

**INVESTIGATING THE EXTENT AND EFFICIENCY OF  
COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE  
IN KHAYELITSHA, CAPE TOWN**

**SELLO TSOABISI**

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SUPERVISOR: PROFESSOR M.S. BAYAT

CO-SUPERVISOR: DR I.W. FERREIRA

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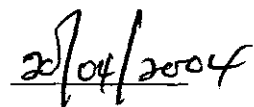
## DECLARATION BY THE CANDIDATE

I, Sello Tsoabisi, hereby declare that the contents of this thesis represent my own unaided work, and that the thesis has not previously been submitted for academic examination towards any qualification.

Signed:

A handwritten signature in black ink, appearing to be 'Sello Tsoabisi', written over a horizontal line.

Date:

A handwritten date '20/04/2004' in black ink, written over a horizontal line.

## **ABSTRACT**

The evolution of the South African health system has been characterised by inequities, imbalances as well as fragmentation. The unification of South Africa in 1910 did not consolidate public health administration, which was characterised by increasing institutionalisation, professionalism and organisation. This was the status-quo up until after 1990, whereby there were marked efforts and endeavours to effect defragmentation.

In the context of the dramatic political changes that the country has seen over recent years, many aspects of local health care have been upgraded. Issues such as policy making and planning, the development of human resources and training for health care and the establishment of health systems and structures requires a different approach from the previous. Effective human resources development and management in consultation with communities, can contribute towards improvement of service delivery around health issues. Personnel matters and skills development should be considered in the exercise to boost employee morale and job satisfaction.

The challenge facing South Africa has been to design a comprehensive programme to redress social and economic injustices, to eradicate poverty, increase efficiency and reduce waste. In the health sector this has been ongoing to involve the complete transformation of the national health care delivery system and the relevant institutions.

Health care workers jointly, require the right skills, knowledge and expertise with attitude in their duties and obligation to serve the community. However, the end-user, namely, the communities must have a role to play and contribute to the efforts of addressing the health concerns and provision of quality and efficient primary health care.

The purpose of the study has been to investigate the extent to which community participation is enhanced and expanded in primary health care matters. As the area of focus, Khayelitha means "new home" and like any other black township, it was created during the apartheid era as a dormitory area for the working class. It was established in 1984 during the tribal war outbreak in K.T.C. and Crossroads informal settlement. It became the first black township on the Cape Flats to own a community radio station, Zibonele Community Radio Station, which used to deal with community health matters.

With an initial population of about 400 000 (now estimated at 1.1 million), the township is 35km away from the central business area in Cape Town. Distance from commercial area, where customers get discount consumables, frequently means that Khayelitsha residents are either paying more for goods and or have to pay high transport costs. Although Sanlam Center has brought a national chain retailer into the area and is located to a station, many people have to pay R2 per transport to get to the station.

Educare sector needs urgent intervention since problems included high levels of exploitation of workers, negative competition between crèches, lack of resources, inadequate trained staff and a high number of children not attending any educare facility. Four schools were built with high levels of community participation through the Khayelitsha Education Forum as well as education specialists. There has been improvements in the health sector since the community used to be serviced by 7 clinics operated by Tygerberg Municipality and the 3 community health care centers run by the Cape Health Services.

Community participation in health care should be seen as the organised effort to increase control over resources and regulative institutions in given social situations. This is in line with the Batho Pele principles enshrined in the Constitution of the Republic of South Africa Act 108 of 1996.

## **DEDICATION**

To my mother, Bella Ntsai Tsoabisi, lovely wife, Gwendoline Dimakatso Tsoabisi and son, Lesedi Tsoabisi

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I wish to thank God for the strength and wisdom to complete this thesis.

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S. Tsoabisi

Cape Town  
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# CHAPTER 1

## 1.1 INTRODUCTION

This study is intended to investigate the extent and efficiency of community participation in Primary Health Care in Khayelitsha, Cape Town.

The slogan "the people shall govern" is an articulation of the attitude of the public towards its government and administration. Hence, defining the scope of community participation and contributions has been an elusive goal, and one should examine selected key requirements for effective community leadership and participation by recognising and advocating what comprises a professional local government manager. The researcher intends exploring the nature of community leadership provided by local government managers and assessing the changing political and social context in which they operate.

Hence, prescribing increased community participation in projects at the local-community level has its roots in the decentralisation movement. Development experts believed that a solution to the dysfunctions associated with planned development through a highly centralise administrative system was to decentralise the functions of bureaucracy. The problem of implementing plans through a centralised development approach led to call for a more decentralised administrative approach (Gonzalez 111, 1998).

Discussions will focus around solutions and suggestions on how communities can assist in the effective planning, implementing and sustaining of their development efforts. Furthermore, to increase the role of the structurally decentralised grassroots units in policy making through community participation.

Participation as an institutionalised behaviour was assumed to raise the level of commitment of the beneficiaries, thus encouraging them to seek ways and means to

sustain given projects project. Based on the activities and techniques applied, sustainable development essentially become human development (Gonzalez 111, 1998).

Excellence in local government implies involving citizens in government affairs to participate in defining planning of the services that are most critical to the community. It suggests reaching out to all citizens and ensuring that services are equitable and affordable. Achieving effective communication in public involvement requires that managers be good listeners, that is, facilitators who help others to communicate their ideas. This calls for a balanced approach that may, in turn, require a long adjustment process and close the gap that has existed in provision of services by the government.

By creating alternative means of decision-making, decentralisation might offset the influence or control over development activities by entrenched local elites, who are often unsympathetic to national development policies and insensitive to the needs of the poorer and disadvantaged groups (Gonzalez 111, 1998).

## **1.2 BACKGROUND TO THE STUDY**

Traditionally, public officials and public institutions have been accused of narrow-mindedness, rigidity, lack of initiative, self interest, disregard for societal values, secrecy, facelessness and failure to communicate with the public at large.

Government institutions have been created to implement the decisions of the legislators; hence, the appointed public officials should be responsible for the implementation of the legislation. Public opinion, the public interest and public participation are interrelated phenomena. Therefore, members of the public participate in matters that affect them directly, and find a way of expressing their opinions, attitudes and views on specific issues (Rainey, 1991).

Attention has been focused on the knowledge, skills and abilities that a present-day community leader needs in order to be effective. The hope is that practising and prospective community leaders will be made aware of the importance of providing professional leadership in the public sector and that they will be challenged to maximise the effectiveness of their own performances (Newell, 1993).

Community participation is intended to enhance community relations for local government affairs. This role involves participating in local organisations and civic affairs generally. It includes explaining what the local government is doing and what it is proposing as new policies, and also being instrumental in helping to forge partnerships between the government and the community.

Newell (1993) proposes that to be effective as a community leader, one needs a constituency, that is, people in the community who are interested in what is to be accomplished and willing to provide assistance. This should not resemble a political following that permits the leader to stand against the council, but rather a network of individuals and groups through which information can be communicated, received and passed on to others.

### **1.3 LITERATURE REVIEW**

Local government is the base level at which delivery of services to the citizenry takes place, hence, stability and democratisation of this level of government is a prerequisite for efficient and effective implementation of the development programme to the general public (Tsenoli, 1995). The current guidelines for policy for Primary Health Care (PHC) is found in the Primary Health Care Package for South Africa issued by the Department of Health during March 2000 (see Annexure 1).

*Local government is not necessarily 'in-prior' as a result of its "local" status. Perhaps the term "lower" may be construed to imply inferiority, which may not be correct. Hence, the tendency to name "levels" of government as spheres.*

For this to happen, the objective of democratising local government is mainly to improve the efficiency and the level of performance of local delivery institutions and to ensure that local government is developmentally oriented rather than simply being service delivery inclined (Tsenoli, 1995). Local government as a profession confirms and subscribes to the tenets of democracy and features such as client recognition, professional culture, a code of ethics and sufficient discretion to perform at a professional level.

Public officials are expected to be responsible for having a broad and general view of organisational purpose and effectiveness, for goal setting, for creating the general environment and for being the chief contact between the community and the government (Newell, 1993). Consequently, they possess broad responsibilities for establishing the organisational culture and values of the organisation determining its direction.

According to Cloete (1996), citizens are essential elements of the state and contribute to the performance of the public institutions. The quality of such performance will be determined by the culture prevailing in government, which should be seen as the collection of values, norms, attitudes and perceptions developed through the years to guide the conduct of practitioners. The government has been characterised by specific ethical standards, which all citizens should respect, because these standards will ensure that their interests are served. These standards entail codes of ethics aimed at ensuring honesty, fairness, integrity, transparency and accountability.

Cloete (1996) acknowledges that improvement of service delivery and sustaining development requires the community to be prepared and motivated to appraise themselves of the activities of the public institutions and cooperate with them in the provision of public goods and services. Such co-production will require the giving of information to the citizens, the removing of language barriers and social distances, the improvement of knowledge on appropriateness and effectiveness of service delivery by implementing consumer feedback systems and performance analysis to



activate and support individual and collective self-help in families and voluntary action groups which have been cited to be of greater promise for serving public resources.

It will serve no useful purpose to place sound principles of good governance on paper and in constitutional legislation if the bureaucracy does not execute its duties in a manner based on sound public management principles; that is, principles which will ensure acceptable standards of efficiency and effectiveness in the public officials' daily activities in serving the people (Gildenhuis & Knipe, 2000). Hence, officials in government should understand that they are there to serve the people in a positive way and not to rule them in a negative way.

## **1.4 ASSUMPTIONS**

The proposed research is based on the assumption that the existing community expectations and demands in service provision is inadequate and not addressing their needs. Furthermore, working with minimal resources and lack of professionalism from the health care workers can both be obstacles or challenges towards service delivery. The community is neglected and overlooked in matters affecting their health care and welfare. There is lack of consultation with the intended beneficiaries and local citizens.

## **1.5 OBJECTIVES OF THE STUDY**

- To highlight the need for efficient community participation in primary health care and service provision
- The importance of teamwork, inter-personal relationships based on respect and mutual co-operation, a sense of unity built on a common vision, and continuous communication at all levels of the health care services.

- To highlight the extent to which community participation can provide solutions towards efficient and accessible primary health care in Khayelitsha.

## **1.6 RESEARCH DESIGN AND METHODOLOGY**

The researcher has conducted interviews with officials from the following institutions:

Two officials from the Western Cape Health Department providing health services in Khayelitsha, 2 staff members from the Khayelitsha Clinic including 4 community members.

The interviewing process is primarily conducted to establish the role and importance of community involvement in the effective functioning and enhancing health care systems in Khayelitsha. The notion and suggestion from the community representatives that the clinic should provide a 24-hour service was explored through the interviews.

The researcher has attended and participating in one of the ongoing focus group meetings held with the community by the local health institutions or municipalities. Municipalities and government departments have been conducting these workshops to discuss issues such as prioritisation of development needs for the community, provision of essential services and participation in strategic development processes including the use of public resources. The outcome should highlight the importance of effective community participation and service delivery as two complementing and inseparable activities and aspects of local government.

*The nature of the interviews and information gathering from the respondents was primarily to ascertain perceptions of the participants in community participation processes, identify problem areas and develop recommendations to improve the efficiency of community participation.*

## **1.7 SIGNIFICANCE OF THE STUDY**

Current views within the public sector, which revolves around aspects such as managers are often required to be more involved with policy than management, more concerned with equity than efficiency, and more sensitive to matters of due process than tangible results. Neglect on the following factors by managers resulted in an urgent need to address a number of factors such as effective personnel management, a neat and clean physical environment at the clinics, leadership by example, good financial management and courage to take decisions, and the importance of regular meetings with the community and continuous communication to enhance full mutual involvement in service delivery. The study intends endorsing a common sense of managers' commitment to the job, organisational goals, the purpose of what need to be done and a holistic approach to citizens' concerns and aspirations.

## **1.8 EXPECTED OUTCOMES**

Community participation is the organised efforts to increase control over resources and *regulative institutions in given social situations*. This means that participation should be understood as the active involvement of people in the decision-making processes and attending of meetings on issues affecting them. Representatives from the community should be in a position to inform the community of the decisions taken by the health care managers and submit the concerns and aspirations of the ones they represent to the health authorities.

Community involvement means that people, who have both the right and the duty to participate in solving their own health problems, have greater responsibilities in assessing the health needs, mobilising local resources and suggesting new solutions. This means that health authorities must provide for capacity building exercises to be conducted in order to impart knowledge, expertise and skills for decision making with the community representatives.

Managers must advocate meaningful citizen participation, clarifying community values and goals and taking actions to create diverse opportunities in every community for all people. This is in line with the Batho Pele principles enshrined in the Constitution of South Africa Act 108 of 1996 and in service delivery programmes. Participation is considered to be an active process, meaning that the person or group in question takes initiatives and become assertive to a level that members of the community will adopt and identify with the decision and process taken to achieve the set goals.

## **1.9 SUMMARY**

The new South African health system has adopted the Primary Health Care (PHC) in their obligation to serve the community on health care issues. It is argued that this approach is the most effective and cost effective means of improving the population's health. *The approach involves a health system led by PHC services, which may call for communities' input in the effective planning, implementation and sustaining the health system and related development.* This chapter seeks to highlight the need for community participation in promoting Primary Health Care (PHC), examination of the past primary health care system, including the legislative framework post-1994 and the current health care system. A case of Khayelitsha has been explored with the intention to encourage communities to take greater responsibility for their own health promotion and care, suggestions on mechanisms to improve public accountability and promote dialogue and feedback between the public and the health providers, involving communities in aspects of the planning and provision of health services.

The next chapter will explain aspects on the New Health Plan in the Post-Apartheid South Africa.

## **CHAPTER 2**

### **A NEW HEALTH PLAN IN THE POST-APARTHEID SOUTH AFRICA**

#### **2.1 INTRODUCTION**

A new health legislation has been formulated by the new National Government based on the ANC's National Health Plan for South Africa. The new health plan endorsed the philosophy that the health of all South Africans will be secured mainly through the achievement of equitable social and economic development. The legacy of apartheid policies in South Africa has created large disparities between the racial groups in terms of socio-economic status, occupation, education, housing and public health. These policies have created a fragmented health system which has resulted in inequitable access to public and primary health care (A National Health Plan for South Africa, 1994).

Consequently, since every person has the right to achieve optimal health, the ANC's strategy is to promote health care using the Primary Health Care approach as the underlying philosophy for restructuring the health system. Primary health care (PHC) is envisaged to become an integral part of inter-alia, the country's health system, the overall social and economic development of the community on the basis of local health structures. The essential PHC package should be negotiated between the providers and the communities, to ensure that priorities perceived by the communities are addressed and that the communities have understanding of their entitlement. Central to the PHC is full community participation in the planning, provisioning, control and monitoring of public health services especially at local government level which will be discussed in the following sections in this chapter (A National Health Plan for South Africa, 1994).

The National Government's new Health Plan for South Africa is summarised as follows:

## **2.2 DECENTRALISED HEALTH MANAGEMENT**

One of the aims of this plan is to decentralise management of the delivery of services to provinces, districts and institutions in order to increase efficiency, local innovation, empowerment and accountability. In this plan, recognition is given to the central role that the National Health Authority has to play in co-ordination, evaluation and planning, allocation of budgets and health personnel issues including conditions of service and employment of health workers.

The Primary Health Care approach model is centred on the individual, the family and the community. The support they receive for treating, and preventing disease, and for *protecting, maintaining and improving their health is integrated across health and health related sectors*. These include inter-alia, housing, water, sanitation, agriculture, education, social welfare, environment, trade and commerce.

Within the health system, the health services provide the principal and most direct support to the community. Consequently the restructured health plan of the ANC incorporates role-players at various levels of government hierarchy, including the community as beneficiaries. An underlying principle of this system is the promotion of the concept of continuum of health care.

The following sections will explain the key levels of health provision and various roles involving a variety of stakeholders and practitioner involvement.

## **2.3 NATIONAL LEVEL**

The primary role players in a new National Health System for South Africa is as follows:

### **2.3.1 Intersectoral National Development Committee**

This is the highest level of health authorities with representatives from all sectors of the health service arena. It is responsible for intersectoral liaison with other departments and Ministries, namely, Housing and Transport. The Minister of Health is accountable to the Intersectoral National Development Committee. This Committee has to co-ordinate the activities of the Intersectoral Committees at provincial, district and community levels (White Paper for the Transformation of the Health System in South Africa, 1997).

### **2.3.2 National Health Authority (NHA)**

The NHA is chaired by the Minister of Health and include the representatives for community organisations, professional bodies, statutory bodies, non-governmental organisations (NGOs), representatives from Provincial Health Authorities and District Health Authorities. The National Health Authority has the overall responsibility for the development and provision of all health care in South Africa. It is responsible for policy formulation and strategic planning, as well as coordination of planning and the functioning of the overall health system in the country. It is to develop guidelines, norms and standards to apply throughout the health system, and to translate policy into relevant integrated programmes in health development. The central level main function is to elaborate policy statements and health legislation, and coordinate international and donor support (White Paper for the Transformation of the Health System in South Africa, 1997).

### 2.3.3 Functions of the National Health Authority

The NHA's functions are wide and varied. It is responsible for the promotion of community involvement through liaison with the structures of civil society, including trade unions, NGO's, private health providers and other stakeholders, with a view to inter-alia, rendering high quality health services in terms of the people's needs and to eliminate disparities between provinces and districts. Responsibility for the development of multi-sectoral collaboration necessary for the implementation of health programmes in healthy communities, as well as for co-ordination of training programmes for health personnel, rests with the NHA (White Paper for the Transformation of the Health System in South Africa, 1997). The primary functions of the NHA may be categorised as follows:

#### (a) Health Care

- Formulation of national policy, including macro economic analyses in respect of inter-and-intra-sectoral activities.
- Determination of national priorities, plan and strategies and ensuring their implementation.
- Determination of national norms, guidelines and standards of care.
- Overall coordination of both public and private health care.
- Coordination of organisations providing national services.
- International liaison and coordination of international and donor support, including policies and guidelines for that support.
- Planning, coordinating, supporting, supervising and evaluating all services in the provinces and districts, including establishing national norms, policies and guidelines for the building and expansions of public and private hospitals and clinics.
- Promotion of health, and support for health education.



- Support for the preventive interventions and programmes for provinces and districts.
- Planning and controlling the national referral system.
- Co-ordinating of emergency services and disaster relief in collaboration with the PHAs, DHAs and other parties as necessary.

(b) Support services

- Procurement, storage and distribution of pharmaceutical, medical and laboratory supplies and equipment.
- Providing backup services for highly specialised equipment.
- Quality control of laboratory services and equipment.
- Administering certain national programmes, such as vaccine production, virology services and medicine control.

(c) Administration and finance.

- Establishing norms, standards and guidelines for all health resources, namely, funds, human resources, facilities and equipment.
- Negotiating with the Department of Finance for funds to provide the necessary health services and for training.
- Development of financial allocation mechanism, and monitoring and evaluation of the effectiveness and cost-efficiency of the health system.
- Provision of the infrastructure and services needed to underpin the health facilities of the nation.
- Preparing and tabling health and health related legislation for the National Assembly.

(d) Planning and human resources.

- National human resources planning and development.
- Planning and coordination of national health and health related research and research institutions.
- Coordination of academic health institutions.
- Establish and coordinate a national health information system.
- Provision of special technical advise and expertise to the provinces and districts.

### **2.3.4 National Health Advisory Body**

The National Health Advisory Body advises the National Health Authority on policy and health related matters and is represented by members from statutory bodies, the national associations of health professionals, NGO's involved in health services, trade unions and community-based organisations (A National Health Plan for South Africa, 1994).

## **2.4 PROVINCIAL LEVEL**

It is envisaged that the current provincial health authority must support, monitor and evaluate district level services and provide certain provincial level services.

### **2.4.1 Intersectoral Provincial Development Committee**

This body is similar in concept and functions to the District and Community Development Committee and comprises of those members of the provincial legislature (Members of the Executive Committee – MECs) responsible for all sectors impacting on health. Its task is to identify development needs in the province and to mobilise and allocate resources to the advantage of people of that province (A National Health Plan for South Africa, 1994).

### **2.4.2 Provincial Health Authority (PHA)**

The PHA is responsible for the health of all the people in a specific province and its main task is to support and supervise the DHAs. Vital components of this support is specialist hospitals and services, the organisation of training and the coordination, evaluation and planning of primary care services. Specialists working at provincial institutions should visit district health facilities regularly to provide support and specialist teaching, to learn from the people at district and community level, and to facilitate efficient referral between primary, secondary and tertiary care facilities (A National Health Plan for South Africa, 1994).

The PHA is accountable to the elected provincial government and must be chaired by the MEC for Health. Members include the Provincial Director for Health Services, Heads of the Provincial Health Departments, and representatives from the DHAs. It will, within national guidelines, control the budget allocated for provincial health services and coordinate and monitor the budgets allocated to the DHAs (A National Health Plan for South Africa, 1994).

### **2.4.3 Functions of the Provincial Health Authority**

The PHA is to promote community participation and involvement through liaison with community organisation, trade unions, NGOs involved in health, private providers and their organisations, and other stake-holders in the province with a view to rendering a high quality service in terms of the needs of the province. It must ensure that multisectoral collaboration takes place for the proper development of health programmes and healthy lifestyles. The PHA's functions are outlined as follows as espoused in the National Health Plan for South Africa (1994):

(a) Health Care

- Monitor, evaluate and plan all health services in the province, based on national norms, policies and guidelines, including the development of provincial policies and planning guidelines.
- Support and coordinate the work of the DHAs in the province.
- Approve, within national guidelines, standards and norms, the building and expansion of public and private hospitals and clinics.
- Ensure the provision of hospital care, including specialist hospitals and specialised rehabilitation support centers.
- Ensure the maintenance of a safe environment throughout the province.
- Provide certain specialised environmental and auxiliary health services, including forensic services.
- Provide supportive emergency services.

(b) Support services.

- • Procurement, storage and distribution of pharmaceutical, medical and laboratory supplies and equipment.
- Providing backup services for laboratories and medical equipment, including quality control.
- Provision of auxiliary services and coordination of the collection and supply of blood and blood products.

(c) Administration and finance.

- *Coordination of the budgets of the DHAs in the province.*
- Allocation of budgets to, and financial control over, designated provincial health services.

- Management and monitoring of the health finances of the province and reporting thereon as prescribed by the NHA and by other monitoring authorities.
  - Procurement of additional funds for provincial projects.
  - Provision of infrastructure and services to underpin primary, secondary and tertiary care facilities in the province.
  - Preparation of health legislation for tabling in the provincial legislature, and commenting on proposed legislation in other sectors that may affect health.
  - Provision of the means of communication with health facilities, and health authorities within the province.
- (d) Planning and human resources.
- In-service and qualifying training of, and supervision over, relevant health personnel.
  - Provision of technical and logistic support to provincial and district services.
  - Collection, collation and analysis of all relevant health data for the purpose of provincial planning, and the submission of appropriate data to the NHA.
  - Coordination of NGOs, private hospitals and other providers with provincial service and facilities.
  - Planning the provision of health services in accordance with provincial development plans as determined by the Intersectoral Provincial Development Committee.

### **2.4.3 Management Committee**

The Management Committee is responsible for the day-to-day management of the provincial health services, and is led by the Provincial Director of

Health Services, and comprises of the Director and the Heads of the Provincial Departments (A National Health Plan for South Africa, 1994).

#### **2.4.5 Specialist Hospitals**

All specialist hospitals should be coordinated by the PHA. Day to day management of these institutions must be delegated to the staff appointed to run them so that they have a high degree of decentralised administration. Planning, budgeting and general policies must be initiated within institutions and discussions and coordination be done by the PHA. Whereas these hospitals should not provide care that could be provided at a lower level, they should, like clinics and other components of the health services, be accessible and affordable to all who need their level of care. They form an integral part both of the country's health care system, and of the overall social and economic development of the community (A National Health Plan for South Africa, 1994).

Apart from their role in providing individual patient care, specialist hospitals can support primary care workers through efficient referral and consultation systems. They may support and conduct relevant research and have a role to play in both basic and continuing education and training of all types of health workers. It is imperative that emphasis should be based on greater accountability and less bureaucracy to enhance delivery and action taken and easy way to adapt to local conditions.

Hospitals such as the Red Cross for Children situated in Cape Town, forms an integral part of the referral networks of the province and the country. Such hospital will ensure that rational and optimal utilisation of the national resources and certain services may only be provided at designated facilities.

#### **2.4.6 Provincial Health Advisory Board**

The Provincial Health Authority is to receive input from a Provincial Health Advisory Body, similar in concept and composition to that at district level, and should include representatives of stake-holders in the private health sector and of civil society (A National Health Plan for South Africa, 1994).

### **2.5 DISTRICT LEVEL**

Crucial to the health services transformation towards a more legitimate health structure is the proposed new system of health districts. Provinces are to be divided into districts mainly on the basis of functional and geographic coherence. The district boundaries be conterminous with those of the administrative and political boundaries in order to facilitate effective, integrated and comprehensive services delivery (A National Health Plan for South Africa, 1994).

The District Health Authorities are accountable to the elected political authorities. In the case of districts which coincide with the boundaries of a single local authority, the DHA may be an integral part of the latter. Where a district includes more than one local authority, the DHA may include representatives from each of the local authorities in proportion to their population (A National Health Plan for South Africa, 1994).

#### **2.5.1 Intersectoral District Development Committees**

Intersectoral coordination must be ensured through the establishment of an Intersectoral development Committee on which the DHA will be represented. This Committee must ensure that health concerns are addressed by sectors such as Education, Engineering, Water Affairs, Agriculture and by other sectors involved in development activities that affect health (A National Health Plan for South Africa, 1994).

### **2.5.2 District Health Authority (DHA)**

The DHA comprises of representatives from the local authorities, Community Health Committee (who could include service providers from clinics, CHCs or community hospitals), the Director of District Health Services, and Heads of the District Health Units. The main functions of the DHA and its staff is to promote primary health care and to plan, coordinate, support, supervise and evaluate services, based on national and provincial norms, policies and guidelines. The DHA should receive a budget for primary health care and allocate this to different community level services including receiving and controlling the budget for, and run, community hospitals in the district (A National Health Plan for South Africa, 1994).

*Community hospitals are an important component of district health care. At these hospitals general practitioner services including basic primary health care service should be provided. Specialist services may be provided under exceptional circumstances. Community hospitals must work closely with CHCs and provide in-patient care close to where people live and mainly staffed by a team of full-time workers and visited regularly by specialists from the provincial hospital with which they are linked.*

The DHA is to be responsible for ensuring that there are efficient referral systems within the district and between the district, provincial and national facilities such as hospitals and training institutions.

### **2.5.3 Functions of the District Health Authority**

The DHA is to ensure that all health services in the district are rendered within the norms, policies and guidelines agreed to at provincial and national levels, in order to promote equity.



The varied functions of the DHA are listed as follows as highlighted in the ANC's National Health Plan for South Africa (1994):

(a) Health care.

- Promotion of PHC and monitoring, evaluation and planning of services.
- Management and coordination of health promotion activities and all the different elements of comprehensive health care that are provided by primary care workers.
- Provision of clinical services in community hospitals, clinics, community health centers and through outreach services.
- Provision of accident, emergency and response services.
- Control of the acquisition, storage, handling and disposal of all hazardous substances in the district.

(b) Support services.

- Procurement, storage, distribution and stock control of pharmaceuticals and medical and laboratory supplies and equipment.
- Provision of support services such as dispensaries, laboratories, radiological services in the appropriate public facilities.

(c) Administration and finance.

- Management and control of the district health budget.
- Procurement of additional local funds for projects.
- Provision of transport and possibly ambulance services.

(d) Planning and resources.

- Personnel management of public sector employees.
- Coordination of all health workers, including NGOs and private providers, in the local area.
- In-service training of health workers.

#### **2.5.4 Management Committee**

This Committee is responsible for the day-to-day management of the district health services and to be led by the Director of District Health Services. It is comprised of the Director and Heads of the District Health Units (A National Health Plan for South Africa, 1994).

#### **2.5.6 District Health Advisory Board**

To ensure community participation and involvement, the DHA is to receive advice from the District Health Advisory Committee, community-based organisation, trade unions, professional bodies and other health worker organisations (A National Health Plan for South Africa, 1994).

### **2.6 COMMUNITY LEVEL**

Since the community is the most important entity in health care services all communities should be encouraged to form intersectoral Community Development Committees with membership from within the communities. The function of these committees is to liaise with people at various levels of health care services to examine health budgets, to assist in the determination of health policies, to identify and prioritise community health needs in co-ordination with District Health Authorities.

The foundation of the National Health services is the Community Health Centres which is to be involved in providing comprehensive health services including promotive, preventive, curative and rehabilitative care. Each CHC is responsible for health care in its own area with health clinics as the center of public health services. In order to ensure that health services are accessible to communities in the most remote parts of the country, decentralised health units, namely, Health Posts, should be created. Health Posts are places that are not used as full time health facilities but are visited regularly by teams of health workers from nearby clinics of CHCs. They are important for bringing services closer to the people who need them most, viz: the elderly and the disabled (A National Health Plan for South Africa, 1994).

## **2.7 ROLE OF THE PRIVATE SECTOR AND INDEPENDENT PRACTITIONERS**

It is mentioned in the National Health Plan for South Africa (1994) that the private health sector is a large industry, comprising a number of different institutions, stakeholders, organisations including personnel. These include, inter-alia, the pharmaceutical industry, medical technology industry, private hospitals and facilities, medical aid, and a range of private practitioners including traditional and complementary health healers. The high cost spiral within the health care industry necessitates a restructuring and change in the ethos of the private sector, in consultation with all relevant role players.

The current structure of the private sector has created incentives which detract from the ultimate objective of health for all, and instead has created incentives which allow financial interest to take precedence over the patient's interests. It is a system which has been abused by some, and this detracts from the constructive role that the private sector has to play. Under the new and dynamic National Health System restructuring, the private sector can enhance its important role in improving the health of the nation. *Mutual understanding between the private and public sectors can promote a positive*

climate in which the two sectors can work together, with the common goal of achieving health for all.

### **2.7.1 The Independent Practitioner**

The private practitioner is an important, and often underestimated resource at the primary level of care. It is hoped that the majority of private practitioners of all categories will work increasingly in the public sector, deriving their income from health authorities, but maintaining their independence. This group of practitioners is referred to as independent practitioners. Independent practitioners should be encouraged to form multidisciplinary group practices which can be recognised as an important contribution to comprehensive health care at the primary level. Independent practitioners play an important role in improving access to the health system, especially in areas where services are difficult to provide (A National Health Plan for South Africa, 1994).

Equity in the distribution of independent practitioners should be encouraged through incentives to work in under served areas. Private practitioners should be encouraged to work in public clinics, health centers and hospitals on a regular rotational basis and have access to the CHCs for the follow-through of their patients.

### **2.7.2 Cost Containment**

The rational and appropriate use of resources is essential. The private sector can play an effective role in helping to identify and implement alternative, more cost-effective therapies. This can be done through the development of therapeutic guidelines, clinical audit, peer and utilisation reviews. The cost spiral within the private sector can be largely attributed to expenditure on drugs and private hospitals. A system of nondiscriminatory pricing of drugs,

and generic substitution must be effective in helping to contain costs on drug expenditure (A National Health for South Africa, 1994).

### **2.7.3 Private Facilities and Institutions**

The ANC's National Health Plan for South Africa (1994) suggests that better regulatory framework should be applied to the licensing of private sector facilities. Other systems of remuneration should be investigated to replace fee-for-service payments in private health facilities to reduce the incentive to over-service. Conflicts of interest that promote over or under-servicing whereby the patient's interest is subordinate to the financial interest of the health worker or institution should be discouraged. In particular, health workers should not be permitted to hold shares in private clinics and hospitals.

### **2.7.4 Traditional and Complementary Healers**

Traditional healers play an important role in the health care of a large proportion of population, and the need for a coordinating body should be investigated. The role of complementary health practitioners needs to be recognised, and mechanisms to integrate them into the health service require investigation (A National Health Plan for South Africa, 1994).

### **2.7.5 Statutory Bodies**

The National Health Plan for South Africa (1994) is endorsing that all statutory bodies relevant to health must be reviewed with a perspective *directed towards rationalisation*. *Coordination between the statutory bodies* is required to ensure that they interpret and implement national health policies. The objectives of those Statutory Bodies that govern the registration of health personnel is aimed at ensuring that compliance to the following aspects is adhered to:

- uphold the rights of patients and safeguard their interests.
- promote health standards and training standards.
- authorise the education, training, registration and practise of all health professionals.
- regularly review the curricula of health personnel education programme to be in line with national guidelines.

### **2.7.6 Role of Non-Governmental Organisations (NGOs)**

NGOs have historically provided local health services under a variety of conditions in South Africa. In most cases NGOs services have filled a void created by neglect of health care needs for underserved population. In many instances NGOs have paved the way for development of sustainable health care services at the community level. In other instances NGOs have the capacity to create innovative services which do not fit into conventional health service provision (A National Health Plan for South Africa, 1994).

The government has to create within the national policy, a framework that takes into account specific objectives of NGOs, rationalisation services, supervision of standards of care and promotion of efficiency and outcome measures. The payment for the provision of specific services can depend on the submission of budgets and performance appraisal. Their services need to be integrated into, and coordinated with the rest of the health services in order to avoid fragmentation, and where they meet the needs of communities they must be encouraged and supported.

### **2.7.7 Role of International Organisations**

The government is responsible for defining specific areas for which external support is needed. It is not only financial resources that international agencies can bring to South Africa health's care reconstruction efforts, but the technical assistance and appropriate technology for health care services.

A further contribution is the sharing of knowledge and experience about public health services in other provinces. It is imperative that the government swiftly formulate health liaison between service providers so as to muster support for innovations around the health care system

## **2.8 SUMMARY**

The history of existing health policy in South Africa demonstrates the failure of fragmented health planning especially in a Metropolitan setting. Apart from the existence of racial segregation in health services, the single factor constraining the development of a comprehensive health system has been the political division of health functions between national and provincial levels of government.

The formulation of national health policies in the past was the concern of the Department of National Health and Population Development. This Department was responsible for the coordination of public health services, provision of additional health services, establishment of national health laboratories, promotion of a healthy and safe environment, promotion of family planning and conducting research in health services for the improvement of the health and well-being of all people within the Republic of South Africa. The Department failed in this objective due the policy of separate development.

It is envisaged that the present government and the policies in place will remain in force until the task of restructuring and transformation of the public health is adequately and properly addressed. A District Health System based on Primary Health Care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population living within a clearly delineated administrative and geographical area such as Khayelitsha. It includes all the relevant health care activities in the area, whether government or otherwise.

To this end, this chapter presents a description of the framework within which public health services have been rendered in South Africa.

The next chapter will explain and elaborate on the development of the District Health System (DHS) since the evolution of the South African health system.



## **CHAPTER 3**

### **DEVELOPMENT OF THE DISTRICT HEALTH SYSTEM**

#### **3.1 INTRODUCTION**

The evolution of the South African health system has been characterised by inequities, imbalances as well as fragmentation. The unification of South Africa in 1910 did not consolidate public health administration, which was characterised by increasing institutionalisation, professionalism and organisation. Almost three decades after union, confusion, inefficiency, inertia and extravagance, were still features of a divided public health sector (Van Rensburg, Fourie & Pretorius, 1992).

In 1948, the success of the National Party signalled the beginning of legislated race discrimination, which not only affected the organisation of health services, but also the very health of people. The following four decades constituted a phase in which health policy development closely mirrored the ideology and social engineering of the minority government. Systematic fragmentation of the South African society during the apartheid era affected the organisation of health services (Van Rensburg, Fourie & Pretorius, 1992).

After 1990, there were marked efforts to effect *de-fragmentation*. The final phase in the history of health policy in South Africa is characterised by the country's first democratic elections, followed by the implementation of a National Health System based on the primary health care approach. Such a mammoth task of restructuring South Africa's health system is an attempt to address many of the imbalances and disparities in the health sector.

The challenge of implementation is to translate provincial commitment and administrative reorganisation into real improvements in health care delivery at local

level and to develop effective community participation in health service planning, management and provision.

The Department of Health at national and provincial level is clearly committed to district systems development as a means of improving health care. An injection of support from the "bottom-up", aimed at strengthening local capacity to effect real changes in health care delivery and to involve communities in the process, will enhance the efforts of the Department of Health.

In the context of the dramatic political changes that the country has seen over recent years, many aspects of local health care have been reappraised. Issues such as policy making and planning, the development of human resources for health care and the establishment of district health systems require approaches very different from those that existed before.

In this chapter, attention will be focused on a review of the South African Health System during the Apartheid Era, the Health Reform in Post-Apartheid South Africa and the District Health Systems Framework for Quality Assurance Development.

### **3.2 SOUTH AFRICAN HEALTH SYSTEM DURING THE APARTHEID ERA**

The establishment of the Union of South Africa in 1910 heralded a totally new era in the country's history – the era of self-determination and independence. Unification had significant implications for health care, especially in as much as a unified political framework created the possibility of a unified health care system. Structural features and trends, which were established in the evolution of South African health care and which were clearly visible in the organisation of health services prior to unification, were reaffirmed, strengthened and expanded (Van Rensburg, Fourie & Pretorius, 1992).

According to Van Rensburg, Fourie & Pretorius (1992), the following features characterise the evolution of South African health care:

- Dominance of Western-scientific, curative and medico-professional health care;
- Intensification of colour segregation, racial apartheid and racial fragmentation in health care;
- Expansion of the pluralistic structure of health care;
- Continuation of structural, functional and geographic fragmentation of health care; and
- Deepening of rural-urban discrepancies and inequalities in health care.

The preceding outline of structural trends, which shaped South African health before Unification, also determined the structure of health care after Unification and eventually came to the fore even more strongly in later years. At the time of Unification, health care in South Africa was characterised by vague policy arrangements, the absence of an encompassing control structure and the significant split between curative and preventive functions under separate controlling bodies (Van Rensburg, Fourie & Pretorius, 1992).

It was only after the 1918 disastrous influenza epidemic that South Africa's health care was re-oriented and re-organised. This resulted in the Public Health Act 36 of 1919 which established uniform control of preventative health services by co-ordinating health care at national level. It provided for the establishment of a Department of Public Health which, in addition to the provincial administration and local authorities, would be responsible for public health services in South Africa and which would co-ordinate the network of health services of the local authorities (Van Rensburg, Fourie & Pretorius, 1992).

In terms of provincial administration, they retained responsibility for the establishment, maintenance and management of general hospitals and charitable institutions, as well as associated itself with curative services in South Africa. Local authorities, on the other hand, were responsible for the control of contagious

diseases and environmental health. The 1919 legislation was defeated by autonomy with which provincial administrations provided hospital services, the deepening polarisation between preventative and curative services and the creation of the belief that the Department of Public Health was merely a financing agent for the local authorities (Van Rensburg, Fourie & Pretorius, 1992).

The Act legitimated organisation fragmentation in the public health sector, while neglecting to clarify the role and place of the rapidly emerging private health sector. Even though the Public Health Act of 1919 was repeatedly amended in later years, its broad organisational framework still remained in so far as the three tier authority structure of the public health system, the divided control of different sectors of health care and the sharp rift between the loci of curative and preventative services (Van Rensburgh, Fourie & Pretorius, 1992).

Against the above background and diverse events such as the Great Depression and the poor white problem, much reformist thinking originated from various sources such as the Gluckman Report of 1944. The Report can be viewed as a culmination of the reformist thinking that had been developing over time. The report outlined the following shortcomings in the organisation of South African health care:

- Lack of co-ordination in the provision of health services;
- Private practices were established in wealthy areas, consequently making health services inequitably available; and
- Prevention of disease or community-based care was neglected in favour of curative and institutional care.
- Insufficient environmental measures and the critical shortage of medical services needed for preventing illness.

According to Van Rensburg, Fourie & Pretorius (1992), the National Health Act of 1977 aimed to achieve the following:

- Clearly define the duties, powers and responsibilities of the respective health authorities;
- The establishment of a health Matters Advisory Committee and the National Health Policy Council to co-ordinate services between the various tiers of authority;
- Establish a nationally co-ordinated health policy so that resources could be optimally and effectively used;
- Emphasise comprehensive and preventive care while ensuring that all have reasonable access to health services; and
- Encouragement of the private sector to provide its services freely.

In comparison to the legislation, the National Health Act of 1977 not only delineated the three tiers of authority and stipulated their duties and functions, but it took concrete steps to effect greater co-ordination between the three tiers. Further to this, it initiated a move towards the prevention of illness and promotion of health (Van Rensburg, Fourie & Pretorius, 1992).

According to Van Rensburg, Fourie & Pretorius (1992), the Health Act of 1977 failed in the following areas:

- Reinforced fragmentation in the organisation of health care brought about by the existence of the three tiers of authority;
- Health care organisation pertained only to health services in white South Africa;
- The existing socio-political dispensation of white dominance and apartheid was accepted as the given framework for the structuring of health care; and
- Continued emphasis on curative services.

The National Health Plan of 1986 with the following recommendations as outlined below:

- Central responsibility for planning and policy decisions and decentralised executive responsibility at the second and third tiers of government;
- Optimal use of resources by elimination fragmentation and duplication;
- Encouragement of private initiative and input in the health field; and
- Rectification of the division between preventive and curative services.

The National Health Plan of 1986 brought about much reorganisation in respect of existing authority structures in the country's health care system, but still failed to redress the long-standing distortions of the wider socio-political order which was so clearly embedded in the health care structure.

*Escalating shortcomings in the prevailing health care dispensation made it necessary for the government to alter the organisational structure of public health services in the late 1980's. Among others, all executive functions were transferred from the Department of National Health and Population Development to the provincial administrations. Provincial administrations would also be involved in central policymaking, overhead planning and co-ordination of health services (Van Rensburg, Fourie & Pretorius, 1992).*

These initiatives and efforts by the government to reform the South African health care system can be described as meaningless as they once again failed to penetrate to the core of the larger structural problems in South African health care. The reform initiatives were no more than patchwork, again dictated by the framework of the preceding decades.

The 1990's is often regarded as being a watershed in the history of South Africa. For the South African health care system, the government for the first time jolted the actual framework of the underlying structural problems in health care.

The Health Act of 1990 emphasises on the individual responsibility of inhabitants in South Africa for their own well-being, recovery of costs from inhabitants incurred in medical treatment, provision by the state and local authorities of a comprehensive health service and encouragement of the private sector to provide health services. The Act introduced the new Health Matters Committee, Administrators Health Council and Health Policy Council, while curbing the powers of provincial administrations. One must concede that by rearranging authority structures and functions, the National Policy for Health Act of 1990 made it possible for the state to determine and execute national health policy.

The National Health Service Delivery Plan (1991) stated the government's intention to contribute to the progressive improvement of the health status and quality of life for all peoples of South Africa. It was accepted that in future, South African health services would have to comply with the principles of accessibility, effectiveness, affordability, equity and acceptability.

It can be argued that while changes have taken place in South African health care over the past decades, these changes were cosmetic by nature and indicative of a drift in the same direction. As a result of the absence of fundamental change and of the continuous and constant reinforcement of the pluralistic and racial character of South African health care, the problematic and structural problems of the South African health care system actually remained intact up to the early 1990's.

### **3.3 HEALTH REFORM IN POST-APARTHEID SOUTH AFRICA**

The apartheid health system was one of the most unequal, fragmented and wasteful in the world. Fourteen different health departments administered health and duplicated services on a racial basis. There were ten Bantustan health departments, three "own affairs" health departments for the White, Coloured and Indian population and one general affairs department.

There were also provincial health departments as well as 382 local authorities that were responsible for some health issues. Hospitals were segregated until 1990 and even when this fell away, they were still controlled by racially segregated health departments.

According to Van Rensburg, Fourie & Pretorius, 1992, the restructuring of the health sector was intended for the following reasons:

- To unify the fragmented health services at all levels into a comprehensive and integrated national health system. A district health system is seen as the best way to achieve this;
- To reduce inequalities in health service delivery; and
- To mobilise all partners, including the private sector, non-governmental organisations and communities in support of an integrated national health system.

Changes were required if the South African health care system had to meet the needs of people and ensure equitable distribution of health resources. It called for the organisation and strengthening of health infrastructure on the basis of primary health care World Health Organisation (WHO).

World Health Organisation (1981) pointed out a way forward which demands a revolutionary change in the way of thinking about health care. The key to change lies in the following aspects:

- Equity and universality – results to accessibility and adequacy
- Community involvement – acceptance and enjoy support from members
- *Prevention and promotion – through education and knowledge*
- Cost-effectiveness and appropriate technology – for efficiency and effectiveness
- Teamwork – for diversity and belonging
- Multi-sectoral approach – breaking barriers and ignorance.



The South African health care system prior to 1994 did not reflect any of the features. To restructure the South African health care system, it is imperative to incorporate these fundamental features to achieve acceptable standards of health care.

### **3.4 SIGNIFICANCE OF THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME ON HEALTH REFORM**

The Reconstruction and Development Programme (RDP) is a policy framework for integrated and coherent socio-economic progress. It seeks to mobilise all citizens and South Africa's resources towards the final eradication of the results of apartheid (White Paper on RDP, 1994).

The policy instrument directs the progress of the transformation strategy as incorporated in the six basic principles of the RDP – integration and sustainability, people-driven, peace and security, nation building, meeting basic needs and building the infrastructure, democratisation and finally assessment and accountability (White Paper on RDP, 1994).

The RDP has highlighted the need for massive reform in the provision and delivery of health services in South African in view of gross mal-distribution of health care resources between the public and private sectors, regionally and between levels of care. It identified an urgent need to redress these inequities, particularly in terms of the development of primary care infrastructure in under-served per-urban and rural areas.

The White Paper on RDP (1994) advocates that health reform must not only consider the state of existing service delivery infrastructure and the changes that could be implemented to ensure improved efficiency, but reform must also look towards a model that provides health services, equitably to a minimum level that is acceptable to the whole country. The management of PHC services at the district level is important in the respect. *The new management structures for the District*

Health System has to be implemented within the broad framework of the PHC approach.

The approach taken by the White Paper on RDP (1994) to the reform of health care services has been to identify programmes that will collectively deliver a minimum level of acceptable health care and the reduction of all inequalities of access of health care. The implication is that provision of services and facilities need to be increased in some areas while services in others need to be redefined.

In terms of health programmes, the White Paper on RDP (1994) has emphasised the primary health care approach. This embraces the concept of community development, community participation in the planning, provision, control and monitoring of services as well as intersectoral collaboration. It is therefore crucial that health priorities and programmes are comprehensive, integrated with relevant sectors and defined and allocated according to need. The delay in establishing democratic local government structures negatively impacted on DHS development within many district health municipalities. This impeded RDP processes at the ground level and depriving recipients of health care and service delivery.

The objectives to achieve a minimal level of acceptable health care as mentioned in the White Paper on RDP (1994) are as follows:

- Free health care, and access, for children under 6 years of age not covered by a medical scheme, at all public sector facilities;
- Free health care, and access, for antenatal, delivery and postnatal care, for those not covered by a medical scheme, at all public sector facilities.
- Expansion of the free primary school feeding scheme to include a nutrition supplementation programme for those children under the age of 6, pregnant and lactation women in need;
- The provision of emergency care in at least one 24-hour facility in all health districts;

- The expansion of immunisation coverage and the eradication of polio and neonatal tetanus;
- Control of the spread of tuberculosis;
- Inclusion of the HIV/AIDS and STD programme development by the National Aids Convention of South Africa (NACOSA);
- Reasonable access to comprehensive primary health care services; and
- Improvement of health services in rural and peri-urban areas by the introduction of service incentives to attract health personnel to under serviced communities.

The implementation of White Paper on RDP (1994) promises and plans, and especially the lack of implementation, has been the subject of much criticism. It is based both on the RDP's failure to meet its own standards and the growth in health problems. Standards proposed by the RDP need to be collaboratively pursued by all regulators within the health sector, so that the ultimate aim of quality health care can be enjoyed by all citizens. The policy should direct the collaborative actions of all public managers who must be skilled in the various management applications so that PHC can be effectively and efficiently provided to the consumers.

The White Paper on RDP (1994) aims at addressing the transformation of the health sector as follows:

- The training and retraining of public sector employee is central in the transformation process.
- Focus on research and development, training and international comparative programmes are integral to meeting the needs of both the public service and the wider society.
- Introduction of educational programmes in project management and human rights law issues.
- Widening the availability of institute training facilities to extend into civil society and extending the skills taught so that they become transferable between the government and civil society.

- Accreditation of institute training programmes within the context of the National *Qualification Framework* is imperative.

It is imperative that there is co-operation between national and provincial governments on training, to avoid unnecessary, duplicated expenditure on consultants to conduct civil service training at provincial level.

To give effect to these concepts, the following implementation strategies are necessary as espoused by the National Institute for Economic Policy (1994):

(a) Human Resources

- Establishment of a human resource unit responsible for the planning, production, development and utilisation of human resources appropriate to the needs of the country;
- Emphasis on multi-disciplinary, community based and community oriented education and training;
- Programmes for retraining and reorienting of all existing health workers to the primary health care approach;
- Redistribution of personnel through more appropriate training, incentives to work in under-serviced areas, limited openings for private practice in over-serviced areas; and
- Transformation of health worker training through improving human resource planning and management systems, reviewing all training programmes, reviewing selection procedures and developing training programmes to train new categories of health workers.

(b) Legislative reform

- Promulgating a new Health Act to establish a National Health Service to provide a legislative and institutional framework within which all health care providers can function efficiently;

- Establishing district health councils, defining district boundaries and the functions of national, provincial and district authorities in the promotion of health and provision of services in conjunction with provincial and local authorities;
- Reviewing the role and governance of training and tertiary care institutions;
- Establishing a commission of inquiry to make recommendations on the conditions of service and employment of all health workers in the public sector; and
- Reviewing legislation governing all professional councils that register health workers to ensure that the councils became more representative of South African Society.

(c) Financial and management reforms

- Development of mechanisms for inter- and intra-provincial resource allocation;
- Introduction of a zero-based budgeting process for the health system;
- Establishment of an integrated national health information system, which should include both the public and private sectors.

It can be stated that the White Paper on RDP (1994) relates essentially to the provision of a minimum level of acceptable health services for the country as a whole. The role of the RDP for health is to ensure that services are improved and extended in order to make this possible. The availability of skilled health personnel to meet these goals is important. Human resource management has to focus on ensuring that health personnel are adequately trained to function optimally within the DHS. Strategies to maintain adequate staff within the various levels of the DHS are necessary to meet the increasing demands of the citizenry (White Paper on RDP, 1994).

### **3.5 NATIONAL HEALTH PLAN FOR SOUTH AFRICA**

A major challenge facing the Government of National Unity since 1994 has been to design a comprehensive programme to redress social and economic injustices, eradicate poverty and increase efficiency and to promote greater control by communities and individuals over all aspects of their lives.

According to the African National Congress' National Health Plan for South Africa (1994), focus should be geared to the following aspects in drafting the health care policy:

- Emphasising health care and not only medical care;
- Redressing the harmful effects of apartheid health care services;
- Encouraging and developing comprehensive health care practices that are in line with international norms, ethics and standards;
- Emphasising that all health workers have an equally important role to play in the health system, while ensuring that teamwork is a central component of the health system;
- Recognising that the most important component of the health system is the community, and ensuring that mechanisms are created for effective community participation, involvement and control;
- Introducing management practices that are aimed at efficient and compassionate health care delivery;
- Ensuring respect for human rights and accountability to the users of health facilities and the public; and
- Reducing the burden and risk of disease affecting the health of all South Africans.
- Establishing mechanisms to integrate traditional and other complementary practitioners in the health systems
- Ensuring and providing for new cadres of personnel for all areas of the health sector

- Retaining and implementing incentives to reallocate personnel to the underserved areas

The role of the Reconstruction and Development Programme on health concerns, is to ensure that services are improved and extended in order to afford broader communities access to health facilities and medication. The availability of skilled health personnel to meet these goals is imperative. Human resource management will have to focus on ensuring that health personnel is adequately trained to function optimally to meet the increasing demands of the citizenry.

In acknowledging that the ANC has immensely contributed in the creation and drafting of the framework for the restructuring of the health system in South Africa, the following principles have guided the process:

- Equity

The health of all South Africans will be secured and improved mainly through the achievement of equitable social and economic development.

Among others, the promotion of healthy lifestyles and provision of accessible health care service should be addressed.

- Right to health

Every person has the right to achieve optimal health and it is the responsibility of the state to provide conditions to achieve this.

- Primary health care approach

The ANC is committed to the promotion of health through prevention and education. The primary health care approach is the underlying philosophy of the restructuring

of the health system. It embodies the concept of community development, community participation as well as reducing inequalities in access to health services.

- National health system

A single, comprehensive, equitable and integrated National Health System (NHS) will deal with health, based on national guidelines, priorities and standards. It will co-ordinate all aspects of both public and private health care delivery and be accountable to the people of South Africa through democratic structures. All existing public sector departments of health will be integrated into the National Health System, thereby eradicating any forms of discrimination.

- Co-ordination and decentralisation

The provision of health care will be co-ordinated among local, provincial and national authorities. These will extensively coincide with provincial and local government boundaries. Authority, responsibility and control over funds will be decentralised to the lowest level possible. Clinics, health centres and independent practitioners will be the main points of the first contact with the health system.

- Priorities

Health services will be planned and regulated to ensure that resources are rationally and effectively used to make basic health care available to all South Africans, giving priority to the most vulnerable groups.

- Promotion of health

Health workers at all levels will promote general health and encourage healthy lifestyles. The government will also seek to establish appropriate mechanisms that will lead to the integration of traditional and other complementary healers into the National Health System.



- Respect for all

Within the health system, health workers must respect the right of all people to be treated with dignity and respect. A Charter of Patients Rights will be introduced. Individuals, interest groups and communities have the right to participate in the process of formulating and implementing health policy.

- Health information system

Appropriate and reliable data will be systematically collected and analysed as part of a comprehensive health information system essential for National Health System planning and management purposes. It will also allow for the promotion of relevant research to address the most important health problems of the community. The health information system of the National Health System will thus gather universal, opportune, reliable, simple and action-oriented types of data to inform the entire system and increase its effectiveness.

The PHC approach directs the development, structure and functioning of the health management system at the level of the DHS.

### **3.6 STRUCTURE OF THE NATIONAL HEALTH SYSTEM**

According to the National Health Plan for South Africa (1994) the function of the Government of National Unity is not only to create, monitor and amend the framework (the National Health System) within which health is promoted and health care is delivered, but it also has to be a major provider of services.

The framework is essential for purposes of planning, for protecting the public as consumers of health care from exploitation and abuse and for mediating between conflicting interests. Such a framework includes the powers, functions, rules and regulations of all the various authorities and statutory bodies.

The primary health care approach therefore necessitates decentralised management of the delivery of services to provinces, districts and institutions in order to increase efficiency, local innovation, empowerment and accountability. Decentralisation can only be effective if there is central co-ordination within an integrated, unique and comprehensive National Health System. In the absence of this, the health services in South Africa will become even more fragmented and inequitable.

The Government of National Unity has adopted decentralisation as the model for both governance and management. Decentralised governance is embodied in the Constitution in the form of the powers and functions of the three spheres of government. The powers and functions of the local sphere of government bears testimony to the importance of this sphere in particular (The Constitution of the Republic of South Africa, 1996).

Decentralisation implies the shift of power, authority and functions away from the centre to greater equity and efficiency; greater involvement of and responsiveness to communities; the reduction in the size of the bureaucracy far removed from the community being served; and greater co-ordination between social sectors. The World Bank views the decentralisation of public health services as potentially the most important force for improving efficiency and responding to local conditions and demands (Pillay, McCoy & Asia, 2001). In South Africa, district health services have been devolved to local government.

As a new democracy for which nation building is an important objective, it is important that decentralisation does not lose the national coherence being sought. The challenge, as has been articulated in the White Paper on the Transformation of the Health System, is to build a unitary national health system that is also decentralised. Unity and national coherence in the national health system is important to ensure the achievement of a degree of equity in health care delivery within and between provinces, and secondly, to promote efficiencies that are gained through economies of scale.

In addition, there are health functions that can only be applied or managed at a national level, but which require the involvement of provincial and sub-provincial levels of administration and management for their implementation.

Examples of such functions include the implementation of national policies and programmes such as the primary school nutrition programme (PSNP). This should ideally be done in a way that integrates national functions with those of provinces and lower down (Pillay, McCoy & Asia, 2001).

There is a need within a decentralised system to move away from a bi-polar approach that sees power and authority merely shifting between two ends of a centre-periphery spectrum, to one that sees power and authority being appropriately shared in a non-polarised system consisting of different levels of government and administration that can ensure national coherence, efficiency and equity with the delivery of health care. In other words, a well-functioning decentralised health system must not be seen in terms of the centre versus the periphery, but in terms of a system that allows the centre and the periphery to work together in a way that allows the potential benefits of a decentralised system to be realised (Pillay, McCoy & Asia, 2001).

The Constitution of the Republic of South Africa (1996) spells out the powers and functions of the three spheres of government that form the bedrock for the division of functions within the national health system. Thus, the national level has the power to make national legislation, set norms and standards, related to international organisations and Ministries of Health of other countries, monitor the delivery of services and take over this function when a province is incapable of providing services, and providing services, which because of economies of scale or financial constraints cannot be provided at a provincial level. The provinces are charged with planning, regulating and providing health services with the exception of municipal health services. Local government or municipalities are responsible for the rendering of municipal health services.

### **3.7 EXISTENCE OF A DISTRICT BASED HEALTH SYSTEM**

The health district is not a separate, completely autonomous unit; it forms an integral part of the National Health System, within which there are three major levels mentioned by Owen (1994):

- The national department of health, responsible for the overall co-ordination and determination of policy for the country's health system, and for monitoring and support of the provinces;
- The provincial departments of health, responsible for the co-ordination of the health system within each province, for the provision of specialist health services, and for monitoring and support of the districts; and
- The district health authorities, responsible for the provision of non-specialist health services within each district.

In practice, each of the provincial health departments set up regional sub-offices responsible for the establishment, monitoring, evaluation and support of the district health authorities. These regional offices become progressively smaller as the districts become better established and more self-reliant.

Provinces are subdivided, for managerial purposes, into regional sub-units, and the districts are also subdivided for managerial purposes, into smaller service areas. These are referred to as community areas. The community health services to these areas are managed by a multi-professional team (employed by the district health authority), usually based at a community health centre and at several smaller clinics, or at a district hospital. The health centre provides a fully comprehensive 24-hour service, and provides effective support to the clinics in its area through regular visits of various members of the team, and through receiving referrals from the clinics.

It is particularly at the community level that the opportunity exists for the concrete implementation of intersectoral health programmes. The community health centre

and its staff have the potential to play a major role in the development of the community, which they serve (Owen, 1994).

Regional sub-offices of the provincial health department initially facilitated the establishment of the district health authorities. They were responsible for capacity development within the districts through the provision of training and of management and other technical support, and through the co-ordination of the districts with each other and with the provincial office. The provincial health department formulates norms and standards for district health services and protocols for health programmes and strategies.

The provincial health department, via its regional sub-offices, continuously monitors and evaluates the effectiveness of district strategies and programmes, and promotes the use of evidence-based procedures and quality assurance methods. Clinical support to the districts is provided by secondary specialist referral hospitals, managed by the Provincial Health Department. These hospitals receive patients referred from district hospitals, and they provide effective outreach services, support and in-service training to the staff at the district facilities through regular visits of specialists and registrars. Referral pathways and support responsibilities of the various levels of the health system (and of the facilities within each level) are clearly delineated (Owen, 1994).

In most urban areas the District Health Authority (DHA) is likely to be a municipality, but in rural and some peri-urban areas where the local authorities do not have the capacity to provide health services, these services will be rendered by the provincial department of health. Where the provincial department provides health, the District Health Authorities are accountable to elected political authorities. All community level health services in the public and private sector fall under the District Health Authority. Policy decisions over matters affecting the local community are made locally (A National Health Plan for South Africa, 1994).

The development of the District Health System (DHS) nationally is co-ordinated and facilitated by the National District Health System Committee on which there is national, provincial and local government representation. Each province has a Provincial District Health Systems Committee on which provincial and local government is represented. These Committees meet regularly, and the main issues to be discussed include co-operative governance strategies and the integration of health services.

A National Health Plan for South Africa (1994) suggests that the National Department of Health can play an enabling role in respect of task allocation in the health system to be as follows:

- (a) Generating and disseminating policy advice.

The National Department has scarce policy expertise and knowledge of changes outside the health sector which can be used to suggest appropriate ways to develop the DHS and hospital decentralisation, and to point out the advantages and disadvantages of specific courses of action.

- (b) Providing targeted technical support.

Provinces can benefit from technical support in translating broader policy frameworks into detailed legislation and policy guidelines suited to each specific situation.

- (c) Facilitating experience and information exchange.

The National Department can play a pivotal role by giving provinces the opportunity to benefit from an exchange of experience and information across provinces.

(d) Advocacy concerning decentralisation.

Officials in the National Department tasked with decentralisation can play an advocacy role to ensure that the necessary powers are devolved to provinces and districts for the effective implementation of the DHS.

(e) Co-ordinating policy activities.

National officials have a critical role to play in drawing together the implementation work of different directorates around the common theme of strengthening districts.

(f) Supporting the monitoring process.

The National Department can play an important role in establishing appropriate indicators, undertaking periodic evaluations, supporting provincial steps in monitoring and evaluation, tying these initiatives to the development of an integrated health and management information system, assessing the evaluation lessons and sharing these across provinces.

The decentralisation of power from national level to community level in South Africa's national health system can be seen as significant in improving South Africa's health status so that traces of inequity and fragmentation can be eradicated over time. The National Health Act (2002) states that a District Health Authority may be a municipality, a provincial department or a body constituted in terms of provincial health legislation. The view reiterates that the final home of the district health system is within local government. A culture of community participation in the affairs of local government is encouraged.

Nicholson (2001) explains the two central features of the new local government system in South African context, namely:

(a) Local government will be developmental.

The Constitution of the Republic of South Africa (1996) states that local government in South Africa must be developmental. This means local governments must work with their communities to improve economic and social conditions and to overcome inequity. Equitable redistribution is central to the system. To do this, more resources must be directed to the areas that have the least resources.

This is a marked change from the past, where local government was mainly concerned with providing services to white communities and with matters such as traffic regulation, issuing of licenses and providing parks and recreational facilities.

(b) Local government will have more power: changing from tiers to spheres.

The tier system of national, provincial and local government is a top-down approach. Local government is the lowest level and the national government is all-powerful. The Constitution has specifically chosen to use the word 'spheres', to describe the national, provincial and local governments in the country. A sphere is a round shape. It does not have a top or a bottom.

One is not above the other and that at some points all spheres are linked to each other. They represent the system that has now been set in place in South Africa, where national, provincial and local governments function within a framework of co-operation. This is sometimes called a decentralised system (Nicholson, 2001).

Local governments are no longer just the agents of the provincial governments. They now have the power to make and carry out laws, raise taxes and govern themselves in all matters that have been allocated to them



by the Constitution. They include municipal health services. Although it is useful to see each sphere of government with its own areas of responsibility and authority, ultimately all spheres of government have joint and shared responsibility for ensuring that the basic services of the population are met. It is imperative that the three spheres of government work towards a common vision for equitable, effective and efficient delivery (Nicholson, 2001).

While local government will be an independent sphere of government with a constitutional duty to provide "municipal health services", the mechanisms of the national and provincial departments of health to ensure standardisation between different health districts, and the redistribution of health resources in pursuit of equity is important. For example, a common health information system so that district health indicators are comparable and can be easily aggregated is a vital mechanism.

The ability for provinces to ensure some resource redistribution from the advantaged to the disadvantaged health districts will be very important if equitable health care delivery is to be achieved. Given that the bulk of health care resources are tied up in personnel, the departments of health, local government and the unions, need to ensure that human resources rules, regulations and laws serve the needs of those dependent on public services (South African Health Review, 1999).

The balance of authority and responsibility between provinces, local government and health districts has to ensure both the benefits of centralised co-ordination, cohesion, redistribution and economies of scale and the benefits of local autonomy and decentralised management.

In addition, the National Health Act (2002) elaborates on the establishment of a district health system. It advocates that the entire area of the Republic of South Africa must be demarcated into health district, while the boundaries of all health districts must be consistent with municipal boundaries. The Act states that a District

Health Authority may be a municipality, a provincial department or a body constituted in terms of provincial health legislation.

### **3.8 PRIMARY HEALTH CARE IN A DISTRICT HEALTH SYSTEM**

One of the major objectives of the Department of Health as stated in the White Paper for the Transformation of the Health System in South Africa (1997) is to establish a district health system in which all communities are covered by a basic health unit which offers an essential package of care.

The national District Health Systems Committee suggested the following definition, incorporating that of the World Health organisation (South African Health Review, 1995):

"A district health system based on primary health care is a more or less self-contained segment of the National Health System. It comprises first and foremost 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. A district health system therefore consists of a large variety of inter-related elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services" (South African Health Review, 1999).

The health district, because of its size and closeness to the people it serves, has the potential to allow for structured community participation and control at all levels of its management system, down to each community health centre and clinic. It should coincide with similar areas of service delivery of other sectors, thus enhancing intersectoral collaboration.

The following normative guidelines must be incorporated in District Health System (DHS) development to give effect to the Primary Health Care (PHC) approach (White Paper for the Transformation of the Health System in South Africa, 1997):

(a) Overcome fragmentation.

An effective strategy is needed to rationalise service delivery and to overcome the present fragmentation as quickly as possible.

(b) Equity.

The promotion of equity has two aspects:

- A rapid and substantial improvement in the delivery of services to under-served communities.
- The development of a system that will ensure equity in service provision in the long term.

(c) Comprehensive services

District health services must be planned, managed and delivered in a comprehensive, integrated manner. This includes both comprehensive community health services as well as non-specialist district hospital services. The previous practice of local authorities rendering preventive primary health care services while provincial staff provided curative primary health care services must not be continued.

(d) Effectiveness

Resources must be targeted appropriately in order to achieve a demonstrable health gain.

(e) Efficiency

Maximal health gain must be achieved at lowest possible cost. A balance must be found between the advantages of local responsibility and those of economies of scale so that services can be run efficiently.

(f) Quality

Services should be of the highest possible quality taking into account local needs and resources.

(g) Access to services

Health authorities may not deny access to public sector health services to any person on the grounds that they may be resident outside the area of that authority. Provision must be made for cost recovery mechanisms between authorities for inter-district health service delivery.

(h) Local accountability

Mechanisms must be established to ensure that staff and services in a district or in a local area within a district are accountable to the local communities they serve.

(i) Community participation

There should be full participation of the users, as well as their political representatives in the planning, provision, control and monitoring of health services. Community representation should be in the majority on governance structures at community and district levels.

(j) Decentralisation

It is vital that sufficient powers are devolved to the managers of the districts and their facilities, especially with respect to personnel and financial controls. This will increase both accountability and efficiency but is also important as a means of boosting staff morale and encouraging local initiative and flexibility in the light of local and changing circumstances.

(k) Developmental and intersectoral approach

The health system must actively promote health and prevent ill-health. It must empower individuals and communities to take responsibility for the promotion and maintenance of their health. This requires that the health system be based on a developmental and intersectoral philosophy, drawing on all the various elements required to build healthy individuals and communities.

(l) Sustainability

The district services must be sustainable and must have a secure financial base to allow for long term planning.

Commitment to the most logical, cost-effective service possible will improve the quality of health care. But if institutional interests are put ahead of a commitment to quality care, progress will be sabotaged. As health services are planned there is a need to put in place a "people-plan" – a way of making sure that people help to promote change. Five important points of the "people plan" as outlined in the National Health Plan for South Africa (1994) are as follows:

(a) Commitment to becoming one team

Health personnel work in the private sector, non-government organisations, for local or provincial authorities, in the community, or in a clinic or hospital. In order to meet the health needs of the people of the district, everyone needs to be looking at the same picture, setting the same broad goals, and working together to achieve those. This will require trust, honesty and openness.

(b) Focus on the quality of care

It is easy to be sidetracked by administrative problems or political disagreements. The starting point should always be the goal of improving the quality of the service – remembering that a quality service is efficient, effective, accessible and equitable. A common commitment to equity will go some way to overcoming these tensions.

(c) Negotiate "space" to make things happen

Plans and goals with the regional and provincial offices of the Department of Health, and with the local authorities need to be shared as well as the authority and support of those accounted to. Involving everyone in the process of setting goals and developing plans are important so that reasons and motives are clear to everyone. In this way the support and the space to make things happen are easier to achieve.

(d) Initiative

One of the most distinguishing aspects of district-based health care is that the frontline provider is seen as a person – not a robot, who is responsible for improving the quality of the services provided. Wherever possible, own solutions to problems are found rather than referring everything to a higher level.

(e) Service provision

Service provision is the most important reason for structuring a health service. Once there is an agreement between health workers and communities on what responsibilities a community will have in maintaining health, it can be argued that this constitutes a community services package.

The primary health care approach however is not related to a particular level of the health system. Its principles apply to the entire health system and all levels of services. This means taking a more developmental approach to health, where communities could be partners in health care, resources and finances would shift away from high-tech, tertiary hospitals to primary level services and specialist doctors would play a more supportive role to nurses working in clinics. This would be a critical move towards health equity (South African Health Review, 1999).

The approach is based on the following principles as outlined in the South African Health Review (1999):

- Resources must be distributed equitably. This does not mean that all areas must be given the same resources. It means that those areas that have the least resources should be given the most assistance.
- Communities should be involved in the planning, provision and monitoring of their health service. This allows for different needs to be met in different communities.
- Greater emphasis should be placed on services that help prevent disease and promote good quality health. There is a shift away from curative services.
- Technology must be appropriate to the level of health care. For example, this would mean ensuring that all clinics have fridges that work for the storage of vaccines before equipping them with high-tech medicine facilities.

- There should be a multi-sectoral approach to health. In the primary health care approach, the provision of nutrition, education, clean water and shelter become central to health care delivery. The Departments of Water Affairs and Education are important role-players within the health system.

According to Lenneiye (1999) the success in setting up a district programme for primary health care, thereby incorporating the above pillars depends very much on the following:

- Awareness among all stakeholders of basic health problems.
- Commitment to improve the health of the population for its own sake and as a foundation for economic and social development. This is as true at the district level as at the national level. This commitment needs to be expressed through the health system as a commitment to primary health care.
- A national commitment should be expressed in a National Health Plan which should take into account human resource planning, training programmes, health programmes and design of health education material.
- The need for District Health Teams to identify what is already taking place in the community, support and develop it, as well as knit it into whatever new activities and services may be planned.
- Community involvement is the greatest source available to lay the foundation on which the whole health system is built. Guidance and assistance can be welcomed by rural communities to build their own health services if it is genuinely offered in practical ways in which the local population presume to be appropriate. Skills and understanding of how to work with communities in this way are fundamental to successful primary health care.



The District Health Team is the "nerve team" for overseeing the work of the district. The team approach provides an opportunity for better decision-making, continuity and common policies. The establishment of a multi-level structure with clearly defined systems. The roles of personnel at each level of the health system needs to be clearly understood because such roles are specific to primary health care and needs to be related to the needs and requirements of the particular local situation. Individuals holding these roles may need formal training, but that training may not be sufficient and require supplementing and developing (Lenneiye, 1999).

To give effect to the primary health care approach as a basis for a National Health System in South Africa, the South African Health Review (1999) presented the following missions, goals and objectives which embraces the fulfilment of the mental, physical and social well being of all the inhabitants of South Africa:

- Primary health care mission

To ensure the provision of cost-effective primary health care to all the inhabitants of South Africa.

- Primary health care goals

The goals of primary health care are embodied in the critical elements thereof and must be provided on a basis which will ensure:

- Accessibility;
- Availability;
- Affordability;
- Equity; and
- Acceptability.

- Primary health care objectives

The objectives include the following:

- To establish criteria to ensure equity in primary health care services;
- To establish accessible health care facilities within a reasonable distance for most members of a community;
- To ensure that relevant vertical health programmes are integrated with horizontal programmes;
- To establish a mechanism for intersectoral co-ordination;
- To establish a formula for the allocation of funds and other resources for primary health care;
- To establish a mechanism for community involvement;
- To establish a programme for training of appropriate primary health care personnel;
- To establish norms and standards for effective and efficient primary health care delivery;
- To establish criteria for the evaluation of primary health care services;
- To establish guidelines for appropriate research in primary health care; and
- To establish a linkage mechanism between different health sectors and levels of service.

These objectives must be incorporated in the detailed district health plans to meet the primary health goals.

From the aforementioned, it can be stated that the need for a District Health Plan formulated by consensus within the District Health Team is obvious for giving direction to the health activities within the district. Without such a direction towards defined objectives, health facilities will continue to perform routine tasks without making any tangible progress. This requires attainable targets and objectives to be defined and the health resources of the district need to be matched with the problems and the defined targets (Lenneiye, 1999).

Health personnel constitute the crucial part of the health resources of the district. Their training, deployment and support at all levels is a major challenge in health management. In the absence of such back-up and support of health personnel even the most carefully designed plans cannot succeed.

It is imperative to encourage the importance of building an effective health organisation which will ensure that the right personnel are deployed at the right level and regularly receive the material and equipment to deal with the tasks set for the level.

### **3.9 DISTRICT HEALTH SYSTEMS FRAMEWORK FOR QUALITY ASSURANCE DEVELOPMENT**

While putting the "health" of the nation back into our health care system, there is a need to focus on the priorities. Quality means making choices, and this can be achieved if we set and enforce standards in the health care systems. Involving all sectors in the development and implementation of important frameworks and strategies is essential. Provision of PHC services can and has been proven to work.

Any attempt to build an integrated and comprehensive health service capable of delivering health care to all South Africans using the primary health care approach has to develop a framework advocating quality assurance in the development of district health systems.

Lenneiyee (1999) highlighted the following quality assurance indicators for DHS development in South Africa.

- Service provision

In many health systems, it is accepted policy that communities have a responsibility to maintain their health before seeking care from health facilities. At clinic and community health centre levels, the range of services depend on the type of personnel available, equipment provided, and the space to house both personnel and equipment. The range of health conditions that can realistically be dealt with at that level constitutes the services package.

- Community health initiatives

Community empowerment means the possibility of communities to make inputs and influence the management of health resources in response to community priorities. Health education is a basic tool for empowering communities with technical knowledge where this is lacking, or with survey results to influence behaviour change with unhealthy practices are a result of cultural or other practices rather than from ignorance.

Communities are often quite willing to consult traditional healers and pay, but they often expect to receive free health care from formal health facilities. The readiness of communities to pay for health care can be tapped by health workers (in countries where this is government policy) by encouraging them to raise funds for the improvement of health facilities and for community-based health

interventions rather than focusing on cost-recovery at the point of service provision.

- Managerial processes

The district development plan contains information on goals, and resources for the development of a district. It is an invaluable tool for the district health manager when managing health services within an inter-sectoral framework. The production of this plan is nevertheless not a responsibility of the health department, but that of local government or municipalities. The district strategic health plan links closely with the district development plan and informs the operational plan.

The district needs to develop a number of tools – to facilitate supervision, a recording of various activities, and an assessment of the quality of services provided. An important process for district health managers is to set priorities and use available resources to meet the highest priorities. This process of programme planning is crucial to the provision of services within the district health system development framework.

Health research, evaluation, and trends contribute to a district health information system; which is used to brief various stakeholders and to communicate to higher levels on district health needs and means of affording the community basic health services and access to health institutions.

- Management structures

Boundaries are meant to regulate the flow of resources, and should as far as possible reflect the behaviour pattern of populations. A boundary that ignores human behaviour is likely to cause problems to health care providers and patients. Governance structures are critical to the definition of a district health system. District administration usually defines the bureaucracy set up to service

the governance structure in a district. The district administration is important in the promotion of integration of health with other district-level development activities headed by different professionals. In South Africa, this aspect of local government has unfolded and its impact on health services integration will become clearer in the years to come.

Health facilities management enables health managers to clearly define the role of various stakeholders. A district manager can legitimately urge the district governance body to allocate resources to the water department in a district as part of inter-sectoral actions for health. At the clinic level, inter-sectoral action can lead to the involvement of community leaders, working in partnership with clinic-based health workers, in the design of a programme to overcome problems in the community (Lenneiye, 1999).

- Resource management

Efficient management of resources can positively impact on equity and cost-effectiveness. A district budget allows district managers to plan ahead, and to make rational decisions on how resources can be used to meet high priority problems. Even at the household level, rational planning is only possible when the total household income can be established. The same applies to district health services whereby the total budget needs to be known to the planning team even if there are several budget-holding authorities (Lenneiye, 1999).

### **3.10 SUMMARY**

Presently, the South African health system has undergone restructuring geared towards equity in health service provision. Inherent challenges like fragmentation, centralisation, imbalances in health investments and a large private sector are hurdles which the health department has grappled with. The task of transforming the health sector is formidable and successfully meeting the challenge of implementation cannot be taken for granted. The adoption of a district health

system based on the primary health care approach is recognised as the fundamental building block of South Africa's unified health system which is in contrast to the previously centralised and fragmented health system of the past which led to poor planning, duplication of services, inappropriate resource allocation and demoralisation among health workers.

A framework to establish co-operation and accountability between the various spheres of government is integral to the success of the district health system in South Africa. Sustained and effective leadership, clarity regarding the task at hand and a willingness to evaluate the process and strategy of reform continually are among the vital elements of securing success in South Africa's health reform.

Chapter 4 focuses on the overview of the Primary Health Care System in South Africa and the Nature of Community Participation.

## **CHAPTER 4**

# **OVERVIEW OF THE PRIMARY HEALTH CARE SYSTEM IN SOUTH AFRICA AND THE NATURE OF COMMUNITY PARTICIPATION**

## **4.1 INTRODUCTION**

"Health is a basic human right and essential for social and economic development." (Jakarta declaration on Health Promotion into the 21<sup>st</sup> Century,1997). In this context, this research intends raising and addressing the process and principles of service delivery embedded in health care services. In the following paragraphs, an overview on the existing state of affairs in South African health care system will be provided.

## **4.2 OVERVIEW OF THE HEALTH CARE SYSTEM IN SOUTH AFRICA**

According to the National Health Plan for South Africa (1994), prepared by the ANC, the democratic national health service demands that it be sensitive to the needs of the community. It would appear that whatever approach people adopt, most community practitioners emphasise that where possible primary prevention be given more priority than treatment. The net result has been a system which is highly fragmented, biased towards curative and the private sector, inefficient and inequitable. Team work has not been emphasised, and medical doctors has played a dominant role within the hierarchy. There has been a little or no emphasis on health and its achievement and maintenance, but there has been a great emphasis on medical care.

The challenge facing South Africans is to design a comprehensive programme to redress social and economic injustices, to eradicate poverty, reduce waste, increase efficiency and promote greater control by communities and individuals over all



aspects of their lives. In the health sector this will involve the complete transformation of the national health care delivery system and all relevant institutions. In order to address the problems within the health sector the Department of Health developed policies on a wide range of issues that are contained in the White Paper for the Transformation of the Health Sector in South Africa released in April 1997. The White Paper presented what needs to be done to correct the ills of the health system and proposes how the Department intends to go about the process of reconstruction.

A significant departure from the past is the decision to create a unified but decentralised national health system enabling people to participate and take initiative and lead in some of the processes. One of the main reasons for this is the belief that this system is deemed to be the most appropriate vehicle for the delivery of Primary Health Care. In addition, the decision to decentralise the delivery of health care is consistent with the overall policy to decentralise government. Hence, unity and national coherence in the national health system is important to ensure that the nation can achieve a degree of equity in health care delivery within and between districts and groups of people, and secondly promote efficiencies that are gained through economies of scale. This should take into consideration aspects such as the optimal resources utilisation, equity as mentioned earlier, ethical considerations for decision making processes and the commodification of health according to standards deemed feasible. In this context, it is imperative that in decentralising services and managerial roles, the national coherence is not compromised since the challenge is to build a unitary national health system that is also decentralised.

The National Health Plan for South Africa (1994), propounds initiatives such as the health of all South Africans must be secured through the achievements of equitable social and economic development. The legacy of apartheid policies in South Africa has created large disparities between racial groups in terms of socio-economic status, occupation, education, housing and health. These policies have created a fragmented health system, which has resulted in inequitable access to health care.

In addition to the above, the National Health Plan for South Africa (1994) is intended to form the integral part, both of the country's health system, and of the overall social and economic development of the community. Central to the Primary Health Care (PHC) approach is full community participation in the planning, provision, control and monitoring of services. Democratically elected representatives must play a major role in the structure of the health services. These may include the community based organisations, a member from the youth forum, pensioners, educators and religious leaders.

Health problems may have many and complex causes which solution demands an intersectoral approach. Other sectors such as those providing clean water, sanitation, and housing, will have a greater impact on health, than health services alone. The health sector has an important advocacy role to play and therefore mechanisms have to be developed to ensure that intersectoral activity takes place. The health sector must increase awareness that a health population is necessary for social and economic development. International population trends recognise development strategies which improve the quality of life of the population.

Population programmes must maximise the capacity for individuals to fully develop their potential for social stability and economic growth. It is also a major provider of services, however, a single government structure must coordinate all aspects of both public and private health care delivery and all existing departments can be integrated. This calls for the provision of health care to be coordinated among local, district, provincial and national authorities. Authority over, responsibility for, and control over funds should be decentralised to the lowest level possible that is compatible with rational planning, administration, and the maintenance of good quality care. Furthermore, resources must be rationally and effectively used, and priority be given to the most vulnerable groups, and to the eradication, prevention and control of major diseases (National Health Plan for South Africa, 1994).

## **4.3 A VISION FOR HEALTH IN SOUTH AFRICA: GUIDING PRINCIPLES**

A National Health Plan for South Africa (1994) envisaged the following components as the guiding principles for the vision for health care in South Africa:

### **4.3.1 Equity**

The health of all South Africans can be secured and improved mainly through the achievement of equitable social and economic development such as the level of employment, the standards of education and the provision of housing, clean water, sanitation and electricity. In addition, reductions in the levels of violence and malnutrition, and promotion of healthy lifestyles should be addressed, as well as the provision of accessible health care service.

### **4.3.2 Right to Health**

Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve the set goals. Health and health care, like other social services, and particularly where they serve women and children, should not be allowed to suffer as a result of foreign debt towards structural adjustment programmes.

### **4.3.3 Coordination and Decentralisation**

The provision of health care must be coordinated among local, district, provincial and national authorities. These can as far as possible coincide with provincial and local boundaries. Authority over, responsibility for, and control over funds must be decentralised to the lowest level possible that is compatible with rational planning and the maintenance of good quality care. Clinics, health centres and independent practitioners should be the main points of first contact with the health system.

#### **4.3.4 Priorities**

Health services must be planned and regulated to ensure that resources are rationally and effectively used, and to make basic health care available to all South Africans, hence, giving priority to the most vulnerable groups. Individual respect must be afforded to members of the society and be treated with dignity and respect. Furthermore, individuals, interest groups and communities must be given the right to participate in the process of formulating and implementing health policy.

#### **4.3.5 Accountability and Community Participation**

An imperative principle in the primary health care approach is accountability to community structures at local, district, provincial and national levels. Democratically elected representatives must be involved in the appointment of staff and the control of budgets. This is seen as an important mechanism for increasing local control and responsibility over health matters. However, control over the executive functions in the health care system is not the same as community participation. Effective community participation as envisaged in the PHC approach means that democratically elected community structures, integrated with representatives of the different sectors and stakeholders involved in health and community development, have the power to decide on the health issues. Community participation is an essential element of openness, transparency, accountability and general welfare of the society.

### **4.4 THE NATURE OF COMMUNITY PARTICIPATION**

#### **4.4.1 Defining the Nature of Community Participation**

Community participation is the organised effort to increase control over resources and regulative institutions in given social situations, on the part of groups and movements of those hitherto excluded from such control including their sharing in the benefits of development programmes, and their involvement in decision making.

In addition, it is considered a voluntary contribution by the people to one or another of the public programmes supposed to contribute to national development but the people are not expected to take part in shaping the programme or criticising its content. A key requirement for efficient community participation is recognising what it entails for a professional local government manager. Because it involves issues of politics and policy, defining the scope of community participation has been an elusive goal (Newell, 1993).

A professional approach to community relations has to involve a distinctive objective, method, and standard of conduct. Firstly, the manager's objective will be to increase the capability of government to respond to public needs with a professional commitment to advance the public interest. Secondly, professional expertise is applied to the tasks of community leadership with methods and systematic techniques to promote citizen participation and community goal setting. Thirdly, an official in government is bound by the standards of the profession to promote the participation of all the citizens in community affairs, to ensure impartiality in assessing demands and seeking resolution of conflicts, and to advance equity in the distribution of resources (Newell, 1993).

It is with in-depth understanding that communities need to be made aware that local participation would effect capacity building which is geared towards allowing local communities to represent their own interests, hence, the stronger the form of involvement in participation, the better the outcome of the process.

#### **4.4.2 Viewpoints on Participation**

Similarly to community and development, participation is also an elusive concept since participation is always connected to the actions of communities, groups or individuals related to the development, improvement or change of an existing situation (Swanepoel & De Beer, 1998). Furthermore, opinions are divided with regard to the origin and initiation of participation. According to Swanepoel and De Beer (1998), this depends on whether participation is intended as a system-

maintaining or a system-transforming process. Participation efforts are often undertaken in a top-down fashion, while there are few examples of participatory experiences from self-reliant grassroots organisations.

In the early days of community development the term self-help was used. In this context, participation was viewed to some extent as a matter of cheap labour, though not necessarily spelt out in such terms. The following section will explain participation as cheap labour, followed by an exposition of viewpoints on participation as involvement and, finally elaborate on empowerment or popular participation.

(a) Participation as cheap labour.

People were mobilised to participate and provide labour input in line with self-help projects. This mobilisation took place primarily to involve individuals and communities in programmes predetermined by government agencies. It is a typical example of a top-down, co-opted involvement of people which left little room for their initiatives and empowerment, hence, when forced contributions or the well-known self-help labor contributed to a project, it can hardly be labelled as participation.

(b) Participation as involvement.

Involvement seems to refer to co-option or, at best the mobilisation of communities to participate or be involved in the execution of top-down determined development plans and projects. Once the correct climate is created, it can be said that people will realise the benefit involvement holds for them. Involvement in all the above cases revolves around making communities or groups realise the benefits of becoming part of a development project or programme predetermined by an outside agency. It boils down to the mobilisation or co-option of people to support an action which they have not initiated.

In principle, the above exposition does not rule out the need for education, for meetings, for agency planning or for getting to know community leaders. Where participation means empowerment, all the relevant factors come into play, but in a different milieu and with a different ultimate objective. According to Swanepoel & De Beer (1998), in the participation as involvement, it may be argued that the emphasis may be on initiatives, whereby government and aid agencies identify the needs, plan the action, manage the projects and mobilise the communities or groups.

(c) Popular participation or empowerment.

Deciding on who controls development is an open question even though the beneficiaries are to be the main players and decision makers. Yet, the government has been and will always be responsible for providing material and other support to developing communities. Aid agencies have a role to play, as has the private sector including multinational corporations. Empowerment also requires assistance from the outside in terms of skill and organisational training, credit, income-generating schemes, appropriate technology, education and access to basic services.

Decision processes should be fully informed the values and needs of the community as participants in that process.

#### **4.5 THE BASIC PRINCIPLES OF COMMUNITY PARTICIPATION**

It can be suggested that following principles should address concerns and frustrations around the community participation process. These principles can be used as a tool for better management and co-ordination of decision-making and implementation, related to public services and general development objectives within an area of responsibility. The guidelines and principles are therefore drafted in accordance with the following criteria as espoused by Swanepoel & De Beer (1998):

#### **4.5.1 Principles of Abstract Human Needs**

A human being has basic needs such as food, water, clothing and shelter. Human beings also have abstract needs such as self-reliance, happiness and human dignity. Hence, the most abstract need is human dignity, since dignity is enhanced by giving people recognition, by recognising them as capable of making their own decisions and assuming the responsibility for the decisions that they have made. Dignity is also enhanced by becoming self-reliant and self-sufficient and by becoming able to organise oneself.

#### **4.5.2 Principles of Learning**

While people are striving to fulfill their needs they become better at doing so. Hence, most individuals participating in development programmes become knowledgeable through realities. This means that an individual must not participate in such programmes with preconceived plans or agendas. Information must be disseminated to all participants so that they can make enlightened decisions. It also means guarding against the elite whose actions may water down the participation of the poor to something like co-option.

#### **4.5.3 Principles of Empowerment**

The people must assume power in the sense that they must take responsibility for their own development. Constitutionally, they have the right to do this, but having the right without the ability means little. The people's empowerment is a process fed by information, knowledge and experience, that brings them confidence in their own abilities.

#### **4.5.4 Principles of Ownership**

Propounds that the most important outcome of participation and empowerment is the establishment of ownership where it really belongs and that is with the



community. Furthermore, community development projects are not the property of government departments but the people, so that the humanistic nature of development is not in jeopardy. This will also enhance self-reliance, poverty relief and adaptability.

#### **4.6 POLICY FRAMEWORK FOR COMMUNITY IN SOUTH AFRICA**

The local government transformation process in South Africa followed three well-defined phases, starting with a pre-interim phase that began in 1993 with the enactment of the Local Government Transition Act 209 of 1993, (Second Amendment Act, 1995). Representatives from the established local government bodies and those groups that had previously been excluded from the local government but represented local people were constituted as local forums that performed local government functions during this phase.

According to McLaverty (2002), the interim phase was ushered in by municipal elections in November 1995 and June 1996. The final phase followed an extensive process of research resulting in the White Paper on Local Government (White Paper on Local Government - WPLG, 1998) and it introduced the final form of local government. The final phase and local government structures are guided by principles provided for in the Constitution of the Republic of South Africa that is mandating local government, among others, to promote local social and economic development. It is in this context that development at the local level is seen as linked to the democratisation process and the inclusion of citizens and community groups in the design and delivery of development programmes.

The White Paper on Local Government (1998) views building local democracy as a central role of local government and states that development agents should develop strategies and mechanisms to continuously engage with citizens, business and community groups. Active participation by citizens is also required in respect to citizens as voters, consumers and end-users, and as organised partners involved in

the mobilisation of resources for development via business, non-governmental organisations and community-based institutions (McLaverty, 2002).

According to the Local Government Municipal Structures Act (2000), all municipalities must adopt an appropriate approach and also put in place appropriate structures to ensure effective participation. These principles included the following:

- Informing, negotiating and commenting on decisions in the course of the planning and/or decision-making process
- Institutionalising community participation in order to ensure that all residents of the country have an equal right to participate
- Specific rules and procedures on who is to participate or to be consulted, on behalf of whom, on which issue, through which organisational mechanism, and with what effect.
- Institutionalised and structured to provide sufficient form for diversity, i.e. for different participation styles and cultures.
- Finally, participation should be done in particular with regard to disadvantaged or marginalised groups and gender equity in accordance with the conditions and capacities in a local municipality.

In the light of the above, it is expected that these principles will enhance the ability of the local government and the community to create an atmosphere where community participation can take place without constraints. A question that remains unanswered, is even if the representation and participation works according to plan, will the standard of good governance and efficient community participation be adequate to see this process through delivery?

#### **4.6.1 Existing Legal Framework for Community Participation**

The Constitution stipulates that one of the objectives of municipalities is to encourage the involvement of communities and community organisations in matters of local government. Furthermore, the White Paper on Local Government (WPLG - 1998) emphasises the issue of public participation. It goes into some detail on how to achieve public participation and of the role local government has to play to ensure the involvement of citizens in policy formulation and designing of municipal programmes, as well as the implementation, monitoring and evaluation of such programmes. Community participation is meant to promote local democracy. While the WPLG (1998) emphasises that the municipalities should develop appropriate strategies and mechanisms to ensure participation, a number of hints on how to proceed are given, such as:

- Forums of organised formations (especially in the fields of visioning and on issue-specific policies, rather than on multiple choices)
- Structured stakeholder participation in council committees
- Participatory action research, with specific focus groups for in-depth information on specific issues
- Formation of association especially among people in marginalised areas such as the rural settings and informal houses

Community participation should be a structured process rather than a process of public mass meetings. Public officials are not only expected to find their own ways of structuring participation, but are expected to become active in encouraging and promoting participation, especially when it comes to the participation of marginalised groups and women.

While the Local Government Municipal Structures Act (2000) defines municipality as a "corporate entity" which consists not only of its "structures, functionaries and

administration”, but also of its “communities, residents and ratepayers”, it differentiates clearly between the roles and responsibilities of the “governing structures”, and the communities, residents and ratepayers. The community participation chapter of the Local Government Municipal Structures Act (2000) is guided by the principle that formal representative government must be complemented by a system of participatory governance.

Participation in the decision making processes of the municipality is determined to be a right of communities, residents and ratepayers. The decision on appropriate mechanisms, processes and procedures for community participation is largely left to the municipality. The only prescribed participation procedures are the receipt, processing and consideration of petitions and complaints and the public notice of council meetings. No procedures are prescribed for participation in the Primary Health Care forums.

In the final instance, municipalities are requested to create conditions for public participation and, moreover, to encourage it. The only prescribed tool for promotion of community participation, however, is the dissemination of information on mechanisms and matters of community participation, on rights and duties residents and on municipal governance issues in general.

#### **4.6.2 Principles of Community Participation**

The role of participatory democracy is to inform, negotiate and comment on decisions taken in a broader forum, in the course of the planning and decision making process. The Local Government Municipal Structures Act (2000) advocates the following principles:

- Community participation has to be institutionalised in order to ensure that all residents of the country have an equal right to participate.

# Institutionalising participation means:

- setting clear minimum requirements for participation procedures which apply for all municipalities by means of regulations.
  - Providing legally recognised organised framework
- Structured participation proposes clear rules and procedures specifying who is to participate or to be consulted, on behalf of whom, on which issue, through which organisational mechanism, with what effect (Local Government Municipal Structures Act, 2000).
  - Diversity dictates different participation styles and cultures. While there has to be a common regulatory framework for institutionalised participation in the country, such work has to be wide enough for location-specific adjustments to be made by provinces and municipalities (Local Government Municipal Structures Act, 2000).
  - Promotion of community participation by municipal government has to distinguish between the following functions which must always influence the choice of appropriate procedures and mechanisms for community participation:
    - creating conditions for community participation, and offering people choices between services.
    - encouraging community participation, which should be done in particular with regard to disadvantaged or marginalised groups and gender equity in accordance with the conditions and capacities of municipalities.
    - Citizen and client-oriented ways of service delivery and public administration, hence, giving the communities the right of petition and complaint desk.

- Appropriateness of solutions using the knowledge and experience of local residents and communities in order to arrive at sustainable problem solution and measures
- Community ownership in line with mobilising local residents and communities' initiatives and resources, and encouraging co-operation and partnerships between municipal government and residents for implementation and maintenance
- Empowerment of communities in order to establish a forum for negotiating conflicting interests, finding compromise and common ground and, thereby, creating the basis for increased transparency and accountability of local government towards local residents.

A democratic national primary health care service demands that it be sensitive to the needs of the people. The professional ethos sometimes breeds a sense of superiority which inhibits the health officers from learning about the poverty issues and any underlying factors from the ordinary folk of a community. Most importantly, the establishment of community health projects requires joint participation, constant consultation and informed consent before implementing new policies. The latter practice is contrary to the prevailing work ethos in everyday private professional life which largely comprises individual decision-making. While joint participation may be more democratic it is a lengthier process and this, in itself, can be exasperating for the professional, who often places emphasis on efficiency and centrality in decision-making processes (Urban Sector Network, 1998).

In order to rectify the situation where most South Africans do not have access to basic primary health care, a costly development and extension of community primary health care centers and staff is necessary. Finance for expansion could be procured through the dismantling of an expensive bureaucracy and duplicatory and fragmented primary health care services. It should be noted that the dismantling of the then Bantustan bureaucracies highlighted a number of problems. The first one being that public officials in the various structures experienced resistance to change since there was a fear of losing jobs. Secondly, the attempt to improve the primary

health care service heightened expectations, thus increasing demands. The majority of people would have been dissatisfied with the second-rate services and demanded from the government service equal treatment. In the light of the above, if promises are not kept, antagonism towards those who are attempting to reconstruct a more equitable health service will develop, making the process of transformation even more difficult (Urban Sector Network, 1998).

#### **4.7 UNDERSTANDING THE ESSENCE OF HEALTH PROMOTION**

Health promotion is defined as the process of enabling individuals and communities to increase their control over the determinants of health and thereby improve it. It is a process whereby communities, policy makers, professionals and the public are activated in favour of health-supportive policies, systems and ways of living. Health promotion can be described as social, educational and political action that enhances public awareness of health, fosters healthy lifestyles and community action in support of health and empowers people to exercise their rights and responsibilities in shaping the environment, systems and policies that are conducive to health and well-being (Cilliers, 1990).

Health education is the central tool in the definition. Health promotion and health education are not synonymous terms and cannot be referred to as one and the same policy, philosophy or process. Whereas health education is aimed at facilitating voluntary changes in health related behaviours to improve health, health promotion is any combination of health education with related organisational, political and economical interventions designed to facilitate behavioural and environmental adaptations that serve to improve or protect health in individuals, groups or communities (Cilliers, 1990).

According to Cilliers (1990), the aim of health promotion is to empower people to make behavioural choices. Empowerment is a process of focusing on the needs of the individual and encouraging self-responsibility by altering self-limiting beliefs. Empowering the community to be responsible for its own health means that all

people in the community must work together to increase their control over events influencing their health and well-being. The partnership between individuals and group involvement involves not only power sharing but also mutual respect for the contribution of all partners.

In the light of the above, any health promotion practices should be located in both affluent and poor communities since it functions within the context of preventable diseases, poor quality of life and the dependence of these factors upon the larger political and social environment.

#### **4.7.1 Principles of Health Promotion**

Cilliers (1990) outline the following principles aimed at achieving health as a basic human right for all.

- Health promotion involves the population as a whole, rather than focusing on the individual at risk of disease
- Health promotion targets the determinants of health
- Health promotion combines diverse but complementary methods
- Health promotion is aimed at effective community participation
- Health promotion is basically a health and social activity and not a medical service.

#### **4.7.2 Methodologies for Health Promotion**

The Ottawa Charter (1986) describes the following methodologies for Health Promotion as strategies of social action:



(a) Advocacy for health

Advocacy encourages leaders, policy makers and legislators to act in support of health, create environments, facilities and conditions that make people's choices easier and more feasible. It places health high among the priorities for development. It involves assessing the overall well-being of the society and its key determinants, undertaking a multi-sectoral analysis of people's needs and views, social conditions, human resources, the environment, public policy and media attention by creatively framing issues of intense public interest. Advocacy involves the following aspects:

- Policy analysis
  - This is the first step in advocacy and involves examination of the way a policy is made and how it is best influenced to ensure that policies are more than ordinary written documents; policy offers guidelines for decision and actions, reflects the values of society, demarcates who has power, control and provides indications for future trends.
  
- Legislative analysis
  - This involves examining the existing and any proposed legal framework which surrounds relevant policy areas; it necessitates an understanding of how Acts become law; the lengthy process allows for many opportunities for input, for opposing groups to change or delay legislation.

The implementation steps of successful advocacy involves various approaches which include working with the mass media, lobbying, building alliances and mobilising grass root support. Media advocacy provides health promoters with an opportunity to reframe issues and capture symbols of public debate (Ottawa Charter, 1986).

### **4.7.3 Success indicators for Health Promotion**

Research has shown that there are various success signs which can be identified and utilised to indicate that the health promotion strategy is flourishing. These indicators include the following:

- Understanding and responding to people's needs so that they are empowered to take control over their health which is explicitly demonstrated
- Building on sound theoretical principles and the findings of applied research actions justified
- Collecting, analysing and using information from comprehensive needs assessment and programme evaluation, and linking with the media
- Sustainable connections with all sectors and settings
- Participation and ownership resulting in more effective delivery of health promotion
- Key decision makers becoming reorientated towards policy formation and control
- Provision of technical and managerial support which reaches the total control in the accessibility of health care facilities
- Visible use of complementary approaches at both the individual, social and environmental levels resulting in lifestyles and structural changes to promote health
- Undertaking specific actions and programmes with specific health focus via personal education, mass media information, community action, organisational development, environmental programmes and policy formulation.

## **4.8 SUMMARY**

Health promotion covers aspects of activities that seek to improve the health status of communities and individuals. It includes attempts to produce environmental and legislative changes conducive to good health. Health education and health promotion involves supplying a person with enough new and correct knowledge about disease process to make preventive measures required available and reasonable.

This process enables a person to be concerned about health of others and inspire communities to develop skills and the confidence to help themselves around health issues. This essence lies in changing attitudes, beliefs and lead to active and dynamic participation by individuals, groups and communities in the health programmes.

Health education is aimed at increasing individual and group capabilities for involvement and self-reliance in health and promote healthy behaviour with regard to family nutrition, environmental health, healthy lifestyle practices and disease prevention and control. Good vibrant health does not mean the absence of disease but to use physical and mental potential to the maximum so that the individual is able to lead a socially and economically productive life in harmony with the environment.

The process of Primary Health Care activities and guidelines is found in the Primary Health Care Package for South Africa issued by the Department of Health during March 2000 (see Annexure 1).

The next chapter explains the Legislative Framework of the South African Health System which is intended to outline the guiding policies and procedures in the health care systems for South Africa.

## **CHAPTER FIVE**

# **LEGISLATIVE FRAMEWORK OF THE SOUTH AFRICAN HEALTH CARE SYSTEM**

## **5.1 INTRODUCTION**

The South African government has set itself the task of developing a unified health system capable of delivering quality health care to all citizens efficiently and in a caring environment. As part of the reform process of the health care system, various ministerial task teams and committees with wide representation were put in place. In the following paragraphs, a brief analysis and overview of the content of the legislative frame will be discussed as quoted from the White Paper for the Transformation of the Health System in South Africa (1997).

Underpinning the above was the recognition of the need to make healthy choices easy for communities and individuals. The importance of this aspect of health promotion cannot be underestimated, and in South Africa, one has seen huge strides taken in the development of the health public policy since 1994. For example millions more homes and families have gained access to safe drinking water, and the anti-smoking legislation is amongst some of the progressive legislation in the world (Health Promotion Update, July 2000, Issue No. 53).

It is also a truism that human resources determine the success or failure of health sector transformation. Hence, The White Paper on the Transformation of the Health System in South Africa (1997) acknowledges the importance of the human resources management, monitoring and evaluation and leadership development. This chapter will explore in detail the legislative framework and context in which primary health care system is designed.

## **5.2 MISSION, GOALS AND OBJECTIVES OF THE HEALTH SECTOR** ~

The task of improving the health of South Africa's population must not be that of the health sector alone. A framework should be put in place whereby the health of all South Africans must reflect the wealth of the country and lay the foundation for a process of democratising the State and society and foster the empowerment of all citizens and promote gender equality. Current debates indicate that poverty is widely recognised as a major determinant of the health status of individuals, households and communities, and gains in health can only be possible if poverty alleviation is addressed through economic development means. Furthermore, equipping individuals with the necessary knowledge to care for themselves can be a major step towards improving their health. Finally, in our quest of meeting the basic needs of the society, there is need to improve on housing component and services like water and sanitation, the environment, nutrition and health care. It is common understanding that for the government to realise the above mission, broader consultation exercise will incorporate all stakeholders, including the government sector, non-governmental organisation, the private sector and especially, the communities (National Health Plan for South Africa, 1994).

## **5.3 GOALS AND OBJECTIVES** ~

The White Paper for the Transformation of the Health System in South Africa (1997) outline the following objectives and goals:

- (a) To unify fragmented health services at all levels into a comprehensive and integrated National Health System (NHS):
  - In this context, the activities of the public and private sectors, including the NGOs and traditional healers must be integrated to maximise the effectiveness and efficiency of all available health care resources

- (b) To promote equity, accessibility and utilisation of health services:

In essence, there is a need to establish health care financing policies to promote greater equity between people living in rural and urban areas, and between people served by the public and private health sector, and distribute personnel throughout the country in an equitable manner.

- (c) To develop health promotion activities:

The focus is mainly on promoting a healthy environment and improve the psychological well-being of people and communities. Furthermore, ensure access health-related information, community support, reduce on alcohol and other drug abuse, with particular emphasis on tobacco, glue, mandrax, cocaine, heroine and marijuana.

- (d) To develop the human resources available to the health sector:

The White Paper for the Transformation of the Health System in South Africa (1997) espouse the notion of promoting the optimal use of the skills, experience and expertise of all health personnel, develop the education and training programmes aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve, promote a new culture of democratic management in the health sector and ensure that the composition of human resources in the health sector reflects the demographic pattern of the general population.

- (e) To foster community participation across the health sector:

This is the most crucial concern for improving health sector planning and the monitoring of the health status and services.

Involving communities in various aspects of the planning and provisioning of health services will assist in establishing a mechanism to improve public

accountability and promote dialogue and feedback between the public and health provider. This will encourage members of the community to take greater responsibility for their own health promotion and care. Hence, the process of community participation will ensure building of capacity at the provincial, district, local levels to develop plans based on the priority issues and ensure appropriate cost-effective intervention.

#### **5.4 OBJECTIVES OF THE WHITE PAPER FOR THE TRANSFORMATION OF THE HEALTH SYSTEM IN SOUTH AFRICA**

The White Paper for the Transformation of the Health System in South Africa (1997) was intended to establish a legislative and regulatory framework for the delivery of health services throughout South Africa. In order to deal with health services effectively and efficiently, there is need to create uniformity across the nation in the delivery of health services by establishing norms and standards, framework and national policies.

Furthermore, it must contain provision regarding the rights and duties of health care providers and of users of health services. The rights of users to information health services, emergency medical treatment and to participation in decisions affecting their personal health and treatment are recognised, as are user's rights to be given information concerning his or her health and treatment. It must provide for the laying of complaints by users and other persons concerning establishments and the duties of users with regard to their health, their use of health establishments and their dealings with health care providers.

In addition to the above, provision must be made relating to health establishments. It governs the classification, setting up and operation of health establishments and contains provisions regarding certificates of need. No one may establish, construct, modify or acquire a health establishment or health agency without a certificate of need. Provision is made for enforcement, sanctions and remedies regarding compliance with certificate of need conditions and for certain conditions for the

provision of health services at public health establishments, giving the Minister of Health the power to determine those conditions. It also covers the delivery of health services at non-health establishments, like schools and other public places (White Paper for the Transformation of the Health System in South Africa, 1997).

The Minister is given the power to prescribe conditions with regard to traditional health practices and the activities of traditional initiation schools. Provisions governing relationships between public health establishments and between public and private health establishments are contained in the document. Private health establishments are obliged to take insurance over to indemnify users for certain damages (White Paper for the Transformation of the Health System in South Africa, 1997).

## **5.5 KEY ACTION AREAS**

The other milestone in the development of primary health promotion was the Ottawa Charter, emanating from the first ever conference on Health Promotion held in 1986. The Ottawa Charter has been instrumental and responsible for the development of a health promotion methodology.

The five action areas identified in the Charter are explored in the following section:

### **5.5.1 Create Supportive Environments**

Environmental health issues often are of critical importance in developing countries trying to balance economic development with conservation of rich natural environments. Hence, the challenge faced by health sector education and training institutions, is to develop programmes designed to train and support health personnel at various levels of the public service to facilitate the process of change in the health and welfare services.



### **5.5.2 Strengthen Community Action**

Underpinning this is the recognition that the health of communities is inextricably tied to their ownership and control of their own activities and future. This will ensure accessibility and a structured public health education able to meet target audience's need and respond to the challenges posed by the new public health and the creation of decentralised PHC system.

### **5.5.3 Develop Personal Skills**

Health promotion supports personal and social development through information, education for health and building life skills. It has to be noted that human resources are often the greatest thread to the success of reforms as a lack of development and training lead to low levels of staff morale, low productivity, high turnover and a drain of human resources into the private sector or other countries

### **5.5.4 Reorient Health Services**

The emphasis is on the need to ensure that the training of health professionals incorporates a full understanding of the social and environmental causes of ill-health, as well as providing training to enable health workers to work in partnership with communities.

### **5.5.5 Working together for Health**

This should include different sectors as well as all levels of governance and society and ensuring a multi-sectoral approach towards health promotion and services. People centered and community driven programmes such as awareness campaigns and workshops to inform community about the dire need and adherence to Primary Health Care practices is enhanced.

The Jakarta Declaration on Health Promotion into the 21<sup>st</sup> Century, emanates from the fourth international health promotion conference and emphasises on moral and economic action, specifically recognising the role of the private sector.

The following areas were identified in order to address the state of health services:

(a) Promote Social Responsibility for Health.

Building on the Ottawa Charter identification of the need for Health Public Policy, both public and private sector decision makers were urged to promote policies and practices that encourage social responsibility.

(b) Increase Community Capacity and Empower the Individual.

Further strengthening earlier calls to promote community action and develop personal skills, the Jakarta Declaration indicates the need for social, cultural and spiritual resources to be harnessed to maximise the access of marginalised communities to the decision making process.

The South African resistance movement used a variety of methods to achieve health and other goals, and that the ANC 's policy on health promotion is a product of this history, which has the following features:

- Community action mobilisation
- Community control of health resources
- Community demands often being directed at other sectors
- Concrete links being made with other sectors
- Community development and community based-services
- The idea that health is linked to wider underlying socio-economic issues

## **5.6 HUMAN RESOURCES IN THE DRAFT NATIONAL HEALTH BILL 32 OF 2003**

The section on Human Resources (HR) in the Draft National Health Bill has undergone numerous changes over the years, and the final version must spell out regulations governing human resources development within the National Health System (NHS). Furthermore, the Minister's responsibilities has been espoused as follows:

- (a) Ensure the availability of adequate resources for the education and training of health care providers and health workers to meet the human resource requirements of the NHS.
- (b) Ensure the education and training of health care providers and health workers at all levels in accordance with recognised norms and standards in order to meet the requirements of the NHS.
- (c) Identify shortages of key skills, expertise and competencies within the National Health System and prescribe strategies for recruitment of health care providers or health workers from other countries or strategies for the education and training of health workers in the Republic of South Africa in order to make up the deficit in respect of scarce skills, expertise and competencies.
- (d) Prescribe strategies for the recruitment and retention of health workers and health care providers within the NHS and circumstances in which health workers and health care providers may be recruited from other countries to be employed as such, or to deliver health services, within the Republic of South Africa.

The draft Bill is intended to continue giving great prominence to academic health services complexes, however, it is silent on issues of distribution and equity, it does

identify the key challenges of planning and training for adequate and appropriate skills and competencies. It furthermore spells out the need to develop management policies and practices, which will ensure recruitment and retention of staff.

## **5.7 CAPACITY AND SKILLS**

With the move towards decentralised health systems, many health workers require in addition to clinical skills, substantial public health skills in planning, advocacy, programme design, programme implementation and monitoring and evaluation which are fundamental to the successful implementation of the Primary Health Care (PHC) Approach. These are skills for which few of the newly appointed district and programme managers received training, resulting in a wide gap between existing and required job competencies (National Primary Health Care Facilities Survey, 2000).

According to the National Primary Health Care Facilities Survey (2000), the positive effect of a health worker's ability to engage with communities and other sectors on quality of care has been highlighted in several projects. An initiative in Khayelitsha, Cape Town, to reduce worm infestation in children saw health workers, community members and teachers working together to assess the size of the problem and then plan and implement intervention. As a result, worm infestation among children in 12 schools dropped from 80% to under 20%. Hence, skills development in established and emerging clinical areas as well as in aspects of public health and PHC such as management, community participation and multi-sectoral collaboration can clearly lead to substantial improvement of programmes and at all levels will assist the development of skills development strategies (National Primary Health Care Facilities Survey, 2000).

## **5.8 WORKLOADS**

Workloads, particularly at PHC facilities, continue to be a controversial issue, although uneven, fixed facilities had substantially lower patient-intake in the year 2000 compared to 1997. But views on what constitute appropriate workloads continue to vary. The PHC survey reported views of health managers that considered a range of between 20 and 35 patients per day to be appropriate (National Primary Health Care Facilities Survey, 2000).

Workload is not only a question of individual nurses' efficiency and productivity, although these are undoubtedly contributing factors, which need to be taken into account. Rather, workload is quite fundamentally determined by dramatic structural differences, such as location, size, staffing levels, infrastructure and resourcing.

## **5.9 MANAGEMENT AND SUPPORT**

Management and support are crucially important to health personnel performance, hence, good management including planning and supervision will vastly improve work satisfaction and ability to function productively, while lack of management and support contribute substantially to low productivity and demotivation and lead to what can be termed "transformation fatigue" among health personnel. In addition, a mismatch often exists between job description and actual functions performed. While the focus should lie on support and supervision of clinics and their staff, most supervisors find themselves occupied with a range of other activities, namely, lending a helping hand by rendering clinical care in understaffed clinics, taking full responsibility for provisioning of clinics, attending large numbers of unscheduled meetings and workshops throughout the province, Western Cape. The negative and disruptive impact of a proliferation of unscheduled and unnecessary meetings, pointing to a lack of planning capacity, particularly at provincial level, is regarded as one of the areas of concern (Pycroft, 1998).

Careful and regular supervision is increasingly being identified as another factor, which impacts profoundly on quality of service delivery. Without proper clinic supervision staff easily feel unappreciated and insecure, particularly in the implementation of new policies and treatment regimes. This sense of insecurity and lack of appreciation may in turn again lead to disenchantment with and resistance to the transformation process in the health sector.

#### **5.10 CRITERIA FOR SUCCESS IN LEGISLATIVE FRAMEWORK OF THE SOUTH AFRICAN HEALTH CARE SYSTEM**

The World Health Organisation (1998) suggests the following criteria for success in the promotion of Primary Health Care:

- (a) Firstly; all health promotion activities must be given in accordance with the target group and educational level of participants. Clear and precise objectives must be set before any health education is given to ensure what must be taught.
- (b) The health promoter and practitioner must be very knowledgeable so as to increase individual and group capabilities for involvement and self reliance in decision making around health issues. This will ensure and encourage active participation and dynamic co-operation between communities and public officials.
- (c) The attitude that health care is someone else's responsibility other than communities, has resulted in health officials and professionals depriving people of their decision making power and capabilities with regard to health matters. Hence, the new attitude will be to encourage confidence and skill development in and around communities to make the right decisions.

## 5.11 SUMMARY

Capacity development will remain a focus area for the foreseeable future. In the light of the overwhelming need it is advisable that development efforts significantly concentrate on priority programme areas. Both clinical and management skills areas should be continuously developed, based on skills and needs assessments. There is an urgent need for management and leadership development across all levels of service, which should be preceded by a systematic needs and impact assessment. Of course, the ongoing capacity development of staff in the service is only one leg of human resource production. The Legislative Framework of the South African Health Care System should and must incorporate issues of training, curricula and community partnership and participation in service provision (Pycroft, 1998).

Decision-making bodies should be fully representative, democratically elected and accountable, which implies that representation forms an equally important building block in the success of participation. The people who participate, should represent the grouping they belong to and be accountable to them. The importance of institution building is, therefore, to ensure that all people in the community are represented through participation.

In order for community participation to become an instrument of empowerment, it needs infrastructure from where it can be initiated and ensure that the government responds to community participation in an authentic manner.

The following chapter will focus on the research design and interpretation of data including recommendations in addressing the involvement of communities in Primary Health Care processes and provision of services.

**RESEARCH DESIGN, INTERPRETATION OF DATA AND A  
CONCEPTUAL FRAMEWORK FOR COMMUNITY PARTICIPATION  
– A CASE OF KHAYELITSHA**

**6.1 INTRODUCTION**

In any research, it is essential that an acceptable research design and methodology be followed. Failure to do so, may negatively impact on the credibility of the research and on the universal acceptability of it.

In the following paragraphs, an explanation will be provided of the research design that was followed in this research.

**6.2 RESEARCH METHOD**

Although there are other approaches to research, for this research, a method was selected which was deemed to be the most acceptable for the particular type of research study which was undertaken to investigate the efficiency of community participation in Primary Health Care in Khayelitsha.

The method that was considered is qualitative research as defined by its extensive use of verbal information, its preference for developing full information on relatively few cases and its consideration of the unique features of each case (Newell, 1993).

The qualitative research method was applied for data collection in three phases, namely:

- One on one interview with the Community Primary Health Care workers from the clinic.



- Discussion groups with the officials, professional practitioners, and community representatives.
- Observations of the daily activities at the clinic or care centres.

The overall objective was to investigate and evaluate the implementation of the Primary Health Care programme, determine the extent to which community participation exercise was implemented and identify the factors that facilitate or hamper successful implementation.

Collection of data from different sources allowed for triangulation and strengthening the basis from which to draw conclusion and make recommendations about efficient community participation in Primary Health Care programme. The data was analysed thematically and key statements were quoted and used to support discussions. Observations at the clinic and group discussions were used in the analysis.

Some of the findings included the following:

- # To achieve the aim of providing high quality health service, which is accessible to all South Africans, health care system reform will need to take place at a variety of levels. Although progress has been uneven across provinces, in many areas the necessary administrative structures for implementation of the Primary Health Care programmes in now in place. The challenge is now to translate provincial commitment and administrative reorganisation into real improvements in health care delivery at local level.
- # Quality within health care has been defined as the success of the health services in meeting the health related needs of the population in a manner that is consistent with local goals, national goals and resource constraints. Although a political commitment to providing high quality primary health care is an important initial step, experience has shown that there is often a gap between the intended role of primary health care services and their real

capacity to deliver, chiefly as a result of lack of resources and management capacity.

- # The District Health System is recognised as the most appropriate vehicle for the delivery of Primary Health Care. Hence, the National policy decisions and administration can be integrated with local conditions and needs within the District. Furthermore, the District contains sufficient public service infrastructure for service delivery whilst the focus is near enough to communities to allow a certain transparency of community-wide problems and constraints.
  
- # Since the District is the natural meeting point for bottom-up planning and top-down planning support, it becomes clear that many key development sectors are represented at the District, thus facilitating intersectoral co-operation and the management of services across a broad front and the co-ordination and integration of services and vertical programmes allows for increased efficiency in community participation in Primary Health Care provision.

### **6.3 QUALITY ASSURANCE IN PRIMARY HEALTH CARE**

Historically, the quality of public services in developing countries has been neglected with little attention being paid to the quality of PHC provided. The perceived lack of ability of PHC workers to adequately treat common childhood illnesses such as diarrhoea disease and acute respiratory infections, provided the impetus for a process whereby quality assurance methods were applied to developing countries. The quality assurance movement has grown in South Africa, hence, there is clear development of norms and standards consistent with the aims of PHC and the incorporation of equity and accessibility (White Paper on the Transformation of the Health System in South Africa, 1997).

### **6.3.1 A CRITIQUE OF QUALITY ASSURANCE – CITIZENS RESPONSE**

Although one cannot argue that improvements in the quality of care provided are desirable, the approach and methods used in the process have drawn criticism. These criticism include the following issues drawn from the Urban Sector Network (1998) document and were raised by communities during workshops conducted with the service providers:

(a) Why measure quality?

The deficiencies of primary health care and community participation in the process is well documented. Some critics argue that resources should rather be channelled into addressing these issues, rather than on further documentation of shortfalls

(b) Lack of concern about access and equity

Access and equity which are central principles of PHC form no part of the traditional quality assurance discourse. The rise of the quality assurance movement has for the most part developed within a milieu which encourages health care to be regarded as a commodity which should be regulated by market forces.

(c) How is quality assured

Quality assurance programmes run the risk that health personnel can become dependent on check lists at the expense of dynamic, creative monitoring of health workers performance. However, quality of care relates to the meeting of qualitative standards in the processes of health care delivery and performance which relates more to the quantitative response to the health needs of the served communities.

In addition various tools for assessment of quality care for specific areas in Khayelitsha have been put in place. During the interviews, it became clear that such tools for assessment of quality may involve a number of key components, that is, observation of care management, interviews with clients and staff, interviews with health personnel, checklists for assessing facilities and supplies, and review of clinical records.

#### **6.4 ASSESSING COMMUNITY ATTITUDE AND PERCEPTIONS IN PRIMARY HEALTH CARE APPROACHES**

The emergence of a negotiated settlement for a new dispensation paved the way for a process of development oriented local government in order to enhance the quality of life of all the people. Hence, community participation is considered pivotal to achieve this goal within post-apartheid South Africa. Community participation is perceived to be a vehicle for working in close collaboration with the local community to find sustainable ways to meet the socio-economic and material needs of all residents within the jurisdiction of the municipality (Pycroft, 1996)

Developmental Local Government is defined in the White Paper on Local Government (1998) as multi-faceted, and is seen as the dynamic way in which local councils work together with local communities to find sustainable ways to meet their needs and improve their lives. Following from this definition it can be discerned that a municipality is compelled to work together with the diverse local communities in order to enhance democracy and participation, thereby ensuring that their different needs are addressed and effectively met. Community participation is instrumental in realising this objective. This is evident from the following point that there is also a very obvious locally generated commitment to popular legitimacy which depends on having everyone represented at all stages of planning and implementation of local government activities and tasks (Urban Sector Network, 1998)

It is argued that local authorities, being the sphere of government that is closest to the people, are in a better position to understand perceived local realities. In which

ways they will react to these challenges and opportunities will depend on the willingness of the communities to take ownership of the PHC programmes and projects in and around Khayelitsha areas. The community will be in a position to be empowered in accepting the full responsibility for collectively working out a common destiny with the council and its officials. In this respect Reddy (1999) argues that the transfer of power and resources to the local level will assist in empowering communities to work together to define and resolve their problems. Future local government must therefore play a central role in representing the communities and meeting their basic needs. This can be achieved by focusing its efforts and resources on improving the quality of life of all its citizenry (White Paper on Local Government, 1998).

## **6.5 INCLUSIVE DEVELOPMENT AND PARTICIPATION**

Inclusivity is a feature of community participation and stakeholder involvement. It means that practically every individual, group or stakeholder who wishes to get involved in the process must be allowed to participate. This aspect may be questioned on the ground that it is not practically possible, sometimes even not feasible, to accommodate all people in a process of participation. However, the assumption of collective action which will follow on community participation, leading to empowerment of the participants, is an ideal that appears difficult to realise. The ideals of participation often do not take sufficient account of the reality that a community is not an easily defined, isolated static entity that can be directed to participate in the Primary Health Care programmes since communities are unique, dynamic social entities continuously changing and adapting to the various social, economic and political environments (Liebenberg & Theron, 1997).

To achieve the objective of inclusivity, municipalities must adopt inclusive approaches to foster citizen participation. These include strategies aimed at actively encouraging the participation of marginalised groups in the community (White Paper on Local Government, 1998). Burkey (1993) views participation as an essential part

of human growth, development of self confidence, pride, initiative, creativity, responsibility and cooperation.

When participation is analysed in this context, the key elements is collective effort. This means people must come together and pool their human and material resources in order to obtain the objectives which they set for themselves. Authentic grassroots participation and involvement creates a social learning process which in turn leads to the empowerment of those participating.

## **6.6 RECOMMENDATIONS FROM THE DATA COLLECTED AND INTERPRETATION**

Against the backdrop of the community participation process in general, it is suggested that the following recommendations aimed at service providers and health care workers in Khayelitsha be considered:

- (a) The first recommendation concerns the issues of attitudes and perceptions of all internal and external stakeholders. They must critically evaluate their mindset and move towards a mindset which reflects the values, attitudes and perceptions of a changing South Africa. This demands a shift from a search for a quick fix solution towards a view of development as a long term, learning and incremental process.
- (b) A second recommendation involves the issue of inclusivity and participation. The legislative directives should make provision for all stakeholders to be partners in the process of determining Primary Health Care matters affecting the community. All stakeholders have to be involved and mobilised by means of workshops to participate in the PHC programmes. It is through participation that people learn to take charge of their own lives and are enabled to solve their own problems.

Failure to acknowledge the importance of community participation in the PHC, could result in less local support of initiatives from the local authority and health centres.

- (c) A third recommendation involves the empowerment of people, in particular those who have been marginalised in the past. Empowerment is a process that makes power available so that it can be used for direct access to resources, which is essential for development and active involvement as well as influence in the decision affecting those resources. It is through a meaningful participation that people are empowered to influence the decisions that affect their livelihood. A community should thus be empowered by actively involving it in all phases of a project through available structures.
- (d) Another recommendation involves the issue of capacity building. Capacity building is a process of increasing the ability of people to initiate, direct and control the process of social change in which they are involved. The citizenry should therefore be mobilised to lead their own change processes through active participation in PHC. By building the capacity of the people a development milieu should be created in which the people become actors themselves and not mere subjects of change.
- (e) A further recommendation relates to a process of social learning. The learning process approach is focused on the bottom-up approach to decision making and partnership. In formulation PHC programmes, local government should foster a learning attitude from the start and should institute a culture of learning whereby people are included in the learning process. In embarking on this approach the aim would be to bring together the elements of planning and design, the local authority involved in implementing the plan, and the beneficiaries of the plan. This implies that the health care planners and administrators must be flexible in such a way as to accommodate errors, plan in conjunction with stakeholders and bring the actions of the local council in line with the process of knowledge building.

- (f) Another recommendation relates to mechanisms that should be put in place to ensure effective feedback to all stakeholders. For meaningful participation to take place, the community needs to be fully informed and able to transmit its views. The community should have access to user-friendly information. The establishment of a communication care centre should be considered where issues relating to local governance in general can be addressed. Such a communication care centre should accommodate all queries, questions from the stakeholders and community.
  
- (g) The changing role of municipalities and the legislative obligation regarding Primary Health Care can be considered an opportunity for positive change. The positive attitudes of councillors, practitioners and officials from the health department towards PHC, should be communicated to the community at large. It is, however, essential that the health department and its officials should work in close collaboration with community to ensure transparency, accountability, efficiency and sustainability.
  
- (h) Community participation in PHC places more responsibility on local government to perform developmental tasks. However, local government should not perform this task alone, but the vast pool of skills and expertise of the external stakeholders can be utilised to create an environment which is conducive to the improvement of the lives of citizens within the jurisdiction of the municipality. This means that the municipality must work together with its diverse communities in order to fulfil its developmental mandate. The inputs of the people with their diverse skill, knowledge and energy must be coordinated in the process and consolidated by the officials in municipalities.



## **6.7 ADVANTAGES OF COMMUNITY PARTICIPATION – LESSONS LEARNT**

One of the advantages has been that community participation will only be successful if the community is accepted as active members of the team. Furthermore the community should participate in the identifying health needs and priorities and should agree on the nature of personal contribution towards solving the identified problems. Different cultural problems and communication between the community and the Primary Health Care worker can often present obstacles to community participation. Hence, a strong educational component is necessary for community participation to be sustained, because the community might not know what it wants, or could be reluctant to become involved due to previous unfulfilled expectations.

Furthermore, through participation the community will become self-reliant, self-sufficient, self confident and independent, this resulting in empowerment of the community to make decisions about its own affairs. By means of discussions between the primary health care worker and the people, power differences and potential corruption can be reduced since planning could be done according to the local circumstances and available resources. In addition, through community participation the health team would obtain first hand knowledge about local conditions and needs of the people.

There is also a need to enhance community participation skills of the health care workers and public officials in the following aspects:

- A belief in the potential of the community
- Skill in the community participation approach
- Ability to motivate
- Ability to create awareness
- Understanding of the community values and culture
- The ability to identify or create structures to assist with community participation

## **6.8 INVOLVEMENT OF CITIZENS**

It is essential that citizens be involved in most activities that relate to promoting and planning the future of the community. Involving community members in a visioning process offer a number of advantages and opportunities. Firstly, individuals and groups within the community bring experience and expertise beyond that which exists within the organisation. Secondly, by involving communities throughout the process, one could generate support for the implementation phase of any programme, and finally, one may assist in developing an extended group of leaders and knowledgeable citizens within the community. This will eventually form a critical element in the democratic process of community participation and service delivery (Newell, 1983)

According to Marx (1998), in addressing community participation in the health sector, there is a need to ensure value for money audit and effective audit. Marx (1998) describes value for money audit as an examination of economy and efficiency to bring to light examples of wasteful, extravagant or unrewarding expenditure, failure to maximise receipts or financial arrangements detrimental to the exchequer and weaknesses leading to them. Whilst effectiveness audit is described as an examination to assess whether programs or projects undertaken to meet established policy goals and objectives have met those aims.

## **6.9 MANAGEMENT STRUCTURE**

Flatter management structures are to be found increasingly in both private and public sectors. These structures result in fewer levels of management hierarchy through which decisions have to be passed up and down. This helps to facilitate a more devolved management structure. In a devolved management structure decisions are taken and operations are carried out at the lowest appropriate level in an organisation.

Another facet of decentralisation is attempting to make services physically more accessible to the public. The delivery of some local government services has traditionally been delivered on a local basis, for example, education and social work. This type of physical decentralisation may be facilitated by providing a one-stop access point at which access and information about a wide range of health services can be provided (Marx, 1998).

Decentralisation has staff training implications, in that whoever is employed at the local access point will be required to receive training to gain knowledge of a wide range of clinic and primary health care centres (Marx, 1998). This is particularly relevant for front line staff who have the main contact with the public and who contribute greatly to the so-called transactional quality of the service. The dangers of this approach is the tendency to evaluate performance of planning departments on the time taken to make decisions on planning applications, rather than the quality of the decision in relation to the interests of the community as a whole.

## **6.10 THE ENABLING AUTHORITY AND CULTURE**

According to Marx (1998), the concept of enabling authority is that of an authority that is conceived with all matters concerning its citizens and their welfare and would not merely confine itself to a service delivery role. In other words, an enabling authority would consider itself to be much more than the sum of its services. Such an authority would be prepared to cooperate and network with other agencies in the private, public and voluntary sectors in meeting the needs of its citizens. Such a role did not necessarily imply any dilution in the authority's service delivery role, but that its scope would extend well beyond it.

A final factor is the stronger user focus. Since communities are no longer restricted to considering service delivery, the focus then shifts towards the outcome of the service. In this situation, performance review will be required to allow the service to be effectively monitored for efficient community participation in Primary Health Care (PHC).

## **6.11 SERVICE PLANNING**

Strategic plans are normally drawn up at the executive level of the organisation. There is a need to operationalise these commitments and relate them to departments or sections that will actually deliver the service. Marx (1998) recommends the use of the Service Plans and Action Plans in providing Primary Health Care, namely:

### **(a) Service Plans**

These are normally developed for a given service and over a particular period of time and must at least reflect the priorities laid down by the strategic plan. Service Plans would normally be updated annually and these are based in every department for effective and efficient service delivery.

### **(b) Action Plans**

These are short-term plans, that is, usually a year or even less. Generally they translate the Service Plan into specific actions for which various individuals are responsible. The Action Plans are valuable in ensuring that a Service Plan is actually implemented and in establishing appropriate accountability (Marx, 1998).

Service Plan will generally facilitate linking the budget to the policy and performance review system since the resource implication of any development in the Service Plan should be made transparent. Furthermore, the health sector and various institutions and stakeholders involved including the communities, should clearly outline service objectives which must be consistent with supporting the goals of the national health department.

With the move towards a decentralised health system, many health workers would now require, in addition to clinical skills, substantial public health skills in planning, advocacy, programme design, programme implementation, monitoring and evaluation which are fundamental to the successful implementation of the Primary Health Care approach. These are skills in which few of the newly emerging generation of health personnel received training, resulting in a yawning gap between existing and required job competence. Consequently, health personnel development not only assumes a priority place but is also a primary step in health systems development. This poses a considerable challenge to tertiary health science institutions, charged with the training of health personnel, to respond to changing needs. Failure to respond to this challenge of reorientation, training and support leads to a lack of capacity to implement policies and plans at local level (Marx, 1998).

## **6.12 A CONCEPTUAL FRAMEWORK FOR COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE**

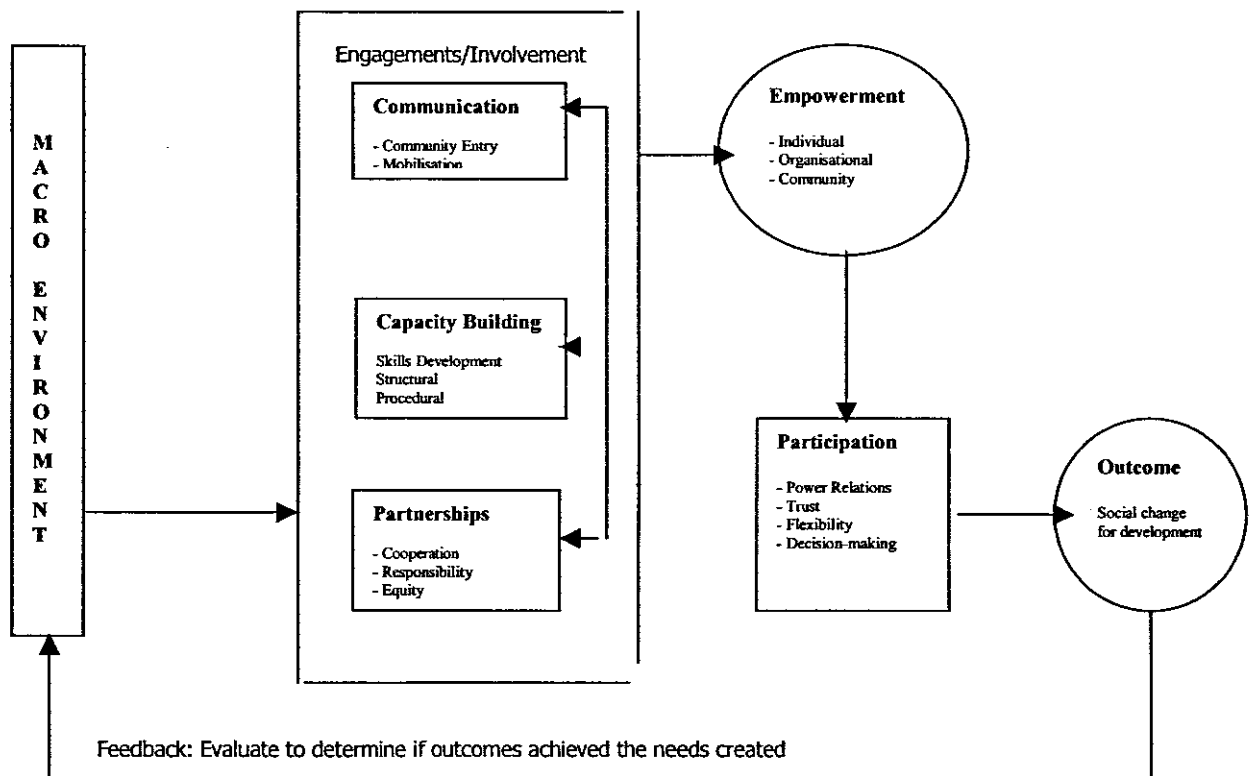
Community participation occurs when members come together to share and discuss their problems, prioritise them and find possible solutions. Community members thus undertake an active role in the planning, implementation and evaluation of activities that will benefit them. Real, active community participation results in effective decision-making and promotes commitment to ensure that plans are realised. However, this process does not exclude participating and supporting agencies. Substance is given to participation by enabling individuals and organisations to become more responsible, and the involvement all role-players on a consultative basis (Local Government Municipal Structures Act, 2000).

The Local Government Municipal Structures Act (2000) provide the legislative foundation, which creates the opportunity for communities to play a significant role in their development. In spite of this, there exist no theoretical framework to conceptualise community participation processes.

The intention is not merely to suggest another strategy for community participation but to propose a conceptual model that could be used as a theoretical framework that will lead to successful, real and active participation in PHC programmes in around Khayelitsha.

Planact (1997) recommends the conceptual framework (Fig.1) which can be utilised as a theoretical framework that will lead to successful, real and active participation. The framework consists of the macro environment; engagement/involvement; empowerment; participation; and outcome. These components and the relationship among them will be subsequently described.

**Fig. 1: Conceptual Framework for Community Participation**



## **Framework Components:**

### **Macro Environment**

The macro environment represents the context that gives rise to health needs that stimulate community participation. It incorporates sustainable development issues that directly or indirectly affect the quality of life.

### **Community Involvement/ Engagement**

This is a process where people express their right to be active in the development of appropriate health services. It is a collaborative partnership between individuals groups, organisations and health professionals to mobilise resources and change relationships. Individuals initiating community engagement activities must understand the belief system held by community members, especially if these are different from their own. It therefore becomes important to apply the principles of communication; capacity building; and partnerships.

#### **(a) Communication:**

One should be clear of the purposes and goals of the engagement effort and the communities you want to engage. Thus, become knowledgeable about the community in terms of its dynamics, structure, norms and values. Relationships must be established with formal and informal leaders in order to build trust and create the processes for mobilisation.

#### **(b) Capacity Building:**

Capacity building is based on the premise that people can lead their own change processes in order to become actors and not merely subjects of change. It is unrealistic to expect individuals or groups to make complex decisions and become involved with major projects. Community capacity

building is developmental in nature. It involves training and providing resources that strengthen the ability to establish structures and systems, upgrade skills, and develop procedures that enable them to participate and take community action.

(c) Partnerships:

Partnerships with the community is characterised by mutual cooperation and responsibility. The main aim of establishing partnerships is to reach a compromise that entail the recognition of self-help activities, respect for the individual and a willingness of authorities to cooperate.

Thus, partnerships emphasise the potential, in both the communities and health authorities, to address issues such as equity and equality.

(d) Empowerment:

A critical element of community participation relates to empowerment. Empowerment is the process whereby individuals, communities and organisations gain confidence, self-esteem and power to articulate their concerns and take action to address them. Empowered persons are motivated to change problems that they face and mediate the negative effects over things which they have no control. Real participation can only start once the ability to influence has been reached. Empowerment cannot be divorced from a social action model where communities wield a certain degree of influence through accountable representatives. Key to the empowerment of communities is the unrestricted access to relevant information and the development of skills and capacity to utilise that information.



(e) Participation:

Participation refers to the sum of actions taken by ordinary members in order to influence or attempt to influence an outcome. Participation varies in extent and intensity and considered increasingly intensive as more people engage in it. It should be viewed as an evolutionary process that starts with planning and ends with operation.

(f) Outcome:

The outcome of any community participatory project should be social change for development in addressing the needs created by the macro environment. It therefore becomes important to evaluate the outcome to determine if it addresses the needs created.

Planact (1997) highlight the following four factors as having an effect on participation:

- Power relations:

Needed to reduce the power distance between those who have information and money. Many authorities fear the loss of control and do not want to release control of actions or interventions. Communities themselves may compose of factions that contend for power and influence.

- Trust:

It is essential to maintain high ethical standards as ethical failures create distrust among community members. Community and the authorities do not have to have equal skills but they do have to trust each other and share commitment. Ethical action is the only hope for developing and maintaining trust.

- Flexibility:

Communities and authorities should be flexible in meeting each other's changing needs. Greater flexibility is strongly associated with greater responsiveness to needs.

- Decision-making:

Community participation will only be truly democratic if the community has the right and opportunity to participate in actual decision-making.

In the light of the above, it is imperative that community participation is encouraged and taken as a lead factor in determining the needs and aspiration of the citizenry and effective service delivery in the health care systems.

## **6.13 SUMMARY**

The government has over the past five years put in place a range of policies to transform the health system with the aim to improve efficiency as well as equity. With the policy framework largely in place, the challenge is now one of implementation. Successful implementation depends crucially on an adequate supply of equitably distributed and competent personnel.

Community participation is considered to be an active process, meaning that the person or group in question takes initiative and become assertive to all levels that members of the community will adopt and identify with the decision and process taken to achieve the set goals. Community members must be seen as change agents, responsible for empowering the community to gain greater control over the political, economic, social and environmental factors that affect their lives.

In this context, communities are sources of ideas about where they should head in the future and how they should get there. Not only is this often an avenue for coming up with innovative ideas, it is also an excellent way of getting people committed to the plans and to particular ideas about the future courses of action.

While the study has provided one with insight to unpack the efficient ways of involving communities in matters affecting them, such as Primary Health Care systems, it will serve as a point of departure for further investigating and could readily be applied as a basis for a doctrate.

## **CHAPTER 7**

### **SUMMARY AND CONCLUDING REMARKS**

#### **7.1 SUMMARY**

This research was undertaken in terms of the following chapters:

##### **Chapter 1:**

The new South African health system has adopted the Primary Health Care (PHC) in their obligation to serve the community on health care issues. It is argued that this approach is the most effective and cost effective means of improving the population's health. The approach involves a health system led by PHC services, which may call for communities' input in the effective planning, implementation and sustaining the health system and related development. This chapter seeks to highlight the need for community participation in promoting Primary Health Care (PHC). To encourage communities to take greater responsibility for their own health promotion and care, suggestions on mechanisms to improve public accountability and promote dialogue and feedback between the public and the health providers, involving communities in aspects of the planning and provision of health services.

##### **Chapter 2:**

This chapter explains the history of the existing health policy in South Africa demonstrating the failure of fragmented health planning especially in a Metropolitan setting. Apart from the existence of racial segregation in health services, the single factor constraining the development of a comprehensive health system has been the political division of health functions between national and provincial levels of government.

It explains the formulation of national health policies in the past which was the concern of the Department of National Health and Population Development. This Department was responsible for the coordination of public health services, provision of additional health services, establishment of national health laboratories, promotion of a healthy and safe environment, promotion of family planning and conducting research in health services for the improvement of the health and well-being of all people within the Republic of South Africa. The Department failed in this objective due the policy of separate development.

It is envisaged that the present government and the policies in place will remain in force until the task of restructuring and transformation of the public health is adequately and properly addressed.

To this end, this chapter presents a description of the framework within which public health services has been rendered in South Africa.

### **Chapter 3:**

Presently, the South African health system has undergone restructuring geared towards equity in health service provision. Inherent challenges like fragmentation, centralisation, imbalances in health investments and a large private sector are hurdles which the health department has grappled with. The task of transforming the health sector is formidable and successfully meeting the challenge of implementation cannot be taken for granted. The adoption of a district health system based on the primary health care approach is recognised as the fundamental building block of South Africa's unified health system which is in contrast to the previously centralised and fragmented health system of the past which led to poor planning, duplication of services, inappropriate resource allocation and demoralisation among health workers.

This chapter explains the development of the District Health System in South Africa which resulted in drafting of a framework to establish co-operation and

accountability between the various spheres of government is integral to the success of the district health system in South Africa. Sustained and effective leadership, clarity regarding the task at hand and a willingness to evaluate the process and strategy of reform continually are among the vital elements of securing success in South Africa's health reform.

#### **Chapter 4:**

This chapter explains the concept of health promotion which covers aspects of activities that seek to improve the health status of communities and individuals. It includes attempts to produce environmental and legislative changes conducive to good health. Health education and health promotion involves supplying a person with enough new and correct knowledge about disease process to make preventive measures required available and reasonable. This process enables a person to be concerned about health of others and inspire communities to develop skills and the confidence to help themselves around health issues. This essence lies in changing attitudes, beliefs and lead to active and dynamic participation by individuals, groups and communities in the health programmes.

Suggestions are made on health education which is aimed at increasing individual and group capabilities for involvement and self-reliance in health and promote healthy behaviour with regard to family nutrition, environmental health, healthy lifestyle practices and disease prevention and control. Good vibrant health does not mean the absence of disease but to use physical and mental potential to the maximum so that the individual is able to lead a socially and economically productive life in harmony with the environment. Health promotion needs to develop policies in harmony with the principles of Primary Health Care with reference to

Reference is made to the process of Primary Health Care activities and guidelines enclosed in the Primary Health Care Package for South Africa issued by the Department of Health during March 2000 (see Annexure 1).

## **Chapter 5:**

This chapter explains the relevance of capacity development which will remain a focus area for the foreseeable future. In the light of overwhelming need it is advisable that development efforts significantly concentrate on priority programme areas. Both clinical and management skills areas should be continuously developed, based on skills and needs assessments. There is an urgent need for management and leadership development across all levels of service, which should be preceded by a systematic needs and impact assessment. Of course, the ongoing capacity development of staff in the service is only one leg of human resource production.

Recommendations are made in this chapter by Pycroft (1998) on the Legislative Framework of the South African Health Care System that it must incorporate issues of training, curricula and community partnership and participation in health care service provision.

Decision-making bodies should be fully representative, democratically elected and accountable, which implies that representation forms an equally important building block in the success of participation. The people who participate, should represent the grouping they belong to and be accountable to them. The importance of institution building is, therefore, to ensure that all people in the community are represented through participation.

The chapter the essence for community participation to become an instrument of empowerment, it needs infrastructure from where it can be initiated and ensure that the government responds to community participation in an authentic manner.

## **Chapter 6:**

Pycroft (1998) argues that with the policy framework largely in place in transforming the health system in South Africa, the challenge remains on implementation. Successful implementation depends crucially on an adequate supply of equitably distributed and competent personnel. In this context, communities are sources of ideas about where they should head in the future and how they should get there. Not only is this often an avenue for coming up with innovative ideas, it is also an excellent way of getting people committed to the plans and to particular ideas about the future courses of action. While the study has provided one with insight to unpack the efficient ways of involving communities in matters affecting them, such as Primary Health Care systems, recommendations and concluding remarks are provided in the next section.

### **7.2 CONCLUDING REMARKS**

There has been an increased tendency to afford favourable consideration to the notion of local participation in health care policies and services. Interpretations of community participation include the individual's responsibility for own health; individual or community involvement in decisions about health care; and the individual's contribution to resources. Community participation has come to be seen as a way of rapidly improving the health services available to the majority of people.

Community participation is a non-medical function and its vital role is to advocate development. Community members must therefore be seen as change agents, responsible for empowering the community to gain greater control over the political, economic, social and environmental factors that affect their lives. However, community members are (through their training and experiences) empowered to gain control over certain factors. In other words they mobilise the community and solicit information from them. The empowerment process should not stop there.



Clear distinction must be made between community involvement and community participation. The confusion arises when involvement is seen as community participation. Community participation means participating in the initial assessment of the situation, defining the main health problems, setting priorities for programs, implementing activities, monitoring and evaluating the results. In order to do this, the community needs to be made aware and then equipped with the necessary knowledge and skills. The duty to create awareness and to provide the community with the necessary knowledge and skills, rest with those who promote community participation.

The concept of "Community Participation" must be properly introduced. In many cases the proper entry method have been followed but an incomplete message delivered. Community ownership and how to promote it should be fully explained.

At the heart of the primary health care challenges for local government is the premise that appropriate health care services cannot be provided without meaningful participation from local communities. A shift in attitudes and changing emphasis gave rise to new challenges within community participation. Approaches that saw communities as passive recipients have given way to those that acknowledge the potential that community participation might offer to enhance accountability and to improve responsiveness of the health services. Participation can be viewed as a dimension of an intervention and allowing for more community participation in the planning process. This can result in public health plans that meet both professional and community requirements for the utilisation and efficient use of resources.

Planact (1997) outlines the following reasons on why communities participate in various projects and programmes:

- Creates sense of ownership over programmes and services that affect their lives
- Serve as entry point to the service providers

- Instills confidence in the self, community and supporting systems
- Leads to greater project effectiveness
- Further the principles of accountability and transparency
- Enables greater acceptance of programmes and services
- Enables members of the community to acquire knowledge and skills that they can apply, thus leading towards empowerment.

Human resources are the most important cost in the provision of health services. It is important that guidelines on how health staff members are distributed between facilities, workload and size of the population are available. Such guidelines allow for improved relations between managers and health workers. Job descriptions are important management tools that allow a manager to even re-deploy staff in times of shortages. Equipment must be readily available, allocated, replaced and maintained to avoid any mismanagement and inability to address the needs of the community when requested.

The establishment of an efficient health service is only one of the positive steps towards the goals of "health for all". Once the health services are established, the community must move towards development in the quality of their life that allows for growth and self-expression. Although interest in the quality of health care has grown, it is not yet an integral part of the delivery of care. With decentralisation of health care delivery to district level, an accompanying shift should occur with regard to responsibility for the quality of the services provided, so that solving health problems and improving care will be easier, due to decreased bureaucracy. The district authority is ideally placed to take responsibility for the improvement of quality.

The improvement of quality is best integrated into the daily activities of health care delivery. It should not be a vertical programme – the responsibility of one person in a facility or an activity that has its own separate identity. The improvement of quality is effective only if it is a value cherished by all staff, widely supported goal and a regular part of all daily activities.

Health personnel constitute an important part of the health resources of the district. Their training, deployment and support at all levels is a major challenge in health management. In the absence of such back-up and support of health personnel even the most carefully designed plans cannot succeed. The importance of building an effective health organisation which will ensure that the right personnel is deployed at the right level and regularly receive the material and equipment to deal with the tasks set for the level.

Implicit in the issues raised on the importance of primary health care in South Africa, it is clear that it forms an integral part both of the country's health system, of which, it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bridging health care as close as possible to where the people live and work and constitutes the first element of a continuing health care process.

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## ANNEXURE

### **The Primary Health Care Package for South Africa – a set of norms and standards**

#### **Part 1 Norms and standards for health clinics**

#### **Part 2 Norms and standards for community based clinic initiated services**

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Department of Health

Pretoria

March 2000

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#### **TECHNICAL TASK TEAM MEMBERS**

- Dr John MSH Equity Project  
Bennett

- Dr Gary Morris Child Survival Project, Bergville Kwa Zulu Natal
- Dr Abdul G. Elgoni Centre for Health Systems Research and Development, University of Free State
- Dr Cameron Bowie UK DFID consultant for Department of Health

## QUALITY ASSURANCE TECHNICAL AND SUPPORT STAFF

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**The Primary Health Care Package for South Africa – a set of norms and standards**

## **INTRODUCTION**

Primary health care is at the heart of the plans to transform the health services in South Africa. An integrated package of essential primary health care services available to the entire population will provide the solid foundations of a single, unified health system. It will be the driving force in promoting equity in health care. This document sets out the norms and standards that are to be made available in the

essential package of primary care services. For the first time it will be possible for individuals to see what quality of primary care services they can expect to receive. It also acts as guidance for provincial and district health authorities to provide these services.

This introduction describes the background to the work, the way the package and standards have been produced, their potential uses and how they are likely to evolve with time and experience.

## THE BACKGROUND

The draft Health Bill requires the production of norms and standards to be used by provinces to provide health services at acceptable levels. Providing acceptable levels of service to all people will help the process of redistribution and reduce inequalities. The Year 2000 targets included the objective of having "*defined comprehensive services which are to be delivered at primary care level of health service delivery*". The task to define and produce norms and standards falls to the Directorate: Quality Assurance, Department of Health.

A primary health care package was defined following detailed consultation over four years with national experts and provincial staff. It forms the basis of this document, which contains norms and standards for clinic and community services. A national task team has undertaken the production of the norms and standards. Norms and standards for community health centres and Level 1 hospitals will follow.

## THE CHOICE OF NORMS AND STANDARDS

All necessary components of a comprehensive primary care package are described and norms and standards for each component are provided. The norms and standards are largely derived from existing national policy documents or, if unavailable, other authoritative sources such as WHO and research work undertaken in the country. All the norms and standards are verifiable (some more easily than others) by staff providing the service. Some of the norms were taken from the Year 2000 Objectives and Indicators. An attempt has been made to ensure

that the standards are practical, essential and comprehensive and describe the range of services that should be available to all South Africans.

## POTENTIAL USES

It is hoped that the norms and standards are comprehensive enough to be used: --

- By local staff to help assess their own performance and that of their clinic.
- By the community who are able to see the range and quality of services to which they are entitled.
- As planning guidelines by district and provincial health planners to help assess the unmet needs of their population and draw up plans to bring services up to national standards.
- By provincial governments to guide resource allocation.

This wide range of uses requires the document to be available in different formats and selecting particular sections. Once this core document is published, it will be widely distributed to all stakeholders. Components can for example be adapted for use as checklists for local staff.

## A LIVING DOCUMENT

The document has two parts – one on clinic services, the other on community services. The community health centre and level-1 hospital sections are given a separate document. The choice of separate documents follows the precedent set by the EDL and permits each document to remain of reasonable size.

Not every primary health care component has been fully documented. National policies will change and service standards will be able to be enhanced, as more resources are made available. The document is the first of its kind. The task group believes that, with experience of its use, many things will be found that can be improved. Feedback from patients and staff is essential. Some provinces have set up norms and standards initiatives themselves. This is good as the more experience that is gained with their use the more can be shared.

## DEFINITION OF NORMS AND STANDARDS

FOR THE PURPOSE OF THIS DOCUMENT NORMS AND STANDARDS ARE DEFINED THUS:

A **NORM** is defined as *a statistical normative rate of provision or measurable target outcome over a specified period of time.*

A **STANDARD** is defined as *a statement about a desired and acceptable level of health care.*

A common framework used to develop these standards addresses health service inputs, processes, outputs and outcomes. This approach has been adopted. Standards are best developed in incremental stages and according to national priorities. These represent the first stage of this process for primary health care. Standard setting takes place within specific dimensions of quality – acceptability, accessibility, appropriateness, continuity, effectiveness, efficiency, equity, interpersonal relations, technical competence and safety. The most important dimensions have been chosen for each service.

## INTERPRETATION

Two important issues need to be taken into account when interpreting these norms and standards in the local setting. The first relates to the role of national and provincial health authorities. The second relates to staff competency.

## WHAT SERVICES ARE REQUIRED NOT HOW SERVICES ARE PROVIDED

The national task is to define what services are required to best meet the health needs of the nation. It is for provinces and local government to decide, in the light of local circumstances, how these services are to be provided. Because of these different roles this national document is about what services at what standard are required. The standards do not specify how the services are to be provided and at

what level the standards will be met. It is for provinces and Local Gto harden up the standards with verifiable time limited measures based on existing performance and anticipated improvements.

Different kinds of facilities will be required to provide the same services in different situations. Take for instance the use of mobile clinics in remote rural areas compared to polyclinics in high-density urban areas. For this reason national standards about facilities and staffing norms are not offered. In some instances some standards about special facilities are included without which a service would be impossible to provide, for example a confidential room to talk to a sexually abused patient.

## **STAFF COMPETENCY**

Many standards are about staff competency. It is to be expected that some staff will not be trained, or if trained, remain competent to provide all the services specified. It is the responsibility of professional staff to seek to rectify the deficit in themselves and their staff by arranging appropriate training. It goes without saying that no members of staff should undertake tasks unless they are competent to do so. The safety of the patient is paramount.

## **CONTENT**

The document is arranged in a logical order. There are two parts; the first deals with health clinics and the second section with community based services. The part on health clinics starts with a chapter on patient rights, which is followed by one on core norms and standards for all clinics whatever services they are providing. For instance all clinics are expected to have and use the Essential Drug List. The standard is therefore included as a core standard. It is not repeated in later chapters

although its use is essential for most if not all services. Chapters succeeding the core standards one do not duplicate core standards.

Then follows chapters on individual services in life cycle order starting with maternity care and women's health through children and adolescent services to communicable diseases and finally non-communicable diseases.

Each chapter has three paragraphs. The first describes the service to be provided and is taken from the document "The Primary Health Care Package. The second paragraph describes the norms, chosen to represent key measures of what is required. All clinics should be aspiring to measure and reach these norms. The third paragraph describes the standards for each service and it is divided into 9 sections. The first three sections describe the essential written material, equipment, supplies and medicines required. Successful performance to meet these standards requires good organisation and logistics.

Sections 4 and 5 are perhaps the most important of all in describing the required competence of staff, without which services will be of poor quality. These sections will be of help to individual professionals as they assess their own capabilities against what is required of them. They will also be of help to managers and training departments in offering a backbone for training curricula and supervisory support. Sections 6 – 9 relate to other professional tasks required but which are not directly related to individual patient care. They are nevertheless important, as they are to do with improving the health of the local community.

Part 2 is about community based clinic initiated services. The format is similar. Documentary sources are listed at the back, which together with the documents listed in sections 1 of each chapter, reference the authoritative evidence on which the norms and standards are based.

### *Your comments and feedback*

Please send your comments to:

Ms Assy Moraka, Directorate:

Quality Assurance

Department of Health



Pretoria.

Fax (012) 323 5053

Email.claasl@health.gov.za

**NB : KEEP THIS PAGE IN COLOR THAT WILL REPEAT ITSELF THROUGHOUT  
PART 1**

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**PART 1**  
**NORMS AND STANDARDS FOR HEALTH CLINICS**  
**BATHO PELE – PEOPLE FIRST**

**INTRODUCTION**

Access to decent public services is the rightful expectation of all citizens especially those previously disadvantaged. Communities are encouraged to participate in planning services to improve and optimise service delivery for the benefit of the people who come first.

**STANDARDS**

All communities will know from displayed posters about the eight principles of Batho Pele, which are:

**CONSULTATION**

Communities will be consulted about the level and quality of public services they receive and where possible will be given a choice about the services offered.

**SERVICE STANDARDS**

Citizens would know the level and quality of public service they are to receive and know what to expect

**ACCESS**

All citizens have equal access to the services to which they are entitled

**COURTESY**

Citizens should be treated with courtesy and consideration.

**INFORMATION**

Citizens should be given full accurate information about the public service they are entitled to receive.

#### **OPENNESS and TRANSPARENCY**

Citizens should be told how national and provisional departments are run, how much they cost and who is in charge.

#### **REDRESS**

If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy, when complaints are made, citizens should receive a sympathetic positive response.

#### **VALUE FOR MONEY**

Public services should be provided economically and efficiently in order to give citizens and communities the best possible value for money.

#### **Implications for health staff**

In line with these principles the local health services for a community will provide:

- services with a high standard of professional ethics
- a missions statement for service delivery
- services which are measured with performance indicators displayed, so community can understand the level of achievement
- services which are in partnership with or complement other sectors e.g. the private sector and non-government organizations and community based organizations
- services which are customer friendly and confidential
- opportunities for community consultation
- types of outreach which can reach to all communities and to families in greatest need
- easily accessible and effective ways of dealing with complaints or suggestions for improvement
- current information on services available and hours of service, staff changes

of movements and extra activities such as health days.

## **PATIENTS RIGHTS CHARTER**

### **SERVICE DESCRIPTION**

The purpose and expected outcome of the patients rights charter and complaints procedure is to deal effectively with complaints and rectify service delivery problems and so improve the quality of care, raise awareness of rights and responsibilities, raise expectations and empowerment of users, change attitudes by strengthening the relationship between providers and users, improve the use of services and develop a mechanism for enforcing and measuring the quality of health services.

### **STANDARDS**

1. Each clinic displays the patients rights charter and patient responsibilities at the entrance in local languages.
2. The twelve patient's rights are observed and implemented. Every patient has the right to:
  - a healthy and safe environment
  - access to health care
  - confidentiality and privacy
  - informed consent
  - be referred for a second opinion
  - exercise choice in health care
  - continuity of care
  - participation in decision making that affect his/her health
  - be treated by a named health care provider
  - refuse treatment and
  - knowledge of their health insurance/medical aid scheme policies
  - complain about the health service they receive.
3. The ten patient's responsibilities are displayed alongside the patients rights charter. These include:

- Living a healthy lifestyle
  - Care and protect the environment
  - Respect the rights of other patients and health staff
  - Utilise the health system optimally without abuse
  - Know the health services available locally and what they offer
  - Provide health staff with accurate information for diagnosis, treatment, counselling and rehabilitation purposes
  - Advise health staff on his or her wishes with regard to death
  - Comply with the prescribed treatment and rehabilitation procedures
  - Ask about management costs and arrange for payment
  - Take care of the patient carried health cards and records.
4. There is provision for the special needs of people such as a woman in labour, a blind person or a person in pain.
  5. Services are provided with courtesy, kindness, empathy, tolerance and dignity.
  6. Information about a patient is confidential and is only disclosed after informed and appropriate consent.
  7. Informed consent for clinical procedures is based on a patient being fully informed of the state of the illness, the diagnostic procedures, the treatment and its side effects, the possible costs and how lifestyle might be affected. If a patient is unable to give informed consent the family is consulted.
  8. When there is a problem the health care user is informed verbally of the health rights charter with emphasis on the right to complain and the complaints procedure is explained and handed over.
  9. The clinic has a formal, clear, structured complaint procedure and illiterate patients and those with disabilities are assisted in laying complaints.
  10. All complaints or suggestions are forwarded to the appropriate authority if they cannot be dealt with in the clinic.
  11. A register of complaints and how they were addressed is maintained.
  12. The name, address, telephone number of the person in charge of the clinic is

displayed.

## **CORE NORMS AND STANDARDS FOR HEALTH CLINICS**

### **CORE NORMS**

1. The clinic renders comprehensive integrated PHC services using a one-stop approach for at least 8 hours a day, five days a week.
2. Access, as measured by the proportion of people living within 5km of a clinic, is improved.
3. The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities.
4. The clinic has at least one member of staff who has completed a recognised PHC course.
5. Doctors and other specialised professionals are accessible for consultation, support and referral and provide periodic visits.
6. Clinic managers receive training in facilitation skills and primary health care management.
7. There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.
8. There is annual plan based on this evaluation.
9. The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit.
10. Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires.

### **CORE STANDARDS**

#### **1. References, prints and educational materials**

##### **1.1 Standard treatment guidelines and the essential drug list (EDL)**

manual.

1.2 A library of useful health, medical and nursing reference books kept up to date.

1.3 All relevant national and provincial health related circulars, policy documents, acts and protocols that impact on service delivery.

1.4 Copies of the Patients Charter and Batho Pele documents available.

1.5 Supplies of appropriate health learning materials in local languages.

## 2. Equipment

2.1 A diagnostic set.

2.2 A blood pressure machines with appropriate cuffs and stethoscope.

2.3 Scales for adults and young children and measuring tapes for height and circumference.

2.4 Haemoglobinometer, glucometer, pregnancy test, and urine test strips.

2.5 Speculums of different sizes

2.6 A reliable means of communication (two-way radio or telephone).

2.7 Emergency transport available reliably when needed.

2.8 An oxygen cylinder and mask of various sizes.

2.9 Two working refrigerators one for vaccines with a thermometer and another for medicines. If one is a gas fridge a spare cylinder is always available.

2.10 Condom dispensers are placed where condoms can be obtained with ease.

2.11 A sharps disposal system and sterilisation system.

2.12 Equipment and containers for taking blood and other samples.

2.13 Adequate number of toilets for staff and users in working order and accessible to wheelchairs.

2.14 A sluice room and a suitable storeroom or cupboard for cleaning solutions, linen and gardening tools.

2.15 Suitable dressing/procedure room with washable surfaces.

- 2.16 A space with a table and ORT equipment and needs
- 2.17 Adequate number of consulting rooms with wash basins, diagnostic light (one for each professional nurse and medical officer working on the same shift).

### **3. Medicines and Supplies**

- 3.1 Suitable medicine room and medicine cupboards that are kept locked with burglar bars.
- 3.2 Medicines and Supplies as per the essential drug list for Primary Health Care, with a mechanism in place for stock control and ordering of stock.
- 3.3 Medicines and Supplies always in stock, with a mechanism for obtaining emergency supplies when needed.
- 3.4 A battery and spare globes for auroscopes and other equipment.
- 3.5 Available electricity, cold and warm water.

### **4. Competence of Health Staff**

#### **Organising the clinic**

#### **4.1 Staff are able to**

- 4.1.1 map the clinic catchment area and draw specific and achievable PHC objectives set using district, national and provincial goals and objectives as a framework.
- 4.1.2 Organise outreach services for the clinic catchment area.
- 4.1.3 Organise the clinic to reduce waiting times to a minimum and initiate an appointment system when necessary.
- 4.1.4 Train community health care promoters to educate caretakers and facilitate community action.
- 4.1.5 Plan and implement a district focused and community based activities, where health workers are

familiar with their catchment area population profile, health problems and needs and use data collected at clinic level for this purpose.

### **Caring for patients**

4.2 Staff are able to follow the disease management protocols and standard treatment guidelines, and provide compassionate counselling that is sensitive to culture and the social circumstances of patients.

4.3 Staff are positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.

4.4 Patients are treated with courtesy in a client-oriented manner to reduce the emotional barriers to access of health facilities and prevent the breakdown in communication between patients and staff.

4.5 The rights of patients are observed.

### **Running the clinic**

4.6 A clear system for referrals and feedback on referrals is in place.

4.7 All personnel wear uniforms and insignia in accordance with the South African Professional Councils' specifications.

4.8 The clinic has a strong link with the community, civic organisations, schools and workplaces in the catchment area.

4.9 The clinic is clean, organised and convenient and accommodates the needs of patients' confidentiality and easy access for older persons and people with disability.

4.10 Every clinic has a house keeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse.

4.11 Every clinic provides comprehensive security services to protect property and ensure safety of all people at all times.

4.12 The clinic has a supply of electricity, running water and proper sanitation.

4.13 The clinic has a written infection control policy, which is followed



and monitored, on protective clothing, handling of sharps, incineration, cleaning, hand hygiene, wound care, patient isolation and infection control data.

## **5. Patient Education**

5.1 Staff are able to approach the health problems of the catchment area hand in hand with the clinic health committee and community civic organisations to identify needs, maintain surveillance of cases, reduce common risk factors and give appropriate education to improve health awareness.

5.2 Culturally and linguistically appropriate patients' educational pamphlets are available on different health issues for free distribution.

5.3 Appropriate educational posters are posted on the wall for information and education of patients.

5.4 Educational videos in those clinics with audio-visual equipment are on show while patients are waiting for services.

## **6. Records**

6.1 The clinic utilises an integrated standard health information system that enables and assists in collecting and using data.

6.2 The clinic has daily service registers, road to health charts, patient treatment cards, notification forms, and all needed laboratory request and transfer forms.

6.3 All information on cases seen and discharged or referred is correctly recorded on the registers.

6.4 All notifiable medical conditions are reported according to protocol.

6.5 All registers and monthly reports are kept up to date.

6.6 The clinic has a patient carry card or filing system that allows continuity of health care.

## **7. Community and Home Based Activity**

7.1 There is a functioning community health committee in the clinic catchment area.

7.2 The clinic has links with the community health committee, civic organisations, schools, workplaces, political leaders and ward councillors in the catchment area.

7.3 The clinic has sensitised, and receives support from, the community health committee.

7.4 Staff conduct regular home visits using a home visit checklist.

## **8. Referral**

8.1 All patients are referred to the next level of care when their needs fall beyond the scope of clinic staff competence.

8.2 Patients with a need for additional health or social services are referred as appropriate.

8.3 Every clinic is able to arrange transport for an emergency within one hour.

8.4 Referrals within and outside the clinic are recorded appropriately in the registers.

8.5 Merits of referrals are assessed and discussed as part of the continuing education of the referring health professional to improve outcomes of referrals.

## **9. Collaboration**

9.1 Clinic staff collaborate with social welfare for social assistance and with other health related public sectors as appropriate.

9.2 Clinic staff collaborate with health orientated civic organisations and workplaces in the catchment area to enhance the promotion of health.

## **CORE MANAGEMENT STANDARDS**

### **10. Leadership and planning**

10.1 Each clinic has a vision/mission statement developed and posted in the clinic.

10.2 Core values are developed by the clinic staff and posted.

10.3 An operational plan or business plan is written each year.

## **11. Staff**

11.1 New clinic staff are oriented.

11.2 District personnel policies on recruitment, grievance and disciplinary procedures are available in the clinic for staff to refer to.

11.3 The staff establishment for all categories is known and vacancies discussed with the supervisor.

11.4 Job descriptions for each staff category are in the clinic file.

11.5 There is a performance plan/agreement and training plan made and a performance appraisal carried out for each member of staff each year.

11.6 The on-call roster and the clinic task list with appropriate rotation of tasks are posted.

11.7 An attendance register is in use.

11.8 There are regular staff meetings (at least once a month).

11.9 Services and tasks not carried out due to lack of skills are identified and new training sought.

11.10 In-service training takes place on a regular basis.

11.11 Disciplinary problems are documented and copied to supervisor.

## **12. Finance**

12.1 The clinic, as a cost centre, has a budget divided into main categories.

12.2 The monthly expenditure of each main category is known.

12.3 Under and over spending is identified and dealt with including requests for the transfer of funds between line items where permitted and appropriate.

## **13. Transport and communication**

13.1 A weekly or monthly transport plan is submitted to the supervisor

or transport co-ordinator.

13.2 The telephone or radio is working.

13.3 The ambulance can be contacted for urgent patient transport to be available within two hours.

#### **14. Visits to clinic by unit supervisor**

14.1 There is a schedule of monthly visits stating date and time of supervisory support visits.

14.2 There is a written record kept of results of visits.

#### **15. Community**

15.1 The community is involved in helping with clinic facility needs.

15.2 The community health committee is in place and meets monthly.

#### **16. Facilities and equipment**

16.1 There is an up-to-date inventory of clinic equipment and a list of broken equipment.

16.2 There is a list of required repairs (doors, windows, water) and these have been discussed with the supervisor and clinic committee.

#### **17. Drugs and supplies**

17.1 Stocks are secure with stock cards used and up-to-date.

17.2 Orders are placed regularly and on time and checked when received against the order.

17.3 Stocks are kept orderly, with FEFO (first expiry, first out) followed and no expired stock.

17.4 The drugs ordered follow EDL principles.

#### **18. Information and documentation**

18.1 New patient cards and medico-legal forms are available.

18.2 The laboratory specimen register is kept updated and missing results are followed up.

18.3 Births and deaths are reported on time and on the correct form.

18.4 The monthly PHC statistics report is accurate, done on time and filed/sent.

18.5 Monthly and annual data are checked, graphed, displayed and discussed with staff and the health committee.

18.6 There is a catchment area map showing the important features, location of mobile clinic stops, DOTS supporters, CHWs and other outreach activities.

## **INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS**

### **SERVICE DESCRIPTION.**

Promotive, preventative (monitoring and promoting growth, immunisations, home care counselling, de-worming and promoting breast feeding), curative (assessing, classifying and treating) and rehabilitative services are given in accordance with provincial IMCI protocols at all times that the clinic is open.

### **NORMS**

1. Reduce the infant and under-5 mortality rate by 30% and reduce disparities in mortality between population groups. (National Year 2000 Goals, Objectives and Indicators.)
2. Reduce mortality due to diarrhoea, measles and acute respiratory infections in children by 50%, 70% and 30% respectively. (National Year 2000 Goals, Objectives and Indicators.)
3. Increase full immunisation coverage among children of one year of age against diphtheria, pertussis, Hib, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to at least 80% in all districts and 90% nationally. (National Year 2000 Goals, Objectives and Indicators.)
4. Eradicate poliomyelitis by 2002. (National Year 2000 Goals, Objectives and Indicators.)
5. Increase regular growth monitoring to reach 75% of children <2 years. (National Year 2000 Goals, Objectives and Indicators.)
6. Increase the proportion of mothers who breast-feed their babies exclusively for 4-6 months, and who breast-feed their babies at 12 months. (National

Year 2000 Goals, Objectives and Indicators.)

7. Reduce the prevalence of under weight-for-age among children <5 years to 10%. (National Year 2000 Goals, Objectives and Indicators.)
8. Reduce the prevalence of stunting among children <5 years to 20%. (National Year 2000 Goals, Objectives and Indicators.)
9. Reduce the prevalence of severe malnutrition among children <5 years to 1%. (National Year 2000 Goals, Objectives and Indicators.)
10. Eliminate micro nutrient deficiency disorders. (National Year 2000 Goals, Objectives and Indicators.)
11. All children treated at the clinic are treated according to IMCI Guidelines.
12. Every clinic has at least two staff members, who have had the locally adapted IMCI training, based on the WHO/UNICEF Guidelines.
13. Every clinic has a rehydration corner.
14. A supervisor, who also evaluates the degree of community involvement in planning and implementing care, undertakes a six monthly assessment of quality of care.

## **STANDARDS**

### **1. References, Prints and Educational Materials**

- 1.1 National and Provincial wall charts and booklets.
- 1.2 A copy of the IMCI Standard Treatment Guidelines, relevant to the Province.
- 1.3 Child Health Charts to supply to new-borns and children without charts.
- 1.4 Copies of the National Essential Drugs List and Standard Treatment Guidelines.
- 1.5 Tick charts stuck to the desk as a reminder.

### **2. Equipment**

- 2.1 An oral rehydration corner set up for immediate rehydration.

2.2 Emergency equipment available for intravenous resuscitation of severely dehydrated children.

### **3. Medicines and Supplies**

3.1 The clinic has litre measures and teaspoon measures, cups for feeding, sugar and salt (for the child that is not dehydrated) and rehydration powder (for the dehydrated child).

### **4. Competence of Health Staff**

4.1 Every clinic has nurse practitioners able to treat clients in accordance with the IMCI guidelines.

4.2 IMCI trainer makes regular mentoring/supervision visits, initially 6 weeks after training, thereafter every 3 months.

4.3 Each clinic has an annual review of quality of care by IMCI Supervisor.

4.4 At least one member of staff takes overall responsibility for the assessment and management of the child.

4.5 Staff are able to establish trust and credibility through respect, courtesy, responsiveness, confidentiality and empathy, approaching consultations in a patient-centred way.

4.6 Staff are able to organise and implement an effective triage system for clients attending the clinic based on the IMCI protocol.

### **5. Referrals**

5.1 Children with danger signs and/or severe disease are referred as described in the IMCI provincial protocol.

### **6. Patient Education**

6.1 The mother or caregiver is counseled in accordance with the IMCI counselling guidelines.

6.2 Key family/household practices to improve child health are promoted as described in the IMCI community component.

## **7. Records**

7.1 An adequate patient record system is in place, using the child-health chart as the basic tool.

7.2 Patient details are recorded using the SOAP format.

## **8. Community and Home Based Activity.**

8.1 This takes place in line with the IMCI Guidelines for the Community Component.

8.2 The clinic works in close co-operation with community-based health programmes like community health worker schemes or care-groups.

## **9. Collaboration**

9.1 Clinic staff collaborate with social workers, NGOs, CBOs, creches and other sectors to improve child health.

### **MANAGEMENT OF ASTHMA**

#### **SERVICE DESCRIPTION**

This service aims at managing chronic asthma in infants, children and adults with treatment schedules for either mild or moderate to severe asthma. The service can also recognize, assess initiate treatment and refer emergency situations of acute bronchospasm associated with asthma and chronic obstructive bronchitis.

#### **NORMS**

Reduced incidence of emergency referrals due to asthma

#### **STANDARDS**

### **1. References, prints and educational materials**

1.1 Each clinic has the National and Provincial protocols and policy documents on management of acute and chronic persistent asthma.

1.2 Standard treatment guidelines and essential drugs list manual

1.3 Education materials for patients on allergy and avoidance of allergens and on the use of inhalers with or without spacers



## **2. Equipment**

2.1 See clinic core standards

2.2 Oxygen and nasal catheters for children and masks for adults

## **3. Medicines and Supplies**

3.1 As per the EDL

## **4. Competence of Health Staff**

4.1 The clinic staff are able to diagnose and treat attacks of bronchospasm and give appropriate health education as per EDL.

4.2 The clinic staff able to take complete patient and family histories on episodes o per week, night time or wheeze, number of times inhalers are used per week and identify possible allergens and other irritants.

4.3 Clinic staff are able to optimize treatment using peak expiry flow rates and give psychological support before referral for further care.

4.4 Staff are able to use inhalers with spacers and masks for infants and small children.

4.5 Clinic staff can interact with caretakers and family of patients to ensure improved control of asthma with emphasis on prevention and early management.

## **5. Referrals**

5.1 Refer to assess and confirm diagnosis when in doubt and to optimise therapy.

5.2 Refer severe non-responding attacks of bronchospasm

5.3 Refer pregnant women with worsening asthma

5.4 Refer patients presenting with repeated asthma exacerbations

5.5 Refer patients with previous life threatening exacerbations

5.6 Refer if there are unsatisfactory social and personal factors such as inadequate access to health care, unavailable transport, difficult home conditions or difficulty with the home management plan

## **6. Patient Education**

6.1 All patients and caretakers attending the service receive health education on prevention of exposure to known allergens and inhaled irritants such as cigarette smoke or allergens in animals, nuts or drugs.

6.2 The use and technique of inhalers is taught and demonstrated

6.3 Carers and patients understand the safety of continuous regular therapy and need for follow up

## **7. Records**

7.1 Clinic records are kept up to date with history of episodes, rate of use of drugs and inhalers, identified allergens and periodic PEFR recorded.

## **8. Community Based Services**

8.1 Conduct educational campaigns in school and community during pollen grain seasons

8.2 Community based programmes stress the need for smoke free environment and give guidelines on reducing common household allergens

## **9. Collaboration**

9.1 Staff collaborate with other departments like Environmental health, Education and other sectors to educate and support sufferers and their caretakers.

9.2 Staff collaborate with the National Asthma Education program and the Allergy Society of South Africa to obtain their educational materials

### **DISEASES PREVENTED BY IMMUNISATION**

#### **SERVICE DESCRIPTION**

Immunization is an essential service that is available whenever the clinic is open and based on an uninterrupted and monitored cold chain of constantly available vaccines.

#### **NORMS**

1. All clinics provide immunisations at least for 5 days a week and if the community desires additional periods specifically for child health promotion and prevention.
2. Every clinic has a visit from the District Communicable Disease Control Co-ordinator every 3 months to review the EPI coverage, practices, vaccine supply, cold chain and help solve problems and provide information and skills when necessary.
3. Every clinic has a senior member of staff trained in EPI who acts as a focal point for EPI programmes.

## STANDARDS

### 1. References, prints and educational materials

- 1.1 Copies of the latest editions of EPI (SA) *Vaccinators Manual Immunisation That Works*.
- 1.2 Copies of the Cold Chain and Immunisation and Operations Manual.
- 1.3 Copies of the Technical guidelines on immunisation in South Africa.
- 1.4 Copies of the EPI Disease Surveillance Field Guide.
- 1.5 Copies of the current Provincial Circulars on particular aspects, e.g. acute flaccid paralysis, flu virus, Haemophilus influenzae type b (HiB surveillance, Adverse Events Following Immunisation (AEFI) investigation and reporting.
- 1.6 Patient and community information pamphlets in appropriate languages.
- 1.7 Copies of the EPI Posters and other EPI disease and schedule promotional materials.

### 2. Equipment

- 2.1 Correct needles and syringes according to Vaccinators manual.

2.2 A working refrigerator, properly packed, with thermometer and temperature recorded and a spare gas cylinder if gas operated.

### 3. Medicines and Supplies

3.1 An uninterrupted and monitored cold chain of constantly available vaccines as recommended by EDL.

### 4. Competence of Health Staff

4.1 Staff are able to :-

4.1.1 Routinely perform correct immunisation practices according to protocol. Vaccines are checked periodically to ensure no frozen DPT, HBV, TT, HIB and none out of date or indicators showing expiry.

4.1.2 Provide mothers with correct knowledge of what is needed for the child, what is given and possible side effect and when to return for the next immunisation.

4.1.3 Provide group education for mothers and antenatal care attendants.

4.1.4 Follow up suspected cases of measles at home to determine the extent of a possible outbreak.

4.1.5 Take steps to increase coverage using the self-generated vaccination coverage graph (available in the Vaccinators manual) to address progress during the year.

4.1.6 Implement correct disposal of sharps.

4.1.7 Initiate post exposure prophylaxis for HIV in case of needle stick (according to Provincial protocol).

4.1.8 Ensure all reported and notified AFP, measles, NNT and AEFI cases are reported to EPI Coordinator and followed up within 48 hours by district investigation team of which the nurse in clinic is a co-opted member.

4.1.9 Organise immunisation service as a daily component of comprehensive PHC and to minimise

waiting/queuing times.

4.2 Community health committees are given the lay case definitions of acute flaccid paralysis, measles and neonatal tetanus and urged to report suspected cases immediately.

4.3 The clinic has a good relationship with the Environmental Health Officer for assistance in outbreaks investigations.

4.4 Ensure that appropriate laboratory specimens are taken for the investigation of all AFP, NNT, measles and AEFI investigations are taken or else referred to the nearest hospital where specimens can be taken.

4.5 A 24 hour toll free number for notification - (0800 111 408) is on the clinic wall.

4.6 All HIV positive children must be immunized with all vaccines except for BCG in children with symptomatic AIDS.

4.7 Clinics arrange mass immunisation or mopping up campaigns in their communities as required by the District Manager.

4.8 Remote villages have mobile outreach sessions to provide routine services and to improve coverage where necessary.

4.9 Reduce missed opportunities and ensure that ill children and women in the childbearing age are immunised as appropriate.

## **5. Referrals**

5.1 Children with signs and symptoms of the EPI priority diseases (AFP, measles, NNT and AEFI) are referred as in the IMCI Provincial protocols.

## **6. Patient Education**

6.1 All clients attending clinics for immunization services receive the appropriate health education, information and support.

## 7. Records

7.1 Patient records and patient notification forms.

7.2 Monthly immunisation statistics.

7.3 Case investigation forms for flaccid paralysis.

7.4 Case investigation forms for measles.

7.5 Case investigation forms for neonatal tetanus.

7.6 Case investigation forms for adverse events following immunisation.

7.7 Supply of child road to health charts.

## 8. Community Based Services

8.1 Communities participate in campaigns and national health days.

8.2 Clinic staff follow up suspected cases of measles at home to determine extent of outbreak.

## 9. Collaboration

9.1 Staff collaborate with other departments like education and other sectors to promote immunization and improve coverage.

### **ADOLESCENT AND YOUTH HEALTH**

#### **SERVICE DESCRIPTION**

Adolescents are aged between 10-19 years and youths between 15-24 years as defined by the World Health Organization. The services provided to these specific groups are tailored to ensure a holistic approach with emphasis on special needs.

#### **NORMS**

1. Regular visits by Primary Health Care coordinators to review health services for adolescents and youth.
2. Staff has continuing professional education on needs of youth and adolescents.

## STANDARDS

### 1. References, prints and educational materials

- 1.1 Clinic has a copy of rights of the child.
- 1.2 All legislation relevant to youth and adolescents is kept in the clinic.
- 1.3 List of relevant NGOs, CBOs and community youth organisations in district.
- 1.4 Planned Parenthood Association of South Africa booklet and other relevant materials to help parents discuss sexuality with youth.
- 1.5 IEC materials and a library of youth related materials.

### 2. Equipment

- 2.1 Adequate equipment suitable for a youth friendly service catering for the health needs of this group.

### 3. Medicines and Supplies

- 3.1 Provided according to EDL.
- 3.2 Condoms are placed in areas where it is not necessary to ask for them and where they can be taken without being watched

### 4. Competence of Health Staff

- 4.1 Staff are able to
  - 4.1.1 Map catchment area and if relevant prisons, orphanages, street children shelters, sports fields, schools and NGOs.
  - 4.1.2 Provide accessible youth friendly services with times or days to suit youth.
  - 4.1.3 Encourage youth to ask questions and seek information.
  - 4.1.4 Communicate well and avoid asking intrusive, irrelevant questions.

4.1.5 Know and work well with youth organisations, sports coaches, teachers, police and traditional circumcisors in the catchment area of clinic.

4.1.6 Educate parents about parenting and provide guidance on improving intra-family and community relationships.

4.2 Clinic have at least one member of the staff competent in counselling and able to assist an individual (or group) to gain an understanding of the situation and make and implement appropriate decisions.

4.3 Staff ensure no opportunity is missed to assist youth in managing fertility and preventing STDs and HIV/AIDS.

4.4 Staff involves adolescent and youth in planning and implementation of services.

## **5. Referrals**

5.1 Referred according to protocols for the relevant conditions.

5.2 Ensure a mechanism for feedback of referred cases

## **6. Patient Education**

6.1 Assist in organizing and participate in awareness campaigns on relevant adolescent and youth health issues

6.2 Involve youth in peer education and support peer education

6.3 Supply of patient information pamphlet in relevant languages on

6.3.1 Growth and development

6.3.2 Gender specific needs of adolescents

6.3.3 Oral care

6.3.4 Nutrition

6.3.5 risks to health of alcohol, smoking, drugs

6.3.6 safe sex, condom use

6.3.7 STD, HIV, AIDS, TB



## **7. Records**

7.1 Staff use information system records to analyse conditions affecting youth (e.g. STD, accidents, infected circumcisions, sports injuries, behaviour problems, teenage pregnancy, TOP, rape, sexual abuse, etc).

7.2 There is a register of disabled youth that indicates all dates of efforts to improve rehabilitation and refer to special school.

7.3 Record is kept of occupational problems of youth in the area e.g. sex work, domestic work, agricultural work etc.

## **8. Community Based Activity**

8.1 Staff are aware of community based initiatives aimed to prevent and respond to problems of youth.

## **9. Collaboration**

9.1 Clinic staff work with social workers, social structures, NGOs and CBOs on adolescent and youth health issues including children at risk problems (adolescents and the law, poor hygiene, sexual abuse, glue sniffing, etc).

9.2 Staff collaborate with other sectors to improve youth health especially with teachers in schools in setting up a child-to-child programme.

## **MANAGEMENT OF COMMUNICABLE DISEASES**

### **SERVICE DESCRIPTION**

This chapter deals with the management of communicable diseases in general with the emphasis on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death. Separate chapters deal with Tuberculosis, HIV infection and AIDS, sexually transmitted diseases, cholera, rabies, leprosy, shigella dysentery and malaria. These are the diseases, which are either priority national public health diseases or are ones associated with the possibility of causing outbreaks. The communicable diseases, which are included in the South African Expanded Programme of Immunisation, and scabies, are dealt with

separately under childhood diseases. Rheumatic fever and helminths are also dealt with separately.

## **NORMS**

1. All clinics are supervised every three months by the District Communicable Disease Control Co-ordinator.
2. All clinics send to the local authority or district health office an immediate telephonic report of acute flaccid paralysis or cholera.
3. Cases referred as notifiable diseases to hospital are notified by the hospitals on a weekly basis on Form GW 17/3.
4. All clinics send an individual notification on Form GW 17/5 to the local authority or district health office as soon as possible.
5. Monthly report on deaths from a notifiable disease are notified on Form GW 17/4.

## **STANDARDS**

### **1. References, Prints and Educational Materials**

1.1 Each clinic has the National and Provincial protocols and policy documents on communicable Diseases and every 6 months reviews them with the Environmental Health Officer of the area.

### **2. Equipment**

2.1 See clinic generic equipment

### **3. Medicines and Supplies**

3.1 As per EDL

### **4. Competence of Health Staff**

4.1 All clinics have a book of notifiable disease forms GW17/5 and complete a form for every notifiable disease. Cases confirmed in

hospital send a copy back to the clinic with the lower part of the form completed.

4.2 When the district office receives a notification the communicable disease control co-ordinator initiates a response, together with the District Environmental Health Officer and the local clinic staff. The Infection Control Nurse of the Hospital and in the case of an outbreak, the outbreak teams and the laboratory are also involved.

4.3 The clinic staffs are able to commence action by taking more complete patient and family histories and by visiting the home and environment to identify other cases and causes which can be prevented. Clinic staff are responsible for stabilising cases before hospitalisation and for taking initial specimens for the laboratory.

4.4 Clinic staff can interact with community health committees to maintain surveillance for cases and to ensure control measures after suitable education.

4.5 The emphasis is always on prevention, early diagnosis and initiation of measures to prevent transmission and serious morbidity, disability and death.

4.6 In endemic areas for Malaria, Schistosomiasis, Cysticercosis and Trachoma clinics receive extra protocols on management from the District Health Offices.

## **5. Referrals**

5.1

## **6. Patient Education**

6.1 All patients attending the service receive health education.

## **7. Records**

7.1 Clinic records of communicable diseases are kept up to date.

## **8. Community Based Services**

8.1

## **9. Collaboration**

9.1 Staff collaborate with other departments like Environmental health, Education and other sections within health like MCHW and Health Promotion.

### **CHOLERA AND DIARRHOEAL DISEASE CONTROL**

#### **SERVICE DESCRIPTION**

Diarrhoeal disease control is an essential daily element of clinic services as well as an element in outbreak prevention and control.

#### **NORMS**

1. Every clinic considers itself part of the Provincial and National Diarrhoeal Disease Control Programme.
2. All staff are trained in the management of diarrhoeal disease and have continuing education every 6 months or when there are reports of cholera outbreaks in neighbouring countries or regions.
3. Every clinic is able to contact and works with the environmental health officer in whose area it falls.
4. Reduce mortality due to diarrhoea in children by 50% (Year 2000 Health Goals and Objectives)

#### **STANDARDS**

##### **1. References, prints and educational materials**

1.1 The clinic has the latest copy of Guidelines for Diarrhoeal diseases and Cholera Control.

##### **2. Equipment**

2.1 Cholera packs for diagnosis and the protocol for stool collection.

##### **3. Medicines and Supplies**

3.1 List of drugs in accordance with the Essential Drugs List

3.2 The clinic maintains a buffer supply of ORS and intravenous fluids.

3.3 Clinic staff know where extra stocks can be obtained quickly in case of emergency

#### **4. Competence of Health Staff**

4.1 Staff have knowledge of the clinical presentation of diarrhoeal diseases and cholera and refer severe cases to hospital having first starting rehydration. Less severe cases are managed at clinic level with oral rehydration.

4.2 Clinic staff are able to manage cases of diarrhoea and dehydration daily during epidemics.

4.3 There is always a state of preparedness for an outbreak of cholera by maintaining a buffer supply of ORS and intravenous fluids.

4.4 Staff are able to recognise the clinical presentation of cholera.

4.5 Suspected cases are reported immediately by phone or other communication method.

4.6 Oral rehydration (with ORS sachets) are used and the patients state of dehydration is monitored while having the ORS.

4.7 Clinic staff encourage use of salt and sugar home-prepared solution when ORD sachets are not available.

4.8 Staff know that cholera infection can be asymptomatic or cases can be mild and indistinguishable from other diarrhoea.

#### **5. Referrals**

5.1 All severely dehydrated cases should be referred to hospital

#### **6. Patient Education**

6.1 All patients and caretakers receive health education on oral rehydration therapy, refuse disposal and cleanliness.

#### **7. Records**

7.1 Patient's records are kept up to date.

7.2 A weekly chart is kept in clinics showing diarrhoea cases under 5

and cases over five and any undue rise especially of cases over 5 is reported to the District Manager.

#### **8. Community Based Services**

8.1 Education is carried out in the community on hygiene, latrine use, hand washing, food safety, boiling of water and milk, chlorination of drinking water if feasible, use of tap water or delivered tanker supplies during an epidemic.

8.2 The value of breast-feeding as a preventive measure is a permanent part of the clinics community health education programme.

#### **9. Collaboration**

9.1 Staff collaborate with other departments like Environmental health, Education and other sections within health like MCHW, Health Promotion.

### **TRAUMA AND EMERGENCY**

#### **SERVICE DESCRIPTION**

Clinics provide emergency and resuscitation service, treatment and referral of patients that have experienced trauma and/or injury and have arrangements to deal with disaster situations.

#### **NORMS**

1. All clinics provide trauma and emergency services.
2. Reduce intentional and unintentional injuries among adolescents, including teenage suicide. (National Year 2000 Goals, Objectives and Indicators.)
3. Increase the proportion of emergency health staff who has basic ambulance assistance qualifications, and who are able to provide emergency care to victims of poisoning, injuries and maternal emergencies. (National Year 2000 Goals, Objectives and Indicators.)

#### **STANDARDS**

## **1. References, prints and educational materials**

- 1.1 Wits University PHC Training Manual for Trauma.
- 1.2 Primary Health Care Manual of the Essential Drugs Programme.
- 1.3 The South African Medicines Formulary.
- 1.4 Any local protocols as decided by the medical directorate of clinic services.

## **2. Equipment:**

2.1 There is an "Emergency Box", containing those items which are needed in an emergency, and a system in place for replenishing it when it has been used.

2.2 The following equipment is kept available:

2.2.1 Clean, preferably sterile, instruments for suturing, with adequate replacements or a sterilising system.

2.2.2 Suture materials

2.2.3 Equipment and IV solutions according to the Essential Drug List.

2.2.4 Stretchers, with or without wheeled trolley.

2.2.5 Crutches.

2.2.6 Wheeled chair.

2.2.7 Body bags / shrouds for dead bodies.

**NOTE:** Even where skills are not routinely available it is still worth having emergency equipment that can be used by visiting staff.

## **3. Medicines and Supplies:**

3.1 The following drugs should be kept, as part of an "emergency box" according to EDL

## **4. Competence of Health Staff**

4.1 A clinic has staff capable of dealing with any anticipated trauma in a safe and effective way and to stabilize and refer patients as

appropriate.

4.2 Staff have skills to identify the nature of injury, and decide on the management needed and its urgency.

4.3 Assess the significance of possible poisoning and institute appropriate counter-measures

4.4 Understand the psychological implications of attempted suicide and ability to render effective immediate care.

## **5. Referrals**

5.1 Staff have a clear understanding of:

5.1.1 Indications for transfer and degrees of urgency, as outlined in local policy.

5.1.2 The mechanism of transfer and the immediate referral channel.

5.1.3 The management of seriously ill patient during transfer.

5.1.4 The management of less severe injuries without transfer.

5.2 A reliable means of communication and transport is available when required.

## **6. Patient Education**

6.1 A mechanism is in place at District level to identify the significant causes of trauma locally.

6.2 Staff identify possible interventions that might be made, involving the community in discussion of implementation and education both in schools and communities.

6.3 The consultation in the clinic is used as an opportunity for talking about prevention and first aid of burns.

## **7. Records**

7.1 A reliable patient-held record system is available.



7.2 Data is routinely recorded and used to anticipate and prepare for disasters

## **8. Community and Home Based Activity.**

8.1

## **9. Collaboration**

9.1 The clinic staff collaborate with the Police and Social Welfare Departments.

9.2 The clinic have clear guidelines on referral and support from the District Hospital and Ambulance Service.

## **ORAL HEALTH**

### **SERVICE DESCRIPTION**

The Basic Primary Oral Health Care Services at clinic level should as a minimum consist of promotive and preventive oral health services (oral health education, tooth-brushing programmes, fluoride mouth rinsing programmes, fissure sealant applications, topical fluoride application); and basic treatment services (an oral examination, bitewing radiographs, scaling and polishing of teeth and simple fillings of 1-3 tooth surfaces including atraumatic restorative treatment (ART)) and emergency relief of pain and sepsis (including dental extractions).

### **NORMS**

1. Expose at least 50% of primary schools to organised school preventive programmes.
2. Everybody in the catchment area is covered by basic treatment services.

### **STANDARDS**

1. References, prints and educational materials
  - 1.1 National Oral Health Policy
  - 1.2 National Norms, Standards and Practise Guidelines for Primary Health Care

1.3 Provincial Operational Health Policy

1.4 Oral health educational material (posters, pamphlets etc).

## **2. Equipment.**

2.1 Dental unit complete with chair, light, hand piece unit with hand pieces, suction and compressor

2.2 Aseptic trolley

2.3 Dental Autoclave

2.4 Amalgamator

2.5 Dental X-ray unit

2.6 Intraoral X-ray film processor

2.7 X-ray view box

2.8 Lead apron

2.9 Ultrasonic scaler

2.10 Dental operating stool (2)

2.11 Dental hand instruments (refer 1.2 above)

Portable dental equipment where fixed facilities are not available.

## **3. Medicines and Supplies**

For details of material required, refer to 1.2 above

3.1 Medicine according to the EDL

3.2 Local anaesthetic materials

3.3 Exodontia and oral surgery procedure materials

3.4 Prophylaxis materials

3.5 Conservative procedure materials

## **4. Competence of Health Staff**

4.1 Community health workers offer oral health education to patients.

4.2 The dental assistant is competent to do patient administration, surgery cleanliness and infection control as well as chair-side assisting.

4.3 The oral hygienist is competent to conduct oral examination, apply

<p>fissure sealants, topical fluorides, scaling and polishing and taking of intra-oral x-rays.</p> <p>4.4 The dental therapist is able to carry out oral hygienist competencies as well as tooth extractions and simple 1 to 3 surface filling of teeth.</p>
<p><b>5. Referrals</b></p> <p>5.1 All patients whose needs fall beyond the scope of services provided at the clinic are referred to the next level of care.</p>
<p><b>6. Patient Education</b></p> <p>6.1 All patients receive oral health education.</p>
<p><b>7. Records</b></p> <p>7.1 Patients records.</p> <p>7.2 Patient register.</p> <p>7.3 Statistics.</p>
<p><b>8. Community Based Services</b></p> <p>8.1 School oral health programmes consist of oral health education, tooth brushing and fluoride mouth rinsing and ART.</p>
<p><b>9. Collaboration</b></p> <p>9.1 Collaboration with other departments: Education, Water Affairs, and Forestry and other sections within health such as Child Health, Health Promotion, Environmental Health, Nutrition, Communication etc..</p>

## **MENTAL HEALTH**

### **SERVICE DESCRIPTION**

Mental health services form part of integrated comprehensive Primary Health Care. The service seeks to improve mental health and social wellbeing of individuals and communities. Promotion of community mental health is included in clinic and

community based IEC. Preventive measures for mental disability are included in all services such as antenatal, infant, child, reproductive health and curative care.

## **NORMS**

1. All clinics have regular visits (for patient care, training, supervision and support) from dedicated mental health or psychiatric nurses from health centers, hospitals or mobile teams based in the district.
2. All clinics have access (by referral or by periodic clinic visits) to specialist mental health expertise (psychiatrists, psychologists, occupational therapists) and social workers from district or regional level at least once a month.
3. In every clinic there is a member of staff who has had continuing education in psychiatry or mental health (including community aspects) in the last year.
4. In every clinic there is at least one person trained in counselling and the management of victims of violence and rape.

## **STANDARDS**

1. References, prints and educational materials
  - 1.1 Mental health policy document for provinces.
  - 1.2 List of visiting psychiatric staff at nearest health centre, district hospital, psychiatric specialist hospital or outreach service.
  - 1.3 Mental health assessment guidelines.
  - 1.4 Psycho-social rehabilitation checklist for community work.
  - 1.5 Checklist for daily living skills for rehabilitated patients.
  - 1.6 Admission procedures under current Mental Health Act.
  - 1.7 Emergency medication protocol.
  - 1.8 Essential drug list for Primary Health Care.
  - 1.9 24 Hour ability to telephone or use radio to psychiatric unit of district hospital or nearest Mental Hospital.
  - 1.10 Posters and pamphlets on mental health, severe psychiatric conditions, available services and user rights.

## **2. Equipment**

2.1

## **3. Medicines and Supplies**

3.1 Emergency and routine medication provided according to protocol and EDL.

## **4. Competence of Health Staff**

### **Recognising mental illness**

4.1 Clinic staff consider risk factors for mental health within their catchment area: poverty, social power, unemployment, ill health, homelessness, migrancy, immigrants, isolated persons, HIV positives etc.

4.2 Staff identify and provide appropriate interventions for patients with depression, anxiety, stress related problems, male violence, substance abuse and special needs of women (childbearing, abortion, sterilisation, disability, malignancy etc.)

4.3 Clinic staff recognise the expression and signs of emotional distress and mental illness early (especially in young patients or in relapse of a psychiatric condition).

4.4 Clinic staff participate in the promotion of healthy life style in clinic attendees and the community.

### **Organising services**

4.5 Staff organise the clinic to have quarter periods of the day set aside for booked interviews.

4.6 Staff provide prompt help from or at the clinic if a patient's condition in the community deteriorates.

4.7 Staff ensure time is allocated for home visits to patients who have returned from mental hospital.

4.8 Staff ensure there is no segregation or stigmatisation at the clinic of

patients who have to use other services e.g. family planning, antenatal care, etc.

4.9 Staff arrange access to a consistent member of staff for each consultation.

### **Managing care**

4.10 Specially trained staff are able to

4.10.1 Maintain relationships with patients that are just, caring, and based on the principles of human rights.

4.10.2 Perform an adequate medical examination which:-

4.10.2.1 Identifies the general mental state e.g. psychotic or depressed.

4.10.2.2 Identifies the severity and level of crisis.

4.10.2.3 Rules out systematic illness.

4.10.2.4 Records temperature and blood glucose level.

4.10.3 Take a history that includes previous service use such as admission to hospital.

4.10.4 Take a family history and evaluate support.

4.10.5 Develop a sustained therapeutic relationship with patients and their families.

4.10.6 Know and implement standard treatment guidelines especially the section on delirium with acute confusion and aggression, acute psychosis and depression.

4.11 General nurses are able to:-

4.11.1 Detect and provide services for severe psychiatric

conditions as a component of comprehensive Primary Health Care.

4.11.2 Make appropriate and informed referrals to other levels of care.

4.11.3 Provide basic psychiatric care and assess urgency and severity of symptoms.

4.11.4 Provide individual community maintenance and care for stable long-term patients who have severe psychiatric conditions and have been discharged from hospital.

4.11.5 Provide each stable long-term user with individualised comprehensive care which includes:-

4.11.5.1 An ongoing assessment of mental state, functional ability and social circumstances.

4.11.5.2 Familiarity with the internationally recognised diagnostic system.

4.11.5.3 An ability to detect and monitor distress and relapse.

4.11.5.4 An ability to provide basic counselling and support to patient and family.

4.11.5.5 A basic knowledge, criteria and pathways for referral for disability grants.

4.11.5.6 Knowing community referral and support organisations.

4.11.5.7 The follow-up of all cases returned to community after hospitalisation and keeping a register.

4.11.5.8 An ability to use records to facilitate continuity

of care, such that:-

4.11.6 The condition of patients in the community is monitored and poor compliance, functional deterioration, substance abuse and family conflict community ridicule are identified.

4.11.7 The onset of mental deterioration in HIV positive patients is recognised.

4.11.8 The prescription of sedation for aggressive of violent patients only as appropriate when other measures fail.

4.11.9 Coping with disturbed, intoxicated, aggressive suicidal behaviour without resorting to violence, abuse of undue physical restraint.

4.12 Clinic staff provide patient and caregiver satisfaction with assistance in alleviating family burden, achieving social integration, improving quality of life and general functioning while improving symptoms.

4.13 Clinic staff conduct consultations in privacy and in a confidential way and informed consent is obtained for communication to others.

## **5. Referrals**

5.1 Referral pathways to other levels or types of care are known and



expedited.

## **6. Patient Education**

6.1 Patients, relatives and the community receive high quality information on mental health and mental illness.

6.2 Patients and their supporters are given individualised education when their situation is reviewed.

6.3 Patients and their supporters are educated on how to recognise predisposing factors and conditions to prevent relapse.

6.4 Clinic staff use education in the family and community to address ignorance, fear, and prejudice regarding patients with severe psychiatric conditions attending the clinic.

## **7. Records**

7.1 Records are kept according to protocol with emphasis on confidentiality and accuracy.

7.2 A register of psychiatric patients in the community is maintained.

7.3 Staff record mental health indicators on:-

7.3.1 The number and mix of cases

7.3.2 The frequency of contact

7.4 Staff analyse indicators and develop appropriate action.

## **8. Community and Based Activity**

8.1 Staff participate in community awareness programmes for mental health according to the national and international calendar.

8.2 Staff participate in the training of family and carers of patients to plan an active role in their rehabilitation.

8.3 Staff encourage patient and caregiver support groups in community.

8.4 Staff keep the addresses and phone numbers of people assisting with mental health and social problems (e.g. women's shelters, community self-help groups).

## **9. Collaboration**

9.1 Staff respect and where appropriate seek collaborative association with local traditional healers.

9.2 Staff collaborate with all community services e.g. crisis counselling (lifeline, priests with counselling skills) and mental health groups especially those for youth.

9.3 Staff collaborate with the hospital for planning discharges to the community.

## **VICTIMS OF SEXUAL ABUSE, DOMESTIC VIOLENCE AND GENDER VIOLENCE**

### **SERVICE DESCRIPTION**

The service, requires co-operation between the health sector, the police and the Department of Justice, provides counselling and referral of victims, STD prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence.

### **NORMS**

1. Every clinic has established working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year.
2. A member of staff of every clinic has received training in the identification and management of sexual, domestic and gender related violence. The training includes gender sensitivity and counselling.

### **STANDARDS**

#### **1. References, prints and educational materials**

- 1.1 All relevant guidelines / protocols related to women health issues.
- 1.2 A suitable library of references and journals on sexual offences, domestic and gender violence.

1.3 The clinic has a list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with these cases.

1.4 The clinic has a list of names and addresses of NGOs or other organisations (e.g. CBO) which undertake appropriate counselling (e.g. FAMSA, ATIC) for violence, child abuse and sexual offences.

## **2. Equipment**

2.1 There is a room available at short notice for private, confidential consultations.

## **3. Medicines and Supplies**

3.1 Emergency contraceptive pills.

## **4. Competence of Health Staff**

4.1 The clinic staff fast track in a confidential manner any rape victim to a private room for appropriate counseling and examination.

4.2 The staff always include a question on gender violence in the history taking from women with depression, headaches, stomach pains or a known abusive partner.

4.3 The staff include diplomatic probing of the domestic situation in taking histories of children with failure to thrive, recurrent episodes of trauma or behavioural problems.

4.4 All cases of sexually transmitted disease in children are managed as cases of sexual offence or abuse.

4.5 When a person presenting at a clinic alleges to have been raped or sexually assaulted the allegation is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity.

4.6 A detailed medical history is recorded on the patient record card and a brief verbal history of the alleged incident is taken and noted - with an indication that these are not a full account. These notes are kept for 3 years.

4.7 Staff explain that referral is necessary to an accredited health practitioner and arrangements are made expeditiously and while awaiting referral emergency medical treatment is given with the consent of the victim: prophylactic treatment against STD and post-coital contraception.

4.8 The victim is given information on the follow-up service and the possibilities of HIV infection and what to discuss with the accredited health practitioner at the hospital or health centre.

4.9 The staff even though non-accredited are not prohibited from dealing with rape victims but must keep patient records.

4.10 Victims are not allowed to wash before being seen by an accredited health practitioner.

4.11 Women who have been raped or abused are attended to by a female health worker and if this is not possible (e.g. a male district surgeon comes to the clinic) then another women is present during the examination.

4.12 The victim is given brief information about the legal process and the right to lay a charge.

4.13 If the victim now indicates a desire to lay charges the police are called to the clinic.

4.14 Clinic staff inquire if charges will or have been laid with the SA Police Service.

4.15

## 5. Referrals

5.1 All patients are referred to the next level of care when their needs fall beyond the scope of competence of clinic staff.

## 6. Patient Education

6.1 All patients, community, and children attending clinic are educated and informed on abuse.

## 7. Records

7.1 Patients records are kept according to protocol with emphasis on confidentiality and accuracy.

7.2 The clinic keeps a confidential record of all claims of sexual offences, wife battering and child abuse (sexual, physical, emotional and nutritional).

## **8. Community Based Services**

8.1 Clinic staff establish links with relevant organisations already operating and providing services for victims of abuse.

8.2 Staff encourage community participation on health promotion to curb domestic and gender violence.

## **9. Collaboration**

9.1 Staff collaborate with other departments like the police, relevant NGOs and CBOs to reduce the violence and give reassurance and support.

### **SUBSTANCE ABUSE**

#### **SERVICE DESCRIPTION**

By preventing and managing substance abuse in the clinic, the service aims to reduce substance abuse among adolescents and also to reduce alcohol related motor vehicle morbidity and mortality. Prevention and management of substance abuse also has relevance for tuberculosis, STDs and HIV/AIDS, mental illness, family violence and educational attainment.

#### **NORMS**

1. Reduce school attendees admitting to drink alcohol and smoke tobacco.
2. Reduce the use of illegal substances including cocaine, mandrax, heroin and marijuana.
3. Reduce the consumption of alcohol and other drugs among women and especially pregnant women.

#### **STANDARDS**

## **1. References, prints and educational materials**

1.1 The latest Report of Mental Health and Substance Abuse.

1.2 Health learning materials on alcohol, cannabis, mandrax and other drugs in local languages.

## **2. Equipment**

2.1

## **3. Medicines and Supplies**

3.1

## **4. Competence of Health Staff**

4.1 Clinics have regular visits by mental health trained staff where training includes care of substance abusing patients.

4.2 Patients are able to request visits by social workers.

4.3 In problem (urban) areas staff attend workshops on relevant substance abuse.

4.4 Patients needing detoxification for substance abuse withdrawal symptoms have entry to clinic care via NGOs, teachers, employers, traditional healers, police and are referred rapidly to general hospitals with detoxification facilities and have a social worker to arrange follow up and social reintegration on discharge.

4.5 Patients referred to clinics by NGO, teachers, employers, traditional healers and police (not requiring detoxification) are given appointments with periodically visiting specially trained mental health nurses.

4.6 Clinic staff have rapport with their communities and are culturally accessible to substance-abusing patients to discuss their problems or have their families discuss their problem with them.

4.7 Patients with TB, STD/HIV, mental disorders and families with violence are sufficiently at ease with staff to be able to bring out any

problem of alcohol or drug abuse.

4.8 In the clinic catchment area or district of the clinic, staff are able to work when required with correctional services, educators, labour, welfare and NGOs (e.g. Alcohol Anonymous).

4.9 Staff can identify tobacco, alcohol and marijuana abuse and provide basic counselling for behaviour changes and referral to NGOs specialising in substance abuse.

4.10 Staff are aware of the age groups at risk and the predominant social settings in the community for substance abuse: e.g. male youth of 10 – 15 age, limited social integration in the family, shebeens and people who have been in prison.

4.11 The clinic arranges meetings between SANCA and parents and teachers to initiate a drug prevention, education and early identification programme.

4.12 Staff participate in life skills programmes in schools and discuss substance abuse.

4.13 Staff mount community awareness programme with youth, NGOs and CBOs.

4.14 The clinic is maintained as a smoke free zone.

4.15 Staff are able to recognise the problem of foetal alcohol syndrome and include education on this with antenatal groups.

4.16 Staff identify patients needing referral, do this with patient compliance, accept patients back for follow up and assist with family reintegration.

4.17 Staff identify school children with behaviour problems and discuss with parents and teachers the possibility of drug involvement.

## **5. Referrals**

5.1 All patients are referred to the next level of care when their needs fall beyond the scope of competence of clinic staff.

## **6. Patient Education**

6.1 All patients attending clinics for service receive health education.

## **7. Records**

7.1 Patients records kept up to date.

## **8. Community Based Services**

8.1 Community encouraged to initiate community based services.

8.2 In client and community discussion staff advise on harm reduction strategies (cigarette smoking, alcohol, glue sniffing) and collaborate with traditional healers who assist substance-abusing clients.

## **9. Collaboration**

9.1 Staff collaborate with other sectors like education, correctional services, labour, welfare as well as other relevant NGOs and CBOs to improve mental health.

9.2 Staff collaborate with traditional healers for involvement in improving mental care at community level.

## **REHABILITATION SERVICES**

### **Basic considerations**

Rehabilitation services are an integral part of the services provided at the primary level. This constitutes a reorientation of rehabilitation from mainly institution-based services to community oriented and community based services. Communities and particularly people with disabilities should be involved in designing, implementing and monitoring services for people with disabilities. This precludes a disability service from being seen narrowly as a therapy service provided only by a certain category of staff. All health personnel in co-operation with all other sectors and the communities/people themselves are responsible for making society inclusive of all people including people with disabilities.

The clinic is the first point where people with disabilities, their family members or caregivers meet health staff. Clinics need to become creative in their approach to the problems experienced by these patients.

### **SERVICE DESCRIPTION**



The purpose of rehabilitation at clinic level is to provide a service to prevent disabling conditions, to detect disabilities early so to prevent complications and the worsening of the effects of a disability on a person's functional ability, to treat disabling and potentially disabling conditions and to provide access to rehabilitative services for people with disabilities, making them appropriate and acceptable.

The pivotal person at the clinic, through whom people with disabilities will access the rehabilitation service, is the PHC Nurse. The Therapy Assistant (Community) is the person providing the rehabilitation service at this level, in consultation with the visiting Therapist. The visiting generalist doctor is important in providing access to treatment of potentially disabling conditions, which would otherwise be difficult for people to access on a regular affordable basis.

**Specific rehabilitative services** include a basic assessment of people with disabilities e.g. stroke, spinal injury, cerebral palsy, developmental delay, blindness, communication problems, arthritis, amputations, backache, followed by an appropriate treatment programme, in consultation with the disabled person and his family. Consumable assistive devices e.g. continence devices, rubber ferrules and other aids to daily living are prescribed, provided and people trained in their use. Management of continence problems of patients with spinal cord injury, spina bifida, mental retardation, traumatic conditions and the elderly includes the supply of continence devices and devising continence programmes.

Patients are assessed for disability and care dependency grant applications.

#### **NORMS**

1. Improve access to comprehensive health services for the disabled. (National: Year 2000 Goals, Objectives and Indicators.)
2. Have a responsive and area-specific disability information system in place, which will feed into the general information system of the district and clinic.
3. Institute a functional referral system between the community-clinic-district hospital, as well as other relevant sectors.
4. Institute a system of obtaining, repairing and maintaining essential assistive devices for rehabilitation at clinic level.

## STANDARDS

### 1. Reference, Prints and Educational Material:

1.1 A register of all local, regional, provincial and national resources for referral for rehabilitation, education and training.

1.2 OT reference pack.

1.3 "Disabled village children" by David Werner, as reference book

### 2. Equipment:

2.1

### 3. Medicines and Supplies:

3.1 Consumables such as axillary rubbers, rubber ferrules and cane tips.

3.2 Ready-made packs on order per specified patient:

### 4. Competence of Health Staff

Clinic Staff are able to:

4.1 Use of standardised questionnaire for the detection of hearing loss.

4.2 Identify and refer patients requiring rehabilitation.

The Therapy Assistant is able to

4.3 Teach prevention of pressure sores and pressure sore care.

4.4 Identify and implement techniques in a walking re-education programme.

4.5 Construct simple aids for daily living from locally available materials and teach the patient how to make and use them.

4.6 Teach mobility and daily living skills to a blind person.

4.7 Identify articulation, language and fluency disorders.

4.8 Plan, implement and monitor language stimulation programmes.

4.9 Use augmentative and alternative communication methods with

appropriate patients, construction of simple communication boards, and teach the family how to use them.

4.10 Plan, implement and monitor basic programmes for the rehabilitation of people with neurogenic disorders of communication.

4.11 Counsel the family and teachers of a person with hearing impairment on simple measures to improve communication.

4.12 Have knowledge of available resources for rehabilitation.

4.13 Construct and instruct in the making of corner chairs with table, standing frames and walkers out of Appropriate Paper Technology.

4.14 Construct and instruct in the making of toys out of locally available waste materials and plan, implement and monitor play and stimulation activities to facilitate development.

4.15 Teach basic maintenance of wheelchairs, hearing aids, callipers and crutches.

4.16 Teach an exercise programme for the prevention and treatment of backache.

4.17 Instruct on back care and joint protection principles to decrease pain and maintain the range of movement in the treatment of back pain and other conditions involving joints.

**Visiting Therapist are able to**

4.18 Design treatment/rehabilitation programmes for people with stroke, spinal injury, spina bifida, cerebral palsy, barriers to learning, sports injuries, backache, arthritis, amputations, blindness, to be implemented by the therapy assistant or family members of the person with a disability.

4.19 Assess people with disabilities for the need for Specialised Assistive Devices, and prescribe and order these from the District, Regional or Tertiary Hospital.

4.20 Assess patients with burn scar tissue, and prescribe and order pressure garments.

4.21 Assess scholars with barriers to learning

4.22 Guide doctor in assessment of degree of disability for applications for disability and care dependency grants.

4.23 Design and direct needs driven awareness raising, education and prevention programmes.

4.24 Assess the need for surgical release of contractures and other corrective procedures.

4.25 Supervise and arrange the continuing education of community therapy assistants.

The visiting PHC doctor is able to

4.26 Assess continence problems, and advise suitable continence management in consultation with the therapist or therapy assistant, patient and family.

4.27 Manage spasms related to spinal injury with drug treatment and/or detection and treatment of stress factors.

4.28 Assess persons for disability grants and care dependency grants.

4.29 Use a Schiotz Tonometer.

4.30 Diagnose disabilities as early as possible, and develop a system of referral. (National Year 2000 Goals, Objectives and Indicators.)

4.31 Clinics are accessible to wheelchairs and trolleys and have toilet facilities for people on wheelchairs.

4.32 People with disabilities are given preference when queuing for services and, where feasible, appointments are given to patients to reduce waiting times.

## 5. Referrals

5.1 From district hospital to clinic:

5.1.1 All patients with newly acquired disabilities, who have completed the acute phase of their rehabilitation for follow up by the therapy assistant.

5.1.2 All newly detected patients with disabilities, who have been assessed by a therapist, doctor or specialist,

for follow up and rehabilitation at the nearest clinic.

**5.2 In the clinic to the rehabilitation service:**

5.2.1 All children detected with a developmental delay for assessment.

5.2.2 Patients with healed burns that cover a joint surface for the prevention of contractures and treatment of scarring.

5.2.3 Patients with disabilities for alleviation programmes and rehabilitation.

5.2.4 All patients with chronic deforming arthritis.

**5.3 Referral of patients to doctor or multidisciplinary team:**

5.3.1 Patients with spinal chord injury with troublesome spasms.

5.3.2 Patients with continence problems for institution of an adequate continence programme.

**5.4 From clinic for specialist assessment or treatment:**

5.4.1 Patients with physical disabilities amenable to corrective surgery, assuming that a therapy follow-up service is available.

5.4.2 Patients with chronic disabling rheumatoid arthritis for assessment and monitoring.

**5.5 From clinic to hospital:**

5.5.1 Patients requiring intensive daily rehabilitative therapy.

5.5.2 Patients with extensive bedsores.

5.5.3 Patients in need of more assistive devices not available at district level.

5.5.4 Complicated burns (facial, perineal, burns involving a joint or over 10% of body surface).

5.5.5 Patients with spinal injury and sudden increase in spasms, temperature and high blood pressure.

5.6 From clinic to other sectors:

5.6.1 Children with sensory loss to LSEN schools.

5.6.2 Patients with disabilities who are capable of working, to department of labour for employment opportunities.

5.6.3 Patients with disabilities for training in suitable occupational skills.

5.6.4 Patients with disabilities that are not suitable for the open labour market, to community groups for disabled people, self-help groups, or protected workshops.

5.6.5 Any other sectors which are deemed useful for the development of social and economic independence of the disabled person e.g. training centres for the blind.

5.6.6 Peer support groups.

5.6.7 Patients with disability who are not acceptably cared for in the community to the welfare department.

5.6.8 Severely disabled children, who are not accepted at schools to community day care centres.

## **6. Patient Education**

6.1 Prevention of bedsores in debilitated patients and patients with sensory loss.

## **7. Records**

7.1 Data collected at clinics to be used for development of a district data base on disability for use for programme planning

7.2 Patient information recorded using the SOAP Format.

7.3 Initial assessment and follow up forms standardised for the district, and kept in the chronic file of the patient at the clinic.

7.4 A summary note of the diagnosis, referral and treatment is in the patient held record.

7.5 The visiting therapist ensures that data and information, and records are accurately and consistently maintained.

7.6 Data fields for clients referred for rehabilitation are included in the clinic register.

## **8. Community and Home Based Activity.**

8.1 Refer patients to community monitoring programmes, mobilise community support, where indicated by the patients' social circumstances to ensure compliance with treatment.

8.2 Needs analysis for rehabilitation in the community, to plan appropriate and effective intervention programmes.

8.3 Home visits on patients to gain insight into their social situation.

8.4 Devise home based rehabilitation programmes for people requiring extended rehabilitation, in collaboration with the disabled person, his family, and/or community.

8.5 Maintain contact with clients through follow up visits.

8.6 Identify and mobilise community resources for groups and peer support, skills training and income generation.

8.7 Supervise, advice and assist community therapy assistants.

8.8 Recommend and assist with implementation of adaptations to client's homes, communities, work areas, or schools.

## **9. Collaboration**

9.1 Develop a responsive disability information system and database in consultation with PHC Nurse, Generalist Doctor, Disabled People's Organisations and Community

**NB : IN COLOR THAT WILL REPEAT ITSELF THROUGHOUT PART 2  
PREFERABLY A DIFFERENT COLOR FROM PART 1**

**PART 2**  
**NORMS AND STANDARDS FOR COMMUNITY BASED CLINIC INITIATED**  
**SERVICES**  
**COMMUNITY LEVEL WATER AND SANITATION**

**INTRODUCTION**

A water supply and sanitation project is part of a comprehensive development strategy. It is people driven and is not sustainable unless people themselves are directly involved. Communities are involved in the planning, design, financing, construction and maintenance of improved water supplies with women's groups taking the leading role. Public and private sector resources provide initial training and long-term support to create an environment in which community management can function. Technology is affordable and sustainable. Development activities are demand driven, community based and of a level to provide a healthy environment which is a human right.

**NORMS**

1. There are functioning community participation structures.
2. There is access to district health expertise including the services of an environmental health officer.
3. Reduce the under 5 mortality rate by 30%.
4. Reduce the mortality of children under 5 due to diarrhea by 50%.
5. Eradicate poliomyelitis by 2002.
6. Reduce the prevalence of underweight for age among children under the age of 5 to 10%.
7. Reduce the prevalence of stunting among children less than 5 to 20%.
8. Reduce the prevalence of severe malnutrition in children under 5 to 1%.
9. Eliminate micro deficiency disorders.
10. Ensure 9.5 liters of water per person per day.
11. The maximum distance that a person has to cart water to their dwelling is 200m.
12. The flow rate of water from the outlet is not less than 10 liters per minute and water is available on a regular daily basis.
13. A water service does not fail due to drought more than once in 50 years and



there is no more than one week's interruption in supply per year.

14. Once minimum quality of water is available, health related quality is important and in accordance with currently acceptable minimum standards with respect to chemical and microbial contaminants and acceptable to consumers in terms of its potability.
15. Adequate basic provision of sanitation is one well-constructed VIP toilet to agreed standards per household.
16. Phase out the bucket system over 5 years.
17. Responsibility for sanitation services lies with the local authority or, if not, the local water committee is the vehicle for sanitation development.

## STANDARDS

1. The capacity building hygiene education and training of the community health committee is achieved through linkage with the health sector as well as other development sectors such as water affairs and forestry.

### The competence of Environmental Health Officers (EHO)

2. The EHO working with the community has the following competencies and hence able to:
  - 2.1 Work with other sectors in development projects.
  - 2.2 Work with local clinic staff for teamwork in motivating community committees to improve water and sanitation.
  - 2.3 Work with health staff of clinics, NGOs and local government structures if present to provide hygiene education and training and build capacity of communities.
  - 2.4 Empower committee through training, technical advice and continuing support and monitoring to undertake and manage their own development including water and sanitation.
  - 2.5 Provide information to schools on undertaking water and sanitation and personal and public health.

2.6 Monitor that sanitation and water systems do not create environmental problems.

2.7 Assist communities develop the capacity to use the cycle of participation — assessment, analysis, and action — and provide particular assistance in preliminary assistance through environmental surveys.

2.8 Work with DWAF personal to explain to communities through individual leadership dialogue or community, workshops the contents of the White Paper:

2.8.1 Water supply and Sanitation Policy 1994

2.8.2 National Sanitation Policy White Paper Oct. 1996, Guidelines for ground water protection for Community water supply and sanitation programme.

### Communities

3. Through education, training and improved communication communities develop the following competencies and hence are able to:

3.1 Get rid of human excreta, dirty water and household refuse in a sustainable way without harm to the environment.

3.2 Improve personal habits and behavior relating to water and sanitation.

3.3 Relate diarrhoeal disease and its effects on nutrition, growth and development of children, skin disease, trachoma, periodic outbreaks of diarrhoea, dysentery, worm infections (including schistosomiasis) to poor water and sanitation in their community.

3.4 Through women's groups work together to achieve both water and sanitation norms for their community and be more competent in rearing their children with good hygiene behavior.

3.5 Ensure that sanitation systems in their community do not pollute rivers, dams and underground water supplies.

3.6 Understand the reasons for and be able to pay for maintenance of

their water and sanitation services.

3.7 Conduct assessments or surveys of the state of water supply and sanitation in their own community.

3.8 Analyse the behavioural, cultural and socioeconomic factors leading to their health problems related to inadequate water and sanitation.

3.9 Through community based education (through schools, churches, groups) ensure that the transmission pathways of disease from waste and excreta are known. These are hands, flies, food, fluids, and soil. The ways of blocking transmission by personal hygiene, household and community hygiene are also known.

3.10 Achieve community hygiene through a high percentage of homesteads improving household hygiene so that there is no environmental contamination from excreta, dirty water and solid waste.

3.11 Improve community hygiene by food vendors and other food handlers being educated about food hygiene based on the WHO Ten Golden Rules for Safe Food Preparation.

3.12 Be aware of community problems created by keeping animals next to homes and of problems arising from blocked drains.

## Health Personnel

4. Clinical staff working with the EHO have the following competencies and are thus able to:

4.1 Ensure that health facilities are models for the community with respect to water and sanitation including patient toilets, staff toilets, and hand washing facilities.

4.2 Lead school or community programme in environmental cleaning days.

4.3 Provide health education on personal hygiene and health to patients, community groups, pre schools and schools.

4.4 Initiate behaviour change dialogue with the community on the use of toilets and use of water to improve health.

4.5 Feedback to the community information of the burden of water / sanitation related illness in the community as shown by analysis of the health information system.

4.6 Ensure that all schools in the catchment area of the clinic are health-promoting schools (good toilets, good water supply, hygienic school feeding programme, hand-washing facilities, continuing education on hygiene).

4.7 Work with community committees to ensure improved sanitation facilities at churches, sports grounds, markets, bus stops and crèches.

4.8 Assist communities obtain government subsidies after having organized themselves and planned a project.

4.9 Provide advice to farmers on improvement of water and sanitation to their workers while also providing hygiene education to the workers.

5. Clinic teams and District Health Management Teams have the capacity to work with local NGOs in sanitation programmes and to assist them

5.1 In their training and capacity building,

5.2 In helping communities plan and implement projects,

5.3 provide health and hygiene education,

5.4 Prepare communication material.

#### **COMMUNITY LEVEL HOME-BASED CARE**

#### **NORMS**

1. Every community provides some home-based care and has access to community-based care through partnership of community-based and clinic-based health services.
2. All clinics serving communities in their catchment areas identify home-based carer co-ordinators for formal and informal sector activities.
3. All communities with home-based care have access to a referral system and to comprehensive support services.
4. All clinics have access to home-based care guidelines and palliative care guidelines so that they can assist communities and families.

## STANDARDS

1. Home-based care is comprehensive and holistic, person centered, sensitive to culture, religion, values and respects privacy and dignity and maintains self-esteem.
2. It empowers and promotes functional independence of the individual and family.
3. The patient, the carer and the community are provided with appropriate targeted education.
4. Home-based care assists in reducing unnecessary visits and admissions to health facilities.
5. Community groups and individual home-based carers receive training from the nearest competent resource – NGOs or the local clinics or visiting health team.
6. Community groups and clinics maintain records of home-care and it's continuity and consistency.
7. Patients referred from a health facility for home care have the homestead carer prepared and given adequate instruction on medication and daily living care. Referring facilities also provide prescribed medicine and assistive devices.
8. Protocols or manuals of care are provided to home-care patients from the local clinic on palliative care and the management of pain.
9. Community-based training of home-carers is based on adult education principles and practical simple guidelines.
10. Health staff assist in the development of case management plans which consider physical and psychological needs, environment social networks, diet, exercise and rest, personal habits, sexuality, recreation, dressing, washing, feeds, toilet, continence, hearing, seeing and home layout.
11. Community groups, family, neighbours or volunteers assist with continuing home needs.
12. Social workers assist with arranging legal assistance (e.g. wills) and application for disability grants and other social support.

13. Integrated community home-based services have a mosaic of categories, (medical, counselling, pastoral, rehabilitation and traditional) brought together around the individual and family through professional co-ordination.

#### Home Care for AIDS

14. Home care for AIDS in the community includes access to common drugs, emotional support, consideration of families; help with households, kind relationships from clinic staff and financial support if available through social welfare or self-help groups.

15. The community care of AIDS patients involves a continuum of care, which links all available resources in a community.

16. The continuum of care starts from initial counselling to include care of psychosocial needs, medical and nursing needs and family needs such as care of children, legal advice and assistance.

17. Clinics, hospices, NGOs and community groups are linked in a network and this can be initiated by the clinic, NGOs or community groups.

18. The aims of AIDS home care are the same as for any home-based health care programme:

18.1 to prevent problems when possible

18.2 to take care of existing problems

18.3 to know when and how to get help.

#### **DIRECTLY OBSERVED TREATMENT (SHORT COURSE) STRATEGY**

#### **"DOTS"**

#### **Service description**

The national TB control strategy of directly observed treatment short course 5 key elements, are :-

- Directly observed treatment by the clinic/treatment supporter for 6 months.
- Short course chemotherapy and uninterrupted drug supply
- Standard reporting and recording system.
- Diagnosis based on positive sputum microscopy.
- Commitment to the DOTS programme by all.

## **NORMS**

Achieve a minimum community-based directly observed tuberculosis treatment cure rate of new sputum positive TB cases of 85%.

## **STANDARDS**

### **Accessibility**

1. DOTS supporters for TB cases are as near to the home of cases as is convenient to ensure regular treatment and periodic clinic supervision.

### **Equipment**

2. Community supporters of DOTS will have:
  - 2.1 a box in which to store the supply of drugs specific for each patient being supported,
  - 2.2 a supply of green cards for recording (as a duplicate) the treatment given while the patient keeps the original card issued by the clinic,
  - 2.3 patient education material in the correct language.

### **Training**

3. All community DOTS supporters have received a course of training equivalent to at least one week, either continuous or in sessions.
4. Training covers knowledge, attitude change and skills in communication, simple counselling and problem solving in providing correct continuous directly observed treatment.
5. Suitable training manuals and health learning materials are provided.

### **Supervision**

6. DOTS supporters in the community receive supportive supervision by regular contact with the clinic nurse who will also record continuity of progress in the clinic TB register.

### **Evaluation**

7. Success is measured by recording:

7.1 The number of missed treatments and

7.2 The rapidity of re-establishing continuous treatment and sputum conversion at 2 months for new cases and 3 months for re-treatment cases and at 6 months and 8 months for new and re-treatment cases respectively.

7.3 % of patients on DOT.

7.4 smear conversion rate at 2/3 months of treatment.

7.5 % of patients who are cured.

### **Community Support**

8. The community health committee participates in identifying new potential DOTS supporters. This is a partnership between supporter, patient and clinic *with the patient deciding who his supporter will be.*

9. Committees may provide non-financial incentives such as community recognition of outstanding voluntary DOTS support.

### **Referrals and Transfers**

10. All referrals and transfers of community based DOTS patients are documented on the correct forms and followed up by the referring or transferring health facility.

## **INTEGRATED NUTRITION PROGRAMME**

### **BASIC CONSIDERATIONS**

The vision for nutrition is optimum nutrition for all South Africans. It is recognised that nutrition is multi-sectoral and complex. Nutrition status is improved through a mix of direct and indirect nutrition interventions implemented at various points of service delivery such as clinics, hospital and communities and aimed at specific target groups.

### **NORMS**



1. Ensure that 25% of all health facilities are baby friendly.
2. Increase the proportion of mothers who breastfeed their babies exclusively for at least six months of age and who breastfeed their babies for at least 12 months of age.
3. Contribute to the reduction of mortality due to infectious diseases particularly diarrhoea, measles, and acute respiratory infections in children 5 years of age by 50%, 70% and 30% respectively, through nutritional support and counseling.
4. Contribute to the prevalence of low birth weight to 10% of all live births.
5. Increase regular growth monitoring to reach 85% of children 2 years of age.
6. Reduce the prevalence of under weight (weight-for-age) among children 5 years of age to 10%.
7. Reduce the prevalence of severe underweight (weight-for-age) among children 5 years of age to 1%.
8. Reduce the prevalence of stunting (height-for-weight) among children 5 years to 20%.
9. Reduce the prevalence of wasting (weight-for-height) among children 5 years of age to 2%.
10. Eliminate micro nutrient malnutrition:
  - Reduction of Vitamin A deficiency in children under 5 years of age with serum retinol 20ug/dl,
  - Reduction of Iron deficiency anaemia rates in children and women.
  - Reduction of Iodine deficiency rates.
11. Reduce disease of lifestyle related to over-nutrition.

## **STANDARDS**

### **1. References, prints and educational materials**

- 1.1 The South African Breastfeeding Guidelines for Health Workers.
- 1.2 Policy Guidelines and Protocols on Vitamin A Supplementation.

- 1.3 Vitamin A Brochures for Health Workers.
- 1.4 Guidelines for Health Facility Based Nutrition Interventions to Prevent Malnutrition in South Africa.
- 1.5 Integrated Management of Childhood Illnesses Manuals (Nutrition Module in the IMCI Manuals).
- 1.6 Integrated Nutrition Programme for South Africa. Broad Guidelines for Implementation- Draft Document 5 January 1998 (Being Reviewed).
- 1.7 National Food Service Management Guidelines (Draft)
- 1.8 National Guidelines on Nutrition for People Living with HIV/AIDS (Draft)
- 1.9 Growth Monitoring and promotion guidelines and manuals (draft)

## **2. Equipment**

- 2.1 Road-to-Health Charts
- 2.2 Weighing scales
- 2.3 Non-stretch tape measures
- 2.4 Dolls for demonstration purposes.
- 2.5 Nutrition Education tools.

## **3. Medicine and Supplies:**

- 3.1 Vitamin A capsules.
- 3.2 Iron and folate capsules
- 3.3 Nutrition supplements. ("PEM" scheme)

## **4. Competencies:**

4.1 Staff working at the district level have the following competencies, particularly applied to community- based, integrated nutrition (the competencies listed below are applicable to health workers other than dieticians and nutritioninst):

- 4.1.1. An understanding of the principles of nutrition.
- 4.1.2 An understanding of the conceptual framework for

the analysis of nutrition problems in communities.

4.1.3. The ability to design, implement and evaluate intersectoral programmes.

4.1.4. The capacity for project management and application of innovative approaches to nutrition issues.

4.1.5. The ability to communicate with a target group, analyse its needs and make appropriate choices of communication media and materials.

4.1.6. The ability to train at community and other levels using good educational practice.

4.1.7. The ability to follow-up and monitor the growth of children using the Road to Health Chart

4.1.8. The ability to recognise under-nutrition, micronutrients deficiency and obesity, and appropriately counsel and advise clients.

4.2. The ability to give basic nutrition advice and counseling particularly on the following:

- Nutrition during pregnancy, breast feeding and complementary feeding
- Infant feeding options for HIV positive mothers
- Feeding during illness such as diarrhoea and other infections
- Young child feeding practices
- Importance of micro-nutrients and choice of micro-nutrient rich foods
- Food hygiene

4.3. The ability to recognise severe signs of malnutrition and take appropriate action

## 5. Referrals:

There is effective and efficient referral and counter referral system between district health facilities and community based services.

5.1. Mothers are referred to breastfeeding support groups

5.2. Clients on the Supplementation Programme are referred to the next level of care.

5.3. Severe cases of malnutrition are referred to the next level of care.

5.4. Patients with a need for additional health and social services are referred as appropriate.

**6. Patient Education:**

6.1 Appropriately counsel and advise clients on under-nutrition, micronutrient deficiency and overnutrition.

6.2 Appropriately counsel and advise clients on breastfeeding and complementary feeding.

6.3 Appropriately counsel and advise clients on infant feeding options for HIV positive mothers.

6.4 Counselling and support of current coping strategies.

6.5 Counseling on growth promotion

6.6 Counseling on nutrition during the life cycle as appropriate.

**7. Records:**

7.1 Children's weight and height is recorded and graphed accurately on the Road to Health Chart.

7.2 Charting of weight and other appropriate parameters by the client on a home monitoring programme.

7.3 Supplement provided recorded on statistical returns

**8. Community and Home Based Activity:**

8.1 The active participation of households, community leaders and structures, NGOs, CBOs and other community role players are mobilised in the district.

8.2 Household coping strategies already in place are supported.

8.3 Communities are empowered with the necessary skills and knowledge to become self-reliant with regard to their food and nutrition needs and to be in control of factors affecting their nutritional well being.

8.4 Community health workers are utilised to initiate community growth monitoring and identification of nutrition problems.

## **9. Collaboration:**

9.1 Intersectoral collaboration of line departments and other sectors are mobilised at all levels to ensure joint action to ensure nutrition problems are addressed

9.2 Collaboration between health-facilities and community-based programmes to implement the community component of the Integrated Management of Childhood Illness.

### **SCHOOL HEALTH SERVICES**

#### **Basic Considerations**

The School Health Service is expected to provide a health promoting services by acting in a co-ordinating role, making use of the skills and capacity in different sectors of society, including the community, the learners themselves, educators and NGOs.

Standards set for the School Health Service need to take into account the diverse situation of schools and school health services at present and the changing philosophy introduced by the education sector, including outcomes based education and inclusive education. The introduction of the philosophy of inclusive education means that children with barriers to learning will be included in ordinary schools and that these schools and communities will have to be develop to provide acceptable services for these children. Teachers generally do not have the capacity to deal with these children and the school health services can play a role in enabling teachers to identify and integrate these children into the classroom. School Health personnel may not have the capacity to implement their new role so a transformation-training programme is required. New resources for school health promotion need to be developed and funded. The School Health Teams are becoming an integral part of the primary health team and intrasectoral (i.e. they work with other sections of the Health Department).

These recommended standards are based on the assumption that the Primary Health Service is built on the Sub-district approach to service delivery.

#### **Service Description**

The school health service is a health promotive service dealing with the individual in the context of the family and community and with the school environment. The

service encourages the school to seek to develop and implement school policies that promote and sustain health, improve the physical and social environment within which children learn and develop and improve children's capacity to become and stay healthy.

#### **Norms:**

1. Each sub-district has a minimum of one School Health Promoting Team.
2. Every clinic will be able to access a specially trained nurse on school health within the district
3. District School Health Promoting Teams are supported from provincial level with an appropriate, effective transformation training programme, and the development of standardised resource packs and the training occurs during those times of the year when schools are closed. The transformation is completed by the year 2003.
4. Screening Programmes are provided to give adequate coverage to identify all children at risk of barriers to learning and are not limited to certain age groups.
5. The School Health Promoting Service creates a positive learning environment, by identifying barriers to learning, and developing ways to remove these barriers in a community inclusive way.
6. School Health Promotion Programmes promote acceptance and celebration of diversity among individuals through a learner centred approach.
7. An accessible, healthy physical and social environment in which children can learn is promoted.

#### **Standards**

##### **1. References prints and Educational Material**

1.1 A standardised questionnaire for use by teachers to screen for the presence of factors causing barriers to learning in the individual (e.g. "School Readiness Screening Pilot: April – July 1997, School and Youth Health Directorate" and a questionnaire developed by an

Intersectoral team in the Ladysmith Region of Kwazulu-Natal).

1.2 A standardised questionnaire for use by school health promoting teams to assist them detecting barriers to learning in the environment of the learner (e.g. the draft of "The Index - an instrument to assess Health Promoting Schools in South Africa").

1.3 A resource register for the district for use by School Health Promotive Teams and Educators, by which available health services can be identified, and how they can be accessed, to be compiled by each district and regularly updated.

1.4 Health promoting educational materials in the local language and accessible to people with disabilities, including films, videos, posters, booklets, visual aids and audiotapes.

## **2. Equipment**

2.1 As for mobile teams

2.2 Projector, video recorder, slide projector, white boards and audiotapes.

2.3 Access to administrative support, including typing services, telephone and fax, photocopying services, stationary and appropriate transport for the environment.

## **3. Medicines, supplies and assistive devices**

3.1 Access to medication for control of specific disease conditions identified at district level, e.g. prevention of blindness from trachoma, treatment of scabies outbreak.

3.2 Assistive devices for daily living for people with disabilities. (Assistive devices required to access education is supplied by the Education Department).

## **4. Competencies**

4.1 The School Health Promoting Team is able to:

4.1.1 Function as an effective and efficient team.

- 4.1.2 Promote the whole person and life-style skills development of pupils and educators.
- 4.1.3 Identify resource people and involve them to promote the transformation.
- 4.1.4 Promote community participation and the participation of all stakeholders in programmes e.g. Participatory Learning and Action (PLA) skills.
- 4.1.5 Plan and implement health promoting programmes.
- 4.1.6 Apply and interpret the screening questionnaires for individuals and schools and transfer these skills to the teachers.
- 4.1.7 Identify gaps in the service and barriers to learning.
- 4.1.8 Promote healthy nutrition, mental health and reproductive health.
- 4.1.9 Counsel for substance abuse and victims of violence including rape.
- 4.1.10 Identify and seek to reduce stress.
- 4.1.11 Promote healthy sexuality and deal with the results of unhealthy sexual behaviour.

## **5. Patient Education**

- 5.1 Address health risk behaviors with the provision of behaviour specific knowledge and opportunities to practice knowledge and skills.

## **6. Referrals**

- 6.1 Refer to nearest clinical service, the students that require more intense clinical assessment and management.

## **7. Records**

- 7.1 An information system at all levels of the service, which informs the different sectors to make effective use of existing services, identifies gaps in the service and monitors the progress toward the development of Health Promoting Schools.



## **8. Community based activities**

8.1 Promote the development of child-to-child programmes as an important resource.

8.2 Work with school boards to promote activities in the community such as libraries and sport activities.

## **9. Collaboration**

9.1 Clinic staff collaborate with and involve officials from health, welfare, education, agriculture sectors, educators, learners, parents, community leaders CBOs and NGOs,

9.2 School Health Promoting Teams are intra- and intersectoral.

### **COMMUNITY BASED REHABILITATION**

#### **Service description**

The philosophy of Community Based Rehabilitation (CBR) is to promote the concept of shared governance, namely the active participation of people with disabilities and their family members in:

- Developing of a vision for their lives within the society in which they live,
- Identifying the needs and resources of people with disabilities within the community,
- Planning and implementing the vision and
- Monitoring and evaluating its implementation.

This participatory approach to governance and service implementation takes place at all levels of society from central government down to community groups and home based care. This chapter describes what happens in the community and at home, after listing the norms and standards that apply at all levels in society.

#### **Norms**

#### **STANDARDS**

#### **1. References, prints and educational materials:**

- 1.1 Disabled Village Children: David Werner
- 1.2 WHO Manual on Community based Rehabilitation.

## 2. Equipment:

### 2.1

## 3. Medicine and Supplies:

3.1 Medical and surgical supplies and assistive devices are accessed from the nearest health facility.

## 4. Competencies:

### 4.1 Community groups skills are available

4.1.1 To organise and run regular, focused and functional meetings.

4.1.2 In record keeping and minutes taking.

4.1.3 To run committees and resolve conflicts.

4.1.4 In bookkeeping, financial reporting and operating a bank accounts.

4.1.5 In writing proposals and fund-raising.

4.1.6 In developing job descriptions and monitoring the services of employees like cooks, day-care providers, drivers, etc.

### 4.2 Day caretakers have

4.2.1 Basic training in early education and can carry out a basic rehabilitation programme under the guidance of a therapist or therapy assistant.

4.2.2 The ability to

4.2.2.1 do a basic assessment of the rehabilitation needs of the children in their care, and record this in the local vernacular

in a standardised format.

4.2.2.2 keep a progress record of a child in his/her care in the local vernacular.

4.2.2.3 keep a daily journal of their activities, attendance and incident registers and write half-yearly reports of the child's progress to the parents.

4.2.2.4 construct toys from locally available material and plan stimulation programmes for a group of children.

4.2.2.5 counsel parents on handling of the child.

4.2.2.6 Identify children who are not adequately cared for by their families, even with support from community services, and refer these to welfare services.

4.2.2.7 Know which social grants are available to people with disabilities and how to apply for such assistance.

4.2.3 Self-help and Income Generating Groups have skills are available in financial management and marketing products made.

### **Organising the service at all levels**

4.3 Districts have a community-based level of service for rehabilitation, which is provided in partnership with people with disabilities and their caregivers.

4.4 Councils are in place at district and community level, based on the shared governance structure described as the model in the white paper on disability.

4.5 Health Department representatives at these levels participate in,

and actively promote, the shared governance structures, in an empowering way, putting the leadership into the hands of the people with disabilities.

4.6 Health forums, hospital boards and community health committees have at least one member with a disability.

4.7 Meetings of the committees and boards are conducted in barrier free circumstances.

4.8 Services for people with disabilities are given priority.

4.9 The Health Sector gives technical support to shared governance structures and community-based services.

4.10 People with disabilities are involved in setting up and implementing disability information systems at all levels of service provision, and this information is used to prioritise and plan services.

#### **Organising the service at community level**

4.11 Opportunities are developed for care givers of disabled children, or people with disabilities to be involved in providing community based services.

4.12 Community based services include day care facilities for children with multiple severe disabilities, support groups, self help groups, protected workshops, home based care, sport opportunities and instruction for people with disabilities.

4.13 Each sub-district has a centre for rehabilitation with, as a minimum, facilities for day care and a workshop.

4.14 Community based service points are visited by a therapist or therapy assistant.

4.15 Suitable space is available for these services to be provided on or within health service facilities, if needed.

#### **5. Referrals:**

5.1 There is effective and efficient referral and counter referral system between district health facilities and community based and owned

facilities.

**6. Patient Education:**

6.1 Assist in empowering people by them recognising their self-worth.

6.2 Handling of behavioural problems.

**7. Records:**

7.1 A progress record of a child in his/her care in the local vernacular.

7.2 Daily journal of day care centres, their activities, attendance and incident register.

7.3 Regular reports on the child's progress to the parents.

7.4 Record of a basic assessment of the rehabilitation needs of the children in their care in the local vernacular in a standardised format

**8. Community and Home Based Activity:**

8.1 Needs driven community training, counselling and awareness raising programmes to address issues concerning people with disabilities operate from these centres.

8.2 Community groups are actively involved in awareness raising activities within the district, especially the International Day of Disabled and other special days with related topics.

**9. Collaboration:**

9.1 People with disabilities are involved in the planning, setting of *standards and monitoring of the services of which they are the main benefactors.*

9.2 Issues pertaining to disability are addressed, through intersectoral collaboration, with the community at community based service points.

9.3 Community based services are provided within a framework of accountability to a committee made up of stakeholders, which receives technical support from a service provider.

9.4 Rehabilitation centres are further developed to provide contact/service points with other sectors, e.g. welfare, labour,

education, agriculture, as well as community gardens and adapted gardens for people with disabilities, sports facilities for disabled persons, and short term half way house boarding facilities.

9.5 Therapists and therapy assistants assist community-based groups to contact services from other sectors, NGOs and Disabled People's Organisations (DPO's).

9.6 District maintenance personnel provide technical support for these services e.g. construction of aids for daily living for individual clients.

9.7 Opportunities to contract the provision of services for the health sector to people with disabilities are developed e.g. making of pressure garments, sewing or repair of hospital linen, making of special chairs from Appropriate Paper Technology, garden services.

9.8 The education sector makes use of the resources within the Community Based Rehabilitation service to cater for the educational needs of children and adults with barriers to learning, and provides technical support to the groups.

9.9 Community Groups remain in contact with the Department of Labour, and are given priority in suitable skills training programmes.

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## ABBREVIATIONS

AEFI	Adverse Effects Following Immunisation
AFP	Acid Fast bacillus
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante natal care
ARI	Acute Respiratory Infections
ART	Atraumatic Restorative Treatment



ATICC	Aids Training and counseling center
BCG	Bacillus
CBO	Community Based Organisation
CBR	Community Based Rehabilitation
CDL	Chronic Diseases of Lifestyle
CHW	Community Health Worker
CSF	Cerebro Spinal Fluid
DISCA	District STD Quality of Care Assessment
DOTS	Direct Observed Treatment
DPO	Disabled People's Organisation
DPT	Diphtheria-Pertussis-Tetanus
EDL	Essential Drug List
EHO	Environmental Health Officer
EPI	Expanded Programme of Immunisation
FEFO	First expiry, first out
FP	Family Planning
HBV	Hepatitis B Virus
HIB	Haemophilus vaccine
HIV	Human immunodeficiency Virus
IEC	Information Education and Counselling
IMCI	Integrated Management of Childhood Illnesses
INH	Isoniazid
MCWH	Maternal Child and Women's Health
MTCT	Mother To Child Transmission
NCSNET	National Commission of Special Needs in Education and Training
NCESS	National Committee on Education Support Services
ORS	Oral Rehydration Solution
OT	Occupational Therapy
PEP	Perinatal Education Programme
PHC	Primary Health Care
PLA	Participatory Learning and Action
PNC	Post Natal Care
POP	Plaster of Paris
RPR	A syphilis test
SOAP	Subjective, Objective Assessment Plan
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TBA	Traditional Birth Attended

TOP	Termination of Pregnancy
TT	Tetanus toxoid
UV	Ultra Violet
UNICEF	United nations Childrens Fund
VDRL	Venreal Diseases Research Laboratory Test for Syphilis
VIP	Ventilated latrine
WHO	World Health Organisation

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