumstances.

According to studies reviewed in this chapter, community participation can strengthen the health system and has a potentially beneficial role in the delivery of health care. Community participation in South Africa, for example, centres on the presence of functional hospital boards and clinic committees. These governance structures promote communication and collaboration between the health facilities and communities. In KwaZulu-Natal, the introduction of the multi-sectoral committees at district, municipal and local levels has introduced a promising approach for integrated and multi-sectoral delivery of public services. Despite the information and emphasis on community participation by the provincial government, there is currently no policy, framework or guidelines for the implementation of community participation in the KwaZulu-Natal’s PHC system. The extent of community participation in health activities is largely influenced by the physical, social and cultural environment or what is referred to as the contexts of participation. The literature based information on community participation has been used in this study as a reference for the construction of the theoretical framework for assessing community participation in the KwaZulu-Natal’s PHC system.
CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter discusses details of the methods and approaches used during the implementation of this study. The study is typically comprised of three inter-related phases. Phase one, which was implemented during the years 2011 and 2012, is concerned with the situational analysis of community participation in the KwaZulu-Natal province. During this phase, data was collected and analyzed in order to understand the methods used to encourage community participation as well as to identify various stakeholders and other community participation initiatives of the Department of Health. The knowledge of participating stakeholders, namely providers and communities, as well as the challenges facing community participation were also assessed and analyzed.

The second phase of the study was implemented during the years 2013 and 2014. During this phase, PHC professionals were consulted regarding the various systems in place, and on the processes used by health professionals to involve communities in health. The purpose of this consultative process was to identify the building blocks of the ideal community participation model for the KwaZulu-Natal PHC system. The four projects were identified and proposed by the stakeholders as pilot projects that were to be implemented to demonstrate the role of community participation in health promotion. In addition, the PHC stakeholders contributed to the identification of process indicators and to the development of implementation guidelines for the proposed community participation model.

Phase three of the study was conducted during the years 2015 and 2016 to determine the applicability of participatory methods on the facilitation of health promotion projects. Four community participation projects were then implemented and evaluated by the researcher in four sub-districts in KwaZulu-Natal. Phase three methods were mostly driven by the findings of the situational analysis and by inputs from the phase two discussions with PHC stakeholders. The core principles of community participation, namely consultation, participatory approach and empowerment, were employed during the implementation of these pilot projects.

The development of the public health model of community participation in this study, therefore, was based on qualitative methodology in line with “triple A approach” of assessment, analysis and action. The following sections of the chapter discuss the design,
data collection methods and analytic techniques that were used during each of the three study phases.

3.2 RESEARCH SITES

Out of ten health districts in KwaZulu-Natal, two districts namely eThekwini and uThungulu districts, were purposely selected for the study because they fully represented the socio-economic demographics of the KwaZulu-Natal population. The populations of the two study districts constitute approximately 42% of the KwaZulu-Natal population. Whilst eThekwini district is the biggest urban district with a population of 3 701 235 people, the uThungulu district is the biggest rural district with a population of 976 984 people (Statistics South Africa, 2015). Within eThekwini district, two hospitals and four clinics were selected from the southern sub-district. Similarly, two hospitals and four clinics were selected from the northern sub-district. In Uthungulu district, two hospitals and four clinics were selected from the Umhlatuzo sub-district. Two hospitals and four clinics were selected from the Nkandla sub-district. The study was therefore implemented in two districts in which four sub-districts, eight hospitals and sixteen clinics were sampled. Eight household visits were conducted in each of the four sub-districts, resulting in a total of thirty-two household respondents participating in the study (see table 2).

3.3 RESEARCH DESIGN AND DATA COLLECTION METHODS

3.3.1 DESIGN

This study employed a case study design and utilized qualitative methods of data collection.

Stake (1995) described case study methodology as a strategy of inquiry in which the researcher explores in-depth a program, event, activity, process or one or more individuals. For this study, the phenomenon under investigation was systems and processes used by the KwaZulu-Natal PHC system to encourage community participation. A multi-case study method served the purpose of this study because, as a descriptive method, it deepened the researcher’s understanding of the processes and circumstances that underpinned community participation in the KZN’s PHC system.

The following theoretical framework was used to inform the design of the study:
Fig. 10: Framework for community participation. [Constructed based on Arntein’s (1969) and Rifkin’s (1988) theories.]

The above framework is derived from the synthesis of activities and outputs of community participation, as described by various researchers and policy makers (see chapter 2). In general, the engagement of communities through consultations, empowerment and health mobilization, is likely to improve community’s awareness about health issues. The long term benefits of these engagements include better service utilizations, ownership of health by communities as well as partnership between health professionals and communities.

3.3.2 DEVELOPMENT OF DATA COLLECTION TOOLS

This study used interview questionnaires (appendices 5-11 and 16-21), records review (appendix 13), focus group discussions (appendices 14 and 22) and observation checklist (appendix 12) to collect data from participants. The content validity of the interview questionnaires was verified by conducting literature review on community participation in order to determine which content should be covered. A public health expert was also asked to evaluate the instruments’ representativeness of the content. The reliability of the questionnaires was verified through pre-testing of interview questionnaires on 10 health professionals and 10 community representatives to ensure that the questionnaires were understood by participants. After the pre-testing of the questionnaires, the questionnaires were revised to improve clarity of questions. The expert provided input on the discussion guide and content for the focus group discussions. The observation checklist was mostly informed by literature data on the implementation and evaluation of health promotion.
projects. The details of the content and application of data collection tools during the three phases are described in the following section.

3.3.3 DATA COLLECTION METHODS

Data collection for this study was conducted in three inter-related phases (see figure 11):

A. PHASE ONE: SITUATIONAL ANALYSIS OF COMMUNITY PARTICIPATION IN THE KZN’S PHC SYSTEM

The assessment of the existing systems and processes of community participation in the KwaZulu-Natal PHC system was guided by the following objectives:

- To identify sectors, organizations and other governmental departments that work with the KwaZulu-Natal’s health Department in the delivery of PHC services
- To identify community structures that participate in the department’s PHC system
- To assess knowledge and understanding of community participation by providers of primary health care services
- To assess knowledge and understanding of community participation by communities
- To identify methods used by the health Department, as a service provider, to involve communities in the PHC system
- To identify methods used by the community participation structures to involve communities in the PHC system
- To identify methods through which communities participate in the KZN’s PHC system
- To assess how the health promotion projects are facilitated by health professionals at PHC level
- To identify challenges of community participation in the PHC system

During the situational analysis, data was collected through semi-structured interviews, observations and record reviews.

(i) Semi-Structured Interviews

The interview is considered as one of the most important methods for data collection within a case study (Yin, 2009). For purposes of this study, the researcher used semi-structured interviews to collect data on the methods, understanding and challenges of community participation in the KwaZulu-Natal primary health system. The semi-structured nature of the interviews allowed for flexibility (Miller & Brewer, 2003: 167,169), as follow up questions
were asked and responses recorded under comments section of the questionnaire. The interview questionnaires (see appendices 5-11) were mostly guided by the study objectives and by the literature on community participation initiatives and approaches.

To gain a detailed depiction of the community participation processes and challenges in the KwaZulu-Natal’s PHC system, the researcher interviewed health professionals and representatives of communities using semi-structured interview questionnaires. The assessment of community participation in this study was therefore conducted from both the provider and community perspectives. For each participant (service provider or community representatives) the researcher used a customized questionnaire to collect data on various aspects of community participation, as per the objectives of the study.

Participants interviewed included health professionals, community members, chairpersons of hospital boards, chairpersons of clinic committees, directors of municipal community services, municipal counsellors and community care givers. Health professionals were interviewed in their health facilities to collect data on the knowledge of community participation by professionals, to identify stakeholders with which they worked in the planning and provision of health services as well as the assessment of resources for community involvement and empowerment. The professionals were further interviewed about the methods they used to involve communities in health services; the empowerment activities in place as well as the challenges of community participation they experienced.

The questionnaire for community members identified strategies that were being used by communities as part of their participation in health matters. The participants were asked about their involvement in health promotion programmes such as support groups, home-based care and clinic committees. Community members further described the methods used by the health department to encourage community participation in the communities. These included the interaction and communication between communities and clinic committees as well as between communities and the community care givers. The participants were asked to identify and share the challenges and constraints that affected their participation in health.

The questionnaire for the chairpersons of hospital boards and for the clinic committees was designed to collect data on the functionality and effectiveness of hospital boards and clinic committees as community participation structures. The knowledge of participants was assessed using a set of knowledge indicators such as advocacy, empowerment, partnership, social mobilization and ownership of health. The composition of these “governance and participation structures” was assessed to determine their capacity and potential to add value.
to their health institutions. The chairpersons were further asked to indicate any health promotion activities or projects that they had organized for their communities. The respondents were requested to identify challenges which affected the community participation processes of hospital boards and clinic committees.

The interviews for the directors of community services assessed the composition of multi-sectoral committees in order to identify various stakeholders that participated in these service delivery forums. The interview questionnaire for the directors also included the assessment of their knowledge of community participation, the strategies of community involvement as well as the challenges experienced by the multi-sectoral committees. As representatives of communities at sub-district (municipal) level, the municipal counsellors were interviewed to assess their community involvement activities, community participation challenges as well as their knowledge of community participation. The assessment of the knowledge of community participation by counsellors was based on indicators of community participation, namely advocacy, partnership, empowerment, social mobilization and ownership of services by communities.

The interview questionnaire for the community care givers was administered to participating community care givers to assess their knowledge and understanding of community participation, to understand their community involvement strategies as well as challenges they faced in their community work. During these interviews, the researcher also investigated the practical challenges of community participation that were facing both the health service providers and communities in the KwaZulu-Natal’s PHC system. The participating service providers, community representatives and community members were asked to describe the challenges or constraints which were most commonly experienced in their facilities or communities. The participants were further asked to state whether or not their health facility, participation committee or community was experiencing each of the challenges in the interview checklist.

All participants were informed about the study as per the participant information sheet, and informed consent was received from each of them before the interview was conducted. The participants representing “providers” were interviewed in English in their workplaces. More than 90% of the participants representing communities or community structures, however, were interviewed in isiZulu language. The interview questions used in this situational analysis were informed by the objectives of the study. The duration of the interview for each participant was, on average, 30 minutes. All responses were manually recorded on the customized interview questionnaires for participants and later loaded on the electronic database.
(ii) Record Reviews

As Yin puts it, documents are important in a case study because they can be used to substantiate and to supplement evidence from other sources (Yin, 2009). Furthermore, inferences can be made according to the information kept in the records. This data collection method was used during this study’s situational analysis specifically to study the minutes of hospital boards and clinic committees in order to assess their functionality and their contribution to community participation.

During the situational analysis, the records of meetings were checked to determine the frequency of meetings and commonly discussed agenda items as recorded in the minutes of the meetings. The minutes were also studied to gather the recorded evidence of actions and interventions by the hospital boards and clinic committees. The data obtained from the records were manually transcribed on the records review questionnaire (see appendix 13).

(iii) Observations

Direct observations allow researchers to see the behaviours and practices of target participants in the system or program (Yin, 2009). In this study, direct observation of eight health promotion projects in the health facilities allowed the study to assess inputs, processes and outputs of these projects, using the observation questionnaire (see appendix 12). The observation of the projects during this research was conducted within the confines of scientifically acceptable research ethics and practices. The observation checklist was informed by the principles of health promotion namely needs assessment and planning, intervention programming, intervention implementation and evaluation (Simons-Morton et al 1995). The analysis of these principles allows for the identification of indicators that can be used to assess the inputs, processes and outputs of health promotion projects. Simons-Morton points out that the health project intervention should address the need of the community and should create social progress through community self-help, cooperation and democratic decision making.

Table 1 shows the eight health promotion projects that were observed by the researcher in different hospitals of KwaZulu-Natal.
### Table 1: Health promotion projects observed during the situational analysis of the study.

<table>
<thead>
<tr>
<th>NAME OF THE HEALTH PROJECT</th>
<th>SUB-DISTRICT</th>
<th>VENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Awareness on sexually transmitted infections</td>
<td>Nkandla</td>
<td>Ekombe hospital</td>
</tr>
<tr>
<td>2. Tuberculosis awareness</td>
<td>Nkandla</td>
<td>Chwezi community</td>
</tr>
<tr>
<td>3. Women’s health awareness</td>
<td>UMhlathuze</td>
<td>Lower Umfolozi hospital</td>
</tr>
<tr>
<td>4. Women’s health awareness</td>
<td>UMhlathuze</td>
<td>Khandisa community</td>
</tr>
<tr>
<td>5. School Health promotion</td>
<td>eThekwini Southern</td>
<td>Clairwood hospital</td>
</tr>
<tr>
<td>6. Mental Health awareness</td>
<td>eThekwini Southern</td>
<td>Prince Mshiyeni hospital</td>
</tr>
<tr>
<td>7. Occupational Health and Wellness awareness</td>
<td>eThekwini Northern</td>
<td>Cato Manor community</td>
</tr>
<tr>
<td>8. Medical male circumcision event</td>
<td>eThekwini Southern</td>
<td>Charles James hospital</td>
</tr>
</tbody>
</table>

The above projects were organized by health professionals as part of health promotion campaigns for their target communities. The observation focussed particularly on involvement of stakeholders and community empowerment processes such as education of the community on health knowledge and skills. The participatory approaches used by health professionals during these health promotion projects, were also studied. Data on inputs such as availability of stakeholders and resources were collected for each project. Outputs such as number of screened participants were also collected and recorded as per the observation checklist (Appendix 12). The observation checklist was based on Simons-Morton’s indicators (Simons-Morton et al 1995) for evaluating health promotion programmes.

**Sampling procedure and sample size during the situational analysis**

Purposive sampling was used to select the participants for the interviews during the situational analysis. Purposive sampling strategy is useful in identifying participants that are relevant for the purpose of the study, question under consideration, resources available and constraints of the project (Krathwohl, 1998). The participants were purposely selected based on their professional association with health promotion. In this study, all participants were directly or indirectly involved in community participation at primary health care. In general, every participant that was interviewed in this study was a representative of either the service providers or community at different levels of PHC system. The eight health promotion projects which were assessed during the situational analysis phase were selected conveniently because the timing of their implementation coincided with the period of the situational analysis in such health facilities. Members of the communities who participated in the interviews during household visits, however, were selected at random within each target sub-district.
The following is the list of participants that were interviewed during the situational analysis in all participating sub-districts:

<table>
<thead>
<tr>
<th>Level of PHC</th>
<th>Focus group</th>
<th>Participant category</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td>Health professionals</td>
<td>District managers: Health and EMRS</td>
<td>4</td>
</tr>
<tr>
<td>Sub-district</td>
<td>Health professionals</td>
<td>Directors of community services</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>Municipal counsellors</td>
<td>4</td>
</tr>
<tr>
<td>Hospital</td>
<td>Health professionals</td>
<td>Hospital CEO’s</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>Chairpersons of hospital boards</td>
<td>8</td>
</tr>
<tr>
<td>Clinic</td>
<td>Health professionals</td>
<td>Clinic managers</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>Chairpersons of clinic committees</td>
<td>16</td>
</tr>
<tr>
<td>Community</td>
<td>Health professionals</td>
<td>Community care givers</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>Community members</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Total sample</strong></td>
<td><strong>108</strong></td>
</tr>
</tbody>
</table>

Table 2: Sample categories and number of participants representing providers and communities at various levels of the health care system

B. PHASE TWO: DEVELOPMENT OF THE COMMUNITY PARTICIPATION MODEL

The objectives of this phase were:

- To engage PHC stakeholders in the identification of the components (inputs, systems and processes) and interventions that could contribute to a model of improving community participation in primary health care.
- To identify pilot participatory projects to be implemented based on the identified principles of the ideal community participation model

Phase two of the study was implemented mainly through a focus group discussion.
(i) Focus Group Discussions

A focus group is “a data collection procedure in the form of a carefully planned group discussion among people plus a moderator and observer, in order to obtain diverse ideas and perceptions on a topic of interest in a relaxed, permissive environment that fosters the expression of different points of view, with no pressure for consensus” (Tang et al., 1995). The focus group participants are important sources of research information because they have expert knowledge, information or experiences about the subject. Group dialogue tends to generate rich information, as participants’ insights tend to trigger the sharing of others’ personal experiences and perspectives in a way that can more easily or readily tease out tensions associated with complex topics (Anthony et al., 2009). In this study, focus group discussions with PHC professionals were instrumental in identifying inputs for developing the community participation model (see appendix 14).

This phase was a participatory process through which PHC professionals provided expert inputs and experience-based ideas about what constituted systems and processes of community participation in KwaZulu-Natal. The process was facilitated through a focus group discussion held in uThungulu and eThekwini districts. Each of the focus group discussions was facilitated by the researcher and observed by the research mentor in both study districts. Using a focus group discussion tool (appendix 14) as a guide, the participants identified stakeholders, activities and resources they considered essential for community participation. The proceedings were recorded by two note takers and further transcribed in English by appointed participants on flip charts. Each of the two focus groups was attended by 10 members who were employed by the health department as professional nurses. The professional nurses who participated in the focus groups were purposely invited to participate in the discussions based on their involvement and experience in working with communities at primary health care level.

The identification of systems and processes of community participation involved the analysis of responses from the two focus groups. During the focus group discussions, important primary thematic categories were revealed, and these were classified either as system factors or processes of community participation (see table 20). The PHC professionals were further asked to identify health promotion projects that could be implemented to demonstrate the usefulness of community participation principles such as stakeholder engagement, empowerment and participatory approaches during the facilitation of health promotion projects.
C. PHASE THREE: IMPLEMENTATION AND EVALUATION OF FOUR PILOT PARTICIPATORY PROJECTS OF HEALTH PROMOTION

The objectives of this study phase were:

- To implement the pilot health promotion projects.
- To evaluate the processes of projects’ implementation and their potential effect on improving community participation.
- To finalize the development of the community participation framework, guidelines for its implementation as well as performance indicators for community participation.

(i) How the pilot projects were implemented

In this study, the piloting of pilot projects was mainly influenced by the research question: “how can the existing systems and processes of community participation be used to strengthen health promotion in the PHC?” Pilot health projects offer particular advantages for health system reforms (PHRplus, 2004). According to Partners for Health Reform,

- Pilot projects allow policy makers to “try out” alternative arrangements for the health care system in a relatively free way, including determining political and technical factors that would affect the institutionalization or nationwide implementation of the intervention.
- Piloting may generate lessons regarding technical design and implementation that can feed into further implementation and refinement of the intervention or strategy.
- Pilot projects can demonstrate the benefits of the intervention in a tangible and experiential manner.

From the list of departmental priority programmes and potential projects, the members of the focus groups identified the following projects: (1) Training and capacity building of the clinic committee, (2) Anti-teenage Pregnancy Campaign, (3) Facilitation of diabetes health promotion project and (4) Establishment and induction of the patient Support Group. The main considerations in the selection of projects for piloting were project feasibility, the researcher’s capabilities as well as the projects’ relevance to the study.

Sampling procedure and sample sizes during the implementation and evaluation of pilot projects

The participants in the health promotion projects were general members of the communities
for whom each project was intended. The participants in the clinic committee training project were members of the clinic committee for Luwamba clinic. Twelve (12) members of the committee participated in the training and in the evaluation of the project. In the anti-teenage pregnancy project, 90 school learners of Velangaye High School participated in the empowerment project. The diabetes awareness project was attended by 180 members of the community for whom the health promotion project was planned. Participants responded to the official invitations which were issued by the local Osindisweni hospital. The support group project was attended by 45 diabetic patients who responded to the recruitment campaign for the formation of the support group. Of the 45 recruited members, 35 members voluntarily participated in the evaluation of the support group project.

(ii) Details of the implementation of pilot projects

The details of the inputs and processes for each pilot project are summarized in appendix 15. Appendix 15 outlines the implementation dates, processes, key outputs and evaluation for each pilot project. The components of community participation, as identified during the consultative process, were used as guiding principles during the implementation of all the pilot projects. These include consultation, multi-stakeholder involvement, empowerment and participatory approach.

(iii) How the pilot projects were evaluated

Health program evaluation is concerned with decisions regarding the implementation, continuation or adoption of a program (Simons-Morton et al, 1995). The types of decisions to be made from the results of an evaluation have led to the identification of three categories of evaluations: (1) diagnostic, (2) formative, and (3) summative. Diagnostic evaluation forms part of the needs process. It is commonly applied to groups to determine what they most need in the form of knowledge, attitude change or behaviour change. Formative evaluation is carried out partway through the program or intervention process to identify any adjustments during implementation. Summative evaluation takes place after the program is completed in order to determine whether the program should be continued or to identify needed modifications prior to the program's next use.

Others (Greene & Kreuter, 1991) have described three levels of evaluation: (1) process evaluation, (2) impact evaluation and (3) outcome evaluation. Each level asks a different question about the program or activity, and considers different indicators. Although any one of the three may be used exclusively under certain conditions, two or all three are often used
in combination. Process evaluation asks, “how well is the program being implemented?” For programs directed to individual-level behaviour change, it involves a review of the program’s external features such as training level of instructors, quality of materials and resources, instructional plans, time management and the participation rate. Some program managers evaluate resources (input evaluation) and short-term results (outputs) separately. The purpose of impact evaluation is to assess changes in knowledge, attitudes, beliefs, values, skills, behaviours and practices as a result of the intervention (Simons-Morton et al, 1995). Outcome evaluation, on the other hand, measures improvements in health or social factors as a result of the program or intervention. Principles of epidemiology are important in the design of the health outcomes study.

Each of the four pilot projects in this study was evaluated by both the project participants and by the PHC professionals. A non-experimental evaluation design was used to study and to analyze the perceptions of participants (the target community) and those of the health professionals regarding the planning, implementation and potential benefits of each of the four community participation projects. The approach used during the evaluation of pilot projects involved systematic gathering of evidence regarding the project’s implementation or success. The evaluation involved the analysis of the perceptions of participants and health professionals in respect of the projects’ application of identified core principles of community participation which are inter-sectoral collaboration, consultation and empowerment. A questionnaire used to evaluate the pilot projects included three main indicators of community participation:

- Engagement of stakeholders
- Empowerment of participants with knowledge and skills and
- Participatory approach

Furthermore, each project was evaluated by PHC professionals through focus group discussions to assess the experiences, perceptions and opinions of PHC stakeholders about the implementation of the four projects. One focus group discussion was held in uThungulu district for the two pilot projects, namely the anti-teenage pregnancy campaign and the training of the clinic committee. The focus group discussion held in eThekwini District evaluated the facilitation of the health promotion project and the establishment of the patient support group.

(iv) Evaluation of the project: Training of the clinic committee

The initial evaluation of this pilot project involved the statistical comparison of the knowledge of committee members before and after the training. The evaluation focussed on the impact
of training on the knowledge of the committee members with regard to the duties of the committee and the understanding of the clinic’s referral system. The participants were also assessed on the understanding of basic budgeting, human resources principles as well as standards of care in the health facility. The training of the clinic committee was also evaluated by means of a post-training written questionnaire to assess the members’ perceptions of project implementation and impact (see appendix 17). The participants were asked to rate, (using “good”, “average” and “below average” measures), their satisfaction about the process followed during the project facilitation as well as the information gained.

(v) Evaluation of the project: Anti-teenage pregnancy project

The Anti-teenage Pregnancy Project was implemented in Velangaye High School in Nkandla sub-district. This school-based project was evaluated through the assessment of the impact of the project on the knowledge of learners. The knowledge of learners regarding pregnancy, reproductive health issues as well as prevention of sexually transmitted infections and HIV, was assessed at baseline and after the 6-month empowerment project. Only learners who participated in all health education sessions, were selected to participate during the post-project assessment. In addition to the evaluation of the impact of the project on the knowledge of learners, the evaluation questions were also administered to educators and members of the School Governing Body (SGB) in order to evaluate their perceptions about the project usefulness and acceptability. These participants were further asked whether or not, according to their opinions, the “X-Press Anti-Teenage Pregnancy Campaign” had the potential to reduce the teenage pregnancies in the future (see appendix 19).

(vi) Evaluation of the project: Diabetes health promotion project

The implementation of the diabetes pilot project was evaluated by the health workers who attended the project. These participants were comprised of nurses, dieticians, pharmacists, and other health professionals. The evaluation of the facilitation of the health promotion project was through a self-administered questionnaire and was based on the project standards which included effective planning, sufficient consultation and collaboration, quality presentation of health promotion messages, participatory approach during facilitation and screening of participants to identify persons who required follow-up medical care (see appendix 20).
(vii) Evaluation of the project: Establishment of the patient support group

The intended outputs of the patient support group were the empowerment and encouragement of diabetes patients to play an active role in their treatment. To achieve these outputs, members were encouraged to attend regular support group meetings, to share health information and experiences as well as to adhere to their treatment plans. The establishment of the patient support group was evaluated through the assessment of the perceptions of group members about the project usefulness. The evaluation was conducted after the members of the support group had been trained and after they had attended their first meeting. Using a written questionnaire, the members of the support group were asked to rate, on a scale “good”, “average” and “below average”, the usefulness of the training they attended as well as the quality of information they received during the support group meeting (see appendix 21).

(viii) Evaluation of all projects by PHC professionals

All four pilot projects were further evaluated by means of group discussion with PHC professionals (see appendix 22). The PHC professionals were clinic professional nurses and district based PHC co-ordinators who were purposely invited to participate in the discussion and evaluation of all the pilot projects. The planning, processes and outputs of each project were presented to a group of PHC professionals in order for them to assess the implementation of the project and to provide inputs for the implementation of similar projects in the future. The group evaluation of the projects focussed on the planning, the implementation aspects of the projects as well as on their compliance with core principles of community participation, which had been identified as inter-sectoral collaboration, consultation, empowerment and community mobilization. After the projects had been presented and their implementation discussed, the participants were asked to discuss and report back on the following questions:

The details of the evaluation of each pilot project are shown in the evaluation questionnaires (appendices 16 – 21)

3.4 DATA ANALYSIS

In analysing data from the situational analysis, the researcher used both the deductive and inductive data analysis approaches (Burnard et al., 2008). In their paper “Analysing and presenting qualitative data”, Burnard et al. describes deductive analysis as the use of a structure or predetermined framework to analyse data. In this approach, the researcher uses a theoretical frame as reference for analysing interview transcripts. The researcher found
this approach useful in this study because community participation processes and challenges have been extensively studied elsewhere and the researcher wanted to analyse the extent to which these approaches and challenges applied to the KwaZulu-Natal health context. As opposed to the deductive approach, the inductive approach does not rely on predetermined theory, structure or framework but it uses only the data to create the structure for the analysis. Although the literature review on community participation approaches was extensive, the researcher found the inductive approach useful in order to limit bias and to understand context specific issues that might not have been described in the international literature.

For deductive analysis of the phase one data the researcher relied on several theoretical propositions which were illustrated within the study’s conceptual framework (fig.10). The first proposition involved an assertion that community participation approaches should include one or more of the following systems and methods:

- Stakeholders, which include health professionals, community members as well as participatory structures such as hospital boards, clinic committees and community advisory committees.
- Activities for involving communities in health services
- Empowerment of the community
- Methods through which communities participate in health services
- Advocacy for health and development
- Inclusiveness in service delivery
- Shared responsibility for health by health professionals and communities
- Partnership between service providers and communities

The second assertion within the study’s analytical framework is that previous studies have already identified challenges of community participation which in most cases included lack of community empowerment, inadequate responsiveness of the health system, attitudes of health professionals and inadequate resources. The design of the situational analysis questionnaires sought to infer the extent to which the health department implemented the community participation initiatives and to establish the nature of challenges to community participation initiatives within the health system. Each of these theoretical frames influenced the study’s conceptual framework and it is these theoretical frames that were used when engaging in the data analysis.

Relying upon the previously stated theoretical frames, the researcher engaged in data analysis surrounding explanation building (Yin, 2009) where the goal was to “analyse each
case study by building an explanation about the case” (p141). The above analysis was based on the inductive data analysis methodology. The first part of the analysis focussed on the first research question, namely the identification of inputs, systems and processes of community participation in the KwaZulu-Natal's PHC system. Qualitative data which arose in response to “how” questions and other follow-up questions were analysed using the inductive data analysis methodology. Such questions include “what the participant understands by community participation”, “how the participant promotes advocacy for health”, “how the health facility involves communities in health”, “what community participation challenges the participant or facility is experiencing” etc. This data was coded and thematically analysed through ATLAS.Ti. This data analysis followed the Thomas’s five-step process of qualitative data analysis (Thomas, 2006):

- Step 1: In line with the research objectives, the researcher read through the transcripts a multiple time and reflected on the overall meaning to gain a general sense of the information and ideas that the participants conveyed.
- Step 2: The researcher began the coding process by organizing material into segments and into categories.
- Step 3: The researcher used the coding process to generate codes for the descriptions, which then led to generalizing a smaller number of categories.
- Step 4: The researcher then reorganized the themes in a way that they would be represented in the qualitative narrative.
- Step 5: The researcher interpreted the meaning of data. During the interpretation, the researcher focussed specifically on what the participants said, the perceptions they had, their experiences and examples they mentioned.

Using critical narrative review, the findings were further interpreted to illustrate the degree and extent of partnership between health professionals and communities in the health facilities.

Furthermore, deductive analysis of findings was carried out to illustrate the extent to which previously identified community participation models or practices were applicable to the KwaZulu-Natal primary health care system. Deductive analysis was used to identify and assess the knowledge of participants against the literature based practices of community participation such as advocacy, ownership, social mobilization, partnership and empowerment. The deductive analytic approach was also employed in the analysis of the extent of stakeholder engagement and in identifying health promotion campaigns that were
being implemented by health facilities as part of the annual health calendar. All observation data was collated and analysed against the observation checklist to understand processes followed by health professionals during the facilitation of health promotion projects.

Phase 2 data from the focus group discussions was thematically analysed to identify the inputs, systems and processes that were regarded as essential for effective community participation. Inputs include stakeholders, resources and other ingredients necessary for community participation. Processes refer to methods and approaches that promote community participation in the health system. The systems considered during the analysis included the platforms available or required to support community participation. The thematic categories from the analysis were interpreted and accepted as the building blocks for the subsequent drafting of the community participation model and for the identification of pilot projects.

The analysis of phase 3 data focussed mainly on the evaluation of the implementation processes for the pilot projects. The analysis of the processes used to implement the pilot projects followed a combination of deductive and inductive approaches (Burnard et al., 2008). Burnard et al. defines the deductive approach as the use of a structure or predetermined framework to analyse data. In the inductive approach, there is little or no pre-determined theory, structure or framework. The inductive approach uses the actual data as the only reference to derive the structure of the analysis. The common conceptual principles that underlined the implementation of all pilot projects were consultation of stakeholders, participatory approach and empowerment of the target community with health knowledge. These principles were used to develop indicators for the evaluation of the pilot projects by participants and by the focus group of PHC professionals. The deductive approach to the evaluation of pilot projects relied mostly on process indicators such as the involvement of stakeholders, impact of the project on the knowledge of participants and the use of participatory approach in each of the four projects. The impact of the clinic committee training and the anti-teenage pregnancy projects on the knowledge of participants was analysed quantitatively by comparing the level of their knowledge before and after the projects. The evaluation questionnaires also allowed for the analysis of perceptions and comments of the participants. For this inductive analysis, open coding was used as the main method of data analysis. ATLAS.TI was used to categorize data, to develop themes and to analyse relationships and comparisons between information gathered.
3.5 FINALIZATION OF THE MODEL

The lessons from the assessment of existing processes of community participation as well as from the implementation of the pilot projects were used as inputs and foundation for the design of the community participation model for the KwaZulu-Natal health system. Upon the analysis of the existing systems and processes as well as the lessons learned from the implementation of pilot health promotion projects, a researcher-facilitated consultative workshop was held with a multi-disciplinary team of health care managers. The workshop was attended by 15 professional nurses, 4 hospital CEO’s and 6 municipal officials. The aim of the workshop was to identify key components of the community participation framework for the primary health system. During this consultative workshop, the summary of the findings of the situational analysis and the evaluation of pilot projects, was presented to the participants. During the break-away sessions, participants were asked to reflect on the existing systems and processes of community participation and to identify specific activities as well as performance indicators for the involvement of communities in the KwaZulu-Natal PHC system. The breakaway task teams addressed the following aspects of community participation:

*Group 1:* Based on the findings of the situational analysis of community participation, what can we consider to be the systems that can be used to develop the model of community participation for the KwaZulu-Natal primary health care system?

*Group 2:* Based on the findings of the situational analysis of community participation, what can we consider to be the processes that can be used to develop the model of community participation for the KwaZulu-Natal primary health care system?

*Group 3:* Which routine activities that can be implemented, and what performance measures can be used by health providers to encourage community participation at different levels of the primary health care system?

*Group 4:* Which routine activities that can be implemented, and what performance measures can be used by communities to encourage community participation at different levels of the primary health care system?

The feedback from each task team was discussed by all participants and further inputs were incorporated in the final report. The inputs and recommendations of the workshop were recorded by the appointed participant on the flip charts.
The following table summarizes the processes followed by the study in developing the community participation model, based on the existing and proposed systems and processes of community participation in KwaZulu-Natal PHC system:

<table>
<thead>
<tr>
<th>Existing systems and processes of community participation</th>
<th>Suggested systems and processes of community participation</th>
<th>Model to guide community participation and to monitor its implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong></td>
<td><strong>Phase 2</strong></td>
<td><strong>Phase 3</strong></td>
</tr>
<tr>
<td>• Situational analysis of community participation in the KwaZulu-Natal primary health care system</td>
<td>• Consultative process for the identification of the components and key processes necessary for the ideal community participation model</td>
<td>• Implementation and evaluation of pilot health promotion projects • Finalization of the model and guidelines for its implementation</td>
</tr>
<tr>
<td><strong>Assessment of health promotion projects; Interview of officials and representatives of communities</strong></td>
<td><strong>Consultation of PHC stakeholders in the identification of model components and pilot projects</strong></td>
<td><strong>Training of clinic committee Anti-teenage pregnancy project Diabetes awareness project Patient support group project Community participation model</strong></td>
</tr>
</tbody>
</table>

**Figure 11:** The three phases of the study

### 3.6 TRUSTWORTHINESS

As opposed to quantitative research, which relies on measures of reliability and validity, qualitative research can be evaluated by its “trustworthiness”. Trustworthiness includes (1) credibility, (2) transferability, (3) dependability and (4) confirmability. (Lincoln & Guba, 1985).

**Credibility**

Miles and Huberman (1994) suggested that research results be scrutinized according to three basic questions: (1) Do the conclusions make sense?, (2) Do the conclusions adequately describe research participants perspectives? and (3) Do conclusions authentically represent phenomena under study?. The researcher used triangulation in
various data collection processes to enhance credibility of this study. Lincoln and Guba (1985) describe triangulation as the collaboration of results with alternative sources of data. In this study, data was collected from both health professionals and from community representatives. Furthermore, the evaluation of projects was done by both participants and by PHC professionals.

**Transferability**

Similar to the concept of generalizability in quantitative studies, transferability seeks to determine if the results relate to other contexts and can be transferred to other contexts (Miles & Huberman, 1994). To enhance transferability of the findings, the analysis of community participation in KwaZulu-Natal was based on national and international theoretical frameworks which were used as reference during deductive data analysis.

**Dependability**

Similar to the concept of external validity in quantitative studies, dependability refers to whether or not the results of the study are consistent over time and across researchers (Lincoln & Guba, 1985). To ensure dependability of findings in this study, the data collection questionnaires used to collect situational analysis data were designed specifically for each category of participants, such as hospital CEO’s, clinic managers, caregivers, community members and so on. The design and questions for each participant category took into account the nature of the participant’s role and their experiences in community participation. In this way, the findings were analysed according to the category of participants and they are therefore more likely to be reproducible.

**Confirmability**

Confirmability ensures that the findings are reflective of the participants’ perspectives as evidenced in the data, rather than the researcher’s perception. This study was conducted in four districts within the KwaZulu-Natal Department of Health. The data for the situational analysis was collected from participants at different levels of the PHC spectrum and, in the case of hospital boards and clinic committees, records of their activities were reviewed to improve the objectivity of the data collected.

**The person of the researcher**

The researcher’s educational and professional background in health policy was instrumental during the implementation of this study. Whilst working as a hospital CEO in the KwaZulu-Natal Department of Health, the researcher developed passion for community participation. Data obtained during the situational analysis, including information gathered during the
consultative processes, was verified for authenticity and relevance against the Department’s policies and procedures.

3.7 THE SCOPE OF THE STUDY

Many public health researchers have attempted to study the effect of community participation on health outcomes. However, there is no agreement among planners and professionals about the contribution of community participation to health improvements (Rifkin, 2001). Despite this disagreement, community participation has continued to be promoted as a key to health development. In South Africa and KwaZulu-Natal, there are many programmes and activities that encourage involvement of communities in health planning and development. Health promotion, as an essential component of the primary health care system, is used by health professionals to encourage healthier lives for their target communities. Whilst it may be difficult to prove the beneficial effect of community participation on health outcomes, it is possible to demonstrate the potential benefits of community participation on health promotion. Through the piloting of participatory health promotion projects, this study demonstrated the role of community participation principles on health promotion. This study may be useful, therefore, in improving the understanding of community participation approaches by health professionals and by community members.

3.8 ETHICAL CONSIDERATIONS

In the past, reports have documented research participants encountering physical and psychological harm during the research process (Slowther, 2006). One of the international ethical codes of conduct in healthcare research is to promote benefits to the participants directly or to the wider population and the benefits should significantly outweigh potential harm to the participants. The principles of justice, honesty and integrity have been widely highlighted by authors. In weighing up the risk to benefit balance in research, the following principles (Scott et al., 2002) should be taken into account:

- The importance, originality and topicality of the research question
- The scientific validity of the study
- The likelihood of achieving meaningful results
- The potential impact on participants, the local community, the disease group or the global community
- The potential risks to participants and researchers
In view of these ethical principles, this study was conducted in line with the need to respect human rights, which included right to dignity, right to informed consent as well as right to privacy and confidentiality. The study received ethical approval from the University of the Western Cape Ethics Committee and the KwaZulu-Natal Department of Health granted permission for data collection to be conducted in its health facilities. Participants, including focus groups, gave voluntary consent for participating in the study. Participation was free and voluntary at all stages of the study. Participants were informed of the nature and intention of the study in their language of choice. The participants were further informed of their right to withdraw from the process at any stage of the project. Participants were informed about the nature and purpose of the study, and that there was no harm or risk involved during their participation. Participants were assured of their privacy, confidentiality and anonymity of any information provided. Codes were used to protect participants’ identities when results were captured. The information acquired through this research was kept in secured lockers and access to electronic versions of data was controlled through access codes.
3.9 SUMMARY

The study “Development of the Public Health Model of Community Participation in the KwaZulu-Natal PHC”, was implemented in four sub-districts in KwaZulu-Natal. The goal of the study was to explore how the existing systems and processes of community participation could be used to strengthen health promotion projects and to develop the community participation model for the primary health care system.

This qualitative study was undertaken in three phases, namely (1) situational analysis, (2) identification of the components of the community participation model as well as the (3) implementation and evaluation of pilot projects. The situational analysis of community participation was conducted at various levels of the primary health care system as per the study design. Both health service providers and representatives of communities participated in the study. The situational analysis was followed by the consultative process in which PHC professionals contributed to the identification of the systems and processes that supported community participation in KwaZulu-Natal health system. Four community participation projects, namely the training of the clinic committee, the anti-teenage pregnancy campaign, the diabetes health promotion project and the support group project, were also proposed. These pilot projects were implemented and evaluated during phase three of the study.

Based on the analysis of the findings of the situational analysis and considering the outputs of the pilot community participation projects, the community participation model was developed.
CHAPTER 4
FINDINGS

4.1 INTRODUCTION

The assessment of the existing systems and processes of community participation in the KwaZulu-Natal PHC system was guided by the following objectives:

- To identify sectors, organizations and other governmental departments that work with the KwaZulu-Natal’s health Department in the delivery of PHC services
- To identify community structures that participate in the department’s PHC system
- To assess knowledge and understanding of community participation by providers of primary health care services
- To assess knowledge and understanding of community participation by communities
- To identify methods used by the health Department, as a service provider, to involve communities in the PHC system
- To identify methods used by the community participation structures to involve communities in the PHC system
- To identify methods by which communities participate in the KZN’s PHC system
- To assess how the health promotion projects are facilitated by health professionals at PHC level
- To identify challenges of community participation in the PHC system

This chapter presents the findings of the study. These are presented in the following three sections: Phase 1 (findings of the situational analysis), Phase 2 (identification of the model inputs and pilot health promotion projects) and Phase 3 (implementation and evaluation of pilot health promotion projects).

4.2 PHASE 1: FINDINGS OF THE SITUATIONAL ANALYSIS OF COMMUNITY PARTICIPATION

The findings of the situational analysis represent answers to the first research question: “What are the existing systems, processes and challenges of community participation in the KwaZulu-Natal primary health care system?” The respondents of phase 1 of the study are displayed in table 3.
### CHARACTERISTICS OF THE SAMPLE FOR THE SITUATIONAL ANALYSIS

<table>
<thead>
<tr>
<th>Service providers</th>
<th>Sample size</th>
<th>Age (yrs)</th>
<th>Highest qualification</th>
<th>Ethnicity: African Coloured Indian White</th>
</tr>
</thead>
<tbody>
<tr>
<td>District managers</td>
<td>4</td>
<td>35 – 56</td>
<td>Postgrad degree=4</td>
<td>A=4</td>
</tr>
<tr>
<td>Hospital CEO’s</td>
<td>8</td>
<td>39 – 60</td>
<td>Postgrad degree =8</td>
<td>A=4</td>
</tr>
<tr>
<td>Clinic managers</td>
<td>16</td>
<td>27 – 53</td>
<td>Postgrad degree =7</td>
<td>A=4</td>
</tr>
<tr>
<td>Community Care Givers</td>
<td>16</td>
<td>23 – 68</td>
<td>Matric=16</td>
<td>A=4</td>
</tr>
<tr>
<td>Directors of community services</td>
<td>4</td>
<td>42 – 55</td>
<td>Degree=2</td>
<td>A=4</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community representatives</th>
<th>Sample size</th>
<th>Age (yrs)</th>
<th>Employment</th>
<th>Ethnicity: African Coloured Indian White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipal counsellors</td>
<td>4</td>
<td>48 – 65</td>
<td>Politician=4</td>
<td>A=3</td>
</tr>
<tr>
<td>Chairpersons of hosp. boards</td>
<td>8</td>
<td>40 – 66</td>
<td>Teacher=3, Business=3, Unemployed=2</td>
<td>A=3</td>
</tr>
<tr>
<td>Chairpersons of clinic committees</td>
<td>10</td>
<td>50 – 69</td>
<td>Business=2, Unemployed=8</td>
<td>A=10</td>
</tr>
<tr>
<td>Community members</td>
<td>32</td>
<td>30 – 61</td>
<td>Teacher=6, Business=6, Other=8, Unemployed=12</td>
<td>A=18</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 3:** Characteristics of participants during the situational analysis

The above table shows that the majority of participants representing service providers were African between 23 and 68 years of age who possessed a tertiary qualification. The participants representing community groups were mostly African between 30 and 69 years who were either unemployed or self-employed.
The following table summarizes the findings of Phase 1 of the study:

<table>
<thead>
<tr>
<th>Objective of Phase 1</th>
<th>Summary of the findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating sectors, organizations and community structures</td>
<td>Multi-sectoral committees, municipalities, schools, District Health Councils, hospital boards, clinic committees, CBO's, traditional authorities, churches, prisons, traditional health practitioners, business, sports organizations, youth organizations, culture organizations, patient support groups, disabled persons organizations</td>
</tr>
<tr>
<td>Knowledge of community participation by service providers</td>
<td>Adequate understanding of advocacy, ownership, social mobilization, empowerment and partnership</td>
</tr>
<tr>
<td>Knowledge of community participation by community representatives (municipal counsellors, chairpersons of hospital boards and clinic committees)</td>
<td>Adequate understanding of advocacy, empowerment and partnership. Inadequate understanding of ownership and social mobilization</td>
</tr>
<tr>
<td>Knowledge of community participation by community members</td>
<td>Adequate understanding of empowerment and partnership. Inadequate understanding of advocacy, ownership and social mobilization</td>
</tr>
<tr>
<td>Methods of involvement by service providers</td>
<td>Training of communities, health awareness days, multi-sectoral committee meetings, hospital boards and clinic committees, school health services, co-management of facilities improvement projects, outreach services (environmental health services, community care givers and family health teams)</td>
</tr>
<tr>
<td>Methods by which community structures/representatives involve communities in health</td>
<td>Advocacy and routine communication with health facilities and communities</td>
</tr>
<tr>
<td>Methods through which communities participate in health</td>
<td>Health seeking, self-help health promotion</td>
</tr>
<tr>
<td>How health promotion projects are facilitated</td>
<td>Resources allocation is inadequate, uses “top-down” education of participants, lack of skills education of participants, inadequate interaction or participatory approach, poor referrals and follow-up of screened participants</td>
</tr>
<tr>
<td>Challenges of community participation for service providers</td>
<td>Lack of interest by communities. Lack of training on community participation. Inadequate resources. Lack of support systems for community participation</td>
</tr>
<tr>
<td>Challenges of community participation for communities</td>
<td>Low socio-economic level. Unsatisfactory delivery of health services. Lack of recognition of communities by health authorities. Lack of incentives to encourage participation</td>
</tr>
</tbody>
</table>

**Table 4: Summary of the Phase 1 findings**
4.2.1 SECTORS, ORGANIZATIONS AND OTHER GOVERNMENTAL DEPARTMENTS THAT WORK WITH THE KWAZULU-NATAL'S HEALTH DEPARTMENT IN THE DELIVERY OF PHC SERVICES

The main interview question for the identification of the department's stakeholders was “which governmental and non-governmental role players does your health facility or health office work with in the planning and delivery of health services?”. Of the 28 health officials interviewed (CCG’s excluded), 6 managers mentioned internal stakeholders which included matrons, medical manager, quality assurance manager, public relations officer and pharmacy manager. During the analysis, these 5 “role players” were not accepted as entities that represented inter-sectoral collaboration in the context of community participation, and they were therefore excluded in the final category list. The responses from 22 respondents were coded into 3 thematic categories of role players: war rooms, municipality and no role players.

(i) War rooms

“War rooms” are multi-sectoral committees that had been established by the KwaZulu-Natal government to coordinate service delivery of all government departments at all levels of governance. War rooms were mentioned by 8 respondents as participatory structures with which they planned health services. The war rooms, or Task Teams as they are sometimes called, were comprised of government departments, NGO’s, CBO’s, community leaders and other community representatives. They operated at district (District Task Team), sub-district (Sub-District Task Team) and community (Ward Task Team) levels. When asked about the role of the “war rooms” in the planning of health services, one hospital CEO responded that:

“There are many social determinants of health and disease. Other service providers should also be involved in promoting health; for example the department of transport should ensure that people have roads in order to access health services”

Participants reported that their health facilities participated in the multi-sectoral committees and that members of the committees were seen by service providers as part of the strategy for the delivery of primary health care services at local level. This view is represented by the following response from one of the clinic managers

“It is a requirement for clinic managers to represent the health department in the sub-district multi-sectoral task team, in order to report health plans to community leaders and representatives”.

http://etd.uwc.ac.za
(ii) Municipalities

Six hospital representatives mentioned that they involved the municipal officials during their strategic planning process. In some hospitals, the municipal officials were participating as members of the hospital boards. The hospital plans were also required by some local municipalities as part of the inputs for the municipality’s integrated development plans. The role of the municipality in the planning and delivery of primary health services is illustrated by the following response from the hospital CEO:

“The hospital plans provide inputs into the Integrated Development Plans and vice versa. When we plan health services we therefore involve municipality officials such as Director of Community Services and Counsellors”.

(iii) No role players

Fourteen health officials reported that their health facilities were not involving any external stakeholders in their planning. Many responses suggest that the planning of health services is confined to health facility managers. The following quote from one respondent illustrates this finding:

“The hospital management team comprising of myself the hospital CEO, Nursing Manager, Finance manager, Systems Manager, HR Manager and departmental representatives is responsible for strategic and operational planning of the hospital”.

It appears from these responses that there was very little input, if any, that was contributed by other sectors and organizations to the planning and delivery of health services at primary health care level.

4.2.2 COMMUNITY STRUCTURES THAT PARTICIPATE IN THE DEPARTMENT’S PHC SYSTEM.

The findings presented in this section are based on both the inductive and deductive analysis of responses from participants in both study districts in KwaZulu-Natal. When asked “which community structures does your health institution regularly work with, in health service delivery?”, the respondents mentioned various community stakeholders, which were interpreted, categorized and reduced into two themes: community participation structure and community. These were then used to categorize responses from all interviews. The community participation structures were represented by appointed hospital boards and clinic committees. The theme community was given to a group of individuals, representatives or
members of an organisation who shared common interests, goals or health destiny. The “school”, for example, was categorized as the “community”.

(i) Community participation structure

In this study, the hospital boards and clinic committees emerged as the most important community structures that were recognized by health officials as partners in service delivery. The involvement of hospital boards and clinic committees in the delivery of health services, was reported by 7 hospital CEO’s and by 10 clinic managers, respectively. One of the clinic managers stated:

“The community we serve is represented in the clinic by the elected representatives who participate in the clinic committee and such committee is involved in the oversight of clinic performance on daily basis”.

The nature and degree of involvement of hospital boards and clinic committees by health professionals was not assessed in this study. However, all managers who reported to be involving hospital boards and committees regarded active participation of these forums as involvement in the governance of health facilities.

(ii) Community

All respondents reported to be “working” with communities in the delivery of services. This “working together” was understood by participants mostly as the involvement of communities in the planning and implementation of health promotion programmes. The school community was reported as a major beneficiary and partner in the PHC system. Many study participants reported that “we have a school health service…”. Every hospital in the study had a functional school health service, which was part of the annual operational plan of the institution. Other segments of the communities that were reported to be participating in local health services were traditional health practitioners, traditional leaders and to a limited extent, the CBO’s. A community care giver in one sub-district stated:

“In our sub-district we work closely with Nkandla HIV/AIDS Network, which is a network of community organizations that promote healthy living in the communities”.

Examples of communities, as per the general profile of most communities, were also used to verify the extent to which communities were being involved by their local health facilities. This data collection approach was used to validate initial data and to compensate for possible gaps in the understanding of the term “community” by different categories of participants. The findings presented in table 4 show that the community participation
systems in the KwaZulu-Natal were not adequately capacitated to cater for different categories of communities.

The findings in table 5 show that only CBO’s, schools, traditional health practitioners, business community and youth organizations were participating in health services at the district health level. At district level, where PHC services were coordinated, the study found minimal partnership between health officials and communities. Although there was some interaction through the governmental multi-sectoral committees (District Task Teams), health services were not planned or coordinated jointly with community representatives. The emergency medical services (EMS) were coordinated and managed at district level in both study districts, and the district managers for emergency medical services reported no involvement of communities in the EMS programmes in both districts. Participation by communities at hospital and clinic level, however, was broader, as shown by a slightly bigger proportion of hospitals and clinics which involved community sectors such as traditional leaders, schools, traditional health practitioners, youth and patient support groups. Noticeably, the churches, prisons and disabled organizations did not feature in the plans of any health facility.
<table>
<thead>
<tr>
<th>Community Structure</th>
<th>District Health Managers (n=4)</th>
<th>Hospitals (n=8)</th>
<th>Clinics (n=16)</th>
<th>CCG’s (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Traditional Authorities</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>2. CBO’s</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>3. Schools</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>4. Churches</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>5. Prisons</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Traditional Health Practitioners</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7. Business</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>8. Sports organizations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>9. Youth organizations</td>
<td>2</td>
<td>3</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>10. Culture organizations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>11. Patients Support Groups</td>
<td>0</td>
<td>8</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>12. Elderly organizations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13. Disabled persons organizations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14. District Health Council</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>15. Hospital Boards</td>
<td>N/A</td>
<td>7</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>16. Clinic Committees</td>
<td>N/A</td>
<td>N/A</td>
<td>11</td>
<td>16</td>
</tr>
</tbody>
</table>

**Table 5:** Health workers and health facilities who involved different categories of communities in their programmes

All hospital CEO’s stated that they provided services to all communities “when needed” them. Most health managers recognized mainly the hospital boards, clinic committees, patient support groups and schools as their regular partners in service delivery. Although the patient support groups were reported as partners in service delivery, many health officials mentioned that the support groups were not as functional as they should be. The community care givers reported broader interaction with their communities. One community care giver stated:
“We as the CCG’s do not have so-called target communities in our worklist but we interact with a variety of communities from individuals to schools, including churches and community organizations”

This category of health workers was more accessible to CBO’s, schools, churches, traditional leaders as well as community organizations such as youth and sports organizations.

4.2.3 KNOWLEDGE AND UNDERSTANDING OF COMMUNITY PARTICIPATION BY PROVIDERS OF PRIMARY HEALTH CARE SERVICES

Considering that the involvement of communities is mostly dependent on health officials, one of the focus areas of this study’s situational analysis was the assessment of the understanding of community participation by officials. The study sought to determine how the understanding of community participation was shaping community participation processes in the health system. The question “what do you understand by community participation in health”, was administered to officials who represented the providers of PHC services.

All officials responded by providing their definitions of community participation. Upon the reading of all transcripts, codes were developed. The codes were categorized into 2 clusters. A core cluster contained 3 elements or themes: working together, mutual support and community taking responsibility for their own health. A second cluster centred on six elements that reflected existing systems and processes of community participation. Instead of defining community participation, some respondents mentioned activities and examples of systems and processes of participation which were coded as social mobilization, advocacy, empowerment, community participation forums, appointed community representatives as well as complaints/compliments/suggestions mechanisms.

Except for their level of detail and examples used, there were no differences in the degree of the understanding of community participation processes and initiatives among the 5 participant groups. This is partly because of the self-explanatory nature of the term “community participation” itself, and the fact that community participation was, directly or indirectly, part of the work responsibilities of every participant. While all institutional health managers mentioned hospital boards or clinic committees as essential components of community participation, the district managers and directors of community services referred mostly to the governmental level multi-sectoral committees, or service delivery task teams as powerful vehicles for involving and mobilizing communities. The following statement from the director of community services is worth quoting:
“Community participation should involve profiling of community needs through Operation Sukuma Sakhe (multi-sectoral committees) and service delivery departments should work together with communities at local level.”

The knowledge of community involvement by community care givers was mostly influenced by their responsibilities and experiences in the field. This category of participants interacted more with communities and, as such, the majority of them identified advocacy activities as essential in community participation. None of the respondents demonstrated comprehensive understanding of community participation, which should include inter-sectoral collaboration (identification of stakeholders), involvement processes by both the officials and by communities as well as the role and anticipated benefits of community participation in the health system. When the participants were requested to rate the degree to which they agreed with a series of statements or examples of community participation, there was variability in the understanding of advocacy, ownership of health, social mobilization, empowerment and partnership among the five participant groups (table 6).

The district managers demonstrated good understanding of the various principles and approaches to community participation. Based on their responses to the “advocacy”, “empowerment” and “partnership” statements on the questionnaire, all district managers displayed correct understanding of community advocacy and ownership of health by communities. The concept of “ownership” of health was however, correctly interpreted by half of the district managers. The directors of community services, on the other hand, showed limited knowledge and understanding of various community participation methods.
## Table 6: Understanding of selected community participation principles by participating health officials.

<table>
<thead>
<tr>
<th>Community Participation principle</th>
<th>District managers (n=4)</th>
<th>Directors of community services (n=4)</th>
<th>Hospital CEO’s (n=8)</th>
<th>Clinic managers (n=16)</th>
<th>Community care givers (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No. of officials who correctly understood “advocacy”</td>
<td>4 (100%)</td>
<td>2 (50%)</td>
<td>8 (100%)</td>
<td>8 (50%)</td>
<td>10 (62.5%)</td>
</tr>
<tr>
<td>2. No. of officials who correctly understood “ownership”</td>
<td>2 (50%)</td>
<td>1 (25%)</td>
<td>6 (75%)</td>
<td>10 (62.5%)</td>
<td>8 (50%)</td>
</tr>
<tr>
<td>3. No. of officials who correctly understood “social mobilization”</td>
<td>1 (25%)</td>
<td>2 (50%)</td>
<td>7 (87.5%)</td>
<td>8 (50%)</td>
<td>6 (37.5%)</td>
</tr>
<tr>
<td>4. No. of officials who correctly understood “empowerment”</td>
<td>4 (100%)</td>
<td>4 (100%)</td>
<td>8 (100%)</td>
<td>16 (100%)</td>
<td>10 (62.5%)</td>
</tr>
<tr>
<td>5. No. of officials who correctly understood “partnership”</td>
<td>4 (100%)</td>
<td>1 (25%)</td>
<td>8 (100%)</td>
<td>16 (100%)</td>
<td>12 (75%)</td>
</tr>
</tbody>
</table>

35% of the directors of community services correctly understood the five community participation principles. Because of their municipal background, directors of community services regarded “ownership of health care” mostly as the need for local community members to be employed in health facilities.

The hospital CEO’s demonstrated good understanding of advocacy and ownership of health by communities. All hospital CEO’s correctly recognized advocacy as the need for communities to organize themselves and to motivate for the improvement in service standards and access to health care. The CEO’s also understood that self-help community projects, rather than employment opportunities, were the correct approaches for ensuring ownership of health and sustainable participation by communities. Similarly, the clinic managers showed good understanding of the various approaches for promoting participation by communities. All clinic managers knew that the involvement of clinic committees in planning and monitoring of health services was an example of partnership between clinics and their catchment communities. Although 33.5% of clinic managers believed that...
employment of local community members in the clinics could encourage ownership, all of them believed that the implementation of health-promoting projects was the correct activity for promoting co-ownership of health and for achieving primary health care goals.

The community care givers in general showed less understanding of the different approaches to community participation. Whilst the majority of them correctly understood “community advocacy” and “ownership of health”, their understanding of other methods of community participation was limited. The majority of community care givers understood routine communication of health information to communities as part of social mobilization. A third of the community care givers also believed that the assessment of health needs by visiting professional nurses constituted the empowerment of communities.

This study found no inter-district and inter-subdistrict differences in the understanding of community participation by health officials. Health officials in all sub-districts and health facilities of the KwaZulu-Natal Department of Health had not been trained on community participation and the department did not have a policy or guidelines for supporting community participation practices in the health facilities. The lack of training and guidelines for health facilities was likely a contributor to the inadequate understanding of community participation processes by most health officials.

4.2.4 KNOWLEDGE AND UNDERSTANDING OF COMMUNITY PARTICIPATION BY COMMUNITY REPRESENTATIVES AND COMMUNITY MEMBERS

Previous studies have illustrated that communities have a role to play in the health system. In view of this, the situational analysis of community participation in this study included the assessment of the understanding of community participation by communities in KwaZulu-Natal. Four categories of communities, namely municipal counsellors, chairpersons of the hospital boards, chairpersons of the clinic committees and ordinary members of the communities were interviewed. Of the 16 clinics visited, only 10 had functional clinic committees, hence data was collected from 10 committee chairpersons. Using the interview questionnaire, participants were asked to explain what they understood by community participation in the health system. Responses from all participants were thematically categorized into 2 clusters of elements or themes. The first cluster included working together and mutual support. In the second cluster, the descriptive elements included social mobilization, advocacy, empowerment and governance. The understanding of participation as the “working together” between health officials and communities was mentioned by 50 (92.6%) participants. One municipal counsellor described community participation as “The representation of communities in the affairs of the government”. All the chairpersons of hospital boards and clinic committees described participation as a two-way process,
characterized by empowerment of communities and support of health facilities by the community. The co-governance of health facilities by health managers and community representatives was also mentioned by most chairpersons of hospital boards and clinic committees as a critical element of community participation. The chairperson of the hospital board described community participation in the context of facility governance as follows:

"Health facilities belong to the community, therefore it is important for communities to participate in the running of their local health facilities, to support facility management and to hold health officials accountable for service delivery".

Advocacy for improved health services appeared in the descriptions of 68.8% of the community members. Although 87.5% community members who were interviewed in the households viewed community participation as means for promoting health, some community members understood community participation merely as the empowerment of poor people. The following quote from the interview participant living in an urban suburb was note-worthy. When asked about community participation, the participant responded:

"We are on our own here, and we don’t need the health department. The public health department is for poor people in the township, those are the people that need to be involved"

When the knowledge of community participation by community representatives was deductively assessed against specific principles of community participation, namely advocacy, community ownership, empowerment, social mobilization and partnership, the understanding of specific participation approaches by all categories of participants, was found to be limited among most participants (table 7).

Although the municipal counsellors played a big role in community involvement in all municipal areas, their understanding of various approaches to community involvement was limited. 75% of the municipal counsellors agreed that communities must stand up for their rights to access quality health services. However, many counsellors believed that empowerment of communities included recruitment of more community care givers and employment of local members of the communities. The chairpersons of the hospital boards showed good understanding of “community advocacy” and “partnership in health”. All chairpersons of the hospital boards agreed that the motivation for additional resources such as mobile health services, was an example of community advocacy and a recognition of the role of the community’s right to participate in the health services. 62.5% of the chairpersons of hospital boards, however, did not fully understand the social mobilization strategy in the context of health services. This proportion of community participants understood the
The communication of health information by health professionals to be an example of social mobilization.

<table>
<thead>
<tr>
<th>Community Participation principle</th>
<th>Municipal councillors (n=4)</th>
<th>Chairpersons of hospital boards (n=8)</th>
<th>Chairpersons of clinic committees (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No. of community representatives who correctly understood “advocacy for health”</td>
<td>3 (75%)</td>
<td>8 (100%)</td>
<td>8 (80%)</td>
</tr>
<tr>
<td>2. No. of community representatives who correctly understood “ownership of health”</td>
<td>0 (0%)</td>
<td>4 (50%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td>3. No. of community representatives who correctly understood “social mobilization”</td>
<td>1 (25%)</td>
<td>2 (25%)</td>
<td>3 (30%)</td>
</tr>
<tr>
<td>4. No. of community representatives who correctly understood “partnership in health”</td>
<td>1 (25%)</td>
<td>5 (62.5%)</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>5. No. of community representatives who correctly understood “empowerment”</td>
<td>2 (50%)</td>
<td>3 (37.5%)</td>
<td>2 (20%)</td>
</tr>
</tbody>
</table>

**Table 7: Understanding of selected community participation principles by participating community representatives.**

The analysis of responses from the chairpersons of clinic committees showed limited understanding of community approaches by this category of community representatives. Whilst 19 of the respondents correctly understood “community advocacy” and its role in community participation, less than 12 of them correctly understood such community participation principles such as “ownership”, “social mobilization”, “partnership” and “empowerment”.

In the study sample, the municipal councillors and chairpersons of hospital boards were more educated than the chairpersons of the clinic committees. Unlike the chairpersons of hospital boards who had just been trained, the chairpersons of the clinic committees had not undergone any training on the functioning of clinic committees. When asked about the activities that represented different aspects of community participation, most members of the communities correctly identified such activities as activities that could be used to improve their involvement in health care. The responses from community members are summarized in table 8 below.
Community Participation Activity | Community members who correctly understood the participation activity | Community members with incorrect understanding of the participation activity
---|---|---
1. Advocacy  
“Communities motivate for changes in health policies in order to improve services” | 7 (21.9%) | 25 (78.1%) |
2. Ownership  
“Communities take care and responsibility for their own health and for service delivery” | 24 (75%) | 8 (25%) |
3. Social mobilization  
“Communities form CBO’s and Support Groups to address health problems” | 30 (93.8%) | 2 (6.2%) |
4. Partnership  
“Communities work together with the health facility in planning and health promotion” | 32 (100%) | 0 (0%) |
5. Empowerment  
“Health professionals organize ongoing education of community members” | 32 (100%) | 0 (0%) |

**Table 8: Understanding of selected community participation activities by community members.**

The findings of knowledge assessment among community members show that communities in the study were aware of their rights to advocate for better service delivery, but their activities were not aimed at influencing health care policies. Only 7 respondents believed that communities could influence health policies through advocacy activities. Motivations for additional mobile clinics were among the most commonly mentioned examples of advocacy during the study. A quarter of community members were aware of their duty to take care of their own health through self-care and healthy lifestyles. The majority of community members seemed to understand social mobilization. 30 respondents understood the role of CBO’s and patient support groups as participation agents for addressing health problems in the communities. The CBO’s were reported to be implementing life skills training, community based interventions as well as healthy lifestyles education. The participants also mentioned that treatment compliance and adherence to therapy formed part of the community’s duties and responsibilities. In this regard the use of family members and community care givers to support patients and communities played a big role in encouraging ownership of health by communities. All participating community members responded positively to the need for partnership between health service providers and communities. However, apart from the hospital boards and clinic committees, many participants could not identify examples of other activities that could be used by communities to partner with health institutions. The participants mentioned several examples through which communities should be empowered.
These include the empowerment of communities on health skills such as the use of condoms, healthy nutrition, antenatal and postnatal care.

4.2.5 METHODS USED BY THE HEALTH DEPARTMENT, AS A SERVICE PROVIDER, TO INVOLVE COMMUNITIES IN THE PHC SYSTEM

The health officials were asked, during the interviews, how their health facilities involved communities in health care services. The follow-up question, which was to be used for the deductive analysis of the involvement processes, consisted of indicators of involvement: use of hospital boards and clinic committees, consulting communities through media or community leaders, outreach community visits and training of community members. Further questions were used to obtain details of the methods used by health professionals and health facilities to involve communities in health development. One such question investigated the extent to which hospital boards and clinic committees were being involved in institutional processes such as planning, handling of patient complaints and satisfaction surveys. Another question addressed the implementation of the health awareness calendar by the health facilities, training of patient support groups as well as community health practitioners such as traditional health practitioners and traditional birth attendants (see appendix 5).

All the 52 government officials who were interviewed, described the methods through which their institutions involved communities in health. Nine (9) descriptive elements were identified and these were categorized into 4 distinct themes that were represented in the responses of 5 or more respondents (table 9). These are provision of outreach community-based services, use of consultative and co-governance forums, empowerment of communities as well as involvement of communities in co-governance of improvement projects.
Table 9: Analysis of the methods used by health facilities to involve communities.

(i) Provision of outreach community-based health services

The use of community care givers was mentioned by 4 hospital CEO’s and 8 clinic managers as their means of involving communities in health. 7 hospital CEO’s and 2 district managers mentioned that School Health and Environmental Health Services were playing a useful role in involving communities and in improving accessibility of essential primary health care services for the communities. The study participants also mentioned that the health institutions were conducting outreach services to mobilize the communities. These included routine visits to the communities by medical professionals to conduct ophthalmic care, medical male circumcisions and management of chronic diseases. All hospital CEO’s and 5 clinic managers mentioned that the Family Health Teams were useful in involving
communities. The family health teams were part of the KwaZulu-Natal Department of Health’s latest initiative in response to the need to implement the national integrated strategy for conducting outreach health services to the communities. The newly introduced Family Health Teams, which were comprised of the nurses and other medical professionals conducted joint outreach visits to different communities on scheduled days. In this way the health professionals were able to share resources and the communities were benefitting from the increased package and accessibility to health services. Despite group differences in saliency, frequency and co-occurrence of the 3 involvement practices, the overall response pattern indicates that these core 3 practices were universally recognized within the PHC system, if not by every health professional. All themes reflected the practices followed by the health facilities and municipalities to encourage community participation.

Statements that community involvement was difficult were made by 10 health professionals across all sub-districts. Illustrating one obstacle to community involvement, the following is a statement from the clinic manager in a rural sub-district:

“We always try to encourage community members to participate in our health campaigns, but attendance is often limited to old women because the youth and men are away at work or at school during working days when we conduct these campaigns”.

When respondents were asked whether or not they the involvement strategies in the interview questionnaire, more respondents reported that their institutions were using such methods to involve communities. The checklist of involvement methods included (1) the use of hospital boards and clinic committees, (2) consulting of communities through community leaders, (3) use of health promotion campaigns to reach out to communities, (4) training of communities on self-care and (5) implementation of the health awareness calendar.

(ii) The use of consultative and co-governance forums

The multi-sectoral committees were described as service delivery structures in which all governmental departments, NGO’s, community leaders, CBO and other community representatives worked together to plan and to monitor all social services. These multi-sectoral committees were found to be functional in all four sub-districts that were selected for this study. The district manager of each health district participated in the district multi-sectoral committee. The hospital CEO’s and clinic managers participated in the sub-district and ward-level committees, respectively. The findings of this study showed that the health professionals were increasingly becoming reliant on these multi-sectoral committees as the main consultative forums for the health facilities and communities.
Although most health officials reported to be using the hospital boards and clinic committees for involving communities in the primary health system, this study did not find sufficient evidence that the hospital boards and clinic committees were effective platforms for involving wider communities in the health system. This is further illustrated in the review of the operations and functionality of the hospital boards and clinic committees (see section 4.2.6).

The role of hospital boards and clinic committees was found to be co-governance and support to the health facility, rather than the facilitation of health promotion in the communities. The extent to which the hospital boards and clinic committees were involved in the governance of the health facilities was found to be limited. This is shown by the deductive analysis of the involvement of hospital boards and clinic committees in planning, health awareness campaigns, handling of patient complaints and patient satisfaction surveys in the health facilities. The findings of the analysis reflect poor partnership between these community representatives and their local health facilities. None of the district managers was conducing health planning, health awareness campaigns or satisfaction surveys in collaboration with representative community forums. All clinics and 7 hospitals were not conducting their operational and strategic planning jointly with their clinic committees and hospital boards, respectively. Only one hospital and five clinics involved representative community forums (hospital boards and clinic committees) in the management of client complaints in their facilities. The joint visits by facility managers and community representatives to the facility service points, was reportedly conducted in 87.5% of hospitals and 68.8% of clinics. This was seen as a positive sign of the growing partnership between these health facilities and community representatives. The following statement from the participant in Nkandla sub-district illustrates a successful advocacy role that was played by a local clinic committee:

“In response to the motivations by the clinic committee, we have eventually introduced a new mobile health point to address the lack of clinic services in the community”.

(iii) Empowerment of communities

The role of empowerment in the involvement of communities in the KwaZulu-Natal PHC system was examined through in-depth review of training programmes that were targeted at communities. The presence of health promoting teams and outreach workers in all hospitals that were visited during this study is suggestive of the important role of skills transfer in the primary health care system. All health professionals recognized the need to empower the communities with useful skills that were necessary for self-care and community-level health
interventions. Whereas the health professionals at hospital level empowered communities mostly with knowledge and information, the community care givers played a bigger role in providing life skills, for example home-made remedies, to community members. In all sub-districts, the empowerment of communities seemed to be the responsibility of the lower categories of health officials in particular the community care givers. The community care givers were seen as the main messengers of community empowerment, and as such they had undergone extensive training in almost all aspects of primary health care. All the community care givers had received health training to empower them with health knowledge and skills for their community based health care role.

When the study participants were asked whether they were conducting the training of traditional health practitioners (THP’s), traditional birth attendants (TBA’s), patient support groups and basic first aid for citizens, the findings of the situational analysis showed limited provision of empowerment activities for the selected target groups. None of the districts, hospitals and clinics in the sample, were conducting the training of traditional health practitioners and traditional birth attendants. The training of patient support groups on life skills was found to be conducted by 37.5% of the CCG’s, 81.3% of the clinics and by all eight hospitals. The study found that 35% of the community care givers were communicating health knowledge to traditional health practitioners, traditional birth attendants and patient support groups during their household visits. Some health facilities were found to be making noticeable efforts in empowering pregnant women and breastfeeding mothers. This observation is consistent with the department of health’s prioritization of antenatal and postnatal care in primary health care facilities. The training of the public on basic first aid did not feature in the work plans of the District Emergency Medical Care Services (EMS) in both districts. The scope and work priorities of the district managers for Emergency Medical Services was confined to the allocation and management of ambulances for responding to emergency call-outs.

To understand the extent to which they empowered the communities on health knowledge, health professionals were asked whether their health facilities had conducted each of the ten health calendar awareness events during the previous twelve months. The ten health calendar events in the questionnaire were derived from the annual national health calendar and were based on the department’s priorities and which targeted the health conditions of high prevalence in the communities. The list was comprised of nutrition awareness, healthy lifestyles awareness, tuberculosis awareness, diabetes awareness, anti-tobacco awareness, traditional medicines awareness, drug abuse awareness, heart/hypertension awareness, women’s health awareness and HIV/AIDS awareness. The district managers for Emergency
Medical Services were excluded from the interviews, since the implementation of the health calendar was predominantly outside the scope of their practice.

The findings confirm that the implementation of the health calendar in the KwaZulu-Natal health care system was generally limited. Sixty percent (60%) of the major health awareness campaigns were not conducted by the district managers, hospitals and clinics in the study sample, during the financial year 2013/14. Despite budgetary constraints, however, most health facilities were making every effort to implement the HIV/AIDS, tuberculosis and women’s health awareness campaigns in all sub-districts. As shown by 100% of health facilities who conducted HIV and AIDS awareness campaigns, priority and effort was given to the fight against HIV infection which was still a major concern in KwaZulu-Natal. The following statement was quoted from the comments of more than 50% of the respondents:

“Due to cost-containment measures of the department, we no longer organize open days and health campaigns in line with the annual National Health Calendar”

In the hospitals and clinics, health promotion was often integrated into daily health education of patients. Health calendar awareness campaigns were seen as expensive projects that required additional staff and resources. In addition to staff and resources, the implementation of health calendar projects in the community setting required venues and meals, both of which were prohibited budget items in terms of cost containment measures of the provincial treasury. District teams, on the other hand, were better placed to co-ordinate and implement health promotion campaigns in line with the health calendar. The district health establishment in all health districts had standardized compliment of professional staff that was responsible for various health programs such as HIV/AIDS, TB, nutrition, environmental health etc. However, the implementation of the health calendar at district level was found to be limited to HIV/AIDS, tuberculosis and women’s Health priorities.

(iv) Involving communities in the co-governance of improvement projects

All health professionals reported availability of functional complaints handling mechanisms and suggestion boxes in their health facilities. The complaints mechanisms involved the recording of verbal and written complaints from patients and other users of services. In most health facilities such complaints were being handled on monthly basis by either the quality assurance committee or by the complaints handling committee. The suggestion boxes were reportedly used as consultative and communication method by the health facility and its clients. One hospital CEO’s commented: “The clients make many suggestions such as the
need for heaters in the wards, but many of the suggestions are beyond our scope and budget”

The methods through which the KwaZulu-Natal health department involved communities, were identified and described in this section. The analysis of these methods showed that the health professionals had access to adequate enabling systems and a variety of options for involving communities in the health system. The involvement of communities through these methods, however, was not standardized and, as such, the extent of community involvement varied from facility to facility.

4.2.6 METHODS USED BY THE COMMUNITY PARTICIPATION STRUCTURES (HOSPITAL BOARDS AND CLINIC COMMITTEES) TO INVOLVE COMMUNITIES IN THE PHC SYSTEM

The situational analysis of community participation in this study showed that hospital boards and clinic committees were regarded by health officials as important partners in support of service delivery, health promotion and community mobilization. The extent and effectiveness of hospital boards and clinic committees, as participation forums, depends in part on their capability and motivation in promoting local participation and in the provision of information and services. To understand the role played by these participation structures in community involvement, a sample of 8 chairpersons of hospital boards and 10 chairpersons of clinic committees was asked to describe the methods through which they involved communities in health programmes. In addition, each respondent was asked whether or not his or her forum had organized each of the community health projects such as health awareness campaign, self-help health project, fundraising for health or “community open day”.

During the analysis of responses from all respondents, the methods through which boards and committees involved communities, fell into 2 thematic categories, advocacy and communication.

(i) Advocacy

Twelve respondents understood their involvement function as representing communities through “speaking out for them” and 16 respondents mentioned “information transfer” as the method of involving communities in the affairs of the health facilities. The chairperson of the clinic committee in the south eThekwini district addressed the interview question by expressing his communication role as follows:
The members of this community are frustrated with the standards of service in our clinic, in particular the long waiting times and negative attitudes of staff. We, as the clinic committee try to encourage communities to co-operate with the health authorities in view of the shortage of professional staff and operational resources).

(ii) Communication

“Two-way” communication of information was mentioned by all chairpersons of hospital boards and clinic committees as the method of involving communities. As shown by the following quotation from respondent 5, the communication included the transfer of messages from health facilities to communities:

“As the clinic committee, we understand our involvement role as that of communicating health information from the clinic nurses to the communities and also to provide feedback from communities to the clinic management”.

Health professionals relied, in most cases, on clinic committees for the announcement of health visits and planned health promotion projects in the communities.

The checklist of health-promoting activities was used to conduct deductive analysis of the extent to which hospital boards and clinic committees involved communities in health matters. As shown in table 10, none of the hospital boards and clinic committees facilitated community Open Days, health awareness projects or health-related community projects for their communities. Only 1 hospital board and only 2 clinic committees had conducted a consultative meeting to discuss health issues with their communities.

(iii) Record review of the activities of boards and committees

The reviews of the minutes of hospital boards and clinic committees during field visits found that 7 hospitals and 10 clinics, respectively, had functional hospital boards and clinic committees. The minutes of the meetings were available in all health facilities with active hospital boards or clinic committees. The hospital boards were scheduled to meet four times per year, as opposed to the clinic committees which were expected to meet monthly. For purposes of this study, the hospital board or clinic committee was classified as “functional” if it had successfully convened at least two and at least six meetings, respectively, during the recent twelve-month period. Six clinics in the sample of sixteen clinics did not have active clinic committees at all, and such clinics were considered as facilities without functional committees. Based on the records of meetings, the agenda items most commonly discussed by hospital boards and clinic committees were staffing issues in the health facility, financial
reports, updates on priority health programmes, in particular HIV/AIDS and tuberculosis as well as employment opportunities at the facility. Except for one clinic committee which successfully motivated for an additional mobile health stop, the minutes of the meetings of boards and committees did not show evidence of achievements, problem solving and new health initiatives.

These findings have revealed that, although hospital boards and clinic committees in KwaZulu-Natal PHC system were generally regarded as community involvement structures, these structures were not providing any health-promoting activities within their communities (table 10).

<table>
<thead>
<tr>
<th>Health-promoting activity</th>
<th>Hospital Boards (n=8)</th>
<th>Clinic Committees (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of boards/committees who conducted Open Day</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>2. Number of boards/committees who conducted Health Awareness Campaigns e.g. TB, HIV, etc.</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>3. Number of boards/committees who conducted community consultative meeting/Workshop etc.</td>
<td>1 (12.5%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td>4. Number of boards/committees who visited a community structure e.g. school, church, traditional structure, sports club, political gathering, social club, cultural club</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>5. Number of boards/committees who implemented the health–related community project e.g. vegetable garden, etc.</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>6. Number of boards/committees who established the health-related support group/s</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>7. Number of boards/committees who conducted health supporting voluntary work</td>
<td>0 (0%)</td>
<td>3 (30%)</td>
</tr>
<tr>
<td>8. Number of boards/committees who conducted fundraising for health</td>
<td>2 (25%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>9. Number of boards/committees who organized a donation or loaning of capital or other form of resources to support health initiatives</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>10. Number of boards/committees who conducted any other health-promoting initiative</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

*Table 10: Analysis of selected health-promoting activities that were conducted by hospital boards and clinic committees during 2013/14 financial year*
4.2.7 HOW COMMUNITIES PARTICIPATE IN THE KWAZULU-NATAL PHC SYSTEM

The strategies and activities through which community members participated in the health system were identified from responses of 32 community participants. The responses were categorized into 3 themes: health seeking behaviour, treatment compliance and self-help health promotion. 25 respondents described their participatory role in terms of “cooperating with nurses to ensure that medicines are taken correctly and appropriately”.

(i) Health seeking behaviour

Most community members viewed their role as attendance of clinics and community awareness meetings. This is demonstrated by the following response by one of the participants:

“I participate by attending to my clinic appointments and making sure that I collect my chronic medicines on monthly basis”

(ii) Treatment compliance

All community respondents viewed treatment compliance as one of the means for their participation in health programmes. One respondent commented: “nurses often complain about poor collection of medicines by patients from the clinics”. Members of the communities, fortunately, understand their role in working cooperatively with health professionals in order to improve effectiveness and efficiency in service delivery.

(iii) Self-help health promotion

Responses from five participants showed that it was possible for members of the communities to participate indirectly in health development, and not necessarily through the appointed participation forums. One such approach is the establishment of CBO’s for community advocacy and self-help health programmes, as illustrated by a young community member during the interview:

“We, as communities can improve our participation by forming organizations to deal with our health problems and to represent our health needs”.

Interestingly, these respondents related community participation to health promotion, in particular the individual roles of community members as co-partners in the implementation of health programmes. One respondent highlighted his role as an agent of his own health:

“I, as a citizen, make sure that I lead healthy lifestyle and avoid unhealthy behaviours such as tobacco, alcohol abuse and drunken driving “.
In response to the inputs from the respondents, each respondent was further asked whether he or she was a member of the community participation committee, patient support group, home-based care project, CBO or nutrition project. In this deductive assessment, there was no evidence that any of the participants in the study sample was participating actively in health promoting initiatives in their communities. Although the participants understood the importance of these community structures, none of them reported to be a member or a participant in the hospital board, clinic committee, patient support group, home-based care project, CBO or community nutrition project. When asked whether they knew their community health care givers, only 5 respondents were aware of their local community health givers. None of the respondents was aware of the community representative in their local hospital’s board or clinic committee.

In view of these findings, it is clear that the ordinary members of the communities were either unaware of, or unable to implement community participation initiatives on their own. Whether these findings reflected the gaps in empowerment or involvement by health officials, is a subject for further research.

4.2.8 HOW THE HEALTH PROMOTION PROJECTS ARE FACILITATED BY HEALTH PROFESSIONALS AT PHC LEVEL

In view of the important role of community empowerment, and considering the potentially useful role of community participation in health promotion, this study assessed the existing methods by which the health professionals were facilitating health promotion projects for their communities, in particular the application of primary health care principles. In consultation with facility managers, at least one scheduled project in each of the 4 sub-districts was selected for the assessment. A total of 8 projects were assessed during the situational analysis phase of this study (table 1). Using a standard observation questionnaire, the assessment of each health promotion project focussed on the planning, the educational processes and results of the project.

The findings of this section are presented in the following sections, in line with the input, process and output indicators that were used to assess each project.

(i) Inputs

For purposes of this assessment, all planning activities were recorded as inputs for each project. The results from the observation of health promotion projects in the KwaZulu-Natal’s PHC system showed that the projects were mostly implemented in line with the operational
plans of programme managers and not necessarily in accordance with the national health calendar or health promotion schedule (table 11). The health promotion projects varied in the respect of the inputs and general resources required for the implementation of the projects. Formal planning meetings were conducted by organizers in six of the projects. The aim of the planning meetings was to engage stakeholders, to identify resource needs and to plan the health education programme.

The planning of the campaigns in general focussed on the preparation of educational messages as well as the invitation of participants and other community stakeholders. Due to well-known shortage of health promotion resources, some organizers did not have access to suitable community venues, communication equipment and transport. Because of these logistical issues, some health workers preferred to organize health promotion activities within the health facilities. In a few community-based campaigns, the use of community resources such as halls for health promotion events demonstrated a useful collaboration between communities and health facilities and was seen as positive step towards co-ownership of health and a collaboration between professionals and the community.

During the planning of the health promotion projects, none of the planning teams conducted the analysis of the target health problem or considered the relevant epidemiological factors during planning. As a result, no statistical information was available to inform educators and communities as well as to identify communities at risk. Consequently, projects were mostly accessed by persons who were interested or who had means to attend, instead of targeted communities or persons at risk.

<table>
<thead>
<tr>
<th>Input indicators</th>
<th>Number (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects in which planning was formally and adequately conducted</td>
<td>6</td>
</tr>
<tr>
<td>Projects in line with the health calendar</td>
<td>3</td>
</tr>
<tr>
<td>Projects in which the situational analysis of the target health problem was conducted before implementation</td>
<td>0</td>
</tr>
<tr>
<td>Projects in which the Education and Communication material, visuals &amp; other communication material was available</td>
<td>1</td>
</tr>
<tr>
<td>Projects in which incentives for participation were available</td>
<td>0</td>
</tr>
<tr>
<td>- Entertainment</td>
<td>0</td>
</tr>
<tr>
<td>- Catering</td>
<td>0</td>
</tr>
<tr>
<td>Projects in which resources were available and suitable</td>
<td>8</td>
</tr>
<tr>
<td>- Venue</td>
<td>0</td>
</tr>
<tr>
<td>- Sound System</td>
<td>0</td>
</tr>
<tr>
<td>- Transport</td>
<td>1</td>
</tr>
</tbody>
</table>

_Table 11:_ Analysis of health promotion projects which complied with selected input targets.
Medical supplies and equipment for screening services and patient examinations were often sourced from the hospital pool of resources. Except where donations had been received from local business, participants did not get food during their participation. The supply of food to persons, other than hospital patients, was a “prohibited budget item” in the department of health. The public address and communication equipment was available in only one of the projects. The majority of the health promotion projects were conducted through well-organized programmes, in which effective health messages were provided by skilled and experienced facilitators and subject matter experts.

(ii) Processes

In all projects, the participants were empowered through knowledge and information for the prevention and treatment of the health problem for which they were invited. Presenters and other facilitators were friendly to participants and the positive attitudes of professionals created friendly and joyous atmosphere in most of the projects. In six of the projects, however, the number of presentations was more than the available time and this restricted interaction between facilitators and participants. As shown in Table 12, the resources for the facilitation of health promotion were generally limited in all projects.

<table>
<thead>
<tr>
<th>Process indicators</th>
<th>Number (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projects whose programs were well designed and organized</td>
<td>5</td>
</tr>
<tr>
<td>Projects in which program activities were well executed</td>
<td>2</td>
</tr>
<tr>
<td>Projects in which health messages were relevant and practical</td>
<td>7</td>
</tr>
<tr>
<td>Projects in which facilitators and presenters displayed good attitudes toward participants</td>
<td>7</td>
</tr>
<tr>
<td>Projects in which sound and technology functioned effectively</td>
<td>1</td>
</tr>
<tr>
<td>Projects in which there were adequate interaction, inputs and participation by the audience</td>
<td>1</td>
</tr>
<tr>
<td>Projects in which proceedings and information were documented</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 12: Analysis of health promotion projects which complied with selected process targets.

The presentations were often difficult to accommodate within the available time and very little inputs and feedback were received from participating community members. In the absence of food for participants, the lengthy educational programmes could not sustain the attention and participation of the audiences.
Good attendance was observed in hospital-based campaigns. However, the participants here were mostly patients, hospital staff and some visitors. The documentation of proceedings was done in five of the projects. The record keeping was however limited to medical data of screened participants, and did not include community’s inputs and suggestions which could require attention or follow-up by health managers at a later stage. The health projects, therefore, were not being used by the health professionals as an opportunity to interact with communities and to invite inputs for health planning and service delivery.

(iii) Outputs

The outputs from the eight health promotion projects are shown in table 13. The attendance at the health promotion meetings was variable but generally inadequate. Attendance seemed to be higher for health promotion projects which targeted women. All health meetings were held during weekdays, to avoid overtime personnel costs which could otherwise be incurred if they were held during weekends. Most meetings, therefore, attracted mostly women and a few unemployed and elderly men. Attendance by middle-aged men and the youth was poor in all the projects. On a positive note, all projects, except for the mental health awareness, were used as an opportunity for the health screening of participants and for treatment of minor ailments. Patients who required further treatment were referred to the hospital for follow-up care and treatment.

All patients who were screened on site, e.g. chronic patients and patients suffering from sexually-transmitted infections, received their screening findings on the same day. The samples which were sent to the laboratory for testing, took long to process and although the results were sent to the community clinics, very few patients collected them from their clinics. As a result of inadequate follow-up plan, there was no evidence that action was taken in response to abnormal medical findings for screened patients in most of the health promotion projects. The evaluation of the implementation and outputs of the health promotion projects was not conducted by the organizers of all the projects.
<table>
<thead>
<tr>
<th>Output indicators</th>
<th>STI Awareness</th>
<th>TB Awareness</th>
<th>Women’s Health Awareness-1</th>
<th>Women’s Health Awareness-2</th>
<th>School Health Promotion</th>
<th>Occupational Health and wellness</th>
<th>Mental Health Awareness</th>
<th>Medical Male Circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>90</td>
<td>150</td>
<td>180</td>
<td>210</td>
<td>85</td>
<td>40</td>
<td>52</td>
<td>30</td>
</tr>
<tr>
<td>Number of participants screened or tested</td>
<td>25</td>
<td>73</td>
<td>115</td>
<td>145</td>
<td>10</td>
<td>18</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>Number of screened participants who received their laboratory test results back from the facility</td>
<td>25</td>
<td>10</td>
<td>35</td>
<td>55</td>
<td>10</td>
<td>18</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>Actions taken in response to abnormal screening findings</td>
<td>On site treatment was provided</td>
<td>Referrals were done</td>
<td>No evidence of follow-up care</td>
<td>No evidence of follow-up care</td>
<td>No evidence of follow-up care</td>
<td>No evidence of follow-up care</td>
<td>N/A</td>
<td>Follow-up visits were scheduled</td>
</tr>
<tr>
<td>Evaluation of the project by the organizers</td>
<td>Not done</td>
<td>Not done</td>
<td>Not done</td>
<td>Not done</td>
<td>Not done</td>
<td>Not done</td>
<td>Not done</td>
<td>Not done</td>
</tr>
</tbody>
</table>

**Table 13:** Outputs of the health promotion projects assessed during the situational analysis.
The assessment of the facilitation of health promotion projects in the KwaZulu-Natal PHC system provided better understanding of the efforts of the health professionals in empowering communities and in mobilizing them to care for their health. In line with the fifth objective of this study: “to identify methods used by the health department to involve communities in the PHC system”, health promotion projects played an important role in involving communities and as platforms for encouraging community participation in KwaZulu-Natal.

The main lessons were the screening of participants who attended the campaigns and the involvement of stakeholders to ensure multi-sectoral approach to health promotion. Had there been adequate and dedicated health promotion budget, however, the projects could have been better supported with effective resources for facilitating communication. The impact of health promotion could also be improved through proper planning and targeting of communities at risk. The observation of these health promotion projects found that the facilitation of education messages lacked the participatory aspect and typically followed a top-down transfer of information by health professionals. Furthermore, the empowerment of the participating communities did not include adequate practical skills for handling the health problems which were being addressed by each project. Based on the assessment of these health promotion projects, it can be concluded that there was still a room for improvement with regard to the use of participation strategies to strengthen health promotion in the KwaZulu-Natal PHC system.

4.2.9 CHALLENGES OF COMMUNITY PARTICIPATION IN THE PHC SYSTEM

The final objective for this study’s situational phase is the assessment of the challenges of community participation in the KwaZulu-Natal’s PHC system. This study interviewed various categories of service providers to assess the challenges of community participation in their respective health facilities.

The findings from different categories of service providers and community representatives indicate that the challenges of community participation were related to the role, experiences and expectations of the different categories of participants. Four themes emerged from the responses of two or more categories of service providers. These were: lack of interest by communities, inadequate resources, lack of training in community participation, inadequate resources to encourage participation and lack of support systems for community participation. The themes representing community-related challenges were low socio-
economic level, unsatisfactory delivery of health services, lack of recognition of communities by health authorities and lack of incentives for participating.

A. CHALLENGES FOR SERVICE PROVIDERS

(i) Lack of interest by communities

According to the health professionals, community health campaigns were poorly attended by members of the communities, in particular males and the youth. In most cases, this was due to the timing of the projects as well as to the lack of financial means to attend. The manager from an urban sub-district said:

“Even if we organize our health campaigns during the weekend, attendance is limited mostly to elderly participants, in particular women”.

The majority of the participants expressed concerns about poor attendance and the fact that communities were not playing proactive roles as partners in health services. This is illustrated in the following response from the hospital CEO:

“The Department of health is trying its best in educating the public about health and diseases, but the people continue to contract preventable diseases such as HIV and AIDS”.

(ii) Lack of training on community participation

The health professionals acknowledged that they did not have adequate knowledge on community participation mechanisms. Respondents believed that this was partly due to lack of training, policy and community participation guidelines. The following comment from one of the clinic managers represents the sentiments of most participating managers:

“In the absence of a policy and guidelines on community participation, training of managers on community participation can probably improve our role in the clinic committees and in the (multi-sectoral) Task Teams”.

(iii) Inadequate resources to encourage participation

Most health professionals mentioned that inadequate resources were hindering social mobilization and outreach services. One hospital CEO expressed his opinion as follows:
“community involvement requires adequate and dedicated human and operational resources for outreach and community mobilization”.

The municipal directors of community services, experienced community participation challenges to a greater degree than the health professionals. The directors of community services, as co-ordinators of community participation, were responsible for community involvement and for all social services within their municipal areas. Among other responsibilities, they co-ordinated HIV/AIDS prevention services through the Local Aids Councils. These officials, therefore, experienced a wide range of challenges in respect of community participation. The low socio-economic status of communities and the shortage of municipal resources came out strongly as major constraints to community participation and development. As illustrated in the following statement from one of the participants, these challenges were mostly related to the limited capacity of the municipalities to meet the social needs of their communities:

“The government has introduced the Operation Sukuma Sakhe (multi-sectoral service delivery committees), and this has sharply increased the expectations of communities. This programme did not come with additional resources and there is very minimal support from the government “

The above statement indicates that organized community participation initiatives are essential but, in the absence of supportive systems and financing, they may demotivate both the government officials and representatives of the communities.

(iv) Lack of support systems for community participation

All district managers reported the lack of appointed District Health Councils as a challenge to community participation. Despite the District Health Councils being mandatory consultative forums in terms of the National Health Act, both districts did not have appointed and functional councils at the time of the study’s implementation. Most the hospital CEO’s and clinic managers mentioned that the functioning of hospital boards and clinic committees was affected negatively by the lack of financial incentives for the members.

The community care givers in the KwaZulu-Natal’s PHC system also experienced many challenges during their day to day activities in the communities. The local health institutions and communities alike, relied to a great extent, on community care givers for community empowerment, social mobilization and feedback from communities they served. According to
the community care givers, the health promotion campaigns were not adequately attended by the communities. The community care givers further reported that, due to their occupational ranking, they were often underrated by both the department of health and by communities. This category of health workers was employed on contract basis and they were essentially regarded by the health department as volunteers. The following statement from one of the community care givers was representative of the sentiments expressed by all participants in this category:

“More and more responsibilities are delegated to us, as the ambassadors of the department in the communities, but we remain contract staff and we are always told that we are volunteers “

B. CHALLENGES FOR COMMUNITIES

(i) Low socio-economic level

The assessment of community participation challenges among the appointed representatives of communities in KwaZulu-Natal revealed mostly the socio-economic implications of participation as illustrated in the following quote from the chairperson of the clinic committee:

“We don’t even afford to take care of our own health. How can we afford to take care of the health of other people?”

This finding suggests that the members of the communities were not ready or capable of contributing their time and resources to promoting health within their own local communities.

(ii) Unsatisfactory delivery of health services

All municipal counsellors mentioned that the slow pace of service delivery, and to some extent the inadequate empowerment by health professionals, was a hindrance to community’s participation and support of the health programmes. The following statement from one municipal counsellor illustrates this view:

“Communities are not motivated to partner with hospitals and clinics because they are not happy about the standards of service delivery by health professionals".
The chairpersons of hospital boards and clinic committees, on the other hand, did not associate poor participation of communities with negative attitudes of health professionals. Instead, they believed that poor pace of service delivery was related to inadequate resources in the PHC facilities and that this was complicated by the increasing burden of disease in the population. All chairpersons of the clinic committees mentioned that communities did not know of their rights to participate and to influence health policies. A statement “we are not aware of our role…” was mentioned by community members during the interviews.

The members of the communities also mentioned that the health professionals were not creating friendly and conducive atmosphere to encourage a sense of health service ownership by communities and patients.

“Our clinic has a suggestions box for our complaints and comments but we have no idea whether these boxes are used”.

(iii) Lack of recognition of communities by health authorities

The lack of recognition of participation efforts by health authorities was reported as one of the constraints that limited participation by communities in CBO’s, hospital boards and clinic committees. This was reported by 23 community members as a challenge to community participation. This concern is reflected in the following statement from one of the participants:

“The government has always encouraged us to form community organizations but these organizations are not recognized by the officials and they don’t pay us anything “

The findings also reveal that some community members knew of their rights to participate in health development. However, they viewed health facilities as not being responsive to their health needs, a challenge that was reportedly affecting their interest to participate in health promotion initiatives. The community respondents further mentioned that the health department no longer welcomed community volunteers in the health facilities, as this was often interpreted by volunteers as a promise of possible employment in the future. A respondent who has previously worked in a local hospital as a volunteer, said:

“We used to volunteer in our health facilities for free, but our services are no longer needed”.
(iv) Lack of incentives to encourage participation

The chairpersons of the hospital boards and clinic committees in rural health facilities reported that there was a high turnover in the membership of their forums. In contrast to the urban health facilities, rural health facilities relied on older unemployed citizens for the membership of the hospital boards and clinic committees. These members often walked long distances to attend meetings and, due to lack of food provision at the meetings, their participation in the meetings was neither productive nor sustainable. The chairperson of the hospital board was quoted as saying:

“The Department of health says we are volunteers, they are no longer providing food even during hospital board meetings”

The challenges that have been identified by this study, suggest that community participation in the KwaZulu-Natal health system requires improvement of various enabling systems and processes in order to address problems that undermine community participation efforts in the health system.
4.3 PHASE 2 FINDINGS: IDENTIFICATION OF THE INPUTS, SYSTEMS AND PROCESSES NECESSARY FOR THE DEVELOPMENT OF THE COMMUNITY PARTICIPATION MODEL IN KWAZULU-NATAL

This section focuses on the identification of the existing systems and processes to be used to develop a model of community participation for the KwaZulu-Natal’s primary health care system. Findings are presented according to the objectives of the second phase of the study:

- To engage PHC stakeholders in the identification of the components (inputs, systems and processes) that could contribute to a model of improving community participation in primary health care.
- To identify pilot participatory projects to be implemented based on the identified principles of the ideal community participation model

4.3.1. CHARACTERISTICS OF THE MEMBERS OF THE FOCUS GROUPS

A 10-member focus group discussion was conducted in each of the two study districts to further analyse and interpret the community participation systems and processes in the KZN PHC system (see appendix 14). The combined sample of participants was comprised of 16 (80%) females and 4 (20%) males. Of the 20 participants, 14 (70%) were African, 4 (20%) Indian and 2 (10%) coloured. The average age of participants in the group was 38 years and all participants possessed a tertiary qualification in primary health care.

The first step in this participatory meeting involved the presentation of the findings from the situational assessment on community participation in the KwaZulu-Natal primary health care. Participants were then given a set of questions to discuss and report back on during a plenary session.
The following table summarizes Phase 2 findings:

<table>
<thead>
<tr>
<th>Objective of Phase 2</th>
<th>Summary of the findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified inputs</td>
<td>Community participations resources, personnel</td>
</tr>
<tr>
<td>Identified systems</td>
<td>Service provider stakeholders – health facilities, other governmental departments and institutions, non-governmental organizations</td>
</tr>
<tr>
<td></td>
<td>Community stakeholders – patients, patient support groups, schools, CBO’s, other community representatives</td>
</tr>
<tr>
<td></td>
<td>Co-governance forums – multisectoral committees, hospital boards, clinic committees</td>
</tr>
<tr>
<td>Identified processes</td>
<td>Inter-sectoral collaboration, consultations, partnership, empowerment, community mobilization</td>
</tr>
<tr>
<td>Identified pilot health promotion projects</td>
<td>Training and empowerment of the clinic committee Anti-teenage Pregnancy Campaign Diabetes Health Promotion Project Establishment and orientation of patient Support Group</td>
</tr>
</tbody>
</table>

**Table 14: Summary of the Phase 2 findings**

(i) Inputs

The discussion question used to guide health professionals in the identification of inputs for the community participation model was: “what resources are needed by the health institutions in order for them to effectively involve communities in health services?” a group participant said: “The most important resource for community involvement is the health promotion budget to enable health professionals to reach out to communities”. The health professionals further stated that transport, infrastructure, public address systems and dedicated budgets, were essential for community mobilization. The following quote illustrated the importance of health promotion resources:

“All hospitals require tents for use as accommodation facility during community campaigns such as medical male circumcision”

(ii) Systems

The guiding discussion question for the identification of community participation systems was: “which stakeholders should health institutions work with, in order for them to effectively deliver health services to the community?”
The participants described the stakeholders they worked with in their day to day delivery of health services, and proposed that government departments, business and NGO’s be involved as partners in the provision of health services:

“In addition to the other government departments which we already work with in the multi-sectoral committees, we need public-private-partnerships between health facilities and NGO’s as well as business community”.

Another hospital CEO commented that: “Local NGO’s should be identified and empowered on health promotion and home-based care services”. The participants recognized the hospital boards and clinic committees as partners and as official representatives of communities in the health system: “Every hospital should have a functional hospital board and every clinic should likewise have an ongoing working relationship with its clinic committee”. The focus groups identified the need for health managers to conduct community profiling in order to identify community stakeholders and other interest groups that could add value to community participation:

“It is the responsibility of every health facility to identify and address specific health needs of various categories of communities such as chronic patients, prisoners and other interest groups”.

Major community stakeholders mentioned by the health professionals were patients support groups, schools, prisons, churches, community leaders and community organizations.

(iii) Processes

The following are guiding discussion questions used to facilitate the identification of processes of community participation:

- How should the health professionals or health institutions involve communities in health services?
- How should the health professionals or health institutions consult the communities?
- How should the health professionals or health institutions mobilize the communities to take care of their own health?
- How can communities partner with health authorities in order to improve prevention and fight against diseases in the communities?
The processes through which community participation should be facilitated were reported by the focus group participants as community consulting, empowerment as well as mobilization of communities to take care of their own health. The need to empower community based organizations and role players such as traditional health practitioners and traditional birth attendants was emphasized in both focus group discussions. The PHC professionals identified practical methods such as the training of traditional health practitioners and patient support groups, as essential for the involvement and empowerment of communities. Illustrating the need for the empowerment of communities with skills, the feedback from one group made reference the recent newspaper article, as follows:

“Recently in Melmoth, in uThungulu district, a 49 year old man passed away due to lack of first aid skills in the community. The victim choked and died in the wedding as he was trying to swallow a piece of meat and no person was able to save him. When the emergency health services crew arrived, the person had already passed on”.

The professionals further raised the importance of identifying community needs, to encourage partnerships and to mobilize communities to take care of their own health.

“Health professionals should not assume that they understand the needs of the communities. Needs assessment should be conducted regularly through consultative meetings, health campaigns and through organized community profiling”

True partnership was recognized as the involvement of community representatives in the planning, monitoring and evaluation of health services. Appendix 23 shows the proposed activities that were identified during the consultative process for the development of the community participation model during phase 2 of the study.

(iv) Community participation guidelines

Finally, the focus groups of health professionals identified process and output indicators that could be used to guide and to evaluate the implementation of health promotion projects by health facilities.

The inputs, systems and processes of community participation in the KwaZulu-Natal primary health care system, are summarized in table 15 below:
**Table 15**: Proposed inputs, systems and processes for developing the community participation model in KwaZulu-Natal

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Category</th>
<th>Interpretation and examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Effective allocation of resources</td>
<td>Resources such as budget and infrastructure should be effectively allocated and utilized to encourage participation</td>
</tr>
<tr>
<td>Systems</td>
<td>Category</td>
<td>Interpretation</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Service provider stakeholders</td>
<td>Health facilities, other governmental and NGO's should work with their communities in the planning and provision of health services</td>
</tr>
<tr>
<td>Community stakeholders</td>
<td>Patients, schools, support groups, CBO’s and other community representatives</td>
<td></td>
</tr>
<tr>
<td>Partnership structures</td>
<td>Partnership and co-governance forums</td>
<td>Multi-sectoral committees, hospital boards and clinic committees are official structures for community participation and co-governance at facility and community levels</td>
</tr>
<tr>
<td>Processes</td>
<td>Category</td>
<td>Interpretation</td>
</tr>
<tr>
<td>Multi-sectoral collaboration</td>
<td>Involvement of stakeholders</td>
<td>All relevant stakeholders should be identified and involved at all stages of service delivery</td>
</tr>
<tr>
<td>Consultation</td>
<td>Identification of community’s health needs</td>
<td>Health officials should consult communities regarding health needs</td>
</tr>
<tr>
<td>Partnership</td>
<td>Joint planning and delivery of services</td>
<td>Health officials should work together with their communities in planning, implementation and evaluation of health programmes</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Education on health knowledge and skills</td>
<td>Communities should be educated on health issues and about participation</td>
</tr>
<tr>
<td>Community mobilization</td>
<td>Health promotion at community level</td>
<td>Communities should be encouraged to take care of their health through self-help initiatives such as formation of CBO’s and community-based health committees</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Category</td>
<td>Interpretation</td>
</tr>
<tr>
<td>Guidelines</td>
<td>Policy and implementation guidelines</td>
<td>There should be guidelines for monitoring the implementation of community participation at various levels of the PHC system</td>
</tr>
</tbody>
</table>
The analysis of the community participation initiatives by PHC professionals confirmed that
the existing community participation systems were useful and that they could potentially be
used to develop and guiding model for strengthening the PHC system in KwaZulu-Natal.

**B. PILOT HEALTH PROMOTION PROJECTS**

The members of the focus group proposed four health promotion projects in order to pilot the
implementation of the identified community participation principles during phase 3 of the
study. The four pilot projects were proposed in order to demonstrate the role of the following
principles of community participation principles on health promotion:

- Inter-sectoral collaboration
- Empowerment and
- Participatory approaches

The projects were (1) training and capacity building of the clinic committee, (2) anti-teenage
pregnancy campaign, (3) facilitation of participatory health promotion project and (4)
establishment and training of the patient support group.

**4.4 PHASE 3: FINDINGS FROM THE EVALUATION OF PILOT PROJECTS**

The third research question is “can the existing systems and processes of community
participation be used by the health professionals to strengthen health promotion projects?”. The
objective of the third phase of the study was “to implement and evaluate the pilot health
promotion projects”. The projects, training of the clinic committee, diabetes awareness
campaign, anti-teenage pregnancy campaign and the patient support group were
coordinated by the researcher during phase 3 of the study. The approaches, methods and
outputs of the four projects are summarized in appendix 15.

The findings of the evaluation of the four pilot projects are summarized below.
CHARACTERISTICS OF THE PARTICIPANTS WHO PARTICIPATED IN THE EVALUATION OF THE PILOT PROJECTS

<table>
<thead>
<tr>
<th>Training of the clinic committee</th>
<th>Sample size:</th>
<th>Age (yrs)</th>
<th>Employment</th>
<th>Duration in current job/community (yrs)</th>
<th>Highest qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of the clinic committee</td>
<td>12</td>
<td>35 – 56</td>
<td>Self-employed=2 General= 4 Unemployed=6</td>
<td>4 -12</td>
<td>Grade 10</td>
</tr>
<tr>
<td>Anti-teenage pregnancy campaign</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School learners</td>
<td>90</td>
<td>14 – 20</td>
<td>Learners</td>
<td>-</td>
<td>Grade 11</td>
</tr>
<tr>
<td>Educators and members of the SGB</td>
<td>14</td>
<td>26 – 60</td>
<td>Self-employed=4 General= 4 Educators=6</td>
<td>6 – 20</td>
<td>Degree=5</td>
</tr>
<tr>
<td>Facilitation of health promotion project</td>
<td>14</td>
<td>28 – 49</td>
<td>Prof nurse=8 Med officer=1 Pharmacist=3 Dietician=1 Social worker=1</td>
<td>8 – 29</td>
<td>Postgrad degree=4</td>
</tr>
<tr>
<td>Health workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient support group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members of the support group</td>
<td>35</td>
<td>38 – 56</td>
<td>Self-employed=6 General= 18 Unemployed=2 Unknown =9</td>
<td>4 – 18</td>
<td>Diploma=10</td>
</tr>
<tr>
<td>All pilot projects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC professionals</td>
<td>20</td>
<td>28 – 49</td>
<td>Professional nurses</td>
<td>8 – 29</td>
<td>Postgrad degree=6</td>
</tr>
</tbody>
</table>

**Table 16:** Characteristics of participants during the evaluation of pilot projects

Full details on the implementation of the health promotion projects are shown on appendix 15. The evaluations findings for all pilot projects are detailed on appendices 16 – 21.
C. THE EVALUATION FINDINGS

4.4.1 Training of the Clinic Committee

The clinic committee was trained on their duties and roles as facilitators of community participation in the primary health care. The findings of the evaluation of the clinic committee training project demonstrate the effect of empowerment on the knowledge of the members of the clinic committee.

The comparison of the test scores for the knowledge of community members before and after the training project, showed the beneficial effect of the project as an empowerment initiative (table 17).

<table>
<thead>
<tr>
<th>Evaluation criteria</th>
<th>Members of the Clinic Committee Baseline (n=12)</th>
<th>Members of the Clinic Committee Post-training (n=12)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of members who adequately understood the duties of the clinic committee</td>
<td>4 (33.3%)</td>
<td>10 (83.3%)</td>
<td>0.0143</td>
</tr>
<tr>
<td>No. of members who understood the referral methods for their clinic</td>
<td>3 (25%)</td>
<td>12 (100%)</td>
<td>0.0027</td>
</tr>
<tr>
<td>No. of members who correctly understood the levels of health care for the health department</td>
<td>3 (25%)</td>
<td>8 (66.7%)</td>
<td>0.0196</td>
</tr>
<tr>
<td>No. of members who knew the budget for their clinic</td>
<td>0 (0%)</td>
<td>6 (50%)</td>
<td>0.0143</td>
</tr>
<tr>
<td>No. of members who correctly understood the employment procedures of their clinic/health department</td>
<td>5 (41.7%)</td>
<td>9 (75%)</td>
<td>0.0455</td>
</tr>
<tr>
<td>No. of members who knew the National Core Standards for quality assurance</td>
<td>0 (0%)</td>
<td>12 (100%)</td>
<td>0.0005</td>
</tr>
<tr>
<td>No. of members who correctly understood the role of the committee in promoting healthy lifestyles</td>
<td>4 (33.3%)</td>
<td>8 (66.7%)</td>
<td>0.1025</td>
</tr>
</tbody>
</table>

Table 17: Comparison of the knowledge of committee members before and after training

The baseline assessment of the knowledge of committee members showed that most members of the clinic committee understood their role as that of supporting clinic staff and communicating messages from the clinic nurses to the community. Few members were
aware of the levels of health care and in some cases the referral of patients to hospitals was thought to be due to the shortage of medical competencies and supplies in the local clinic. None of the committee members knew the annual budget for their clinic. The knowledge of the committee members was generally lacking in the aspect of quality management at the clinic. Although the members were aware of the importance of healthy lifestyles, their role in health promotion was not clearly understood.

After the training, the number of committee members with correct understanding of their role increased to 10. The discussion of the departmental systems and administrative procedures during the training, proved to capacitate the committee members on how the health facilities operate, including the management of finances and human resources. The training of the committee members on National Core Quality Standards for health establishments, further ensured that all members of the clinic committee understood and appreciated how the quality of services was being managed in the health facility. The majority (10) of the members of the clinic committee expressed their satisfaction about the knowledge they had received during the workshop. With reference to the process used during the facilitation, 8 members reported their satisfaction rate as good. The chairperson of the clinic committee expressed his comment:

"The use practical exercises and examples during the training gave us relevant skills for addressing our committee tasks"

This project demonstrated the important role of health professionals in empowering the clinic committees in order for the committees to play an effective role as community participation forums. One participant commented: “We have been made aware that we also have a role in promoting good health in our communities”. The findings further showed that the training of committee members on both governance and service delivery aspects, improved their appreciation of the partnership role they played in health care management and development. The members of the clinic committee welcomed the participatory approaches of the clinic officials in the planning and implementation of health programmes. This is reflected in the comment: “Nurses often consult us when community projects are to be conducted..”. Although the members of the clinic committee represented various categories and sectors of their communities, this project could not adequately illustrate wide inter-sectoral collaboration. The project was specifically intended to highlight mainly the role of the committee in community participation.
4.4.2 The Anti-teenage Pregnancy Campaign

The findings of the evaluation of this project demonstrated the role of inter-sectoral collaboration, participatory approach and empowerment, in addressing the high rate of teenage pregnancy in the community. The Sexuality and Pregnancy Education, Surveillance and Support (“X-Press”) project, implemented in Velangaye High School in Nkandla sub-district was driven by three interventions: education, surveillance and support. The baseline analysis of learners’ knowledge of sexuality and health issues was conducted using a standard self-administered questionnaire that was completed by a random sample of 85 learners. The same indicators were used to assess the knowledge of leaners after six months of their participation in the project. The indicators (see appendix 18) used during the baseline and post-workshop assessment of learners’ knowledge in Velangaye High School were:

- Knowledge about fertility
- Knowledge about ante-natal care
- Knowledge of the dangers and complications of teenage pregnancy
- Knowledge about the prevention of sexually transmitted infections
- Knowledge about family planning and “emergency contraception”
- Knowledge about “termination of pregnancy” and
- Knowledge about “statutory rape”

The comparison of the knowledge of learners before and after the project, showed the beneficial effect of the project as an empowerment initiative (table 18).
Table 18: Evaluation of school learners’ knowledge of sexuality and teenage pregnancy.

When the number of learners with correct understanding of the various aspects of sexuality and teenage pregnancy after the project is compared with baseline data (table 15), the two-sample Wilcoxon rank-sum (Mann-Whitney) analysis showed that the anti-teenage pregnancy project significantly improved ($p>|z| = 0.00001$) the knowledge of learners.

Prior to the implementation of the X-Press anti-teenage pregnancy project, the school learners demonstrated satisfactory knowledge of methods used for preventing sexually transmitted infections and family planning. Most learners were aware of emergency contraception and they understood the role and importance of antenatal care for pregnant women. The majority of learners over-estimated the child bearing age and most respondents believed that women above fifteen years were more at risk of falling pregnant. The project seems to have increased the knowledge of learners regarding the possible risks and medical complications of teenage pregnancies. Before this project was implemented, there were very few learners who were aware of the availability of the termination of pregnancy service at the public hospitals but after their participation in the project, all learners became aware of this
The beneficial effect of the X-Press anti-teenage pregnancy project was shown by the sharp improvement in the knowledge of the school learners regarding antenatal care, family planning and risks of teenage pregnancy after their participation in the project.

The project was further evaluated by educators and members of the School Governing Body (SGB) in order to analyse and assess the community perspective of the project’s acceptability and to obtain further inputs for future implementation of a similar project. These stakeholders were asked to rate, using “good”, “average” and “below average” measures, the perceived success of the project processes. The interview questionnaire focussed on the planning aspects, quality of information given as well as the participatory approaches used.

As shown in table 19 below, all participating stakeholders rated the various aspects of the project implementation positively.

<table>
<thead>
<tr>
<th>Aspect of the project that was evaluated</th>
<th>Responses by educators and members of the SGB (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Good”</td>
</tr>
<tr>
<td>Planning aspects of the project</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>(71.4%)</td>
</tr>
<tr>
<td>Consultation and engagement of various stakeholders</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(85.7%)</td>
</tr>
<tr>
<td>Relevance of information for the school learners</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>(57.1%)</td>
</tr>
<tr>
<td>Quality of information transfer by presenters</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>(64.3%)</td>
</tr>
<tr>
<td>Number of participants who believed the project could reduce teenage pregnancies</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>(71.45)</td>
</tr>
</tbody>
</table>

Table 19: Evaluation of the X-Press anti-teenage project by educators and members of the SGB

According to these evaluation findings, a good proportion of participants was satisfied with the quality and extent of stakeholder engagement as well as consultation of community stakeholders in this project. Most participants agreed that the involvement of health officials, learners, educators, NGO and members of the school governing body was a good demonstration of inter-sectoral collaboration in the promotion of public health.

The findings of the evaluation show that the school governing body played an oversight and supportive role as the representatives of the parents and the community. One respondent, the member of the SGB, stated:
"The surveillance part of the anti-teenage pregnancy project acted as a deterrent to many school learners who felt that they were being watched".

All educators and members of the School Governing Body who participated in the project evaluation, expressed their hope that the X-Press Anti-teenage Pregnancy Project had a potential to reduce the rate of teenage pregnancies in the future.

One school educator commented: "The X-Press project is worth our effort and should be integrated into the school’s life orientation programme".

Participants further mentioned that the role and participation of all stakeholders in the project was well explained and promoted.

4.4.3 The Diabetes Health Promotion Project

The health care officials who participated in the evaluation of the diabetes project were asked to rate, using “good”, “average” and “below average” measures, the following processes and outputs of the project: attendance by target the target community, availability of health promotion resources, quality of information provided, attitudes of facilitators to community members, the interaction or participatory approaches used, screening services provided and follow-up care for screened participants. As shown in table 20 below, most aspects of the project implementation were rated by participants as “good”.

<table>
<thead>
<tr>
<th>Aspect of the project that was evaluated</th>
<th>Responses by health workers (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Good”</td>
</tr>
<tr>
<td>Attendance of the event by target community</td>
<td>14 (100%)</td>
</tr>
<tr>
<td>Availability of health promotion resources</td>
<td>7 (50%)</td>
</tr>
<tr>
<td>Quality of information provided</td>
<td>10 (71.4%)</td>
</tr>
<tr>
<td>Attitudes of facilitators to community members</td>
<td>8 (57.1%)</td>
</tr>
<tr>
<td>The use of information, communication and education aids</td>
<td>6 (42.9%)</td>
</tr>
<tr>
<td>Recording and documentation of proceedings</td>
<td>7 (50%)</td>
</tr>
<tr>
<td>Interaction or participatory approaches used</td>
<td>9 (64.3%)</td>
</tr>
<tr>
<td>Screening services provided</td>
<td>10 (71.4%)</td>
</tr>
<tr>
<td>Follow-up care for screened participants</td>
<td>4 (28.6%)</td>
</tr>
</tbody>
</table>

Table 20: Evaluation of the diabetes health promotion project by health workers.
According to these evaluation findings, all participants believed that the health promotion project was well attended by the community. Half of the participants were happy about the availability of resources, in particular the education materials, public address system, medicines and food catering for participants. The findings show that the participants were generally happy about the planning aspect of the project, in particular the consultation of stakeholders and involvement of various community structures. As illustrated in the following quote from one of the respondents, most health workers stated that the audience received relevant information through participatory approach by facilitators.

“The use of expert patients and public figures living with diabetes gave hope that the disease is manageable”.

The services, in particular glucose screening was also seen by health workers as a good approach to health promotion, since new cases of the disease were identified and referred for further medical treatment. This finding is reflected in the following comment from one of the evaluation members:

“mass education of the community has improved detection of new cases of the disease so that treatment can be commenced early”.

According to the evaluating team, the project did not, however, have an effective strategy or tracing mechanism for patient follow-up and care. This aspect was highlighted by the member of the evaluation team in the following statement:

“The register of screened participants was simply a once-off record instead of a monitoring tool that could be used for follow-up care and for tracing defaulters”

The findings of the evaluation of this project demonstrated the role of inter-sectoral collaboration, participatory approach and empowerment of the community on diabetes. The participants stated that the collaboration of health workers, patients, community representatives and CBO’s made the project stand out as a joint health promoting project. The awareness and information communicated during the project, helped mobilize the members of the community and patients to partner with health professionals in the prevention initiatives for the chronic lifelong illnesses. The participants viewed the pilot project as potentially effective in strengthening efforts for prevention, early detection and management of diabetes in the community.
4.4.4 The Patient Support Group Project

The evaluation of the support group project highlighted the beneficial role of empowerment approach and mobilization of patients in the management of diabetes.

The table 21 below, summarizes the findings of the project evaluation based on the responses by the members of the support group:

<table>
<thead>
<tr>
<th>Aspect of the project that was evaluated</th>
<th>Responses by members of the support group (n=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Good”</td>
</tr>
<tr>
<td>Satisfaction about the orientation and training received by the members</td>
<td>28 (80%)</td>
</tr>
<tr>
<td>Satisfaction about the medical information and education received by members during group training</td>
<td>25 (71.4%)</td>
</tr>
<tr>
<td>Number of participants who believed that the support group could improve disease management</td>
<td>30 (85.7%)</td>
</tr>
</tbody>
</table>

Table 21: Evaluation of the support group project by members of the patient support group.

According to the evaluation findings, participation in the support group increased access to information and support for diabetes patients. When asked to evaluate the orientation and training they received, 28 members of the support group rated the project’s induction programme as “good”. 25 participants appreciated the disease-related information they received and they expressed optimism in the group's potential to improve management of their illness. Although the treatment compliance rate was not measured at the time of the evaluation, the members felt that the closer relationship between members and health professionals would improve their treatment collection. This is illustrated in the following comment by one of the members:

“…we have been advised that we will receive our chronic treatment during our support group meetings”.

The support group project applied a combination of patient mobilization and empowerment approaches to encourage partnership between health professionals and patients at health
facility level. The evaluation of this project produced evidence of the potentially useful role of the support group in increasing access to information and medical resources. The opportunity that was offered by the support group project, ensured better interaction between health professionals and their patients, and it encouraged patients to advocate for their medical needs and service standards.

4.4.5 Evaluation of all projects by PHC professionals

The main findings of the focus group discussions by PHC professionals are summarized in appendix 24. The interpretation of responses in this section is based on the summative reports of the evaluation of inter-sectoral collaboration, empowerment and participatory approaches of each project by the PHC professionals.

The training of the clinic committee was viewed by professionals as a positive step towards the empowerment of communities in playing their role in health promotion. The PHC professionals pointed out that the X-Press anti-teenage pregnancy campaign was a good demonstration of the working relationship between the parents, teachers, learners, health professionals, NGO’s and other providers who care for the needs and welfare of the school community. The content used and the processes used during the project implementation was a result of wide consultation of stakeholders during project planning. According to the PHC professionals, the participation by the School Governing Body in the project represented the role community representatives could play in promoting health and in managing social problems at community level. The inter-sectoral collaboration among different categories of health professionals as well as between professionals and various community representatives, was noted by the PHC professionals as a strong aspect of the diabetes health awareness project. One participant mentioned that:

“A positive aspect of all the projects is the involvement of different categories of health professionals in addressing the public health problem”.

The professionals observed that, during project planning, the consultation of communities brought about many useful inputs and contributions such as the use of community hall, participation by community cultural groups in the programme, to mention a few. Highlighting the effect of empowerment, one participant stated:

“The value of community involvement was demonstrated during the facilitation of health promotion messages. The participating members of the communities shared their
experiences about diabetes and community role models encouraged patients and the general public to look after their own health and to advocate for improved health care in the local health facilities and in the communities”.

According to the PHC professionals, the diabetes health promotion project needed to pay more attention to the practical aspects of health promotion such as home-based health care and self-medication in order to improve self-care and self-reliance by members of the communities.

The patient support group was viewed by PHC professionals as an advocacy platform through which patients could conveniently access health services and information on their illness. The support group offered a good opportunity for partnership between health professionals and patients. As members of the support group, patients became empowered with knowledge and skills necessary for them to implement self-care initiatives and to take control over their own health. The participants viewed the support group as a partnership platform where patients were empowered and service delivery challenges addressed. The evaluators however expressed concern that the low socio-economic standing of the members could negatively affect the sustainability of their participation in the future.

According to the PHC professionals, the four pilot projects were potentially useful in supporting health promotion through increasing community awareness, access and uptake of services. The mobilization of communities through participatory projects was seen as one of the strategies for encouraging community ownership of local problems. The application of stakeholder engagement, empowerment and participatory approaches during the implementation of pilot projects, was viewed by the PHC professionals as the effective strategy to strengthen health promotion through community participation. The health professionals concluded that:

“The four pilot projects have employed key principles of community participation such as needs assessment, stakeholder involvement, empowerment and participatory problem-solving to address the key health priorities in the communities”.
4.5 FINDINGS OF THE CONSULTATIVE WORKSHOP FOR THE FINALIZATION OF THE MODEL

The consultative workshop by the multi-disciplinary team of health officials consolidated the inputs for the community participation model based on the findings of the situational analysis and on the findings of the evaluation of the pilot health promotion projects. The workshop outlined details of the systems, processes and performance measures for community participation activities in the health system. In line with the inputs from the focus groups involved in the identification of the initial model inputs, the workshop participants emphasized the importance of stakeholders and community participation forums as systems which are necessary to support community participation. The processes for effective community participation were proposed as inter-sectoral collaboration, advocacy, co-governance and community’s control of their own health. The proposed guidelines and indicators for the implementation and monitoring of the community participation processes at different levels of the primary health care system are detailed in appendices 25 – 34.
4.6 SUMMARY

The findings of this study have provided high level insights about the existing systems and processes of community participation in the KwaZulu-Natal primary health care system. Stakeholders and various sectors of the communities that participated in the department’s health system were identified. The various methods through which the health professionals involved communities were also described. The study found that the hospital boards, clinic committees and the multi-sectoral committees played important roles as facilitators of communication and community engagement. Community participation systems, approaches and challenges varied according to the levels of health care as well as according to different categories of service providers and communities. The appointed community representatives participated directly in the planning and delivery of services through multi-sectoral committees, hospital boards and clinic committees. Although community members recognized their responsibility to comply with treatment plans, most of them, however, were not participating in CBO’s where they could indirectly influence health services through advocacy and self-help initiatives. During consultation with PHC professionals, four pilot projects were proposed for implementation in order to demonstrate community participation approaches, in particular, inter-sectoral collaboration, empowerment and participatory methods during the implementation of health promotion projects.

The training of the clinic committee was implemented in order to empower the committee with knowledge necessary for its governance and service delivery roles. The anti-teenage pregnancy project employed broad-based inter-sectoral approach to address the high rate of teenage pregnancy in the local school. During the diabetes awareness project, the communities were mobilized to screen for diabetes and to practice healthy lifestyles in an effort to reduce new cases of the disease. The establishment and capacity building of the patient support group was piloted in order to encourage advocacy and to improve accessibility of health services for diabetes patients.

During the evaluation of the pilot projects, the participants expressed satisfaction with the knowledge gained and with the processes followed during the facilitation of the projects. The health professionals viewed community participation as a process, and they were confident that the combination of multi-sectoral approaches and empowerment in all the pilot projects could potentially strengthen health promotion efforts within the department’s primary health care system.
CHAPTER 5
DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of this study was to develop the public health model of community participation for the KwaZulu-Natal primary health care system. The study examined the existing community participation initiatives and explored their applicability in the design of the participation model and in strengthening health promotion. Three fundamental research questions were key to the study:

- What are the systems, processes and challenges of community participation in the KwaZulu-Natal primary health care system?
- How can the existing systems and processes be used to develop a model of community participation for the KwaZulu-Natal primary health care system?
- Can the existing systems and processes of community participation be used to strengthen health promotion in the KwaZulu-Natal primary health care system?

This chapter discusses the systems, processes and challenges of community participation in the KwaZulu-Natal’s PHC system. The study’s health promotion pilot projects, namely the training of the clinic committee, the anti-teenage pregnancy project, the facilitation of the diabetes awareness project and the establishment of the patient support group showed that the combination of inter-sectoral collaboration, empowerment and participatory approaches have a potentially beneficial effect on the facilitation of health promotion and they have contributed useful data for the development of the ideal community participation model for the primary health care system.

5.2 SYSTEMS, PROCESSES AND CHALLENGES OF COMMUNITY PARTICIPATION IN KWAZULU-NATAL

The assessment and analysis of community participation in this study revealed that inter-sectoral collaboration, multi-sectoral committees, hospital boards and clinic committees were major platforms for supporting community participation in the KwaZulu-Natal PHC system.

5.2.1 INTER-SECTORAL COLLABORATION

The inter-sectoral approach to the delivery of PHC services in KwaZulu-Natal was cited by most health professionals as an important policy position of the health department. This
finding is in line with the observations by other researchers who have highlighted the importance of partnerships in the delivery of health services. In the study of the factors shaping inter-sectoral collaboration in primary health care, the Australian research revealed a unanimous endorsement of inter-sectoral activities and cited a range of outcomes supporting PHC objectives (Julia Anaf et al., 2014). In their conceptualization of integration and collaboration in public health, Axelsson and Axelsson (2006) noted that public health was a field of welfare with strong inter-organizational character. The authors state that in an inter-organizational field such as public health there should be functional differentiation of roles and tasks in connection with disease prevention, health promotion, medical treatment, rehabilitation etc. In this study, the scope of direct collaboration between the KwaZulu-Natal’s health facilities and other organizations was found to be limited to a few NGO’s and the department of education, in particular the local schools. There is significant reliance on traditional medicine in South Africa (Dookie & Singh, 2012). The role of traditional health practitioners and other community stakeholders in primary health care must therefore be considered.

Axelsson and Alexsson agree that collaboration in public health may be organized according to need and depending on the degree of horizontal integration required. In the KwaZulu-Natal PHC system, collaboration was also organized in such a way that multi-disciplinary teams of officials worked together across formal organizational boundaries to provide services to patients in the community. This organization is in line with Adeleye’s and Ofili’s view of inter-sectoral collaboration, in which they argue that the collaboration can be between different actors within the government, for example between school health services and schools (Adeleye & Ofili, 2010).

5.2.2 MULTI-SECTORAL COMMITTEES

In this study, the interviews of different categories of service providers found that the governmental multi-sectoral committees at district, sub-district and community levels, were used as platforms for sectoral collaboration and they co-ordinated delivery of public services in KwaZulu-Natal. Apart from their important value in community participation, the multi-sectoral committees played an important role in enhancing participatory local governance and development at different levels of service delivery in KwaZulu-Natal. It appears that, contrary to the perceived notion that the governmental multi-sectoral committees were drivers of service delivery, the multi-sectoral committees in KwaZulu-Natal were found mainly to be co-ordinators and accounting forums for the provision of services by various government departments, including the health department. This was because these forums
did not have dedicated budget and resources for community mobilization and service provision (Macwele B.M., 2014). A similar observation has also been made by Terence Smith (2008) in his assessment of the role of ward committees in enhancing local governance and development in South Africa. Smith observed that although the committees were formally nominated and were representatives of the communities and other interest groups, their effectiveness was limited by lack of resources and support by officials. It is for this reason that Smith recommended a national fund to support these participatory committees. As part of the Operation Sukuma Sakhe programme, the multi-sectoral committees are major platforms for the integrated service delivery in KwaZulu-Natal. Their effectiveness as community participation structures, however, is limited by lack of dedicated budget and resources (Macwele B.M., 2014).

5.2.3 DISTRICT HEALTH COUNCILS, HOSPITAL BOARDS AND CLINIC COMMITTEES

The lack of appointed District Health Councils in both districts in which this study was implemented, indicates a weak bridge between the health department and the communities at district health level. In South Africa, the consultative platforms for communities are a requirement of the health legislation (National Health Act, 2003). The legal requirement for the District Health Councils seemed to have been overshadowed by the introduction of district multi-sectoral committees which were among the political priorities in KwaZulu-Natal. According to the findings of the situational analysis of community participation, 75% of hospitals and 65.2% of clinics respectively, had functional hospital boards and clinic committees. The hospital boards and clinic committees played a major role in supporting health facilities and advocacy for better health care services.

It appears from the findings of the situational analysis, that there were no equity targets or criteria for the representation of various community sectors in the hospital boards and clinic committees. The competencies or professional backgrounds of candidates were also not a consideration in their appointment. As a consequence, there was often a lack of diverse expertise and experiences in most boards and committees and this limited their advisory role to health managers. This study found that most hospital boards and clinic committees were composed mainly of unemployed community members, self-employed persons and retired nurses and educators. Hospital boards and clinic committees that are not representative of different community sectors and interest groups are arguably less likely to understand community needs and to play effective advocacy roles in primary health care.
The findings of this study are consistent with the study which investigated the impact of hospital boards in strategic decision making for hospitals (Ford-Eickhoff et al., 2011). In their study, the researchers explored the connection of both the hospital boards' direct involvement in the stages of strategic decision making and the breadth of expertise among board members with a hospital's strategic orientation. Ford-Eickhoff and co-researchers concluded that when board members were not well versed in the issues affecting the hospital industry or when top management failed to seek counsel, boards were not effective as advisors and the expertise that board members brought from their own industries provided little value to the hospital.

The findings of the KwaZulu-Natal's study of community participation further suggest that the hospital boards and clinic committees were well placed to involve communities in health and thus to enhance efficiency in the delivery of health services. However, their inadequate empowerment by health professionals limited their capacity to play a productive role in community mobilization. The role of clinic committees, in particular, was seen more as symbolic rather than meaningful governance of health facilities. In a related study, the researchers assessed the status of clinic committees in public health facilities in South Africa (Padarath & Friedman, 2008). Realizing the potentially useful role of clinic committees on community participation, the researchers studied the factors that were perceived by clinic committee members as either facilitating or impeding the effective functioning. The study found that factors such as negative attitudes of facility staff, lack of operational resources, poor socio-economic status of members, lack of training and unavailability of operational guidelines for the clinic committees, were major factors which negatively influenced the functioning of clinic committees nationally.

The hospital boards and clinic committees have a potential to improve co-operation and partnership between health professionals and communities in the primary health care system. Apart from the gaps assessed, this study has also identified opportunities for improving the functioning of the hospital boards and clinic committees. These include the need for formal empowerment programme and formalization of the role of the hospital boards and clinic committees in community mobilization and health promotion.

This study has identified communities that were being involved by the health department and those who did not enjoy the privilege of being involved in health services. Based on these findings, it is clear that the health department relied mainly on the multi-sectoral committees, hospital boards and clinic committees as drivers of community participation. The lack of involvement of other stakeholders such as CBO’s, traditional health practitioners and other...
governmental departments seemed to be related to the absence of a guiding framework or policy for encouraging broader community participation at institutional level. Under these circumstances, it was seemingly difficult for the health professionals to evaluate the extent to which the health facilities were meeting the unique health needs of the different categories of communities. The findings of this study, therefore, are suggestive of the need to identify efficient means through which the local stakeholders can directly participate in the planning and management of health services at primary health care level.

5.2.4 UNDERSTANDING OF COMMUNITY PARTICIPATION

The overall response pattern during the assessment of the understanding of community participation, indicates that health professionals in KwaZulu-Natal understood community participation as a mutually beneficial relationship brought about by the efforts of both service providers and communities in the health system. Previous studies have highlighted the need for the understanding of community participation by health professionals and by communities. When assessed against the study’s knowledge indicators, the level of knowledge of community participation by health professionals demonstrated the effect of the lack of training or guidelines on community participation in the KwaZulu-Natal PHC system. According to Bandesha and Litva (2005), health care professionals who are not trained on community participation approaches may find it difficult to enable participation from the public.

Given the findings, however, it can also be argued that the understanding of community participation by the health professionals in KwaZulu-Natal has improved in recent years. A previous study (Mchunu & Gwele, 2005) of the understanding of community involvement in KwaZulu-Natal showed that most health professionals understood community involvement to be the cooperation of the community members with the existing health programmes. The improving understanding of community participation may be due to the participation of health professionals in government-driven multi-sectoral committees which promote participatory approaches to service delivery. The views and perceptions of community participation by health professionals in KwaZulu-Natal is in agreement with such authors as Kahssay and Oakley (1999) that people’s involvement should not just be in support of health services but it should include their involvement in decision making and actions that affect their health.

The understanding of community participation among community representatives and ordinary members of the community in this study was found to be influenced to some degree
by their interaction with the local health facilities. According to WHO (1985), access to information as well as right of people to exercise power over decisions that affect their lives are key characteristics of community participation. According to this study’s findings, emphasis is still needed on the role of communities in health planning and decision making. Whilst the participants in urban sub-districts believed that communities had enough rights to advocate for improvement in service delivery, the rural communities were of the view that ownership of health through CBO’s and self-help health projects could promote community participation and achieve better health. Community members who interact more with their local health facilities, or who were involved in the activities of health committees or CBO’s, seemed to have better experience of community participation than those who were not involved in health matters. This is because of the knowledge and experience that these community representatives acquired during their participation. It can be deduced from the assessment of participation activities of the communities in the KwaZulu-Natal PHC system that the understanding of participation by communities might be related to the quality and extent to which they can participated in service delivery. This finding is consistent with the observation by Ghanaian researchers who pointed out that meaningful participation depended on the knowledge of participation by communities (Baatiema L et al., 1013).

5.2.5 HOW COMMUNITIES PARTICIPATE IN THE KWAZULU-NATAL PHC SYSTEM

This study’s assessment of participation strategies identified health-seeking, treatment compliance and self-help health promotion as the main methods through which KwaZulu-Natal communities viewed their participatory role in the health system. These activities correctly represent direct and indirect methods through which communities could participate in health and development. The communities in the KwaZulu-Natal PHC system saw participation initiatives as opportunities to influence the provision of health care by health facilities. This view of participation by the communities is more progressive when compared to that observed by Padarath and Friedman (2008) in a study in which 74% of community respondents understood their role as problem solving in community health clinics.

Whilst community participation has mostly been studied from the perspectives of service providers (Preston et al. 2009), this study assessed the practices and perceptions of community participation from both the service provider and the community perspectives. In their systematic review of community participation, Preston and co-researchers used 309 publications and 326 related documents to assess the benefits of community participation in rural health service development. The researchers learned in their review that the community perspectives on community participation were rarely captured, and they
concluded that “it would be worthwhile to investigate how communities have viewed and valued their own participation in many of the programs reported in the studies”. In a related perception study, Mchunu and Gwele (2005) found that communities in KwaZulu-Natal understood their role as collaboration, cooperation with health officials and involvement in decision making.

The findings of the KwaZulu-Natal study of community participation have shared some light on the perceptions and understanding of community participation by communities in the KwaZulu-Natal PHC system. The measurement of the extent to which involvement efforts by health professionals encouraged participation by communities, was beyond the scope of this study. The findings, however, do have implications for policy makers and researchers who intend to evaluate community involvement efforts against the corresponding scope and extent of participation by communities.

5.2.6 PARTNERSHIP BETWEEN HEALTH FACILITIES AND COMMUNITIES

The assessment of community involvement initiatives in this study found that most health officials recognized their local communities and they involved community representatives in health promotion projects. The study used joint planning, implementation and evaluation of health activities or projects by health managers and communities as measures to assess the level of partnership between health professionals and communities in the KwaZulu-Natal PHC system. The findings showed that the KwaZulu-Natal PHC facilities involved communities mostly in the planning of community based projects such as health awareness days, medical male circumcision campaigns and vaccination campaigns. The community representatives were however not part of the planning or monitoring of operational or strategic health programs. The level of partnership seemed to be stronger at facility level compared to sub-district and district health care levels.

As shown by the lack of community-driven health projects in all study sub-districts, the partnership role of the members of hospital boards and clinic committees was limited in KwaZulu-Natal. The members of the hospital boards and clinic committees did not see community-based health promotion projects as part of their responsibilities, but instead as the role of the local health authorities. Partnership is the third highest stage in Arnstein’s ladder of participation (fig.1). At this level, members of the community and decision makers share planning and decision making responsibilities through joint boards, planning committees and other informal mechanisms for resolving problems and conflicts (Choguill, 1996).
Judi Abel, in her classification of community participation identified four levels of participation namely low, moderate, high and highest levels. According to Judi Aubel’s partnership framework, the highest level of partnership is achieved when community members are directly involved in making decisions about all aspects of program management, resource allocation process and outcome evaluation (Aubel, 2001). At this level, equity and inclusiveness are present in all areas of the program, including representative leadership. Using Aubel’s classification as a reference for assessment, the level of partnership between communities and service providers in KwaZulu-Natal PHC system can be classified as “moderate”, meaning that the communities in the KwaZulu-Natal PHC system were aware of the health programs and issues and they did assist in certain health needs assessment, planning and implementation of some activities at the direction of the professional health workers. Major health decisions however remained with the professional health workers.

The processes used by the KwaZulu-Natal health professionals to encourage community participation in the KwaZulu-Natal PHC system, were found to be comparable to the methods and principles that have been proposed by researchers for South Africa and other developing countries. Some of the lessons learned from a South African study were that community representation, sense of ownership and regular communication are crucial elements in partnership (Ansari & Phillips, 2009). An argument can be made, from the organizational perspective, that the conditions in which communities participate can be improved through increased engagement and empowerment of community members and representatives. Similarly, the extent of community involvement activities can be strengthened through support and training of health professionals on community participation procedures.

5.2.7 CHALLENGES OF COMMUNITY PARTICIPATION

The situational analysis of this study revealed several systemic and operational challenges at different levels of the primary health care system in KwaZulu-Natal. Based on the interviews with health professionals and community representatives, the top-ranked challenges of community participation were identified as:

- Lack of interest by communities
- Inadequate knowledge of community participation processes by health officials
- Inadequate resources for community mobilization
- Lack of support systems for community participation
- Low socio-economic level of communities
• Unsatisfactory delivery of health services
• Lack of recognition of communities by health authorities
• Lack of, or inadequate incentives for encouraging community participation

Similar to the observations of this study, other researchers have noted that the challenges of community participation vary according to the context and circumstances under which the participation initiatives were being implemented. For example, Kyobutungi and Nayar identified that poor attitudes and practices of health professionals were a constraint to community participation (Kyobutungi & Nayar, 2005). In the paper discussing the role of community participation in primary health care, Roy and Sharma analysed several possible obstacles that might be encountered during the implementation of community participation programmes (Roy & Sharma, 1986). These included diverse political interests, resistance by some administrators to decentralization of services, difficulty in mobilizing communities and difficulties in maintaining sustained community participation efforts.

The lack of training for clinic committees was one of the challenges that affected the effectiveness of these participation forums. The clinic committees and hospital boards did not appear to be effective agents of health promotion and due to their average poor educational and professional backgrounds, they could not play a meaningful role in health promotion. This observation is supported by the previous South African study of clinic committees, which found that clinic committees did not have formalized methods for communicating with their constituencies (Padarath & Friedman, 2008).

The observation of health promotion projects during the situational analysis phase of this study found that these projects played a major role in empowerment of communities. However, the lack of the practical component of the empowerment during the facilitation and poor follow-up of screened patients were found to be limiting the potential effectiveness of the campaigns. The participants were not adequately involved during the facilitation of these projects. In the study of health promotion meetings in India, Anja Welschhoff also noted the importance of communication and good facilitation during the transfer of health information by health professionals (Welschhoff, 2006). Anja Welschhoff found that the facilitation of health promotion was “top-down” and messages were not adapted to local knowledge and educational level of participants. She also found that questions from the participants were hardly entertained and the programme was hindered by time constraints. Anja Welschhoff, like other researchers share the view that the participatory approaches were not effectively used by health professionals during the facilitation of health education. The facilitation of
health promotion projects by health professionals was characterized by inadequate resources such as venues, facilitation equipment and meals for the audience. The role of resources in health promotion has also been highlighted by other health researchers. In their study of health promoting programs, Weiss and co-researchers (2016) found that the availability of resources was a common problem. They point out that without proper resources, achieving health promotion objectives and health goals suffers. In a developing country like South Africa, health professionals and communities consistently require logistical support and operational resources to maintain community participation activities.

The lack of community participation policy and guidelines was the contributor to the limited knowledge of health professionals and the inadequate involvement procedures such as community consultations, empowerment and mobilization. The findings of this study suggest that the lack of training of health managers was affecting the extent to which they were involving communities in health matters. Due to their low socio-economic status, most members of the communities did not have enough capacity and interest to participate in health programmes or to apply health promotion messages in their lifestyles. These members of the communities perceived the health system to be unresponsive to their health needs, and consequently they did not believe that their participation, or the participation by formal advocacy organizations in health programmes, would have a positive impact on service delivery or health outcomes.

The community participation challenges identified by this study, justify the need for a policy on community participation and the framework for integrating community participation into the KwaZulu-Natal’s primary health care system. The policy and framework may be useful in empowering health professionals and in guiding them through the implementation of community participation activities. The framework can also address some of the participation challenges facing health service providers and communities.

In line with the objectives of this study, the systems and processes used by the KwaZulu-Natal Department of Health to encourage community participation in the PHC system, were identified and described. Despite the challenges identified, there is sufficient evidence that there are adequate systems and initiatives for community participation in the KwaZulu-Natal PHC system.
5.3 INPUTS AND INITIATIVES FOR MODELING COMMUNITY PARTICIPATION IN KWAZULU-NATAL

The second research question for this study is “how can the existing systems and processes be used to develop a model of community participation for the KwaZulu-Natal primary health care system?”. The effective implementation of community participation requires adequate understanding of processes which can be used by health professionals to enhance participation. The situational analysis and the consultative process conducted in this study has shown that there are a wide range of initiatives currently in place for improving the understanding and implementation of community participation in KwaZulu-Natal. Engaging with communities is core to the development of innovative services and health promotion in primary health care (Neuwelt et al., 2005). The following section describes the inputs available and the processes used by the KwaZulu-Natal health department to shape community participation at primary health care level.

5.3.1 STAKEHOLDER ENGAGEMENT

The health professionals, in both focus groups, recognized that stakeholders were crucial in any community participation programme. Stakeholders participate as partners in service delivery or as potential beneficiaries for the services or programme. The role of stakeholders in health programmes has been assessed by several health researchers. In her dissertation “stakeholder engagement in health-related decision making: the case of mother-to-child HIV transmission”, Elizabeth Shayo described who should participate, why they should participate and how they should participate (Shayo, 2015). Shayo explains that stakeholders should be consulted and they should actively participate and communicate their ideas or ideas of their respective communities. In the study of stakeholder engagement in malaria prevention in Rwanda (Ingabire et al., 2016), the researchers stated that the input from a wide range of stakeholders was essential for developing a participatory, consensus-building process that meets the needs and expectations of both the implementers and community. In this study, researchers identified the following stakeholders as potential supporters of the malaria elimination programme:

*Community Health Workers, rural health staff, community-based health insurance staff, administrative sector office staff, drugstore staff, private clinic staff, cooperative members, school staff, church leaders and NGO’s.*
5.3.2 THE ROLE OF CONSULTATION

As reflected by the findings of this study, various platforms and strategies are used by the health professionals to consult communities. This study has found that many KwaZulu-Natal health professionals worked with participatory forums such as the multi-sectoral committees, hospital boards and clinic committees to plan services and to address complaints from patients and the public. These forums generally played a visible role as consultative platforms and partners for the health professionals at various levels of the primary health care system. The involvement of communities in the KwaZulu-Natal PHC system is reflective of participation activities as presented in Arnstein’s ladder of participation (Choguill, 1996). As recommended by the Arntein’s model of community engagement, the KwaZulu-Natal health professionals involved communities through informing, diplomacy, dissimulation (the use of advisory committees), consultation, empowerment and partnership.

5.3.3 THE ROLE OF OUTREACH HEALTH SERVICES

The use of outreach health strategies such as school health services, family health teams and community care givers, has gained increasing attention as strategy for increasing access to services as well as for mobilizing communities to participate in health programmes. The public health value of involving communities in health care has been demonstrated in several studies. In a systemic review of PHC studies, Marston et al., concluded that community involvement had a positive effect on the maternal and new-born health outcomes in Nepal, India and Kenya (Marston et al., 2013). These outcomes included service utilization rates and delivery rate in health facility. In a study assessing community contribution in tuberculosis control in developing countries, the researchers established the beneficial effects of community involvement on awareness raising, case finding, access to treatment, addressing the tuberculosis stigma, patient support, record keeping and tracing of treatment defaulters (Hadley & Maher, 2000).

5.3.4 THE ROLE OF EMPOWERMENT

There is some evidence that the empowerment of communities by the KwaZulu-Natal health professionals had a positive effect on health awareness by communities. The empowerment involved mostly the transfer of health information through community care givers and during the health promotion projects. The value of empowerment in involving communities was highlighted by Roy and Sharma (Roy & Sharma, 1986) in their description of community participation. They described community participation as “an educational and empowering
process in which the people, in partnership with those who are able to assist them, identify the problems and the needs and increasingly assume responsibilities themselves to plan, manage, control and assess the collective actions that are proved necessary”. This study found that the focus of empowerment by the KwaZulu-Natal health professionals was more on health awareness than the transfer of health-related skills. This was possibly due to time constraints and lack of facilitation guidelines as observed in almost all health promoting projects in this study.

By empowering communities with health information and skills, health professionals may improve the community’s capacity to take care of their own health. This view was articulately illustrated by the study of the effect of empowerment in the Indian primary health care system. In an underdeveloped Indian population with high infant and maternal mortality rate, the community was empowered with practical skills such as water disinfection, construction of soakage and compost pits, establishing nutrition gardens as well as in management of minor ailments and communicable diseases. Communities were also involved in family planning programme and other child health activities. According to the researchers, the antenatal and postnatal care of pregnant women and the immunization programme improved markedly over a four year period. The incidence of diarrheal disease, infant mortality rate and malaria decreased and there was a noticeable improvement in contraception uptake (Roy & Sharma, 1986).

5.3.5 THE ROLE OF COMMUNITY MOBILIZATION

The health promotion campaigns are essential for mobilizing communities to take care of their own health and to implement community-based health promotion programmes. When eight health promotion campaigns were observed against input, process and output indicators, this study’s situational analysis found that health promotion in the KwaZulu-Natal health facilities was mostly educational in approach.

This study found the facilitation of health promotion by the health professionals in KwaZulu-Natal to be empowering to the participating community members. The facilitation of health promotion projects by the KwaZulu-Natal health professionals was generally “top-down” education and not interactive. Other related studies have shown that health promotion projects with strong participatory approach were more likely to have impact on community mobilization. As seen in the study “addressing neonatal health in India” (Abhay et al., 2005), the health promotion project included training and education in health as well as research to shape health policies. The project included, among other things, practical training of
community health workers and birth attendants on new-born resuscitation, breastfeeding, medical screening and dispensing of medicines. The evaluation of the project showed the decline in neonatal mortality rate in the intervention area from 62 deaths per 1000 births in 1993-1995 to 25 per 1000 births in 2001 -2003.

A related project was conducted to improve reproductive health in Nepal. The adolescent reproductive health project was set up with a quasi-experimental study design pairing the participatory approach for research, intervention, monitoring and evaluation at two intervention sites with a more traditional educational approach at two control sites (Sanyukta et al. 2004). The researchers found that for reproductive health outcomes, the participatory approach was generally more effective that the traditional approach. The participants in the intervention sites showed better knowledge of sexually transmitted infections and HIV/AIDS of participants. The youth reproductive health also improved in the intervention sites. The improvement included age at marriage, initiation of childbearing, prenatal care, institutional delivery and increased male awareness of the reproductive health needs of women.

The health promotion projects described in the above studies incorporated strong participatory approaches and training of participants on the practical skills for health. Gryboski et al., in their analysis of community participation, concluded that projects that included community participation could improve health (Gryboski et al., 2006). The case studies referred to in this section, illustrate the important role of participatory health promotion on health outcomes. The KwaZulu-Natal study of the facilitation of health promotion identified the need and opportunity for health professionals to utilize more effective ways to carry out health promotion activities.

5.4 THE EFFECT OF COMMUNITY PARTICIPATION ON HEALTH PROMOTION

The third research question of this study was:

“Can the existing systems and processes of community participation be used by the health professionals to strengthen their health promotion projects?”.

Considering the established benefits of community participation on health outcomes within specific health contexts (Marston et al., 2013), this study was undertaken in order to explore how health promotion in the KwaZulu-Natal PHC system could be strengthened through community participation. Although the relationship between community participation and health promotion has not been adequately studied, engaging with communities has been
found to be at the centre of the development of innovative services and health promotion in primary health care (Neuwelt et al., 2005). Through the evaluation of the facilitation of eight health promotion projects and the piloting of four health promotion projects, this study found that the existing systems and processes of community participation can be used to strengthen health promotion in the KwaZulu-Natal PHC system. This finding is further illustrated in the following outputs of the health promotion projects:

5.4.1 LESSONS FROM THE ASSESSMENT OF HEALTH PROMOTION PROJECTS IN THE HEALTH FACILITIES

Through health promotion projects, health professionals in KwaZulu-Natal were able to foster closer relationships and partnerships between health facilities and communities. Some degree of consultation of communities by health workers, was noted in most of the health promotion campaigns and this indicated the potential consideration of community inputs in the planning and engineering of health services. Although it was limited in some cases, the engagement of other sectors and stakeholders, such as NGO’s and CBO’s during health promotion, was a demonstration of the positive role that inter-sectoral collaboration can play in improving the efficiency of health promotion by health facilities. In almost all health promotion projects that were assessed during the situational analysis phase of the study, patients were empowered with health knowledge and they were screened for health conditions that required further management. These efforts improved access to health care as well as community interest in their health affairs. It can be deduced, therefore, that the community participation principles and approaches used by health professionals in KwaZulu-Natal, did add some value to their health promotion efforts.

5.4.2 LESSONS FROM PILOT HEALTH PROMOTION PROJECTS

As shown by the findings of the pilot projects during phase three of this study, community participation approaches did assist in the strengthening of the pilot health promotion projects. Although this study did not assess the effect of community participation on specific health outcomes, the findings from the evaluation of the pilot projects did contribute to the understanding of the processes and strategies through which community involvement could be used to improve the effectiveness and efficiency of health promotion in the primary health care system. There is some evidence that stakeholder involvement, combined with empowerment and participatory approaches, had a positive effect on the health promotion projects. Some of the benefits were only of perception, and were not necessarily reflected in any health outcome. The improved knowledge of participants who participated in some pilot
projects, however, was indicative of a generally positive impact of empowerment on the health education program.

(i) The Clinic Committee Training Project

The clinic committee capacity-building project addressed the need to improve the effectiveness of the Luwamba clinic committee members as partners and advisors to their health facility. Other researchers support the view that, unless they are familiar with the health industry, the advisory committees are not effective as advisors and they add little value to the health institution (Ford-Eickhoff et al., 2011). The training of the Luwamba committee members on the structure and functions of the department of health was in line with this view and this is shown by an improvement in their knowledge and understanding of their roles as committee members after training. The study of the status of clinic committees in South Africa (Padarath & Friedman, 2008), suggested that governance structures were made vulnerable by limited capacity, lack of training and confusion over mandates and areas of functioning. The researchers concluded that there was a need for long term support and capacity building of community members who were elected onto governance structures. This pilot project contributed to the understanding of factors which limited the functioning of the clinic committee, and through formal empowerment and engagement of the committee members, the role of the committee in health promotion was clarified.

(ii) The Anti-teenage Pregnancy Project

The Sexuality and Pregnancy Education, Surveillance and Support (“X-Press”) project was a collaborative effort among health professionals, NGO, learners, educators and the school governing body to address the high rate of teenage pregnancy in Velangaye High School. Teenage pregnancy is a global public health concern. The consultative approach used in the “X-Press” pilot project is related to the approach used by the public health practitioners in the Community-based Abstinence Education Programme (CAEP) in the United States of America (USA). Realizing that, despite the high rate of teenage pregnancy in the USA, some parents were reportedly reluctant to have sexual issues taught in schools, the researchers conducted a survey of learners, parents and teachers to obtain their inputs on possible approaches to this public health problem (Kaizer Family Foundation, 2000). The survey found that most parents, teachers and learners themselves would like sex education and curriculum in schools. In the South African context, consultation of relevant stakeholders, as demonstrated in the X-Press project, may be useful in identifying specific underlying causes
of teenage pregnancy, and to assist affected learners and parents with medical and other support services.

The approach used during the X-Press pilot project is also related to the intervention implemented by researchers to assess the effects of community participation on improving uptake of care for maternal and newborn health (Marston et al., 2013). In their systemic reviews, researchers identified the public health value in increasing the knowledge of reproduction, contraceptive use and danger signs in pregnancy among women. The studies also showed improved newborn care and increase in the uptake of women receiving skilled childbirth care. Although the anti-teenage pregnancy pilot project in KwaZulu-Natal could not be implemented over enough period of time, through the empowerment of learners the project improved the understanding of the strategies necessary for the prevention of unwanted pregnancies and other sexually transmitted infections. The project evaluation team agreed that the empowerment of learners, teachers and learners on sexuality and pregnancy-related issues was a potentially good investment in the community by health professionals. The participation of the educators and the school governing body in the project was also seen by the participants as the example to demonstrate how health promotion could be developed and sustained by community-based stakeholders.

The rate of teenage pregnancy in Velangaye high school was not accurately known at the beginning of the anti-teenage pregnancy project. The impact of the project could not therefore be evaluated using the number of teenage pregnancies avoided or reduced. Also, the project did not run throughout a full academic year, as previously planned. However, through the promotion of partnerships among health professionals, NGO, educators and communities, the anti-teenage pregnancy project laid the foundation for exploring the use of community participation approaches in the fight against teenage pregnancies in the schools.

(iii) The Diabetes Health Awareness Project

Diabetes is a condition of multiple medical and social aetiology. Like most other public health problems, diabetes management requires the participation of various stakeholders in the promotion of prevention and treatment efforts for the disease. This health promotion project complements many other projects that have been implemented by health professionals and researchers in order to assist patients in dealing with their chronic diseases in other settings. The success of the community empowerment project depends on the quality of the project as well as its effect on the specific needs of the target patients. In the synthesis of nine qualitative studies, Yin Kwa Ho et al., investigated what patients perceived as being an
effective empowerment strategy for diabetes self-management (Yin Kwa Ho et al., 2010).

Four central metaphors that influenced empowerment were identified as trust in nurses’
competences and awareness, striving for control, a desire to share experiences and nurses’
attitudes and ability to personalize. The study emphasized the fact that health professionals
needed to understand and address modifiable behaviour-specific factors affecting their
participants or target communities. Apart from the education of communities on diabetes, the
KwaZulu-Natal diabetes awareness project managed to mobilize communities and patients
to make healthy choices and to take better care of their health. Through screening and
referral services, the health promotion project encouraged the health-seeking behaviour by
the affected members of the community. Had the project been conducted in collaboration
with CBO’s, the chances of the project sustainability and co-ownership could have been
improved.

(iv) The Patients’ Support Group Project

The support group encourages advocacy for services and it improves partnership between
health professionals and their patients. Similar to the observations of previous researchers of
support group projects, the KwaZulu-Natal support group project was a major empowerment
initiative for the diabetes patients. In their systemic review of public health studies, Crawford
and co-researchers (Crawford et al., 2002) identified several benefits of involving patients in
the planning and development of health care. The review found that patients who
participated in health initiatives welcomed the opportunity to be involved and that their self-
estem improved as a result of their participation. Among the most frequently reported
effects of involving them was the production of new or improved sources of information for
patients. The involvement was reported to increase accessibility to services, advocacy and
general effect on organizational attitudes. Several papers on community participation have
commented that patients who participated in support group initiatives derived more than just
medical benefits. The evaluation of support groups for women with breast cancer in Canada,
found that the support group produced various emotional, informational and practical support
benefits (Till, 2003).

Chronic diseases contribute significantly to the workload in all health facilities. In many
cases, the attending health professionals struggle with the problems of drug compliance,
non-adherence to medicine collection schedules and disease complications. The support
group concept is one of the strategies to bridge the gap between health professionals and
the target groups of patients. The diabetes support group is a potentially useful intervention
to address the challenges associated with the management of diabetes patients in the
primary health care facilities. The members of the support group have access to ongoing empowerment by health professionals and their interaction with their health service providers is useful in addressing their needs and for co-operative problem solving. Through the patient support group, patients also learn from each other and they can derive inspiration and motivation from expert patients and role models.

The high patient satisfaction rate, obtained from the evaluation of the KwaZulu-Natal support group project, indicates the potential for the project to positively influence patients’ behaviours as well as the attitudes of health professionals towards their patients. The limitation of the project, however, was lack of dedicated budget to provide the support group with such incentives as transport and food. Because of this constraint, the attendance and participation in the project by some patients may not be sustainable in the long run. There was also lack of sound output indicators to monitor the impact of the support group interventions on treatment outcomes.

5.5 THE IMPLICATIONS OF THE STUDY FINDINGS FOR THE COMMUNITY PARTICIPATION MODEL

The third objective for phase three of this study was to finalize the development of the community participation framework, guidelines for its implementation as well as performance indicators for community participation.

As has been shown by the findings of this study, there are adequate and scientifically appropriate systems and processes of community involvement in the KwaZulu-Natal PHC system. The ideal community participation requires the identification of stakeholders, profiling of communities as well as clear strategies and activities for involving communities. Direct partnerships with communities or indirectly through appointed forums is needed at all levels of the primary health care system. Although these initiatives were in place, they were not being implemented to their full potential, partly because of the lack of an instrument or framework to guide health professionals and to monitor their implementation.

The gaps identified during the situational analysis of community participation as well as the inputs from the health professionals suggest the need for a community participation model for the KwaZulu-Natal primary health care system. The inconsistencies and lack of standardization with regard to the involvement of communities and facilitation of health promotion projects by various health facilities, was related to the inadequate understanding of community participation processes by health professionals and by representatives of
communities in KwaZulu-Natal. This was one of the main messages from the focus group discussions. The importance of the understanding of community participation by health professionals has also been highlighted in previous studies of community participation in other developing countries. During their intensive dialogue with health workers in Philippines, Dr Laleman and co-researchers found that there was a lack of clear understanding of the concept of community participation by health officials (Laleman & Annys, 2000).

Because of its complexity, community participation requires a model and guidelines to improve its implementation and hopefully its effectiveness as a strategy for strengthening health promotion. A review of seven community participation models during this study, showed that community participation frameworks are often designed to highlight one or two aspects of participation, commonly the broad activities and the degree of community involvement. Most models lack specific activities through which health professionals can involve communities and, in most instances, stakeholders are often not described. The information derived from the consultation of PHC professionals and from the piloting of health promotion projects in this study, allows for the application of key components of the community participation in the design of the model of participation for the KwaZulu-Natal PHC system.

The community participation model presented in the following section, therefore, builds on the foundations of previous models whilst considering the existing systems, processes and challenges of community participation in the KwaZulu-Natal’s PHC system.

5.6 THE COMMUNITY PARTICIPATION MODEL FOR THE KWAZULU-NATAL PHC SYSTEM

5.6.1 THE OBJECTIVE OF THE MODEL

The community participation model improves the understanding of community participation processes by health professionals and community representatives. It provides health managers and policy makers with systematic guidance on how to effectively integrate community participation into the PHC programmes, to monitor the degree of its implementation and to assess its effect on health promotion programmes.
5.6.2 THE KEY COMPONENTS OF THE MODEL

The approach used in the design of the community participation model was informed by Dr Soumya Sahoo’s description of the public health model (Soumya, 2015). According to Dr Soumya, the public health model addresses health or social problems e.g. health promotion and it targets policies in order to improve health interventions. As opposed to a mathematical model, for example, the public health model of community participation described in this section, is intended to illustrate graphically, the relationships between stakeholders and it proposes evidence-based activities that are essential for effective community participation.

Born out of the assessment of community participation and consultation of health professionals in the KwaZulu-Natal PHC system, the community participation model (figure 12) is unique, as it illustrates the major principles of participation, namely inter-sectoral collaboration, empowerment and partnership. In terms of this model, stakeholder engagement at various levels of the primary health care system (figure 13), is key to building mutually beneficial and sustainable relationships between healthcare providers, governmental departments, non-governmental sectors as well as community stakeholders. Various community stakeholders, shown in the model, represent the interests of different groups of people and, as beneficiaries of PHC services, they must be recognized and engaged in the planning and delivery of health services.

Power inequalities often exist between providers and communities with respect to decision-making process, control of resources and equitable provision of services. In order to achieve meaningful community participation, it is essential to recognize these power inequalities and to address them through formal empowerment programmes.
**Figure 12:** The Community Participation Model for the KwaZulu-Natal's primary health care system
The model recognizes key stakeholders and outlines essential activities through which health professionals can involve communities. The activities through which communities can partake in health affairs, are also proposed. The model has two possible implications for healthcare. First, the model predicts that the greater the extent of involvement of communities by health professionals, the better are the prospects of participatory activity by various sectors and representatives of the communities. For example, consultation of communities can encourage direct participation through improved health-seeking behaviours or indirectly through the establishment of self-help health projects. The second assumption is that adequate involvement of communities through empowerment and mobilization can strengthen the health promotion efforts of the health system.

**Figure 13:** Providers and participating community representatives at different levels of PHC
5.6.3 THE ENABLING SYSTEMS FOR COMMUNITY PARTICIPATION

The usefulness of the proposed public health model will depend on a variety of enabling systems for community participation such as political, social, health and professional systems. The vibrant political systems at all levels of governance in KwaZulu-Natal promote human rights and democratic structures which create conducive environment for community participation in public services. The government and the people continually endeavour to improve the health and wellbeing of communities through allocation and sharing of human and material resources. The media also plays an important role in the social system by empowering communities with information and by promoting social dialogue. In the health system, co-governance structures such as hospital boards and clinic committees have traditionally been used as platforms of communication between health professionals and communities. With proper training and empowerment, the hospital boards and clinic committees have a potential to contribute meaningfully to governance of health institutions and to the promotion of the health of the communities.

The South African government implements policies and mechanisms to encourage public participation at different levels of governance. The health facilities are expected to implement the patients’ rights charter through which both managers and communities can monitor the provision of health care to the patients. In addition to the health system measures, the communities have access to various other professional bodies which protect and promote the health of the public. Professional bodies such as the Health Professions Council of South Africa (HPCSA), South African Nursing Council (SANC) and the South African Pharmacy Council (SAPC) are open to the views, feedback and complaints from the public, and they also offer opportunities for the members of the general public to influence health policy and service delivery.

5.6.4 THE COMMUNITY PARTICIPATION GUIDELINES

As the main drivers of community involvement, health professionals should understand the activities they should implement at least on monthly basis in order to encourage community participation in their catchment areas. Standard indicators should be used to guide the implementation and monitoring of the participation activities by health professionals at different levels of the primary health care system. Community participation in the health system should also be seen as the co-responsibility of both the health professionals and communities. Considering the existing systems of community participation in the KwaZulu-Natal PHC system, there are various methods through which communities can promote their participation and thereby contribute to the functioning and development of the health system.
Due to the potentially beneficial effect of community participation in health promotion, participatory approaches should be enforced during the facilitation of health promotion projects. Participatory approaches encourage partnerships and co-ownership of health by health professionals and communities. As shown in figure 14, a health promotion project requires proper planning, resources and effective facilitation of health promotion messages.

As far as possible, the evaluation of the project’s outputs should be conducted in order to assess its effectiveness and to identify areas requiring improvement.

**Fig. 14:** Proposed inputs, processes and target outputs for the health promotion projects.

The activities and indicators for guiding the implementation of community participation as identified during this study’s consultative process, are shown in appendices 25 - 34.
5.7 LIMITATIONS OF THIS STUDY

Although the objectives of this research were met, some limitations were noted during data collection. The qualitative data used in the assessment of community participation and in the development of the model is based on observations, records reviews, participant interviews and perceptions of PHC professionals. Some of the findings of the study may therefore contain biases normally associated with qualitative research methods. During the observation of health promotion campaigns, for example, some of the facilitators were aware that they were being observed by the researcher and they might have made extra efforts to meet the expectations of the observer. Some of the qualitative data obtained during the situational analysis did not add value to the study. For example, the information obtained from certain respondents, such as the community care givers, reflected their work-related frustrations which were beyond the scope of this research. Record keeping in certain health facilities was not up to date, and this might have compromised the quality of some record-based data.

Another limitation of the study was the lack of outcome-based measures for evaluating the impact of the pilot community participation projects on major public health targets. Certain aspects of the pilot projects could not be evaluated by the community members, and the investigator relied mostly on the perceptions and observations of health professionals. The findings from the evaluation of pilot projects, in particular the training of the clinic committee and the establishment of the patient support group, could have been biased due to the fact that the evaluation participants were beneficiaries of the projects. The duration of the implementation of most pilot projects was not adequate enough to allow for the effective assessment of the effects of the project interventions on the key health outcomes. Although the study was implemented in four sub-districts of the KwaZulu-Natal province, the sample sizes for some of the categories of participants were small. Because of the structure of the primary health care system, the number of target participants was, in certain cases limited. This is because the researcher had access only to appointed officials for each of the target category of participants. For example, every district has only one health district manager and every sub-district has one director for community services.
5.8 MAIN CONTRIBUTIONS OF THE STUDY TO THE EXISTING BODY OF KNOWLEDGE

This study has assessed and analysed the systems and processes governing community participation in the KwaZulu-Natal primary health care system. The implementation and evaluation of the four pilot projects in this study showed that stakeholder engagement, participatory approaches and empowerment, to a large extent, contributed to the strengthening of health promotion.

According to the USAIDS’ sponsored project (PHRplus, 2004), pilot projects have a potential to improve efficiency or to increase coverage to services. Pilot projects may be used:

- To generate a demand for the service
- To investigate empirically, the advantages and disadvantages of alternative program designs
- To develop or refine the health system design
- To demonstrate how the new system would work and to demonstrate its feasibility
- To build capacity among implementers and perhaps fine-tune the implementation process.

In line with the above benefits of pilot projects, this study has demonstrated the relationship between community participation processes and positive outputs of health promotion. The evaluation of pilot projects further showed that the empowerment of communities during health promotion should include both health information and basic health skills in order for the communities to understand their role in health as well as to encourage community-driven health interventions.

The KwaZulu-Natal study of community participation was conducted across various levels of the primary health care spectrum, namely district, sub-district, hospital, clinic and community level. Using data from both service provider and from community perspectives, the study found that the degree and extent of community participation varies according to the level of the PHC system. Community participation should therefore be planned and implemented according to the systems that are in place at different levels of the health care system. The study has improved the context-based understanding of inter-sectoral collaboration by identifying the stakeholders and various categories of communities that are necessary to support community participation in the PHC system. Considering that community participation is a joint responsibility of both health professionals and communities, the design
of this study has contributed to the understanding of community participation from both the health professionals and community perspectives.

The study produced some evidence that the extent of involvement of communities by health professionals determined the outputs of community participation such as the level of the understanding of community participation by communities. The study established that community members saw their involvement beyond mere representation by municipal counsellors, hospital boards or clinic committees in the health system, but as participation in activities which promote health. Direct participation by communities include health-seeking behaviours, advocacy for health, attending health promotion campaigns etc. Indirect participation, on the other hand, includes healthy behaviours and various self-help initiatives through which communities can participate in the promotion of their health and development of the health system.

This study culminated in the development of the evidence-based community participation model which will hopefully improve the understanding of, and implementation of community participation in KwaZulu-Natal and in South Africa. The guidelines and indicators for the implementation of the model were developed to facilitate the measurement and monitoring of community participation in the primary health system.
5.9 CONCLUSION AND RECOMMENDATIONS

The study of community participation in the KwaZulu-Natal’s primary health care system has provided useful information for the understanding of the methods and challenges of community participation. The pilot projects that were implemented as part of this study showed that the combination of inter-sectoral collaboration, empowerment and community mobilization have a positive effect on health promotion outputs.

The existing systems and processes of community participation in the KwaZulu-Natal PHC system proved sufficient in shaping the design of the community participation model. The model has its roots in the principles of participation as well as in the existing systems and processes in KwaZulu-Natal. It builds on real world phenomena such as collaboration, consultation and empowerment. The model is intended to encourage engagement of stakeholders as partners in the delivery and governance of health services. The activities and outputs of the model need to be institutionalized and monitored using the community participation indicators that have been proposed in this study.

Considering the findings of this study, the following recommendations can be proposed for the future efforts to improve community participation in the KwaZulu-Natal’s health system:

1. The district health councils should be established in the health districts in order to encourage consultation and community participation in line with the National Health Act (Act 61 of 2003).
2. The health facilities should continually profile their catchment communities in order to identify various community structures and stakeholders with which they must work closely in addressing their specific health needs.
3. The hospital boards and clinic committees should be trained on both their governance and service delivery roles in order to increase their effectiveness as partners and advocates for service delivery.
4. The role of the hospital boards and clinic committees should be extended to health promotion and self-help health programmes in their respective communities.
5. Patient support groups should be revived and strengthened through empowerment and support, in order to ensure that they play a meaningful role in community involvement and treatment programmes.
6. Health facilities should intensify and integrate health promotion programmes for the ongoing empowerment of communities on health knowledge and skills in line with the
national health calendar. The empowerment should include health skills and should encourage the implementation of self-help health promoting projects by the communities.

7. Health districts should allocate dedicated health promotion budgets for the implementation of the health calendar at sub-district and health facility levels.

8. The lack of consultative forums and outreach services for District Managers responsible for Emergency Medical Services (EMS), necessitates the introduction of such initiatives in order to improve the effectiveness of this critical service. Alternatively, the existing consultative structures should be more effectively utilized to engage communities in EMS services and to involve communities in the planning and monitoring of the service.

9. Emergency Medical Services should establish the health promotion component which should include basic first aid training for communities, community organizations and volunteers.

10. The facilitation of health promotion campaigns by health professionals should be well planned, be participatory in approach, and be used to address the medical needs of the participants and target communities. Extra efforts should be made to improve follow-up care for screened participants and for persons who require further medical treatment.

11. The members of co-governance structures, in particular hospital boards and clinic committees, should be involved by their health facilities in service planning as well as in the monitoring of services through quality programmes such as complaints mechanisms and client satisfaction surveys.

12. Community participation should be included as one of the key job responsibilities in the job descriptions and performance agreements of PHC managers and other relevant officials.

13. The policy on community participation should be developed and implemented to support health facilities and to monitor community participation in the health care system. The model (fig.12) and guidelines (appendices 25 -34) can be used as a reference or toolkit for the management of community participation at various levels of the primary health care system.

There are no anticipated constraints in the implementation of the proposed community participation model and the recommendations of this study. More research work, however, is still needed to determine the association between the degree of community participation and health outcomes in the health system. In the light of this need, better designed studies will be needed to build better knowledge base for community participation in the future.
Monitoring community participation through routine information management or through surveys will assist future researchers in assessing the added value of community participation processes in the primary health care system. The value of community participation in the health system should be seen beyond just positive health outputs and health promotion. Community participation should eventually bring health professionals and communities closer to permanent partnership in which “working together” brings about long-lasting effects such as community’s self-determination and dignity.
REFERENCES


http://etd.uwc.ac.za


APPENDICES

APPENDIX 1: INFORMATION SHEET

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959, Fax: 27 21-959
E-mail: tipuane@uwc.ac.za

INFORMATION SHEET

Project Title:
Development of the Public Health Model of Community Participation
in the KwaZulu-Natal Primary Health Care System.

What is this study about?
This is a research project being conducted by Mbuso Ishmael Mntambo at the University of the Western Cape. We are inviting you to participate in this research project because you are an important stakeholder in the delivery of Primary Health Care services in this health District.

The purpose of this research project is to assess and understand community participation in the KwaZulu-Natal PHC system, as well as to assess community participation challenges for the purpose of developing and testing a community participation model.

What will I be asked to do if I agree to participate?
You will be asked to respond to interview questions for a duration not exceeding 30 minutes. The study will take place in the area of your work or residence, whichever will be more convenient to you. The questions to be asked will include your knowledge, thoughts and experiences about community participation in the health care system. You will also be asked to share the challenges that are experienced by yourself or by the structure that you represent.

Would my participation in this study be kept confidential?
We will do our best to keep your personal information confidential. To help protect your confidentiality, your name will be recorded in a code that will not reveal your identity. The survey is anonymous and will not contain information that may personally identify you.
name will not be included on the surveys and other collected data. A code will be placed on the survey and other collected data. Through the use of an identification key, the researcher will be able to link your survey to your identity. Only the researcher will have access to the identification key.

All information will be kept in secured storage areas as well as password-protected files in a private computer. If we write a report or article about this research project, your identity will be protected to the maximum extent possible. All participants shall confirm that they will respect confidentiality of information obtained from participating persons and researchers and that they will not share it with anyone else.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

**What are the risks of this research?**

There are no known risks associated with participating in this research project.

**What are the benefits of this research?**

By participating in this study, you will be contributing valuable information which may be used by the Department of Health to improve effectiveness of health services at community level. This research is not designed to help you personally, but the results may help the investigator learn more about the role of community participation in health care. We hope that, in the future, other people might benefit from this study through improved understanding of the role played by the communities in health service delivery.

**Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

**Is any assistance available if I am negatively affected by participating in this study?**

Should you be negatively affected through participating in this study, all effort will be made to assist you with correct interventions such as advocacy for your rights, counselling and referral to appropriate care.
What if I have questions?

This research is being conducted by Mr Mbuso Ishmael Mntambo, School of Public Health at the University of the Western Cape.

If you have any questions about the research study itself, please contact Mr Mbuso Ishmael Mntambo at:

P.O. Box 10466
Empangeni
3880

Contact number: 0834079962; e-mail address: mbusomntambo@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, contact:

Head of Department: Dean of the Faculty of Community and Health Sciences:
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the UWC’s Research and Ethics Committees.
APPENDIX 2: DEPARTMENT OF HEALTH'S LETTER OF APPROVAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email: hrmk@kznhealth.gov.za
www.kznhealth.gov.za

Reference: HRKM 193/12
Enquiries: Mr X Xaba
Tel: 033 – 395 2805

Dear Mr M. Mntambo

Subject: Approval of a Research Proposal

1. The research proposal titled ‘Development of the Public Health Model of Community participation in the KwaZulu Natal (KZN) Primary Health Care (PHC) system’ was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at eThekwini and Uthungulu Districts for a period of six months. Facilities to be included in the study are listed in appendix D.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

[Signature]

Dr E Lutge
Chairperson, Health Research Committee

Date: 16/01/2013

uMnyango Wezempilo. Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope
APPENDIX 3: CONSENT FORM FOR INTERVIEW PARTICIPANTS

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959, Fax: 27 21-959
E-mail: tpuoane@uwc.ac.za

CONSENT FORM

Title of Research Project: Development of the Public Health Model of Community Participation in the KwaZulu-Natal Primary Health Care System.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to maintain the confidentiality of the information discussed by all participants and researchers during the focus group discussion.

Participant’s name…………………………………………
Participant’s signature………………………………
Witness……………………………………………………
Date……………………………………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator’s Name: Prof Thandi Puoane
University of the Western Cape
Private Bag X17, Belville 7535
Telephone: (021)959-2809
Cell: 0827075881   Fax: (021)959-2872
Email: tpuoane@uwc.ac.za
APPENDIX 4: CONSENT FORM FOR THE FOCUS GROUP PARTICIPANTS

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959, Fax: 27 21-959
E-mail: tpuoane@uwc.ac.za

CONSENT TO PARTICIPATE IN A FOCUS GROUP STUDY

Title of Research Project: Development of the Public Health Model of Community Participation in the KwaZulu-Natal Primary Health Care System.

The purpose of the group discussion and the nature of the questions have been explained to me.

I consent to take part in a focus group discussion about my experiences, including some ways to improve community participation in Primary Health Care. I also consent to be tape-recorded during the focus group discussion.

My participation is voluntary. I understand that I am free to leave the group at any time. None of my experiences or thoughts will be shared with anyone outside of this community participation research unless all identifying information is removed first. The information that I provide during the focus group will be grouped with answers from other people so that I cannot be identified.

___________________________________   _____________________
Please print your name     Date

___________________________________
Signature

___________________________________   _____________________
Witness signature      Date
APPENDIX 5: INTERVIEW QUESTIONNAIRE – HEALTH PROFESSIONALS

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _________________

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ________________

2. Ethnicity: African ____ Coloured _____ White ____ Indian _____ Other ____

3. How old are you? _________________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>Level</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: __________________________________

6. How long have you been working in this position? _________________
B. GENERAL INTERVIEW QUESTIONS

1. In your professional role, do you consider yourself to be directly, indirectly or not responsible for Community Participation?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Directly responsible</td>
<td>1</td>
</tr>
<tr>
<td>Indirectly responsible</td>
<td>2</td>
</tr>
<tr>
<td>Not responsible</td>
<td>3</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
</tr>
</tbody>
</table>

2. What do you understand by the term “community participation in health”?

_________________________________________________________________________

_________________________________________________________________________

Follow-up: Does the following activity represent:

2.1. Advocacy for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Community leaders request the number of mobile clinic points to be increased</td>
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<td></td>
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<tr>
<td>(ii) Community volunteers use their own vehicles to transport patients to the hospital</td>
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<td></td>
</tr>
</tbody>
</table>

2.2. Ownership of health by communities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Support Groups for pregnant women</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(ii) Health facilities employ local people to provide security and housekeeping services in the clinics</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
2.3. Social mobilization for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals promote the Anti-smoking Campaign through television</td>
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<td></td>
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<td>(ii) Health managers communicate health information and reports to the communities on regular basis</td>
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</tbody>
</table>

2.4. Partnership in health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health managers involve Community Care Givers in the health strategic planning</td>
<td></td>
<td></td>
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<tr>
<td>(ii) Hospital Boards and Clinic Committees participate in the planning and monitoring of health services</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

2.5. Empowerment (of community) on health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals train Traditional Health Practitioners on health matters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) PHC nurses visit the community to assess their health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Which strategies are often used by health professionals to involve community members in health matters?

Follow-up:

<table>
<thead>
<tr>
<th>Possible strategy</th>
<th>Used</th>
<th>Not used</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Through Governance and Participation structures – Hospital Boards and Clinic Committees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Consult communities through media, community leaders, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Use outreach health campaigns to reach out to communities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Empower communities with skills for self care and development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Implement health promotion as per the Health Calendar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Other (explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Does your facility or health institution have functional suggestion boxes?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Comment (if any) ____________________________________________________________

5. Does your facility or health institution have functional complaints/compliments mechanisms?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Comment (if any) ____________________________________________________________
6. Which of the following empowerment activities does your health institution conduct at least once a year?:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Training of Traditional Health Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Training of Traditional Birth Attendants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Life skills to major patients Support Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) First Aid to citizens or other role players</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Breastfeeding techniques</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. During the **past 12 months**, which of the following activities were conducted by your health facility in consultation or jointly with your District Council, Hospital Board or Clinic Committee?:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Yes</th>
<th>No</th>
<th>Comment (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Strategic Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Operational Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Imbizo/Open day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Major Health Awareness event</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Patients Complaints handling (from suggestion boxes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Patient Satisfaction Surveys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Hospital or clinic Rounds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. Which of the following health calendar events did your institution conduct during the 2013/2014 financial year?:

<table>
<thead>
<tr>
<th>Event</th>
<th>Yes</th>
<th>No</th>
<th>Comment (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Nutrition Day/Week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Healthy Lifestyles Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Tuberculosis Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Diabetes Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Anti-Tobacco Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Traditional Medicines Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Drug Abuse Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(viii) Heart and/or hypertension Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ix) Women’s Health Day (any women’s health program)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(x) HIV/ AIDS Awareness</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

9. Which of the following community empowerment resources does your health institution have?:

<table>
<thead>
<tr>
<th>RESOURCES</th>
<th>YES</th>
<th>NO</th>
<th>COMMENT (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Dedicated Tracer Staff for HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Dedicated Tracer Staff for TB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Public Address system (loud speakers or sound system) for health outreach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Tent/s for health outreach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Other (explain):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. Which governmental and non-governmental role players does your health facility (or health office) work with in the planning and delivery of health services?

________________________________________________________________________

11. Which community structures does your health institution regularly work with?:____

________________________________________________________________________

Follow-up: Does your health facility regularly work with each of the following:

<table>
<thead>
<tr>
<th>Community structures</th>
<th>Yes</th>
<th>No</th>
<th>Comment/example</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Schools</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Churches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Cultural groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Sports groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Traditional local councils (&quot;Izinduna&quot;, &quot;Amakhosi&quot;)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Traditional Health Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Business (shops, markets, transport operators)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(viii) Pension and grants paypoints and old age homes (elderly &amp; disabled)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ix) Old age homes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(x) Support groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xi) Prison</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xii) Youth or Youth Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xiii) Community Based Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xiv) Disabled persons or Disabled Persons Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xv) District Council, Hospital Board or Clinic Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. What are the most common challenges of community participation in your health facility?

________________________________________________________________________

________________________________________________________________________
APPENDIX 6: INTERVIEW QUESTIONNAIRE – COMMUNITY MEMBERS

Modeling Community Participation in Primary Health Care – a KZN Study

____________________________________________________________________

District: ___________________: Date _________________: Unique ID _____________

____________________________________________________________________

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured _____ White ____ Indian ____ Other ____

3. How old are you? ________________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>Level</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: __________________________________________

6. How long have you been working in this position? ____________
B. GENERAL INTERVIEW QUESTIONS

1. What do you think is your role, as a member of the community, in local health services?

_________________________________________________________________________
_________________________________________________________________________

Follow-up: Are you a member of any of the following community structure or project?

<table>
<thead>
<tr>
<th>Community activity or project</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Hospital Board or Clinic Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Patient Support Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Home-based Care Project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Community Based Organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Nutrition Project</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. How can you, as a member of the community, participate in health care?

_________________________________________________________________________
_________________________________________________________________________
Follow-up: Which of the following processes or activities can be used by the community as part of “community participation”? Give one example of what you have observed in your community.

<table>
<thead>
<tr>
<th>Process or activity</th>
<th>Yes</th>
<th>No</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Communities motivate for changes in health policies in order to improve health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Communities take care and responsibility for their own health and for service delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Communities form community based organizations and Support Groups to solve health problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Health professionals organize ongoing education of community members on health matters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Communities work together with the health department or health facility in planning and health promotion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Do you believe that your community is adequately involved by the local health authorities in health issues?

<table>
<thead>
<tr>
<th>Yes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Why do you think so? Give your reasons

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

http://etd.uwc.ac.za
4. In the past 12 months, has any health promoting event been held in your community?

Yes [ ] No [ ] Comment [ ]

5. Do you know the Community Health Care Giver for your village or community?

Yes [ ] No [ ] Comment [ ]

6. Are you aware of the Clinic Committee that represents your community in the health affairs of your local clinic?

Yes [ ] No [ ] Comment [ ]

7. What do you consider as the most common challenges affecting your participatory role in health care?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Thank you for your time!
APPENDIX 7: INTERVIEW QUESTIONNAIRE – CHAIRPERSONS OF THE HOSPITAL BOARDS

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _____________

____________________________________________________________________

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________Female ______________

2. Ethnicity: African _____ Coloured _____White ____Indian _____Other ____

3. How old are you? _______________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>None</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: __________________________________________

6. How long have you been working in this position? _______________
**B. GENERAL INTERVIEW QUESTIONS**

1. How many times is your Hospital Board scheduled meet per year? _______________

2. How many times did the Hospital Board meet during the last (2013/14) financial year? __________

3. What do you understand by “community participation in health”?

Follow-up: Does the following activity represent:

**3.1. Advocacy for health?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Community leaders request the number of mobile clinic points to be increased</td>
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<td>(ii) Community volunteers use their own vehicles to transport patients to the hospital</td>
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</tbody>
</table>

**3.2. Ownership of health by communities?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
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<tbody>
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<td>(i) Support Groups for pregnant women</td>
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<tr>
<td>(ii) Health facilities employ local people to provide security and housekeeping services in the clinics</td>
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<td></td>
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</tbody>
</table>

**3.3. Social mobilization for health?**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals promote the Anti-smoking Campaign through television</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health managers communicate health information and reports to the communities on regular basis</td>
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<td></td>
</tr>
</tbody>
</table>
3.4. Partnership in health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health managers involve Community Care Givers in the health strategic planning</td>
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<td></td>
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<tr>
<td>(ii) Hospital Boards and Clinic Committees participate in the planning and monitoring of health services</td>
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</tr>
</tbody>
</table>

3.5. Empowerment (of community) on health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals train Traditional Health Practitioners on health matters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) PHC nurses visit the community to assess their health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. How does your hospital board involve communities in health services?

________________________________________________________________________
________________________________________________________________________

Follow-up: Which of the following has your Hospital Board organized in the past 12 months:

<table>
<thead>
<tr>
<th>Event/activity</th>
<th>Yes</th>
<th>No</th>
<th>Comment (e.g. date, place, N/A etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Open Day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health Awareness Campaigns e.g. TB, HIV, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Community Consultative Meeting/Workshop etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Visit by Board and Hospital Management to a community structure e.g. school, church, traditional authority structure, sports club, political gathering, social club, cultural club</td>
<td></td>
<td></td>
<td>Specify:</td>
</tr>
<tr>
<td>(v) Health –related community project e.g. vegetable garden, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Which of the following sectors or organizations are represented in your Hospital Board?

<table>
<thead>
<tr>
<th>Field or Organization</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) <strong>Schools or Education</strong> sector (or at least a committee member from/with Education background)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) <strong>Law or Justice</strong> sector (or at least a committee member with law/justice background)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) <strong>Finance</strong> (or at least a committee member with finance background)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) <strong>Disabled Persons Organization</strong> (or at least a committee member who’s disabled)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) <strong>Health</strong> (or at least a committee member with health background)</td>
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<td></td>
</tr>
<tr>
<td>(vi) <strong>Other</strong>: Please mention any special field or background of any member</td>
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<td></td>
</tr>
</tbody>
</table>

6. What are the most common challenges affecting the community participation role of your hospital board?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured _____ White ____ Indian _____ Other ____

3. How old are you? _______________ years

4. What is your highest educational qualification?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: __________________________________________

6. How long have you been working in this position? ______________
### B. GENERAL INTERVIEW QUESTIONS

1. How many times does your Clinic Committee scheduled to meet per year? _______
2. How many times did the Clinic Committee meet this (2014/15) financial year? ______
3. What do you understand by “community participation in health”?_________________
   __________________________________________________________________________
   __________________________________________________________________________

Follow-up: Does the following activity represent:

#### 3.1. Advocacy for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Community leaders request the number of mobile clinic points to be increased</td>
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<td></td>
<td></td>
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<tr>
<td>(ii) Community volunteers use their own vehicles to transport patients to the hospital</td>
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<td></td>
</tr>
</tbody>
</table>

#### 3.2. Ownership of health by communities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Support Groups for pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health facilities employ local people to provide security and housekeeping services in the clinics</td>
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<td></td>
</tr>
</tbody>
</table>

#### 3.3. Social mobilization for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals promote the Anti-smoking Campaign through television</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health managers communicate health information and reports to the communities on regular basis</td>
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<td></td>
</tr>
</tbody>
</table>
3.4. Partnership in health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health managers involve Community Care Givers in the health strategic planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Hospital Boards and Clinic Committees participate in the planning and monitoring of health services</td>
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</tr>
</tbody>
</table>

3.5. Empowerment (of community) on health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals train Traditional Health Practitioners on health matters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) PHC nurses visit the community to assess their health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. How does your clinic committee involve communities in health services?____________________
________________________________________________________________________
________________________________________________________________________

Follow-up: Which of the following has your Clinic Committee organized in the past 12 months:

<table>
<thead>
<tr>
<th>Event/activity</th>
<th>Yes</th>
<th>No</th>
<th>Comment (e.g. date, place, N/A etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Open Day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health Awareness Campaigns e.g. TB, HIV, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Community Consultative Meeting/Workshop etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Visit by Committee and Clinic Management to a community structure e.g. school, church, traditional structure, sports club, political gathering, social club, cultural club</td>
<td></td>
<td></td>
<td>Specify:</td>
</tr>
</tbody>
</table>
(v) Health–related community project e.g. vegetable garden, etc. |  |  
(vi) Health-related support group/s established |  |  
(vii) Health-supporting voluntary work |  |  
(viii) Fundraising |  |  
(ix) Donation or loaning of capital or other form of resources to support health initiatives |  |  
(x) Any other Health Promoting initiative | Specify: |  

5. Which of the following sectors or organizations are represented in your Clinic Committee?

<table>
<thead>
<tr>
<th>Field or Organization</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Schools or Education sector (or at least a committee member from/with Education background)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Law or Justice sector (or at least a committee member with law/justice background)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Finance (or at least a committee member with finance background)</td>
<td></td>
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<tr>
<td>(iv) Disabled Persons Organization (or at least a committee member who’s disabled)</td>
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<td></td>
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<tr>
<td>(v) Health (or at least a committee member with health background)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Other: Please mention any special field or background of any member</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. What are the most common challenges affecting the community participation role of your clinic committee?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
APPENDIX 9: INTERVIEW QUESTIONNAIRE – MUNICIPAL DIRECTOR: COMMUNITY SERVICES

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _____________

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured _____ White ____ Indian ____ Other ____

3. How old are you? ________________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>Level</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. How long have you been working in this position? _________________
B. GENERAL INTERVIEW QUESTIONS

1. As a Director for Community Services and a member of the sub-district Inter-sectoral Committee, do you consider yourself to be directly, indirectly or not responsible for Community Participation?

<table>
<thead>
<tr>
<th>Directly responsible</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirectly responsible</td>
<td>2</td>
</tr>
<tr>
<td>Not responsible</td>
<td>3</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
</tr>
</tbody>
</table>

2. Which of the following stakeholders or community structures are represented in the service delivery Inter-sectoral Committees for your local municipality?:

<table>
<thead>
<tr>
<th>Community structures</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i).Schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii).Churches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii).Cultural groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv).Sports groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v).Traditional local councils (&quot;Izinduna, Amakhosi&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Traditional Health Practitioners (&quot;Abalaphi bendabuko&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii).Business (shops, markets, transport operators)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(viii) Youth or Youth Organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ix) Non-governmental Organization (NGO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(x) Community Based Organization (CBO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xi) Local health authority (district management, hospital of clinic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xiii) Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. What do you understand by “community participation in health or social services”?

Follow-up: Does the following activity represent:

### 3.1. Advocacy for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
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<tr>
<td>(i) Community leaders request the number of mobile clinic points to be increased</td>
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### 3.2. Ownership of health by communities?

<table>
<thead>
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</tbody>
</table>

### 3.3. Social mobilization for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
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<tbody>
<tr>
<td>(i) Health professionals promote the Anti-smoking Campaign through television</td>
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<td>(ii) Health managers communicate health information and reports to the communities on regular basis</td>
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</table>

### 3.4. Partnership in health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health managers involve Community Care Givers in the health strategic planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Inter-sectoral Committees participate in the planning and monitoring of health services</td>
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</tbody>
</table>
3.5. Empowerment (of community) on health?

<table>
<thead>
<tr>
<th>Activity</th>
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</table>

4. How does your municipality involve communities in health or social services?________________________
________________________________________________________________________
________________________________________________________________________

Follow-up: Which strategies does your Municipality use, to involve communities in health matters?

<table>
<thead>
<tr>
<th>Possible strategy</th>
<th>Yes</th>
<th>No</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Governance and Participation structures (Sub-district multi-sectoral Committee) are available and discusses health issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Municipality communicates community issues through media, community leaders, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Municipality uses outreach campaigns to reach out to communities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Municipality empowers communities with skills for self care and development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Municipality mostly relies on the Health Department or local health facilities to engage communities in health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Other (explain):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. What are the most common challenges affecting the community participation role of your municipality’s multi-sectoral committee? ____________________________________________
________________________________________________________________________
________________________________________________________________________
APPENDIX 10: INTERVIEW QUESTIONNAIRE – MUNICIPAL COUNSELLOR

Modeling Community Participation in Primary Health Care – a KZN Study

____________________________________________________________________

District: ___________________: Date _________________: Unique ID _____________

____________________________________________________________________

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured _____ White ____ Indian _____ Other ____

3. How old are you? ________________ years

4. What is your highest educational qualification?

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</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. How long have you been working in this position? _________________
B. GENERAL INTERVIEW QUESTIONS

1. As a Municipal Counsellor and as a participant in the sub-district Inter-sectoral Committee, do you consider yourself to be directly, indirectly or not responsible for Community Participation?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Directly responsible</td>
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<tr>
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<td>4</td>
</tr>
</tbody>
</table>

2. What do you understand by “community participation in health or social services”?

Follow-up: Does the following activity represent:

2.1. Advocacy for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
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<tbody>
<tr>
<td>(i) Community leaders request the number of mobile clinic points to be increased</td>
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</table>

2.2. Ownership of health by communities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Support Groups for pregnant women</td>
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<td></td>
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<tr>
<td>(ii) Health facilities employ local people to provide security and housekeeping services in the clinics</td>
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<td></td>
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</tbody>
</table>
2.3. Social mobilization for health?

<table>
<thead>
<tr>
<th>Activity</th>
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<th>Disagree</th>
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<tbody>
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<td>(ii) Health managers communicate health information and reports to the communities on regular basis</td>
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</table>

2.4. Partnership in health?

<table>
<thead>
<tr>
<th>Activity</th>
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<th>Disagree</th>
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</thead>
<tbody>
<tr>
<td>(i) Health managers involve Community Care Givers in the health strategic planning</td>
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</table>

2.5. Empowerment (of community) on health?

<table>
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<tr>
<th>Activity</th>
<th>Agree</th>
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<tr>
<td>(i) Health professionals train Traditional Health Practitioners on health matters</td>
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<tr>
<td>(ii) PHC nurses visit the community to assess their health needs</td>
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</tbody>
</table>

3. How do you, as a municipal Counsellor involve communities in health or social services?

_________________________________________________________________________
_________________________________________________________________________
Follow-up 1: Which of the following strategies do you, a municipal Counsellor use, to involve communities in health matters?

<table>
<thead>
<tr>
<th>Possible strategy</th>
<th>Yes</th>
<th>No</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) You participate in the Governance and Participation structures (the sub-district Inter-sectoral Committee)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) You consult and communicate with communities through community leaders and meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) You conduct outreach campaigns to reach out to communities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) You mostly rely on the Health Department or local health facilities to engage communities in health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Other (explain):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Follow-up 2: Which of the following have you, or previous Counsellor organized in the local community within the past 12 months:

<table>
<thead>
<tr>
<th>Event/activity</th>
<th>Yes</th>
<th>No</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Open Day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health Awareness Campaigns e.g. TB, HIV, etc.</td>
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<tr>
<td>(iii) Community Consultative Meeting/Workshop etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Visit to a community structure e.g. school, church, sports club, social club, cultural club etc.</td>
<td></td>
<td></td>
<td>Specify:</td>
</tr>
<tr>
<td>(v) Health–related community project e.g. nutrition garden, etc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Health-related support group/s established</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Any voluntary work that supports community health and/or welfare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(viii) Fundraising for health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ix) Donation or loaning of capital or other form of resources to support health or welfare initiatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(x) Any other Health Promoting or Welfare Promoting initiative</td>
<td></td>
<td></td>
<td>Specify:</td>
</tr>
</tbody>
</table>
5. What are the most common challenges affecting the community participation role of your hospital board?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Thank you for your time!
APPENDIX 11: INTERVIEW QUESTIONNAIRE – COMMUNITY CARE GIVERS

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _____________

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________Female ______________

2. Ethnicity: African _____ Coloured _____White _____Indian _____Other _____

3. How old are you? ________________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>None</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. For how long have you been working as a Community Care Giver?

____________________
B. GENERAL INTERVIEW QUESTIONS

1. As a Community Care Giver, do you consider yourself to be directly, indirectly or not responsible for Community Participation?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Directly responsible</td>
<td>1</td>
</tr>
<tr>
<td>Indirectly responsible</td>
<td>2</td>
</tr>
<tr>
<td>Not responsible</td>
<td>3</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
</tr>
</tbody>
</table>

2. What do you understand by “community participation in health”?____________________

________________________________________________________________________
________________________________________________________________________

Follow-up: Does the following activity represent:

2.1. Advocacy for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Community leaders request the number of mobile clinic points to be increased</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Community volunteers use their own vehicles to transport patients to the hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.2. Ownership of health by communities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Support Groups for pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health facilities employ local people to provide security and housekeeping services in the clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.3. Social mobilization for health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals promote the Anti-smoking Campaign through television</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Health managers communicate health information and reports to the communities on regular basis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.4. Partnership in health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health managers involve Community Care Givers in the health strategic planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Hospital Boards and Clinic Committees participate in the planning and monitoring of health services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.5. Empowerment (of community) on health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Agree</th>
<th>Disagree</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Health professionals train Traditional Health Practitioners on health matters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) PHC nurses visit the community to assess their health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How do you, as the Community Care Giver, involve communities or community members in health care?

_________________________________________________________________________
_________________________________________________________________________
Follow-up: Which strategies do you, the Community Care Giver use, to involve communities in health matters?

<table>
<thead>
<tr>
<th>Possible strategy</th>
<th>Yes</th>
<th>No</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) You participate in Governance and Participation structures: sub-district Inter-sectoral Committee or Clinic Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) You consult or keep in contact with communities through community leaders and/or meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) You conduct household visits to reach out to communities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) You empower communities with skills for self-care and development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Other (explain):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Which of the following empowerment activities do you conduct at least once a year?:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Training of Traditional Health Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Training of Traditional Birth Attendants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Life skills to major patients Support Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) First Aid to citizens or other role players</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Breastfeeding techniques</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Which of the following health calendar events did you organize or participate in, during the last (2013/2014) financial year?:

<table>
<thead>
<tr>
<th>Event</th>
<th>Yes</th>
<th>No</th>
<th>Comment (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Nutrition Day/Week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Healthy Lifestyles Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Tuberculosis Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Diabetes Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Anti-Tobacco Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Traditional Medicines Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Drug Abuse Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(viii) Heart and/or hypertension Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ix) Women’s Health Day (any women’s health program)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(x) HIV/ AIDS Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Which of the following community structures do you regularly visit or work with?:

<table>
<thead>
<tr>
<th>Community structures</th>
<th>Yes</th>
<th>No</th>
<th>Comment/example</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Schools</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Churches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Cultural groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Sports groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Traditional local councils (“Izinduna, Amakhosi”)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Traditional Health Practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(“Abalaphi bendabuko”)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Business (shops, markets, transport operators)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. What are the most common challenges affecting your community participation role as a Community Care Giver?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Thank you for your time!
APPENDIX 12: OBSERVATION CHECKLIST – HEALTH PROMOTION PROJECTS

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _____________

Background

1. Name of the organization ________________________________________________
2. District_______________________________________________________________
3. Name or theme for the event _____________________________________________
4. Venue for the event____________________________________________________
5. Originator or proposer of the event_________________________________________
6. Organizer/s of the event_________________________________________________
7. Date of the Event_______________________________________________________
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>YES</th>
<th>NO</th>
<th>REASON OR COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPUTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Was the timing of the event correct  (in line with health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>calendar or health priorities)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Was the situational analysis of the health problem done?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Was the anticipated number of participants (attendance)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>estimated?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Were the following incentives for participation available?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Entertainment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Catering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Were the following resources available and suitable?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Venue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sound System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Were the following role players adequately represented?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Subject matter experts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRITERIA</td>
<td>YES</td>
<td>NO</td>
<td>REASON OR COMMENT</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>PROCESS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Was the program well designed and organized?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Was the atmosphere friendly and joyous, including conducive environment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Did the Program Director facilitate the proceeding in accordance with the programme?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Did presenters/ facilitators display adequate knowledge of the subject</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Were program activities well executed? Were messages well presented?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vi) Were messages relevant and practical?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Did the sound and technology function effectively?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(viii) Did the participants/presenters display good attitudes toward the audience?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ix) Was the audience given the opportunity to participate in the programme through asking questions or providing inputs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(x) Were the relevant health screening services adequately provided during the day?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(xi) Were activities, inputs and tasks properly documented?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRITERIA</td>
<td>OUTPUT INDICATOR</td>
<td>OUTPUT</td>
<td>COMMENT</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>(i)</td>
<td>Number of participants?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii)</td>
<td>Number of participants screened or tested?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii)</td>
<td>Number of screened participants who received their laboratory results back from the facility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv)</td>
<td>Actions taken in response to abnormal screening findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v)</td>
<td>Was the evaluation of the project conducted by the organizers after implementation?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 13: RECORDS REVIEW – HOSPITAL BOARDS AND CLINIC COMMITTEES MEETINGS

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _____________

HOSPITAL BOARD OR CLINIC COMMITTEE: ________________________________

Review the Minutes of Hospital Board/Clinic Committee to answer the following questions

1. Is the Board/Committee active? Yes ________ No __________

2. Explain ____________________________________________________________

3. Minutes available ________ Well written ________ Well kept _________

4. Main matters/activities discussed by the Board/Committee: __________________

_____________________________________________________________________

5. HIV and AIDS matters discusses Yes ____________ No _______________

Notes____________________________________________________________

_____________________________________________________________________

6. Evidence of achievements ___________________________________________

_____________________________________________________________________

7. Identified challenges _______________________________________________

_____________________________________________________________________

8. Other comments ________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

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___________________________________________________________________

___________________________________________________________________

___________________________________________________________________
FOCUS GROUP DISCUSSION – DEVELOPMENT OF MODEL BY THE PHC PROFESSIONALS

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _____________

FOCUS GROUP DISCUSSION GUIDE

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African _____ Coloured _____ White _____ Indian _____ Other _____

3. How old are you? ______________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>None</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>
B. INTRODUCTION

(i) The participants are seated comfortably.
(ii) The participants complete the attendance register and record their demographic particulars.
(iii) The participants are welcomed, orientated and invited to get something to eat.
(iv) The Researcher introduces himself as the moderator and also introduces the assistant.
(v) The Researcher discusses the research title and research objectives, as well as the purpose of the focus group discussion.
(vi) The participants’ rights are explained and what the focus group will entail.
(vii) Consent forms are completed.
(viii) Ground rules, discussion procedures and time frames are communicated.

C. PROCESS

(i) The Investigator inserts an ice-breaker to increase comfort and levels the playing field.
(ii) The Investigator leads the discussion by asking questions (and probing, if needed) as per the discussion guide.
(iii) The assistant takes notes and records the proceedings on the charts.

D. DISCUSSION QUESTIONS

(i) In your opinion, which stakeholders should health institutions work with, in order for them to effectively deliver health services to the community? And why?

(ii) How do you think health professionals or health institutions should involve communities in health services?

(iii) How do you think health professionals or health institutions should consult the communities?

(iv) What resources are needed by the health institutions in order for them to effectively involve communities in health services?

(v) In your opinion, how should health professionals or health institutions mobilize the communities to take care of their own health?

(vi) In your opinion, how should communities partner with health authorities in order to improve prevention and fight against diseases in the communities?
(vii) Which four community projects do you think can be piloted to demonstrate community participation approaches and strategies in health promotion?

(viii) What process and output indicators should be used to evaluate planned pilot projects? (The group participants brainstorm and agree on quality and efficiency measures to be used)

E. CONCLUSION

(i) The facilitator summarizes the discussions and provide feedback to participants.

(ii) The facilitator confirms whether the summary is a true reflection of what was discussed.

(iii) The facilitator asks if group participants have any questions, and addresses them.

(iv) The Investigator thanks the participants for attendance and for participation.

(v) All recorded information, charts etc. are collected for analysis.
### APPENDIX 15: IMPLEMENTATION OF HEALTH PROMOTION PILOT PROJECTS

<table>
<thead>
<tr>
<th>Project inputs and processes</th>
<th>Training of the clinic committee</th>
<th>Anti-teenage pregnancy campaign</th>
<th>Diabetes health promotion project</th>
<th>Establishment of the patient support group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venue</td>
<td>Luwamba clinic</td>
<td>Velangaye high school</td>
<td>Oakland</td>
<td>Osindisweni hospital</td>
</tr>
<tr>
<td>Sub-district</td>
<td>Umhlathuze</td>
<td>Nkandla</td>
<td>Ethekwini</td>
<td>Ethekwini</td>
</tr>
<tr>
<td>Target community</td>
<td>Members of the clinic committee</td>
<td>School learners</td>
<td>General members of the community</td>
<td>Diabetic patients</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Clinic nurses</td>
<td>School educators</td>
<td>Dept. of health hospital</td>
<td>Dept. of health hospital professionals</td>
</tr>
<tr>
<td></td>
<td>Members of the community</td>
<td>Members of School Governing Body</td>
<td>professionals</td>
<td>Community leaders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dept. of Health midwife</td>
<td>Local sugar industry</td>
<td>Community leaders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NGO</td>
<td>Community leaders</td>
<td>Community care givers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Expert patients</td>
<td></td>
</tr>
<tr>
<td>Key inputs</td>
<td>The original training and</td>
<td>The “Sexuality and Pregnancy</td>
<td>The health promotion event</td>
<td>The guidelines for the</td>
</tr>
<tr>
<td></td>
<td>resource guide was developed</td>
<td>Education, Surveillance and</td>
<td>implementation tool was</td>
<td>establishment and facilitation of the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support” (“X-Press”) Tool was</td>
<td>developed</td>
<td>patient support group were</td>
</tr>
<tr>
<td></td>
<td></td>
<td>developed</td>
<td></td>
<td>developed</td>
</tr>
<tr>
<td>Consultation</td>
<td>The researcher convened</td>
<td>The stakeholders were</td>
<td>The planning of the project</td>
<td>A consultative meeting was held</td>
</tr>
<tr>
<td></td>
<td>one consultative meeting</td>
<td>identified and consulted</td>
<td>was conducted in</td>
<td>with hospital management to plan</td>
</tr>
<tr>
<td></td>
<td>with the PHC manager of the</td>
<td>individually to mobilize them</td>
<td>consultation with the eThekwini</td>
<td>the project. The health workers</td>
</tr>
<tr>
<td></td>
<td>clinics in uThungulu district.</td>
<td>for the project and to discuss</td>
<td>district management, the</td>
<td>(mainly PRO, nurses and care</td>
</tr>
<tr>
<td></td>
<td>The meeting culminated in the</td>
<td>their roles in the project</td>
<td>management of Osindisweni</td>
<td>givers) participated in the</td>
</tr>
<tr>
<td></td>
<td>identification of Luwamba as the</td>
<td></td>
<td>hospital and representatives</td>
<td>recruitment drive for membership of</td>
</tr>
<tr>
<td></td>
<td>clinic where the project would</td>
<td></td>
<td>of the community</td>
<td>the support group</td>
</tr>
<tr>
<td></td>
<td>be implemented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>Monthly visits by the multi-disciplinary team were conducted to the school. Health education focussed on knowledge and skills necessary for prevention and management of sexually-transmitted infections, HIV and pregnancy. Learners were given information about referral centres for further health and social assistance.</td>
<td>The participants were given information on prevention, treatment and life skills related to diabetes. The expert patient (popular radio presenter) shared his experiences and insight into diabetes management.</td>
<td>During orientation and training, the members of the support group were empowered on diabetes management and life skills necessary for them to participate in effective management of their condition.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Key health promotion messages</strong></td>
<td><em>Legislative and policy framework for governance structures</em>&lt;br&gt;<em>Procedure for the appointment of clinic committees</em>&lt;br&gt;<em>The structure and organization and objectives of the department of health</em>&lt;br&gt;<em>The legislative and policy framework</em>&lt;br&gt;<em>Human resources management</em>&lt;br&gt;<em>Principles of financial management</em>&lt;br&gt;<em>National Core Standards for health establishments</em>&lt;br&gt;<em>Duties, responsibilities and activities of the committees</em>&lt;br&gt;<em>The role and guidelines for the clinic committee in the governmental capacity building project</em>&lt;br&gt;<em>Procedure for meetings</em>&lt;br&gt;<em>Knowledge about fertility</em>&lt;br&gt;<em>Knowledge about ante-natal care</em>&lt;br&gt;<em>Knowledge of the dangers and complications of teenage pregnancy</em>&lt;br&gt;<em>Knowledge about the prevention of sexually transmitted infections</em>&lt;br&gt;<em>Knowledge about family planning and emergency contraception</em>&lt;br&gt;<em>Knowledge about termination of pregnancy</em>&lt;br&gt;<em>Knowledge about “statutory rape”</em>&lt;br&gt;<em>Knowledge on signs, symptoms and complications of diabetes</em>&lt;br&gt;<em>Information on diagnosis and treatment of diabetes</em>&lt;br&gt;<em>Life skills and lifestyle issues for diabetes patients</em>&lt;br&gt;<em>Management of social issues for diabetes patients</em>&lt;br&gt;<em>Role and responsibilities of the patient support group</em>&lt;br&gt;<em>Benefits of participating in the patient support group</em>&lt;br&gt;<em>Health information that would be shared during the support group meetings e.g. drug information, healthy life styles, management of complications etc.</em>&lt;br&gt;<em>Importance of compliance to treatment</em>&lt;br&gt;<em>Procedures for the support group meetings</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Other processes
- Resource guides were issued to the participants for future use and for reference.
- The surveillance system for monitoring teenage pregnancy was implemented.
- The health screening services were provided by the professional staff.
- The members were encouraged to advocate for their health needs and to implement self-care projects.

### Participatory approaches
- The empowerment and capacity building of the committee members was participatory in approach. The training was interactive and participants were given the opportunity to ask questions and to contribute their ideas.
- During health education, the team worked with the educators and members of the SGB in addressing the needs of the learners. The presenters also afforded the learners the opportunity to ask questions and to share their experiences and opinions.
- The presentation of health promotion messages was participatory in approach and it focussed on the practical needs and expectations of the participants. Enough time and attention was given to the questions, inputs and experiences of the participating audience.
- The meetings of the support group was participatory and it encouraged cooperative problem solving and collaboration between members and the health professionals.

### Key outputs
- The workshop was attended by committee 12 committee members.
- 505 learners attended at least 6 X-Press education sessions at the school.
- The event was attended by 180 community members. Of the 63 persons screened, 10 cases of high glucose levels were referred for further care.
- Forty eight (48) patients were recruited to join the support group.

### Evaluation
- The knowledge of participants was assessed before and after training. The project was further evaluated through perception survey of committee members.
- The knowledge of learners was assessed before and after training. The project was further evaluated by members of SGB, educators and through focus group of PHC nurses.
- The project was evaluated by a team of health professionals and through focus group of PHC nurses.
- The project was evaluated by members of the support group. The project was further evaluated through focus group of PHC nurses.

### Major findings
- The members gained additional knowledge, confidence and motivation from the training project.
- Broad inter-sectoral collaboration was used to address a public health problem. The knowledge of learners on sexuality and pregnancy was improved.
- Multi-professional approach was used to health promotion. The community and patients were educated on diabetes. New cases of the disease were identified.
- Advocacy for better health care was encouraged. Patients were encouraged to get involved in decision making.
APPENDIX 16: EVALUATION – TRAINING OF THE CLINIC COMMITTEE

Modeling Community Participation in Primary Health Care – a KZN Study

PRE AND POST-ASSESSMENT OF COMMITTEE KNOWLEDGE BY COMMITTEE MEMBERS

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured ____ White ____ Indian ____ Other ____

3. How old are you? ________________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: ____________________________________
B. QUESTIONS

(i) Give 5 duties of the Clinic Committee

- __________________________________________________________
- __________________________________________________________
- __________________________________________________________
- __________________________________________________________
- __________________________________________________________

(ii) Why and how are patients referred by your clinic to other health institutions?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

(iii) What do you understand by Levels of Health Care in the Department of Health?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

(iv) What was the budget of your clinic during the last financial year? _______________

(v) Briefly explain the procedure for the appointment of staff (employees) in the clinic or
Department of Health) ____________________________________________________
____________________________________________________________________
____________________________________________________________________

(vi) Have you been informed about the National Core Standards for ensuring quality of care
in health facilities? Yes _________________ No _______________________

Explain: _______________________________________________________________
____________________________________________________________________

(vii) What is the role of the Clinic Committee in promoting healthy lifestyles in the
community? __________________________________________________________
____________________________________________________________________
APPENDIX 17: EVALUATION – TRAINING OF THE CLINIC COMMITTEE

Modeling Community Participation in Primary Health Care – a KZN Study

______________________________________________________________
District: ___________________: Date _________________: Unique ID ____________

______________________________________________________________

EVALUATION OF THE TRAINING PROJECT BY COMMITTEE MEMBERS

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________Female ________________

2. Ethnicity: African ____ Coloured _____White ____Indian _____Other ____

3. How old are you? ________________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>None</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: ____________________________

6. How long have you been a member of the Clinic Committee? ___________
B. EVALUATION QUESTIONS

Using “good”, “average” and “below average” as measures, how would you rate the following aspects of the Clinic Training project?

<table>
<thead>
<tr>
<th>Activities</th>
<th>Good</th>
<th>Average</th>
<th>Below average</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Your satisfaction about the process followed during the facilitation of this training?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) The knowledge and information received in this training?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) What comments or recommendations do you have regarding the training of Clinic Committee members?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 18: EVALUATION – “X-PRESS” ANTI-TEENAGE PREGNANCY CAMPAIGN

Modeling Community Participation in Primary Health Care – a KZN Study

__________________________________________

PRE AND POST-ASSESSMENT OF LEARNER KNOWLEDGE

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured _____ White ____ Indian _____ Other ____

3. How old are you? ________________ years

B. QUESTIONS

(i) From what age can a boy make the girl pregnant? _________________________

(ii) From what age can the girl fall pregnant? ________________________________

(iii) What three family planning methods are you aware of? ________________________

_______________________________________________________________________

(iv) What is the benefit of “ante-natal care”? ________________________________

(v) At what stage or date of pregnancy must a woman start attending the clinic?________

(vi) What are the risks (dangers) and/or complications of teenage pregnancy? ________________________________

_______________________________________________________________________

(vii) What are the three ways in which sexually transmitted infections and unwanted pregnancies be prevented? ____________________________________________

_______________________________________________________________________

(viii) What do you understand by emergency contraception or “morning after pill”? ________________________________

_______________________________________________________________________

(ix) Are you aware of the “termination of pregnancy” service at the hospital?

Yes _____ No ____________________
Explain

(x) What do you understand by “Statutory Rape”? ______________________________
APPENDIX 19: EVALUATION – “X-PRESS” ANTI-TEENAGE PREGNANCY CAMPAIGN

Modeling Community Participation in Primary Health Care – a KZN Study

CAMPAIGN EVALUATION BY EDUCATORS AND MEMBERS OF SGB

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured ____ White ____ Indian ____ Other ____

3. How old are you? ______________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>None</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
</tbody>
</table>

5. Occupation: ____________________________
B. QUESTIONS

(i) Using “good”, “average” and “below average” as measures, how would you rate the following aspects of the Anti-Teenage Pregnancy project?

<table>
<thead>
<tr>
<th>Project aspect</th>
<th>Good</th>
<th>Average</th>
<th>Below average</th>
</tr>
</thead>
<tbody>
<tr>
<td>The planning of the project</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The engagement of various stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The relevance of information to school learners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The quality of information transfer by presenters</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) Do you believe that the “X-Press Anti-Teenage Pregnancy Campaign” has a potential to reduce the rate of teenage pregnancies in the future?

Yes  No  Comment

Yes  No  Comment
**APPENDIX 20: EVALUATION – FACILITATION OF THE DIABETES HEALTH PROMOTION PROJECT**

Modeling Community Participation in Primary Health Care – a KZN Study

----------------------------------------------------------------------------------------------------------------------

**EVALUATION OF THE PROJECT BY THE PARTICIPATING HEALTH WORKERS**

**A. SOCIO-DEMOGRAPHIC INFORMATION**

1. Gender: Male ____________Female ______________

2. Ethnicity: African _____ Coloured _____White ____Indian ____Other ____

3. How old are you? ________________ years

4. What is your highest educational qualification?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: ____________________________
B. QUESTIONS

Using “good”, “average” and “below average” as measures, how would you rate the following aspects of the Diabetes Health Promotion project that you participated in?

<table>
<thead>
<tr>
<th>Project aspect</th>
<th>Good</th>
<th>Average</th>
<th>Below average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance of the event by target community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of health promotion resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of information provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes of facilitators to community members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The use of information, communication and education aids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recording and documentation of proceedings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction or participatory approaches used</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening services provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up care for screened participants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 21: EVALUATION –ESTABLISHMENT OF THE PATIENT SUPPORT GROUP

Modeling Community Participation in Primary Health Care – a KZN Study

EVALUATION OF ESTABLISHMENT OF THE SUPPORT GROUP BY MEMBERS

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender:                       Male ____________ Female __________________

2. Ethnicity: African ____ Coloured ______ White ____ Indian ______ Other ___

3. How old are you? _______________ years

4. What is your highest educational qualification?

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

5. Occupation: ____________________________
B. QUESTIONS

(i) Using “good”, “average” and “below average” as measures, how would you rate your satisfaction about the following aspects of the Patient Support Group project?:

<table>
<thead>
<tr>
<th>Project aspect</th>
<th>Good</th>
<th>Average</th>
<th>Below average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation and training you received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and information you received during the support group meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) Do you believe that your membership to the Support group will improve the management of your disease?

Yes  No  Comment
APPENDIX 22: FOCUS GROUP DISCUSSION – EVALUATION OF ALL PILOT PROJECTS BY THE PHC PROFESSIONALS

Modeling Community Participation in Primary Health Care – a KZN Study

District: ___________________: Date _________________: Unique ID _____________

FOCUS GROUP DISCUSSION GUIDE

NAME OF THE PILOT PROJECT: __________________________________________

A. SOCIO-DEMOGRAPHIC INFORMATION

1. Gender: Male ____________ Female ______________

2. Ethnicity: African ____ Coloured _____ White ____ Indian _____ Other ____

3. How old are you? ___________ years

4. What is your highest educational qualification?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>
B. INTRODUCTION

(i) The participants are seated comfortably.
(ii) The participants complete the attendance register and record their demographic particulars.
(iii) The participants are welcomed, orientated and invited to get something to eat.
(iv) The Researcher introduces himself as the moderator and also introduces the assistant.
(v) The Researcher discusses the research title and research objectives, as well as the purpose of the focus group discussion.
(vi) The participants’ rights are explained and what the focus group will entail.
(vii) Consent forms re completed.
(viii) Ground rules, discussion procedures and time frames are communicated.

C. PROCESS

(i) The Investigator inserts an ice-breaker to increase comfort and levels the playing field.
(ii) The Investigator starts the group by presenting the whole process that was followed during the piloting of each pilot project. The presentation includes planning, stakeholder involvement, consultations, educational methods, community empowerment, participatory approaches used as well as the outputs of the project.
(iii) The Investigator leads the discussion by asking questions (and where necessary, follow-up questions) as per the discussion guide.
(iv) The assistant takes notes and records of the proceedings.

D. DISCUSSION QUESTIONS

(i) For each project, identify positive aspects of the project do you think best illustrated:
   • Inter-sectoral collaboration
   • Consultation of communities and other stakeholders
   • Empowerment of the target community
   • Participatory approaches
   • Mobilization of communities to take care of their own health
(ii) What aspects of the project could have been implemented, or improved in order to better illustrate:

- Inter-sectoral collaboration
- Consultation of communities and other stakeholders
- Empowerment of the target community
- Participatory approaches
- Mobilization of communities to take care of their own health

E. CONCLUSION

(i) The Investigator thanks the participants for attendance and for participation.

(ii) The Investigator and the assistant conduct the debriefing.

(iii) All recorded information, charts etc. are collected for analysis.
### APPENDIX 23: RESULTS FROM THE HEALTH PROFESSIONALS WHO PARTICIPATED IN THE FOCUS GROUP DISCUSSION DURING SITUATIONAL ANALYSIS

<table>
<thead>
<tr>
<th>Discussion question</th>
<th>Quoted responses</th>
<th>Thematic interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which stakeholders should health institutions work with, in order for them to effectively deliver health services to the community?</td>
<td>“schools”, “other government departments”, “NGO’s”, “CBO’s”, “community leaders”, “traditional healers”, “sponsors”, “funders”, “donors”</td>
<td>The PHC system requires broad participation by providers and community representatives</td>
</tr>
<tr>
<td>How should the health professionals or health institutions involve communities in health?</td>
<td>“through hospital boards and clinic committees”, “outreach health services”, “visits by CCG’s”, “patient support groups”</td>
<td>Health professionals have a duty to use various systems and processes to involve communities in health care development</td>
</tr>
<tr>
<td>How should the health professionals or health institutions consult the communities?</td>
<td>“feedback from CCG’s and other outreach workers”, “community leaders”, “hospital boards and clinic committees”</td>
<td>Consulting communities generates inputs and feedback necessary for health improvement</td>
</tr>
<tr>
<td>What resources are needed by the health institutions in order for them to effectively involve communities in health?</td>
<td>“transport”, “first aid kits and first aid medicines for outreach workers”, “public address equipment”</td>
<td>Health institutions require dedicated resources for community participation and social mobilization</td>
</tr>
<tr>
<td>How should the health professionals or health institutions mobilize the communities to take care of their own health?</td>
<td>“implementation of health calendar”, “empowerment with relevant life skills”, “support of community health initiatives by health institutions”, “media campaigns”</td>
<td>Empowerment is an essential aspect of community participation</td>
</tr>
<tr>
<td>How can communities partner with health authorities in order to improve disease control and fight against ill-health?</td>
<td>“through functional and effective boards and clinic committees”, “CBO’s”, “other community health projects”</td>
<td>Communities are equally responsible for their health in partnership with health professionals</td>
</tr>
</tbody>
</table>
## APPENDIX 24: RESULTS FROM THE HEALTH PROFESSIONALS WHO PARTICIPATED IN THE FOCUS GROUP DISCUSSION DURING THE EVALUATION OF PILOT PROJECTS

<table>
<thead>
<tr>
<th>Discussion Item</th>
<th>Quoted statements</th>
<th>Thematic Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which aspects of the projects, in general, illustrated inter-sectoral collaboration</td>
<td>“involvement of different professionals”, “private and community sectors”, “better relationships between health workers and communities”</td>
<td>There was adequate collaboration among relevant stakeholders</td>
</tr>
<tr>
<td>Which aspects of the projects, in general, illustrated consultation of communities and other stakeholders</td>
<td>“involvement of community leaders”, “participation by various health sectors”</td>
<td>Stakeholders and participants were consulted</td>
</tr>
<tr>
<td>Which aspects of the projects, in general, illustrated the empowerment of the target community</td>
<td>“sharing of valuable information”, “encouragement of healthy lifestyles”</td>
<td>Communities were empowered with relevant health information</td>
</tr>
<tr>
<td>Which aspects of the projects, in general, illustrated good participatory approaches</td>
<td>“questions and inputs from participants were addressed”</td>
<td>The target participants were involved in the health promotion program</td>
</tr>
<tr>
<td>Which aspects of the projects, in general, illustrated mobilization of communities to take care of their own health</td>
<td>“projects should include practical skills and training for self-care”, “inadequate resources for health promotion”</td>
<td>There was inadequate practical component in the education package</td>
</tr>
</tbody>
</table>
## APPENDIX 25: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR SERVICE PROVIDERS AT DISTRICT LEVEL

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
<th>MONTHLY OUTPUTS/ACTIVITIES</th>
<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Participate in the district inter-sectoral committee and district health council.</td>
<td>Record of attendance and participation in the inter-sectoral committee.</td>
<td>District manager Manager: PHC</td>
</tr>
<tr>
<td>Consultation</td>
<td>Community profiling and analysis of community health needs.</td>
<td>There must be an updated district health profile and records of other consultation activities.</td>
<td>District health management team (DHMT)</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Conduct health education and promotion campaigns.</td>
<td>There must be a functional and integrated district-based health promotion programme.</td>
<td>DHMT</td>
</tr>
<tr>
<td>Outreach services</td>
<td>Conduct district-based outreach health services.</td>
<td>Monthly report on district outreach services.</td>
<td>DHMT</td>
</tr>
<tr>
<td>Allocation and utilization of community participation resources</td>
<td>Procure and supply communication, facilitation as well as operational equipment and supplies for community based health promotion.</td>
<td>There must be adequate and suitable resources for community involvement.</td>
<td>DHMT Finance manager</td>
</tr>
</tbody>
</table>
APPENDIX 26: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR SERVICE PROVIDERS AT SUB-DISTRICT LEVEL

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
<th>MONTHLY OUTPUTS/ACTIVITIES</th>
<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Participate in the sub-district inter-sectoral committee.</td>
<td>Record of attendance and participation in the inter-sectoral committee.</td>
<td>Hospital CEO’s Managers: PHC</td>
</tr>
<tr>
<td>Consultation</td>
<td>Community profiling and analysis of community health needs.</td>
<td>There must be an updated sub-district health profile and records of other consultation activities.</td>
<td>Hospital CEO’s Managers: PHC CCG’s</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Conduct health education and promotion campaigns.</td>
<td>There must be a functional and integrated sub-district health promotion programme.</td>
<td>Managers: PHC PHC professionals CCG’s</td>
</tr>
<tr>
<td>Outreach services</td>
<td>Conduct sub-district outreach health services.</td>
<td>Monthly report on sub-district outreach services.</td>
<td>Managers: PHC PHC professionals CCG’s</td>
</tr>
<tr>
<td>Allocation and utilization of community participation resources</td>
<td>Procure and supply communication, facilitation as well as operational equipment and supplies for community based health promotion.</td>
<td>There must be adequate and suitable resources for community involvement.</td>
<td>Hospital CEO’s Managers: PHC Finance managers</td>
</tr>
</tbody>
</table>
## APPENDIX 27: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR SERVICE PROVIDERS AT HOSPITAL LEVEL

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
<th>MONTHLY OUTPUTS/ACTIVITIES</th>
<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Involve other service providers and community representatives in the planning, implementation and monitoring of health service.</td>
<td>Record of inter-sectoral activities and projects for the hospital.</td>
<td>Hospital CEO Manager: PHC</td>
</tr>
<tr>
<td>Consultation</td>
<td>Community profiling and analysis of community health needs.</td>
<td>There must be an updated community health profile and records of other consultation activities.</td>
<td>Hospital CEO Manager: PHC CCG’s</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Conduct health education and promotion campaigns.</td>
<td>There must be a functional and integrated hospital health promotion programme.</td>
<td>Hospital CEO Manager: PHC PHC professionals CCG’s</td>
</tr>
<tr>
<td>Outreach services</td>
<td>Conduct hospital outreach health services.</td>
<td>Monthly report on hospital outreach services.</td>
<td>Hospital CEO Manager: PHC PHC professionals CCG’s</td>
</tr>
<tr>
<td>Allocation and utilization of community participation resources</td>
<td>Procure and supply communication, facilitation as well as operational equipment and supplies for community based health promotion.</td>
<td>There must be adequate and suitable resources for community involvement.</td>
<td>Hospital CEO Manager: PHC Finance manager</td>
</tr>
</tbody>
</table>
# APPENDIX 28: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR SERVICE PROVIDERS AT CLINIC LEVEL

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
<th>MONTHLY OUTPUTS/ACTIVITIES</th>
<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Involve other service providers and community representatives in the planning, implementation and monitoring of health service.</td>
<td>Record of inter-sectoral activities and projects for the hospital.</td>
<td>Clinic manager</td>
</tr>
<tr>
<td>Consultation</td>
<td>Community profiling and analysis of community health needs.</td>
<td>There must be an updated community health profile and records of other consultation activities.</td>
<td>Clinic manager</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Conduct health education and promotion campaigns.</td>
<td>There must be a functional and integrated clinic health promotion programme.</td>
<td>Clinic manager</td>
</tr>
<tr>
<td>Outreach services</td>
<td>Conduct clinic-based outreach health services.</td>
<td>Monthly report on clinic outreach services.</td>
<td>Clinic manager</td>
</tr>
<tr>
<td>Allocation and utilization of</td>
<td>Procure and supply communication, facilitation as well as operational equipment and supplies for community based health promotion.</td>
<td>There must be adequate and suitable resources for community involvement.</td>
<td>Clinic manager</td>
</tr>
<tr>
<td>community participation resources</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**APPENDIX 29: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR SERVICE PROVIDERS AT COMMUNITY LEVEL**

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
<th>MONTHLY OUTPUTS/ACTIVITIES</th>
<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Involve other service providers and community representatives in the planning, implementation and monitoring of health service.</td>
<td>Record of inter-sectoral activities and projects for the hospital.</td>
<td>PHC professionals CCG’s</td>
</tr>
<tr>
<td>Consultation</td>
<td>Household profiling and analysis of health needs.</td>
<td>There must be an updated household health profile and records of other consultation activities.</td>
<td>PHC professionals CCG’s</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Provide ongoing life skills and health promoting education.</td>
<td>There must be a sustainable and holistic health education programme.</td>
<td>PHC professionals CCG’s</td>
</tr>
<tr>
<td>Outreach services</td>
<td>Conduct regular household visits.</td>
<td>Monthly report on household visits</td>
<td>PHC professionals CCG’s</td>
</tr>
<tr>
<td>Allocation and utilization of community participation resources</td>
<td>Procure and supply communication, facilitation as well as operational equipment and supplies for community based health promotion.</td>
<td>There must be adequate and suitable resources for community involvement.</td>
<td>PHC professionals CCG’s</td>
</tr>
</tbody>
</table>
APPENDIX 30: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR COMMUNITIES AT DISTRICT LEVEL

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
<th>MONTHLY OUTPUTS/ACTIVITIES</th>
<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Participate in the district inter-sectoral committee.</td>
<td>Record of attendance and participation in the inter-sectoral committee and health council.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Communicate the community’s health needs to health managers and motivate for improvement in health services.</td>
<td>Record of health services and projects established in response to community proposals.</td>
<td>Members of the inter-sectoral committee.</td>
</tr>
<tr>
<td>Co-governance and partnership</td>
<td>Participate in the district health council.</td>
<td>There must be a functional district health council.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Community’s control over their health</td>
<td>Participate in health education campaigns and implement self-help health projects.</td>
<td>Record of attendance at the health education campaigns and self-help community projects.</td>
<td>Members of the communities. CBO’s.</td>
</tr>
</tbody>
</table>
### APPENDIX 31: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR COMMUNITIES AT SUB-DISTRICT LEVEL

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
<th>MONTHLY OUTPUTS/ACTIVITIES</th>
<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Participate in the sub-district inter-sectoral committee.</td>
<td>Record of attendance and participation in the inter-sectoral committee.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Communicate the community’s health needs to health managers and motivate for improvement in health services.</td>
<td>Record of health services and projects established in response to community proposals.</td>
<td>Municipal counsellors. Community representatives.</td>
</tr>
<tr>
<td>Co-governance and partnership</td>
<td>Participate in the sub-district inter-sectoral committee, integrated development planning and the local AIDS council.</td>
<td>Record of community participation in the inter-sectoral committee, integrated development planning and the local AIDS council.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Community’s control over their health</td>
<td>Participate in health education campaigns and implement self-help health projects.</td>
<td>Record of attendance at the health education campaigns and self-help community projects.</td>
<td>Members of the communities. CBO’s.</td>
</tr>
</tbody>
</table>
### APPENDIX 32: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR COMMUNITIES AT HOSPITAL LEVEL

<table>
<thead>
<tr>
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<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Participate in the hospital strategic planning and other consultative forums.</td>
<td>Record of participation in the hospital strategic planning and other consultative forums.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Communicate community’s health needs to hospital management and motivate for improvement in hospital services.</td>
<td>Record of health services and projects established in response to community proposals.</td>
<td>Community representatives.</td>
</tr>
<tr>
<td>Co-governance and partnership</td>
<td>Participate in the hospital board, strategic planning and quality improvement.</td>
<td>There must be a functional hospital board.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Community’s control over their health</td>
<td>Participate in health education campaigns and implement self-help health projects.</td>
<td>Record of attendance at the health education campaigns and self-help community projects.</td>
<td>Members of the communities. CBO’s.</td>
</tr>
</tbody>
</table>
## APPENDIX 33: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR COMMUNITIES AT CLINIC LEVEL

<table>
<thead>
<tr>
<th>ELEMENT OF COMMUNITY PARTICIPATION</th>
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<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Participate in clinic committee and other consultative meetings.</td>
<td>Record of participation in clinic committee and other consultative meetings.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Communicate community’s health needs to the clinic management and motivate for improvement in clinic services.</td>
<td>Record of services and projects established in response to community proposals.</td>
<td>Community representatives.</td>
</tr>
<tr>
<td>Co-governance and partnership</td>
<td>Participate in the clinic committee, clinic strategic planning, quality improvement and health promotion campaigns.</td>
<td>There must be a functional clinic committee and record of collaboration in health services.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Community’s control over their health</td>
<td>Participate in health education campaigns and implement self-help health projects.</td>
<td>Record of education campaigns and self-help community projects.</td>
<td>Members of the communities. CBO’s.</td>
</tr>
</tbody>
</table>
**APPENDIX 34: PROPOSED COMMUNITY PARTICIPATION ACTIVITIES FOR COMMUNITIES AT COMMUNITY LEVEL**

<table>
<thead>
<tr>
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<th>INDICATORS FOR MONTHLY MONITORING</th>
<th>RESPONSIBLE OFFICIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Participate in the ward inter-sectoral committee.</td>
<td>Record of attendance and participation in the inter-sectoral committee.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Communicate the community’s health needs to the inter-sectoral committee and motivate for improvement in health services.</td>
<td>Record of health services and projects established in response to community proposals</td>
<td>Community representatives.</td>
</tr>
<tr>
<td>Co-governance and partnership</td>
<td>Participate in the ward inter-sectoral committee and health committees.</td>
<td>There must be a functional ward inter-sectoral committee and health committees at community level.</td>
<td>Appointed community representatives.</td>
</tr>
<tr>
<td>Community’s control over their health</td>
<td>Participate in health education campaigns and implement self-help health projects.</td>
<td>Record of attendance at the health education campaigns and self-help community projects.</td>
<td>Members of the communities. CBO’s.</td>
</tr>
</tbody>
</table>
APPENDIX 35: UNIVERSITY ETHICS APPROVAL LETTER

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

05 December 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:

Ml M Mutambo (School of Public Health)

Research Project: Development of the Public Health Model of community participation in the KwaZulu Natal Primary Health Care System.

Registration no: 12/10/21

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7555, South Africa
T. +27 21 859 2900/2950  F. +27 21 859 3370
E. pgo@uwc.ac.za
www.uwc.ac.za

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