COMMUNITY PARTICIPATION IN THE DELIVERY OF PRIMARY HEALTH CARE SERVICES IN THE CITY OF CAPE TOWN: AN EVALUATIVE STUDY OF THE ATHLONE HEALTH DISTRICT

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A minithesis submitted in partial fulfilment of the requirements for the degree of Master of Administration in the School of Government, University of the Western Cape

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KEYWORDS

Community Participation

Primary Health Care Approach

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Local Government

Intersectoral collaboration

Decision Making

Capacity building

Alma Ata Declaration

Health Services

Health Policy

ABSTRACT

The South African Health Department Endorsed the Primary Health Care Approach based on the Alma Ata Declaration. In one of its official policy documents, it listed ten principles for the health system, one of which was the full participation of the communities.

To date, little progress has been made in effectively involving communities in the delivery of health services.

In this research we have focused on the Athlone District as a unit of the National Health System and the Primary Health Care Services, to evaluate the extent to which people are asked to participate and the level at which they are allowed to participate. The findings of our research confirms the need for communities to become involved in the delivery of health services in a more objective way and not be mere recipients of health services. This minithesis is concluded by providing useful recommendations which will be of benefit to improving the way in which we engage communities in the public health services, especially at the Primary Health Care level.

DECLARATION

I declare that *Community participation in the delivery of Primary Health Care Services in the City of Cape Town: an Evaluative study of the Athlone Health District* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Godwin Diteko Mabuya November 2002

Signed:.....

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I thank my God the Almighty for giving me the grace to complete this work.

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CHAPTER ONE
INTRODUCTION

This chapter provides a brief introduction to the research project. It will start by defining the problem and sharing some related research. It will also provide the objectives, the methodology, and the significance of this study. The chapter will end by explaining important concepts and terms as well as describing the rest of the chapter outline of this work.

Statement of the Problem

The South African Government of National Unity, through its adoption of the Reconstruction and Development Programme (RDP) in 1994, committed itself to the development of a District Health System based on the Primary Health Care Approach as enunciated at Alma Ata in 1978.

This meant that health services in South Africa would be delivered on a district basis. The district therefore is a semi-autonomous geographical unit of the total National health system. Central to the delivery of District Health Services is the full participation of the community in the planning, provision, control and monitoring of the health services.

The National Health System provides for Primary Health Care Services to be delivered by Local Government in South Africa. This places a greater responsibility and accountability towards the public that they serve on local government health service providers.

This makes the role of public participation crucial. Opportunities for the public to participate in the planning and decision-making processes of local authorities have increased dramatically since 1994. This trend has been driven by the demands of the civil society and is underpinned by Government's commitment to promote democracy and public participation, as reflected in a wide range of policies and laws affecting virtually every aspect of public life in South Africa.

Communities are also becoming increasingly aware of their rights to be involved in the decisions that will ultimately affect their health.

Factors such as the spiralling cost of medical care, social and political changes and improved standards of education have all contributed to the greater demand by the community to enter into a partnership with the health team when it comes to matters that affect the community.

This research assumes that community participation is not maximal in the delivery of Health Services in the Athlone District. Communities often do not have say in the planning, provision, monitoring and evaluation of health services. Community participation in impoverished communities like Manenberg and its surrounds is important, not only in the delivery of health services, but in the broader community development work. Past experience has proved to us that imposing on South African communities have often created more problems.

The health status of the people of the Athlone District can be advanced and improved for the benefit of everyone living in that district. One can only appreciate that this status quo can be changed, once there is a high level of participation on the side of the people of the Athlone District in taking responsibility to improve their own health and quality of life.

The philosophy of the previous South African government regarding public participation has left the country with an impaired health care system, similar to those of many other economically and politically disempowered countries. This legacy means that despite the change of government, inequity based on race still has great impact on the levels of effective involvement of the people.

South Africa still needs to define public involvement and community involvement in its own context. Should direct public involvement such as development of health committees be promoted, or should participation be restricted to a passive, indirect form, such as voting for local representatives? This is the question that this study seeks to address by looking at the experience of the Athlone Health District.

Related Research

Mahler (in Levin 1981:179) commented that "if health doesn't start with the individual, the home, the family, the working place, and the schools, then we will never get to the goal of health for all".

Although in theory community participation is an accepted principle of present-day health care, it is often misinterpreted as meaning that community resources (money, labour, and materials) must be made available so that government planned and controlled programmes can be implemented.

According to Morley et al (1983:85), a more correct interpretation of community participation is that it is the process through which the people gain control over the social, political, economic and environmental factors that determine their health. The process of participation starts with an evaluation of the situation by everyone involved. During the process, the community defines its most important health problems and decides on priorities.

The above statements support the notion of individual and societal empowerment for a healthy lifestyle and environment. Once people have knowledge about health risks and factors that influence health, it becomes easier to engage them to take full responsibility for their own health. The health service therefore has a responsibility to empower the community in order to ensure that they participate constructively and effectively in the delivery of health services.

Wall and Lischeron (1977: 37) discuss involvement as an aspect of participation, and suggest that it "concerns the essentially interactive, constructive and problem-solving orientation of those involved". They also refer to the element of decision-making in participation, and suggest that participation is not a unitary concept, but it consists of interrelated elements, which manifest in decision-making processes.

They maintain that influence, interaction and information sharing are three elements central to the concept of participation.

Vandervelde, in Kramer and Specht (1983:95), states that people should be involved in decisions which affect them, and places great emphasis on what she terms "participative decision making". What is clear from the above is that community participation, to be effective, must be a collaborative effort, must acknowledge the importance of power sharing, allows community involvement in decision-making processes and assist the community in the achievement of equality in health.

Sekgobelo (1986:30) lists the following advantages of community participation:

- Through community participation the health team can obtain first-hand information about local conditions and needs.
- Community members will be more committed to community projects if they are involved in the planning, preparation and maintenance of projects they consider important.
- Community participation gives the community an opportunity to exercise its democratic right to be involved in its own development.
- Through participation the community will become more self-reliant, self-sufficient, self-confident and independent.
- Through joint discussions between the health planners and the people, power differences and potential corruption are reduced.

- ❖ Planning is more likely to be done according to local circumstances and available resources if the community is involved.
- ❖ Community participation supplements community services.

World Health Organisation (1991) summarises the advantages of community participation in health as follows: -

- ❖ Community involvement is a basic right of all people.
- ❖ Involvement in the decisions and actions affecting people's health builds up self-esteem and encourages a sense of responsibility.
- ❖ Through community involvement, limited resources can be applied more appropriately to satisfy needs as identified by the local community, and can complement and supplement formal health services.
- ❖ Community involvement in health can help to create political awareness, encourage people to get involved in other areas of development of the community.

Vuori (1984:338) draws attention to the psychological and material benefits that participation holds for the individual. Psychological benefits relate to the satisfaction derived from fulfilling a civic duty, while material benefits are obtained as a result of the decisions which one has influenced through participation. Involvement in decision-making gives community members a sense of control over their lives, and thereby promotes social justice.

Through participation, co-operation between the members of the community is developed, allowing them through their acceptance of responsibility and accountability for activities, to develop self-reliance. This enables the community to make a meaningful contribution towards the achievement of equality in health.

A further advantage of participation relates to the personal benefit or satisfaction that the individual derives from community togetherness. As social beings, humans need to relate closely to the members of the community to which they belong. Community participation, if practised effectively, not only achieves the primary objectives of such environment, but also satisfies people's need for belonging and togetherness.

The World Health Organisation (WHO) reminds us that "today, some sixteen years after Alma-Ata, the concept of community action is receiving greater interest and support than ever before. Governments, communities and non-governmental organisations (NGOs) are exploring the possibility of creating innovative types of partnerships for health which could contribute to making the goal for health for all a reality" (WHO, 1994:2).

Plummer (2000:1) highlighted the fact that engineering-led, capital intensive professionals who find the concept of community participation irrelevant dominate the majority of local governments. WHO (1993: 72) states that it is futile to decide urban health policy without the effective involvement of the public.

The most deprived population groups in urban areas are those who are most likely to have weak forms of community organisation and whose interests are least likely to be effectively represented. The health sector needs to recognise that its experience and skills in promoting the participation of the public are limited, and that a special effort is needed to re-orientate and re-train health workers for this important task. Special attention and effort should be devoted to developing and sustaining innovative health services that effectively involves the public. According to King in Dennill et.al (1995:54), community participation in health care delivery is more than a basic requirement for the attainment of optimal health of the community.

Objectives of the Study

- To discuss related research in the area of public participation for the purposes of identifying best practices.

- To evaluate community participation and involvement in the delivery of health services in the Athlone Health District with specific reference to the public's knowledge of health services, their own understanding of public participation and their views on decision making and public participation in the delivery of health services.
- To look at health policy in relation to public participation in the South African context.
- To make useful recommendations, based on the findings of this research project, to the public health service providers.

Methodology of the Study

Rifkin et al (1988) considered the problem of finding measurements for community participation and developed a methodology to assess the level of participation. A mark is plotted on a continuum for the five factors that influence community participation- needs assessment, leadership, organisation, resource mobilisation and management. For each factor the continuum can be developed with wide participation (community people plan, implement and evaluate programmes using professionals as resources) at the one end and narrow participation (professionals take all decisions) at the other. Because community participation is better measured and researched using qualitative research techniques, the above methodology can be useful to evaluate the involvement of the public in health services. The evaluation of health services will often provide insights and lessons, which can eventually lead to true participation. Rifkin's work is indicative of the need to involve the public more meaningfully in the planning and provision of health services instead of leaving it all to the health professionals.

Research on community participation should not be viewed as a static exercise, but must be highly participatory in order to maintain its relevance. The dynamic process of community participation takes many forms and occurs in different settings.

Thus, evaluation instruments must be flexible enough to examine the processes and mechanisms within the community and between the community and health workers.

This study combined quantitative and qualitative methods of research. A literature review was undertaken in the related research section as well as in chapter two of this report. A random sample was used in the Athlone District and the structure of the health services and its policy on governance and public participation in health services were explored. For the purpose of extracting data, a questionnaire, developed by the researcher, was used (See Annexure A).

A total number of fifty (50) clients were interviewed, using the questionnaire, from the five (5) Primary Health Care Clinics in the Athlone District namely; Philippi Clinic, Manenberg Clinic, Silvertown Clinic, Heideveld Clinic and Hanoverpark Clinic. Ten clients were interviewed, at random, at each of the above-mentioned clinics during the month of August 2002. Permission to conduct interviews at these clinics was sought from the District Health Management in the Athlone District. The questionnaire sought to establish people's understanding of public participation in health services with specific reference to their own situation. The questions used in the interviews were both open and closed questions.

All the respondents were regular users of the services at the various clinic facilities. The interviews were conducted during normal operational hours of the clinics and clients were interviewed as they were waiting to be assisted in the waiting areas. The researcher explained the questionnaire thoroughly to each respondent as they were interviewed.

Each one of the respondents was given the choice to answer the questions in the language that they felt most comfortable with and their permission was also first sought before the actual interview. The researcher took each respondent through the questionnaire and used open-ended questions to give them enough time to share their personal experiences and encounters with the health services. The City of Cape Town Health Department's policy and protocol on public participation and Health committees was also studied and reviewed by the researcher.

Significance of the Study

This study is motivated by the dire need to find universally acceptable practices of public participation with specific emphasis on the understanding and role of the two categories of partners, namely the health professionals and the community. Health professionals tend to stipulate what the programme should be, and often "negotiation" with the community means expecting the community to rubber stamp the health professionals' ideas.

This study will therefore benefit the health professionals and particularly Dstrict Management Teams in employing flexible processes that will ensure maximal community participation.

Definition of Major Terms

Community Participation: a process where people participate individually and collectively as part of their right and duty, in the planning, implementation and control of activities for their health and related social development.

Primary Health Care Approach: the underlying philosophy for the provision of health care services that are based on the Alma Ata Declaration, i.e. preventive, promotive and rehabilitative care within the context of amongst others, community participation and intersectoral collaboration.

District Health System: a more or less self contained segment of the National Health Care System. It comprises first and foremost of a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional.

Local Authority: administrative structure that is responsible for the provision of a service within a local government.

Organisation of the Study

This study has five chapters. Chapter One is the introduction, which presents the definition of the problem statement, some related research, the objectives, methodology and the significance of the study as well as the definition of major terms.

Chapter two focuses on international perspectives of Primary Health Care Services and Community participation. It also spells out the advantages of community participation. This chapter ends with a brief discussion on the public policy implications of community participation.

The third chapter gives a brief description of primary health care delivery with specific reference to the South African context. In chapter four, the Athlone District is described and the findings of the researcher are presented and discussed.

The conclusion and recommendations are laid out in chapter five.

CHAPTER TWO
PRIMARY HEALTHCARE SERVICES AND COMMUNITY PARTICIPATION: INTERNATIONAL PERSPECTIVES

This chapter reflects on the Alma Ata Declaration as a key international document that begins to set the standard for the involvement of communities in health systems. It also looks at the advantages of Community participation and policy implications.

The 1978 Alma-Ata Declaration on Primary Healthcare

Community participation is one essential aspect of poverty alleviation and the attainment of health. The active involvement of community members in health care decisions was formally endorsed as a principle in the Alma-Ata Declaration on Primary Health Care (PHC) in 1978. This Declaration reflected the belief that health could not be only attained through the improvements in formal health service delivery. A holistic approach to health was needed that addressed the root causes of poor health and empowered communities to actively participate in the improvement of their health. Community participation in decision-making was endorsed as one of the five pillars of Primary Health Care Approach for nearly twenty years. The five pillars of Primary Health Care are: -

- Community participation in decision making;
- Focus on preventive and promotive health services;
- Appropriate (not necessarily low-cost) technology; and
- Multi-Sectoral approach
- Equitable distribution of resources;

Since 1978, when the Primary Health Care initiative was launched, Primary Health Care was seen as the most appropriate vehicle to achieve health for all by the year 2000 (WHO 1978). There was a worldwide shift in development thinking. The Alma-Ata Declaration "requires and promotes maximum community and individual self reliance and participation in the planning, organisation, operation and control of primary health care, making full use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;"(WHO 1978).

Further, the Declaration contained a series of recommendations to implement the Primary Health Care approach. One recommendation stated "that governments encourage and ensure the full community participation through the effective propagation of relevant information, increased literacy, and the development of the necessary institutional arrangements through which individuals, families, and communities can assume responsibility for their health and wellbeing." Community involvement in health describes a process where people express their right to be active in the development of appropriate health services. It is a partnership between individuals, groups, organisations, and health professionals in which all parties examine the root causes of health issues and together agree on approaches to address these issues.

It is important to recognise the radical nature of the concept of community participation at the time of the declaration and even today.

During the 1950s and 1960s, international trends in the health sector moved toward the introduction of high technology, modernisation of health facilities, and the importance of large hospital complexes.

Communities were viewed as passive groups of individual recipients of health care services planned and provided by health professionals. There was little scope for self determination or community empowerment in the health care system. Interactions at a community level occurred only in the epidemiological context. Thus, acceptance of the Primary Health Care approach, which places great emphasis on full community participation, would force countries to totally reorient their health systems and implementation would require nothing short of complete transformation.

The South African health system also turned out to be very curative and mechanistic with an approach that saw people as mere recipients of health services only. If we are to accept the principle of community participation based on Alma-, we should accept that our health system had and has to change drastically to embrace this change.

Community Participation in Primary Healthcare Delivery

The Alma-Ata Declaration propounded a broad and consistent philosophy and strategy for the attainment of Health For All, and this philosophy became known as the Primary Health Care approach.

The Primary Health Care approach calls for a major change in attitude both towards the concept of health and in our understanding of appropriate actions to improve the unacceptably low health status of many groups in society. It also recognises the need for a new relationship between health service professionals and members of the community.

According to Green (1992), the interpretations given to public participation under the Primary health care approach entails the following:

The individual's responsibility for health

This involves the need to empower individuals in their relations with the health professions, and to return to individuals the control over their own bodies. Furthermore, there was an increasing recognition of the importance of non-medical factors such as life-style in the promotion of health. These were seen as the responsibility of the individual rather than that of the health professionals. The key strategy to achieving this is seen as the transmission of health education on matters affecting health.

Individual or community involvement in decisions about health

This interpretation of community participation concerns involvement in decisions about the general type and pattern of health care (as opposed to the application of this in individual cases). This approach is promoted for at least two reasons. Firstly, the concept of the accountability of public services suggests that the funders of public health care should be entitled to some say in how these are provided.

Secondly, at a more pragmatic level, it is recognised that the involvement of potential users of the services are likely to increase the possibility of the of the services being acceptable to them, and so used by them.

The above interpretations therefore suggests that health care providers should endeavor to develop structures and processes for public participation that are neither exploitative nor ignorant of the needs of sections of the community.

Advantages of Community Participation

Drawing upon the public participation literature, local and international experience, the following key advantages of public participation can be identified:

Building local democracy

Not only does public participation increase government accountability, it provides opportunities for citizens to learn about their rights, to develop a range of skills central to a functional democracy (including negotiation and organisational skills), to mobilise community resources, and to build constructive relationships, founded on trust , that improve prospects for working together.

Improving relationships

Public participation can build trust between partners and lead to long-term collaborative relationships that facilitate working together – the essence of cooperative governance. Each successive opportunity for public participation builds on the successes of past processes. Fostering co-operative governance is consequently a long term and cumulative process of relationship building. Building consensus at various stages of the participatory process, helps to reduce the potential for destructive conflict.

Promoting transparent governance

Public participation fosters open and transparent planning and decision-making processes thereby holding government accountable, and ensuring that the public interest is more effectively served.

The Municipal Structures Act (1998) Section 44(3) and Municipal Systems Act (2000) section 17 suggests that transparent government is enhanced by public consultation by stating that municipalities have responsibility

for "… developing mechanisms to consult the community and community organisations in performing its functions and exercising its powers". The Access to Information Act (2000) reiterates the need to promote transparency, accountability and effective governance of all public and private bodies, by educating everyone to, amongst other things, effectively scrutinise, and participate in decision-making by public bodies that affects their rights.

Improving the quality of decisions

Involving the public in planning and decision making processes ensures that the local knowledge and lived experience of the public contribute to more informed

decision-making. Decisions that are informed by public opinion are also much more likely to be actively supported by the public, and are therefore more likely to succeed.

Increasing the prospects for effective implementation

The development literature is replete with examples of well-intentioned efforts by "third parties" to meet community needs that do not work in practice. Many of these efforts have been unsustainable simply because they lacked community support.

Creating meaningful opportunities for public participation is therefore an important strategy for improving the prospects that plans and decisions are effectively implemented.

Public Policy Implications of Community Participation

In recent decades, public participation has become an integral part of governmental activities around the world. There is, however, often a yawning gap between the rhetoric and reality of public participation practices.

Various national and provincial policies and laws stipulate the need to promote public participation. For the purposes of this paper, it is important to highlight that the Constitution of South Africa (Section 152) requires local government to "provide democratic and accountable local government for local communities" and to "encourage the involvement of the community and community organisations in the matters of local government".

Public authorities should therefore integrate public participation as an ethos into everything that they do. It should not be about setting up special public participation units but rather about integration, it should be about a philosophy that sees public participation as a key, necessary and valuable component of any development process and not as an unnecessary, time consuming and expensive burden that should be avoided as far as possible.

CHAPTER THREE
PRIMARY HEALTHCARE DELIVERY IN SOUTH AFRICA AND COMMUNITY PARTICIPATION

Chapter three puts into perspective the evolution of public participation in the primary health care services in South Africa. It provides the background from the apartheid era, through the period 1990 to 1994 and the 1996 Constitutional era. The policy of the Health Department, the District Health System (DHS) and the role of local government are also discussed.

The Health System during Apartheid

Before 1994, the Department of Health and Population Development in South Africa expressed a commitment to involve communities in the health system, but it put few mechanisms in place to make these commitments a reality. In 1990, the Department formally endorsed the Primary Health Care (PHC) approach. It listed ten principles for the health system, which included the involvement of the communities. Upon closer examination, many NGOs and other members of civil society challenged whether the government was committed to the principles of Primary Health Care (PHC) as outlined at Alma-Ata.

There is thus a long history of suppression of political and community organisations which have attempted to express the aspirations of the majority of the population.

In certain limited circumstances, communities were able to move beyond the political oppression and form links with certain health care providers working in the public health sector. This was, however, the exception rather than the norm. It is also important to note that the state generally limited the role of civil society and consulted the white enfranchised community almost exclusively. In the absence of democratic freedoms and extremely limited access to health services, there was little community control of public sector health services.

NGOs fostered some independent efforts at community involvement during this period. They established health committees and other structures. These committees were typically created to provide support to the Community Health Worker programmes. Popular mobilisation against the apartheid government grew, particularly from the 1970s, providing a basis for the subsequent public participation approaches.

However, a somewhat "schizophrenic" view on the role of civil society emerged as the period drew to a close. On the one hand, civil society was seen to provide a counter balance to the weight of the state and to play a vital role in overthrowing the apartheid government. On the other hand, civil society was seen to play a crucial "watchdog" role in ensuring that democracy was achieved and sustained, and the hope to see public participation thriving in South Africa. Civil society thus had an enhanced, albeit somewhat confused role to play in the late 1980s.

The period between 1990 and 1994

During the transition period (1990 – 1994), participatory processes came strongly to the fore. Opposition organisations were unbanned and political activity was liberalised as negotiations were initiated and carried out in preparing a new constitution for the country. In parallel with these negotiations, there was an exponential increase in the involvement of civil society in matters of public policy, planning, development and public management at all levels of government. Public participation became a fundamental modus operandi during this transition. Public participation was a novel experience for many people and required considerable learning and capacity building in government and civil society.

In1990 the Department of Health and Population Development developed a policy advocating the introduction of a new national Community Health worker Programme. This policy appeared to meet many of the demands of progressive NGOs at that time. The national Community Health Worker programme was not envisaged as an extension and supplementation of the formal health system, but rather as a low-cost alternative for poor communities. A national Community Health Worker programme was never implemented.

The 1996 Constitution and Community Participation

Since the 1994 elections, national policymakers have expressed a strong ideological commitment to community involvement in health and development.

The Reconstruction and Development programme (RDP), formerly endorsed by the Government of National Unity, emphasised the need for community involvement. The RDP stated that "the way to real development is through democracy which allows everyone the opportunity to shape their own lives and to make a contribution to development.

People who are affected by decisions must take part in making those decisions." However, democratisation in South Africa had a contradictory impact on the extent to which the public would participate in public planning and decision-making processes. On the one hand, there was a strong emphasis on establishing significant opportunities for public participation in policy making, planning and development initiatives. Certainly this intention was outlined in virtually all policies and laws passed during this period. On the other hand, there was a growing tendency to view the establishment of democracy and the election of public representatives from the national to the local level as a sufficient basis for public decision-making. Within this context, the view increasingly took hold that public participation had become a somewhat redundant exercise.

These contradictory trends coincided with the tensions evident in the pursuit of the Reconstruction and Development Programme (RDP), introduced shortly after the 1994 elections, and the Growth, Employment, and Redistribution Programme (GEAR) introduced in mid-1996. The former concentrated on social reconstruction and included a strong emphasis on involving civil society in the programme of national development.

The latter presents a neo-liberal macro-economic strategy that focuses on creating conditions conducive for economic growth and has a tendency to centralise power in the state. Coupled with this shift towards GEAR, was a discernible and paradoxical alienation of civil society from governance processes. Participatory processes during this period thus became increasingly contested.

The essential social transformation required in South Africa is the transformation of people from dependence to self-reliance – a transformation based on 'hand-outs', compliance to external impositions and a mistrust of authority, to a culture of self-reliance. There is a dire need to give back to the community the capacity to control their own destiny. Public Participation is now entrenched in our Constitution as a fundamental dimension of developing good governance practices; a radical departure from our past. The challenge is to convert this intent into practical reality.

The Health Department

A Policy for the Development of a District Health System for South Africa was adopted as an official document of the Department of Health in February 1996. It presented the Department of Health's long-term vision for the development of the new district health system. It provides for governance structures at the District level. It was clearly in line with the World health Organisation's thinking on the district model and community participation in governance structures.

Today the Health Department has also endorsed the idea of community involvement and participation in its official policy documents. One of the Department's goals for transformation of the health system is "to foster community participation across the health sector, to involve communities in the planning, management, delivery, monitoring, and evaluation of health services, to establish mechanisms to improve public accountability, dialogue and feedback between the public and health providers, and to encourage communities to take greater responsibility for their own health promotion and health care."(Department of Health 1996).

In the Department of Health's official document entitled Restructuring the National Health System for Universal Primary Health Care, there are many statements asserting to the importance of community participation and the necessary decentralisation of authority such as: 'The national Health System should emphasise the needs and rights of users of the system. The National Health System should be congruent with, and should strengthen the emerging district based health care system. The organisation of and the functioning of the National Health System should be based on the principle of decentralised management, which will aim to create the maximum possible management autonomy at health facility level within the framework of national public service guidelines'

The District Health System

The Primary Health Care Approach (1978) also emphasises the need for intersectoral collaboration and co-ordination because it recognises that the provision of health services alone does not create healthy communities and that the social determinants of health must be addressed at all times.

The Department of National Health and Population Development organised a forum in May 1992, at which delegates from a wide spectrum discussed many issues relevant to community participation in health. The forum culminated in the delegates formulating the following Declaration of Intent: -

The forum on community participation, seeing as our goal the need to protect and promote the health of all people by providing acceptable, accessible, affordable, appropriate and equitable health care, acknowledge that community participation: -

- ❖ is an urgent priority,
- ❖ is an essential means to reaching our goal of health for all and development of communities,
- ❖ is the responsibility of us all, including decision-makers, health providers, and recognised representatives of local communities,
- ❖ empowers communities to share control over and responsibility for resources,
- ❖ is a process that will allow the community to identify their priorities and needs,
- ❖ and facilitate that the community contributes to these needs,

- ❖ facilitates co-ordination at a local level, regional and national level to prevent duplication,
- ❖ requires a great deal of support and education for communities and health professionals,
- ❖ requires mutual understanding, trust, respect and sensitivity,
- ❖ is not easy and needs to be evaluated regularly through the development of acceptable indicators and implemented with full participation of recipients and providers of health care, and resolves to seek the commitment of the State (particularly the Department of Health and Population Development), all health authorities and non-governmental organisations to :
- ❖ implement community participation so that planning, management and control of health services is shared,
- ❖ support and educate disadvantaged communities so that effective community participation can take place,
- ❖ facilitate the creation and utilisation of existing and new community structures to promote collaboration and overcome fragmentation of health services,
- ❖ Promote and encourage training institutions to re-orientate their education to meet community needs (Department of National Health and Population Development 1991:6).

While this is an important recognition of the rightful place, role and importance of community participation, slow progress has been made at a local level or district level.

The urgency of community participation and its successful implementation should definitely start with our training institutions and the public health professionals. There must be a purposive drive by all professionals to embrace public participation as an indispensable tool to healthy communities.

The underlying trends and tensions discussed in the preceding section provide important background for clarifying the appropriate role for public participation in the delivery of primary health care services at the district level. The National Policy on the development of the District Health System provides for the establishment of Community Development Forums and/or Community Health Forums for the purposes of governance in the health system.

These forums would comprise all the stakeholders in a defined area, such as CBOs, civics, women's, youth, church, sports, etc. organisations, education bodies, NGO's etc. Every citizen must have the opportunity to participate in such a forum. The functions of these forums are *inter alia*: -

- To meet regularly, and report back to the community.
- To be part of the governance structures of the health facilities in the area, and to have defined powers and functions (some of which may be advisory and some of which may be decision-making) in respect of health personnel, finances, facilities and services within their area of responsibility.
- To participate in needs analysis, planning, implementation and education of primary health care in the area. The public health officials would be serving on these forums on an ex-officio basis.

The Health Department of the City of Cape Town adopted a policy on governance in the health services in line with the National Policy on the District Health System in 1999. The policy provided for the establishment of health committees in each of the areas where there are clinic facilities. Each health committee would have to work closely with the clinic facility in their area. The Clinic Managers and the Environmental Health Officers are responsible for ensuring that the interface with the community health committee is facilitated and sustained.

At the time of the research all the Health Committees at the various facilities were established and active. The observation of these health committees by the researcher can be described as follows: -

- A small minority of the public elects all the committees who show an interest in the health services.
- Each member receives training offered by the National Progressive Primary Health Care Network (NPPHCN).
- Most of the members of health committees do not really understand their role and function clearly even after receiving their training. In fact some of the members see themselves as community representatives who should be doing voluntary work at the clinics.
- The Health personnel, including the District Management Team, at the facilities have no knowledge of the training content of the health committees.

- ❖ All the health committees are not accountable to any Development Forum, which looks at integrated development issues in the area.
- ❖ Health committees in this district have no say in the decisions of the Health Department of the City of Cape Town.
- ❖ The general approach of officials is to share health information with the health committees. The information is often of a health outcome indicators for the area.

The Role of Local Government

The Constitution of South Africa (Section 152) requires local government to "provide democratic and accountable local government for local communities" and to "encourage the involvement of the community and community organisations in the matters of local government". The White Paper on Local Government states that "building local democracy is a central role of local government, and municipalities should develop strategies and mechanisms including, but not limited to, participative planning to continuously engage citizens, business and community groups". The aim is to encourage the development of a citizenry that actively participates in governance – a clear shift away from a history of citizen non-participation in governance. Chapter 4 (1) (b) states that local government should: "contribute to building the capacity of: The local community to enable it to participate in the affairs of the municipality; the councillors and staff to foster community participation; and use its resources and annually allocate funds in its budget, as may be appropriate, for the purpose of implementing paragraph (b)."

These provisions are crucial for the Primary Health Care services, which are officially delivered by local government. Where health services were purely health professionals driven with a strong emphasis on curing, they now have to appreciate the broad context and framework of service delivery, which places a huge emphasis on the involvement of those who are being served.

The Municipal Systems Act (2000) chapter 3, defines public participation as a municipal function in the following terms: "A municipal council must establish appropriate mechanisms, processes and procedures to enable residents, communities and stakeholders in the municipality to participate in the local affairs of the municipality".

Thus, local authorities are bearing the brunt of the growing demands for health services and other basic needs like jobs, housing and infrastructure. Yet they are severely constrained by limited human, technical and financial resources. To compound matters further, local authorities are undergoing a deep process of transformation process that impacts on how it conducts its "business". Together, these factors present both obstacles and opportunities, and underscore the urgent need

to develop innovative participatory approaches to give effect to the commitments to promote co-operative governance and ensure that basic needs are efficiently and effectively met.

The Health Department of the Unicity of Cape Town moved in the direction of implementing the District Health System in July 1999. It has eleven districts, namely, Mitchell's Plain, Central, Nyanga, Khayelitsha, Tygerberg West, Tygerberg East, South Peninsula, Blaauberg, Oostenberg, Helderberg, and Athlone. The next chapter focuses on the community participation experiences of the Athlone District as an illustrative case of the eleven Health Districts.

CHAPTER FOUR
THE DELIVERY OF HEALTH SERVICES IN THE ATHLONE DISTRICT

This chapter first describes the Athlone Health District as a unit of the Health Department of the City of Cape Town as at July 2002. It further presents the findings of the researcher based on the questionnaires and the interviews conducted in the district.

The Athlone Health District

The N2 Road route bounds this District to the North, the Railway line to the East, Lansdowne Road to the South and the M5 road route to the West. A District Manager manages the district with the assistance of a District Management Team comprising of two Area Managers and the Principal Environmental Health Officer.

There are six Clinics and one Environmental Health Office in the Athlone District, serving a total population of about 250 000 people. The services with which this research is concerned include: -

- Family Planning Services
- Child Health Services
- Cytology Smears
- HIV Testing and Counselling Services
- TB treatment and surveillance
- Sexually Transmitted Diseases

- ❖ Health Promotion
- ❖ Environmental Health

Evaluation of Health Services Provided

The researcher administered the questionnaire and the following table provides the summary of the responses from the questionnaires:

VARIABLE	NUMBER OF RESPONSES	PERCENTAGE OF RESPONSES
FEMALES	41	82%
MALES	9	16%
UNEMPLOYED	26	52%
No. OF RESPONDENTS WITH PRIMARY SCHOOL EDUCATION	14	28%
No. OF RESPONDENTS WITH SECONDARY EDUCATION	33	66%
No. OF RESPONDENTS WITH A TERTIARY EDUCATION	3	6%
No. OF RESPONDENTS WHO OWN PROPERTY	7	14%
# RESPONDENTS WHO FEEL THAT HEALTH SRVICES ARE ADEQUATE IN THE DISTRICT	46	92%
# RESPONDENTS WHO FEEL THAT SERVICES ARE NOT ADEQUATE	4	8%
# RESPONDENTS WHO RECALL BEING CONSULTED ON HEALTH ISSUES	24	48%
# RESPONDENTS WHO HAVE NEVER BEEN	26	52%

CONSULTED ON HEALTH ISSUES		
# RESPONDENTS WHO CAME TO KNOW ABOUT HEALTH SERVICES THROUGH THE COMMUNITY	13	26%
# RESPONDENTS WHO CAME TO KNOW ABOUT THE HEALTH SERVICE THROUGH FRIENDS	6	12%
# RESPONDENTS WHO CAME TO KNOW ABOUT HEALTH SERVICES THROUGH THEIR FAMILIES	16	32%
# RESPONDENTS WHO CAME TO KNOW ABOUT THE HEALTH SERVICE THROUGH HEALTH PROFESSIONALS	15	30%
# RESPONDENTS WHO SEE COMMUNITY PARTICIPATION AS THE INVOLVEMNET OF THE COMMUNITY IN DECISION MAKING IN HEALTH	40	80%
# RESPONDENTS WHO SEE COMMUNITY PARTICIPATION AS VOLUNTARISM BY COMMUNITY	1	2%
# RESPONDENTS WHO FEEL COMMUNITY PARTICIPATION IS UNNECESSARY	4	8%
# RESPONDENTS WHO DON'T KNOW WHAT COMMUNITY PARTICIPATION IS ALL ABOUT	5	10%
# RESPONDENTS WHO FEEL THAT THE COMMUNITY SHOULD HAVE THE FINAL SAY IN DECISIONS AFFECTING HEALTH SEWRVICE DELIVERY	23	46%

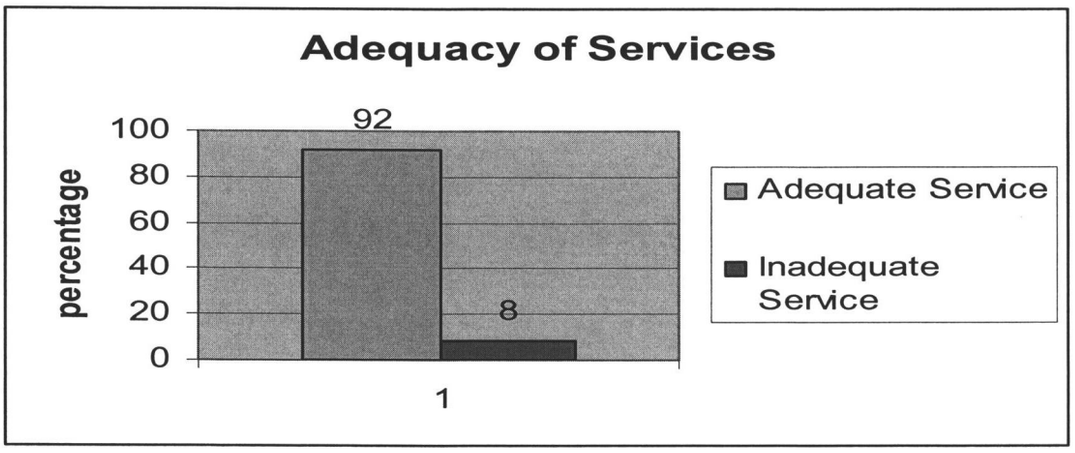
# RESPONDENTS WHO FEEL THAT HEALTH PROFESSIONAL SHOULD HAVE THE FINAL SAY IN HEALTH SERVICE DELIVERY DECISION MAKING	15	30%
# RESPONDENTS WHO FEEL THAT DECISION MAKING IN HEALTH SRVICE DELIVERY SHOULD BE A JOINT PARTNERSHIP	9	18%
# RESPONDENTS WHO FEEL THAT THEY DON'T KNOW WHO SHOULD HAVE THE FIBNAL SAY IN HEALTH SERVICE DELIVERY DECISIONS	3	6%
# RESPONDENTS WHO FEEL THAT THE COMMUNITY SHOULD ORGANISE ITSELF BY FORMING STRUCTURES THAT WILL ENGAGE THE HEALTH AUTHORITIES	41	82%
# RESPONDENTS THAT FEEL THAT HEALTH PROFESSIONALS SHOULD DO OUTREACH TO THE COMMUNITY TO GET THEIR VIEWS ON HEALTH SERVUCE DELIVERY	7	14%
# RESPONDENTS FEEL THEY HAVE NO IDEA HOW THE COMMUNITY CAN MAKE THEIR VOICES HEARED	2	4%

Out of the 50 respondents that were interviewed, 82% were women and only 18% were men. This can be attributed to the fact that these clinics provide mainly Women's Health Care and Child Health Services. 52% of those interviewed were unemployed and only 14% of them owned property. 28% only had primary education level, 66% had secondary school qualifications and only 6% had a tertiary education.

It is significant to record that there was an overwhelming reception from the respondents being willing to answer the questions on the questionnaire and freely sharing their views with the researcher. Only one of the respondents refused to be interviewed. Some of them expressed that it was the first time that they had been asked to share their views on the health services. The responses from the completed questionnaires are summed up in the following categories: -

Adequacy of Health Services

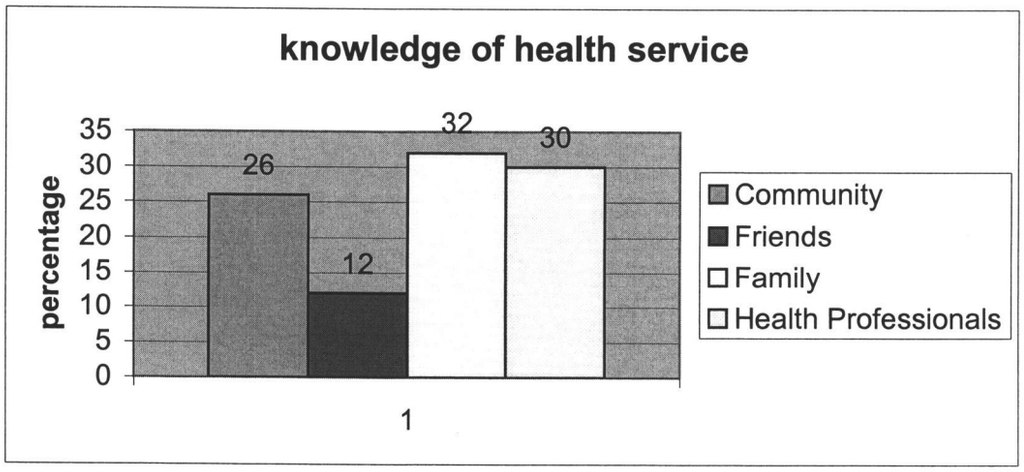
The graph below shows that there is a general feeling that the Primary Health Care Services rendered by the City of Cape Town's Health Department in the Athlone District are adequate. 92% of the respondents felt that the services were adequate. Most of these positive responses had a direct reference to the quality of the Family Planning, Child Health and Tuberculosis clinic services rendered by these facilities. The respondents who indicated that the service was inadequate cited the long patient waiting times and unfriendly staff as reasons for the inadequacy.



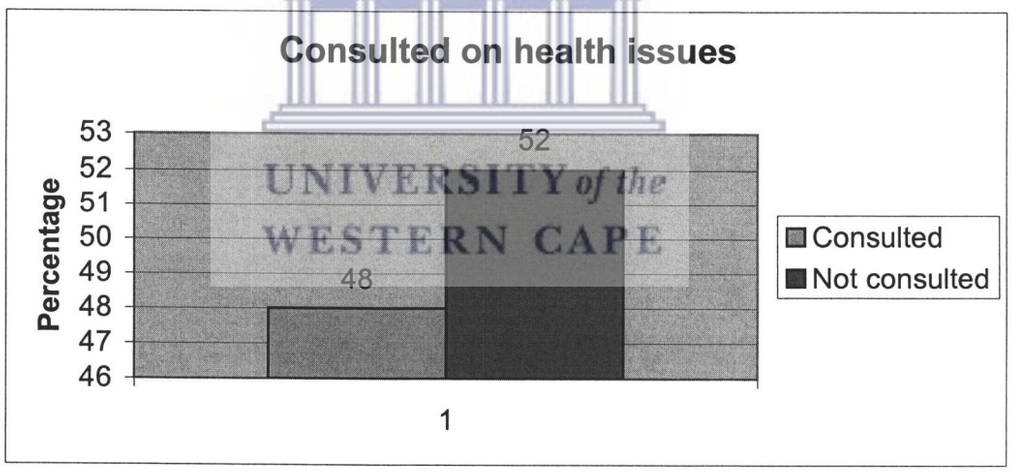
Knowledge of Health Services

Respondents were requested to explain how they came to know about the health services in their area. Most of the respondents said that they came to know about the clinic through their families. These respondents indicated that their mothers brought them to the clinic when they were small. It is also interesting to note that 30% of the respondents came to know about the clinic services through the Health Professionals at the Maternity and Obstetrics Unit s at which they gave birth. After giving birth at the Maternity units in the area, mothers are advised by the health Professionals to visit the clinics nearest to them. This is often explained to them and they are provided with information on specific clinic facilities closest to them. It is also interesting to note that 30% of the respondents came to know about the clinic services through the Health Professionals at the Maternity and Obstetrics Unit s at which they gave birth. After giving birth at the Maternity units in the area, mothers are advised by the health Professionals to visit the clinics nearest to them. This is often

explained to them and they are provided with information on specific clinic facilities closest to them.



Consultation on health issues



The graph above shows that 52% of the respondents said they were never consulted on important health matters or decisions pertaining to the delivery of health services. 48% of the respondents said that the health authority in the area had consulted them. Those who had been consulted by the health authority cited the following encounters.

Some shared that they had received a visit by the Nurses or the Environmental Health Officers from the nearby clinic or health office. This visit would either be related to a follow up on a child who has had to receive prophylactic treatment, a TB patient who had defaulted on his or her TB treatment and now needs to be followed up by the TB Nurse or an investigation of a health nuisance or health complaint by the Environmental Health Officer. All the TB clients could remember receiving a health visit.

Most of the respondents also recalled being part of some health promotion event in their areas of stay. For example, the HIV / AIDS education and awareness projects. Still many others mentioned that the Nurses used to come out every year to do mass immunisations in the residences during the National Polio Campaigns.

None of the respondents could cite an example were they had been consulted by the health authority on any health matter for decision-making. The overall responses reflect that the public are just mere recipients of a health service, which, as shown above, is reasonably adequate. None of the respondents could remember being called to a health committee meeting to discuss health matters. There was a noticeable reaction in most of the respondents' answers and questions on the questions posed to them.

The reaction is one, which showed that they are not empowered to engage the health authorities on something, which is in fact a fundamental human right – the right to quality health services. The fact that health clients equate community involvement to the outreach programmes of the local health service, which in itself is good, is indicative of a community that sees the delivery of health services as a prerogative of the Health Professionals.

One of the interviewees can be quoted as saying "the doctors and the nurses know what is best for the people so they must decide". These respondents did not see how the public could have say in the delivery of health services when they are not trained in health. One would not want to believe that health is such a mechanical issue that only requires the expertise of the health professionals. The health services are provided to the people and they can and should be able to influence its delivery.

There is certainly a great deal of ignorance on the part of the community on their role in health service delivery or there is little, if not none, being done by the health service providers to increase the capacity of the community to understand their role in the delivery of health services. In fact this research shows that there are outreach services by the health providers but it does not seem to be of such a nature to empower and capacitate the community.

Instead, it is more informative and seeks more to persuade the public into changing their attitudes without creating opportunities for the public to participate or even raising expectations about participation.

While health information sharing is important as a step in the participatory process, there should be a commitment to involve the public in decision-making processes. The public needs to realise that its role is to actively participate in the decisions of the health service providers and not to simply be the watchdogs over the actions and decisions of the health providers.

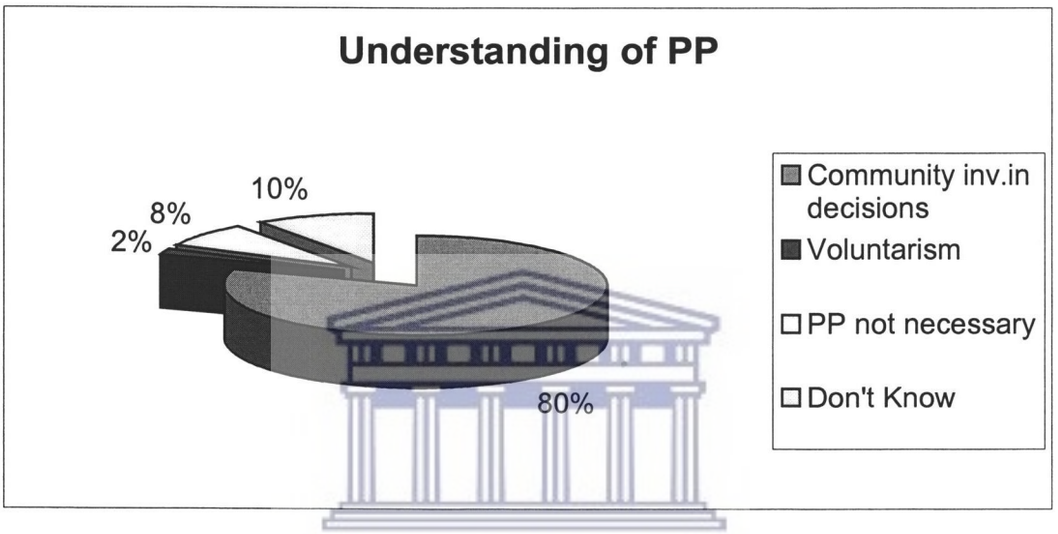
Community Participation

Interviewees proposed a variety of definitions of public participation. Of the total interviewed, 80% understood community participation to be the active involvement of the community in decision-making processes of the health authority. This was a strong view shared by those who cited it. Some of these respondents believed that the community must be involved but were not too sure as to how and when.

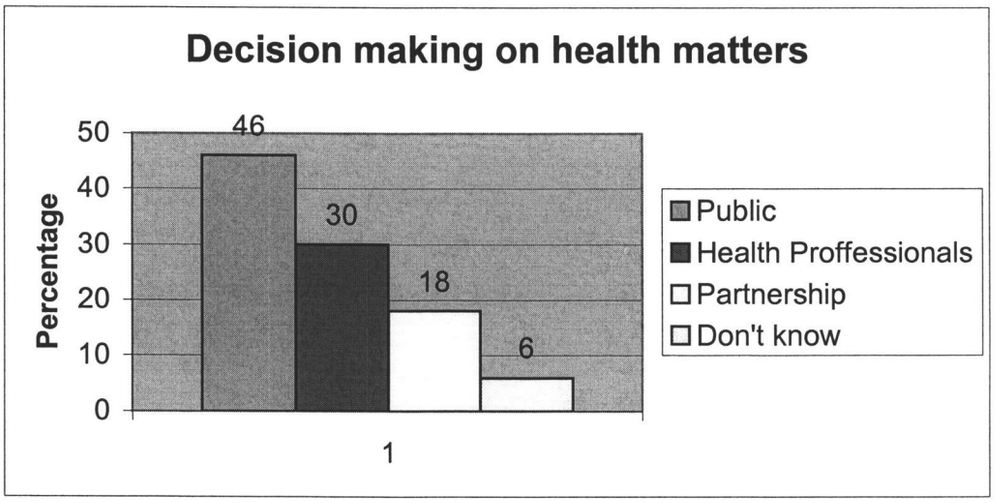
Ten- percent (10) of the respondents had no idea what it meant to them, while 8% of them saw it as unnecessary. The interviewees who did not see the need for public participation felt that the services must just be available to the people. A small number of the respondents were of the view that public participation in health service delivery should be seen as the community doing voluntary work at the health facilities.

As one can see from the responses, several definitions emerged from this question. One should therefore appreciate that not all civil society informants have the same expectations of or an interest in public participation.

While there is a general recognition of the importance of public participation, the interest of informants in it is largely determined by where they are located within the economic, political and social environment of the city. The unemployment rate of the respondents and the education levels mentioned earlier is of critical importance here.



According to a few interviewees, especially those who had some tertiary educational level, public participation should be seen to be a qualitatively deeper process that goes beyond the simple provision of information. They strongly and very forcefully shared the view that the opinions of the public must be sought, and these opinions should, at the very least, be taken into consideration in the design and planning of health services that are being considered.

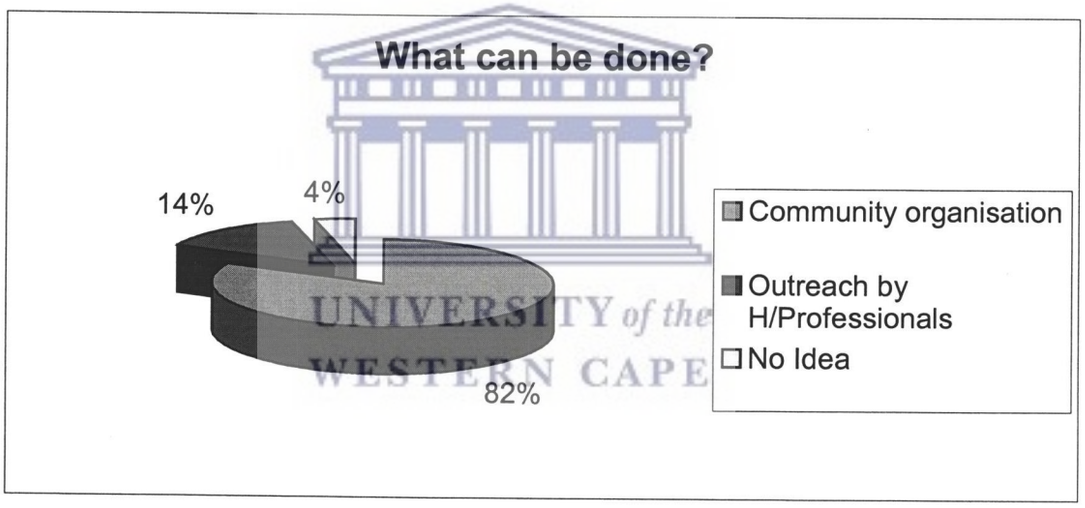


When respondents were asked about who should have a final say in decision making, 46% of them responded that the community must have the final say, while 30% of the respondents felt that the Doctors, Nurses and all other health professionals should have the final say. These interviewees conceded the right of officials to make final decisions on health matters, with the need for quality decisions based on expertise and skills being the predominant reason for this concession.

The notion of having health professionals having the final say ties in with the general impression that one gets that the health clients are only recipients of the health service. One of the interviewees argued that a good public participation process should strike a healthy balance between a 'bottom-up' and 'top-down' approach.

In other words, while it is recognised that health officials have tremendous power to decide on health issues, this should be balanced with input from civil society participants. There was also a call on health personnel or health service providers to implement appropriate participation strategies that elicit the interest and active participation of stakeholders and accountability mechanisms that assure the quality, transparency and legitimacy of the decision-making process.

What can be done to give the community a hearing?



As the graph show above, the greatest majority of the respondents (80%) felt strongly that the community should organise itself by way of a proper representation. Examples cited here were the need for regular community general meetings and the need for a health forum or committee to represent the needs and the positions of the community of important health decisions.

Interpretation of Findings

According to Rifkin and Cassels (1990:39), community participation can be interpreted in one of the following ways: -

- *compliance*: people are motivated to accept interventions, or act according to the advice of professionals
- *contribution*: the community supplements the contributions of professionals
- *collaboration*: the community participates in planning and introducing initiatives
- *Control*: of activities and resources by the community.

While the people of the Athlone Health District are generally satisfied with the primary health care services offered by the local authority's health department, there is a strong call from the respondents in the interviews held for a greater involvement of the community in the delivery of health services. There is a passive involvement of the public at the moment in the health services at local government level. This passivity can be seen in the relationships between the service providers and the clients – who happen to be just patients coming to be assisted by the health professionals.

The lack of knowledge of the community about the importance of community participation and their role in the delivery of health services is quite disturbing. The health officials do not have the same understanding of community participation as the community and even the health committees.

Active community participation, in terms of planning and managing health services, is unheard of in the Athlone district, - in fact it is non-existent. For the least, health policy makers look for the community to advise, consult or receive information about their plans. In most cases, the health department makes plans and announces them to the community as information and compliance is expected.

The existence of health committees in the district does not make much of a difference. There is no clear roles and direction for the health committees, as they are often not accountable to the community that they are meant to represent.

CHAPTER FIVE
CONCLUSION AND RECOMMENDATIONS

As mentioned earlier in chapter one, the objectives of this study were to:

- To discuss the related research
- To evaluate community participation in the Athlone Health District with specific reference to (a) the public's knowledge of health services, (b) their understanding of public participation, (c) their views on decision making on health matters as well as their own role in public participation.
- To look at health policy in relation to public participation in the South African context
- And to make recommendations, based on the findings of this research project, to the public health providers.

The City of Cape Town's Health Department's Policy on health committees, in the Athlone Health District, lacks the substance needed for the effective engagement with the public using the health committees. No long-term mechanisms have been established to keep communities involved in the district.

If we use the interpretation of Rifkin and Cassels, as stated above, we can safely say that community participation in the Athlone Health District is one of *compliance,* in that people are motivated to accept interventions and act according to the advice of health professionals. There is no evidence of collaboration where the community participated in the planning and introducing initiatives on the delivery of primary healthcare services.

In the light of the foregone discussion, the following recommendations will be of benefit to District Managers and District Health Management Teams as well as Public Health Practitioners:

1. Adequacy of health services

This research has revealed that the majority of the users of the Athlone Health District's primary health care service feels that the service is generally adequate. This response should be taken as a strength for the Athlone Health District. What is of great importance here is the need to seize the opportunity that lies behind this overwhelming positive response. We would like to draw the attention of the health professionals to the relationship that is always established between the so called "patients" and the health professional.

It is this very same trust that must be cultivated to engage the users or the public beyond just the receipt of the health service. It may mean that health professionals need to be trained on dealing with the things that are outside the "Medical Model". This can be achieved firstly by adjusting the practical training component of all public health practitioners to suite real local dynamics as well as 'on-the-job training' of all health professionals who are already in the field. The training should include skills on how to deal with conflict, public decision making, community organisation and community capacity building.

2. Knowledge of and consultation on health issues

There should be a concerted effort to build the capacity of the community from them just being passive recipients to a community that takes responsibility for its own health. Public participation is fundamentally about empowering people. The decisions of the health system should be clearly communicated to the public in a transparent and an open manner. At the same time the public needs to be given the opportunity to give feedback or to alter the decision making process or its outcome if necessary. This process of capacity building should be coupled with the broader civic education initiatives.

As both the Health authorities and local government policies are strongly insisting on the need for performance management to become an important part of service delivery, public participation should be build into such performance management practices. Communities should have the opportunity to be trained by their local health professionals (who will have been trained in these matters) to read policy documents, interpret health indicators and be able to provide constructive feedback. The present civic education programmes provided by local government should be expanded to include health related issues.

3. Community participation

There needs to be hands-on impartation on participatory processes as part of the deeper agenda of building local democracy. A wide range of skills needs to be developed, including the protocols of public meetings, negotiation and conflict resolution skills especially for stakeholder groups.

The department must develop accessible guidelines on how the stakeholders can become involved in participatory processes. Public participation must be properly budgeted for. This budget should go a long way in ensuring that the public participation plan is effectively carried out.

The opportunities that are available and possible through intergovernmental relations should be established and maximised for the collective benefit of our communities especially between National Health, Provincial Health and Primary Health Care Services at a local level. Of particular importance here is the need to integrate preventive, promotive, curative and rehabilitation services for the greater benefit of the community. This can be accomplished by the establishment of the District Health Authorities (DHAs) and Provincial Health Authorities (PHAs) as envisaged in recent health policy documents. The link between local health committees and District Health Authorities or District Health fora, should be strengthened and resources pulled together in the interest of community capacity building.

4. Decision-making on health matters

Consideration needs to be given to the question: How can the health department enable the public to assume increasing responsibility for the planning, decision-making, implementation and managing of health services? The department must develop a clear public participation plan in line with the corporate public participation plan. This plan must be structured in such a manner as to specify who is to participate, on behalf of whom, on what issues, through which organisational mechanisms and to what effect. This must be followed by proper evaluation to determine effectiveness.

The role of health committees should be critically looked at. If established, health committees should not be established in isolation. There should be a progressive move towards ensuring that they are an integral part of local development forums. There needs to be a deliberate strategy to foster public involvement in determining health priorities and interventions. A conscious effort is needed to ensure that marginalized groups are explicitly included in this strategy.

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ANNEXURE A

QUESTIONNAIRE

DATE:_____ **AREA:**_____

RESPONDENT No:_____

AGE:_____**SEX:**_____ **CCUPATION**_____

RACE:_____ **EDUCATION**_____ **FAMILY INCOME**_____

DO YOU OWN PROPERTY:_____

2. Are the primary health care services adequate in your area?.....Y/N

3. Where did you hear about the primary health care services?.....
   .....

4. Have you ever been consulted about important health matters in your
   area?.....
   .....

If so, WHEN.....
HOW:.....
.....
.

5. What is your understanding of public participation in health services?.....
   .....
   .....

6. Who should have the final say in public participation processes pertaining to health services?.....
   .....

7. How can the underrepresented and silent voices of the public be more effectively included in the public health processes?.....

8. Other Comments:.....