Cape Peninsula
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A COMMUNITY-INVOLVEMENT MODEL FOR IMPROVING PRIMARY HEALTH CARE SERVICES IN A WESTERN CAPE METROPOLITAN MUNICIPALITY

by

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I further declare that all the sources used or quoted in this thesis have been indicated and acknowledged as complete references.

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ABSTRACT

Community involvement in the public domain is a subject of great complexity, despite the large body of legislation internationally, nationally and within the City of Cape Town. This study analyses attempts by central, provincial and local spheres of government to honour the constitutional provision of the right to have access to health services. The study consists of an extensive review of the literature that comprises books, legislation and journal articles accessed from the internet. In the process, a study is made of community involvement theory, primary health care (PHC) theory and legislation pertaining to health. On the basis of this study, an input/output transformational systems model is presented of how the Health Department of the City of Cape Town can guide its management staff in achieving their primary health care objectives. The model is a normative one intent on assisting managers to attain understanding of set objectives effectively and efficiently. The assumptions underlying the model emphasise that the model strives to improve performance. Data were collected by means of a mixed approach of a questionnaire and semi-structured interviews among clinic management staff in the Health Department and ward committee members from the subcouncil. The analysis of the data collected by the questionnaire was done using SPSS, with the assistance of a registered statistician. Four major focus areas transpired from the quantitative instrument. These areas of significant concern are clinics do not have community profiles; the risk management of prevailing diseases in certain communities; clinic staff are not familiar with ward councillors or community leaders; and inactive health committees. However Ward committees as described in the Municipal Structures Act No. 117 of 1998 part 4 section 72 (3), a ward councillor represents a ward in council, with 10 additional members representing women and disabled, arts and culture, business, community based organisations, designated vulnerable groups, education, environment, faith based organisations, safety and security organisations, sports and youth. This advantages opportunity to incorporate ward committees (legislative governance representative structure) in planning health programmes must be given earnest consideration within the current resource scarce environment. Hence the proposed model for health and wellbeing, indicate “community governed” as component A in the model. The community governed oblidge the clinic to conduct a community needs assessment or focus group (community profile) sessions, that will eventuate into capacity building, partnerships and community self-reliance. Hence ward committees and health committees interrelations across provincial and municipal health governance structures within

the Western Cape. One critical aspect in the provision of primary health care that enjoyed attention during the semi-structured interviews is the inaccessibility of health clinics owing to safety and public transport. The study concludes by advising on the feasibility of conducting further research on the importance of community profiles in the provision of primary health care.

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DEDICATION

This thesis is dedicated to my late father and mother, Christian Abraham and Edith Norah Sayers.

LIST OF ACRONYMS AND ABBREVIATIONS

LIST OF ACRONYMS

AHAC	Aboriginal Health Access Centres
AOHC	Access to Ontario Health Centres
AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
APRM	African Peer Review Mechanism
CBO	Community-Based Organisation
CFHT	Community Family Health Teams
CGPHC	Community-Governed Primary Health Care
CHC	Community Health Centres
CIH	Community Involvement in Health
CDW	Community Development Worker
CoCT	City of Cape Town
CODETA	Congress of Democratic Taxi Association
COSATA	Congress of South African Taxi Association
CPUT	Cape Peninsula University of Technology
DA	Democratic Alliance
DBSA	Development Bank of South Africa
DCST	District Clinical Specialist Team
DHIS	District Health Information System
DMRE	Department of Mineral Resources and Energy
DHS	District Health Services
DMT	District Management Team
DOH	Department of Health
EU	European Union
FET	Further Education and Training
GP	General Practitioner
HBM	Hepatitis B Virus
HCT	Health Counselling and Testing

HFA	Health for All
HFB	Health Facility Board
HiAP	Health in All Policies
HIV	Human Immunodeficiency Syndrome
HRH	Human Resources for Health
HST	Health Systems Trust
IAP2	International Association for Public Participation
IC	Ideal Clinic
ICU	Intensive Care Unit
IDP	Integrated Development Plan
ILO	International Labour Organisation
IY	Imizamo Yethu
IMC	Inter – Ministerial Committee
IMCI	Integrated Management of Childhood Illnesses
MDR-TB	Multidrug-Resistant Tuberculosis
MEC	Minister of the Executive Council
MHWB	Model of Health and Well-being
NACOSA	National AIDS Coordinated Committee of South Africa
NCD	Non-Communicable Diseases
NDoH	National Department of Health
NHA	National Health Act
NHI	National Health Insurance
NDoH	National Department of Health
NDP	National Development Plan
NGO	Non-Governmental Organisations
NHI	National Health Insurance
NPLC	Nurse Practitioners Lead Clinics
PAR	Participation Action Research
PC	Primary Care
PHC	Primary Health Care
PGWC	Provincial Government of the Western Cape
PMTCT	Prevention of Mother to Child Transmission

PPHC	Personal Primary Health Care
RDP	Reconstruction and Development Plan
OHSC	Office of Health Standards Compliance
UNICEF	United Nations International Children's Emergency Fund
UN-Habitat	United Nations Habitat
SANAC	South African National AIDS Council
SANCO	South African National Civic Organisation
SLA	Service-Level Agreement
STI	Sexual Transmitted Infections
TAC	Treatment Action Campaign
TCDV	Technical Cooperation among Developing Villages
TB	Tuberculosis
UHC	Universal Health Care
UNICEF	United Nations Children's Fund
USSR	Union of Soviet Socialist Republic
UCT	University of Cape Town
UHC	Universal Health Care
UWC	University of Western Cape
VHW	Village Health Workers
WCC	World Council of Churches
WIC	Women Infant and Children
WBOT	Ward-Based Outreach Team
WHO	World Health Organisation
WISN	Workload Indicators for Staffing Needs
WPTPS	White Paper on Transformation of Public Service
XDR-TB	Extensive Drug-Resistant Tuberculosis

GLOSSARY OF TERMS

Accessibility

According to Alperstein (2018:8), access means that health care must be available when and where communities can get it. A health service needs to be culturally appropriate and in a language that people can understand to be truly accessible.

Community

According to Visser and Moleko (2014:6), a community is simply a group of people living in a certain area. Borders are easily recognized on a chart and serve to define the boundaries of states, municipalities, and neighborhoods. Communities frequently form interpersonal relationships based on shared experiences and closeness rather than always on preference (Visser & Moleko, 2014:6).

Community involvement

Community involvement concerns the essentially interactive, constructive and problem-solving orientation of those involved. Community involvement denotes that communities have a necessary part to play in community development instead of being dictated to. Communities must therefore be motivated to play an active role in their development (Madumo, 2014:133).

Equity

Above all, those who meet the highest standards ought to be given preference or receive a larger share of the resources allocated to health care. This is the equity principle, which aims to achieve equally good health for all, but it does not imply equal treatment for all. Rather, equity provides additional resources where they are most needed (Alperstein, 2018:24).

Governance

Governance, which goes beyond simple government, implies a means of communication between a government and the society it rules over. A society manages its economic, political, and social affairs through interaction within and among the state, civil society, and private sector through a system of values, policies, and institutions known as governance (Cloete & Mmakola, 2018:106).

Health

Health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity (Van Rensburg, 2012:3).

Ward committees

The responsibility of ward committees is to notify the municipality as a structural representative of the community and its citizens. Inform ward councillors about the needs and matters affecting the lives of communities and escalate it to municipal exco (RSA, 2000).

World Health Organization

The World Health Organization (WHO) was established in 1947. The WHO coordinates international health work and gives direct technical support to countries, thereby aiming to reduce inequities in access to health care both within and between countries, to foster cross-sectoral collaboration, to promote and protect health, and to control specific health problems.

Primary Health Care

PHC is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Dennill & Rendall-Mkosi, 2015:4).

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CHAPTER ONE:
INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

The communities participation discourse is a central tenet for South Africa's democratic dispensation. Therefore, the Republic of South Africa Constitution, Act No. 108 of 1996, the National Health Act No. 61 of 2003, together with the Municipal Systems Act No. 32 of 2000 are important items of legislation, among others, which encapsulate aspects of public participation, referred to as community involvement throughout this thesis. The primary health care (PHC) ideology encompasses community accessibility, including substantive factors such as affordability and local governance that can and will eventuate progressive livelihood (Engelbrecht & Van Rensburg, 2012:484). In the Health Department of the Cape Town municipality, a community involvement model for primary healthcare delivery is outlined in this study. The study objectives include examining the health care legislative framework, analysing the philosophical underpinnings of primary health care (PHC), investigating the community involvement theory, and conducting an empirical qualitative survey among ward committee members and a quantitative questionnaire with managers. The study comprise: an initial, literature review of contemporary, current and accessible books, papers, reports, legislature, policies, media reports and interviews. In the end, the study conducted a pragmatic review using interviews and a questionnaire for a sample of the research population. Recommendations are made to address the research problem based on the empirical study.

1.2 Study background

Since the inception of primary health care (phc) communities have been the intended decision-making participants. The PHC phenomenon adopted at the World Health Organization (WHO) 1978 international conference envisaged aspects for example community self-governance and ownership of health problems as the essence to PHC success. Therefore, collective decision-making regarding the application, development and reviewing of health programming are the standard prescribed by the WHO. However, an autonomous management sentiment persists at City of Cape Town (CoCT) health clinics. Despite the comprehensive policies at national, provincial and municipal levels, one still finds the exclusion of civil society in matters affecting their health.

First, the health committee, as identified in legislation, is a communication medium between public health institutions and civil society. The formal communication structure for phc facilities is the health committee, as agreed by authors. Lack of political commitment, cooperation, support from the health services, and limited participation by facility managers and ward

council members are some of the factors that adversely affect the effectiveness of health committees (McKenzie, Schneider, Schaay, Scott & Sanders, 2017:9). A National Department of Health survey discovered that, out of 2762 health facilities that only 57% of clinics reported having health committees (McKenzie et al. 2017:13).

Lastly, extraction of data is centric to primary health care (PHC) service delivery at the 12 clinics within eastern subdistrict (from Kuilsriver to Gordons bay area) demarcated municipal geographical area. In other words, patient data are being captured without being utilised to manage priority disease trends in certain communities. Data captured by clinics on child immunisation, severe diarrhoea, HIV, TB and other are pivotal for prevention and disease management practice and programmes. Schneider (2011:117) states: “a doctor monitors the health of a patient by taking vital signs – blood pressure, heart rate, and so forth”. Clinic staff monitors the communities wellness by collecting then analysing disease data. The data are called health statistics. Statistics are a vital part of PHC assessment in communities served by the clinics. The statistics are used to identify special risks groups, to identify new health threats, to plan PHC programmes and evaluate the success, and prepare government budgets. Thus community representatives in clinic catchment areas, who possess credibility, local knowledge and skills that health professionals often lack. Should be involve in planning PHC programmes (Schneider, 2011:117). An successful example from a Cape Town community leadership, who transmuted a day clinic into a 24 hour health facility. The facility service hours expansion significantly increased access to emergency services for many in the community, particularly vulnerable and disadvantaged groups, as the closest emergency medical services had previously been out of reach for those without a vehicle or the money to secure transportation (Padarath et al., 2015:236). More reference to community governance outcomes is outlined in chapter five section 5.9.7.

A 2018 National Tuberculosis (TB) survey revealed that 66% from the 15–24-year-old population group did not seek care (Theron, 2021) because health facilities were situated too far from their homes, or they were not able to attend because they could not take off a whole day from work to seek care. Also, TB prevalence in men was 1.6 times higher than among women (Refer to Appendix 1: email communication). The male population in particular did not seek clinical care while experiencing TB symptoms (Theron, 2021). It is important to identify the reasons why clinics is not accessed by men with TB symptoms. So that barriers to health care must be addressed. Such behaviour impacts on clinic indicators. Indicators are numbers (or data) used to measure changes over time (Loveday, 2015:306). They provide an indication of the health of people living within a district, the excellence of health provision within the district, including the effect of such services on the individuals who use them. In this situation

males are not accessing (using) services which is contrary to the districts health management system.

The TB symptomatic males not attending clinic for treatment are an anti-partnership behaviour. In other words the level of relation between civil society and the clinic is in question. Which becomes detrimental for disease management. This reality coincides with Shuster's (2014: 216) view that "partnership in identifying problems and setting goals is especially important because it brings commitment from all persons involved, which is essential to successful change". Community-involvement, in terms of problem identification and a collective approach to addressing problems, is a World Health Organization phenomenon central to the South African healthcare system. Hence, a paradox remains in the health subdistricts within the Cape Town municipality, to the detriment for target population groups that are in dire need of healthcare. Communities across South Africa are disillusioned with service delivery in the municipal areas and, considering people's dissatisfaction, a multitude of resources is required in this respect. The subsequent research problem is in context to the aforesaid:

1.3 Problem statement

Nonexistence community involvement in the development of primary healthcare programmes has detrimental effects on health-service delivery. The child, youth and male target populations are not accessing the services they need. Primary healthcare facilities are often situated far from neighbourhoods, or services are not accessible for particular communities. These deviations from the prescribed community involvement standard outlined in the WHO Primary Health Care Declaration of 1978 are notable, especially among the poorest and most vulnerable communities, and lead to health services deficiencies.

1.3.1 Research subproblems

A few complexities have evolved from the central problem, as highlighted below.

1.3.1.1 Subproblem 1

Low levels of consultation exist with communities regarding matters that affect their health, contrasting the prescribed global, national, and municipal public participative policy framework, notwithstanding its primary health care principle about community involvement.

1.3.1.2 Subproblem 2

The non-existents of communities in clinic programmes development involvement and making decisions on matters affecting their health has detrimental effects on partnership building.

1.3.1.3 Subproblem 3

The low levels of community knowledge regarding health programmes exacerbate the primary health care ideal relating to self-determination, dependence, and co-partnership.

1.3.1.4 Subproblem 4

The nonexistence of community structure profiles by clinic management is detrimental to the access to primary health care of the target population (i.e., children, men, youth, and women).

1.4 Hypothesis

A correlation between community involvement and efficient health services exist.

1.5 Research questions

The following research questions are predicated on the research problem mentioned earlier:

- What causes dissatisfaction within the community regarding primary health care?
- What actions are to be taken to bring a solution for the problem?

1.6 Research objectives

The research study will have the following study objectives:

- To explore the legislative outline that governs community involvement as a means to recommend a community involvement policy, formulated and designed for the municipal clinic level;
- To analyse the philosophical factors that underpin primary health care.
- To search for successful cases that made contribution to community satisfaction.
- To explore community-involvement theory, subject to health care at primary level.
- To conduct a empirical survey regarding involvement of communities in health programmes.
- To propose a community involvement model for health services.

1.7 Preliminary literature review

Initially the literature review mainly describes the techniques used to analyse earlier and current works. Here, the researcher demonstrates which authors, journals and textbooks are applied to examine topic. Hence reference to three studies conducted in Kenya, Malawi, and

Nigeria showed how community leaders by means of the community health structure, actively brought their communities' concerns about healthcare quality to the attention of district health authorities (Karuga, et al. 2022:12). The community leaders expressed worries about employees in health facilities (clinics) who were mistreating, abusive, or evading their duties; they also raised the price of medications or hid financial information from the public. Community leaders compelled district health managers in Kenya and Malawi to remove and discipline facility health workers found who had engaged in misbehavior. According to one study, the community health structure convinced district health authorities to give facilities more medical professionals and support staff. Additionally, they persuaded district authorities to oppose the transfer of healthcare professionals who were doing well (Karuga, et al 2022:12). Chapter Five outlines additional successful outcomes related to the causal effect of community involvement in primary health care.

The effectiveness of Health Committees (HCs) in low- and middle-income countries (LMICs) has been the subject of a systematic literature review. The findings of this review indicate that HCs often provide community representatives with a bottom-up platform for involvement in healthcare monitoring, decision-making, and oversight.

Health centers (HCs) in Kenya are formal institutions with specific responsibilities to bridge gaps in services provision and hold hospitals responsible for the caliber and accessibility of the care they provide. By doing this, HCs can support the right to PHC services ideal and enable the community's collective ownership of those services (Zwama, Stuttaford, Jensen, Haricharan and London, 2019:2).

1.7.1 Legislation governing community involvement

The National Department of Health (NDoH) in South Africa's directive is to justify the implementation of health services by the National Health Act, No. 61 of 2003, and the Constitution of the Republic of South Africa, Act No. 108 of 1996 (Dennill, 2012a: 102). The Municipal Structures Act 117 of 1998, which addresses community prescripts, contains additional authorization. In spite of the Western Cape Facilities Boards and Committees Act, 2016 (see Chapter 5 and Annexure 1), which names ward council members and community members as representative nominees, Chapter 4 of the Municipal Systems Act 32 of 2000 is very clear about community involvement. The following section goes into more detail about each of these.

1.7.1.1 Constitution of the Republic of South Africa (Act no. 108 of 1996)

The Republic of South Africa Constitution aim to give the country a legislative foundation that would solidify the country's people's representative government and underpin all other laws and policies. It was prepared from a political and juristic perspective. The most important contribution that the Constitution makes towards South Africa is in the well-being of all citizenry, acknowledgement of the rights of humns, and equity in health services. The Constitution makes provision for several rights to access what are considered key non-health (social) determinants of health (e.g., water, housing, education, and an environment not harmful to health), as stated by Levendal et al. (2015:253).

Chapter 2 of the South African Constitution (1996) protects human rights and upholds self-governing principles concerning people's self-worth, fairness, and liberty. It further specifies individual rights in sections seven to 33 of the chapter. Section 27 encapsulates survival needs, and health services as essential care, and prescribes legislative frameworks accordingly.

The South African law has a profound effect on health within the context of community involvement, as indicated:

Section 16: information exchange, communication, and knowledge;

Section 24: environmental health rights;

Section 28: basic rights, food, human settlement, and essential services;

Section 29: child and adult rights to access education; and

Section 32: access to state information.

The rights mentioned above outlines the Southern African constitutional law under the Bill of Rights section of the Republic of South Africa Constitution (Chapter 2, section 27 Act No. 108 of 1996).

These privileges make it possible, in principle, for individuals and groups to demand certain basic health care services and locations that are not detrimental in terms of human well-being. It also means that the government can be challenged when these rights are not provided.

1.7.1.2 National Health Act (NHA) (Act No. 61 of 2003)

The NHA (No. 61 of 2003) resides within South Africa's constitutional law and prescribes the context for the functioning of health in the Republic.

Chapter 2 of the Act reflects the rights of citizens as they pertain to health services. People's rights are to:

- have complete understanding of their condition;
- participate in decision-making regarding their health;
- confidentiality; and
- complain about the service.

Chapter 3 is a summary for the Health Department arrangements including the establishment of:

- its Council of Health on National level, a legislative consultative forum that consists of the Health Minister, the entire Executive Members Committees at provincial level in all nine provinces, and representation at municipal government level; including
- the Health Concultive Forum at National level that consists of shareholders within the wider health spectrum.

Chapter 4 within the Act indicates the framework and functions for all departments of health at provincial level.

Chapter 5 sets the basis for the region's health care system and regulates the policy, based on PHC principles, which advocate effective and efficient health care support for communal health requirements (Dennill, 2012a: 205).

The NHA prescribes that municipalities must ensure that effectual and equitable delivery of health care. It is incumbent on certain provincial executive members to assign the health care functions to the municipality in the province through a contractual agreement regarding services that provides for the services to be executed, the resources to be made available, performance standards to be useful in monitoring of services executed by the municipality, includes conditions subject to the contractual agreement can be ended. Constitutionally, therefore, delivery of health services should be shared between the three spheres of government with health services rests on local government. However, the formation for a well-functioning system at district level which includes policy coordination between the three spheres of government remains a challenge, which could be improved upon with increased delegation of power from the province to district and local levels (Freeman et al., 2015:255).

1.7.1.3 Municipal Structures Act (No. 117 of 1998)

Section 19 of the Act, which outlines the municipal objectives, is included in Chapter 3, the section of the Act that deals with municipal councils.

A Municipal Council is obliged by its resources to attain the purposes outlined in the Constitutional Section 152;

- municipalities must analyse the following annually:
    - community essentials;
    - prioritising the essentials;
    - its procedures should include residents in decision-making; and
    - its organisational strategies should satisfy the residents;
- municipalities should design mechanisms to engage residents and non-governmental organisations in the accomplishment of their tasks, while expediting their controls.

The intent is to support municipalities to acuire processes that will enable them to develop local communities, both economically and socially as noted within the Municipal Structural Act (No. 32 of 2000). This legislation also includes principles to allow for universal access to essential affordable services (Dennill, & Rendall-Mkosi, 2015:214). It is incumbent on Municipalities to design instruments to consult communities and commuty organisations pertaining to municipal performance outputs and executing municipal powers. Ward committees are an example of such which offer a critical linkage amongst ward councillors, the communities, with the Mayoral office (Tau, 2022).

1.7.2 Philosophical bases for community involvement in health

Hattingh et al (2006:2) define philosophy as

> a certain attitude towards life that explains the origin, nature, purpose, and existence of life. It directs behavior and conduct. The statement replicates the values, goals, ideas, and beliefs of an individual, community, or discipline. Thus, we believe that statements associated with health, public health, or community health contribute to understanding and providing optimal health care to all citizens of a country.

Therefore, the proclamation named ‘Health for all’ adopted at the conference in Kazakstan, Russia in 1978 by the ‘World Health Organization’ is centric to health care at primary level that’s in reference to the (PHC) philosophy. The PHC philosophy encompasses values such as equity, accessibility, self-reliance and self-determination.

Philosophies are noted to be the application of intellectual thoughts and views that direct research. During the historical development of *homo sapiens*, communities, as well as states developed strategies that dealt with understanding their relationship with one another and with what produced the most desired outcome, as they struggled to relate to their environment (both physically, socially, economically, and politically) to survive and ultimately to turn survival

into a sustainable future to make life more bearable and comfortable (Hattingh et al., 2006:3). Ultimately, groups, communities, and eventually societies that were closely related developed better insights into these existential challenges, and historically agreed on general underlying assumptions and explanations for their experiences. These were later called beliefs (or systems of belief) accepted as authoritative by a group, or a school of thought commonly referred to as philosophy (Wissink & Ballard, 2018:80). Different contexts and their inherent challenges associated with the evolution of cultures produced different philosophies that proved to be useful and pragmatic in terms of their needs. As people in communities engaged in natural competition for resources and opportunities in their struggle for survival and evolutionary progress, social relations emerged involving increasing competition to gain authority or power for better access to these resources and privileges. This process is known as politics and ultimately led to the development of political ideologies (e.g., nationalism, liberalism, conservatism, socialism, communism, capitalism). This distinguished communities, nations, and states in the manner in which they explain and organise themselves to manage the competing interests and growing demand for available scarce resources in their particular contexts (Wissink & Ballard, 2018: 80).

1.7.2.1 Health for All philosophy

During the 1900s the hospital-centred system was designed for European cultures, climates, and diseases, confined to curing as opposed to preventing. Without consideration to the cause-effect amongst human development and health, the building of hospitals predominant in the bigger townships and municipalities near colonist together where elite lived, instead of around rural locations where almost the entire community resides that's destitute. In such top-down curative approach, which did not assess the health care necessities of the communities, did little to augment the requirements of the indigenous people (Alperstein, 2018:20). Throughout the 1960s it unfolded evidently that 'hospital' base-centred treatment has not been helpful for the greater population of the world. Efforts in solving this inequity, by health sectors and organisations in numerous countries on the globe, tested innovative health service strategies. (Alperstein, 2018:20).

a. Missionary doctors

An discovery from Doctors in the Mission fields connected with the 'World Council of Churches' (WCC) beginning to realise the significance of getting individuals in communities with community wealth involved in refining health care. The Primary Health Care (PHC) terminology was applied then first and furmost by the Christian Medical Commission, to

describe this new ‘bottom-up’ approach. The WCC's journal Contact published in 1970 is where the term "primary health care" first arose (Alperstein, 2018:21).

b. Barefoot doctors

In the meantime, newscast had extended from communalist China in the 1960s of great gains in healthiness from the utilisation of health workers based in the set community known as ‘barefoot doctors’. It had been grassroot agriculturalists selected by their societies followed by several months of teaching from medical officers coming from city hospitals. Health workers were thought to use simplitic technology in combination with Western and traditional medication to help communities they serve. They went back to their farms so that they could remain a part of their community. This method aided significantly to regulate epidemics, decrease infant mortality and the escalation life expectation in China during nineteen sixties and nineteen seventies (Alperstein, 2018:21).

Inequality of access to health care remained an issue for marginalised and poor communities worldwide; hence, it was the overarching theme presented in USSR at Alma-Ata 1978 conference convened from the World Health Organization (WHO). The enthusiasm from 134 states, government and non-government organisation to endorsed the PHC philosophy was remarkable. The essence is to fulfill the 2000 "Health for All " goal, which asks for universal access to medical care. The Soviet Union offered funding of 2 million US dollars to host the conference. WHO searched for alternative sites, and a few countries declined the USSR venue. “Nobody could match the economic offer of the Soviet Union, and in the case of Iran there was fear of political instability” (Cueto, 2004:7). The selection criterion for Alma-Ata, was based on its notable health improvements as opposed to its backward state during Tsarist Russia (Cueto, 2004:7).

The adoption of Primary Health Care (PHC) since the year 1978 , a universal healthy method that encompasses preventative, remedial, and rehabilitative services are still in existence. The inception of this worldwide phenomena formalised health services (Botha, 2014:37). In the 21st century, strong emphasis is placed on the PHC ideology. Thus, PHC is an integrated approach linked with secondary health care in terms of ambulance services, hospitalisation, and nutritional services, amongst others. On this basis participatory governance, community socioeconomics, community control, community ownership, and self-reliance are advanced as PHC principles (Botha, 2014:37).

1.7.2.2 Philosophies and good health in communities

The philosophies that communities or individuals have regarding a decent lifestyle vary instinctively because of the information that they have about well-being, coupled with the

values they ascribe to good health. Some clients may place the values related to good health low on their particular scale of values (Hattingh et al., 2006:2). Theron et al. (2016:251) affirm that active and empowered involvement of people in PHC is crucial to making good health the actual goal. In this regard, the principle of true involvement in all development settings encompasses the formation of enabling spaces. Through this, health beneficiaries (communities) are able, not only to influence and direct the planning of their health, but they are also actually empowered to control and own the process. Herein lies the dilemma, not only akin to health-related planning but probably to all development applications: those who are supposed to benefit, through the formation of invited spaces by the state and its health and other agencies to get involved, very seldom manage to "control" or "own" their development. "The latter then often leads, via protest action, to the frustrated beneficiaries inventing their own spaces for participation" (Theron et al., 2016:251).

Therefore, statements of the philosophy of health should include value statements about health and wellness. Individual perceptions about health and well-being or cultural aspects of health could affect the definition of health as well as its philosophical statements. The ideological approach to healthiness in specific communities is manifested by existing procedures applied to maintain decent health, while infection prevention persists. The health system must then be based on a holistic approach. Attainment of such a holistic system, underpinned by the physical, psychological, and well-being of communities including various nations, are acknowledged (Hattingh et al., 2006:2). The health system outlines ethics and principles for a specific institution, noting its significance concerning medical practice, training, and development, as well as administration features, including human rights (Hattingh et al., 2006:2).

1.7.2.3 Modern healthcare philosophies

Inherent to modern health service philosophies is the idea that primary health care is vital in communities, while the realism of resource scarcity limits accessing health services since primary health care services are not immune to resource limitations (Hattingh et al., 2006:4).

In most countries, health care professionals believe that it is extremely important for all citizens to obtain optimal health and that the following statements are inherent in any philosophy pertaining to health services:

- Primary health care (PHC) should positioned itself on holistic care to warrant for health requirements from all 'ages' are reached;
- Communities must realise that health is a personal responsibility;

- The community must be involved and participate in actions to prevent disease and promote health;
- Teaching groups, people, and entities for health matters are pivotal instruments that encompasses their well-being, while participating in the preparation and provision of health care;
- To preserve life is a priority; therefore, decent health care must be stressed; and
- Health developments are an integral segment of social development.

Essentially to achieve the 2000 goal of "Health for All," which calls for universal access to healthcare. Health care professionals should always value the health of all people, as well as their right to be involved in significant decisions concerning health care delivery. They must be committed to developing and utilising existing and potential knowledge, skills, and resources to provide high-quality health care (Hattingh et al., 2006:4).

1.7.3 Community involvement in primary health care theoretical basis

According to Dennill and Rendall-Mkosi (2012:129), “Some writers refer to the term community involvement in health, while others talk about community participation in health. Essentially, they are referring to the same concept, albeit with multiple perspectives”. King (2007:86) affirms that “although the concept of community participation in health care is used in preference to community involvement in health care, in literature both concepts are used interchangeably to refer to the mechanism in which the community is acknowledged as a partner in the process of achieving optimal Health for All”. This ideology forms the basis of the philosophy that directs the delivery of healthcare services in Southern Africa. Healthcare professionals have an ethical obligation to uphold each person's right to health and their capacity to engage in critical choices concerning the delivery of healthcare. The two main views on involvement of communities in health treatment include a utilitarian view including a activist view. The utilitarians (policymakers, donors, and epidemiologists) focus on involvement as a means to achieve an outcome or as an addition to a programme or project, while the activists (social scientists and development workers) perceive involvement more as a principle, process, and an end in itself, that’s necessary in any enablement to thappen among members of the communities including structures.

The emergence of the community involvement in health (CIH) vision as novice method seeks to combine the official, specialised health organisation and grassroot individuals and its information and wealth (Stern & Schaay, 2011).

1.7.3.1 Community involvement through governance structures

Most countries, regardless of their level of development, have mechanisms for community involvement with government and non-governmental services. Some of the involvement of community members is guided by legislative frameworks, or by the organisation's constitution while, in other situations, it is more fluid and the level of the involvement of public supporters probably depends on the organisation's leadership. The formation of societal forums to collaborate with health sector staff has become an international phenomenon within the health domain. In a selection of these partnerships, ordinary members regulate how these public health services should function. It is notable that where public participation exists, demand for health services has increased (Dennill & Rendall-Mkosi, 2012:131). However, the WHO also points out that in many countries the district health system has not been sufficiently established, and power has not devolved to the district governance structures, making community influence on the services through representation either rather weak or non-existent.

1.7.3.2 Facilitation of community involvement processes and intersectoral action

Much has been written over the past few decades on community-involvement in health. On the one hand, people think that there is a specific method that can be followed to promote community involvement and, conversely, people think that the process is entirely organic and cannot be planned. There is a consensus within the health sector that citizen involvement should be practised from the initiation, implementation, and evaluation stages of primary health care (PHC). It comprises the capacity-building for citizens in terms of disease trends and health funding priorities, which will enhance their involvement (Dennill & Rendall-Mkosi, 2015:136).

The National Health Act 61 of 2003 requires health committees to comprise three categories: clinic managers, community members, and ward councillors (Zwama, et al. 2019:2). The primary healthcare approach's guiding principle—community participation—is widely acknowledged in the governance of health systems. Health Committees (HCs) are locally based organisations thats involve in primary healthcare governance. However, prior research conducted in the Cape Town Metropole, South Africa, indicates that the potential of health committees (HCs) are limited by the lack of engagement and knowledge of local health providers (HPs) regarding the roles and functions of HCs. The first research on how receptive HPs were to HCs after a rights-based training. 34 HPs from every Cape Metropole health sub-district took part in this assessment of the qualitative nature of training. Participants filled out pre- and post-training questionnaires. Meanwhile two training groups were subject to

observation (Zwama, et al. 2019:3). Three to four months following training, ten participants participated in semi-structured interviews. After training, HPs realized that HCs were crucial to their ability to communicate with the local community and other HPs. Additionally, HPs believed that HCs could help PHCs become more accessible and high-quality, and that their services could better meet the needs of the local community. HPs emphasized the significance of clearly defining roles and responsibilities for each member of the facility's HC and stated their plans to participate actively in the group. The results of this training evaluation demonstrate HPs' readiness to interact with HCs and their need for the necessary skills to do so. Furthermore, it demonstrates that HPs are essential to the efficient operation of HCs. According to this assessment, training can help close the gap between service delivery and community needs by making HPs more receptive to HCs. As a result, training HPs on HCs may encourage the growth of PHC that responds to patient needs and a health system that is focused on the needs of the individual. As the training is applied in new contexts, it needs to be continuously evaluated (Zwama, et al. 2019:3).

An enabling environment should be set at the government and managerial level to institutionalise community involvement at its initial health planning and management; to maintain sound relations at the local level; to ensure effectual governance in both the private and public sector; and setting interdepartmental relations between health, human settlement, social development, and water and sanitation directorates (Dennill & Rendall-Mkosi, 2015: 131).

Common structures that can be used to encourage community involvement should include hospital boards, clinic and health-centre committees, ward committees, and Integrated Development Plan committees (Dennill & Rendall-Mkosi, 2015:131).

1.8 Research methodology

The methodological approach in the research study used a assessment of relevant writings, an empirical study, with group interviews.

1.8.1 Literature review

According to Howard (2014:101), the philosophy for healthcare services provision in Southern Africa established on these ideas. Healthcare practitioners should always respect everyone's right to health and their ability to participate in important decisions about the provision of healthcare.Thus, appropriate books, documents relating to committee decisions, periodicals, regulations, accounts, and transcripts were reviewed as a means to attain thorough topical insight.

1.8.2 Empirical survey

Empirical studies are the verification of reflections and practices in contrast to the presentation of concepts or judgements on a particular subject matter. The meaning of 'empirical' comes from the word 'experiment'. The term 'survey' is interpreted to mean examining an object with caution. When it comes to the research setting, surveys refer to a statistics-gathering instrument, which comprises a sequence of inquiries intended to gather evidence from a moderately large assembly of individuals. It is quite a widespread exploration instrument that is frequently utilised to collect demographic data (age, ethnicity, sex, race, earnings, etc.), including information about human attributes, sentiments, impressions, levels of satisfaction, and so on (Du Plooy-Cilliers & Cronje, 2014:148).

1.8.2.1 Data collection

An mixed method approach is applicable to this study, for the optimal exploration amongst clinic management and community leaders. It affirms the Mixed Method Appraisal Tool applicable in the study undertaken by Erku et al (2023), titled "community engagement initiatives in primary health care to achieve universal health coverage: a realist synthesis of scoping view". This study eventuated into quantitative themes named the degree of community engagement and supportive inititiatives, thereafter the qualitative themes named (i) communities role clarification in setting priorities (ii) expanded engagement strategies (iii) dual communication.

Similar in section 7.3 for the mixed method approach in this study quantitative and qualitative themes have been developed, primarily to generate novel knowlwdge.

Data collection defines how the researcher approaches in responding to the research question. It offers an review path that comprises a perfect with precise description of in what way information were gathered, the manner findings were resultant including the justification regarding its selection technique.

A key contemplation in this process is the application of a qualitative or quantitative study method, or a dual approach, named the mixed-methods approach (Davis, 2014:14). Mixed-methods research collection approaches include equally quantitative and qualitative exploration, of which the objectives are that quantitative and qualitative methods will be complementary (Du Plooy-Cilliers & Cronje, 2014: 33). This research study has used the mixed-method approach, as it used a survey and a group interview schedule. According to Bless et al. (2013:16), social science can utilise quantitative or qualitative research or both approaches combined. The quantitative approach is statistical-oriented. The qualitative method is frequently applicable from the initial stage. This method works well for sampling.

The phenomenon under study is better understood as a result of the findings. Depending on the situation or size of the issue, qualitative and quantitative methods may need to be used in the same study to complement or advance the other. A mixed-methods study could, for instance, incorporate the following components:

- surveys (quantitative) and case studies (qualitative);
- open-ended interviews with a qualitative component and structured questionnaires; or
- both quantitative and qualitative questionnaires and observations (Bless, 2013:16).

The mixed method for this study comprised of 14 Clinc managers and 12 ward committee members. The clinic managers are accountable for Primary Health Care services for an population of 370 000 adult, children and youth. The ward committee members of 6 wards, are prominent leaders that represents businesses, disabled, education, safety & security, youth, vulnerable groups and women from sub council 21. The quantitative survey administered amongst the clinic managers and the qualitative questions amongst the ward committee members.

1.8.2.2 Research population

A research population is the entire collection of individuals from whom data is necessary (Pascoe, 2014:132). Koonin (2014:97) claims that the population comprises the complete unit of individuals or objects which contain qualities or features that concern the researcher. De Vos (2002:198) defines a population as conventional objects wherein every capacity of importance to the investigator are signified. These bodies may be individuals, including every client encompassing a specific employee's caseload, or items, for instance every research paperwork contained in a particular archive (de Vos, 2002:198). The group in this study is confined to the management teams from 12 municipal health clinics within a geographic subdistrict and 13 ward committees. The City of Cape Town Metropolitan Municipality management teams, from City Health Department clinics comprise 56 clinic managers and 49 senior professional nurses, 105 individuals, which eventuate to 52 teams across eight subdistricts. The two subcouncils are named Subcouncils 8 and 21, the former comprises six wards and the latter seven. The population comprises 45 and 48 ward committee members, and 93 individuals across two subcouncils.

1.8.2.3 Sampling

A sample encompasses the essentials for the study cohort given for connsideration for definite inclusivity. Otherwise, this could be perceived to be a subsection of quantities extracted from the study cohort of interest. To gain an understanding of the population from which a sample was taken, that sample is studied. As a result, the researcher was more interested in

characterizing the sample as a tool to help us elaborate on a particular facet of the study group than as a definitive scenario. Selecting the population to gather data for your study is known as sampling. To find out more about the views of the students at your university, for example, you could survey a sample of one hundred students. Sampling in statistics lets you test a hypothesis regarding a population's characteristics (Du Plooy-Cilliers & Cronje, 2014: 33). The 12 clinics are located in a geographic boundary named Eastern-Sub district. As per Nkrunziza (2016:10), the sub-district under investigation has a population of 508,690, which represents 12.58% of Cape Town's total population (474 669). Notably, this represents a 50.5% increase from the 2001 population of 338 017. According to Nkurinziza (2016), the study also showed that 75% of the population does not have health insurance and must rely on the medical care provided by 12 municipal clinics.

The questionnaire survey involved participation from all managers and senior professional nurses at clinics in the CoCT. The clinic managers are are 7 and 8 senior professional both staff categories oversee the clinics in the area that comprise 12 clinics. The response rate was 95 % of which 14 out of the 15 managers participated in completing thhe questionnaires.

Municipal Structures Act, Section 61. After receiving approval from the researchers to interview members of the ward committee for the research. Members of the ward committee provide recommendations to the Executive Mayor's ward councilor or appropriate sub-council on any issue affecting their ward. A schedule of ward committee meetings and a list of committee members were provided to the researcher. This was in the form of an meeting invitation with the researchers study on the meeting agenda with qualitative questionnaire attached. The study was presented by means of electronic voice recording at six out of seven ward committee meetings in subcouncil 21. The meetings were held after hours, appointments was made according to respondents convenience. Respondents had been very optimistic during the voice recorded in depth interviews, seven open ended questions and focus areas see Annexure 8 that transpired from the quantitative instrument distributed to the clinic management team. The focus areas was (i) governance, (ii) access (iii) equity and (iv) community profiles.

1.8.2.5 Research findings presentation

The research's conclusions are displayed using tables, graphs, and charts.

1.9 Ethical considerations

Safeguarding complex information and identification are notable challenges for study participants (Koonin, 2014:267). The participants was assured by the researcher that their involvement in the study would be kept confidential throughout, and undertook not to register

any name throughout the procedures of the study, taking note not to compare the participants at various stages of the research process, or to match their identification with study responses. Hence, they participated by answering questionnaires without providing identity information. Finally, the questionnaires were analysed without any identification linked to participants.

Along with the assurance of confidentiality, the researcher committed not to divulge participant identification during possible occurrences when identification does become possible, and ensured that information would be confined to the researcher (Koonin, 2014: 267).

1.9.1 Confidentiality

Confidentiality is considered an moral obligation in a significant number of research. Data delivered by respondents, predominantly complex and individual information, must be secured and not to be accessed to anybody beside the researchers (Bless et al., 2006:143). Thus, data collection from participants was reserved under secure conditions.

1.9.2 Anonymity

Confidentiality is the foundation of anonymity. Data about a participant cannot be directly and immediately linked to that participant's name or any other identifier. To maintain the anonymity of participant data, researchers typically assign a number to the data (Bless et al., 2006:143).

The research was approved by the Health Management Team of the City of Cape Town Municipality, who also guaranteed that all information gathered would be kept completely confidential, including the identity of each respondent. Participants in the process were free to leave at any time if it caused them discomfort.

1.10 Study significance

The study should reinforce the Republic of South Africa's Constitution, Act No. 108 of 1996, which stipulates that public administration must adhere to several values, such as meeting the needs of the grassroots and encouraging community involvement in policymaking. Because of this, citizen consultation is described in detail in the White Paper on the Transformation of Public Service (WPTPS) (RSA, 1997), especially about the scope and quality of public services citizens receive. Citizens also need to have a choice in the services that are offered. The aspect of full participation of communities implies that communities need to describe health problems and to design approaches to address the problem (Stanhope, 2014: 39). Hence, women, youth, children, and vulnerable groups from the 12 communities within the municipal subdistrict, require institutionalised representation at clinic level.

1.11 Study limitations

The eastern area of the City of Cape Town, which includes suburbs like Blue Downs, Driftsands, Eerste river, Fagan, Gordons Bay, Kuilsriver, Mfuleni, Nomzamo, Sir Lowry's Pass, Sarepta, Somerset West, and Wesbank, is the only area covered by the research project.

1.12 Layout of the study

A review and discussion of pertinent literature analysis are covered in Chapter 2. Chapter Four presents the study's conclusions, and Chapter Three discusses the research methodology. An overview of the legislative framework governing community involvement was given in Chapter Five. Chapter 6 provides recommendations and the study's findings in addition to a summary of the quantitative and qualitative theories.

Chapter 7 addressed the data interpretation and analysis. The PHC model synopsis and a proposed model of health and well-being in Chapter 8. Chapter Nine contained the study's summary, conclusions, recommendations, and findings.

1.13 Summary

The research problem is stated as the community’s concern about their involvement in decision-making in activities that affect them, especially regarding primary health care services. A brief outline is given of care normative factors which govern primary health care and the legislative framework applicable to the function. The suggested research approach, namely a blend of qualitative and quantitative research, used a questionnaire survey, including focus group discussions with ward committees and clinic managers. The City of Cape Town Municipality permitted the study, subject to the requirements that participants give informed consent and the findings be reported to the municipal management. When it comes to community involvement in clinic health committees, isiXhosa communities demonstrate a greater degree of commitment than communities of color. The City of Cape Town should prioritize building the capacity of specific racial groups in health governance in light of this finding. This finding is based on the clinic manager (study participant) observation while working in various communities. Historically some communities have the overwhelming majority coloureds living the clinic catcment area and the other with isixhosas living in the clinic catchment area.

Furthermore, the study elicited three main themes subject to close-ended questions presented to 14 clinic management staff. The themes found that 57% disagree that poor communities are profiled. The second finding was that 71% disagree that health risks are discussed with

community leaders. Third, 43% disagree that ward councillors serve on health committees and 57% disagree that health committees is active in problem-solving.

The last section focues on open-ended questions that elicited 10 themes named governance, communication, inter-professionalism, collaboration, access to health services, public safety, infrastructure, vulnerable groups, public transport, and public safety and services inequality.

CHAPTER TWO:

COMMUNITY INVOLVEMENT THEORY SUBJECT TO PRIMARY HEALTH CARE

2.1 Introduction

The issue of primary health care research in the City of Cape Town and the analysis approach employed were discussed in the previous chapter. As this chapter demonstrates, the success of primary healthcare depends on community involvement.

The various elements that define an informal settlement community are described later in this chapter for Imizamo Yethu, an informal settlement community in Hout Bay, Western Cape. Creighton (2005), a renowned author and practitioner in the discipline of community involvement, wrote extensively on the subject. One of Creighton's (2005:9) most profound statements is that communities cannot be involved except they obtain comprehensive and information that is objective whereon their judgements can be based. Pypers and Bassuday (2016:2) state that it is the municipality's responsibility to inform the public about the accessible preferences for the provision of essential services. According to Pypers and Bassuday (2016), Section 6 of the Municipal Systems Act (RSA, 2000) outlines the duties of local government. These duties can be fulfilled by providing precise information about the amount and caliber of services that the community is entitled to, as well as by educating the local populace about municipal management practices and budgetary decisions.

Creighton (2005:54) indicates five intensity levels of involvement which comprise co-decision makers, such as local government or key customers. Departmental staff at level two will commit resources, to assure influence on the decisions. Notwithstanding active civic and interest groups, involvement is imperative in the process otherwise they might embark on court or protest action. Third are the members of interest groups such as trade unions or wildlife associations. Those who share a particular interest, are named organised groups. Active citizens on level four are not affiliated with any organisation; however, specific issues are of interest to them. They will address such issues in public meetings or in the form of a letter to authorities. Not to mention, Creighthon (2005:54) describes the general public as unsurprised and apathetic people who choose not to participate in local community planning, decision-making, and program execution. Perhaps they are extensively active at the workplace or extensively active in another lifestyle feature of the community with minimal concentration in the topic of the community-involvement programme. The philosophical view in Chapter Six, section 6.3, according to Arnstein (1969:216), encapsulates Creighton (2005) and the proposed wellness model in Chapter Seven. The view by Arnstein (1969:216) is that

“participation is a mechanism through which ‘have-nots’ are involved in decision-making. Have-nots are individuals or groups of individuals who are normally left out of the decision-making process, consequently, these are the marginalised and poor, for example, blacks, Native Americans, and immigrants”. Notably, within the data interpretation in Chapter Eight, this emphasises the inclusivity of poor communities.

2.2 History of community involvement

Public participation in this research is referred to as community involvement and is substantiated in section 2.3. The community-involvement phenomenon is critical and the most essential instrument used to foster good governance, accountability, and transparency, leading to better and more efficient service delivery (Stuurman, 2019: 325). The debate on the pros and cons of involvement touched South Africa in the 1980s, but a concerted effort to make the ideal of participatory development a realism only commenced in the 1990s through lawful and policy outlines (Theron et al., 2016:135). Despite the efforts of the 1970s, the World Health Organization (WHO) studied community involvement in health (CIH) across a range of domains to outline a definite strategy (Oakley, 1989:v). Chapter Four goes into further detail on the CIH concept. The rejection of community involvement throughout history can be attributed to the fact that, since democracy originated in ancient Greece, not all citizens have been involved in the formulation of governmental policies. Policymaking was a honor appreciated only by political representatives, and the inspiration of residents was minimal. Since then, democracy has grown from being excluded previously. Contemporary democracy is notable for important assurances of resident involvement in the matters of government. Representatives that are elected are no longer the sole policymakers due to residents current ability in effecting the directive from community resolutions. In essence, prassroots political candidates are nominated from the community level, and thus significant accountability are being required by the very communities that designate such and who are also able to be involved in matters which concern them (Mubangizi & Dassin, 2016:194). Thus, community involvement is an empowering component of democracy, linking the breach amongst undeviating and illustrative equality. Community involvement in South Africa pertaining to political matters was constructed by the political uprising opposing apartheid as far as the beginning of the 1990s. However, after the 1994 voting, the in coming administration contained independent supremacy and protracted the power to become involved in matters of governance to the residents. Afterward, community involvement commemorates the Republic of South Africa (RSA) Constitution Act No. 108 of 1996, submitting to administration procedures ought to replicate “the will of the people”. Being an outcome, community

involvement as an feature of equality is currently a common feature in the creation and application for community strategies (Mubangizi, 2016:194).

2.3 Community involvement concept

Community involvement comprises liaising with citizenry in the facts and government policymaking. This segment explores community involvement in a South African metropolitan municipal sphere. Community involvement, community engagement, public participation and community participation are synonymous terms throughout the participatory literature discourse (Dennill & Rendall-Mkosi, 2015:129). Pypers and Bassuday (2016:1) affirm that "public participation can also be referred to as 'public involvement', 'community involvement' or 'stakeholder involvement'". According to Oakley (1989:8), about the concept most pertinent to primary health care: "to be successful [primary health care] needs individual and community self-reliance and the maximum community involvement or participation. That is to say, the active involvement of people living together in some form of social organisation and cohesion in the planning, operation, and control of primary health care using local, national, and other resources. The term involvement is preferable to participation because it implies a deeper and more personal identification of members of the community with primary health care". This statement is underpinned by the Health for All philosophy of the WHO. The Republic of South Africa Municipal Structures Act No. 117 of 1998 and the Republic of South Africa Municipal Systems Act No. 32 of 2000 both specify the involvement component of their respective constitutional frameworks. Section 152 (1) of the Republic of South Africa Constitution, Act No. 108 of 1996, declares "the objects of local government are – (e) to encourage the involvement of communities and community organisation in the matters of local government". In the parliamentary preamble document RSA (2008), it lists interchangeably used terms as follows:

- Citizen engagement;
- Civic engagement;
- Citizen participation;
- Community engagement.
- Community participation;
- Community involvement;
- Public involvement;
- Public participation; and

- Political participation;

The term ‘community involvement’ is deemed most appropriate, aligned with RSA Municipal legislation. It indicates to the Republic of South African ‘Municipal Structures Act No. 117 of 1998’; Chapter 3 section 19 compels a municipality must review annually “its process for involving the community". Therefore, ‘involvement’ is the pragmatic term outlined in this study. The expository remarks are in Chapter Four, sections 4.2 and 4.2.1.

2.3.1 The building blocks for community involvement

Community involvement as a concept comprises two elements, namely the community and involvement. The exposition of community and involvement as sole elements are outlined as follows:

2.3.1.1 Community

This refers to persons in a exact geographic region and period; referring to a community method, a structuring for a lifestyle method, or a social political forum. Traditionally, public is well described to be a cluster of individuals within a geographical and demarcated locality. Precincts demarcate the borders of residences, municipalities, and countries and are simply defined through mapping. Internal interactions in societies frequently are built on vicinity and communal familiarities and not essentially optional (Visser & Moleko, 2014:5).

Other authors have defined community as geographic location, communal interests, and requirements, or in terms of deficiency and shortcoming (Ijeoma, 2018:137), implied about the concept of the traditional African village or the urban slum or squatter or informal settlement. Furthermore, writings describe the community as a cluster of individuals who living in a exact area and implement a certain level of grassroots sovereignty in arranging its community life in such a manner that enable them, from that area, to placate completely the series of its day-to-day requirements. Lastly, a community is a collective gathering assimilated around aims related with the complications ascending out of the cooperative employment and usage of residential space. The community has certain levels of grassroots independence and a measure of grassroots accountability. Civic associations in the townships may, for example, engage in community development, yet they possess no local autonomy. Similarly, it would be exceptional to find a community that can “satisfy the full range of their daily needs” from local resources (Ijeoma, 2018:137)

In terms of a topographic region, a community can be defined as a:

a. Demographic characteristics

These social attributes, which include family life cycle, social class, and gender, are shared by the local population (see Figure 2 and section 2.4).

The term "demography" refers to the scientific study of human population size, composition, and change. Given that it is based on mathematical facts, it is an exact science and, thus, implies that it is a scientific discipline. Mostly quantitative methods of data gathering are utilised but the execution of qualitative methods to gather data is not excluded (Hattingh et al., 2012:208). Population statistics are frequently used in demography (Hattingh et al., 2012:208).

According to Meintjes (2014:59), demography involves the study of the characteristics of a population. The primary tasks of a demographer are to measure the population size, composition, growth, density, distribution and vital statistics. Counting the number of people in a community—a group of people living in a particular area—is one way to determine its population size.

b. Land use and quality of housing

Large tracts of agricultural land, informal settlements (see Figure 1), and high-density housing are typical features of the area's development.

c. Infrastructure or formed organisations

The word "community" was first documented circa 1325 BC. The Latin word communitas, which means "joint possession or use," is where the term first appeared. There is a commonality among members of a community, such as a common culture or geographic location (Thesaurus.com, n.d.). A community, according to Hattingh et al. (2012:210), is a collection of individuals in a precisely defined geographic area who are able to communicate with one another and share common goals and objectives.

Communities without shared goals cannot survive, even though some may have distinct, even antagonistic, cultures and worldviews. These could include goals like accepting individual differences and protecting one another's privacy. Individual actions within communities can impact other members of the same community as well as the environment in which they reside. This definition implies that communities can be small or large. For example, all mothers in South Africa with children under five, the students at a small farm school, or even the patients in a particular hospital ward can be considered community members (Hattingh et al., 2012:147).

d. Geographically bound communities

- Geographically bound communities are those whose formal boundaries are set by law or whose borders have been acknowledged over time by regional customs. These communities include townships (Gugulethu, Khayelitsha), cities (Cape Town, Durban), and residential areas established through legal processes. Generally, consent from the community is required (Hattingh et al., 2012:147).

The physical features of the environment, including the presence of plants, animals, and artificial environments within its borders, as well as the location of health services, all have an impact on a community. Geographical boundaries have various functions:

- Homogeneity is maintained, but heterogeneity is recognised
- Residents are assured of protection
- A feeling of belonging exists among residents
- Funding and other assistance is allocated specifically to that community
- The separation of labour is developed specifically through the needs of that community
- Specialised roles and cooperation are directed toward the uniqueness of that community
- Social control is exercised over residents or members (Hattingh et al., 2012:147).

A community, in the words of Visser and Moleko (2014:6), is just a collection of individuals who reside in a particular area. Charts show the borders that separate states, towns, and residential areas.

Interpersonal relationships within communities are often formed not so much on preference as on shared experiences and closeness (Visser & Moleko, 2014:6). A community is a precisely defined geographic area that possesses the following attributes:

2.3.1.2 Community as a network of social relationships

A community can achieve its main objectives through group interaction, such as socialization, role completion, goal achievement, and provision. As a result, a community is characterised as a collection of people who share particular characteristics, viewpoints, or pastimes. Social network users are not required to live close to one another to cooperate or belong to a social

group. When any of the following traits are evident, a person feels that they belong to a community:

a. Participation

This has to do with feeling like you belong in a group.

b. Power

the extent to which an individual and the group share an effect.

c. Providing for needs

The group's moral and material distribution satisfies certain criteria.

d. A common emotional bond

Emotional ties between people make them feel connected. Consequently, a community could be a well-planned social structure, with its members interacting to form different subsystems inside the community. Because of their interactions with one another, these subsystems are interdependent and interconnected as a whole (Visser & Moleko, 2014:6).

A community's social boundaries are robust, all-encompassing normative systems. They describe how individuals interact with one another, live in a particular community, and function within a larger social structure. In a community, people know and engage with one another, and the norms, values, and social structures that the community as a whole has accepted govern behaviour and attitudes. The culture and cultural structure within a community are intimately linked to its boundaries.

Geographical boundaries are not always synonymous with social boundaries. To maintain a sense of belonging and to shape social solidarity, groups within a community may try to carry out communal tasks. The members of this community may be geographically scattered, but have a certain feeling of belonging. This sense of belonging sustains the benefits of their association with that specific community. These communities are usually organised groups that share the same interests, views, needs, problems, norms, or any other common feature. Socially bound communities may be those communities with specific interests such as stamp collectors, or groups with special language and cultural interests, such as the Jewish community in Johannesburg (Hattingh et al., 2012:148)

The South African Local Government Municipal Systems Act No. 32 of 2000 Chapter 1, refers to communities in a municipality that comprise:

(a) the people living in the municipality;

(b) the people who pay the rates within the municipality;

(c) any non-governmental, labor, or private sector organizations or bodies that are involved in local matters within the municipality; and

(d) visitors and other people who live outside the municipality but use the services or facilities offered by the municipality as a result of their presence in the city; this group of people includes, more specifically, the impoverished and other disadvantaged sections of the general public (RSA, 2000).

Van der Waldt's (2014:3) claim that local government is confined to specific areas where people reside lends credence to these viewpoints. The "people" or "community" is a crucial component of municipalities.

According to Van der Waldt (2014:27), "community" is defined from the standpoint of local government as the population that lives under the jurisdiction of a specific municipality. These groups include taxpayer associations, non-governmental organizations (NGOs), community-based organizations (CBOs), the business community, and youth and women's organizations.

2.3.1.3 Community as a construction of a way of life

Communities are the byproducts of society, which is shaped by ideology and history. According to this perspective, communication both shapes and changes a community. There may be opportunities and crises related to the interdependence of people, ideas, and problems (Visser & Moleko, 2014:7). These shared experiences, combined with the socio-historical context and the ways in which people interpret particular events, help to shape a common character or way of living. Working in a community reveals how social and physical environments influence people's perceptions of authenticity (Visser & Moleko, 2014:7).

2.3.1.4 Community as a sociopolitical organisation

The sociopolitical meaning of the term "community" is a reproduction of the political ideologies and histories of specific individuals within a given setting. As a result, a community can create a cooperative control structure that promotes making decisions by exact causes and effects. Interest groups can promote moral ideals like opposing gender-based violence against women and children or advancing human rights, while neighborhood residents can support safe and healthy living conditions (Visser & Moleko, 2014:7).

2.3.1.5 Involvement and community organisations

Individuals can work to improve their neighborhoods and gain personally from community involvement initiatives, such as through participation in a ratepayers association or a

community police forum. When correctly interpreted, however, participatory development means dynamic group action—that is, cooperating with the "community of concerned individuals" to accomplish shared objectives. Thus, the concept of genuine and empowering community involvement finds practical expression in the creation of community organizations (Monaheng et al., 2016:219). The importance of community-based organizations (CBOs) cannot be overstated for the impoverished and disadvantaged, who typically have limited financial means and minimal political clout. To put pressure on those in charge of the development process, they have to rely on collective action. As public officials often find themselves in the predicament that they serve two “masters”, (they represent their department, but also their communities), they have to balance carefully two, often different, sets of interest. In this regard, there are calls for congruence between behaviour, attitudes and relationships between development actors and among different levels and different organisations to ensure that all who prioritise development find themselves “on the same page”. The relationship complexities mentioned bring us back to a fundamental ethical question: who decides about and who benefits from involvement? If change agents do not understand this question, their contribution to involvement is debatable (Monaheng et al., 2016: 219).

While local Community Benefit Organizations (CBOs) possess the authority to assert claims against external government departments, this could unintentionally hinder community self-sufficiency. This implies that there might be a conflict between local CBOs' functions as intermediaries for outside aid and as engines of self-reliance. Utilizing outside resources solely to augment domestic resources is one strategy for resolving this dispute; to appreciate and make use of the social capital and indigenous knowledge systems that are already in place, local resources and capacity must be involved and utilized. The well-known theme shows that those who are impoverished can contribute if they believe it will benefit them in the long run (Monaheng et al., 2016: 219). Burkey (1993:211) asserts that one should "don't do anything for people that they can do for themselves."

As was previously said, the integration of two knowledge regimes is crucial in this respect. Which technical skill sets—those of public servants or change agents—can be combined, and how, with local knowledge of the beneficiaries? This pertains to change agents' and public officials' capacity to "understand" local contexts that provide meaning and to familiarize themselves with relevant participatory action research (PAR) methodology to gain a deeper understanding of those contexts. From a more radical standpoint, writers argue that “a people’s organisation is not a philanthropic plaything or a social service’s ameliorative gesture. It is a deep, hard-driving force, striking and cutting at the very roots of all the evils which beset the people”(Monaheng et al., 2016: 220). In this context, while community forums are seen to provide a “collective voice for the community” and to act as a pressure group for improved

service delivery, in a more fundamental way they create the prospective for critical reflection and communal action, and in a mental way they create the prospective for serious reflection and collective action, and for the expanding of awareness. From a radical viewpoint, CBOs are a mechanism to create a more just and equitable society that is established on respect for human rights. In the same vein “social movements” can be seen as instruments for reshaping power relationships as a basis for the attainment of social justice and equity (Monaheng et al., 2016: 220).

Active civil society politics. Because it enables residents and other stakeholders to become involved in civil society issues and community development initiatives(Chaney, 2016:282). Municipalities are oblidged to community development. Therefore, community representatives should only end their engagement with the community when it is convenient for them to do so; In part because it involves more than just one meeting between local officials and the community, they must encourage a mindset of community involvement in all aspects of the municipality (Mdunyelwa, 2015:87). Thus, community involvement is the continuous process of involving members of the community in the design, implementation, and oversight of projects aimed at raising the community's standard of living (Mubangizi, 2016:158). It follows from the above that participation entails more than just approving predetermined decisions. It is a process that involves individuals from the outset when developments are started, through the beginning phase, and ultimately, when expansion programs are implemented. Participation in local expansion projects also fosters a feeling of ownership and community pride among the local populace. According to Mdunyelwa (2015:22), community involvement helps to create responsible, knowledgeable citizens who are aware of all the resources that have been made available to them. As a result of their perception of themselves as integral to the expansion of the neighborhood, the community expects new developments to continue, which directly affects the results of those developments. In fact, community involvement is an essential part of the municipal domain and ought to be ongoing for the good of the local community and the expert. The next section explains that public administration is concerned with, among many other things, ensuring the successful and efficient management of human and physical resources in the community sector. The welfare of its citizens is the priority of the municipality. The municipality aims to maintain a current grasp of the needs, preferences, and experiences of the people through community involvement (Mdunyelwa, 2015:18).

2.3.1.6 Comprehensive definition

A community is implied to be several people who interact with one another consistently over time or in an area – in other words, the catchment area that shares norms, values, and an identity as belonging to that community. In primary health care (PHC), a community is

frequently understood as the population of a geographical area – or, the catchment population that is served by a given health team. There are, however, many other kinds of communities. People may form a community based on a common identity without necessarily living near one another, for example, refugees or ethnic minority groups. Defining a given community may be complex, as people who live near one another are likely to share characteristics (for example, living conditions), but may be different from one another in ways that give rise to different needs and priorities (Sherry, 2018:44).

Visser and Moleko (2014:7) offer a useful explanation of a community composed of multiple cohesive points of view. A community is a precise structure that results from the structural self-organization that a population of people (demography) establishes in a specific location (geography) to survive and thrive as a group (economics). It creates common ways of feeling, thinking, and acting (cultural anthropology) that are absorbed by the whole community and that, to a certain degree, each person identifies with (socialization) in light of their individual experiences and inherited characteristics (psychology). Additionally, it fosters interactive connections between its elements (sociology).

As a result, a community is thought of as a complex system of interactions between elements that are social, political, psychological, ecological, and cultural. This comprehensive explanation states that knowledge of each of these academic disciplines is necessary to comprehend communities (Visser & Moleko, 2014:7). In short, community involvement is the process that permits members of a community to actively contribute to the advancement of the common good. Stuurman (2019:327) quotes from Arnstein (1968) that community involvement is a concept that is linked and associated with the element of citizen power, in which power is distributed to include all the people in the process, as well as the underdeveloped communities and the marginalised people. These are communities that are generally excluded in the decision-making process, be that economically or politically, but the primary goal is to enhance their active participation. Furthermore, two types of community involvement are identified, namely direct involvement and involvement through association. Conversely, direct community involvement refers to a situation by which individuals as citizens actively are involved in the process. Involvement through association, on the other hand, pertains to representative involvement, by which a certain person is nominated to represent what is regarded as the opinions of those individuals or committees who elected such as representatives in the process of making decisions (Stuurman, 2019:327).

Mntambo (2018:9) affirms that community involvement is about individual- insight on wellbeing, and developing action plans based on priorities and available resources. The community is welcome to participate in the planning and management of services, including

the general policies, strategies, and work plans. National government needs to effect community involvement, a high level of decentralization, and resource mobilization. At the grassroots level, institutions that are actively involved and a multisectoral approach to service delivery are necessary.

2.3.1.7 Community involvement basis

Having described what we understand by community, what does it mean for the community to be involved? In the context of PHC, we understand community involvement to incorporate all the customs in which community members jointly get involved that affect their health. This can comprise engaging with health workers and managers about health-service issues, as well as action on broader factors affecting health, such as community access to electricity supply, water supply, and education (Sherry, 2018:47). The information below shows the traits of populations undergoing demographic and epidemiological change that are frequently subjected to challenging social, psychological, and physical environments. When low and higher socioeconomic districts are contrasted, it can be seen that the former have worse mental health services, more air pollution, and less hygienic conditions

and palliative care.

Figure 2.1: Current state of health in Cape Town

The health status of Cape Town is dominated by the quadruple burden of disease (Western Cape Department of Health, 2019). This burden is not experienced equally among the communities of Cape Town (Mumm et al., 2017).

2.4 Cape Town community: Imizamo Yethu (IY)

Established in 1991, Imizamo Yethu, which translates to "the people have gathered their efforts," is a relatively new informal settlement located in the Hout Bay area of Cape Town (Piper, 2015:33). It has expanded rapidly, surpassing the initial 450 dwelling units and erfs with 20,000+ residents (Figure 2.1). This growth is the result of a consistent influx of people from the Eastern Cape and, more recently, the rest of Africa; however, migrant laborers from Angola and Mozambique have long been employed in the fishing industry in Imizamo Yethu. Imizamo Yethu, like the other informal settlements in Cape Town, is primarily an African National Congress (ANC) neighborhood in a metropolitan area governed by the Democratic Alliance (DA) since 2006 and a province run by the Democratic Alliance (DA) since 2009.

Piper (2015:34) interviewed, observed, and conducted several involvement action workshops in Imizamo Yethu in 2011 and 2012, including local leaders, foreign nationals, youth, and business owners. Furthermore, Piper (2015:35) presented a business survey that included questionnaires for significant business categories, as well as an example household survey that established crucial demographic data (Piper, 2015:34).

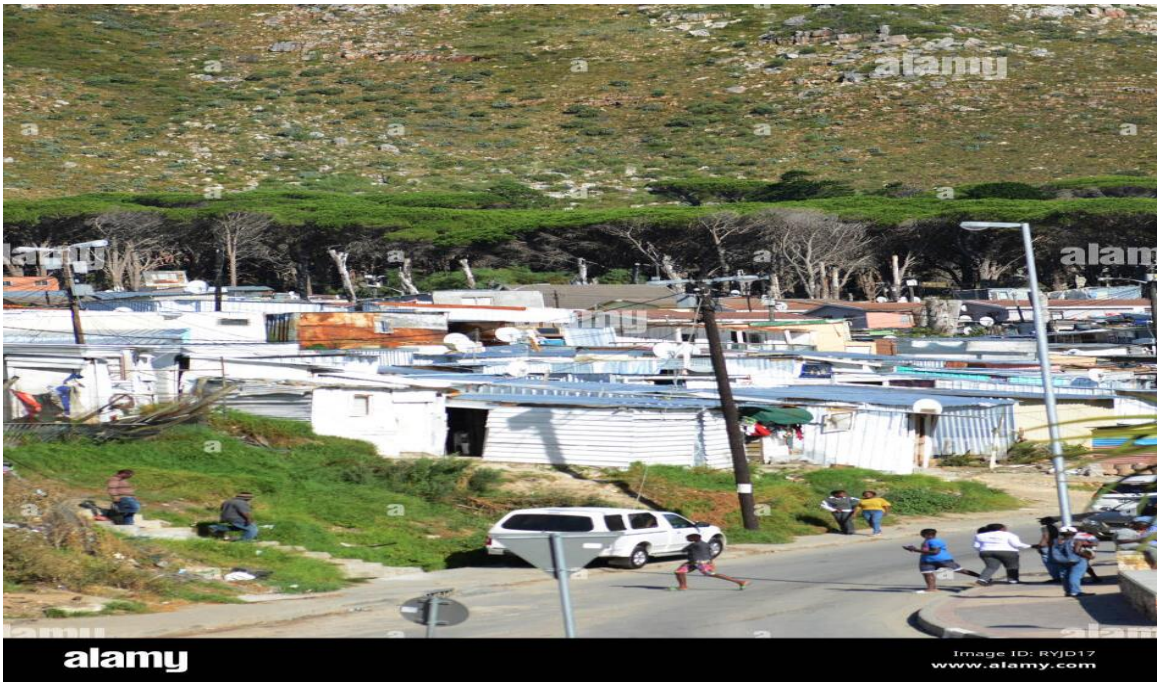


Figure 2.2: Cape Town community: Imizamo Yethu

Source: (SABC News, 18 August 2019)

2.4.1 Community organisation in IY

Imizamo Yethu's community is immensely varied. When asked to define the Imizamo Yethu community, the leadership of the South African National Civic Organization (SANCO) took into account the sizeable populations of Angolans, Namibians, Zimbabweans, Malawians, Congolese, and Somalians. Nonetheless, South Africans were mentioned as SANCO members when the question was posed. The community was consistently mentioned as the person that SANCO most closely resembles. Many foreign residents claim that SANCO is something that only happens in South Africa and that they would never get involved in it. This could be verified by simple decision, as one expat resident clarified. This decision can be trusted because it aligns with views expressed in other parts of the literature regarding the transient mindset and composite concepts of a community that many immigrants have embraced.

However, another contributing factor is that SANCO meetings are held in isiXhosa, a fact that has also irritated some of Imizamo Yethu's Afrikaans-speaking colored residents. That is not the point—you make it difficult for us—was the response given to a SANCO leader who said, "I know you understand Xhosa anyway." From the above, one gets the impression of a diverse population with a hierarchy of political citizenship, ranging from foreign residents to South Africans who do not speak isiXhosa to those who do. These people appear to represent the real political community that some SANCO leaders are aware of when they speak on behalf of the community. The situation mentioned above runs counter to the truth. According to Monaheng, Teek, and Theron (2016:218), each person can take personal responsibility for the development of their community and gain personally from community development initiatives, such as a community police forum. Therefore, the understanding is that participatory development requires an holistic group approach. That means to work together with the “community of concerned individuals” to achieve common goals. The concept of community ownership is thus given concrete expression through the creation of community organizations. Community organizations serve the impoverished and disadvantaged, who individually manage the least amount of financial resources and wield the least amount of political clout. To exert pressure on those in charge of the development process, they must rely on collective action. More fundamentally, they create the potential for serious reflection and shared action and the developing of consciousness. From a radical viewpoint, CBOs are a mechanism to create a more just and equitable society that is founded on respect for human rights. Social movements are viewed by some authors as instruments for reshaping power

relationships as a basis for the attainment of social justice and equity (Monaheng et al., 2016:219).

2.4.1.1 Functions of local community organisations

Within the framework of involvement, CBOs can perform the following functions:

- They can help to arrange and facilitate the delivery of community services by offering precise information regarding the needs, preferences, and capacities of the community's citizens as well as dependable assessments of the results of government programs and services in comparison to those of other development organizations.
- They can organize and supply the means of reciprocal aid and group efforts, including the mobilization, allocation, and use of resources (cash, labor, supplies, and managerial expertise), which lays the groundwork for local capacity-building and self-sufficiency.
- By giving the local population a voice, an option, and the ability to make strong demands of the government and other decision-makers over resources and public policy, they can empower the community.
- By good development planning and management principles like project management, they can serve as mechanisms, forums, or structures for organizing local development as well as for obtaining, coordinating, and utilizing outside assistance (Monaheng et al., 2016:219).

2.4.2 Community organisation complexities in IY

Community involvement is cumbersome and comprises capacity building. In essence, It's about understanding the social or power dynamics. Additionally, there is a risk that specific individuals or groups will control any opportunity for participation. And assert their right to speak for the entire community while ignoring the diversity of needs and interests. The historical, political, and socioeconomic contexts affect the existing relationships between communities and service providers. In and beyond the health care setting. Particularly in rural areas, health workers in South Africa typically enjoy a higher status than the people they serve (Sherry, 2018:50).

The perception that SANCO is the community front-runner is widely held in Imizamo Yethu, as indicated by the second point. This has been evident from all locals, according to Piper (2015:34), with the partial exception of immigrants, who occasionally stated that it depended on your national group. Notably, the principal of the new school, major NGOs working in

Imizamo Yethu, municipal officials, and the Hout Bay police station expressed the parallel viewpoint. Moreover, SANCO and ANC leadership contributed to the hegemony of the idea that community leadership equated to SANCO by explaining that SANCO was responsible for local development, while the ANC concentrated on other issues, which implied broader politics in the ward and beyond.

The perception that SANCO is the community front-runner is widely held in Imizamo Yethu, as indicated by the second point. This has been evident from all locals, according to Piper (2015:34), with the partial exception of immigrants, who occasionally stated that it depended on their national group. Notably, the principal of the new school, major NGOs working in Imizamo Yethu, municipal officials, and the Hout Bay police station expressed a parallel viewpoint. Moreover, SANCO and ANC leadership contributed to the hegemony of the idea that community leadership equated to SANCO by explaining that SANCO was responsible for local development, while the ANC concentrated on other issues, which implied broader politics in the ward and beyond. The role of SANCO as a community leader is not clear, especially when it comes to issues related to development.

The fact that nearly all respondents acknowledged that SANCO is currently split between old and new leadership, both of whom contend that SANCO must lead, added an extra special touch to the most common assumption—that SANCO must lead. The choice to construct a new school in Imizamo Yethu rather than more homes is the historical source of this conflict, which can also be explained in terms of a struggle for dominance between two leadership groups. The story's main focus is on resources. Therefore, during discussions with both groups of leaders, each charged the other with being corrupt in the distribution of housing in Imizamo Yethu, while other members of the community leveled similar accusations against both. Regarding this, several respondents also discussed SA NCO's relative weakness and of SANCO and ANC in 2012 as compared to in the mid-1990s.

According to one respondent, people only attend meetings these days if they hope to receive something tangible, like a house; otherwise, they don't go (Piper, 2015:35). The 1990s were not like that. The entire community would then attend meetings if they were called. Another said, "There are so many people in IY, but there are less than 200 ANC members." Some respondents attributed the decreased participation to the persistent corruption of local authorities, while others attributed it to the large number of foreign residents who reduced the community's homogeneity (Piper, 2015:35).

Late last year, after being ousted from office more than a year earlier, the old faction of SANCO attempted to call a community assembly to discuss the construction of the remaining 50

houses from a project driven by donors. This was perhaps the most deliberate design of SANCO's ongoing legitimacy as the community's development representative. Although they don't have the same relationship with the City and the donor to advance the project, leaders from the new SANCO ensured that the meeting did not take place. Shortly after winning the election, one of the new SANCO leaders expressed worry that nothing [was] happening in Imizamo Yethu, specifically that no new development projects were being worked on or jobs specifically related to projects for SANCO. This implosion was confirmed by a recent interviewee, who stated, "The guys just do not want to admit that they have failed." Thus, the legitimacy of offices is still strong enough to prevent competitors from doing just that, even though the new SANCO has failed to deliver on its promises of service delivery and local jobs.

Undoubtedly, a crucial aspect of the narrative that facilitates understanding the power of the new SANCO over the old is not so much the charge of dishonesty as it is the charge that the former SANCO was too closely associated with the DA-run City and its allies in white society – an apparent betrayal associated with siding with the City and (white foreign) donors in opting to construct a new school in Imizamo Yethu rather than additional housing. The new SANCO leadership frequently brought up the subject of party politics interfering in Imizamo Yethu at higher levels of the province and city. In fact, one defendant claimed that the Premier's office took action as a result of the new SANCO leadership's resistance to the new school. Surprisingly, the division of representative roles with the ANC and the talk of betrayal to the DA settles the intimacy between the two organizations, despite the recurring rights to represent the entire community, regardless of party affiliation. One foreign resident described SANCO as the ANC's younger brother (Piper, 2015:36).

2.5 Insufficient community involvement case – Court judgment

The Department of Mineral Resources and Energy (DMRE) decided to grant environmental authorization for the proposed Searcher Seismic survey project, which aims to search for oil and gas resources on the West Coast. Civil society organizations have vowed to appeal this decision.

“This is the searcher’s second attempt at surveying off the West Coast after its first attempt was stopped by the Western Cape High Court due to insufficient public participation (community involvement), in particular, consultation with affected small-scale fishers” (Engel, 2023:3).

The founder of the civil society organization We Are South Africans, Gilbert Martin, has said that there are problems with the public participation (community involvement) process. He calls this process of community involvement a "ruse," and the South African government only uses it as an excuse to say, "We told you so, and we did let you know" (Engel, 2023:3). The community members, civil society environmental organisations and supporters protested, calling on the government to protect their livelihoods. This matter is considered ratification by Cloete (2018:144), who suggests four community-involvement objectives, listed from least effective to most effective:

2.5.1 Ratification

Ratification implies the approval of decisions after making them; in other words, legitimising decisions after somebody otherwise has taken them. It is a feeble method of involvement in that it is limited to demonstrating provision nonetheless cannot influence the contents of the decision concerned (Cloete, 2018:144).

2.5.2 Consultation

Before or after a unilateral decision is made, consultation is the process of using a group of people as a sounding board to get their thoughts, suggestions, advice, or praise on a subject. Involvement is weak and unproductive if the person making the decisions is not dedicated to taking the opinions of the audience into account. There's no attempt to reach a consensus on the matter. There is no guarantee that the decision-maker will consider the opinions presented to him, and the body that is "consulted" has the power to veto a decision. However, there is still room for influence through persuasion, negotiating, and the threat of some form of coercion. The South African government decided to act in this undemocratic manner, but resistance movements disagreed. For example, Liz McDaid, the strategic lead at Green Connection, stated that stakeholder participation is essential in oil and gas studies. Additionally, those combined effects are examined and discussed (Engel, 2023:3).

2.5.3 Negotiation

In order to reach a joint decision through a passive settlement of policy issues, negotiation implies the active participation of all parties in the deliberations. Negotiation offers a chance to be involved in the decision-making process by trying to support an opponent, reach a compromise, or threaten to use force if one's opinions are not accepted, even though it does not guarantee agreement (or a negotiated settlement). A decision may be overridden by a veto. It is a highly successful engagement strategy (Cloete, 2018:144).

2.5.4 Execution

The word "execution" describes the process of being intimately involved in the planning, development, implementation, and assessment of policy initiatives soon after their acceptance. It is thought to be the most authentic form of involvement since it enables participation and monitoring during the implementation process to ensure that the policy is being implemented correctly (Cloete, 2018:144).

2.6 Involvement

Classifying and communicating grassroots needs is a commitment that comes with involvement (Mubangizi & Dassin, 2014:153). Because it encourages accountability, transparency, and the prioritization of needs when it comes to community service delivery, participation is crucial to democracy and good governance. Therefore, participation allows the public to be heard in municipal affairs through the use of local democratic institutions like ward committees, public meetings, and imbizo. It symbolizes the relationship that exists between the institutions themselves and the people that government agencies help. Mubangizi and Dassin (2014:162) assert that when locals participate in community issues, local resources such as knowledge, creativity, and energy become visible. The community can direct and influence local economic initiatives through community involvement in local government affairs, claim Maxegwana et al. (2016:77). Since involvement is a fundamental component of people-centered development, it must be planned with honesty and sincerity to ensure that communities are truly involved in decision-making, program and project implementation, monitoring and evaluation, and benefit sharing. According to Davids et al. (2009):19, involvement recognizes that people—both individuals and groups—are at the center of the provision of services. It suggests that they have to have access to the places where services are provided. To improve the performance and sustainability of policies, programs, and projects, as well as the capacity and skills of shareholders, participation is required (Davids et al. 2009:19).

To make clear its fundamental elements, the study's next section offers a thorough definition of the phenomenon of community involvement.

2.6.1 Community involvement definition

According to Ijeoma (2018), community involvement refers to any process that involves the public in problem-solving or decision-making and uses their input to make decisions.

“We define community involvement as any process that includes the community in problem-solving or decision-making and that uses community input to make better decisions” (IAP2,

2021:1). Nzimakwe (2012:39) asserts that community involvement is essential to defining the laws and policies that control the country. Furthermore, as noted by Madumo (2014:130), community involvement is a crucial element of democracy and a governance tool that, when used effectively, produces the best possible community service delivery. The community's involvement according to Mubungizi and Dassin (2014:32), is a continuous process towards building a democracy. It encourages citizens to actively participate at local government level, identify with governmental institutions, and familiarize themselves with the legislative process. By giving those involved a voice and a chance to be heard and understood, it improves their civic dignity. In order to create laws that are likely to be broadly embraced and useful in practice, it promotes a spirit of democratic and pluralistic accommodation. It supports the legitimacy of regulations as people understand them. Hence, when locals are compared to public officials who may not reside in the neighborhood, locals are certain to have a greater understanding of their neighborhood. Community involvement is described by Napier (2008:163) as an information-sharing relationship between locals and decision-makers. When designing local policies, projects, or strategies, the intimate knowledge that locals have of their surroundings is crucial. When locals are involved in community matters, local resources like knowledge, creativity, and energy are unlocked. The local community can gain from the combination of these resources (Mubangizi & Dassin, 2014:162). Similarly, Maxegwana, et al. (2015:77) contend that community influence and control over local economic initiatives are made possible by community participation in local government affairs. Hence, when locals are compared to public officials who may not reside in the neighborhood, locals are certain to have a greater understanding of their neighborhood. Community involvement is described by Napier (2008:163) as an information-sharing relationship between locals and decision-makers. When designing local policies, projects, or strategies, the intimate knowledge that locals have of their surroundings is crucial. When locals are involved in community matters, local resources like knowledge, creativity, and energy are unlocked. The local community can gain from the combination of these resources (Mubangizi & Dassin, 2014:162). Similarly, Maxegwana, et al. (2015:77) contend that community influence and control over local economic initiatives are made possible by community participation in local government affairs. According to Mdunyelwa (2015:5), having members of the underprivileged and marginalized community involved in decision-making bodies at the community level gives people a greater voice in decisions that impact their lives. Effective community involvement requires decentralisation of the decision-making official to the municipal level, permitting grassroots communities to be involve in political affairs. In light of this, South African municipalities are acknowledged as distinct entities with decentralized political and administrative power to conduct their own

business. How the public can engage with government decision-making processes are detailed in the following section.

In the end, the International Association for Public Participation's definition is the most suitable for this study (IAP2). Community involvement can be defined as "involving those who are affected by a decision in the decision-making process." Furthermore, it encourages wise decisions by providing participants with the information they require to engage expressively and by educating communities about how their input affects the decision (RSA, 2008).

2.6.1.1 Meaning of involvement

"Involvement" is a word with many definitions. Some use it interchangeably with public information campaigns, meaning spreading awareness within the community. It is commonly used to refer to public hearings where members of the public are invited to comment on proposed actions by public-sector departments. It has also been used to suggest that the public who will be impacted by it has reached a consensus. Without knowing which interpretation applies to their specific program, no one can create a community involvement program (Creighton, 2005:9). Participation gives sustainable goals context and significance for a wide range of stakeholders and fosters local innovations in sustainable development by fostering innovative problem-solving techniques. It will be difficult to engage the community in a transformative way that produces equitable results. Many communities are distrustful due to years of neglect and underfunding. While concentrating on a common vision for a prosperous future, many institutions have not fully realized the benefits of collaboration and community partnerships that are inclusive of voices that have been left behind (Bergstrom et al., 2014:1).

It is best to think of involvement as a continuum. As it's a continuum, there are countless viewpoints all along the way, but for this discussion, there are four main groups, as Figure 2.3 illustrates:

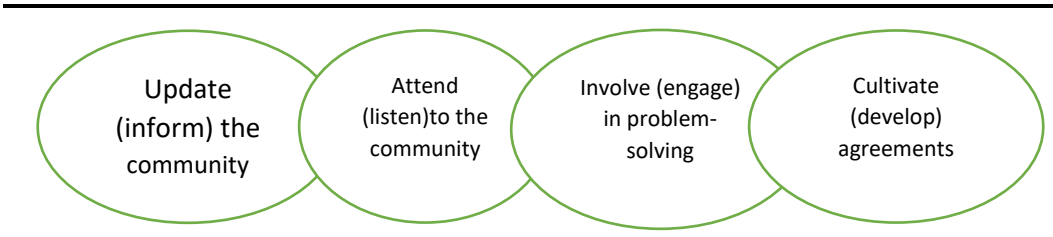


Figure 2.3: Continuum of involvement

Source: (Creighton, 2005:9)

a Inform the community

b Solve problems

c Create aggreements

2.6.1.2 Community information and community relations

Programs that provide community information are essentially one-way dialogues with the community. Community involvement literature often mocks the decide-announce-define authoritarian model, of which they are an essential component. Even if community information doesn't prove community involvement on its own, it's nevertheless a crucial component of a proactive program that promotes community involvement. Without comprehensive and unbiased information to construct their opinions upon, people cannot participate (Creighton, 2005:9). The community must be informed about the accessible options for basic service delivery, according to Pypers and Bassuday (2016:2). This is the responsibility of the municipality. The Municipal Systems Act's Section 6 covers the responsibilities of the municipal administration. In order to attain them, it is necessary to:

• Educate the public in a complete and accurate manner regarding the amount and caliber of municipal services to which they are legally entitled.

• educating the public about the people in authority, the expenses associated with upkeep of the municipality, and its protocols for operation (Pypers & Bassuday, 2016:2).

2.6.1.3 Community participation procedures

Two strategies that many public institutions have used to increase community involvement are public hearings, where the public can comment on proposed actions, and increased access to information, achieved by publishing reports (like environmental impact statements) or setting up information repositories, where the public can access all pertinent studies and documents. One could refer to these methods of community engagement as "checklists" or even "procedural" systems. They are required because, in the absence of other community involvement opportunities, they establish a legal record that the public institution must adhere to and enforce a certain degree of transparency. They don't, however, present many chances for group problem-solving and don't influence decisions (Creighton, 2005:9).

2.6.1.4 Consultation and cooperative issue resolution

When government agencies collaborate with communities to discover a solution that will be widely supported, they have a far higher success rate. Settlements are not always the outcome of this approach. Sometimes the only thing that occurs is that everyone understands the rationale behind the choice and the positions are made clear through interaction.

2.6.1.4 Consultation and collaborative problem-solving

When government agencies collaborate with communities to find a solution that will be widely supported, they have a far higher success rate. Settlements are not always the outcome of this approach. Sometimes the only thing that occurs is that everyone understands the rationale behind the decision and the positions are made clear through an interface. Sometimes enough support is garnered, even from those who oppose the action, to allow the department to proceed with sufficient legitimacy. When government agencies collaborate with communities to find a solution that will be widely supported, they have a far higher success rate. Settlements are not always the outcome of this approach. Sometimes the only thing that occurs is that everyone understands the rationale behind the decision and the positions are made clear through an interface. Sometimes enough support is garnered, even from those who oppose the action, to allow the department to proceed with sufficient legitimacy.

Even if there isn't a final agreement and the department has the final say in what to do, by the time the process is over, the community has typically had some say in the outcome. Even though there is disagreement over the final result, the community's inspiration may have contributed to the definition of the problem, the range of substitutes that were measured, the development of practical assessment standards, and the process by which the decision was made. Pypers and Bassuday (2016:2) highlight the importance of the local community's involvement and consult them regarding the scope, impact, quality, and level of municipal services.

2.6.1.5. Reaching consensus and reaching agreement

One issue with the term "consensus-seeking" is that it can easily be mistaken for the phrase "consensus building," which refers to processes aimed at reaching a comprehensive agreement. Searching for unanimity is the process of consensus building. It entails exerting sincere effort to ensure the well-being of every shareholder. Consensus is reached when everyone feels that the plans can be lived with after all efforts have been made to serve the interests of all parties concerned (Creighton, 2005:10). Then, this is somewhat mitigated: the majority of professionals in dispute resolution think that assemblies or groups should aim for unanimity but also accept an unstoppable agreement that meets the interests of all shareholders as much as is practical.

The primary benefit of the agreement approach is that, in the event of an honest agreement, it permits the intervention to proceed with a reasonable guarantee of implementation. This assumes, of course, that the department has the legal and financial experts to carry out the consensus decision and that the department itself concurs with the decision being made.

Additionally, it is assumed that those who have endorsed the agreement represent the groups they purport to represent and are able to vouch for the agreement's endorsement by these groups. If these conditions are not met, the agreement-seeking approach could set expectations that could worsen ties with the community if they are not fulfilled (Creighton, 2005:11).

2.6.2 Intensity levels for community involvement – centric to the definition

Decision-making is centric on one community-involvement definition throughout the literature. Hence, Figure 2.4 shows the various public categories' levels and intensities of involvement. It consists of multiple orbits revolving around the decision-makers. The diagram shows that the actual decision-makers in the public are represented by, for example, elected officials or heads of government departments, and they form the (1) nucleus of the orbit (Mdunyelwa, 2015). At the level of inspiration (influence) are (2) the staff and technical consultants of all these government departments. These are the folks who will put in the effort and time to make sure they have a say in the choices. They will attend meetings and workshops, participate in an advisory group, organize community events, and engage in other activities. They are giving this some serious thought, and it would be best for the organization if they focused their energies and commitment on your community engagement program. Local government representatives, civic associations, landowners, members of interest groups, and individuals worried about the effects of development or planning on the community are a few examples. It is important to make every effort to ensure that no influential participants are excluded from the public. In support of this, Creighton (2005:54) defines "decision-makers" as those individuals or groups within the organization who will ultimately make the decisions as well as those who successfully exercise their veto power over those decisions. In a progressive society, multiple agencies working together make decisions rather than just one. Co-decision-makers can include primary customers, a controlling agency, a local government with permitting authority, or a joint venture partner (Creighton, 2005:54).

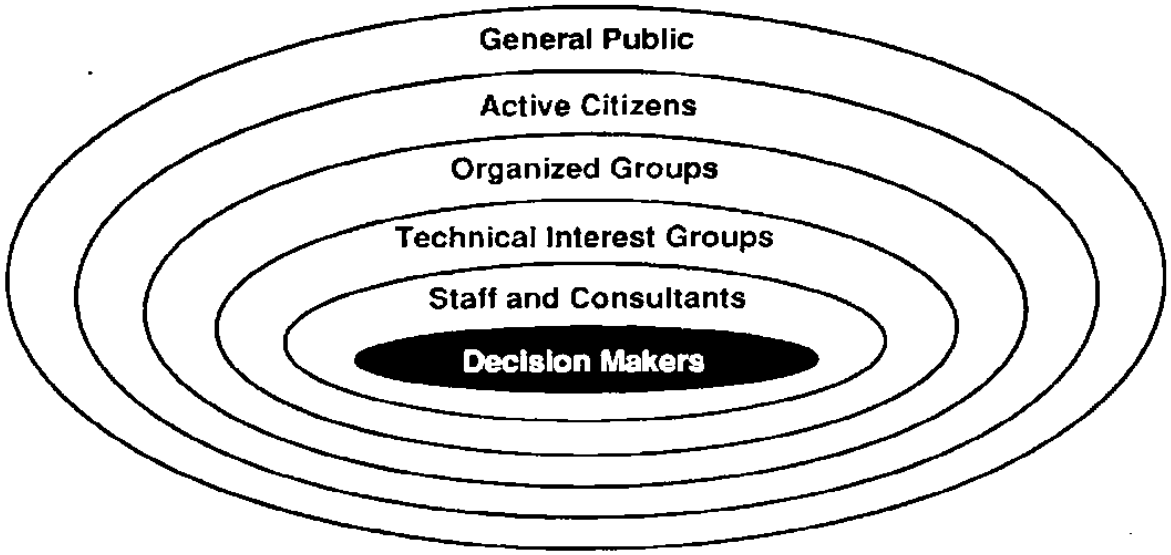
If they are not involved, they might show up late and undermine your efforts, or they might voice their opinions in another setting, like a courtroom or a political channel (Creighton, 2005:54).

Three organized group leaders exist, such as organized trade unions, who are willing to invest the time and energy necessary to try and influence the decision and often hold onto a significant amount of real information or outcomes. According to Creighton's (2005:53) expertise, numerous agencies collaborate to reach a decision. While some agencies may not have participated in reaching the final decision, they do have some degree of decision-making

authority—and occasionally even the only one— in terms of the methods used to assess the results of projects. The final orbit (5) represents the broader public, which observes with curiosity but either stays neutral or refuses to engage in the divisive matters at hand (RSA, 2008). Since they choose not to participate, Creighton (2005:54) claims that this group is unsurprised and uninterested. They may not be very interested in the subject matter of your community involvement program because they are too busy at work or because they are heavily involved in another aspect of the community. Even though they might not be apathetic people in and of themselves—they might be actively involved in their church, school, or other organizations—they are uninterested in your problem. A federal agency whose goal is to protect wildlife habitation, for example, will offer guidelines on how to assess an achievement's impact on wildlife habitat, as the qualification is not surprising (Creighton, 2005:53).

The next group are concerned and engaged citizens (4) who are directly or indirectly affected by the choices or actions made by public officials or other government agencies. These are regular people who are concerned about a particular issue that will have an immediate impact on their communities. They are not members of any formal organization and have chosen to participate. According to Creighton (2005:54), although these groups—referred to as commenters—are drawn to the topic, they also have other responsibilities to attend to. They could offer feedback by sending a message or by speaking during a meeting. They may not be very interested in the subject matter of your community involvement program because they are too busy at work or because they are heavily involved in another aspect of the community. Even though they might not be apathetic people in and of themselves—they might be actively involved in their church, school, or other organizations—they are uninterested in your problem. The qualifier "unsurprised" means you've tried your hardest to educate them (through the media, for example) so they won't be surprised or lose interest when a decision is made. They are free to choose not to take part, though.

FIGURE 2.4. – INTENSITY LEVELS OF INVOLVEMENT



Source: Creighton, (2005:55).

2.7. The rationale for community involvement

Why is participation in the community beginning to be seen as a necessary component of democracy itself? Generally speaking, the ability to select government officials is a key feature of democracy. According to the theory, important decisions are made by designated officials, who then hold the bureaucracies responsible for carrying them out. But the administrative choices made by today's executive branches of government are crucial to the societies that these bureaucracies serve. In the US and every other industrialized nation, the scope and magnitude of all governmental levels have expanded dramatically since the 1930s (Creighton, 2005:15). In addition, a greater variety of decisions are being made, which has an impact on a growing array of aspects of peoples' lives.

Decisions that were previously made by elected officials through a political process have been transferred to pragmatist specialists in large bureaucracies as the government has grown in size and reach.

A large body of management literature developed outlining approaches for "scientific decision-making" and strategies for "maximizing benefits" (Creighton, 2005:15). It was claimed that by using a scientific analysis of "the greatest good for the greatest number," decisions could capture "the community interests" (Creighton, 2005:15).

It was claimed that by using a scientific analysis of "the greatest good for the greatest number," decisions could capture "the community interests" (Creighton, 2005:15).

Today, when elected officials lament their inability to control bureaucracies, democratic theory faces a major obstacle in the form of the bureaucracy's influence in decision-making. How can we ensure that those decisions reflect the will of the people? To what degree does public opinion get distorted or warped by the bureaucracy's own interests?

The function of expertise in administrative decision-making is a central democratic question. The fact that experts are better at discerning what is right for civilization is a hidden benefit of leaving it to them. As a result, a complex issue cannot be resolved by the community. Consequently, the question of "Why should the community be involved in technical decisions?" is posed in the majority of government departments. The community does not always need to be involved in technical decision-making, but departments do make a lot of decisions that they consider technical even though they are not.

Without giving opposing standards that communities value weight or priority, experts are unable to make decisions. There are several ways to categorize the claims made by Du Toit and Le Roux (2014:31), including more or less internalized and more or less dominant values. A person may, for instance, have internalized a value to the point where they are incapable of acting in any other manner. Because general practitioners have come to feel that suffering is not worth it, they may provide cancer patients with palliative care that is more intense than standard dosages. Higher rated standards are perceived as dominating because they are arranged hierarchically. In the industrialized world of the West, the following would be followed examples of dominant values:

Experts are unable to make decisions without giving opposing standards that communities value weight or priority. Assertions valued in the writings by Du Toit and Le Roux (2014:31), may be categorized in numerous ways; for instance, into more or less internalised and more or fewer dominant values. For instance, an individual may have internalised a value so entirely that they merely cannot envisage behaving otherwise. A general practitioner may have internalised that the worth of suffering is improper to such an degree that he applies palliative treatment that may surpass a standard dosage in the pain management of a cancer patient. Standards are organised hierarchically, so those that are rated above others are regarded as dominant. In the industrialised Western world, One could consider the following to be instances of dominant values:

• Achievement and prosperity

• Humaneness, which includes preserving life and providing comfort, love, and assistance when needed;

• Equality; and

• Democracy

These choices have to do with philosophy or values. Department administrators have difficult decisions to make when weighing various benefits that society considers to be "good," such as safety, equity, affordability, or environmental protection. Administrators of departments must determine the reasonable equilibrium point in light of current knowledge Creighthon (2005:15). Will it harm the upcoming elections? Ramaphosa remarked, "I would think not, and our people understand where Decisions about what level of risk to health or safety is "acceptable," how much is "reasonable" to pay to protect an ecological resource, or how prices must be distributed among different classes of people are not specialist decisions, despite requiring a great deal of specialist information. we are." "They are angry, and I accept that they are angry, but they have also accepted and internalized the explanation." We have long known that Eskom poses the greatest threat to both the economy and the lives of our citizens. Wishing that risk away is not the most sensible course of action, so we must manage it. I believe we are currently controlling the risk (Sunday Times, 2021).

For a moment, imagine that a canal crosses through a community. The river has such terrible pollution that no one is brave enough to fish or swim in it. The effluence is a result of multiple sources, such as return flows from upstream agriculture, an upstream manufacturing plant, and runoff from cities. Is it better for the general public or technical experts to decide what needs to be done to clean up the river? The majority of people would concur that the best people to make decisions about:

• The type and degree of effluence in the river?

• What is the best way to clean up the effluence?

• How much would each clean-up alternate cost?

• What is the relationship between exposure level and health risk?

Considering that the experts in practice have

Imagine for a moment that a canal crosses through a community. The river has terrible pollution; it is too dangerous for people to fish or swim in. The effluence is a result of multiple sources, such as return flows from upstream agriculture, an upstream manufacturing plant, and runoff from cities. Technical experts or members of the public are better suited to decide

what needs to be done to clean up the river? In cases where the choice is between determining the type and degree of effluence in a river, technical experts are generally considered to be the most qualified.

• How may the effluent be purified?

• What would each clean-up alternate's cost be?

• To what extent does exposure correspond with health risk?

Even though they might not be apathetic people in and of themselves—they might be actively involved in their church, school, or other organizations—they are uninterested in your problem. A federal agency whose goal is to protect wildlife habitation, for example, will offer guidelines on how to assess an achievement's impact on wildlife habitat, as the qualification is not surprising (Creighton, 2005:53).

The project will, at the very least, divert resources that could be used for housing, healthcare, education, or pothole repairs. Technical experts are required to choose between two values, but only one value dimension—such as cost, health risk, or feasibility—at a time. The issue is no longer merely mechanical; rather, it is now a choice between what is more vital, such as jobs or clean water, explicit freedom or environmental protection, human health concerns or the needs of other species. These are, by definition, values-based decisions.

The majority of difficult decisions, or what are commonly referred to as policy decisions, are essentially this type of values decision that is supported by technical data. According to Khoza (2021:4), Ramaphosa visited Naledi and the Nomzamo Informal Settlement in Soweto before going back to his native Chiawelo. People kept coming up to him along the route to vent their annoyance at the ongoing power outage.

The process of selecting standards involves allocating a mass or priority to an item that the community deems beneficial in relation to another item that the community deems beneficial.

Advocates of Policy A maintain that the social good on the left is more than twice as important as the social good on the right, as shown in Figure 2.4. To give them equal weight is the aim of Policy B. Policy C reverses the priority.

Even in situations where technical specialists occupy managerial positions that require them to make value decisions, their mechanical training does not make them any more qualified than others to do so. Not that professionals in their domain don't consider these kinds of things; in fact, engineers are sometimes criticized for assuming that the most affordable and feasible solution is, well, the best. But that just implies that people who are educated in engineering

are conditioned to value cost highly. The engineer's method may appear partial and self-serving to an individual who prioritizes worker safety or environmental preservation. These decisions may be informed by scientific research and proficiency, but ultimately, proficiency alone cannot serve as a foundation for choosing these key values. Democracy, or equality, is intended to give communities the authority to decide what the ultimate aims and objectives of government accomplishment are.

Participation in the community creates a genuine connection between the people making decisions in the bureaucracy and the community. In its most basic form, community involvement is a means of guaranteeing that individuals who make decisions that impact communities first have a discussion with them. Participation in the community is seen by the community as a way to increase their power over choices that have a big impact on life. Government representatives see community involvement as a means of transforming these differences into real cooperation and as a means of assuring the community that all points of view are taken into account.

Engaging with the community informs decision-makers about the relative importance that the community places on the viewpoints and values that drive a specific decision. That's not to say that knowing public standards offers a simple fix. In terms of community involvement, the electorate as a whole rarely makes up the "community" (Creighton, 2005:17). Similarly, groups within the community often disagree strongly with one another. The mere fact that a decision-maker is aware of the standards that each of these community segments possesses—which is useful information—does not mean that the information should determine the proper verdict.

Local communities frequently agree upon norms that diverge from those of the broader national public.

On the other hand, if cleaning up the area requires costly local labor, the community may purposefully accept a lesser standard than what is required nationally. Attempting to satisfy the demands of every community bordering a canal may result in inadequate management practices for the canal as a whole. Therefore, while the community is informed about the decision-making process, the department is not ultimately made up of the results. Every community, for instance, usually desires extremely high levels of protection against health risks, often above and beyond the financial capacity of the government, which speaks for the entire country. Government agencies are not the only ones that engage with the community. In marketplace economies, private organizations control a large portion of the nation's wealth. Regulated utilities are among the quasi-public institutions that fall under this category. Some are corporations, and due to their vast wealth, they also have significant influence over the

distribution of wealth. Due to government regulations or enlightened self-interest, many of these organizations are now involving the community in decisions such as the location of amenities (Creighton, 2005:17).

2.8 Methods of community involvement – Structured approach

Stuurman (2019:2) refers to Brynard's (1996:46) viewpoint that there are three approaches to involvement, namely structured-, open- and informal involvement. The first approach is structured involvement, which generally depends on the legality it holds to strengthen and advance community involvement. The municipality's ward committee structure serves as a prime illustration of this strategy, which was put in place in accordance with ward committee legislation and acts to promote and strengthen active community involvement. Under this approach, for example, Nzimakwe (2012:153) mentions that the ward committee system legitimises the municipality by reassuring active community involvement and individuals. Therefore, in order to carry out its procedures and accomplish its primary goals, local government must follow a structured methodology.

Secondly, the open community-involvement approach is thought to be the most accommodating and adaptable approach, with the goal of assisting and motivating involved citizens to take part in decision-making processes to the fullest degree possible.

The last approach, which is the combination of structured and open involvement, is referred to as an informal approach. In essence, informal community involvement allows regular citizens and community representatives to voice their needs and goals to the local government and participate in decision-making processes. For example, ordinary citizens and communities are typically invited to submit ideas during the process of creating a municipality's processes, like the Integrated Development Plan, regardless of representation (S This strategy mostly depends on the idea of active advocacy, which holds that the representatives do not have the needs of the people assigned to them, in order to stop the authorities from eventually disregarding and marginalizing the people's basic needs. Because each person is expected to express their interest directly, this approach has the potential to strengthen the trust relationship between municipalities and community members while also enabling the acceleration of development (Stuurman, 2019:3).

As soon as departments understands that community involvement is a project requirement, thereafter the degree of involvement must be determined. The degree of involvement required is pending on the matter and the preferred effects. It is crucial to keep in mind that different strategies don't always work alone; using multiple strategies will consistently produce better results. Often employed techniques consist of the following:

2.8.1 *Imbizo*

Over the years, politicians in the nation have used imbizo as a general technique for communicating about policy issues and government initiatives. An imbizo is an African term for a special meeting that is usually organized by a public official or other person in a position of authority. It has come to be associated with community interface to advance democratic principles since the democratic dispensation began in 1994. Imbizos are intended to identify, analyse, prioritise, and recommend results to the most significant problems of the community, and are circumstances that look for agreement on subjects at all government levels. They are valuable as a instrument to facilitate the entrance of citizens to statistics on public management, and to generate a space for citizens to have a voice in the use of public funds (Van der Waldt, 2014:37).

According to a government website, the idea of imbizo gives participation in democracy more weight and authentic expression, enabling communities to strengthen their right to be heard and support the goal of the country, which is to create a better life for everyone (RSA, 2012).

The Imbizo program, a phase of increased engagement between the national, provincial, and local levels of government and communities nationwide, was introduced by the government in 2001. The Imbizo project serves as a reminder of the vital role cooperative governance plays in enabling the community to react and take a more active part in the collaborative execution of the government's action plan.

Unmediated communication between the government and its communities is the focus of Imbizo. It serves as a platform for enhancing communication and cooperation between high-ranking public servants and regular citizens. Imbizo gives the government a chance to directly address the community with its improvement and action plan. Imbizo also promotes community participation in the program to improve people's lives. Interface via Imbizo identifies particular issues that require attention, roadblocks in the policy's implementation, or potential policy reviews. It encourages community involvement in problem-solving strategies. It allows the President and other officials direct access to community opinions regarding government and service delivery, allowing them to hear about their concerns, grievances, and suggestions regarding the pace and course of government operations.

Since Imbizo is now widely used in South African politics, it can be regarded as a legitimate approach to community involvement, especially when the goal is to have a conversation about one or more important policy or service delivery issues with hundreds or even thousands of local residents in one sitting.

2.8.2 Public trials

Apart from Imbizo, certain government agencies have been conducting public trials in accordance with comprehensive legislation suggesting that public hearings ought to be held prior to the initiation of major policies or infrastructure projects (RSA, 2008). The most recent instance that made headlines was the environmental impact assessment hearings held during the Gautrain project's construction. One mutual way to get the public involved in public decision-making is through public trials (Muronda, 2017:52). Public trials are open to the general public and are held to address topics of particular interest. Through public trials, the general public can have discussions about issues impacting their well-being with local representatives, including ward council members, government officials, and municipal representatives. Because they enable quick communication between the governed and the governors, they are therefore essential to community involvement (Muronda, 2017:52).

2.8.3 Ward committees

Most modern municipalities use ward committees as venues to encourage ward-level community involvement. Ward committees can be used to create "participatory governance at the grassroots level"—a community's active involvement in municipal affairs (Muronda, 2017:52).

According to Nzimakwe (2012:153), the ward committee system encourages community and individual participation, which legitimizes local government. Therefore, local government needs to adhere to a structured methodology to carry out its procedures and achieve its primary goals. Ward committees play a crucial role in ensuring greater community involvement by promoting active citizen participation in decision-making. Ward committees promote community involvement in municipal affairs by acting as liaisons between the community and the local municipality (Mulaudzi & Liebenberg, 2013:153). In addition to being the chairperson of the ward, the ward councillor works in tandem with ward committees to improve and streamline communication between the ward and the municipal council. The Ward Committee Resource Book (DPLG, 2005) states that the main duty of ward committees is to act as an official channel of communication between the local government and the community. Ward committees are platforms used by communities to express their concerns to the municipality sinc According to Nzimakwe (2012:153), the ward committee system encourages community and individual participation, which legitimizes local government. Therefore, in order to carry out its procedures and accomplish its main goals, local government must follow a structured methodology. Ward committees are crucial because they ensure that community involvement is enhanced by motivating residents to take an active role in governing issues. By serving as

a liaison between the community and the local municipality, ward committees encourage community involvement in municipal affairs (Mulaudzi & Liebenberg, 2013:153). By using the ward councillor, who also acts as the ward chairperson, ward committees generally aim to improve and facilitate communication between the ward and the municipal council. Ward committees give citizens a forum to voice their grievances with the local government and guarantee that they are actively involved in the decision-making process (Muronda, 2017:53). To effectively represent the community, local governments must involve the community in municipal affairs. Van der Waldt (2014:58) states that a ward committee is free to suggest any ideas.

One way that government-devolved political and administrative autonomy instills community involvement in matters of governance is through ward committees (Tau, 2013:152). Mayekiso et al. (2013:192) state that ward committees are established under Section 73 of the Local Government: Municipal Structures Act, 117 of 1998, to foster greater community involvement.

Community involvement serves as a forum for public officials to interact with the community in order to involve them in the creation of policies and the identification of solutions to issues that the community faces. Reddy and Sikhakane (2008:693) list ward committees as one of the most important institutions the government has established to promote participatory democracy at the municipal level. Thus, by promoting community involvement, ward committees help local governments make decisions about what the community needs. Participating in the community aids municipalities in identifying the services that the people require and supports the internally displaced person (Thornhill & Madumo, 2011:133). One way that government-devolved political and administrative autonomy instills community involvement in matters of governance is through ward committees (Tau, 2013:152).

2.8.4 Community development workers

To support companion community members in meeting their needs, achieving their goals, realizing their aspirations, and maintaining their well-being over time, community development workers, or CDWs, collaborate with other teams of community-based workers (such as community health workers, social workers, and community rehabilitation workers) (Monaheng et al., 2016:234). Ward committees and community development workers collaborate to communicate vital information between the community and governmental institutions (Muronda, 2017:27). In addition to having close working relationships, CDWs are expected to:

- Living in the community where they work; declaring their job function;
- getting to know the community and its conditions; and
- developing a deeper comprehension of people's needs and wants
- Start by identifying the achievement group or groups that they will collaborate with;

- Take on one or more of the following roles: leader, professional, advocate, enabler, or catalyst (Monaheng et al., 2016:234).

As a result, community development is thought to place a strong emphasis on self-assurance, empowering participation, and bottom-up problem solving (Monaheng et al., 2016:234).

2.8.5 African Peer Review Mechanism (APRM)

To support companion community members in meeting their needs, achieving their goals, realizing their aspirations, and maintaining their well-being over time, community development workers, or CDWs, collaborate with other teams of community-based workers (such as community health workers, social workers, and community rehabilitation workers) (Monaheng et al., 2016:234). Ward committees and community development workers collaborate to communicate vital information between the community and governmental institutions (Muronda, 2017:27). In addition to having close working relationships, CDWs acting as change agents are expected to:

• Live in the community where they work;

• Explain their job function;

• Get to know the community and its conditions;

• Deepen their understanding of people's needs and desires;

• Start identifying the achievement group or groups they will work with; and

• Act in unison.

Accordingly, community development is perceived to emphasise empowering involvement, self-confidence, and bottom-up solution driven (Monaheng et al., 2016:234).

2.8.6 Studies

A survey is used to collect data from a group of people, such as when feedback on a service is required. Reviews are very beneficial and effective, but one of their drawbacks is that they can only be given to a limited number of people (Scheuren, 2004:9). Moreover, studies don't allow the community to express its views. Studies are one way to accomplish community involvement, though.

2.8.7 Nominal groups

An additional tactic for involving the community in decision-making is the use of nominal groups. Small groups known as nominal groups typically consist of eight to twelve people (Muronda, 2017:53).

They are extensively utilized in decision-making, problem-solving, and problem-identification. The major goal of this approach is to give participants the ability to recognize encounters that are already happening and offer solutions for problems that are known or persistent.

2.8.8 Focus groups

Focus groups are a type of qualitative research tool that can provide information about the reasons behind people's opinions. They reveal the members' thoughts and emotions (Muronda, 2017:53). Focus groups are a reliable method of involving the community because they allow participants to express their opinions about particular topics in detail. Since the interviewer and group members exchange data, focus groups are a reciprocal method of involving the community.

2.8.9 Elections

Elections are one alternative means of including the community in decision-making (Netswera, 2012:75). elections that are regularly held to allow communities to select representatives. Since it is expected that representatives will be chosen based on their capacity to represent the needs of the people, they are regarded as a method of community involvement. The voice of their electorates is represented by their elected officials. Elected officials are motivated to fulfill the expectations of their constituents by fear of being recalled or removed in the upcoming election.

2.8.10 Public meetings

"Public meetings are a mechanism for community participation because they offer the community an opportunity for discussion with the political leadership," according to Thornhill (2008:502). In person, community members collaborate with local leaders during the public meetings, voicing their concerns and receiving prompt responses from them. Leaders in the community are also given the opportunity to respond and provide updates on earlier discussions. According to Phago (2008:242), government agencies and municipalities should publicize meeting dates, times, and topics to encourage community participation and give locals enough notice to make plans for the open meetings. Political leaders commonly use open speeches, media discussions, or political campaigns to increase and mobilize support in democratic societies, according to Cloete (2018:143).

2.8.11 Integrated Development Planning (IDP)

The Intergrated Development Plan a well-known mixture of designed and open involvement, denoted to as an informal method. Essentially, informal community involvement involves any member of the community in the decision-making process and enables regular citizens to

communicate their needs and goals to the local government. For example, when expressing a municipality's procedures, like the IDP, common citizens and communities are usually invited to submit their ideas, regardless of presentation (Stuurman, 2019:2).

2.8.12 Open meetings

One method of community involvement that is available to all members of the community is holding open meetings. Open meetings are inclusive of a wide range of individuals, in contrast to closed and restrictive ones. Open meetings are a great way to participate because people from the community usually attend them. They are set up to discuss policy issues like the suggested budget (Muronda, 2017:54).

2.8.13 Referendum

In theory, a referendum consists of all eligible voters casting ballots to decide on a particular issue. The public can make decisions on controversial issues through this method of citizen participation (Kersting & Mossberger, 2011:68-69). A referendum encourages community involvement in policy-making because the outcome is mandatory. For example, communities can vote to approve new legislation or policies. Before a referendum, there are frequently campaigns to inform the public about the issues at stake so that they can vote with knowledge.

2.8.14 Public opinion surveys

Surveys of public opinion are a tool for promoting collective belief. Usually, they are handled through telephone questionnaires or surveys. Public opinion on a variety of topics that are significant to decision-makers and service providers is encouraged by opinion surveys (Muronda, 2017:54). Thus, decision-making involves the general public through public opinion surveys.

2.8.15 Citizen jury/panel

Typically, designated members who will be representing the public make up citizen juries or panels. A panel of randomly selected citizens serves as a referee on a given issue and is called a citizen jury. The panel is informed about the matter and gathers relevant information from witnesses in order to be able to referee. The witness may be subject to a cross-examination by the panel, and it may also call witnesses. (Muronda, 2017:54). The intention is to provide the panel with the much-needed information so they can make an informed decision. A method of community involvement known as citizen juries involves designating a panel to represent the interests of the community.

2.8.16 Consensus conferences

Consensus conferences are a kind of community engagement where professionals and laypeople get together to talk about a specific subject. The debate aims to provide a forum for community members to express their views and to raise awareness and capacity for participation in these kinds of discussions (UN-Habitat, 2002).

2.8.17 Citizen/community advisory committees

The purpose of these advisory committees is to include members of the public in the decision-making process. Despite the differences in their membership, structures, and objectives, they all aim to convey the opinions of the community (Hull, 2010:3). Members of the community are brought together by citizen advisory committees to discuss particular issues, like proposed policies. Citizen advisory committees offer community viewpoints to decision-makers. They are a means of involving the community because they speak for it.

2.9 Origins of community involvement in South African local government

There is no doubt that the advent of the new democracy has made community involvement in South African municipalities even more important. The larger political process that South Africa used prior to 1994, a process that encouraged the participation of regular people in decisions that affected their health, can also be understood in the context of this significance. This involvement philosophy was shaped by broader political practices based on democratic political frameworks, which gave community involvement a theoretical foundation, a political and philosophical viewpoint, and further shaped the concept's conceptualization and discourse within a development-oriented democratic municipality.

This democratic, involvement, philosophy, and ethos originated with the African National Congress's original participatory strategy, which was first made public during the signing of the Freedom Charter. The general grassroots and disenfranchised masses from all over the nation contributed significantly to the creation of the Freedom Charter, an artifact. A fundamental principle of the African National Congress, community involvement is embodied in the Freedom Charter and ought to be fully pursued in a liberal democratic state. According to Muronda (2017), the Freedom Charter manuscript embodied community involvement not only in its conceptualization but also in its treatment of the community's role in matters pertaining to governance under a democratic system.

2.10 Benefits of community involvement

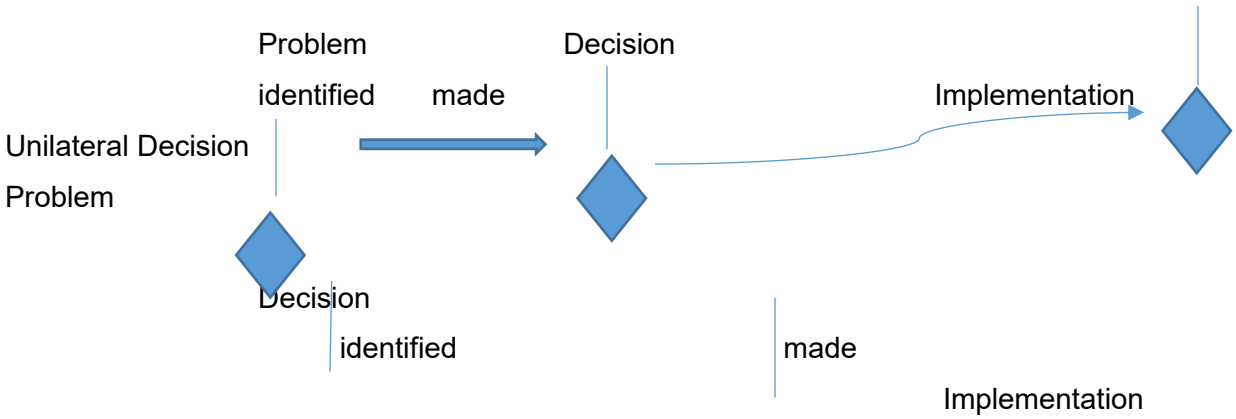
Creighton (2005:18), practiced the following advantages of community involvement:

2.10.1 Improved quality of decisions

Generally, community consultation helps define the goals and requirements of a project or policy. Latent assumptions that need to be reexamined by the community may make it difficult to determine the best course of action. When the community is involved, first-hand alternatives are frequently observed instead of the traditional, possibly stale approaches that have been used in the past. A program's success can often be determined by the vital information that the community possesses about the situation or the best course of action.

2.10.2 Minimising cost delay

Figure 2.4 shows that, even though it's not as time-consuming as some might think, community involvement does take more time when it comes to making decisions. Community consultation typically aids in defining the objectives and specifications of a project or policy. Determining the optimal course of action may be complicated by latent assumptions that the community needs to reexamine. First-hand alternatives are often observed in place of the traditional, potentially stale approaches that have been used in the past when the community is involved. The essential knowledge that the community has regarding the circumstances or the best course of action frequently determines the success of a program. "Plans and development projects often end up in litigation when lack of or poor community engagement has not effectively crafted consensus," according to Bergstrom et al. (2014:2). While disagreements may surface during the planning stage (particularly if there is a track record of abandoned projects or broken promises), the community engagement process fosters constructive dialogue that makes it possible to find inclusive and innovative solutions to problems (Bergstrom et al., 2014). Even in the event that the decision is somehow implemented and the agency then needs something from that community, the procedure will begin with hostility and inadequacy.



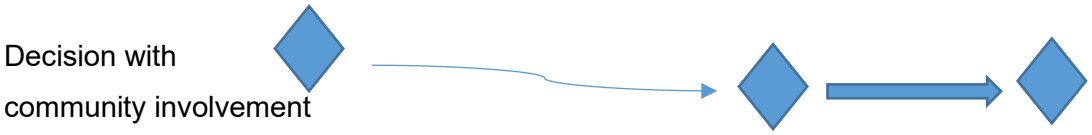


Figure 2.4: Comparison of length of time:Unilateral decision versus community involvement

Source: (Creighton, 2005:61).

2.10.3 Consensus building

Amongst otherwise disparate parties, a community involvement program may build a strong, enduring agreement and commitment. This promotes mutual respect, lessens political polarization, and validates governmental decisions (Creighton, 2005:19). Bergstrom et al. (2014:2) assert that community involvement can improve the quality of difficult conversations about racial disparities, economic conditions, and community development needs by fostering trust among a variety of stakeholders. They see better community-government relations as the result of this concept. By creating a multifaceted process centered on relationship building, trust, respect, and affirmation of community knowledge and power, more effective ways of handling differences will become apparent.

2.10.4 Increased ease of implementation

Communities that participate in decision-making want to see the decision through to the end because they believe they own it. Politically speaking, execution is not only acceptable but communities and individuals may even fully support the initiative. The created plan will incorporate equity outcomes and reflect legitimacy and community support thanks to the meaningful participation of impacted communities (Creighton, 2005:19). For effective implementation, legitimacy fosters political will, ownership, and trust (Bergstrom et al., 2014:2).

2.10.5 Avoiding worst-case confrontations

Resolving a dispute that has become hostile and argumentative is far more difficult. Participating in community events enables people to voice their needs and wants without using force. Early community engagement can lessen the possibility that the community will encounter strong opposition.

Nonetheless, community involvement is not mystic; it will not lessen or remove all encounters (Creighton, 2005:19). By building trust among a range of stakeholders, community engagement can improve the quality of difficult conversations about racial disparities, economic conditions, and community development needs. More productive methods of

resolving conflicts will arise through generating, honoring, and validating community knowledge and power (Bergstrom et al., 2014:2).

2.10.6 Maintaining credibility and legitimacy

When it comes to making difficult decisions, the most effective way to attain and uphold legality is to involve the community in the decision-making process and make sure it is visible and credible to them. Community-based programs will also inform the community about the rationale behind decisions.

2.10.7 Anticipating community concerns and attitudes

When it comes to making difficult decisions, the most effective way to attain and uphold legality is to involve the community in the decision-making process and make sure it is visible and credible to them. Community-based programs will also inform the community about the rationale behind decisions.

2.10.8 Developing civil society

A more educated community is one benefit of community involvement. In addition to studying the subject, those engaged also learn how their government makes decisions and provides justifications. Participating in the community also develops future leaders' skills. Participating in community-involvement programs teaches communities how to form partnerships and empower others. Getting involved in the community teaches people how to collaborate well. Individuals may now only represent interests or groups. They will constitute tomorrow's pool from which leadership at the federal and local levels can be selected. As they become involved in the community, aspiring leaders develop the skill of working together to solve problems.

Creighton (2005:19) based the aforesaid list of community involvement benefits on his experiential learning. This learning comprised an approximate of 300 community-involvement cases. Creighton (2005:19), stated “If you asked me for proof of these claims, I would, like most other practitioners, give you anecdotes. The empirical research on the benefits of public participation has been limited until recently when studies have begun to build a firm empirical base for these claimed benefits”. Beierle and Cayford (2002) provided an illustration of this by examining 239 community-involvement cases spanning a 30-year period. The evaluated community involvement founded on five community objectives. That are quite similar to the benefits of community involvement listed under 2.10 above (Creighton, 2005:20).

Goal 1: Incorporating community values into decisions
Goal 2: Improving the substantive quality of decisions
Goal 3: Resolving conflict among competing interests

Goal 4: Building trust in institutions

Goal 5: Educating and informing the community

Beierle and Cayford conclude: “The case study record of the past 30 years paints an encouraging picture of community involvement. Involving the community not only frequently produces decisions that are responsive to community values and substantively robust, but it also helps to resolve conflict, build trust, and educate and inform the community about the environment” (Beierle & Cayford, 2002:7).

2.11 Community empowerment, participation and involvement

Hattingh et al. (2012:52), believes “community participation, involvement, and empowerment are intertwined as one cannot be explained without the other”. Community development can only be established effectively when the community is involved and empowered. Communities need to take ownership and control over matters affecting their health and life. Table 2.1 defines empowerment, participation, and involvement and shows how the three principles are interconnected.

Table 2.1: Empowerment, participation, and involvement

EMPOWERMENT	**PARTICIPATION**	**INVOLVEMENT**
Empowerment is “the creation of sustainable structures, processes, and mechanisms, over which local communities have an increased degree of control, and from which they have a measurable impact on public and social policies affecting these communities”. Empowering is a sustainable change that builds local communities. Community participation plays an empowerment role in communities, striving to eliminate inequalities such as inequitable health care delivery. Giving communities the freedom to make decisions for themselves is a process. Supporters of the	Community participation occurs when people from a common place or with common interests participate together in advisory groups. Communities can participate in three ways: When it comes to making difficult decisions, the most effective way to attain and uphold legality is to involve the community in the decision-making process and make sure it is visible and credible to them. Community-based programs will also inform the community about the rationale behind decisions. **Informational participation:** Communities are given information about current or upcoming projects as well	Citizen involvement in a community development project leads to more progressive policy development. Community involvement warrants that communities are more advantaged. In discussing community participation, you need to talk about involvement. Community involvement refers to the mechanism in which the community is acknowledged as a partner in the process of achieving a particular goal such as optimal health. Involvement in community development should: • Be essentially interactive • Be constructive • Focus on problem-solving • Orientate those involved.

EMPOWERMENT	PARTICIPATION	INVOLVEMENT
community can assemble to exchange and discuss their complications and desires. They meet to: • Prioritise their health needs • Plan solutions for their problems • Continually monitor and evaluate the systems put in place. Empowerment can be described as something that: • Enables people to identify their own needs and make decisions • Allows people to assess or reflect on environmental factors affecting their health • Encourages people to take steps to effect change • Ensures that there is power sharing within communities where people join hands to work on specific agreed-upon projects.	as resources spent or to be used. **Review participation:** This gives communities the opportunity to plan and design a new project in addition to evaluating the current one. Communities find it easier to recognize and express their own needs as well as to keep assessing the process when there is active participation. **Interactive participation:** The planning and initiation phases of the project involve the community from the outset. They focus mainly on their own needs and redirect the funders into meeting their identified needs. WHO (1994) categorises participation as: • Minimal involvement, where there is a limited community support • Practical participation, in which the community actively participates in determining the primary concern • Organizational participation, in which the community actively participates in developing the project's philosophical underpinnings	

EMPOWERMENT	PARTICIPATION	INVOLVEMENT
	• Compulsive involvement, whereby the community takes part in neighborhood self-improvement projects that have little to no outside financing • Where there are previously defined outside innovations that only require community validation, induced participation occurs. • Compulsory participation, which suggests that groups within communities are arranged to take part in activities over which they have minimal control. Participation is the process by which the government actively looks for community support before putting decisions into action. • Participation in the community , such as control sharing, where members have the right to vote in all decisions and can dissuade ideas that run counter to the group's objectives. Communities must have the right and duty to exercise influence over decisions that impact their well-being, and participation must be action-oriented for it to be effective.	

Source: (Hattingh et al., 2012:53)

2.11.1 Community involvement and participation in public health

Participation of the community in healthcare is widely recognized as one of the essential conditions for achieving the "Health for All" objective. Community involvement is the process through which families, communities, and individuals take charge of their well-being and learn how to contribute to the development of both their own and their communities. The degree of community participation and decision-making related to health is considered a crucial indicator of how seriously a particular government takes this idea politically.

Community participation has been described as a process of empowering communities by enhancing people's capacity to improve their own lives and control their futures. The definition of "community participation" is "participating in or being allowed to participate in the distribution and evaluation of services, the decision-making processes, or the consultation process." The community's involvement makes health care delivery more acceptable, and people are more likely to use the facilities that are available. Involving the community actively in health development at the operational level improves decision-making and fosters dedication to making sure the action plans are implemented (Hattingh et al., 2012:110).

2.12 Summary

This chapter has shown that community involvement is a cost-effective strategy. The effectiveness of decision-making cannot be assessed solely in terms of cost and duration; rather, it also needs to take into account any delays or expenses incurred, as well as the process of decision-making. In the long run, quick decision-making that alienates affected parties and communities could have been highly expensive (Bergstrom et al., 2014:2).

Litigation frequently results from plans and development projects that have not successfully crafted consensus due to inadequate or nonexistent community engagement. While disagreements may surface during the planning stage (particularly if there is a track record of abandoned projects or broken promises), the community engagement process fosters constructive dialogue that leads to the discovery of innovative and inclusive conflict-resolution strategies (Bergstrom et al., 2014). Even though the decision is carried out in part, the process will begin with resentment and shortcomings when the agency later needs something from that community.

A theoretical summary of primary healthcare in South Africa can be found in the following chapter.

CHAPTER THREE:
PHILOSOPHICAL FACTORS THAT UNDERPIN PRIMARY HEALTH CARE

3.1 Introduction

The justification for community involvement in health service delivery was covered in detail in the previous chapter. This chapter covers the philosophical foundations and history of primary healthcare.

This chapter depicts the congruence between the philosophies of Florence Nightingale and the World Health Organizations (WHO). The former has its origins in the 1800s and the latter in the late 1900s. Pfettscher (2018:55) posits that Nightingale believed that sick poor people would benefit from environmental improvements that would affect both their bodies and their minds. The WHO adopted the theme Health for All, centred on the well-being of poor and vulnerable communities. These factors brought forth the theories of social determinants of health care in 3.4.1 and primary health care in 3.10, notwithstanding the aspect of equity also discussed in the chapter.

3.2 What is a philosophy?

Copi (1969:286) claims that the words "philos," which means "love," and "sapiens," which means "wisdom," are the roots of the word "philosophy." Thus, it follows that the literal translation of the word philosophy is "the pursuit of wisdom." According to Copi (1969:286), Greek colonies on Asia Minor's western coast were the birthplace of philosophy in the sixth century BC. According to Coppi (1969:286), the early philosophers believed that they were responsible for all knowledge.

Philosophy is thought of as a particular way of looking at life that clarifies its existence, nature, origin, and purpose. It gives conduct and behavior direction. It is a declaration that expresses the principles, objectives, viewpoints, and convictions of a person, group, or field. The values as a crucial component are described in the section that follows. Therefore, we think that sayings related to health, public health, or community health help us understand and give all of a nation's citizens the best possible healthcare. Philosophy aids in the establishment of one's orientation toward life or a specific facet of it, as well as the justification of one's values and beliefs about other people (Hattingh et al., 2012:2).

According to President Ramaphosa, there are those in our nation and abroad who favor South Africa taking a more antagonistic stance in the Russian-Ukrainian conflict. However, our stance aims to establish the conditions necessary to bring about a lasting resolution to the conflict. By using this strategy, we can speak out to the parties engaged in the dispute as well

as the general public. By doing this, we can converse with them, share our points of view, and exert influence on the subject of dialogue, negotiations, and mediation—all of which have historically served our country well. Since discussion, compromise, and teamwork were crucial to the development of our democracy, we are well aware of their importance (Mbhele, 2022:1).

Brink et al. (2012:26) posit philosophy as a 'worldview'. It signifies our expectations, standards, and principles about the nature of reality, information, techniques of attaining information, ourselves, our well-being, the health sciences, and the setting.

3.2.1 "Health for All" – World Health Organization philosophy

The World Health Organization (WHO) was established in 1947. The WHOs task entail management of global health activity together with providing technical community support. With the underlying aim of eliminating inequitable acces to health care. The WHO sets an enabling environment intersectoral partnership, promote and protect health, and regulates specific health problems. During 1978 the WHO convened the Alma-Ata Conference, under the theme 'Health for All'. The rationale is that no human should be deprived of any health services. This was not reality in the 1970. During this age technological refurbished hospitals was utilised by certain elite populations. Therefore the Alma-Ata Declaration adopted at the conference, is central to health policy and programme formulation globally including South Africa. The Alma-Ata Declaration highlighted numerous elements and principles to augment primary health care services within global societies. These components include health education, provision of essential drugs, treatment of communicable and non-communicable diseases, provision of good nutrition, proper water supply, and good sanitation. Values such as community involvement, intersectoral collaboration, and equity were highlighted. The WHO highlights to achieve the Health for All objective, close interaction is required between health, social, and economic development (Hattingh et al., 2012:92).

The WHO is a specialised organisation of the United Nations that acts as a coordinating expert on global public health. It has the following diverse roles that cater to the community:

- International cooperation in the fight against infectious disease outbreaks, including TB, influenza, malaria, and HIV/AIDS

- Assistance with the creation and dissemination of pharmaceutical diagnostics, medications, and vaccines that are secure and efficient.
- The World Health Organization (WHO) regularly publishes a World Health Report that offers expert assessment of particular global health topics. They do this by using evidence from scientific research to develop norms and standards based on scientific data to inform policy matters.
- Carrying out medical research on injuries, non-communicable diseases, and infectious diseases
- Encouraging Member States to increase their ability to employ and generate research that meets domestic needs
- Fostering medical security in a global society with other agencies
- Enhancing partnerships between countries, institutions, and governments
- Aiming to improve the performance of various countries.

In South Africa, WHO involvement revolved around the development of a tactical plan for combatting extensive drug-resistant tuberculosis (XDR-TB) and multidrug-resistant tuberculosis (MDR-TB), the development of malaria treatment guidelines and a malaria elimination strategy, and it has supported routine immunisation programmes (Hattingh et al., 2012:95).

3.2.2 What are values?

Values give life direction and are a symbol of a way of life. The things that influence our attitudes in life are known as values. In essence, they are attitudes and beliefs about the veracity or merit of any idea, endeavor, or behavior.

A person who firmly believes that a particular course of action is better for them both personally and socially is said to hold a clear set of values. Since good health promotes a high-quality life, it is regarded as an important value (Hattingh et al., 2012:2). According to Newman (2012:11), values serve as a benchmark for judgment that helps people choose acceptable objectives and results. Values serve as the broad standards by which we can evaluate both our own and other people's lives. They justify the social norms that dictate our proper conduct. The value we place on personal property, for example, is reflected in the laws that prohibit theft (Newman, 2012:11).

3.2.3 Stakeholder involved programmes for the affected.

Depending on the subject, different communities exist. Just as the number of people who consistently vote represents a subgroup of the total population, albeit a much larger one, so too do community involvement programs involve a subgroup of the community. Different communities exist depending on the subject. Just as the number of people who consistently vote represents a subgroup of the total population, albeit a much larger one, so too do community involvement programs involve a subgroup of the community.

But the subgroup changes as the problem does.

For instance, the people who will be affected by an electric energy transmission line are usually the ones who are concerned when the line is set. People might be motivated by that transmission line if there is a definite and perfect benefit in terms of energy availability or consistency. However, the estimated visual impact of a 20-mile transmission line is 20 miles long and approximately half a mile wide for the community (Creighton, 2005:22).

This environmental definition is frequently absent from the public health care issue. Even though certain groups of people in some communities may be more impacted by health care decisions than others (such as areas with high concentrations of elderly or low-income residents), political ideologies and financial interests that transcend geographic boundaries are important issues in health care. Put differently, there isn't a specific community—rather, there are seemingly endless groups of people with similar interests.

In actuality, people only get involved when they feel like they have a big say in how the decision turns out. This stake could be deeply ingrained in standards or philosophy, or it could be deeply ingrained in economics, use, or other direct influences. Communities, however, do not participate unless they recognize the advantages or standards that will be impacted. In the field of community involvement, people have tried a variety of ways to explain these constantly evolving notions of the community. Various terms have been tried to describe the particular set of interests that decide to engage in a given issue, including communities, spectators, and a host of other expressions. These days, individuals who decide to get involved in a specific issue are referred to as "stakeholders."

Even though this is a rather complex term, it is becoming more and more common. As long as one keeps in mind that stakeholders are not a unique class of people or that they fundamentally represent communities somewhere else, the term is useful. Anyone can choose

whether or not to be a stakeholder in a well-designed community involvement process. One defines their own membership in the stakeholder class.

However, community involvement programs inevitably address a subset of the larger issue, so they have some fundamental obligations to the larger community. In order for the larger community to make an informed decision about whether or not to participate in the community involvement procedure, they must first be informed about the possible impacts of a decision. As a result, in order to implement and maintain a community involvement program, one must first launch and maintain an effective community information program. Secondly, the community involvement program needs to have conspicuous entry points. If citizens choose to participate, they need to be made fully aware of the location and procedures for doing so.

The two most common problems, according to Creighton (2005:23), with making sure that the community taking part in a community involvement program is representative of the community are the disappointment of not including the full spectrum of beliefs and the failure to include interests for which there are no obvious means of representation.

Other explanations are reflected in most interventions. The best, though, also come with inbuilt perceptual blinders. In almost all cases, agencies that have previously solved water supply issues by building new storing dams will begin by addressing an innovative problem by looking for alternative dam sites, failing to take into account the entire range of institutional and non-structural replacements that are available. Consequently, all of the replacements they stand for are alterations to a central idea.

In a similar vein, most agencies have established relationships with a variety of stakeholders; however, these connections are inevitably made up of individuals who have a common interest and significance to the agency's functioning. Those whose opinions deviate from the mainstream will feel excluded and without a voice if a community involvement process only includes those communities. They are therefore anticipated to consider the community involvement process to be fundamentally flawed. They will seek alternative means of decision-making, such as going around to the courts or appointing representatives, and won't be interested in accepting the result of that process.

According to Creighton's (2005:22) experience, having a diverse range of viewpoints represented in a community involvement program is more important than having a cast of thousands participate. While it is regrettable, people's refusal to participate rarely leads to political conflict. However, it is a recipe for serious conflict if communities feel excluded (Creighton, 2005:22).

3.3 Nightingale environmental philosophy

The originator of modern nursing, Florence Nightingale, was born in Florence, Italy, on May 12, 1820, while her parents were on a lengthy tour; she was given her name after her birthplace. The Nightingales were a wealthy, aristocratic, and well-educated Victorian family. Compared to other girls of the era, Nightingale's father gave her a broader education during her early years. She received instruction in mathematics, languages, philosophy, and religion from her father and other people (Pfettscher, 2018:50).

Nightingale's philosophy was primarily influenced by her presumptions and comprehension of the historical environmental circumstances. She thought that improvements to the environment would help sick poor people, benefiting both their bodies and minds (Pfettscher, 2018:55). She thought that by enhancing the physical living conditions of the impoverished, nurses could play a significant role in transforming their social standing. The living conditions of the impoverished were unknown to many aristocrats of the era. On the other hand, Nightingale's mother had visited and cared for impoverished families in the neighborhoods around their estates. When she was younger, Nightingale went with her on these visits, and as she grew older, she did too. Nightingale, therefore, gained her knowledge of the physical environment and its impact on health by personal observation and experience outside of her cozy home (Pfettscher, 2018:55). Nightingale's philosophy, which is apparent in her writings and life work, expected nurses to address the social forces that impeded their ability to place patients in the best possible condition so that nature could take its course (Grace, 2014:73). "Many of the root causes of poor health are macro-economic and social issues, rapid urbanization, and gender imbalance," according to Dennill and Rendall-Mkosi (2015:126). A child's life expectancy, quality of life, and chances to realize their potential are significantly influenced by the community in which they are born. The section on health determinants that is presented in the thesis' suggested model for this thesis in Chapter Six, states as follows: “Approximately 50 per cent of population health outcomes in Canada are attributable to social and economic determinants which tend to cluster in particular communities”. The poor are centric to Nightingale’s philosophical context, notwithstanding the primary health care principles and legislative literature discussed in Chapter Five. Hence, Ndamane’s (2021:1) direct quote from the inaugural speech of the City of Cape Town new mayor Geordin Hill-Lewis, “’The first major commitment of this administration is to increase our allocation to free basic services by over R600 million in the next financial year. This constitutes a 20% increase in our city’s investment in the free basic services that vulnerable residents rely on most. It will increase the total spent by the City every year on free basic services for the poorest residents, from R3,1 billion to R3.7bn’ … the new mayor intends to hit the ground running and will today

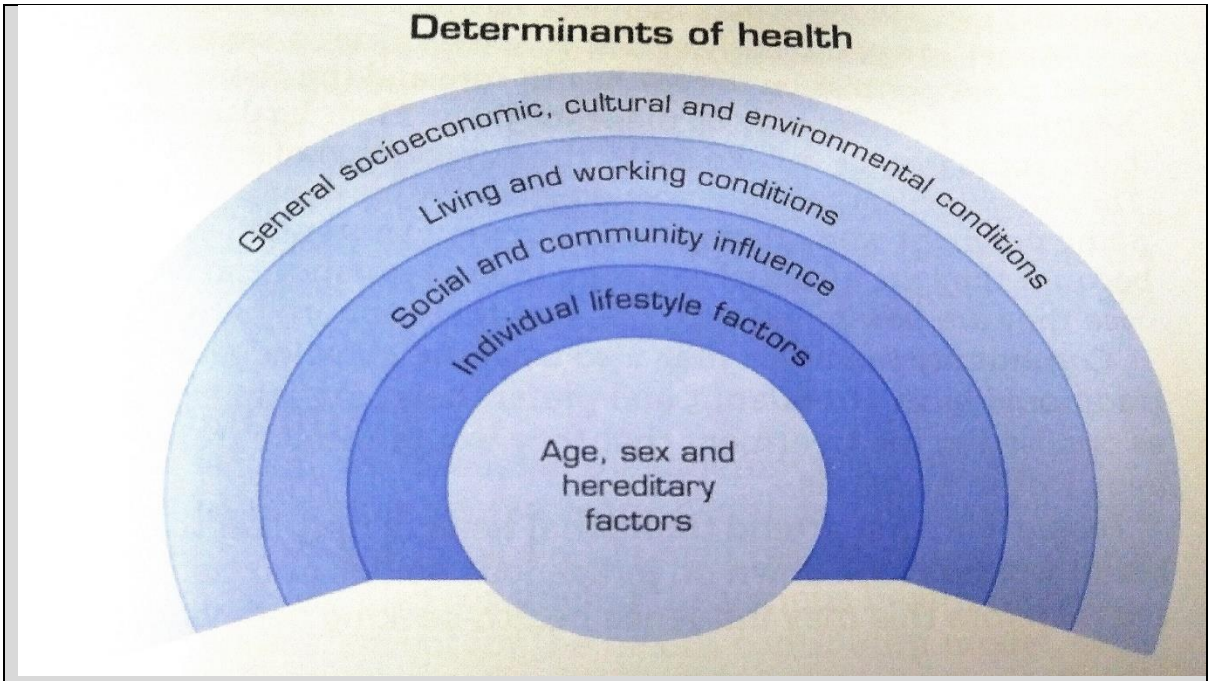
inspect sewage problems in Phoenix near Milnerton and Khayelitsha. He will be joined by City officials and members of the community" (Ndamane, 2021:1). Johnson (2014:162) confirms that Nightingale's theory placed more emphasis on a person's "fundamental needs" than on the course of their illness. She added that Nightingale concentrated more on how an individual interacted with their surroundings than how their illness affected them. The Independent Development Plan 2022–2027 encapsulates the poor and vulnerable community aspect under the legislation segment in Chapter Five of this thesis.

3.4 Nursing philosophy and social determinants of health

Grace (2014:73) states: "Nightingale's (1946) ideas about nursing are viewed as a philosophy and serve as an example of philosophy with unmistakably moral foundations. Nightingale's work stemmed from a desire to serve humankind. She encouraged nurses to attend to the environment of the patient, who could be sick or well (Grace, 2014:73)". It was necessary to manipulate a patient's surroundings to best prepare them for the effects of nature. To understand the laws of health and put them into practice, one needs to observe, experience, and reflect on the situation. A professional nurse who practices by Nightingale's philosophy is dedicated to obtaining and evaluating information regarding the surroundings of a specific patient as well as, on a broader scale, evaluating the environment for its actual or potential impact on people. Consequently, a nurse would not practice well if their scope of practice was limited to handling the current situation alone. According to Nightingale, a nurse who believes her sole responsibility is to inform her patients about the connection between smoking and lung illness, but claims she is unable to address the larger social setting in which the patient developed an addiction, is morally wrong (Grace, 2014:73).

3.4.1. Social determinants of health

Due to various factors that affect an individual's health, some people suffer from illnesses or infirmities more frequently than others. We refer to these elements as health determinants. Social and economic factors lead to significant susceptibility. The social determinants of health care are the variables that lead to a lack of resources, ill health, and health risks. Preconceptions, stress, nutrition, surroundings, education, and socioeconomic standing are some of these variables. Nursing interventions aim to provide the resources necessary for improved health and a reduction in risk factors in order to support communities that are at risk. According to Hutchings and Puoane (2018), poverty is a major cause of vulnerability and is becoming more and more of an issue in South Africa.



Factors influencing the health of the community. (Hutchings & Puone, 2018:78).

Figure 3.1: Determinants of health

Source: (Hutchings & Puone, 2018)

It can be noticed that, in the centre of the diagram, there are factors that concern only the individual – age, sex, and hereditary factors, which come to us from our parents. When we move away from the centre, the circles become concerned with wider determinants, which are not anymore in an indivuals control. Health determinants are categorised as non-modifiable (cannot be changed) and modifiable (can be changed) factors.

3.4.2 Non-modifiable determinants

Aspects that individuals have no control over include age, sex, genetics, and the inheritance of certain traits or illnesses from our parents. These are examples of non-modifiable determinants. For instance, we cannot change the fact that only women, not men, can become parents or that some of our parents' genes cause diseases and incapacitating health conditions (Hutchings & Puoane, 2018:59).

3.4.3 Age

Certain diseases or disabilities are more common in certain age groups. Seniors are expected to suffer from illnesses associated with aging, such as hearing and vision issues, while children are more vulnerable to communicable diseases, or illnesses that can spread, like whooping cough and measles. Cerebral palsy is a disorder that affects a newborn baby's ability to control or use their muscles. It can result from birth distress.

3.4.4 Sex

Women are more likely to experience health issues during pregnancy, such as pre-eclampsia or post-natal depression, due to their propensity to procreate. Because of the nature of their jobs, which puts them at risk for traumatic injuries, men may be more likely than women to die from wounds.

3.4.5 Genetics

Some people get sick because one or both of their parents carried genes that cause a specific disease or disorder. For instance, a son or daughter may experience hypertension if their mother or father had hypertension. Schizophrenia and bipolar mood disorder are two examples of mental illnesses that run in families. A distorted body structure and some forms of intellectual deficiency can also be brought on by genetic defects.

3.4.6 Modifiable determinants

It is possible to alter these components through both public and private initiatives. These include aspects of a person's lifestyle, influences from society and the local community, circumstances at work and home, overall socioeconomic factors, social beliefs, and environmental factors. People's decisions and actions either prevent or contribute to the development of illnesses and incapacitating conditions. Sweeping the streets, for instance, can help keep the environment clean and stop disease-carrying flies. Water-borne disease transmission could be halted by making sure the water is safe to drink and free of pollutants. Wheelchair users and the blind can fully participate in their communities when there are accessible public buildings and transportation, which supports their rights, health, and general well-being (Hutchings & Puoane, 2018:58).

3.4.7 Individual lifestyle factors

It is possible for someone to voluntarily engage in behaviors that are harmful to their health. For instance, someone might choose to take up smoking, putting themselves and others in their vicinity at risk for lung cancer.

3.4.8 Social and community influences

Some people engage in behaviors that put their health at risk due to personal, societal, and communal factors. For instance, alcoholism and domestic abuse are known to exacerbate psychological issues in some communities. In others, children may start smoking because of peer pressure. If there are few job opportunities and healthy recreational options for young adults in a community, drug use among its youth could become the norm.

3.4.9 Living and working conditions

Some people engage in behaviors that put their health at risk due to personal, societal, and communal factors. For instance, alcoholism and domestic abuse are known to exacerbate psychological issues in some communities.

3.4.10 General socioeconomic factors

The causes of global illness are influenced in part by a nation's social and economic standing. Basic services like electricity, water, and primary health care are unequally distributed among the rich and the poor in the majority of developing nations. Illnesses and health conditions that could be prevented if certain economic and social factors were different often affect poor communities. For example, tuberculosis spreads easily in congested informal settlements. When women have limited access to ante-natal care they may develop birth complications that cause their children to be brain damaged or spastic. High-fat diets, which can lead to obesity and heart disease, may be affordable for some people (Hutchings & Puoane, 2018:79). The City of Cape Town is dedicated to collaborating with communities to develop service delivery models suitable for informal settings and to efficiently manage these services, as stated in the Department Policy and Strategy (2022:37). To increase the resilience of underprivileged communities, the City of Cape Town collaborates with the federal and local governments to provide basic utilities like waste management, energy, sanitation, and water.This will be achieved through cross-subsidization and budget allocation for free basic services. (CoCT, Department Policy and Strategy, 2022:37).

3.4.10.1 Poor people

Development requires a concrete local information base, which is necessary for community involvement. Locals who have endured years of hardship and poverty can now benefit from the government's employment of them as employees thanks to the development strategy. Their rational knowledge of the cultural, economic, political, social, and natural environment dynamics can be of countless worth to development efforts. It is therefore important for community workers to ensure that each community member, which includes the most impoverished people, are present when decisions about development are made. Community health care workers with wisdom must precaution the situation of the poorest and preserve the support of the exclusive for the development effort (Nzimakwe & Madumo, 2008:112).

3.4.11 Cultural factors

A group of people's attitudes, beliefs, symbols, customs, and rituals that define their overall behavior and way of life are referred to as their culture. Due to their cultural beliefs, some of

them engage in behaviors that are harmful to their health. For instance, in certain cultures, female circumcision is unavoidable, which leads to problems throughout labour and delivery (Hutchings & Puoane, 2018:80).

3.4.12 Environmental factors

A person's living environment can either support or inhibit leading a healthy lifestyle. For instance, children in urban areas who reside close to freeways are most vulnerable to lead poisoning. It's possible that low-income rural households lack the land or water access necessary to raise livestock or grow vegetables. Food poisoning is a common occurrence for residents of hot climates because leftover food is rarely kept in a cool environment (Hutchings & Puoane, 2018:80).

3.5 Vulnerability and vulnerable communities: An synopsis

False: "All men [and women] are created equal." Every individual has a distinct genetic physiology, skill set, support system, primary healthcare access, and social and environmental resources. People who earn less money and have less education tend to be more vulnerable to health issues (Stanhope & Lancaster, 2014:375). Vulnerability is precisely defined as being susceptible to stresses, real or imagined, that may have unfavourable effects. It is not a sign of weakness in some people to be more prone to illness. Instead, it is the outcome of intricate relationships between a variety of external and internal factors that are largely outside of human control. For example, an individual may have genetic limitations from birth that are made worse by environmental factors like excessive noise, lead-based paint, pollution, or other factors. Communities classified as vulnerable are those where adverse health outcomes are more likely to occur. Risk is an epidemiological term that designates those who are more likely than others to become ill. The agent, host, and environment interact to cause disease or poor health, according to the epidemiologic triangle.

The normal background of an illness framework elucidates the ways in which particular physiologic features and environmental factors—such as customs, social milieu, and physical surroundings—increase an individual's likelihood of developing particular health challenges. For example, smoking causes cellular deviations that increase a smoker's risk of developing

lung cancer. However, not all community members who are at risk have health problems. The health problems that put them at risk are more likely to affect some people than others. Environmental risks include things like melamine added to milk supplies, urine-stained walls that expose lead exposure from lead-based paint, and rodent infestations. Social hazards include things like crime and violence. Personal behaviors include things like diet, exercise routines, and smoking. Biological or genetic makeup includes things like congenital addiction and weakened immune systems. Individuals in susceptible groups frequently suffer from several illnesses, each of which influences the others. Some people who live in marginalized communities refuse to give in to the health risks that threaten them. Finding the elements that enable these communities to withstand the consequences of vulnerability is crucial.Families and vulnerable individuals frequently have a variety of risk factors. For example, nurses treat underprivileged, drug-abusing teenagers who are pregnant and have experienced abuse (Stanhope & Lancaster, 2014:375). Furthermore, nurses treat patients with severe mental illnesses and drug addicts who test positive for HIV and the hepatitis B virus (HBV). Community health nurses provide care to families, marginally housed individuals, and homeless people. They also offer medical care to immigrants and migrant workers. Abuse and violence can be directed towards any of these groups. The vulnerable population groups listed in Table 3.1 Box 1 are of particular concern to nurses:

Table 3.1: Vulnerable groups of special concern

BOX 1 Vulnerable population groups of special concern to nurses
• Deprived and destitute individuals • Pregnant adolescents • Migrant workers and refugees • Mental ill individuals • Drug abusers • Gender based violence victims • Individuals who are at risk for communicable diseases; • Those who have hepatitis B, the human immunodeficiency virus, or a sexually transmitted illness.

Source: (Stanhope & Lancaster, 2014:375)

Compared to general residents, vulnerable populations are more likely to experience health disparities. "Health disparities" refers to the wide variations in health care and health status that exist within particular communities.

Nursing professionals interact in a wide range of settings with the sick, the not-so-ill, and the healthy, according to Du Toit and Le Roux (2019:4). Therefore, nursing professionals must have a thorough understanding of the people they nurse and care for in their entirety. A sick person is not "the woman in Bed 3" or "the heads and necks," but rather a member of a family or social group.

Nursing professionals work in a wide range of settings, but they usually do so in formal institutions like hospitals or clinics. Formal hospitals and clinics are structured around rules and regulations of behaviour. Most hospitals and formal health treatment settings have a mission (the reason for the organisation's existence), a vision (the direction in which the organisation sees itself moving), and policies that act as guidelines for the implementation of behaviour to accomplish the goals within the organization (lower-level elements of policy that are implemented in each division of the health care setting) that it has set for itself.

The rules of behaviour in a health care setting are cold norms. Any deviation from these rules or norms can have serious consequences. If nurses go on strike, they place their patients' lives on the line. It is crucial to realize in this kind of environment that nurses and other medical professionals are in charge of people's lives. Strikes, go slows and work-to-rule actions are frowned upon by most societies for this reason. Good relationships with other health care professions are essential since all these professions work together to get and keep individuals well functioning in a reasonably healthy society. Sociology offers a wealth of scientific information about various cultures, which is one of the main reasons nursing professionals need to study it. Understanding the primary health care system's user is essential in nations like South Africa, which we refer to as the "rainbow nation" due to the wide range of cultures that are defined by various rules or norms of behavior and traits, coexisting and working together. Conducting a correct nursing diagnosis to formulate a nursing care plan requires knowledge of other societal realities and ways of living that are unique to our country, such as informal living settings, like squatter camps, and in very rural areas, like informal and underdeveloped settlements (with sometimes limited facilities). Someone from such a setting who is admitted to hospital may require a different nursing assessment and analysis from the 'customary' ill individual. Sending these clients back to their setting, depending on the extent of their health problems, may require resocialisation, re-education and rehabilitation.

Whether it is privately run or state-funded, the health care environment is, overall, a very complicated, intricate place where a large number of individuals and groups interact and perform. It requires a certain level of knowledge of sociology by nursing professionals because these settings manifest themselves in the society of which nursing professional is also a part (Du Toit & Le Roux, 2019:5). Many different forms of health care settings have evolved since the days of Florence Nightingale. Today, we see a myriad of private health care settings, for example step-down clinics (a type of rehabilitative health care setting where individuals can still receive clinical nursing support), high-care wards (a step-down ward from the ICU), and a variety of specialised health care settings, each developed around a particular health need in society. A knowledge of the family as a societal structure, the socioeconomic status of the family (e.g., whether medical aid is willing to pay for a particular sort of health care such as step-down clinics), the domestic background, and the level and nature of socialisation is advantageous.

Nursing professionals sometimes have a near-impossible task when people in need have to be nursed to recovery. Nursing professionals will be better equipped to perform their duties in one of the greatest professions in the world the more knowledge they gain from the many academic subjects, including sociology (Du Toit & Le Roux, 2019:6).

3.5.1 Factors contributing to vulnerability

Constrained resources have a cumulative effect that leads to vulnerability. Vulnerability is a result of limitations in one's personal, physical, environmental, and biopsychosocial resources (e.g., genetic predispositions, illness) as well as human capital. Limited physical and environmental resources include things like deficiency, poor social support, and working in high-risk environments. Individuals who have pre-existing medical conditions, such as cancer, heart disease, or respiratory disorders, are less physically capable of handling stress than people who do not have these conditions.

All of the strengths, abilities, and knowledge that enable a person to lead a fulfilling life are collectively referred to as human capital. Because they have fewer options than people with higher levels of education, people with less education have less human capital.

Vulnerability has many characteristics. It often stems from a sense of controllessness, victimization, disadvantage, disenfranchisement, and health hazards. It is possible to reverse vulnerability by obtaining resources that boost resilience. Case finding, health education, care coordination, and policy development regarding the improvement of health for marginalized communities are all effective nursing interventions that aim to increase resilience. One vulnerability that denotes a feeling of alienation from established communities is isolation. The

individual doesn't seem to have a responsive relationship with the public at large or with any specific individual. The person doesn't appear to have a responsive relationship with any particular person or with the general public. Certain populations—the impoverished, the homeless, and those employed as refugees—are invisible to the general public and are frequently disregarded in matters of health and community development. Because of their frequently strained ties to formal community organizations like churches, universities, and other such establishments, vulnerable populations run the risk of becoming alienated.

They might also lack many informal support networks, such as friends, neighbors, and relatives. In many respects, vulnerable populations have little control over their short- and long-term health needs. These groups are marginalized and impoverished in many communities because conventional health planning strongly favors the mainstream. A disadvantage can also result from a lack of resources, which some people might take for granted. Social and financial resources are scarce for vulnerable population groups, making it difficult for them to manage their primary healthcare needs.

Women might choose to put up with gender-based violence instead of taking the chance of losing their home and the homes of their children. When they leave an abusive partner, working-class women are more likely to become impoverished. When the partner's income is lost, they might not be able to afford an apartment (Stanhope & Lancaster, 2014:376).

3.6 Philosophies and values regarding good health in communities

The philosophies that communities or individuals have regarding good health vary in nature according to their knowledge about health and the values that they ascribe to good health. Some clients may place values related to good health very low on their particular scale of values. Statements of the philosophy of health should include value statements about health and wellness. The definition of health and philosophical claims about health can be influenced by an individual's health perception or by cultural approaches to health (Hattingh et al., 2012:2).

Most literature emphasises the fact that health encompasses the well-being of body, mind, and spirit. It also encompasses the harmonious interaction of a person with themself, society, and the environment. This implies that health care professionals should provide holistic care for their patients and that health care should meet the needs of an individual as a whole. Holistic health is defined as the integration of the mind, body, spirit, and environment. The actions taken by a community to prevent and promote illness are a reflection of that community's health philosophy. Therefore, the needs of the individual should be taken into account when providing healthcare. To achieve this, most countries accept the notion that

improving and maintaining the social, emotional, and physical well-being of individuals, families, and communities requires comprehensive health care.

A health care system's philosophy is a documented declaration of the organization's values and beliefs that are significant to clinical practice, needs for professional development and education, management considerations, and individual, family, and community rights. Statements of philosophy are crucial in this situation and ought to be accessible to all organizational subsystems, including the various initiatives available to advance community health.

It is generally accepted that the best way to provide health care to a nation's citizens is through an all-inclusive healthcare system. A health philosophy should include value statements that address important questions like:

- What is expected in terms of the attitude, behavioural patterns and levels of performance from the medical practitioner?
- What is the healthcare provider expected to do?
- What is expected from the health care consumer?
- How should the services be provided?
- What course of action is appropriate to follow?

Questions such as these should be translated into action by health care professionals and will subsequently be seen in the attitudes, behavioural patterns, levels of performance, and the quality of care provided. Philosophical statements can be measured, evaluated, or judged. These statements should be realistic and should support the overall philosophy of the health care system (Hattingh et al., 2012:3).

3.7 Modern healthcare philosophies

Inherent to modern health care philosophies is the idea that primary health care is vital to people accomplishing optimal wellbeing in situations where resources are limited, although primary health care is certainly not restricted to situations in which resources are limited.

In most countries, health care professionals believe that it is extremely important for all citizens to obtain optimal health and that the following statements are inherent in any philosophy of health care:

Table 3.2: Statements inherent in a philosophy of health care

- Health services must be comprehensive to provide the health care needs of all age groups.
- All people must understand that their state of health is their responsibility.
- The community must be involved and must participate in actions for prevention of diseases and health promotion.
- Health education is an important tool to teach communities, families, and individuals about taking responsibility for their health and for becoming involved in the creation and advancement of primary health care.
- The main objective is to keep people healthy – good health must be emphasised.
- Health development is an essential share of social development.

Source: (Hattingh et al., 2012:3)

3.8 What is primary health care?

Primary health care, or PHC, is frequently linked to getting treatment in a community clinic or at home. What they mean is primary care, which is the initial point of contact between communities and the formal health care system. PHC, however, is far more than that. PHC's mission is "Health for All". This is predicated on the notion that since poverty and ill health are closely related, fairness or justice, human rights, and the requirement of social and economic integrity and parity are all interconnected. Achieving Health for All requires that everyone benefit equally from having access to social and economic resources like jobs and housing as well as health care. PHC approaches health care holistically since its objectives are so wide (Alperstein, 2018:22). The PHC strategy adopted at the Alma-Ata Conference seeks to enhance everyone's quality of life, especially that of the impoverished, rather than just prevent and treat disease. Eliminating disparities in the social determinants of health is essential to achieving this. According to Hattingh et al. (2006:151), primary healthcare must be accessible to all people in order to provide comprehensive healthcare. It is provided by a multidisciplinary, multisectoral health care team with the goal of promoting health and providing curative care that is reasonably priced, participatory, decentralized, and preventative. This treatment, however, is not of a lesser caliber and is intended for the entire populace, not just the most disadvantaged and marginalized groups. It is delivered through initiatives that run concurrently with the remainder of the healthcare system and involve the public directly, actively, and effectively.

3.8.1 Primary healthcare success

Following a critical examination of the concept of community involvement in health (CIH) as presented by the World Health Organization (WHO, 1978), Oakley (1989:8) provided the following summary:

> Primary health care requires community and individual self-sufficiency as well as maximum community involvement or participation for it to succeed. This means that residents of a community must actively participate in social cohesion and organization through active participation in the planning, management, and control of primary health care through the use of local, state, and federal resources.
>
> The term involvement is preferable to participation because it implies a deeper and more personal identification of members of the community with primary health care (Oakley, 1989:8).

3.9 Primary healthcare origin

Global health care systems were fragmented and chaotic by the 1970s. There was a trend toward the exclusive management of care for a small number of sick individuals rather than offering basic and preventive healthcare to a large number of sick people. These variations were observed worldwide in both developed and developing countries. In response to the global outcry over subpar health care, an International Conference on Primary Health Care was arranged in 1978.

It was co-sponsored by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). Alma-Ata, the Soviet Union's former capital, hosted the Conference from September 6–12, 1978. 134 states were present, as well as a large number of governmental and non-governmental organizations. Maximum community involvement is a PHC idea that was approved as a conference Declaration and looks like this:

> PHC requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate (Dennill & Rendall-Mkosi, 2015:7).

The full declaration is outlined in Chapter Four. An outstanding construct in the PHC definition is the term ‘full participation’, which will be contextualised in the passage below:

3.10 Primary healthcare (PHC) defined

The meaning of the concept, as determined at Alma-Ata, is:

> PHC is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. PHC is a central component of the health system of a country. That is centric to the socioeconomic community development. PHC the first level of contact with the health system making access to PHC much easier (Dennill & Rendall-Mkosi, 2015:4).

3.10.1 Full participation

Complete participation, in the words of Jerome D'Emilia (2014:39), entails community members helping to define health problems and develop solutions. Every community in the nation has access to the cornerstone of primary healthcare, which spans all facets of society.

The most significant challenge in assessment is probably getting admitted or accepted into the community. Typically, the nurse is an outsider who stands for a legitimate healthcare system that the public does not understand or trust. The community may show the nurse indifference or even outright hostility. Furthermore, as community workers, nurses might feel insecure about their abilities, and the community might not see the need for their expertise. Community access is critical because the public's perception of nurses has a significant impact on their success. Usually, the nurse can enter through:

- Participating in community events;
- keeping appointments;
- utilizing an assessment guide;
- paying visits to individuals in formal management positions;
- seeking support from a peer group;
- summarizing community opinions on health necessities;
- and honoring the patient's right to choose whether or not to work with the nurse.

Maintaining anonymity is crucial. Nurses should proceed with extreme caution when community members divulge sensitive or contentious information to protect their identity. Under some conditions, the nurse might think about withholding information; under other conditions, the nurse might be required by law to do so. For instance, reporting incidents of child sexual abuse is required of nurses by law (Shuster, 2014:222).

a. **Identifying community problems**

A list of community strengths and health issues will be produced as a result of the compound database creation and windshield assessment actions, as indicated in Tables 3.1 and 3.2. Every point must be stated unequivocally and forcefully. The identity of the affected individual or individuals, the community issues that exacerbated the issue, and the health risk to the community are all determined. This phase of the pre-planning procedure is very important.

b. Making community health plans

The planning phase entails the following tasks: defining goals and objectives; prioritizing them; assessing the health problems the community faces based on nursing diagnoses; and choosing intervention strategies that will accomplish the goals.

c. Analysis of problems

The nurse tries to ascertain the nature of the issues during analysis. The nurse draws attention to the following:

The people who are worried about the issue and how it will be resolved; • The origins and consequences of the issue; • Possible action timelines.

Finding the following frequently becomes necessary during analysis:

The results of the problem; the causes, both direct and indirect, that make the situation worse

This is important since the nurse can foresee that many of the same traits that contribute to.

d. Problem priorities

The community assessment has identified many health challenges in the community, of which infant malnutrition is just one. Actually, there are a lot of community health issues that could be mentioned. These could include a lack of clinics, subpar housing, a higher than average death rate from cardiovascular disease, and, as many locals have expressed, a desire to give up smoking.

Every issue found during the assessment process needs to go through a ranking process in order to determine how important it is. It's called problem prioritizing. Priority criteria for the problem. The following queries' responses have been useful in order of importance of issues found:

- How much knowledge does the community have about the issue?
- How motivated is the community in solving and managing the problem better?
- Is the nurse capable to impact on solution to the problem?
- Are specialists available to resolve the problem?
- To what extent is the issue understood by the community?
- How rapidly can the problem be solved?

Table 3.3, column number one, lists these six questions using the example of overnutrition in infants. This one-off issue merely serves as an illustration of how to apply the six criteria to evaluate any problem.The partnership's members answer questions pertaining to their problem-solving abilities. Smoking in public buildings is one instance of how the opinions of the community and the community nurse differ: Residents of the community may view smoking as a matter of freedom and personal preference, but the community nurse may view it as a public health concern. For instance, a short while ago, a mid-sized community, working with the Department of health and the municipality, approved a law that forbade smoking in any public area, including bars and restaurants. There has been a lot of noise coming from the locals. Residents believe that government regulations have robbed them of their personal freedoms and rights. The high rate of lung cancer is of no concern to the locals.

Each identified problem-related step of the process is repeated independently. The problems that have been identified are ranked in order of priority. The issues that have the highest priority are the ones that have been carefully selected to be the focus of intervention. Following individual evaluations, Table 3.4 presents the prioritization of all community problems.

Table 3.3 Problem prioritising

Problem prioritising: Infant malnutrition				
Criterion	**Criterion weight (1-10)**	**Criterion rating (1-10)**	**Rationale for rating**	**Problem ranking (weight x rate)**
1. Community awareness of the problem	5	10	Health-service providers, teachers, and some parents have mentioned the problem.	50
2. Community enthusiasm to resolve or better manage the problem	10	3	Many believe that this problem can not be solved since most of those affected are poor.	30
3. Nurse's ability to effect solution to the problem	5	8	Nurses are capable at nurturing consciousness and mobilising support.	40
4. Accessibility of specialist to solve the problem	7	10	WIC programme and nutritionists are obtainable. A county extension agent is concerned.	70
5. Severity of the outcomes if the problem is unresolved	8	5	Effects of marginal malnutrition are not well filed.	40

Problem prioritising: Infant malnutrition				
Criterion	**Criterion weight (1-10)**	**Criterion rating (1-10)**	**Rationale for rating**	**Problem ranking (weight x rate)**
6. Speed with which the problem can be solved.	3	3	Period to mobilise community inside this area is extended.	9

Source: (Shuster, 2014:225)

Table 3.4: Problem prioritising

Problem prioritising: All identified problems			
Criteria	**Problem**	**Rationale for rating**	**Problem priority**
1. Community consciousness of the problem	Community's wish to quit smoking	Health-caree providers, educaters, and a diversity of leaders have stated the problem.	2
2. Community inspiration to solve the problem	Poor housing morals	Most trust that the problem is not soluble due to most of those affected are indigent.	4

Problem prioritising: All identified problems			
Criteria	**Problem**	**Rationale for rating**	**Problem priority**
3. Nurse's skill to effect problem resolution	Mortality rate from heart disease	Nurses are skilled at awareness raising and mobilising care.	3
4. Ready availability of skill pertinent to problem solving	Infant malnutrition in Jefferson County	WIC programme and nutritionists are available. A county extension agent is interested.	1
5. Severity of results if problem is left unsettled	Shortage of primary care clinics	Effects of marginal health services are not well filed.	5
6. Speed with which problem resolution can be achieved	Teenage pregnancy	Time to mobilise a rural community with no account of collective achievement is lengthy.	6

Source: (Shuster, 2014:225)

3.11 Full community involvement in primary healthcare

According to Stern and Schaay (2011:1),

> Community involvement in health development is essentially a process whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the conditions for sustained better health, and in supporting the empowerment of communities for health development.

On the other hand, empowerment refers to the process by which underprivileged individuals organize to take control of the issues that impact their lives and well-being. It is impossible to empower someone else because empowerment is something that individuals accomplish for

themselves. But on occasion, concerned healthcare professionals or facilitators can assist in clearing the path for individuals to exercise self-determination.

Theron et al. (2016:251) state that, to make sure the robust and empowering involvement of individuals in PHC, it is crucial to make decent health the real goal of the communities. In this regard, the principle of realistic involvement in all development settings entails the creation of enabling spaces through which health recipients can not only effect and direct the preparation of their health but are also actually empowered to control and own the process. However, here lies the ‘development dilemma’, not only akin to health-related planning but probably all development applications: those who are supposed to benefit through the invited spaces established by the State and its health and other agencies to be involved, very seldom manage to ‘control’ or ‘own’ their development. The latter often leads, via protest action, to the frustrated beneficiaries inventing their own spaces for involvement.

Within the functional community, PHC is the most popular product. It is based on the needs that community has identified and develops from its economic, sociocultural, and political features. Given that many residents' health needs won't have been satisfied, the expansion of the health sector by itself won't have a significant impact on people's health.

Therefore, a comprehensive approach to PHC is required to improve the health of the community. The integration of health care into national, political, and economic strategies is imperative to provide the public with improved living and environmental conditions, as well as employment and educational opportunities.

An intersectoral and multidisciplinary team approach to health services is used throughout the entire process. As a result, PHC is a broad term that encompasses both community development processes and task-oriented basic health care services.

3.12 The roots of primary health care (PHC)

To understand the beginnings of primary health care (PHC), an overview of the influences on health care, particularly in the last 300 years, is required. Medical science has advanced significantly since the 1800s and 1900s. The development of vaccines, X-rays, and antibiotics was a beneficial discovery for health. These developments led to an increased emphasis on medical care as the primary means of enhancing health. As a result, established strategies for fostering and preserving community health were being disregarded and weakened. However, the budgets for health care services expanded quickly as funds were allocated to hospitals with cutting-edge technology and quickly improving medical treatments. The skyrocketing cost of healthcare was starting to affect even wealthy nations. Simultaneously, community well-being stopped showing significant gains to keep up with rising health care costs. Health in

impoverished communities remained low, particularly in developing nations. Some healthcare professionals and international organizations started searching for innovative approaches to healthcare that could improve health in all communities in response to this circumstance.

Initiatives were implemented globally in both developed and developing countries (London, 2019:15). The primary healthcare approach has been formally implemented since the World Health Organization (WHO) adopted a resolution in 1977 to achieve a level of health that enables all nations to live economically and socially productive lives. Since 1978, primary healthcare has benefited from international support as a way to fulfill the 21st-century objective of "Health for All."

"In South Africa, the goal of Health for All became an integral part of the health care system with the focus on overall social and economic development of the community. The principles of accessibility, affordability, acceptability, equity, appropriate technology, and community participation were emphasized" (Hattingh et al., 2012:97).

Nations have been incentivized to exhibit heightened dedication towards the implementation of fundamental primary healthcare services and the construction of infrastructures that cater to their citizens' healthcare requirements. Regarding this, the World Health Assembly extended an invitation to member nations in 1981 to implement strategies, to monitor the progress towards achieving the aim of 'Health for All', and to evaluate the effectiveness of this goal by using appropriate indicators. Uniform criteria to evaluate commitment and to measure what has been accomplished were introduced by the WHO. Four categories of indicators were recommended by the WHO, namely health and wellness policy, economic and social indicators, basic health status indicators, and provision of primary health care indicators.

Many countries have reported substantial gains in the health of their people, but there are still differences experienced within and between countries that have implemented health care systems based on primary healthcare principles. While developed nations report covering some basic primary health care components at rates of 80% to 100%, access to care remains unequal in developing nations, especially in rural and impoverished urban areas. Although improvements have been made in providing water and basic sanitation facilities, other problems constantly emerge, such as growing squatter areas, uncontrolled urbanisation, war, poor socioeconomic conditions, and HIV/AIDS. Critical world health problems still exist, and include communicable diseases, diarrhoeal diseases, nutritional deficits, malaria, maternal and child health care, lack of recognition of human rights, failure to attain obligation to health care, failure to attain parity in primary health care access and women's ongoing low status. The WHO keeps improving new and universal health policies based on solidarity and equity,

emphasizing the responsibility of the individual, family, and community for one's own health. The objectives of the "Health for All by 2000" initiative have been maintained into the 21st century.

According to the WHO, risk management strategies are needed to achieve a truly healthier future. The focus should be on identifying and defining global risks. International organizations will need to make sure that scientific knowledge is put into practice as well as direct and promote community health throughout the world. The South African government began offering free primary health care services to pregnant and lactating women and children under the age of six in 1994. In the same time frame, the government launched a program that led to the construction of over 1600 clinics. Headcount data indicates a steady increase in access to PHC services. From 67 021 961 in 1998/99 to 101 748 188 in 2007/08, there was an increase in headcount. The District Health Service is in charge of delivering PHC services, which transfers PHC services to the local government. PHC services were transferred to local government by the legislative changes. Those legislative changes were seen to be consistent with participatory democracy, resulting in health care services of better quality that are better attuned to local needs and conditions.

The Health Act (No. 61 of 2003) states that PHC services will be provided through the district health system. District hospitals, community health centers (CHCs), and clinics—which may be mobile or stationary—are the three levels at which PHC services are offered. The main channel via which the wishes and worries of the neighboring communities are communicated is the district health system (DHS).

PHC services are primarily offered by the public health sector in South Africa. Rural areas comprise 44% of the facilities. Twenty percent more facilities offer services in both urban and rural areas. Nearly all facilities offer services for tuberculosis, trauma care, STI treatment, and reproductive health.

The prevention of communicable and endemic diseases, maternity care, immunization, child screening, integrated management of childhood illnesses (IMCI) and child health care, HIV counseling and testing (HCT), management of chronic diseases and diseases of older persons, rehabilitation, accident and emergency services, family planning, and oral health are all considered primary health care services (Hattingh et al., 2012:98).

3.12.1 The birth of primary health care ideas

At the 28th World Health Assembly in 1975, the concept of primary health care was born at Alma-Ata when an urgent need was expressed for different methods to health care services

for everybody and by everybody. Emphasis was placed on developing countries where Malnutrition and potentially fatal diseases were causing suffering and death to hundreds of millions of people avoided through applying basic values of health promotion and disease prevention and by generating basic knowledge and education. In industrialised countries, too, many myriads of people were not appreciating the degree of health that the execution of basic preventative and educational principles could assure (Hattingh et al., 2006:151). In September 1978, health ministers or their representatives from 134 states met in Alma-Ata under the sponsorship of the World Health Organization (WHO) to discuss the shortcomings of health programs in addressing the needs of their respective populations. The resolution "Health for All by the Year 2000" was the result of this meeting. It is here that the comprehensive, expanded primary health care approach was announced.

Table 3.5:The Declaration of Alma-Ata and the definition of health

The Declaration of Alma-Ata and the definition of health
According to the Alma-Ata Declaration (1978:3), achieving the highest possible degree of health is a universal social goal that must be achieved by action from a wide range of social and economic sectors working in tandem with the health sector. Health is defined as "...an essential human right."

Source: (Hattingh et al., 2006:151)

3.13 The roots of PHC worldwide

Indigenous cultures were considered backward by the majority of colonial governments and international organizations in the early 1900s. For them, advancement entailed assisting others in assimilating Western ideals. Most of the time, hospital-based health systems were established by the colonial powers using European models, which were tailored to the diseases, culture, and environment of Europe. They gave little thought to the connection between human progress and health, preferring to concentrate on treating the illness rather than preventing it or promoting health.

Hospitals were located mainly in the bigger capitals and cities that were resident to the colonisers lived, instead of in the rural areas where most of the people resided. This top-down curative approach, which did not assess the health care essentials of the communities, did little to encounter the essentials of the indigenous people.

The majority of the world's population was not receiving hospital-based health care, as was becoming more and more evident during the 1960s. Health organizations and groups started experimenting with novel approaches to treatment in numerous nations across the globe in an attempt to address this issue.

3.13.1 Missionary doctors

World Council of Churches (WCC) missionary physicians began to recognize how important it is to incorporate local resources and people in the process of improving health. The alternative bottom-up approach was initially referred to as primary health care (PHC) by the Christian Medical Commission. The term "primary health care" was first used in the journal Contact, which was published by the WCC in 1970 (Zweigenthal et al., 2009:5).

3.13.2 Barefoot doctors

In the meantime, in the 1960s, word had leaked out of communist China about significant improvements in health brought about by the use of "barefoot doctors," or community-based medical personnel. Local physicians from city hospitals trained these farmers for a few months after they were selected by their communities. In order to help their people, farmers were trained how to use basic technology and blend Western and traditional medicine. To stay a part of their community, they returned to their farms.

Through the 1960s and 1970s, this system significantly increased life expectancy, decreased child mortality, and controlled epidemics in China. However, just as the initiatives of South African physicians Karks and Henry Gluckman, who established the barefoot medical system, also came to an end. When the Chinese government implemented a hospital-based, Western-style healthcare system in the 1990s, it collapsed (Zweigenthal et al., 2009:5).

3.14 The Alma-Ata Declaration – Health for All by the year 2000

In 1978, the WHO Alma-Ata Conference established a global benchmark for nations and organisations towards achieving Health for All. Health for All in modern day known as universal health coverage or in South African context National Health Insurance.

A total 134 countries, with the exception of South Africa, attended the conference and the draft Alma-Ata Declaration documents were sent out extensively in advance. At the conference, the knowledge acquired from numerous health projects was offered and debated. This led to a set of aims and plans intended to achieve ‘Health for All by the year 2000' (Alperstein, 2019:21).

After more than 30 years of investigation by isolated groups of health professionals, the comprehensive primary health care approach originated. The Alma-Ata Conference and its declaration set the direction of many new WHO programmes and changed the health system of many countries. Over time, some countries have had better success than others in moving towards this goal (Alperstein, 2019:21).

3.15 Strategy for the implementation of primary health care

When it comes to the determination of a strategy, firstly there must be commitment from politicians to primary health care and by the government in authority. Urgent matters must be highlighted and then detailed plans of action must be set out. This will differ from country to country, depending on its degree of development, health necessities, and accessible resources. Most health systems need to be reformed to a more community-based or decentralised system so that health care become accessible to all (Dennill, & Randall-Mkosi, 2015:10).

Principles on which a successful PHC strategy should be based:

The six principles outlined by Dennill and Rendall-Mkosi (2015:10), are accessibility, affordability, availability, equity, effectiveness, and efficiency. The pertinent two for this study are accessibility and equity, outlined as follows:

3.15.1 Equal access and equity

Everyone should have admittance to health care service, regardless of social or economic status. Resources that affect health must be distributed equally. This applies within country boarders and between countries. The Alma-Ata Declaration urges countries to cooperate to improve health worldwide.

Most importantly, persons with the highest requirements should get precedence or a better portion of the health care resources. This is the principle of equity, which does not mean equal treatment for all, because it gives extra resources where they are most needed, while equity aims to achieve equally good Health for All. Figure 3.2 summarises the differences between equality and equity (Alperstein, 2018:24).

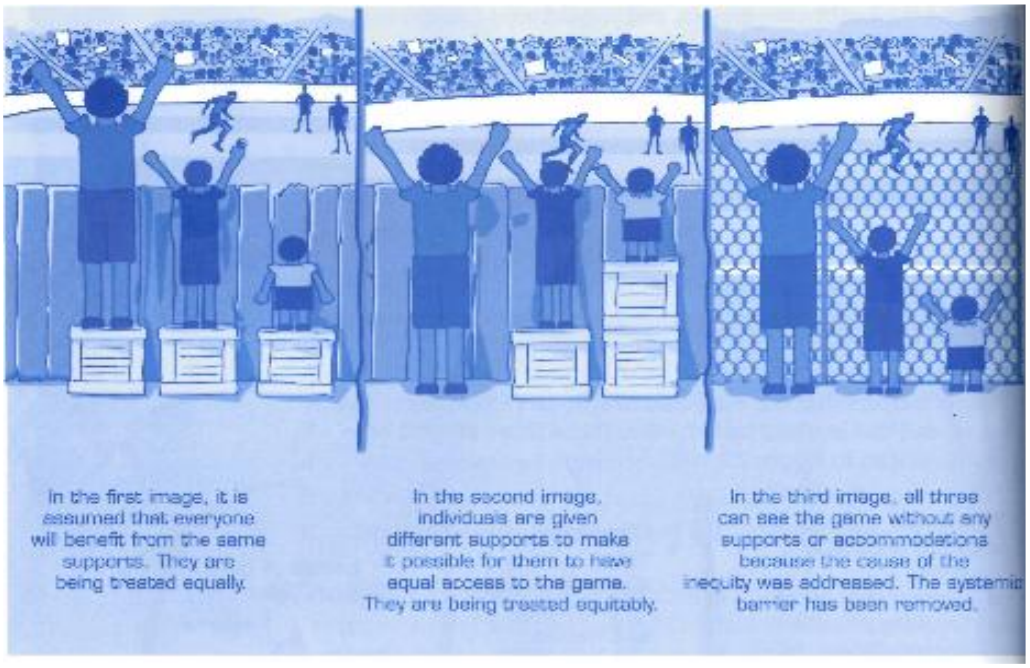


Figure 3.2: Equity diagram

Source: (Alperstein, 2018:24)

For example, the Eastern Cape and Limpopo have always had fewer health care resources than the Western Cape and Gauteng. At the advent of the new government coming into power, it gave extra resources to the provinces in greatest need, like the Eastern Cape and Limpopo, to try to ensure equity. If equality was the principle, it would have given all provinces the same resources, regardless of their different needs. Equal access meant that health care must be obtainable at a location and at times when people can acquire the services. For a health service to be truly accessible, it must relate to its culture.

Table 3.6: Demographic and health indicators

Selected demographic and health indicators for the Eastern and Western Cape 2014		
Indicator	Eastern Cape	Western Cape
Total population	6.9 million	6.2 million
Live in rural area	60%	11%
Live in poverty/poverty prevalence (2011)	41%	23%
Live in formal housing	64%	83%
Infant mortality	40/1000	20/1000
Under-five mortality	60/1000	25/1000

Selected demographic and health indicators for the Eastern and Western Cape 2014		
Life expectancy	54 years	68 years
Expenditure on health per capita	R2 878 per annum	R3 852 per annum
Medical scheme coverage	10%	22%

Source: (Day & Gray, 2016)

According to Hattingh et al. (2006:122), equity in terms of primary health care is described as equal access to health care services, according to need. Equity is also defined in terms of equal utilisation of health care services according to need. The factors that would need to be considered in health planning in terms of the equity principle relate to:

- Physical distance
- The attitudes of health care services providers
- The needs perception
- Cultural constraints.

According to Rifkin et al., (2021:1) “on the 40th anniversary of the Alma-Ata Declaration in 2018, membership countries of the WHO signed the Astana Declaration”. The declaration emphases on promoting PHC by means of (a) provision of primary care services throughout the life course, (b) warranting equity for health care, (c) correcting the social determinants of health, and (d) enabling people and communities. The furtherance of these aims in the post-COVID-19-era, the method forward is to incorporate public health systems and health services to comprise: clinical care, surveillance, and rapid response to dominant communicable and emerging diseases, a population health method, and a respect of better health as both a result of the social determinants of health and a social aim that needs multisectoral action (Rifkin et al., 2021:1).

If equity in health is to be achieved, a multidisciplinary, intersectoral approach to health care provision must be followed. A single individual or discipline will never be able to supply the community with all the care needed to ensure the achievement of optimal health. Nor will the efforts of the health sector alone be sufficient to enable the community to achieve equity in health. The members of the multidisciplinary health team will have to accept that only once there is extensive collaboration will it be possible to provide the community with the best possible solutions to identified health care needs and problems. The WHO defines equity as the absence of avoidable or remediable variances among groups of people, whether those groups are socially, economically, geographically, or demographically strongminded. Health

inequities therefore involve more than inequality concerning health determinants and access to the resources necessary to advance and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. This means that those with the highest requisite should get precedence or a better portion of the resources to overcome many of the determinants of health, in specific, social determinants (Sherry, 2018:81)

3.15.1.1 The three equitable views on community involvement

The 'buzz value' on involvement is so excessive that discussion on whether it is good or bad has stopped. The generous view of involvement sees it as good, particularly if it is organised and orderly. The liberal view emphasises two facts. The first point is that, through involvement, a concrete, local data base is used for programmes. Local individuals who have lived in deprivation for years, enduring the hardships of their poverty, have a certain deep-rooted knowledge that outsiders do not have. Their common-sense understanding of environmental dynamics can be of enormous worth to health programmes. Managers who do not use this knowledge base to the full are placing limitations on health programmes and projects (Swanepoel & De Beer, 2011:51).

The second fact is that it has now been proven that people who do not get involved in their development have no affinity for health programmes and expansion and their effects. The huge problem of sustaining development and maintaining facilities can be solved by having the local people fully present.

Although legitimate, these are not and cannot be the only reasons for involvement. We must also take note of the radical view on involvement. According to this opinion, involvement becomes a way of endorsing equity. Often, the poorest of the poor do not get their fair share of the benefits of health programmes. Therefore, involvement must include them. Furthermore, we must realise that it is the democratic right of individuals to be involved in matters affecting their future. Every adult, whether relatively poor, poor or the poorest of the poor, has the right to be part of the decision-making instrument affecting their health. When people are mobilised to get involved in a project, they are not just there simply to make them feel part of the project; they are not present so that their local practical knowledge can be used; they are not there to do physical work. They are present because it is their democratic right to be part and to make decisions regarding the health programme and/or project that involves their future (Swanepoel & De Beer, 2011:51). The basis of equity transpires from the District Health System, a decentralisation strategy further discussed in section 5.8.3.

3.15.2 Accessibility

Services must be modified to be within the reach of all individuals in the country. Special attention must be given to deprived districts of the country, particularly small remote rural areas. Services must be:

- Geographically accessible, noting that health services should be within a reasonable distance (the WHO suggests 5–10 km) and that transport should be available;
- Affordable and accessible to the individual and the community;
- Operationally accessible, in that the appropriate category of care is obtainable to meet the necessities of the particular community (Dennill & Rendall-Mkosi, 2015:10); and
- Accessible for the the individual to get to your clinic or practice easily without having to negotiate a hostile and stigmatising environment (Lachman, 2014:511).

Alperstein (2018:8) further states that access depicts health care must be accessible at a location and at times that communities can reach the services. For a health service to be really accessible, it must be in a language in which individuals are able to communicate, and it must relay to their culture.

There is a trend towards providing more comprehensive, family-centred “one-stop” services when treating vulnerable population groups. Provision of several services during a single clinic visit is an illustration of a one-stop service. If social and economic assistance are provided and included in interdisciplinary action plans, services can be more reactive to the collective effects of social and economic stressors on the health of special population groups. This situation is at best of times referred to as *wrap-around services*, where comprehensive health services are available and social economic services are “wrapped around” these services.

It is supportive to provide comprehensive services in localities where people live and work, including schools, churches, neighbourhoods, and workplaces. Comprehensive services are health services that concentrate on more than one health challenge. For instance, certain nurses use stationary or mobile outreach clinics to provide a extensive range of health promotion, disease prevention, and disease management services in migrant camps, schools, and local communities. A single customer appointment might emphasis on an severe health problem such as influenza, but it also may include health education about diet and fitness, counselling for smoking cessation, and a follow-up appointment for immunisations once the influenza is over. The shift away from hospital-based care comprises a changed commitment to the public health services that vulnerable communities need to prevent diseases and

promote health, such as the reduction of environmental risks and violence and the assurance of food and water safety (Stanhope & Lancaster, 2014:380).

Nurses focus on advocacy and social justice concerns as well. Advocacy directs to activities taken on in place of another. Nurses may operate as advocates for vulnerable communities working for the opening and execution of policies that lead to improved public health services for these communities. For instance, a nurse may assist on a local partnership for uninsured people and another may work to advance a plan for sharing the delivery of no cost or low-cost health care services by local health care institutions and providers.

Social justice comprises the notions of classlessness and equality. A community that pledges to the notion of social justice would value impartiality and recognise the worth of all members of the community. Such a community would deliver humane care and social care for all individuals. Nurses who operates in advocacy roles and expedite change in public policy are intervening to uphold social justice. Nurses can be advocates for policy amendments to advance social, economic, and environmental aspects that incline vulnerable communities to poor health. The overriding nursing aim for the care of all individuals, comprising those who come from vulnerable communities, is to deliver safe and excellence in health care (Stanhope & Lancaster, 2014:380).

Nurses need to deliver ethnical and linguistical suitable health care services. *Linguistically suitable* health care service known for communicating health-related knowledge in the clients primary language when possible and continue in a language that the client can comprehend. This means using words that the client can interpret. The aspects that incline individuals to vulnerability and the effects of vulnerability generate a cycle in which the effects underpin the predisposing aspects, leading to more negative effects. Except the cycle is fragmented, it is difficult for vulnerable communities to advance their health. Nurses can categorise areas in which they can work with vulnerable communities to discontinue the cycle. The nursing procedure directs nurses in evaluating vulnerable individuals, families, groups, and communities; developing nursing diagnoses of their strengths and necessities; forecasting and implementing suitable therapeutic nursing intercessions in collaboration with vulnerable clients; and assessing the efficacy of interventions.

In certain circumstances, the nurse works with specific clients. The nurse also advances programmes and policies for communitiess of vulnerable persons. In both examples, planning and implementing care for members of vulnerable populations involve partnerships amongst the nurse and client and build on discreet assessment. Nurses must refrain from giving their clients instructions or guidance because doing so could hinder the growth of a trusting

relationship and unintentionally encourage a cycle of dependency and poor self-care. At the outset, it is crucial for nurses to demonstrate their dependability and loyalty. For instance, nurses in a community clinic for drug addicts have to dispel any doubts clients may have about them and calm their fears of being taken advantage of. Among the various roles that nurses working with vulnerable communities may play are those indicated in Table 3.7:

Table 3.7: Nursing roles with vulnerable communities

Nursing function with community work	
• Case investigator • Health educator • Counsellor • Direct care provider • Population health advocate • Community assessor and developer	• Monitor and assessor of care • Case administrator • Advocate • Wellness programme organiser • Participant in developing health policies

Source: (Sebastian, 2014:380)

They use case finding and interventions to draw attention to families and individuals who are at risk. They create programs that address their needs and reassure vulnerable groups about accessing health services. Nurses acquire knowledge about disease prevention and health promotion strategies for vulnerable individuals, families, and groups. They help clients categorize their resources and strengths and offer advice on how to feel more in control of their own lives. In addition to providing guidance on how to feel more in charge of their own lives, they assist clients in classifying their assets and strengths. They provide direct care to patients and their families in a range of settings, such as factories, mobile clinics, shelters, homes, neighborhoods, workplaces, churches, and schools (Sebastian, 2014:381).

Reorganising health care services

It is necessary to shift the focus of healthcare from medical care provided in hospitals to primary care provided in communities. The main goal is to deliver health care services effectively and efficiently through a system that meets community needs at the local, regional, and federal levels as well as providing the required support and referral services at the intermediate, provincial, and local levels. Given that it will be impacted by the political, cultural, technological, and financial aspects of the nation, this change process must be ongoing. In

order to accommodate this new structure, accessible resources will also need to be realigned, with a shift in resources going to the community for basic health services and community-based health care. When government agencies look for easy-to-manage, replicable, and simple interventions to present at the community level across the nation or province, complications occur. This makes it impossible to apply the kind of adaptable and flexible approach needed to apply appropriate primary health care services to meet the needs of individual communities. To combat this complexity, each community's members should be granted far greater autonomy in determining their own health requirements and controlling the way their primary healthcare services are organized to satisfy them. The community's "ownership" of its health care services is crucial to obtaining primary healthcare (Alperstein, 2018:10).

Multidisciplinary approach

The definition of health as defined by the WHO's constitution acknowledges the broader definition of health. Declaring that one's health is the “physical, mental and social well-being, and not merely the absence of disease and infirmity (Van Rensburg, 2012:3)”. Therefore, health is the invention of a individual’s progressive interface with their entire environment. Aspects of this holistic approach towards attaining health are illustrated in the mandala of health (Figure 3.4). This objective cannot be achieved solely by the traditional health team providing healthcare (Dennill & Rendall-Mkosi, 2015:17). The multidisciplinary group must include members of the general public, such as the client and his family, as well as any other interested parties who can help the community in any manner to improve its health status.

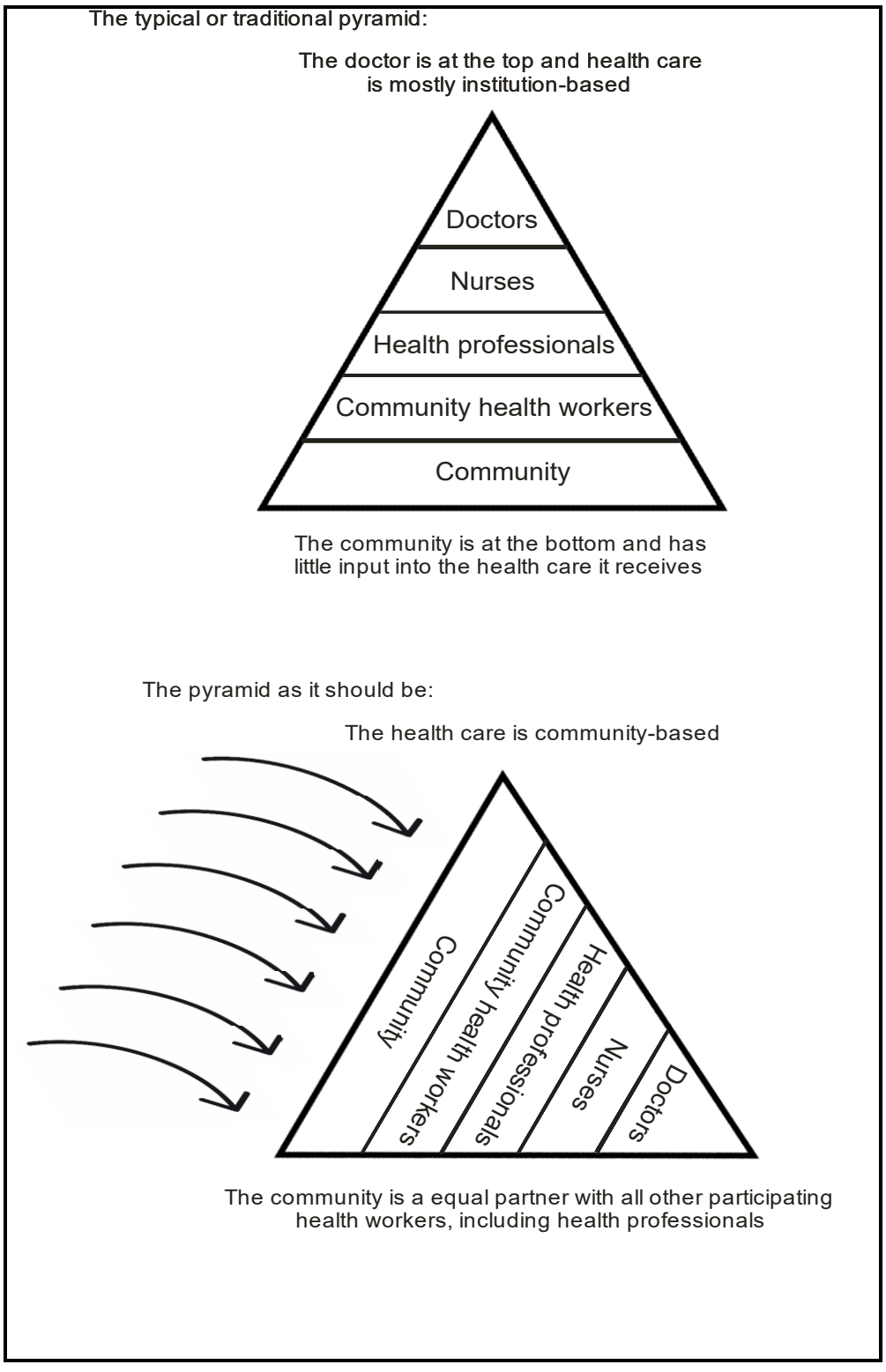


Figure 3.3: Traditional health pyramid

Source: (Dennill & Rendall-Mkosi, 2015:18)

Intersectoral collaboration

Primary health care comprises such diverse interventions which make it difficult to be executed by health workers in seclusion. Numerous divisions have diverse abilities, resources, and technology necessary for the achievement of a healthy community. It is revealed that civil engineers have a higher result on the wellbeing of individuals than health professionals, due to the fact of the role they play in providing the community with water quality and sanitary conditions (Dennill & Rendall-Mkosi, 2015:17).

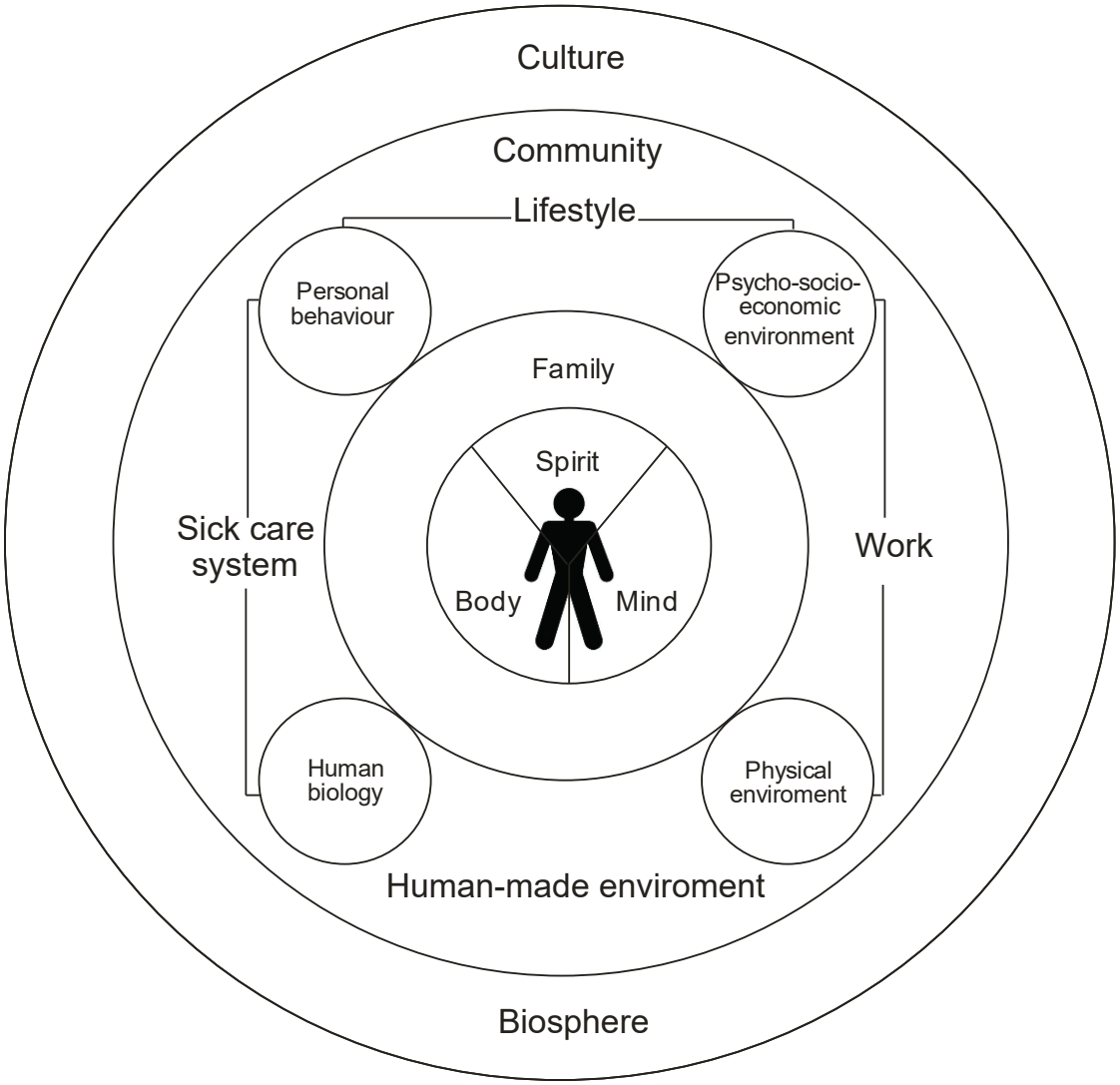


Figure 3.4: The mandala of health – A model of the human ecosystem

Source: (Dennill & Rendall-Mkosi, 2015:21)

There should be multididsciplinary input in defining the policy that effects health or the environment. For instance, the health of a community can be affected both constructively and harmfully by the construction of a large dam in their area. To augment the advantage of such a development to the community, a group approach is needful by the different divisions or stakeholders in the project (e.g. health, engineering, ecology disciplines, etc.). All the people in the community have a right to be healthy, and should therefore have equal access to health care. To achieve equity in health, healthcare delivery must take an intersectoral, multidisciplinary approach. A single person or discipline will never be able to provide the community with all the care needed to achieve optimal health. Furthermore, the health sector's efforts alone will not be sufficient to achieve health equity for the community. The members of the multidisciplinary health team will have to accept that only once there is extensive collaboration, will it be possible to provide the community with the best possible solutions to identified health care needs and problems.

3.15.3 Access constraints

An analysis of the delivery of the advantages arising from consuming health services found that the poorest quintile received 13% of outpatient and inpatient health-service benefits while the richest quintile received 38% of the benefits when considering all public and private sector services (McIntyre et al., 2015:125). Acute and chronic illness serve as a constant reminder that the way in which health care services are delivered is out of step with how benefits are distributed. For example, the burden of infectious diseases (such as TB, HIV, and diarrhoea) is far greater for poorer than for richer groups; although non-communicable diseases (NCDs) are often considered to be “diseases of affluence”, the burden of some of these NCDs, such as hypertension, is already greater for poorer than for richer South Africans, while the distribution of other NCDs, such as diabetes, is relatively evenly distributed across different socioeconomic groups. The only services that poorer groups derive greater benefit from than their richer counterparts were services at public-sector PHC facilities and district hospitals. In contrast, richer groups derived greater benefits from public referral services at regional and particularly central hospitals and all forms of private sector services (McIntyre et al., 2015:126).

3.16 The Alma-Ata primary health care approach

As was already mentioned, the 1970s saw a global health care crisis with disjointed health systems. Rather than providing basic healthcare to a large number of people, the trend was toward costly treatment for a small number of sick individuals. Globally, both developed and developing nations had the disparities.

The enthusiasm amongst the 134 WHO membership countries in adopting the primary health care philosophy in 1978 was notable. It emphasized how important equity is to the management of primary healthcare. Given that nations aimed to eliminate obstacles to healthcare (Freeman et al., 2015:64).

In response to the general dejection over subpar health care, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) worked together to support an International Conference on Primary Health Care. It was held in Alma-Ata, USSR, from September 6–12, 1978, by invitation only.

A comprehensive philosophy, along with guidelines and tactics, for setting up national health systems was outlined in the 1978 Alma-Ata Declaration on PHC. This declaration was based on the ideas of social justice, equity, and health as a fundamental human right. The Declaration recognized the significance of a country's political, economic, social, and cultural background in shaping its health care system over time. The provision of equitable access to high-quality healthcare services, along with preventative and promotional services for urgent medical needs, intersectoral action to address the social determinants of health, and increased community involvement and accountability, are among PHC's key strategies (Freeman et al., 2015:64). The Alma-Ata Declaration's definition of PHC serves as a reminder that PHC advances human development and ultimately strives for independence and self-governance. The Declaration emphasizes that the health sector's efforts alone will not result in the achievement of health for individuals, families, and communities; rather, the cooperative efforts of other sectors are crucial to the realization of health for all. The 1978 World Health Organization Declaration serves as the basis for three key components of the PHC approach: community involvement, intersectoral collaboration, and PHC service delivery reforms. The conceptual framework of analysis depicted in Figure 3.5 is based on the pillars.

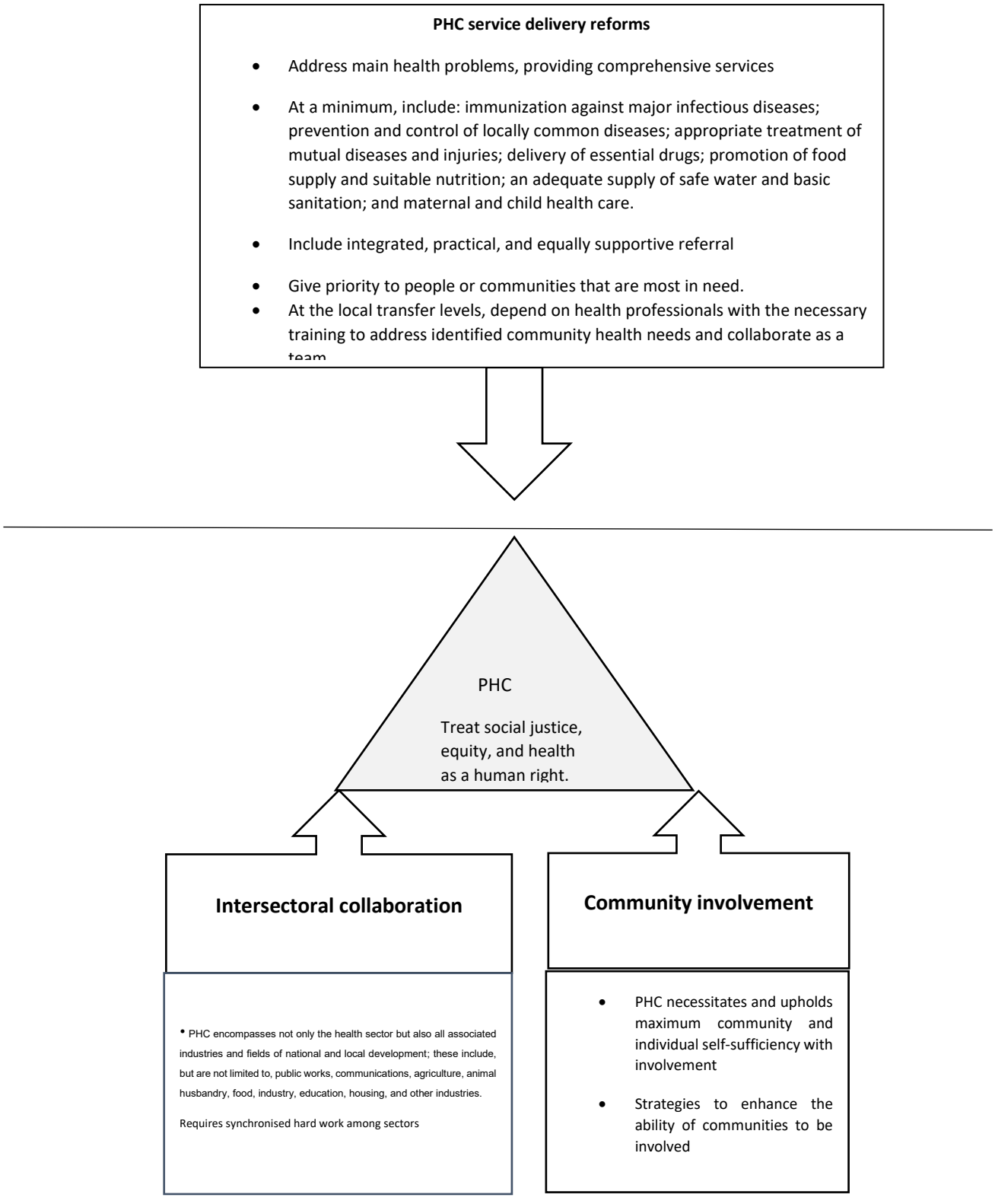


Figure 3.5: Pillars for the primary health care approach

(Conceptual Framework Pillars of the Alma-Ata PHC declaration)

Source: (Adapted from WHO,1978)

3.16.1 PHC service delivery reforms

Although the primary focus has been on service delivery reforms to advance the standard operating procedures of the health care system, Figure 3.5 illustrates how many of the reform initiatives span all three pillars of PHC. A people-oriented approach to health care services, fully addressing significant health needs, improving health outcomes, a district health system that runs smoothly, and an emphasis on the "upstream" factors that affect health are the main tenets of the redesigned PHC structure.

District clinical specialist teams (DCSTs), school health teams, and municipal ward-based primary health care outreach teams (WBOTs) are the three streams of PHC re-engineering.

The Department of Health published a Green Paper on National Health Insurance (NHI) in August 2011. The Green Paper outlines the principles of universal health care coverage, health care access as a right, social solidarity, effectiveness, appropriateness, equity, affordability, and efficiency. It also includes a proposed 14-year implementation plan. The Green Paper establishes links between the NHI and other health sector reforms, including PHC re-engineering, the health workforce, and the establishment of the Office for Health Standards Compliance (OHSC) (Freeman et al., 2015:67).

Much progress has been made in the five-year review period in implementing the reform initiatives. Eleven NHI pilot districts have been set up, with dedicated funding from National Treasury. All provinces have NHI pilot districts, but they are concentrated in regions with a high concentration of underserved communities. The district pilot's specific objectives are to evaluate districts' capacity to take on more responsibility through a "purchaser–provider split," as well as the feasibility, acceptability, efficacy, and affordability of enticing the private sector. Additionally, the cost of establishing a fully functional District Health Authority and the ramifications for expanding to the national level will be assessed. There have been documented improvements in hospital services, district health management, human resources for health, PHC, service quality, essential equipment, health information management, infrastructure, and referral systems. All 52 health districts had established DCSTs by the end of 2013, though most of them lack full teams.

The National Department of Health (DOH) has made significant investments on optimising the functioning of WBOTs, each consisting of a PHC nurse and six community health workers (CHWs). The functions of the WBOTs include conducting community, household, and individual health assessment and testing when required; health promotion; referral for psycho-social support; and treatment defaulter tracing and adherence support. A 2011 audit of CHWs

showed a lack of coordination, poor training, lack of supervision, and no or little evidence of impact as common problems. The DOH developed a model for the deployment of WBOTs that includes standardisation of training relevant to the functions that CHWs are expected to perform (Freeman et al., 2015:67).

Phase 1 of the curriculum covers health promotion, nutrition, TB, HIV, and maternal and child health; Phase 2 covers non-communicable diseases, mental health, youth, older adults, substance abuse, and violence. All of the established ward-based outreach teams have been trained with the support of development partners. Districts could only deploy the ward-based outreach teams once there was proof that they had been trained and had completed Phase 1 training.

A total of 1063 WBOTs had been formed by the end of March 2014, and they had submitted reports on their operations to the District Health Information System (DHIS). The provinces' official employment of CHWs is presently being examined. Currently, a pilot program is being conducted by the National Department of Health (NDoH) to improve the functionality of CHWs using mobile technology.

WBOT members are provided with cell phones and trained to collect and send patient information by cell phone. This mHealth (mobile health) programme was started towards the end of 2012 to improve WBOTs reporting. By the end of March 2014, 518 community health workers had received cell phone training. This improves turnaround time for required patient interventions.

At the end of March 2014, there were 131 school health teams with 60 schools mobile vehicle and 20-panel vans (eight for PHC, eight for dental services, and four for eye-care services) across the NHI pilot districts. At the end of the period under review the percentage of no-fee Quintile 1 and Quintile 2 schools reached ranged between 28% (Gert Sibande district) and 100% (uMgungundlovu district). This reflects the differences in the number of schools in the various districts as well as the differences in the availability of resources, especially vehicles and human resources.

The teams providing health screening, dental care, eye care, diagnosis and treatment of minor ailments, and referral for other services identified barriers to learning (such as eye, speech, and hearing problems) that indicate the need for specialised skills, for instance occupational therapists, hearing therapy and speech, and optometrists. These skills are not readily available in the public sector, indicating that PHC services could benefit from strategic purchasing of these skills from the private sector to enhance the school health program's effectiveness. In 2013, the NDoH entered into a contract with individual general practitioners (GPs) in selected

districts to provide services in PHC facilities in the NHI pilot districts. This constituted a new approach since many of the GPs who are already providing services in the public sector (contracted by the provinces) work mainly in hospitals and health centres. The national contract made provision for GPs to work in a new way by providing skilled clinical care, thereby expanding the range of PHC services provided, and assisting with leadership and capacity-building of the PHC team, as well as contributing to the development of services that address local community needs. Despite significant interest expressed, only 123 GPs had entered into agreements with the NDoH by the end of March 2014.

Table 3.8: Overview of the Ideal Clinic process

Overview of the Ideal Clinic process

- Use of an action-learning approach to respond to health problems was identified.
- The Ideal Clinic wants to create a PHC service platform that is as effective as possible, helping program managers to enhance the general health of the population.
- If a clinic receives 80% or more on an OHSC inspection, it is considered to have achieved Ideal Clinic status, guaranteeing precise weighting for essential measures.
- The Ideal Clinic components are (i) administration; (ii) clinical guidelines and integrated chronic disease management to arrive at integrated clinical service management; (iii) the availability of a doctor; (iv) medicines, supplies, and laboratory support; (v) staffing and professional standards; (vi) communication; (vii) health information management; (viii) infrastructure and support services; (ix) district health system support; and (x) partners and stakeholders.
- The Ideal Clinic is client-centred, works with the community it serves, applies all the relevant resources at its disposal to provide a quality PHC service, and optimally uses its referral network for the benefit of its clients.
- Although the Ideal Clinic's components are in line with the OHSC domains, fixing flaws is the main priority.
- The Ideal Clinic process is also envisaged to assist districts and their facilities to secure the required resources needed to address weaknesses.

Source: (Freeman et al., 2015:64)

These negative aspects raised by GPs provided the impetus for the Ideal Clinic process, which commenced in July 2013. Developing the ideal PHC clinic involves putting in place the necessary administrative, information, clinical, and oversight mechanisms, the required support services (e.g., laboratory, security), effective communications both to workforce and

the community, and also careful integration of the functions of the District Management Team, DCSTs, school health teams, WBOTs and local non-governmental organisations (NGOs). The key elements of the Ideal Clinic are summarised in the overview (Freeman et al., 2015:64).

The study phase to implement the Ideal Clinic, completed in March 2014, confirmed that the clinic is the best place to start the improvement process, as it points to weaknesses in district, provincial and national health management that need to be improved to support the functionality of PHC facilities effectively. Planning for the roll-out of the initiative commenced formally and promised to be the vehicle for sustained quality improvement in PHC facilities.

The NDoH unveiled their Human Resources for Health (HRH) strategy in 2011. The strategy at the time listed the following as major issues with equity in access: a ten-year trend of negative growth in public-sector clinical posts from 1997 to 2006; inadequate planning and budgeting for public sector clinical posts; high turnover from important health professions; inadequate retention of community service professionals, with roughly 23.1% saying they were likely to leave the country due mostly to unfavorable working conditions in the public health sector due to different "push" features and a shortage of public-sector positions – despite the fact that South Africa lags behind its peers in terms of the number of health professionals per 10,000 people: More graduates are qualified than are employed in the public sector due to a lack of positions, an imbalance in the distribution of health professionals between the public and private sectors, rural and urban areas, and poorly managed foreign recruitment (Freeman et al., 2015:70).

In order to help develop staffing norms and standards based on the workload indicators for staffing needs (WISN) approach, the Department of Health and Human Services (DOH) asked the World Health Organization (WHO) country office in 2012. In order to guarantee an equitable and optimal staffing distribution at healthcare facilities across all care levels, from local to national, the WISN approach regulates employment levels. CHCs and primary care clinics have finished the WISN process. Based on the WISN results, the NDoH and WHO are currently developing human resources for health guidelines for PHC. As part of the implementation and upkeep of the Ideal Clinic, the NDoH intends to address staffing needs.

Accessible, sufficient physical infrastructure and health-related human resources are the two essential components of high-quality PHC service delivery. Adequate numbers of appropriately skilled health professionals functioning within good infrastructure (good physical structure, adequate space, and a good supply of water, electricity, and information and communication technology), with the required resources, will ensure that all other prerequisites for quality are in place to provide a good service with poor infrastructure in the

short term. It is not possible to do so for an extended period without compromising patient and staff safety. Good patient flow leading to efficiency and effectiveness is critically dependent on good infrastructure and an environment contributing to a sense of wellness, optimism, and confidence in health professionals.

In 2011, the NDoH commissioned, and guided to completion, a health facility baseline audit, unprecedented in terms of scale and scope. The audit covered 3880 health facilities, including all categories of hospitals and PHC facilities, dealing with every facet of the healthcare system as defined by the WHO. The results of this baseline health facility audit, released by the Health Systems Trust 2012, showed that the scores for infrastructure in the 52 districts of South Africa ranged from 72% in Ugu in KwaZulu-Natal to 52% in JT Gaetsewe in the Northern Cape.

Regarding infrastructure, all health facilities were evaluated for building and site infrastructure (geological land information, geographical topography, geographic zoning, perimeter fencing, internal roads, and paving materials, fire hydrants, fire booster pumps, internal and external walls, and roof, ceiling and floor material), facilities infrastructure management (sanitation, and linen, laundry and food services) and space standards (space to meet service and patient needs, and waiting areas). On averaging the score for the three above aspects, PHC facilities scored 64%, which was 6% lower than the 70% average score that hospitals obtained. A low average of 64% for the total of 3 485 PHC facilities audited indicates that many PHC facilities are in dire straits regarding their infrastructure. The facilities were categorised into those needing minor repairs, those needing major repairs, those needing additional space, and those needing total replacement. The minor repairs are being addressed through an innovative arrangement utilizing the Southern African Development Bank (DBSA) and Further Education and Training (FET) colleges. Final-year FET students, supervised by artisans contracted by the DBSA, provide infrastructure maintenance services at PHC facilities. Maintenance is done and the students obtain the practical experience they require to qualify as artisans. Major maintenance and new constructions continue to be completed through the Department and new constructions through the Department of Public Works while the NDoH, in collaboration with the DBSA, has provided additional space to 102 clinics through innovative building technology in the form of light steel-frame constructions that meet Agreement South Africa certification. Going forward, to halt the deterioration of health facility infrastructure and to decrease the burden of backlog maintenance, the NDoH should ensure a budget for routine maintenance and that provinces appoint appropriately qualified individuals at the district level to manage, together with health facility managers, the execution of routine maintenance by implementing agents.

Of note for PHC services within the DHS is that, during the study phase of the process of realizing and maintaining the Ideal Clinic, the elements relating to the availability of medicines in the clinics were the easiest and quickest to change from orange and red to green. These elements also remained consistently green. A system in which the GPs contracted on the national contract inform the GP contracting management unit at the NDoH about medicine stock-out at the PHC facilities at which they provide their services also indicates that the availability of essential medicines at the PHC level is no longer a problem in South Africa.

Finally, financial resources are crucial for effective health reforms that will bring about equitable PHC services. A monitoring mechanism is required to ensure the resourcing of key areas of health-service provision within hospitals and in The health system in the district reforms. With the National Health Council's 2012 resolution on the non-negotiables, progress has been made. The purpose of this list is to ensure that funding is available during the entire financial year to ensure access to the items on the list in health care facilities. The items on the list are infection control and cleaning materials, medicines and medical supplies, requirements for medical waste, laboratory supply services, blood supply services, food services, and relevant supplies, security services, essential equipment (including maintenance of equipment), children's vaccines, and requirements for the treatment and management of HIV/AIDS, and tuberculosis. The current framework for "non-negotiables" tracks expenditure against the budget for the respective components. However, PHC services are currently underfunded and the District Health Expenditure Review shows marked differences in per capita spending within provinces as well as between provinces. Resourcing of PHC services needs to be addressed adequately for sustained UHC (Freeman et al., 2015:64).

3.16.2 Intersectoral collaboration

The importance of addressing the social determinants of health is acknowledged by the Minister of Health's NSDA, which takes into account the degree of poverty and inequality as well as the disproportionate burden of illness among the poor. In a similar vein, the National Development Plan has made clear how crucial the SDH is to realizing South Africa's development and health goals.

Importantly, the concept of universal coverage and equity is central to the vision for an NHI, which, in turn, is underpinned by the PHC approach. Healthy people will be a key component of the PHC service delivery reform movement. This emphasizes how crucial it is to have initiatives that successfully advance wellness and fend off illness. Keeping citizens healthy requires a Health in All Policies (HiAP) approach. HiAP is an method to public policies throughout all segments that thoroughly takes into account and steers clear of negative

consequences for health and health systems. A successful HiAP approach should make a positive difference to those elements that determine the conditions and opportunities for an individual, a family, and a community and that allow them to realise the best possible developmental outcomes for their lives. HiAP requires that policies across all sectors shouldnconsider how the legislation will affect the health of the citizens of the country. While the health sector has a substantial role in making HiAP a reality, an ever-present HiAP approach should not be the exclusive role of the health sector. HiAP thus calls for focused, goal-orientated intersectoral collaboration.

In this section, we highlight intersectoral collaboration with other government departments, using a life-course approach, and structural mechanisms to address the SDH.

Diverse phases of the human life-course call for different health needs, are affected by different SDH, and thus necessitate a distinct emphasis on programs, content, and activities related to health promotion and sickness prevention. For instance, the health sector will address the health needs of elementary and high school students when collaborating with the Department of Basic Education. Interaction with the Department of Agriculture, Fisheries, and Forestry on food security focuses on the needs of the human being in all the stages of the life course. Issues

being the most common preventable cause of death worldwide, tobacco use is a risk factor for six of the eight major causes of death. Tobacco taxation, sales of tobacco products to minors prohibited, extensive prohibitions on advertising, and the distribution of health-related materials about the risks of smoking—all of which are enshrined in South African legislation—combine to provide the most effective intervention against tobacco use. An example of a high-achievement approach is the government's decision to address both the policy environment and individual behavior to reduce or abstain from smoking.

The new salt regulations addressing the salt content of processed foods are another example of how South Africa is addressing population health through a HiAP approach. Based on available data, the average South African consumes roughly twice as much salt per person

as the WHO's recommended daily allowance of 5 grams. The effects of lowering salt at the manufacturing stage were shown by economic modeling. Using scientific evidence, the NDoH recognised that a reduction in salt intake is fundamental to reducing a range of diseases, especially hypertension, and that the major reduction of consumption has to come from changes in the manufacturing and processing of foods itself, rather than through individual behaviour change. Both the major industry players and the government agreed that if a) the sodium targets and b) the time frames were set at reasonable levels, state regulation was preferable to self-regulation. The final regulations on salt reduction with set targets for 2016 and further reduction targets for 2019 were promulgated on 19 March 2013.

Alcohol is a major threat globally. To address its associated risks, regulations have been proposed on alcohol. Alcohol causes major social and economic hardships and adversity and is implicated in increased crime, women and child abuse, violence, absenteeism, failure to progress at school, poor productivity, unemployment, break-up of families, and many other matters that impact development. Alcohol-related harm is not just to the drinker but has immense implications for innocent others, including unborn children, victims of alcohol-related crashes, violent acts, and so forth. The total tangible costs of alcohol are estimated to be in the region of R38 billion annually. This is about twice what the country receives from alcohol-related excise tax and Value Added Tax combined. The costs to the Department of Health alone are estimated to be about R6.6 billion.

Every major disease area in South Africa, including the widespread HIV and AIDS epidemic, high rates of tuberculosis, high rates of morbidity and mortality among mothers and children, and non-communicable illnesses, and violence and injuries, alcohol is a causative and/or exacerbating factor. The impacts of alcohol-related harm cannot be redressed within health or any other sector alone and require a multisectoral response. This reality and the urgency to act decisively against alcohol-related harm have prompted the Cabinet to set up an Inter-Ministerial Committee (IMC) on Alcohol and Other Substances under the chairpersonship of the Minister of Social Development. The committee comprises 13 ministries, represented at the level of minister or deputy minister. These are the ministers or deputy ministers in charge of the following areas: science and technology, economic development, sport and recreation, trade and industry, health, basic education, higher education and training, police, correctional services, and transportation communications, and Performance Monitoring and Evaluation. The Department of Justice and Constitutional Development has also joined from time to time, where required.

The committee has processed numerous presentations from different experts and lay stakeholders on the impacts of alcohol and on the policy options that are likely to reduce

alcohol-related harm effectively. The committee has chosen a public health approach to assess and analyse alcohol-related harm as this provides them with a broad, evidence-based framework that moves beyond individualised solutions. Importantly, this approach does not restrict members from considering the impacts of alcohol on other areas such as education, crime, violence against women and children, road traffic crashes, and so on. Rather, it provides a broad analytic framework for understanding underlying causes and consequences. While there has been debate in the committee about an individual responsibility approach to addressing alcohol-related harm, this has not received the same traction as a more population-based approach with its emphasis on measures such as alcohol pricing, control of alcohol marketing, stricter controls on the time and places where alcohol can be sold, policy measures to discourage the sale of alcohol to teenagers and children, measures to reduce drink-driving, and so forth. Notwithstanding, the critical role of public education and awareness, especially of school children, has been emphasised.

Various ministries within the Inter-Ministerial Committee have assumed accountability for distinct facets of the overarching objective of mitigating alcohol-associated harm. For instance, the Department of Transportation has stepped up its campaigns against drinking and driving and the enforcement of drunk driving laws; the Department of Social Development has started the process of expanding admission to reintegration services; and the South African Police Service has greatly increased its efforts in closing unlicensed establishments since the implementation of the IMC.

The committee has also spent a great deal of time debating whether the government should outlaw alcohol sponsorships and advertising, raise the legal drinking age to 21 (which falls under the purview of the Ministry of Trade and Industry), and impose a zero-tolerance policy for drinking and driving. Decisions regarding the first two issues were probably made shortly after the time of writing, based on the evidence that was provided to the committee and which indicates that they could be significant options to lessen alcohol-related harm (Freeman et al., 2015:64). After reviewing a voluminous amount of information and supporting documentation, the IMC directed the Minister of Health to draft legislation outlawing sponsorships, advertising, and other forms of marketing. The Cabinet approved the draft bill so that it could be made available for public review. Regarding the potential effects of this legislation, an independent regulatory impact assessment was carried out (Freeman et al., 2015:79). The IMMC has come to the realization that preventing alcohol-related harm necessitates a variety of approaches rather than a single panacea. Policies that work together rather than as separate entities. Raising the legal drinking age, enforcing a zero-tolerance policy for drunk driving, and launching anti-alcohol harm education campaigns in schools are a few examples of policies

that are likely to have less of an impact on drinking behaviors over time. These policies also allow for the glamorization and encouragement of alcohol consumption through advertising. The government cannot afford to let conflicting messages to be sent by commission or omission, to ignore marketing control while enacting other policies.

Interventions that take a 'social determinants' approach often do not have impacts that can be measured immediately after the intervention is introduced. Hence, the impacts of the IMC are difficult to assess scientifically at this juncture. Notwithstanding that, the approach of uniting ministries through an intersectoral committee where strategies can be analysed and assessed, and where different ministries can take responsibility for different aspects at a high level, this presents an excellent opportunity to realise a "whole of government" and "whole of society" approach to health (Freeman et al., 2015:64).

The key enabling factors responsible for the success of South Africa's HIV and AIDS programme are a combination of effective stewardship, improved resource allocation, improved access to health interventions, and improved partnerships with key stakeholders.

While government policy regarding HIV and AIDS was ambiguous for some time, significant progress has since been made in accelerating interventions in collaboration with civil society, business, and other key stakeholders. With the establishment of the National AIDS Coordinating Committee of South Africa (NACOSA) in 1992, a nationwide network of civil society organizations specializing in HIV/AIDS, tuberculosis, and social development was brought together. In order to prevent HIV infection, lessen the personal and social effects of HIV infection, and mobilize and coordinate local and international resources, NACOSA developed a national HIV and AIDS strategy. The strategy was adopted by Cabinet in 1994 and subsequently reviewed in 1997. The South African National AIDS Council (SANAC) improved in efficiency and management following NACOSA's reorganization. Under the supervision of SANAC, national strategic plans were developed for HIV/AIDS, STDs, and tuberculosis for the years 2007–2011 and 2012–2017. Additionally, SANAC improved communication and cooperation between the government and civil society. When SANAC was reorganized in 2007, it consisted of 19 sectors: the government and the business sector made up two of the sectors, and 17 of the sectors were civil society formations.

During the period under review, this collaboration has seen South Africa grow its antiretroviral therapy programme into one of the world's largest programmes for providing treatment to eligible persons living with HIV. This programme has served to reduce new HIV infections and mortality from AIDS, thus ensuring child survival and increased life expectancy.

3.16.3 Community involvement

The realization of the government's goal of "A long and healthy life for all South Africans" depends on increasing the breadth and depth of social mobilization and community involvement in all facets of health care delivery. The National Health Act 61 of 2003 (as amended) stipulates that every year the Ministry of Health must hold a National Consultative Health Forum attended by civil society representatives, academic institutions, private sector representatives, and organised labour. Discussions in the forum centre around current reforms and policy implementation (Freeman et al., 2015:64).

Guidelines for building and strengthening community structures—such as hospital boards, clinic committees, and community health centers—that will participate in planning and decision-making to enhance service delivery were developed by the NDoH. The Ideal Clinic realisation and maintenance process will be scaled up to ascertain the degree to which these (minutes of meetings reflecting pertinent decisions and guidance) are functional.

Since 2010, building on previous work in this regard with assistance through funding from the Atlantic Philanthropies (in the North West province) and later with assistance from the NDoH and Global Fund (in Mpumalanga, North West, and Nothern Cape provinces), the Health Systems Trust (HST) has conducted action research (2010) and qualitative research (in the provinces of Mpumalanga, North West, and Northern Cape in 2013) to determine whether community dialogues could be effective as a means of bringing about the required health awareness amongst communities. The dialogues were conducted looking at the possible impact on programmes aimed at improving the utilisation of maternal and child services, reduction of TB defaulter rates, improvements in the uptake of HIV counselling and testing, improving the PMTCT, and reducing teenage pregnancy. The study reports point to challenges that communities face about access to health services, and report that dialogues have provided insight into what drives the behaviour of the communities towards health and other social weaknesses that the NDoH and provincial health departments need to focus on improving (HST, 2012). Community dialogues, when properly planned and executed, create an environment in which people actively listen to each other without challenging or judging. When health workers and community members practise active listening, a shared identification with and empathy for one another's human reality, perspectives, beliefs,

practices, and traditions can be achieved. This understanding ultimately empowers all parties to fulfil their roles in the decisions and actions that influence health positively. The NDoH, as part of its formal health-promotion strategy, is currently using the direction from the HST 2014 report to draft guidelines for community dialogues to facilitate broader use of this intervention.

As an example of using new technologies to involve communities in raising the standard of healthcare services, Cell-Life is currently piloting an EU funded “Rate My Clinic” service with the OHSC. This provides a means for patients with access to cell phones to rate their experiences per facility in terms of the six core concerns: patient safety and security, staff attitude, infection control, drug availability, waiting time, and cleanliness. It uses technology that is available on all cell phones (Freeman et al., 2015:64).

In 2012, the Ministry of Health and the CEOs of leading South African companies in the healthcare environment signed an agreement strengthening public and private sector collaboration in tackling the shortage of doctors in South Africa (Masombuka, 2012:1). Through this agreement, a three-year multi-million-rand public health enhancement fund was established, with the objectives of expanding the intake of medical students, supporting postgraduate students pursuing health-related studies, and building additional capacity in the management of tuberculosis, HIV, and AIDS. The number of students pursuing master's and doctoral degrees in health-related fields, as well as medical degrees, has increased in this fund. The fund also facilitated the establishment of the NDoH electronic knowledge-management hub (Freeman et al., 2015:81).

3.16.3.1 Involvement for all

The primary healthcare approach encourages individuals and groups to actively participate in their healthcare. This suggests that patients and healthcare providers are jointly responsible for and have control over their care. Making the most use of all available resources is the joint responsibility of both parties. The Ubuntu idea and African philosophy mesh nicely with PHC's and community involvement philosophies. Making decisions as a community and deriving meaning and solutions from relationships within the community are natural ways of being as opposed to the Western preference where people search for their options. In many nations, community involvement in health services is facilitated by formal governance structures like hospital boards, clinic committees, and community health committees comprised of interested community members (Alperstein, 2018:26).

Case study: Problems with participation

A sanitation project was initiated by health service providers in a village located in a former independent homeland. They determined that everyone in the village would participate by

constructing pit latrines. The headman and subheadman of the village issued a warning to the residents, stating that failure to construct a toilet would result in a fine.

A problem was found when non-governmental organization (NGO) village health workers (VHW) visited these households after a while. The villagers received no assistance or materials to construct their latrines. A large number of the villagers were elderly, and only grandmothers with small grandchildren lived in many of the households. How were they going to build or dig a hole deep enough? Some who didn't construct pit latrines received fines from the headman. Others had build wooden structures without a pit inside, to avoid the fine.

The NGO decided to ask the headman to arrange a village meeting. Because the NGO had been in the area a long time and had the headman's respect, he agreed.

At the community meeting, the VHWs explained that fining people in the community would not help their health. They were all poor and had little money for food. If they were fined they would still have no toilet and even less food and would be even more likely to get ill. After many hours of discussion, it was agreed that there would be no more fines. The NGO would help with fundraising, and every household would make a small contribution to the project. Old and young men would help the households headed by women with digging and building. They would also wait for the men working in the city to come home on annual leave to help.

From then on, all healthcare projects were first discussed by the whole community in a village meeting. The meeting would decide on the priorities and ways of managing projects. Even the health-service providers had to follow this process.

Figure 3.6: Case study: Problems with participation

Source: (Freeman et al., 2015:64)

3.17 Summary

This chapter has demonstrated the effect of environmental and social conditions on the health of poor communities. The nursing pioneer Florence Nightingale, despite her affluent

background, expanded her knowledge on the existing settings of the poor. Hence, the environmental conditions of the poor are still centric to nursing in the 21st century. In essence, the poor have been considered since the inception of the primary health care the World Health Organization's 1978 definition. The definition comprises an overarching value, named ‘Health for All’. The chapter encompasses two notable concepts, named access and equity. These concepts feature in South African policies at all three government levels. The next chapter discusses the involvement of communities in health.

CHAPTER FOUR:

COMMUNITY INVOLVEMENT IN HEALTH

4.1 Introduction

The primary health care (PHC) philosophies and the necessity of making the poorest communities the primary recipients of health services were covered in the previous chapter. The idea of community involvement in health care (CIH) is covered in this chapter.

The CIH concept is about taking into account the knowledge of local communities about their health. The success of the official health services is reliant on the contribution of local communities to the preparation and execution of health programmes. This fact is congruent with the notions of self-assurance and self-governance that are centric to the PHC definition in Chapter Three. The concept of CIH in Kasshay and Oakley's (1989) publication has been adopted by academics Stern and Schaay (2011), among others. The benefits of CIH are: more people involved, resource efficiency, goal-orientated, equity, and local capacity-building. The authors contend that "involvement" is a more accurate term than "participation" because it denotes a more intimate and profound identification of community members with basic healthcare. A formal organization comprising local stakeholders interested in advocating for issues affecting the health of the general public is required for CIH. This statement is referenced in both the Facility Boards Act and the Municipal Structures Acts (discussed in Chapter Five).

4.2 Community involvement in health

The concept of community members' involvement in health, which was formalized by Oakley (1989), is highly relevant. Lack of resources is the foundation for its role in primary health care services, especially in developing countries. With the help of CIH, one can supplement the official health services' offerings with additional resources that are based on local data. In a similar vein, CIH can make health services more financially viable and, over time, can lead to a suitable recurrence on funds financing in the health services. It is, however, a substitute for healthcare provided by the government or a means of double taxation.

CIH raise the likelihood that health-related programs and initiatives will be appropriate and effective in identifying local people's health needs rather than the medical facilities' claims of what the local population needs.

Health facilities will have a better chance of success with their programs when they consider local opinions about health requirements and are accomplished with the support of local people (Stern & Schaay, 2011:17). Communities are often aware of the programs and services that will best satisfy their needs. Health care professionals and supervisors can ensure that services are responsive to residential circumstances and requirements by engaging with the community. This approach leads to more efficient use of resources and a healthier community (Sherry, 2018:48).

Tandwa and Dhai (2020:20) cite Kahssay and Oakley's (1989) five key benefits of community involvement: i) coverage and the involvement of more people; (ii) efficiency and the coordination of resources; (iii) effectiveness as a result of more relevant goals and strategy; (iv) equity through focused provision for those in greatest need; and (v) the growth of self-reliance and local capacity. To achieve these benefits, there are many ways that communities can be engaged in health improvement. These can range from large-scale public, formal consultations, with the involvement of democratically elected representatives, to intensive ongoing involvement of small groups of patients in developing services around a common medical condition, to empowering and appropriately remunerating members of small neighbourhood communities to act as advocates, health trainers or community development workers.

> Also, when people are involved in making the decisions which affect their lives, their self-esteem and self-confidence raise, in turn improving their health and well-being. And, of course, many local people have a good understanding of the community's main health problems and priorities for action. Real change can come only from the local community itself by harnessing the energy, skills, and commitment of local people in setting clear objectives for change and forming new partnerships for action (Tandwa & Dhai, 2020:20).

In practice, CIH will be completely meaningless if the term "community" is still applied to a geographically defined area without distinction. In order to involve the people that make up the "community," CIH must first clearly identify them based on social and economic criteria. Then, it must work to involve them in a way that is both appropriate for their skill level and intended to address issues that affect them. CIH must be pertinent to the unique circumstances of the individuals it is attempting to assist. Stern and Schaay (2011:19) continue to use the term "community" in their writing in the absence, for the time being, of a more acceptable unit of economic and social organization for CIH, while acknowledging its shortcomings and the need for a more thorough analysis. One notable feature of CIH is the

specific aim of what a community can donate to health expansion. It is anticipated that it will contribute in proportion to its resources and capabilities. Currently, both rural and urban communities make diverse contributions, across national boundaries, to the delivery and support of regional health care services.

In order to grasp the potential for community support of health development, a valuation process will be necessary, in which the communities will participate to determine what local resources and capabilities are available and how best to incorporate them into health initiatives and programs. More specifically, it is important to develop and make use of local knowledge about medical procedures and practices.

The foundation of CIH preparation is the recognition that communities can contribute significantly and wisely to the effort of addressing health complications, and that it is essential to identify potential influences and incorporate them into health preparation. This approach to CIH also implicitly recognizes that different communities will have different perspectives on what the problems are and how to improve health. Consistent with this broader examination of individuals' involvement, CIH needs to be firmly established on a local organization. It is widely accepted that in order to provide the ways and means necessary to enable involvement, organization is required. CIH also endeavors to establish a community-based organization that serves as a conduit for participation.

An organization of this kind ought to:

• stay local, unique, and based on existing civic organizations and tools;

• be molded, if possible, by local inventiveness;

The proposed form should:

• showcase the benefits of the community members whose affiliation is being sought;

And

• have the potential to become a recognized and accepted descriptive form.

The way CIH is organized is a complicated matter. It goes beyond just starting a community organization, such as a committee on community health. It must be recognized, for instance, that most communities will have conventional means of participation. If the organization is to survive and carry on with its mission of reassuring communities' involvement in health expansion, its creation and growth must be seen as an essential part of the CIH process. In this sense, developing grassroots organizations for CIH may critically depend on improving the district-level primary healthcare systems.

Finally, for those organizations to thrive and legitimately represent the interests of their supporters, national legislation will be necessary. Regarding the role that society plays in CIH, the word "mobilization" and comprehensive cooperative organisation process.

4.3 Understanding community involvement in health

Community involvement in health (CIH) aimed to promote local involvement in the development of health as well as other aspects of development. Community-based involvement in the allocation and planning of essential health care services is known as CIH. In health texts, it's unclear, though, whether to refer to community involvement or community participation (Oakley, 1989:34). For the most part of the development, the final term is preferred. But given its deeper implications, the health sector appears to have designated "community involvement." The distinction between the two terms in primary health care is made clear by the following statement:

In order for [primary health care] to flourish, it is necessary for there to be a certain level of community and specific self-sufficiency as well as a high level of community involvement or participation. This means that by utilizing local, national, and other resources, residents of a community organization must actively participate in the planning, execution, and management of primary health care. The term "involvement" is preferable to "participation" because it suggests a more comprehensive and individualised history of community members receiving primary healthcare.

The idea of taking part in health expansion has been so successful in the past that it is beginning to shape thinking in several related health fields. Since the late 1970s, a large body of research has examined the concept of participation in various facets of health expansion. The vast majority of cases are acknowledged in the literature as the importance of such involvement; however, as expected, there is a wide range of explanation and it is often necessary to define the terms used first. Community involvement in health development is important for many reasons, including the fact that it is a design and execution principle (Oakley, 1989:34).

According to Hattingh et al. (2006:41), one of the fundamental prerequisites for achieving the goal of "Health for All" is the global recognition of community involvement in health care. The process by which families, communities, and individuals take responsibility for their health and well-being and learn how to contribute to both their own and the public's development is referred to as community involvement. The extent to which the community is actively involved in health matters and makes decisions is a crucial sign of the political commitment of a given government to this concept. Community involvement is the process of empowering

communities by enhancing their ability to better their own lives and take charge of their own destiny.

4.4 The arguments for community involvement in health

Undoubtedly, a resurgence of interest in development practices has caused a number of sectors to evaluate past practices closely and express opinions in favor of change. Over the course of the last eight years or so, the CIH theory has caused a great deal of historical practices to be reexamined, areas where they went wrong identified, and necessary changes proposed. The formal idea behind CIH seems to have emerged in the mid-1970s, and numerous publications have since pushed for and suggested the kinds of modifications that it would entail. According to the texts, CIH has apparently been warmly embraced as the last change in approach needed to encourage meaningful health improvement (Stern & Schaay, 2011:19).

Table 4.2: Advantages of a community-involvement approach

Advantages of a community participation approach
I. A community involvement approach is a financially sound way to extend a country's health care system to its borders, though it is by no means free.
II. If communities start to view their health condition more objectively than fatalistically, they may be encouraged to implement a number of preventive measures.
III. Communities are more dedicated to using and safeguarding the resources they create, such as water supplies, when they invest labor, resources, capital, and materials in health-promoting initiatives.
IV. The best method to encourage health is to incorporate health education into village activities.
V. If they are carefully chosen, the community can have confidence in community health workers. They might be aware of the best ways to get reassurance from their neighbors and, at the very least won't probably take advantage of them. They are not as strong a force in the community to support the community in implementing its health-promoting initiatives. But they also need consistent support and resources from the higher echelons of the health system.

Source: (Stern & Schaay, 2011:22)

Not only are the arguments in favor of CIH persuasive, but they are also generally consistent across the literature and often rest on an examination of previous mistakes. The development of health is not a new phenomenon. But plans for regional and national development have always placed a high priority on the growth of other industries, like agriculture. Reactions against earlier health development approaches, especially those associated with the idea of community engagement, propose four primary explanations for their failure:

(i) They have failed to encourage people to think or act independently in an effort to address their health issues, instead pushing them to rely on outside sources for action and solutions.

(ii) Due to insufficient training, the locals are unable to maintain the services that were started. As a result, there was not enough local expertise or funding to keep offering those services.

(iii) Although communities have occasionally donated money and labor for health-related projects and initiatives, there hasn't been a lot of proactive community involvement in their planning or implementation.

(iv) Needs directed toward health conflict with needs related to health, such as housing, water, and sanitation, as determined by the health service and medical profession.

This conflict frequently results in both an incompatibility between the two sets of needs and a lack of community interest in health programs that are externally promoted. As a result, CIH has surfaced as a remedy for the shortcomings mentioned above, and its benefits have been thoroughly covered in the literature. The aforementioned reasons for failure, while somewhat similar, all emphasize how crucial local involvement is to the success of health programs and projects. The following is a compilation of the arguments made in favor of using CIH as a strategy for health development, drawn from a number of studies:

(i) CIH is a basic right that everyone ought to be able to exercise. Participating in decisions and endeavors that promote community well-being fosters self-worth and encourages an accountability-driven mindset (Oakley, 1989:36). As the foundational approach to health development, CIH as an attitude should be promoted as it is crucial to the growth of communities in a larger sense. Participating communities can develop their knowledge and skills, strengthen their bonds with one another, and gain confidence in their ability to address issues that are important to them (Sherry, 2018:48).

(ii) A lot of health services, primarily in developing nations, operate with limited funding. Community-based health (CIH) can be a means to supplement the official health services by offering extra resources that are available through local resources and knowledge. Additionally, it can aid in reducing the overall cost of health services and expanding their coverage (Oakley, 1989:36).

(iii) CIH broadens the pool of options for health programs and initiatives that will be suitable and successful in addressing local residents' definitions of health necessities as opposed to medical establishments' definitions of necessities.

(iv) Programs for health care services will have a better chance of succeeding when they take into account the opinions of the local community and address health needs (Stern & Schaay, 2011:17). Communities often have a better understanding of which services and programs will best meet their needs. Health professionals and leaders can guarantee that services are responsive to local conditions and requirements by listening to the public and working together. This will result in a more efficient use of resources and a healthier community (Sherry, 2018:48).

(v) CIH dismantles the reliance that permeates many efforts to expand health care and, more broadly, awakens residents to the possibility of practically participating in development on a global scale. In the end, CIH can assist in fostering political consciousness and a desire in people to voice their opinions about policies pertaining to development in their nation or area.

4.5 Interpretations of community involvement in health

While community involvement has been widely discussed and defined, very few authors have attempted to define CIH, according to an analysis of the literature on the topic. One study claims that the term "self-reliance" and "self-help" are so vague when it comes to the concept of CIH that it is almost hard to understand. There are certainly a lot of misunderstandings, and it's unlikely that understanding the concept of CIH will be possible given the different accounts of community involvement. According to CIH, local communities ought to be involved in one specific development activity (health, for instance). Although this may require differences in approach and systems, the final decision will be the same. Starting with an operational definition of CIH and working your way up to a variety of modified settings could be a good idea. In this regard, it would appear that the following definition of CIH in primary healthcare is appropriate: "Community involvement" [in health development] is the process of recognizing trust between grassroots communities and management in the organizing, carrying out, and application of health initiatives to gain enhanced "local self-reliance" and "social control" over the organization and apparatus of primary healthcare. This is a broad declaration of intent that also serves as a political commitment with far-reaching implications. It outlines a broad goal to be followed as well as a participation strategy.

But attempting to control the exact meaning's suggestions serves little purpose; instead, it's important to talk about the concerns brought up by any obligation to CIH. Following an analysis of the concept, the WHO inter-regional meeting in Brioni in 1985 proposed two comprehensive, yet different, explanations of the preparation of CIH:

- CIO as knowledge and discussion of health and related issues; and • CIO as data and information accessibility with reference to health-service projects and activities. Communities must be made more aware of the challenges involved in health development as well as the root causes of ill health if they are to play an active role in future health initiatives.The second explanation highlights that in order for communities to participate in planned health actions and to be engaged by others, they must have direct access to accurate data and facts about health-service programs and projects (Stern & Schaay, 2011:19).

CIH needs to be made an essential component of the health distribution system in every state. It must become the basic driving force behind health-related activities rather than just a universal feature of the delivery of health services. However, CIH is eventually tied to resources, and "resource-rich" and "resource-poor" countries will differ significantly in practice. In nations with abundant resources, CIH has primarily been a response to consumer demand for higher-quality healthcare services; in nations with limited resources, it primarily relates to treatment and increased access to basic healthcare services.

The concept of CIH is starting to be accepted and applied in various parts of the world (Stern & Schaay, 2011:23). It looks at the concept and recommends that it be used again in the context of health care; it also makes suggestions about potential changes that CIH may require to the formal health care system; and finally, it highlights the connection between CIH and conventional health care planning and procedures. The Brioni meeting's provincial and national reports provided evidence of the intricacy of the problems that arise when CIH is integrated into medical services and practices.

4.6 The community and community involvement in health

CIH in training encompasses not only health resources and policy, but also the abilities and duties of the "community." Therefore, the first step in any study of CIH must be a thorough investigation of the concept of the "community," which forms the theoretical basis for a specific health program or project. In this regard, the developing world is full of anthropologically oriented lessons that outline the fundamental characteristics of both urban and rural communities (Stern & Schaay, 2011:23). Experiential evidence, however, is still lacking regarding the community characteristics that are critical to their engagement in health expansion. Numerous reports and articles suggest that it's critical to understand the community that will be involved.

Although definitions of "community" vary, the term is frequently used in development writings. For example, the word is used and accepted by anthropologists, psychologists, and

sociologists as more than just a terrestrial expression. In the physical sense of the word, communities can refer to a number of opposing and conflicting organizations and interests. Geographically defined communities can be divided, for example, as follows: Men and women, wealthy and impoverished, traditional and contemporary, and so on. But even these splits are too wide; a finer distinction will need to be made, for example, between tenant farmers and large landowners and between small and large farmers and rural laborers. The particular objective of what a community can do to advance health is a crucial part of CIH; it is anticipated that the community will contribute in accordance with its capabilities and resources. In the past, both urban and rural communities have contributed to the provision and support of local health care services in various ways across national boundaries. In order to fully embrace the prospect of community support for health development, a process of valuation will be required, involving the communities to ascertain what local resources and capabilities exist and how best to integrate them into health initiatives and programs. More specifically, it is important to identify and make use of local communities' knowledge of healthcare and health practices. The core tenet of CIH is the recognition that communities can contribute significantly and wisely to the effort to address health issues, but it is crucial to limit the scope of these contributions and integrate them into medical practice.

The understanding that communities will have opinions about health development and what the complications are is shared by this method and CIH. According to this broader investigation of people's involvement, CIH needs to be essentially founded on a grassroots organization. It is well known that organization is essential in providing the means and ways to make participation possible.

An organization of this kind needs to:

- be residential, ethnic, and based on the devices and structures of the community as it currently exists;
- represent the benefits of the community members whose involvement is being sought;
- be able to grow into a respectable and official illustrative figure; and
- be shaped, if probably, by the ingenuity of its citizens.

The subject of CIH organization is very difficult. It goes far beyond the token creation of a committee on community health or some other kind of resident organization. For instance, it must be recognized that the majority of communities will have customary means of participation. If the organization is to endure and carry on actively reassuring communities engaged in health development, its formation and expansion must be seen as an essential

part of the CIH process. In this regard, building grassroots organizations for CIH may depend heavily on bolstering district-level health structures for primary healthcare. Finally, for those organizations to thrive and legitimately represent the interests of their members, national regulation will be necessary.

The character of the communities in CIH is frequently referred to by the term "mobilization," which describes a fundamental and all-encompassing process of group organization and involvement that leads in the channeling of local human and other resources into development efforts. Stern and Schaay (2011:25) have clarified community mobilization in relation to health expansion as follows: In order to create a sense of community awareness and provide thoughtful inspiration for the identification and utilization of all available community resources for cooperative, strategic changes or activities, community mobilization involves providing emotional, sociocultural, political, and financial training, retraining, and redistribution through appropriate procedures. According to Van Rensburg and Engelbrecht (2012:153), "community involvement in health" services has the potential to grow in a variety of processes. It is carried out at three levels (national, provincial, and municipal) by means of a range of reviews and advisory councils made up of various interested parties from local communities, NGOs, and civil society. There is a compelling argument to link the concept of CIH and the opinion of mobilization. Should CIH be implemented in isolation, through independent health initiatives or programs, it will be useless as a plan. If CIH is to result in widespread and improved health, then broad and continuous involvement is necessary. The goal of CIH is to become a global movement, and an essential step in that process must be mobilization.

It is important to learn from the national mobilizations of individuals for health development that have occurred in the past. Regarding the CIH community, conjecture may be raised as to whether some groups within the community are more gifted or equipped than others to engage in health development. Development workforces categorize communities in other domains (like farming) and try to ascertain which community characteristics are more favorable to development, so this demand is not wholly novel. It goes without saying that such an application requires careful maintenance and shouldn't be used only to determine a community's readiness to contribute to health development.

Specifically, it is important to remember that communities exist within a variety of political contexts (democratic, authoritarian, centralised, etc.), which will primarily shape the topographies of community engagement. Still, these kinds of studies can provide a foundation for assessing CIH potential and expanding upon currently available resources. Considering this, the following is a classification of CIH communities that were founded as a consequence of exploration in the Americas: urban CIH communities and/or communities that have recently

realized that health is the main priority; that health needs are met and other complications take precedence over social cohesion/logic of social, economic, or political mutual interest divisions; a history of ineffective community action, nonexistent action, or action that occurs only once. Such a range of advantageous and disadvantageous traits raises a number of questions and also highlights some aspects that are crucial for efficient CIH. However, terms such as "consensus," "social cohesion," "divisions," and "apathy" will need to be precisely defined; the logical standards of the relevant biographer will serve as a guide in this regard. It is imperative that we look at them objectively rather than subjectively. For CIH, terms like "consensus" and "cohesion" are crucial, but they also need to be genuine, based in accepted norms, and not just signify hurriedly reached community-level agreements. Cohesion is the cornerstone of involvement, but unity needs to extend beyond a shared understanding of the importance of health issues in the community. It's interesting to note that, according to American education, urban areas are typically better prepared for CIH than "traditional" rural areas. This is not surprising in the Americas, considering how quickly the continent is becoming more urbanized and how health services are primarily found in large cities. Urban communities in the Americas are undoubtedly in a better position to engage effectively in development initiatives for a variety of reasons, including access to data and a higher degree of politicization. Other than that, the contrary is presumably true in other regions of the world, like Africa, where a greater proportion of people reside in rural areas. Furthermore, the request regarding the "readiness" of communities may not be pertinent in countries where there has been an era of internal organizational improvement and where communities have been organized and mobilized for development. In these situations, it would be more appropriate to inquire as to whether the bureaucracy of the health services has not kept up with automated variations that have established the groundwork for community involvement. In such cases, the health service's deficiencies, not the local communities' lack of readiness, are to blame if CIH is not starting to emerge. Involving communities has a special benefit for underprivileged and vulnerable populations, such as women and children, whose needs might not be sufficiently satisfied by service delivery methods that do not encourage participation and co-production. It is possible to improve responsiveness and increase marginalized people's use of services by involving members of disadvantage groups in their planning and delivery. In order to address their disproportionate burden of disease and the complex political, cultural, and economic determinants, indigenous communities in Australia, Canada, and Chile have successfully planned and delivered a range of high-quality, integrated social and health services that are acceptable to their culture (Ghebreyesus & Fore, 2018:19).

4.7 Support mechanisms for community involvement in health

Generally speaking, it is required that CIH be under control and not developed without the necessary instruments being available at different stages. These tools, which can function both locally and nationally, are vital to the CIH process. Based on current indicators, it appears that CIH has been able to establish itself in countries where it has started to spread thanks to a range of provision mechanisms. The literature on CIH emphasizes the primary purpose of support devices and offers recommendations (sometimes very specific) regarding the composition and operation of those mechanisms. There is a description of both national and local support mechanisms for CIH, and it is inevitable that there will be a somber relationship between the instruments at the two levels. To begin with, though, it's critical to determine what variables have the potential to positively or negatively affect the CIH instruments. Numerous writers highlight the risk factors and contest the idea that supporting strategies for CIH will be challenging absent favorable circumstances. The factors are uniformly defined in general terms and have a wide scope. The features that are thought to be absolutely necessary for a support mechanism for CIH to succeed are listed in the following compound list:

i. Political assurance is given to CIH. Given that it will determine how well-functioning critical mechanisms like decentralization operate, this might be the most important support for the CIH process. Political assurance is necessary to create the conditions for cumulative involvement, not just for CIH but for the involvement process as a whole. Community involvement will not only not increase in the absence of political commitment, but it might even be purposefully impeded.

ii. Administration reconfiguration for CIH provision. It will take the reorientation of government administration to support the process before the administrative support required for effective CIH becomes apparent. Administrations are usually rigid and meant to transmit information and policies. Until administrative configurations completely reroute their processes and behavior, CIH will never appear.

iii. An increase in the ability to manage oneself. If the accomplishment is not used to develop the organizational and managerial skills of local communities, CIH will fail. As a result, CIH relies more than just disseminating novel ideas about healthcare; it also needs to develop resident competency so that they can take full responsibility for the treatment they provide.

iv. The least basic behavior and structure in health. Without a minimal healthcare system, a sizable number of people having access to medical services, and the financial means both nationally and locally to maintain those services, CIH cannot be implemented. There must be health initiatives that the community at large can participate in. Because of this, CIH is not a universal approach; rather, it is more pertinent to regions with the lowest concentration of health care services.

It is possible that not all administrators or staff members would agree that the support features listed above are necessary for CIH. Naturally, they are proposed as a representation of variables that have emerged from CIH practice rather than as a model that can be applied to all situations. All agree, however, that the features listed require significant changes, and that could be the main factor behind the fact that CIH is widely discussed but rarely implemented in a number of states. For example, administrative reorientation and political obligation are not changes that can or will happen at any time. However, in the absence of the substantial modifications that these attributes suggest, CIH turns into a highly limited notion. It is foolish to downplay the significance of the organizational changes that will be needed to provide the real support that CIH needs and needs in order to operate beyond the partial confines of individual health programs or projects. Despite these comments, it is necessary to assume that the political guarantee to CIH will soon come, and consideration needs to be given to what kind of care instruments could be important. CIH denotes a partnership between health services, local government representatives, and community members. A strictly honorable company verifies appropriate cooperation between the views of the local community and the government. While particular instruments have been discussed in the past, CIH's research to date indicates that the development and use of these instruments should be guided by several straightforward ideologies:

- Single and shared control at the local level is the foundation of CIH. Therefore, support tools should be built into and a part of grassroots management formations and organizations rather than being entrenched externally.
- CIH needs to be upgradable. The instruments that are acknowledged to support CIH, primarily in the community setting, need to be precise and sustainable in such settings. It is not a good idea to design tools, like administrative structures, that rely solely on outside assistance in order to function locally.
- Though the current and outdated approaches to community engagement and healthcare are important as a basis for CIH, organizational care arrangements should be inventive and creative.

If CIH is to be implemented on a daily basis, new arrangements are necessary as it represents a fundamentally novel concept in health preparation. Current CIH practice suggests that these are worthwhile guidelines. It should be highlighted, though, that rather than creating a model that works in every situation, they should be used as a control to the kinds of standards that will matter in the new CIH support instruments.

4.8 Educating and training for community involvement in health

CIH is not the same as health care and expansion, which are simply announced and incorporated into an existing wellness program. In general, CIH differs greatly from conservative health preparation and requires the use of health care services to disseminate speculative and applied information. Therefore, those services will need to have a culture that understands CIH and staff members who are capable of putting it into practice. These two actions—which include, among other things, incorporating CIH into already-existing education and schooling initiatives and, when appropriate, completely reorienting those initiatives to incorporate an explanation of CIH—are essential for the general recognition of CIH. The Brioni convention determined that there was still much to be prepared for and that the states' current situation regarding growth in teaching and preparation for CIH was unsettling. While there are many examples of improvements in health-service workforce training for CIH promotion, it doesn't seem like health-service training has changed significantly to reflect a duty to CIH thus far (Stern & Schaay, 2011:27). The gathering recognized that the majority of health professionals are products of deeply established medical practices, and that a substantial reorientation in teaching would be necessary to successfully integrate CIH into those practices. The assembly attendees argued that, given the current conditions surrounding CIH education, CIH needs to be incorporated into all phases of health education and given particular consideration. The lower echelons of the health care system are usually where CIH education is starting. To ensure comprehensive grounding for CIH, however, it is essential that it occur at all levels, from senior workforce to community supporters.

i. Because there is often insufficient formal teaching, even in cases where there is an assurance to CIH at the advanced stages of health care services, it cannot always be interpreted into training.
ii. It appears that not many health care services have provided the resources and the time necessary for teaching in CIH thus far.

iii. The appropriate teaching material for CIH still needs to be decided upon. In this way, the appropriate distribution of the curriculum for CIH education is crucial; while the majority of medical education concentrates on imparting medical knowledge, CIH training necessitates the transfer of knowledge from other fields, including the social sciences.

Few would contend that these data encapsulate the primary difficulties in this reverence or that instruction and preparation are essential to CIH if it is to grow into a significant portion of healthcare practice. However, research on how education and learning for CIH can be effectively integrated into health care services has been sadly lacking. Not much information on education and training specifically for CIH has been transcribed. Health care services are only now beginning to consider CIH and its implications; therefore, before determining the best course of study and training methodologies, a history of inquiry and investigation will be necessary. To connect content and techniques to the opposing roles and duties of specialists and community members at all three levels of government, it is generally acknowledged that education and training for CIH should be reflected at three levels: professional workforce, community health staff, and community leaders (Stern & Schaay, 2011:27).

4.9 Professional staff

There is little evidence to suggest that, aside from descriptive papers, public statements of commitment, and participation in national and international conferences, any meaningful progress has been made in the systematic recruitment of senior health personnel for CIH. As a result, any such training will have to begin essentially from scratch. The senior health workforce will, of course, have different education and training than their colleagues at other levels because they will not be alarmed by the CIH exercise on a daily basis. However, some would contest that the senior professional level is the important level for CIH instruction and training since lower-level staff won't have the support they need to carry it out if those in charge of policy and resource allocation don't base their decisions on CIH. It is inappropriate to state here that a synopsis of a senior professional staff CIH preparation program cannot be established because there are not enough examples to serve as a model. Teaching at this level comes with unique challenges, not the least of which is the difficulty of dealing with senior staff members who require significant training. Many issues are brought up at the same time:

i. Should CIH training start in formal medical education, given that a large number of senior professional staff members are physicians? Major

changes in medical education could result from such a resolution, which the relevant specialized bodies might contest.

ii. At this level of training, theory might be given more weight than preparation. Senior staff members must understand the fundamentals of CIH and how it affects healthcare services more so than the specifics of its applied use.

iii. Senior workforce members should have ample opportunities during their training to study the conditions at lower levels of the health services under which community involvement in health would be occurring. When relating the idea of CIH training to the senior workforce, it can be challenging to avoid feeling unreal (Stern & Schaay, 2011:27). Training alludes to the application of knowledge and abilities to improve or change performance.

One could argue that the anti-CIH orientation has been integrated into the largely traditional and demanding nature of advanced medical education worldwide, given its emphasis on the distribution of health care services and specialized information. Under these circumstances, it is difficult to see the concept of CIH, in all of its logic, having much of an impact at this level without prior, fundamental changes to the organization and coordination of the health care services. Although certain states (like China and Cuba) have shown signs of success in changing the perspectives of senior professionals, much more needs to be learned about how to change senior staff members' attitudes toward CIH in formal health care settings in Western states. It requires a major reconfiguration in the formulation of policy as well as in the arrangements and delivery of health care services; it is not just a request for community pledges or policy reports.

4.10 Community health workers

The community health worker (CHW or VHW), who works in a village or community, will be the primary and direct contributor to the output of CIH. The Inter-Regional Conference on Community Health Workers, which took place in Cameroon in December 1986, supported more relevant training and emphasized the critical role that CHWs play in maintaining community involvement. Similarly, a recent study by Mhlongo et al. (2020:3), looking at the crucial role that CHWs play as leaders in primary health care, emphasized that a big part of what they do is promote community involvement. As a result, the crucial role that community health workers play in maintaining CIH is widely acknowledged. Since it is at that point that CIH ceases to be an idea or a policy and begins to function as a method of providing healthcare, CHWs are the ones for whom specific knowledge about the initiative is most

important. It is during that stage in official health services that CIH education should take center stage. According to Van Rensburg et al. (2012:375), the role of CHWs in South Africa's health care delivery system is limited to reporting staff shortages in the public health sector and achieving universal access to healthcare. Much consideration has already been given to CHWs' overall training, and there is no lack of literature available to act as a guide. Nonetheless, the majority of research focuses on the medical aspects of CHW education, and as of yet, little empirical research has been done to determine what exactly constitutes suitable CIH instruction for a CHW. For example, a recent significant study on community health workers (CHWs) evaluated many important issues in a commendable way, but offered little guidance on how CHWs could effectively promote CIH. The issue is how to best train CHWs to apply their health knowledge in a clinical setting given the crucial role that CHWs play in CIH and the current focus on CHW education on medical issues.

i. What is the ideal ratio between the various training mechanisms for CIH? Due to a lack of practice-based evidence, a definitive answer to this question cannot yet be provided. We can be certain that the balance is subjective because of how we formed the CHW portion. A provider of health services would seem to need instruction that focused on health information, whereas a change agent would require instruction in more general knowledge and abilities related to community development processes.
ii. When is the ideal time to instruct a CHW in CIH? It is arguable which of the two skills—learning medical knowledge and participation abilities—should come first when it comes to teaching for CIH. Common sense in other development domains, like agricultural extension work, would suggest that instruction in fundamental practical skills should come first, then instruction in participation skills. This seems like a reasonable arrangement that would avoid any misunderstandings that might arise from trying to teach a CHW in similar situations with different features.
iii. When is the best time to give a CHW CIH instruction? When it comes to teaching for CIH, it is debatable which of the two skills—gaining medical knowledge and participation abilities—should come first. In other development domains, such as agricultural extension work, common sense would indicate that training in basic practical skills should come before training in participation skills. This seems like a fair arrangement that would prevent any confusion that could occur when

trying to instruct a CHW in comparable circumstances with dissimilar characteristics.

The planned interconnected matters suggest a course of action. Regarding the first two ideas mentioned, one could argue that CIH implies that a CHW is essentially a mediator seeking to support change in the health care industry rather than merely an extension of healthcare services. Since it controls the CHW's basic coordination, the difference is crucial. A CHW would be more focused on collaborating with conventional health policy, providing community health care, and offering curative medical treatment as an extension of health services. As a change agent, a CHW would be more focused on building the capacity of grassroots people to understand health issues and devise strategies to address them, as well as on laying the groundwork for ongoing local engagement in health promotion. A change agent would also adopt a more comprehensive perspective of the factors that underpin health development (such as connections to agricultural development) and be more proactive in advocating for preventive measures. It is unlikely that the content of CIH training for community health workers will be definitively regulated at this time. It is likely that the following significant aspects of the non-medical content of such instruction will be under control first: thoughtful community involvement: an exploration of the concept, its justification, the way it can be applied in practice, and its claims for the development of health; communities and their basic sociological and anthropological organizational theories, and an analysis of communities and their internal dynamics and communication processes; collaborating with executives in organizations; the concepts and training of communication in the process of development; the techniques and skills of working with small groups by emergence of group consciousness and the capacity to make and implement growth decisions. Naturally, significant refinement and clarification of this general framework are required before a precise teaching course is taken into consideration. The purpose of this article is to suggest the most important non-medical components of CIH upskilling, which would come after and support official health-related training. The most important thing to remember is that CIH training ought to be interactive, regardless of its subject matter. CHWs would learn how CIH should function in practice with the aid of an involved method.

4.11 Community leaders

Because it is unclear exactly what a community leader would be expected to do in CIH, the request for the training and preparation of community leaders in CIH is complex. It is hard to separate involvement in universal development from participation in health development. Health services should attempt to incorporate health development into community involvement rather than creating a separate procedure, as it is recognized as an important procedure.

Thankfully, a body of writings based on community involvement preparation is now available, and as mentioned earlier, this ought to make up a substantial portion of community health worker education. Should it be accepted that community leaders should receive some sort of training for CIH, then the two broad topics of universal health education and specific knowledge domains need to be examined first. One could argue that encouraging community involvement in health development requires a broad program of health education. Communities can become more involved in improving health if they begin to identify issues, think through potential solutions, and gain a better understanding of health complications. The administrative and organizational aspects of community health initiatives show that the creation of community-centered health projects and programs is taken into consideration. The most appropriate approach for developing community leaders for CIH is a limited and gradual one. At minimum, a framework for CIH will have been established if the two large sections that were exposed can be improved. It is imperative to acknowledge that there is currently a dearth of knowledge regarding the structured instruction of community leaders for any formal capacity within CIH (Stern & Schaay, 2011:32).

4.12 Methods of promoting community involvement in health

As the concept of community involvement in health is relatively new and is still mostly in its experimental stages in most health services, it is currently impossible to position tried and true methods of verifying community involvement in health. To be sure, there is little chance that it ever will. In general, no procedures would be suitable. Here, several potential methods that could help advance CIH in a particular context are discussed. Health professionals must understand that community involvement is exclusive to any given setting and choose the approach that best fits their particular situation from among the options available. It is imperative to underscore that the collection of appropriate procedures is just as important to effective CIH as other development features. It was widely acknowledged that the health division needed to observe the common understanding of involvement in other sectoral actions and apply the effects to itself, as there had been little research done thus far with CIH approaches. It was thought that creating CIH approaches would involve a series of challenges that would need to be solved:

i. Their rigid competence creates the risk that official health care services won't be flexible enough to support the development of CIH aids in their workforce. The strict parameters of formal training cannot be used to demonstrate CIH because it is not a specialized action.

ii. The fact that decisions in official health services are made by specialized medical personnel and that communities are not typically allowed to participate in the decision-making process (Stern & Schaay, 2011:35). The presumption is that the community's knowledge is inappropriate, illogical, and at odds with modern medicine, and that the official health workforce controls the majority of health knowledge.
iii. The rigidity of government-run healthcare systems and their general resistance to considering alternative approaches.

These are challenging issues that arise when creating CIH procedures, and it is evident from them that reorienting health care to be based on deeply ingrained professional standards and opinions will not be simple. First, it is crucial to develop methods for verifying community participation in health.

- to reevaluate the instruction provided to health-service personnel, with a focus on the resources and knowledge required of them in order to be equipped to advance CIH;
- to attest that this kind of instruction is a reciprocal duty, with the community and the health-care workforce building the groundwork for future business. It is improbable that suitable methods for maintaining CIH can be developed if there is no guarantee that health service personnel will reorient their professional training.

It is necessary to assume that this kind of commitment will be made in order to evaluate the basis for strategies that will support CIH. We'll start by acknowledging strategies for encouraging community involvement in other aspects of development.

4.13 The basis for methods of promoting community involvement in health

A steadily growing number of writings explaining how involvement functions and providing specifics of the procedures used have emerged as a result of the growing influence of the concept of involvement on development practice generally. Health services promoting CIH should review these writings. Improving CIH promotion strategies within health services without considering the needs of other populations would be a blinkered move. CIH will undoubtedly present unique procedural challenges, but there is still a broad strategy of participation that can be useful in all the various areas of development.

This method views participation as a way to build an organizational foundation that will enable grassroots people to voice their opinions and engage in dialogue and negotiation with the authorities that have an impact on their lives, rather than as a way to obtain community support or a partnership with externally planned development projects. An analysis of multiple

development initiatives across various global domains reveals the following crucial components of this involvement approach:

- Since involvement is a continuous process, it can be difficult to establish clear, quantifiable benchmarks.
- Communities ought to be separated into discrete socioeconomic groups based on the fundamental components of development.
- All planned ideas and conventional prototypes are set aside in favor of innate inventiveness from below.
- Self-sufficiency should be the cornerstone of development; dependence-based development has to be avoided.

- The groups that development actions affect must learn how to act cooperatively in their efforts to explain the complications that threaten them.

- Development actions must be measured by the groups they concern.

These fundamentals seem to comprise a discernible involvement strategy that is consistent with CIH. Rather than encouraging the recognition of external development projects, the focus should be on initiating a source for genuine involvement (Stern & Schaay, 2011:36).

Studies have shown that participatory projects frequently have very little chance of survival on their own. Their primary goal is to establish a foundation for continuing collaborative efforts into which the various divisions' programs, like the health division's, can be integrated when it is appropriate. A CIH strategy would need to take into account the growth of this base and acknowledge that CIH cannot occur in a vacuum; rather, it may be a component of gradually accumulating widespread participation activities by grassroots people.

The essential components of a CIH plan have not received much thorough evaluation. Numerous cases from different nations exist, but they haven't been compiled into a report that makes sense yet. Nonetheless, three important principles that collectively could serve as the cornerstone of a CIH approach can be deduced from the material that is readily available:

- A variety of mobilization techniques to focus attention on and accelerate health development. Mobilization can be focused on particular issues, people, or initiatives. It's the first step toward a more comprehensive engagement in health-related initiatives.

- Leadership demonstrates that CIH development is important. It could originate from within the community or from outside. External agents and traditional community leaders will both have a role to play, but external representatives should never take the lead.
- As health services and healthcare become more deprofessionalized, conditions will be created where CIH can function as a valuable bridge between the various social classes engaged in health development. A few writers have gone a step further and attempted to more thoroughly plan the foundation of a different health development strategy that would reassure CIH (Stern & Schaay, 2011:36).

4.14 Summary

This chapter has demonstrated the inherent health knowledge of local communities. Thus, the importance is revealed of formal and informal organisational structures to enhance communication on day-to-day health matters with such communities. The one aspect of communication mentioned throughout the chapter is listening to the community, for the department to be receptive to the needs of the community. The chapter recommended community health education as a crucial component of fostering community engagement in health development. It was argued that communities can become more involved in health development if they have a better understanding of health issues, are able to identify issues, and are willing to think through solutions. The legal framework governing community involvement in health will be covered in the upcoming chapter.

CHAPTER FIVE: LEGISLATIVE FRAMEWORK THAT GOVERNS COMMUNITY INVOLVEMENT

5.1 Introduction

The idea of community involvement in health and how it relates to governments, businesses, and communities were covered in the previous chapter.

This chapter examines the legal framework pertaining to accountability, responsiveness to community needs, and access to healthcare as a human right. The notion of responsive health governance by global, regional, and local governments has been featured throughout legislation, strategies, and forums. This distinction is ingrained in the Alma-Ata Declaration of the World Health Organization, the Manilla Declaration, the King IV report (Ramalho, 2016), the White Paper on Transforming Public Services, the Western Cape Policy on Public Participation, the Western Cape Facility Boards Act, and the Municipal Systems Act. It includes strategies like the National Development Plan and the Integrated Development Plan. Human rights and service accessibility are two aspects of service excellence that are highlighted in the Alma-Ata Declaration. The development and delivery of health care services is a collective and individual human right. Health care services, then, are clearly defined as the initial point of contact between people, families, and communities and the country's healthcare system, facilitating access to care close to home and continuously. The former interrelates with King IV (Ramalho, 2016), that organisations, in this case, primary health care (PHC facilities or clinics) depend on the community's provision of a conducive operating environment. In exchange, PHC facilities add to the wider community as architects of wellbeing and providers of services, goods, and employment. The concepts of information management and access are clarified in the Manilla Declaration and the White Paper on Transforming Public Services. For communities to make the best and most logical decisions, they need to have access to pertinent, trustworthy information. This aligns with the Batho Pele (people first) principle, which states that communities have a right to complete and accurate information regarding the public health services they are entitled to. The government's obligation to establish an environment of invited spaces is outlined in the Municipal Systems Act and the Western Cape Facility Boards Act. The rationale for these spaces or formal structures is to offer communities a voicey in what manner health services and programmes are managed. The structures comprise health facility boards, health committees, and ward committees with community and health representation.

5.2 Governance

A method of communication between a government and the society it rules over is implied by governance, which goes beyond simple government. This notion of governance is "a system of values, policies, and institutions by which a society manages its economic, political, and social affairs through interaction within and among the state, civil society, and private sector" (Cloete & Mmakola, 2018:106). Governance philosophies are usually classified as either good or bad. Four standards can be used to assess a community's governance method:

The degree of public confidence in the government:

- The response in the government-community relationship;
- The degree of the government's accountability to the people;
- Character of the authority that the state possesses over its people (Cloete & Mmakola, 2018:106).

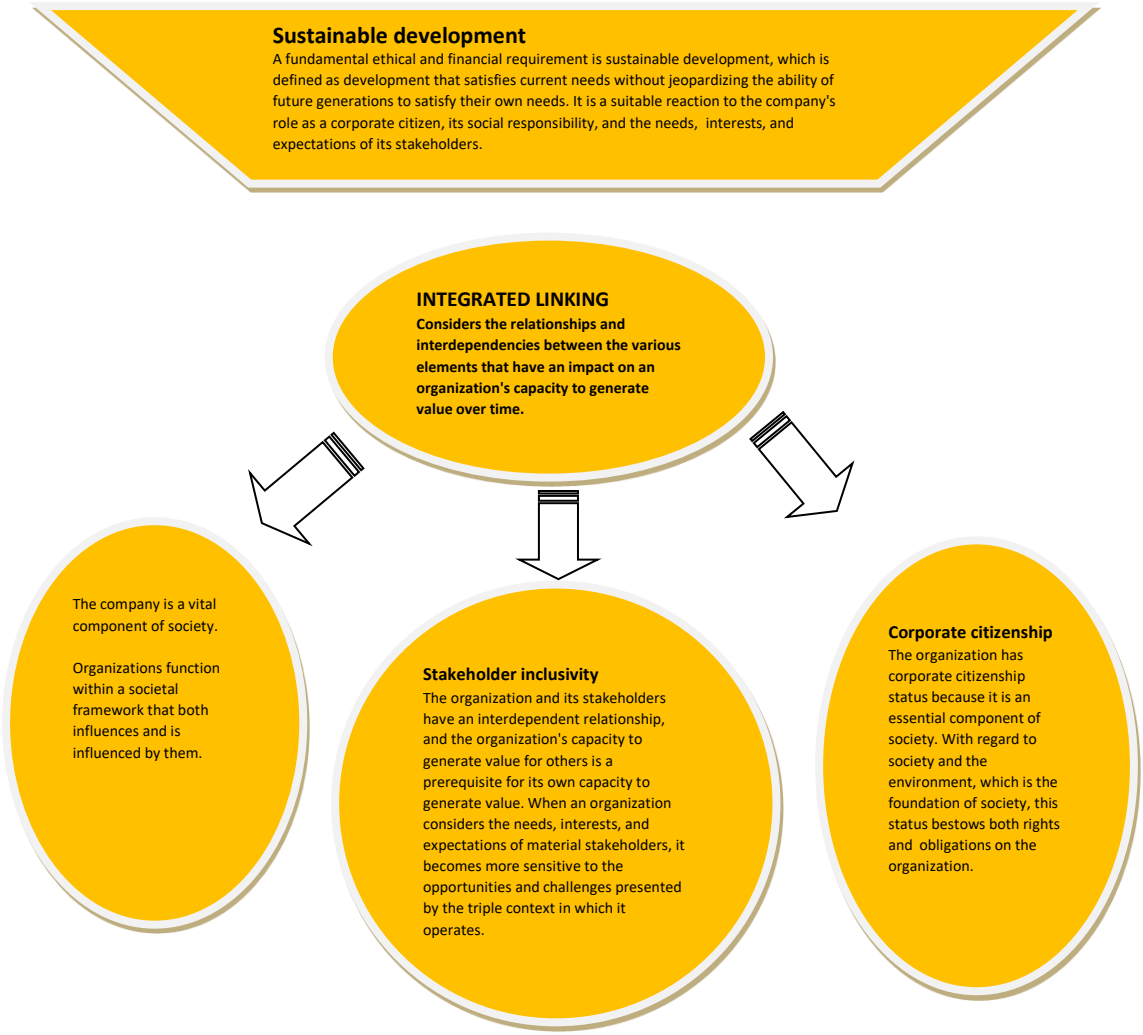


Figure 5.1: The underpinning philosophies of King IV

Source: (Institute of Directors South Africa, 2016)

The terms "health service governance" and "health service management" relate to authority through responsibility and openness. Governance structures exist to encourage stakeholder involvement at all levels of the health service. The health minister has political authority and responsibility, just like in other government agencies. They are chosen by provincial leaders at the regional level and the president at the federal level. The health minister is answerable to the President, the Cabinet, and the Parliament. In Parliament, the health portfolio committee is the forum at which elected members have an opportunity to monitor the performance of the Health Department. There are other regional agreements that resemble these (Loveday, 2018:371). Since the first King I report was published, corporate governance has been practiced in South Africa with a longstanding tradition. King IV (2016), the report's fourth restatement, lists the principles, protocols, prospects, and results that set the standard for corporate governance in South Africa. The King IV (2016) objectives encapsulate good performance and meaningful reporting to stakeholders. Thus, the fundamental concepts in King IV (2016) Figure 5.1 forms the basis of all eight segments outlined in the model of health and well-being in Chapter Six. The Western Cape Facility Boards Act, Act 7 of 2001, in section 5.13, is an indication of health governance. The Act is discreet in terms the responsiveness of health facilities towards patients and community involvement in health facilities programmes.

5.3 Public policy

Community involvement is an important aspect of policy agenda setting. The term ‘agenda’ portay[s] those issues judged to require community action. Public policy is an authoritative declaration made by decision-makers in response to opportunities, societal issues, and shifting conditions that the populace faces on a daily basis. A policy consists of the objectives to be pursued as well as the steps necessary to reach those objectives (Theron & Mchunu, 2016:17).

5.3.1 Integrated thinking

According to King IV (2016), integrated thinking considers the network and interdependencies between the various characteristics that have an impact on an organization's ability to create value over time. The following principles form the foundation of integrated thinking:

- acknowledging the organization as a corporate citizen and an essential component of the community;
- utilizing a stakeholder-inclusive methodology;
- promoting sustainable development; and integrating reporting.

5.3.2 The organisation as an integral part of society

Organizations function within social environments that both influence and are influenced by them.

An organization's internal and external stakeholders who have a material stake in its operations make up its own society. But within the larger society in which it operates, the organization is also of the juristic type. Businesses depend on this larger community to supply them with the necessary skills, a practical customer base, and a conducive working environment, among other things. As a result, organizations benefit society as a whole by producing wealth, employment, goods, services, and funds as well as by developing human capital (Ramalho, 2016:25).

The African philosophy of Ubuntu or Botho, encapsulated in the phrases Umuntu ngumuntu ngabantu and Motho ke motho ka batho - I am because you are; you are because we are - lends support to this idea of interdependence amongst organizations and communities. According to Botho and Ubuntu, the foundation of all human endeavors—including business endeavors—should be a shared commitment to serving humanity.

Because of this interdependence, it makes sense that helping others benefits oneself. This also applies to a juristic person, who benefits the larger community as well as its inner and external participant community in order to better themselves.

In keeping with this nature, since an organization's actions and outputs have an impact on the community as a whole, it should also be held accountable for the environmental consequences of those actions.

5.3.3 Corporate citizenship

The organization has corporate citizen status because it plays a significant role in the community. This status discusses the organization's rights, obligations, and responsibilities toward the community and the regular environment that the community depends on. The concept of corporate citizenship recognizes that the organization's ability to operate is validated by both external and internal stakeholders, as well as the larger community (Ramalho, 2016:25).

5.3.4 Stakeholder-inclusive approach

The organization and its stakeholders have a self-governing relationship, and the organization's ability to create value for others determines how much value it can create for itself. By taking into account the requirements, interests, and expectations of significant

stakeholders, an organization becomes attuned to the opportunities and challenges presented by the triple context in which it operates. The corresponding of benefits over time through prioritization and, in certain cases, dealing off goods is known as stakeholder inclusivity. It takes a dynamic and continuing process to balance the needs, interests, and expectations of stakeholders. How well an organization is able to achieve this balance when making decisions is determined by the quality of its interactions with stakeholders (Ramalho, 2016:25).

5.3.5 Sustainable development

One of the main moral and practical requirements is sustainable development, which is defined as "development that meets the needs of the present without compromising the ability of future generations to meet their needs" (Ramalho, 2016:25). It is a fitting reaction given that the organization is an essential part of the community, its status as a community member, and the needs, assets, and opportunities of its "stakeholders."

Three interrelated subsystems—the triple view of the economy, humanity, and the natural environment—are intricately linked to the existence and success of organizations. One example of a contest that disrupts all three of these subsystems in which organizations operate in the South African context is the attempt to address social disparities through financial alteration (Ramalho, 2016:26). Therefore, section 152 (1) of the Republic of South Africa (RSA), 1996 constitution's objective protects democratic and accountable local government for grassroots communities; guarantees services are delivered in a sustainable manner; supports social and economic development; fosters a safe and healthy environment; and reassures community organizations that they are involved in municipal affairs.

In order to create value over time, organizations and their management must consciously collaborate with and respond to the opportunities and challenges presented by the dynamic triple context system in which they operate, as well as the capital that they use and influence. The organization's primary goal, opportunities and threats, approach, business framework, performance, and sustainability are all presented in King IV (Ramalho, 2016) as integral parts of the value design process because such a cohesive approach is a symbol of sustainable development (Ramalho, 2016:25).

5.4 International health governance

In 1947, the World Health Organization (WHO) was officially recognized. The WHO coordinates international health work and gives direct technical support to countries, thereby aiming to reduce inequities in entree to health care services both within and between countries, to foster cross-sectoral collaboration, to uphold and safeguard health, and control specific health problems (Hattingh et al., 2012:92). The Alma-Ata Conference on Primary

Health Care was held in 1978, and the Alma-Ata Declaration was produced, which was to challenge the entire world community, emerged from this conference. This document is applicable to all nations and has been utilized as a manual for the introduction of comprehensive primary health care policies and programs at the national and international levels. The Alma-Ata Declaration addressed a number of topics and ideas to improve the promotion of health in international societies. These elements include the following: health education; essential medication provision; treatment of infectious and non-infectious diseases; provision of a healthy diet; adequate water supply; and adequate sanitation. Hattingh et al. (2012:92) state that "principles such as community participation, international collaboration, and equity" were highlighted.

The WHO emphasises that, to attain the aim of 'Health for All', close interaction is required between health and socio-economic development.

The concept of "community participation" in the Alma – Ata declaration emerged as follows:

> The process by which individuals and families assume responsibility for their health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their situation better and are motivated to solve their common problems. These enable them to become agents of their development instead of passive beneficiaries of development aid. They, therefore, need to realise that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find suitable solutions (Theron et al., 2016:250).

5.4.1 The Alma-Ata Declaration

Following the Alma-Ata Conference, a statement of intent was created. It lays out the guidelines and procedures that allow for the general establishment of any primary healthcare service. The topic of full participation, which is essential to the fourth point of the declaration and the thesis on community involvement in primary health care, was covered in detail in Chapter 3. As stated during the WHO meeting:

Table 5.1: Declaration of Alma-Ata

DECLARATION OF ALMA-ATA

The following declaration is made by the International Conference on Primary Health Care, which is gathering in Alma-Ata on September 20, 1878, in order to discuss the need for urgent action on the part of all governments, health and development professionals, and the international community to protect and maintain the health of all people worldwide:

DECLARATION OF ALMA-ATA

I.

The Conference reaffirms with force that achieving the highest possible level of health is a globally significant social goal that depends on the accomplishment of many other social and economic divides in order to enhance public health. Health is defined as a state of "complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right" (Padarath et al., 2015:226).

II.

All countries should be concerned about the current extreme disparity in health levels among their populations, which primarily exists between developed and developing nations as well as within them. This disparity is unacceptable from a political, social, and economic standpoint.

III.

The New International Economic Order's foundation for economic and social development is directly related to achieving "Health for All" to the greatest extent possible and reducing the gap between the health status of developing and developed nations. Individual health promotion and protection is essential for long-term social and economic development, as well as for a higher standard of living and international peace.

IV.

Each person has the right and obligation to participate both individually and collectively in the preparation and provision of their healthcare services.

V.

Governments have a responsibility to protect citizens' health, which can only be met by providing adequate social and health services. A primary goal for governments, international organizations, and the global community in the upcoming decades ought to be achieving, by the year 2000, a health level that enables every person on the planet to lead a life that is both socially and economically creative. In order to develop in the spirit of social justice, primary health care is essential to achieving this objective.

VI.

Primary health care is essential medical care that is based on realistic, ethical, and technologically sound methods. It is provided to individuals and families in the general public with full participation at a cost that the community and state can sustain throughout the entire lifecycle of the program, in an effort to promote self-sufficiency and self-governance. It is an essential component of the community's overall social and economic development as well as the state's health system, of which it serves as the primary goal and focal point. It is the initial point of contact between an individual, their family, and the national health system; it serves as the first part of a continuous health care procedure and brings healthcare as close to the place of residence and employment as feasible.

Source: (Theron et al., 2016:250)

5.5 International association on public participation (AIP2)

The International Association for Public Participation (IAP2) was founded in 1990 by a group of committed public participation practitioners. Since then, it has expanded into a global federation of over 6000 professionals in 26 countries who are committed to advancing the field of public participation (P2). Research, education, and networking opportunities with IAP2 counterparts are advantageous for national affiliates and their members (Mchunu et al., 2016:165).

IAP2, a global pioneer in public involvement, has developed the IAP2 Core Values for Public Participation, which will be applied to the development and implementation of the public participation (community involvement) process. Over a two-year period, a broad international effort was made to identify the characteristics of the public that transcend national, cultural, and religious boundaries in order to advance these core values. These "core values" are meant to assist in better decision-making by taking into account the concerns and interests of potentially impacted parties.

The IAP 2's core values are as follows:

- Public participation, also known as community involvement in this thesis, is founded on the belief that those impacted by decisions have a right to participate in the process;
- Public participation includes the possibility that the public's input will influence the decision;
- Public participation upholds sustainable results by acknowledging and connecting the desires and interests of all members, including decision-makers;
- Public participation seeks out and facilitates the involvement of those who may be affected by or drawn to a decision;
- Public participation looks for member input when deciding how to participate;
- Members' contributions and how they impacted the decision are connected through public participation.

Before employing any of the numerous participation strategies provided by the International Association for Public Participation (IAP2), a culture of service delivery in line with the principles such as Batho Pele must be established (Mchunu et al., 2016:165).

5.6 Manila Declaration

The "Inter-Regional Consultation on People's Participation in Environmental Sustainable Development" that was held in 1989 in Manila, Philippines, resulted in the Manilla Declaration (OECD, 2018:15).

One of the Special Committee on the Charter of the United Nations and the Strengthening of the Role of the Organization's major accomplishments is the Declaration, which is the first significant instrument of its work (Mhlongo et al., 2020:10). Upholding international peace and security as well as fostering better relations between states based on respect for the principles of equal rights and popular sovereignty are the goals of the Charter (OECD, 2018:15). The preamble also emphasizes the importance of equal rights and human self-governance, as well as the requirement that all states refrain from using force to deny anyone their inalienable right to freedom, independence, and self-determination—especially those living under racist or colonial regimes or other types of foreign dominance.

To make the best decisions for themselves and their communities, communities need to have access to accurate and pertinent information. Global monitoring systems were suggested in the Manila Declaration as a way to improve people's access to pertinent information so that communities could defend their interests and make informed decisions. It is only through equal representation of men and women that true democratic processes can be realized. Men and women's roles must be equal for people-centered development to succeed, which is a structural issue in many developing countries. According to the OECD, women are crucial to people-centered, sustainable development for a number of reasons:

- Women are more affected than other groups by the problems brought about by poverty;
- Women are important contributors to sustainability as managers of natural resources; and
- The rate of return on investment in female education may be higher than that of any other investment (OECD, 2018:15).

5.6.1 Limitations in involvement

There is consensus that involvement in development programs and projects has many benefits, as evidenced by the 1989 Manila Declaration on People's Participation (Involvement) and Sustainable Development and the 1990 African Charter for Popular Participation in Development and Transformation. This does not mean that involvement is without restrictions.

Centralised, top-bottom, and prescriptive complications are part of the governmental system that is at variance with local community, bottom-upward involvement. Administrative arrangements are often control-orientated and follow firm, blueprint-style procedures set out in legislation. Such arrangements do not permit room for beneficiary contribution into or for control over the expansion procedure. In addition, complications such as impossibility, a ethos of dependence, marginalisation, shortage, supremacy, gender inequality, and the latest surge

of unethical individuals and agencies/ organisations/administrations work against involvement by its proposed recipients. There is no doubt that involvement theory and practice are very different. In order to establish a culture of involvement, involvement strategy expert Chambers (2002) advises against training change agents to conduct involvement interventions. In order to lessen the gap between rhetoric and reality, beneficiaries should be involved in the process of planning and choosing appropriate involvement strategies, as they are local experts with indigenous knowledge systems (Theron et al., 2016:129). According to humanist theory, engagement is a necessary part of personal development. Being a crucial component of human growth, involvement has numerous facets and presumptions that make it just as complex as human nature. The United Nations (UN) Agenda 21, the African Charter for Popular Participation in Development and Transformation (1990), and the Manila Declaration (1989) have all contributed to the realization of this. Even though it is still incorrect, the use of outside interventions and change agents in development is a recognized technique of development facilitation. Participation, however, first requires that the "beneficiaries" of the development process be the most significant role-player (Theron & Mchunu, 2016:17).

5.7 Constitution of Republic of South Africa Act No. 108 of 1996

The Republic of South Africa Act No. 108 of 1996, which established the country's "supreme" constitution, came into effect in 1996. The Republic's Constitution is widely acknowledged as a superb model that upholds the rights of every individual within the country. This upholds the freedom, equality, and dignity of humankind that characterize democracy (Dennill, 2012b:197).

The right to health care services is guaranteed by Section 27 of the South African Constitution, which also mandates that the state, to the extent that resources permit, take reasonable steps to guarantee the progressive realization of this right (RSA, 1996). In addition, Section 27 guarantees the right to social security and an adequate supply of food and water. Other clauses cover the rights to housing, education, and special protections for children. This is consistent with the fundamental principle of PHC, which is the creation of a comprehensive health strategy that, in addition to offering medical care, addresses the underlying social, economic, and political causes of ill health (Padarath et al., 2015:225). "One of the objects of local government is to encourage the involvement of communities and community organizations in matters of local government," in line with the Republic of South Africa's Constitution, Section 152 (1) (e) (RSA, 1996).

At the local government level, the legislative and constitutional provisions are more explicit, according to Cloete and Mmakola (2018:123). Section 152 (1) mandates that local governments encourage community involvement and community organizations' participation in local governance issues. Furthermore, section 195(e) of the Constitution, which outlines the fundamental ideals and principles guiding public administration, places a strong emphasis on the needs of people.

The public should be encouraged to participate in policy-making even though public administration is required to be accountable (s195(f)) and transparency must be promoted by providing timely, accurate, and accessible information (s195(g)). (RSA, 1996). In addition, specific legislative measures require provincial departments to communicate with the public and consult with stakeholders and interest groups on specific sectoral issues.

According to Mubangizi (2016:192), the preamble of the Constitution affects every citizen's quality of life. Therefore, quality of service is the basis for the comparison between the current democratic state and the former apartheid state. The Constitution mandates that public administration follow a number of guidelines, such as

- Individuals' needs must be met;
- services must be rendered impartially, fairly, equitably, and without bias; and
- the public must be encouraged to participate in the policy-making process.

Furthermore, the Bill of Rights in the Constitution of the Republic of South Africa Act (No. 108 of 1996) grants citizens the ability to take action against the government if they believe their constitutional rights have been violated and to obtain information held by the government that they require in order to exercise their rights (Mubangizi, 2016:192).

A PHC method's guidelines call for creative ways to get involved in the scheduling, prioritization, and management of health services, including community-based governance arrangements. In addition to encouraging active staff collaboration to strategically guide the clinic's operations and make it more responsive to the needs of the local community, this will aid in the development of district health plans and budgeting processes (Padarath et al., 2015:226).

Operationally, equitable access to high-quality healthcare and the responsibility of healthcare providers to their communities depend on the health system's actual governance. An integral part of South African health care is good governance. The National Health Act (No. 61 of 2003) provides for community-based governance structures at various stages of the health system through officially established mechanisms. National policy states that the goal of governance

structures like district health councils, hospital boards, and clinic committees is to make community involvement the norm at the local and district levels.

The National Health Act (No. 61 of 2003) provides for community-based governance structures at various stages of the health system through officially established mechanisms. National policy states that the goal of governance structures like district health councils, hospital boards, and clinic committees is to make community involvement the norm at the local and district levels.

A number of goals are outlined for the municipality in Section 152(1) of the Constitution of the Republic of South Africa Act (No. 108 of 1996). "To encourage the involvement of communities and community organizations in the matters of local government" is one of the responsibilities listed for municipalities. The Constitution of 1996 states in section 153 that a municipality can only be considered progressive if it meets the basic needs of the community, fosters the community's social and economic development, and participates in national and local initiatives. According to Monaheng et al. (2016), the Constitution thus establishes the framework for local government to support community development.

5.7.1 The right to involvement and civic engagement

Participation in the decision-making process is essential to enabling people to assert their democratic rights. This right is ingrained in South Africa's Constitution of the Republic of South Africa, Act (No. 108 of 1996), and Section 19, which declares that all citizens are free to participate in political processes and make political choices.

Citizens' rights in a democracy are compensated with the accountabilities of nationality. This compensation is the ultimate responsibility for preserving the policies planned the state.

Once elected into power, government is expected to provide the services it has promised. Community involvement is precarious to this procedure. When communities, as beneficiaries of the services, think that these services are not effective and efficient, they have the right to protest. Poor people need to be given the power to hold policymakers accountable and have their voices and interests heard when decisions are being made for their involvement to be effective. Municipalities must be more responsive and accountable in their role as service providers when there is community involvement. Engaging in community activities strengthens democratic institutions and initiates the process of building a more open, transparent, and inclusive community (Van der Waldt, 2007:28).

5.7.2 National Development Plan – Republic of South Africa

The National Development Plan (NDP), released in 2011, addressed two of South Africa's major challenges, namely poverty and inequity, and provides an opportunity to integrate health within broader socioeconomic development. The key points in the NDP include:

- It is essential to address the social determinants of health (discussed in Chapter Three), such as access to clean water, literacy, and food security, to promote healthy behaviours and lifestyles.
- The lessening of the high burden of illness.
- The ability of humans to provide health services is crucial. In order to be most useful, managers, physicians, clinical associates, nurses, and other healthcare professionals must receive the appropriate training.
- Enhanced governance should be a key component of strengthening national health systems.

Active citizenry forms part of the accountability debate, in that communities must voice the quality of services received (RSA, 2012:474).

5.7.3 Community involvement:The National Development Plan (NDP) prescription

"Participatory governance is a central tenet of post-apartheid legislation on local governance". (South Africa: Department Public Service and Administration, 2012:474). Municipalities are encouraged, rather than hindering, the delivery process, to find methods of forming involvement, as stated in the Local Government White Paper (RSA, 1998). Even though official, generalized structures of involvement were recognized by legislation, municipalities were encouraged to develop their own tools so that the local council, ward committees, communities, mayoral executive, and municipal management could participate collectively in decision-making. The federal government ought to prioritise interacting with people in their natural settings rather than relying on community members to participate in forums established by the government. All levels of government, local, provincial, and federal, can boost community involvement by offering a variety of venues and platforms for mutual information sharing and gathering. These platforms allow the government to update while also allowing communities to assess performance and offer feedback. As these networks expand, all those involved in development—individuals, communities, NGOs, the government, and even the private sector—will be able to use the information flow to work together to develop strategies that allow locals to carry out their duties and fulfill their rights as stipulated by the constitution.

All of the development participants involved must have some degree of reliance for this to happen, and the evidence gathered must be evident, consistent, and accepted as genuine by everyone. The accomplishment of the NDP's objectives, by Mubangizi (2016:194), will thus rely on the monitoring of accountability that occurs at the municipal level, particularly on the ability of the communities to hold municipal ward councillors accountable. Since local political representatives in South Africa's governance structure are chosen by their constituents, who can also vote on issues that affect them, it is possible for those communities to demand greater accountability. Community involvement principles and local government officials' capacity to act as change agents in development by interacting with grassroots beneficiaries in a way that allows them to own, direct, and influence development programs are crucial in this context (Mubangizi, 2016:195).

Active involvement requires inspirational leadership at all levels of communities, as referred to in Figure 5.2. The word "leader" does not refer to one person or even to a small group of people who are close to one another. It is relevant to every aspect of life (Department of Public Service and Administration, South Africa, 2012:474). Public figures and community leaders in particular should demonstrate exceptional leadership in the following areas:

Leadership ability, for example, in enforcing regulations that are appropriate for all parties.

The aptitude to heed, particularly to those with a diverse views, perception and/or urgencies. Leaders should be capable to generate environments that permit everybody to interconnect in open discussion. This necessitates broad-mindedness, endurance, honesty to generosity and acceptaning criticique, a preparedness to disclose errors, as well as the capacity to question one's own presumptions. The mandate of community involvement in the constitution must be implemented by leaders in a way that fosters mutual understanding and allows stakeholders to participate in decision-making.

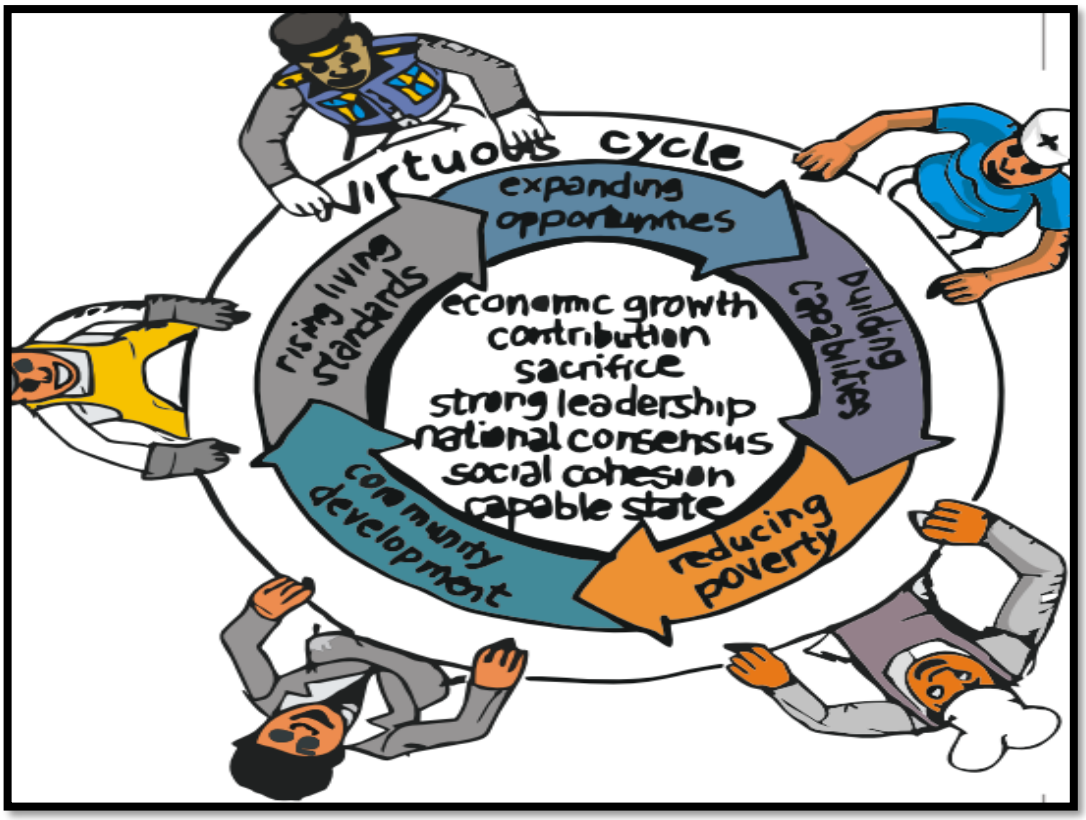


Figure 5.2: Active citizenry and leadership

Source: (NDP Department Public Service and Administration, 2012:474)

5.7.4 Community involvement success in Africa

Most importantly, the success of the NDP requires community involvement. Studies from other countries show the value of community involvement in achieving a country's ideals. For example, in Uganda, actions to promote community involvement have taken the method of both policy frameworks and the expansion of execution modalities (Mubangizi, 2016:204). As result of community involvement led by government departments, the country significantly reduced the levels of HIV/AIDS, whereas in Ghana, community involvement played a significant role in reducing corruption. This is possible within South Africa's context of progressing municipalities. The White Paper on Local Government (1998) defines developmental local government as "local government committed to working with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and improve the quality of their lives" (Mubangizi, 2016:204).

National Health Insurance – South Africa

South Africa's national health system underwent a significant transformation in 2011 with the introduction of the National Health Insurance (NHI) policy. The NHI aims to provide universal

health coverage through a single-payer health care system. Universal health coverage, as defined by the World Health Organization, is guaranteeing that all individuals have access to desired preventative, curative, rehabilitative, and promotional services that are valuable enough to be worthwhile and that they do not have to worry about financing these services. With only 20% of the country's budget going toward health care, 80% of South Africa's population is served by the public sector; these unsustainable "inequities in health care" are the focus of the NHI. This is related to the discussion of equity in Section 3.14.1 of Chapter Three. Many South Africans currently pass away from diseases that are treatable and preventable but are brought on by inadequate medical care. The NHI is the system that offers universal health care in South Africa. Put differently, the health system ought to provide coverage for all South African citizens in terms of promoting wellness, preventing illness, and treating disease. South Africa's two-tiered healthcare system has resulted in subpar health outcomes compared to per capita spending on healthcare. For South Africans, the NHI will guarantee more affordable and equitable health care (Pick & Dudley, 2014:11).

5.7.6 National Department of Health programme

According to the World Health Organization, universal health coverage is the assurance that every person has access to desired preventative, curative, rehabilitative, and promotional services that are valuable enough to be worthwhile and that they are not responsible for paying for these services.

The Ideal Clinic (IC) program was launched by the National Department of Health (NDoH) of South Africa in July 2013 to address and refine primary health care (PHC) clinics in the public sector in a methodical manner. These deficiencies were found during the 2012 completion of the NDoH facilities audit. An optimal clinic would possess a robust infrastructure, an adequate workforce, an adequate amount of medication and supplies, effective administrative procedures, and an adequate quantity of bulk supplies. Along with partner and stakeholder support, it would also leverage pertinent clinical policies, protocols, and guidelines to ensure the community receives high-quality healthcare services.

To address the social determinants of health, An Ideal Clinic collaborates with non-governmental organizations, the private sector, and other government agencies. The patient rights charter, which is part of the Ideal Clinic policy document, states that every resident has the right to participate in the development of health policies and to make decisions about issues that impact their health (Buthelezi, 2020:46). The Ideal Clinic document recommends the following engagement strategies:

5.7.6.1 Community engagement clinic guidelines

The community the facility serves supports the management and staff of the facility by taking part in service planning, accepting responsibility for the facility and its operation, and expressing pride in it.

5.7.6.2 Clinic staff and community leader engagement

Community ownership of the facility and its operations should be promoted in addition to improving disease prevention and health promotion within the community. As such, clinics should plan an annual open day after discussing with staff and local government representatives. The ward councilor should have the privilege of speaking as the guest speaker at this particular event. Please see Annexure 10.

5.8 White Paper on transforming public service delivery

According to Thornhill (2012:265), "the Department of Public Service and Administration launched an initiative called Batho Pele (Sesotho for 'people first') in the White Paper on Transforming Public Service Delivery (1997) to give effect to these provisions of the Constitution (1996)."

By promoting the following eight principles, it is hoped to improve public service delivery's efficacy and financial efficiency:

- Advice. Citizens must be consulted about the quality and standard of the public services they receive.
- Standards for services. The general public must be aware of the types and amounts of services to which they are entitled.
- Access. All citizens must have equal access to the care to which they are entitled.
- Courtesy. Individuals must be treated with decency and civility.
- Information. Thorough and precise information rightful to communities must be provided.
- Openness and transparency. The public must be informed about who is responsible for managing departmental budgets and how they are run.
- Redress. People should be provided with an explanation and/or a prompt resolution if predetermined service standards are not met.
- Value for money. Public services are supposed to be delivered with consideration and knowledge (Thornhill, 2012:265).

5.9 National Health Act (No. 61 of 2003)

The Health Act of 1977 was superseded by the National Health Act 61 of 2003 (NHA). While taking into consideration the government's constitutional obligations regarding health, it offers the legislative framework for the creation of a unified health system (Levendal et al., 2015:254). The NHA was authorized by the President on July 23, 2004, which was a major turning point in the evolution of the health sector. The Act, which is closely related to the Constitution, establishes the guidelines that the South African health system must follow (Dennill, 2012a:205). Establishing a system of cooperative governance and management of all health care delivery within national guidelines, norms, and criteria is one of the Act's other goals. Furthermore, to create a system based on egalitarian, effective, and stable governance principles, decentralized management, internationally accepted research standards, and an inclusive, involvement-promoting advocacy and inquiry culture (Levendal et al., 2015:254). It states that the three branches of government are in charge of creating health services and that all public health facilities and healthcare providers are required to provide equitable health services to the extent that it is feasible given the available resources. The definition of "health services" under Section 35(e) of the Act includes medical care, emergency medical attention, reproductive care, basic nutrition and health care services, as well as municipal health services.

Medical care, emergency medical attention, reproductive care, basic nutrition, and health care services are all included in the definition of "health services" under Section 35(e) of the Act, along with municipal health services. The NHA states that municipal health services include food control, waste management, chemical safety, vector and environmental control, food surveillance, water quality monitoring, and the prevention of communicable diseases (apart from immunizations).

The NHA also requires municipalities to ensure that health services are delivered efficiently and equitably, as was previously mentioned. The relevant members of the provincial executive must sign and assign to the municipality in the province a service-level agreement (SLA) that outlines the services to be rendered, the resources to be made available, the performance standards to be used to monitor the services provided by the municipality, and the circumstances under which the SLA can be terminated.

The federal and provincial governments share responsibility for providing health care, and local governments are in charge of offering municipal health services, according to the constitution. Implementing a district health system that works well and coordinates policies across the three levels of government may be made easier with increased power delegation from the province to the district and local levels.

The strengthening of management at the district and subdistrict levels will result from this delegation of power. According to Levendal and colleagues (2015:255):

> … in South Africa the term health governance structures has traditionally been used to refer to clinic committees, community health-centre committees, hospital boards and district health councils. The intent is community input in planning, and monitoring and evaluation of PHC programmes. The formulation of health policies and provision of PHC services based on equity. Citizen representativity is the essence of a health governance structure in South Africa. As set out in the National Department of Health policy on hospital boards.
>
> The NHA goes on to say that the district health system is still used to provide PHC and district hospital services. The district will keep managing all of its facilities in order to accomplish this:

- The development of district health plans and the use of modern information technologies for service delivery monitoring and reinforcement.
- Excellence of care must be enhanced through medical governance and effective management.
- All health care provided in all district facilities and communities must be held accountable to and overseen by district management teams (DMTs), sub-DMTs, and district hospital CEOs.
- Plans for districts, subdistricts, and hospitals must take into account the primary ministerial urgencies and place emphasis on them. This includes taming the PHC systems and the three intensive streams.

It entails keeping a close eye on all key performance indicators related to bolstering the district health system, acknowledging the role of traditional healthcare, empowering the community,

and acting quickly to make necessary corrections when the aforementioned do not improve as anticipated (Levendal et al., 2015:256).

The Act delineates the responsibilities and entitlements of healthcare providers and recipients. The Act, which also specifies the responsibilities of the National Department of Health, established the National Health Council and the National Consultative Health Forum. In a similar vein, provincial health councils and consultative bodies were established by the Act, as well as provincial health functions (Pick & Dudley, 2014:12).

The creation of the District Health System for the delivery of healthcare at the local level is a novel aspect of the Act (Pick & Dudley, 2014:12).

5.9.1 Factors that underpin the district health system

Inequalities, bottlenecks, deficits, and disparities continue to be features of South African health care. Even with the claim that everyone has theoretical access to health care, there are still glaring differences, unfairness, and obstacles for certain populations in the administration, availability, and utilization of medical resources and facilities. The differences in provisioning between the public and private sectors and between different geographic locations stand out in particular. Because of this, patients in the private sector often receive more services at a higher cost and have far better access to healthcare services than patients in the public sector (Levendal et al., 2015:254). The various provinces, as well as the corresponding urban, peri-urban, rural, and deep-rural areas, all still experience similar discrepancies in provisioning. Furthermore, there are still significant differences and disparities in the way that health care is provided to many communities: the impoverished, especially those who are Black and/or Live in rural areas, often lack the necessary physical resources to be able to pay for and obtain health care. Similarly, less educated and less cultured segments of the community also tend to know less about health and health care, and they use these services less frequently than their counterparts in more educated social classes (Levendal et al., 2015:254).

5.9.2 Community involvement in South Africa: Evidence and examples

It is unclear whether the abundance of policy documents on community involvement (community involvement) that are available in the public service sector has resulted in effective involvement on the ground, even though these documents are infused with the essence and meaning of this ultimate within the general health arrangement. Rather, it seems that there are minimal indicators for interpreting the principles about community involvement in actuality and there is evidence that the process of implementation of health committees has been largely uneven (Padarath et al., 2015:228). Scott et al. (2017:9) affirm that “in South Africa, the value of community involvement and accountability as one of the central components of a

PHC approach is highlighted in legislation, policy documents and strategic plans". Clinic committees been identified as the principal organisational arrangement through which this occurs.

The National Health Act uses the term "clinic committee," so that is how the current body of information about structures for community involvement through clinic committees in South Africa is referred to.

A clinic committee or community health center committee existed in 59% of clinics, according to the 2003 National Primary Health Care Facilities Survey, and this number has remained constant since 2000. Only 35% of these forums appeared to have met in the recent past (Padarath et al., 2015:228).

Additional data is available in the form of a 2008 study conducted by the non-governmental organization Health System Trust on a commission from the NDoH. The study's foundation was an audit method used to check whether clinic committees were present at each public health facility during the primary care phase in all South African clinics and community health centers. A total of 2 762 facilities participated in the survey, which found that 57% of clinics reported having clinic committees. Table 5.2 depicts the provincial breakdown of clinic committee prevalence across the country in 2008. An important caution is that both surveys relied on reporting by facility managers (Padarath et al., 2015:228).

Table 5.2 Percentage of facilities with clinic committees by province, 2008

Province	**%**
Eastern Cape	73%
Free State	78%
Gauteng	46%
KwaZulu-Natal	64%
Limpopo	61%
Mpumalanga	31%
Northern Cape	45%
North West	42%
Western Cape	48%

Total%	**57%**

Source: (Padarath & Friedman, 2008)

While other surveys and reporting conducted at provincial and district level, the information is not comparable owing to methodological and sample differences and has therefore not been included in this chapter (Padarath et al., 2015:228).

5.9.3 Composition of clinic committees

Regarding the qualifications for and elections of clinic committees as community representatives, the National Health Act (No. 61 of 2003) is silent. According to the majority of provincial policies, the approval of clinic committees by the Executive Council's Health Member goes against the spirit of community involvement and the view that clinic committees are representative of the communities served and constitute an independent, authentic voice that can convey the needs of the community. It is also not clear how the interests and needs of the 'vulnerable' and 'marginalised' groupings such as the extremely impoverished, individuals living with frailties, and migrants are presented at clinic level. In the Cape Metro Health District, for example, it was found that clinic committees are often not representative structures for community involvement, with a relative mismatch in the demographics of the committees compared to the community they serve (Padarath et al., 2015:231).

Of all the provincial policies relating to governance structures at clinic level, none considers how these structures fit into the larger health system or provides an avenue for these voices to be elevated through the vertical health system at district and provincial levels, for example, through structured links to the relevant District Health Councils (Padarath et al., 2015:231).

5.9.4 Health committees: roles and responsibilities

Research has highlighted that the lack of clear roles and responsibilities for clinic committees has led to weakened structures with limited effectiveness. While there is consensus that clinic committees should play a role in governance, there is a dearth of information on exactly what this entails. Not all provincial policies mention accountability or stipulate how clinic committees evolved in monitoring and evaluating services or in finding and managing solutions to complaints. For example, in the Eastern Cape's policy on clinic committees, they are described as structures of public accountability, determining that the committees should receive regular reports on the performance of the facility. The role of the facility manager, however, does not involve reporting to the committee; instead, the policy suggests that the facility manager should guide and inform the committee. This leaves the responsibility for ensuring accountability with the committee, requiring that the committee hold the services to account,

a task rendered more difficult because, in most instances, committees have to contend with the traditional authority held by facility managers (Padarath et al., 2015:231).

In the absence of clear roles and responsibilities, clinic committees often end up doing what the facility manager thinks is appropriate, which results in community members of clinic committees developing a loyalty to the service rather than to the community they are meant to represent. If they have been elected directly by and from communities, they are more likely (although not guaranteed) to see themselves as representative of the community constituency and are therefore more likely to report back to communities and to convey community needs to their committee. However, when representatives are selected (either by existing clinic committee office bearers or, more commonly, by the facility manager), they are more likely to be compliant with service needs. The breadth and depth of democratic involvement in society is ultimately reflected in the degree to which communities actively participate in clinic committees and, in fact, influence policies in all spheres of social development.

There is increasing evidence that, notwithstanding South Africa's struggle for democracy as reflected in its constitutional commitments to social and economic rights, democratic involvement presently remains stunted.

Research has also found that the majority of clinic committees function as an extension of the clinic, assisting the clinic in carrying out its day-to-day tasks such as providing security or cleaning services rather than being concerned with governance and accountability (Padarath et al., 2015:231). According to Padarath et al. (2015:231), clinic committees struggle to function efficiently and some undergo cycles of disbandment and revival. Schneider et al. (2017:9) affirm that community involvement and accountability are the central mechanisms of PHC that are highlighted in legislation and strategic plans. However, functional deficiencies are underpinned by limited support from local government councillors and a negative attitude of health workers towards committees (Schneider et al., 2017:9).

5.9.5 Health care workers

Staff attitudes concerning community involvement and authoritative arrangements are an significant factor of the efficacy of entities for instance clinic committees. According to Padarath et al. (2015:232), where facility managers were well orientated to community involvement and to health committee agency, the health committees were more likely to function effectively and to contribute to realising the right to health (Padarath et al., 2015:232). Conversely, where facility managers (clinic managers) were unsupportive, committees were unlikely to succeed. Low employee appreciation of the value of this engagement and their perceptions of being controlled by governance structures were made worse by the health

services' lack of support and indications. These are just a few of the problems resulting from the relationship between the workforce of health facilities and governance structures. Community involvement in health requires a paradigm shift on the part of health care workers that requires them to learn new skills such as adult learning principles, conflict resolution and participatory research, along with adopting a more holistic approach to health. Additionally, given the current human resource shortages, it is unlikely that staff would prioritise attendance at clinic committee meetings. However, initial findings from an intervention in the Nelson Mandela Bay Metro of the Eastern Cape showed that facility managers' unfavorable attitudes disappeared as soon as they received support and instruction in creating and utilizing these structures (Padarath et al., 2015:232).

5.9.6 Community factors

A number of factors may influence community involvement in clinic committees or other structures. Members from the community may be hesitant to be involved in health carservices owing to a observed shortage of talents, information and self-assurance to involve with health facility staff. This is supported by research that demonstrates how unclear and confused roles and responsibilities negatively impact health committee operations and are presumably the most long-lasting issues with authoritative arrangements. The study's investigation showed that the authority and control that are seen to depend on the employees of health facilities are hard to come by and support the effectiveness of governance structures, leading to conflicts between the two groups and increasing pressure. Furthermore, if clinic committees are established in ways that do not provide broad representation or community ownership, and operate without responsibility to report back regularly to community meetings, it is likely that community awareness of, and involvement with, the clinic committee will be low (Padarath et al., 2015:234).

This raises the need for the recognition of community clinic committee members to take a more general form, for example, through name tags and photos of committee members on display in the clinic. This would aid community recognition of this governance mechanism and heighten the committee’s responsiveness and accountability to their communities.

Pararath et al. (2015:234) revealed three sets of factors that impact on effective health committee functioning as follows: health system factors, contextual factors and societal factors. While the number of studies reviewed was small, Padarath et al. (2015:234) found sufficient indications in the literature to suggest that, where health committees are located within wider and comprehensive health system interventions to support community involvement, they can be effective in promoting the community voice and health system

responsiveness. Similar opinions have raised throughout southern Africa, based on the experiences of community-involvement programs in various nations in the area. These perspectives contend that health committees can be crucial in fostering equity in healthcare systems. The most significant and pressing issue, though, is that clinic committees' roles and mandates need to be made clear. Without this, members cannot be properly trained, and trust cannot be established around a program that has been agreed upon to increase community involvement (Padarath et al., 2015:234).

5.9.7 Examples of effective community involvement through clinic committees

The following examples are drawn from fieldwork in which some of these communities were involved, “and provide tangible evidence of interventions by well-functioning clinic committees having achieved positive results and supported better health outcomes” (Padarath et al., 2015:234).

Example 1: How the Ikamvelihle Clinic committee tackled social determinants of health

The Ikamvelihle Clinic in Nelson Mandela Bay has a vibrant clinic committee whose members created a map of the local township community with substantial community gardens and several community-based organisations. The problems are numerous, including poverty, unsafe parks, proliferation of taverns, informal dumping sites, treatment defaulters and an unsafe cemetery. The clinic committee prioritised three issues, the first being informal dumping (Padarath et al., 2015:235).

To address this problem, the members envisaged a clean space where children could play safely and animals could not feed on waste. They sent emails and made calls from the health facility to the municipality, and worked with the local ward councillor, who contacted the head of waste services. The following week, a front-end loader was deployed for three days, clearing the sites. The committee mobilised the local community radio stations. The committee together with the community members monitored the sites and found satisfactory conditions for consecutive months, during year 2014 (Padarath et al., 2015:235).

Example 2: How the Laetitia Bam Community Health-Centre committee secured pharmacy services

When the pharmacist at the Letitia Bam Community Health Centre – a very busy clinic in KwaNobuhle, Uitenhage – resigned and was not replaced, nurses were being called from their posts to attend to patients who were queueing for hours for their medication. The matter was raised at the clinic committee meeting, where the facility manager explained that the nurses had reached breaking point and were threatening to strike.

To avert this disruption and ensure continuous, quality services for the local community, the clinic committee called an urgent community meeting and invited the portfolio councillor for health, local ward councillors and staff members. A large community and staff contingent voiced their deep dissatisfaction with the situation, and the district manager and her team undertook to address the problem and report back to the community a week later.

At the next community meeting, which attracted even greater attendance, the district manager reported that the provincial Department of Health had agreed to fund an additional 23 pharmacy assistant posts for the district; in the interim, emergency arrangements made to ensure that a pharmacist was available for the facility. Thanks to the clinic committee's concerted action, Laetitia Bam CHC now has a pharmacist and two pharmacy assistants (Padarath et al., 2015:235).

Example 3: How effective clinic committees can advance the right to health

In viable health committees, facility managers clearly see the value of the committee's work and assist in numerous ways, such as providing means and access to the facility, and a positive relationship between the committee and facility manager supports joint problem-solving – as demonstrated in a study of clinic committees in the Cape Town Metropole. When one facility manager asked the committee members to encourage women to have a Pap smear (cervical smear for cancer prevention), a Muslim committee member explained that Muslim women would only be able to receive this service if attended to by a female doctor. She was assured that this measure could be accommodated. In another case, women from an informal settlement were concerned that many of them could not have their Pap smears done because they do not have an ID book; they were assured that they would be accommodated, thus making health services available and acceptable. Some clinic committees engaged with facility managers to identify solutions for lack of services and shortages of staff.

Clinic committees are instrumental in terms of right to health. This observation from three Cape Town clinic committees according Padarath et al (2015:236). In one example, the clinic committee observed and investigated patients waiting for long periods and addressed this with the facility manager. The committee also advocated successfully on behalf of patients who felt that the facility staff treated them unfairly, by addressing this with the staff (Padarath et al., 2015:236).

The day clinic became a 24-hour establishment thanks in large part to the efforts of another clinic committee. The expansion of this facility's service hours significantly increased access to emergency services for many in the community, particularly vulnerable and disadvantaged

groups, as the closest emergency medical services had previously been out of reach for those without a vehicle or the money to secure transportation.

Another example was a committee that collaborated closely with the environmental health officer and regularly reported to the inspector unhygienic living conditions and unsafe water quality, which could have led to epidemics throughout the community. This measure guaranteed the community's access to clean, drinkable water as well as proper sanitation (Padarath et al., 2015:236).

5.10 The district health system (DHS)

Rendall-Mkosi (2012:209) states that the District Health System (DHS) is in charge of offering comprehensive PHC services at community clinics, community health centers, and district hospitals. Policy requires that all planning and management responsibilities be decentralized to this level of government, allowing health care to respond to the district's unique health needs.

As part of the legal and policy framework for providing primary health care services, the province is currently in the process of transferring responsibility to the district.

According to the Department of Health's (DOH) general directives, a health district is any particular population that resides inside a precisely defined administrative and geographic area. It is made up of all the institutions and people in the district providing healthcare services. In addition to PHC facilities and district hospitals, this also includes the relevant laboratory and logistical support services, all of which are a part of a DHS.

The National Health Act (No. 61 of 2003) chapter 5, describes the process of establishing the DHS. The metropolitan municipal boundaries guide the procedure of determining district boundaries, where possible, and the Provincial Executive Council was given the task of determining the necessary changes that would be needed to form functional districts and subdistricts for each province (Rendall-Mkosi, 2012:209).

The process of determining the districts proved to be more difficult than was initially thought. In 1998 the Local Government: Municipal Demarcation Act (No. 27 of 1998) was gazetted to deliver standards and processes, including the establishment of an self-regulating body, the Municipal Demarcation Board, to regulate municipal precincts (Rendall-Mkosi, 2012:209).

Communities can participate in health care decisions when they are made at the district level as opposed to the federal level. This health care system makes sure that individuals, groups, and all community health service providers collaborate to promote health. The boundaries of the various health districts that make up the district health system align with those of the

metropolitan municipalities. Subdistricts were created within health districts to aid in managing the large area (Theron et al., 2016:255).

5.10.1 Decentralisation: The DHS fundamental

In various countries decentralisation strategies were approved since of the unsatisfactory outcomes or notable shortages in fundamental planning and administration. The parameters of essential organisation in leading growth at the grassroots phase became manifest during the 1970s, as did the rigidity and insensitivity of principal bureaucracies in various states. Decentralisation was perceived as a method of overpowering or circumventing these restrictions (Rondinelli, 1983:185). Therefore, in order for the DHS to be established in South Africa, the province, which serves as the center, must decentralize or assign its rights, obligations, resources, and powers to the district, which serves as the boundary. The reluctance of the higher echelons of power to cede control to the lower stages is a shared and ongoing restriction that serves this purpose. Strong national policy and unwavering support from higher to lower levels are necessary for the DHS to be successfully established (Engelbrecht & Van Rooyen, 2012:151). Throughout the 1970s and beginning 1980s the prominence of expansion procedures transformed in numerous states away from maximising fiscal progress towards upholding more equitable dissemination of the remunerations of expansion, decreasing discrepancies in earnings and capital amongst urban and rural areas and among districts, and increasing the efficiency and revenue of the underprivileged. Equitable development strategies powerfully inferred the necessity for programmes that were custom-made to resident settings, that stimulated the aid and involvement of local managers and of the individuals they were proposed to support, and that combined the diversity of services necessary to encourage the economies of countryside areas.

The mounting participation of administration in upholding extensive, non-traditional expansion actions made it clear throughout the 1970s that difficult and multidimensional programmes were challenging to direct and control absolutely from the centre. Decentralising growth planning and constructing the administrative capability of local organisations appeared indispensable to refining the efficacy of the central administration, as well as the capability of local managerial components, to distribute services required for growth, specifically in impoverished and distant rural districts (Rondenelli, 1983:185). Mchunu et al. (2016:165) assert that decentralization has the potential to transform the realm of involvement by giving the grassroots the ability to hold the government responsible because of their close proximity to it.

5.10.2 Rationale underlying DHS development in SA

The DHS is founded on two rationales: first, the application of the PHC approach necessitates a decentralized administration; second, the organization of interrelated systems suggests that the district hospital and the dispensary system are managed concurrently by a single team. In terms of the developments that followed Alma-Ata, it was fully acknowledged that the goals set forth there would remain unfulfilled until someone created a precise plan for providing PHC. The DHS idea gained momentum after receiving endorsement from the World Health Organization (WHO).

A DHS based on PHC is an almost self-sufficient part of the national health system (Theron et al., 2016:256). It is made up of a unique community that resides within definite administrative and geographic bounds.

The WHO states that the DHS acts as a channel for the provision of integrated healthcare services. This is a crucial factor to take into account given the Department of Health's policy ruling—expressed in the White Paper on the Transformation of the South African Health System—that dual-incorporated and inclusive service delivery is necessary. The White Paper also points out that the DHS was established with the Reconstruction and Development Programme (RDP) as its cornerstone, which is an important tactic for enhancing the health sector: The health system will give priority to the primary health care (PHC) approach, with regions serving as the primary site of execution. There is broad consensus across the country regarding the ideals that guided the DHS's establishment and its goals. These consist of: overcoming disintegration, fairness, providing inclusive services, efficiency, skill, and excellence. improved community involvement, local accountability, and service accessibility decentralisation, progressive and intersectoral approach, and sustainability (Theron et al., 2016:256).

5.10.3 Community involvement in the DHS

Theron et al. (2016:257) posit that “in the public-sector, strategies to improve the management of district-level health care are being implemented through the decentralisation of decision-making to provinces and districts”. The national, provincial, and local government health departments are a few of the organizations that offer advice on the creation and administration of health districts.

As previously mentioned, community engagement in the health care services domain is widely acknowledged as a means of addressing the alienation and subjugation that ensued from the protracted dominance and marginalization of the apartheid era. In light of this, the DHS's core values include intersectoral cooperation and community involvement.

Health care issues are now being addressed from the bottom up, rather than the top down, with the introduction of democratic governance and participatory dispensation. Community involvement in this instance emphasizes the value of a bottom-up strategy in the design and execution of growth initiatives, like health development, where people are seen as actively participating. This stands in contrast to the conventional top-down strategy, which sees individuals as obedient recipients of initiatives developed by professionals and government representatives. The active participation and facilitation of healthcare recipients in promoting and managing their health is central to the bottom-up approach to health development (Theron et al., 2016:257). This has been a fundamental call by community involvement development experts. These principles are ideals which should be applauded. However, the reality of involvement planning and engagement (at all levels) is complex. As stated before, health care officials should note the appropriate theory and strategies that underlie involvement development before the principles and strategies which accompany these shifts in thinking become an effective and practical solution. In this regard, training in community development principles, involvement planning, capacity-building and programme/project management should be prioritised (Theron et al., 2016:257).

5.10.4 What is meant by decentralisation and the DHS

Decentralization is acknowledged by the Government of National Unity as the ideal system of administration and governance. The Constitution personifies decentralized authority in the policies and legal framework of the federal, provincial, and local governments. The authorities and responsibilities of the local government serve as evidence of the significance of this particular domain. It is important to define "decentralization" before attempting to understand what it entails. In general, the idea points to a shift in meanings, authority, and power away from the core. It's considered a tool for the following tasks:

The Government of National Unity recognizes decentralization as the best form of governance and administration. The decentralized authority found in the laws and policies of the federal, provincial, and local governments is personified in the Constitution. The importance of this specific domain is demonstrated by the powers and duties of the local government. Before trying to comprehend what "decentralization" means, it is important to define it. The idea suggests a general shift in power, authority, and meanings away from the core. It is seen as an instrument to accomplish the following: diminishing the size of the government, which is remote from the communities it represents; improving equity and efficacy; and augmenting community participation and responsiveness.

The basis for the variations in interpretations within the national health care system is the Constitution, which delineates the authorities and responsibilities of the federal, provincial, and local levels of government. Because of this, the national level has the authority to enact laws at the federal level, establish guidelines and standards, communicate with foreign organizations and other nations' health ministries, oversee the provision of services, and assume this role in the event that a province is unable to. It can also provide services that are not able to be provided at the provincial level due to economies of scale or budgetary limitations. With the exception of municipal health care provision, the provinces are in charge of planning, regulating, and delivering health care services. The local government or municipalities are in charge of providing municipal health services. Realizing that no system is perfect is a necessary precondition for guaranteeing the efficient operation of a decentralized system of governance and administration. There will always be an overlap of meanings and accountabilities among various shares of the system, regardless of the type of decentralization and government arrangement that is approved. The current configuration of the system can only define a portion of the boundaries and guidelines that the various actors and clusters within the system are expected to collaborate and work together to achieve the various health goals and objectives (Theron et al., 2016:257).

5.11 Western Cape policy on Public Participation 2010

The International Association for Public Participation (IAP2) values are upheld by the policy. This demonstrates the importance of community involvement (also known as public participation) as a concept and activity. Communities, according to the Republic of South Africa (RSA, 2010:3), are "essential ingredient[s] for good governance in any democratic country." It holds that increasing community involvement can enhance democratic performance, or how closely a government's decision-making process adheres to the democratic ideal. The Western Cape Provincial Government is aware that there is no way to solve the intricate problems the province faces. Working closely with citizens, communities, businesses, civil society organizations, interest groups, and other stakeholders can therefore improve policy deliverables (RSA, 2010:3). One of the values mentioned is community involvement, which is based on the idea that those who will be impacted by a decision should have a say in how that decision is made. Those who might be impacted by or concerned about a decision are sought out and made more easily involved through community involvement. Community involvement connects participants to how their contribution has influenced the decision and provides participants with the information they need to get involved in a meaningful way. Governments everywhere are realizing how important it is to involve the community in decision-making. They recognize this principle's intrinsic value and usefulness

in maintaining and bolstering democratic values and good governance. The benefits of community involvement are rooted in increasing civic capability and public-government trust, broadening the range of decisions that communities can make or influence, and fostering collective accountability and transparency. The development of the evidence base for policy-making, the reduction of execution costs, and the application of improved knowledge and creative repositories in the design and delivery of public services are the essential elements of influential worth (RSA, 2010:3). The Western Cape Province Government (PGWC) is dedicated to good governance and democratic principles. It acknowledges that participation from the community is necessary for efficient government in any democracy. It holds that a government decision-making process's "democratic performance," or how closely it conforms to democratic ideals, can be enhanced by community engagement. It acknowledges that the complex problems the province faces cannot be solved by it alone. The development of the evidence base for policy-making, the reduction of execution costs, and the application of improved knowledge and creative repositories in the design and delivery of public services are the essential elements of influential worth (RSA, 2010:3). The Western Cape Province Government (PGWC) is dedicated to good governance and democratic principles. It acknowledges that participation from the community is necessary for efficient government in any democracy. It holds that a government decision-making process's "democratic performance," or how closely it conforms to democratic ideals, can be enhanced by community engagement. It acknowledges that the complex problems the province faces cannot be solved by it alone. As such, it thinks that close collaboration with people, communities, businesses, civil society organizations, interest groups, and other stakeholders will help it enhance its "policy performance" and its provision (RSA, 2010:5). The Constitutional Court further emphasizes that community involvement is a fundamental component of our constitutional democracy. By highlighting the necessity of facilitating involvement, the Court advanced the minimal standard of rationality regarding community involvement. The highest court decided that substantial community involvement is required for this obligation to be fulfilled. It stated that to engage the communities in fundamental agreement, the government must do more than just comply with formal requirements. In addition to taking reasonable action to ensure that engagements are meaningful and honest, the government must also ensure that engagements are sincere. It further stated that the importance and character of the choice would determine whether or not engagements were required. The government must make the most of encouraging community involvement if the decision or policy has significant and necessary ramifications (RSA, 2010:6).

5.11.1 Public participation (community involvement)

Is a thorough, transparent, and open process that allows locals, interest and community groups, and other participants to voice opinions and decide on matters that have an impact on their lives (RSA, 2010:6).

5.11.2 Public

The public must include all private individuals, interest groups, community organizations, and stakeholders.

5.11.3 Community groups

These people are similar in language, geography, ethnicity, age, gender, sexual orientation, or disability, among other ways.

5.11.4 Stakeholders and interest groups

This includes people or organizations that the decision's outcome will have an impact on.

5.12 Principles

The International Association for Community Involvement developed the Standards for the Practice of Community Involvement, to which the provincial government contributes:

- Community involvement includes the possibility that public participation will impact the decision;
- It actively seeks out and facilitates the participation of those who may be affected by or interested in a decision.
- Community involvement connects participants to how their contribution has affected the decision.
- Public participation gives participants the information they need to participate significantly.
- It is based on the certainty that those impacted by a decision have a right to participate in the decision-making process.
- It supports sustainable decisions by acknowledging and collaborating with the goals and interests of all stakeholders, including decision-makers.

5.13 Policy standards

Three moral standards are promoted by this policy, the most significant of which must be respected by the provincial government in that specific relationship with the community in each case:

Public involvement: the "gold standard"

- Counseling - "the gold standard"
- Disseminating information—"the bronze standard"

5.13.1 The gold standard – community involved

A provincial government is operating under the highest standards when it involves the public in its strategic goals.

- The procedure must be communicated to the relevant individuals or groups. The province government should ensure that the necessary channels of communication are used and that the information is provided so that the relevant individuals or groups are aware of the procedure and understand their potential involvement in it.
- It is necessary to offer participants the option and chance to participate in the process: The province government should make every effort, within the limits of available resources, to guarantee that pertinent individuals or groups can participate in the process, should they so desire.
- Participating in the process needs to be interesting and worthwhile: The required processes will be supplied by the province government.

5.13.2 The silver standard – consulting the community

This is the minimal requirement for laws, significant statutory processes, and other significant initiatives. Although less comprehensive, this stage still aims to interact with the community and solicit its opinions. Every piece of information is handled discreetly (RSA, 2010).

5.13.3 The bronze standard – information sharing

The minimal requirement needed for any statutory processes or community involvement is the bronze standard. This standard has been lowered to merely inform the public about recommended provincial schedules.

- The provincial government should ensure that appropriate channels of communication are used and that the necessary information is supplied so that all pertinent individuals or groups are aware of and comprehend their ability to participate in the process. The pertinent individuals or groups must be made aware of the process. Members need to be given the choice and opportunity to take part in the process:

• The provincial government should take all reasonable measures, within its jurisdiction, to guarantee that the significant individuals or groups can participate in the procedure if they so choose (RSA, 2010:10).

5.14 Policy interventions

In a particular instance, the province government will use creative and appropriate methods to support significant involvement.

5.14.1 Techniques and methods for the implementation of the policy standards (the set of three norms and standards)

From the following menu, the community involvement team will suggest at least one intervention per step after consulting with the appropriate Department (RSA, 2010:10):

(The appropriate methods in each of the following steps also apply to the applicable policy standards, since the bronze and silver policy standards are subsets of the gold standard.)

Step 1: The appropriate individuals or groups must be informed of the process:

- Television advertising, community radio advertising,
- and commercial radio advertising
- Advertise on radio commercially
- Advertise on radio in communities
- Advertising on television
- Advertising on local newspapers
- Brochures and pamphlets
- Loud hailers

Step 2: Allowing participants to participate in the process is necessary:

- Community meetings;
- public meetings;
- taxi rank/station meetings;
- focus groups;
- radio programs;
- social media, door-to-door, and online surveys;
- training workshops

Step 3: The involvement process needs to be interactive and purposeful.

- Community meetings;
- public meetings;
- taxi rank/station meetings;

- displays and roadshows;
- radio demonstrations;
- the process must be listening- and recording-oriented (RSA, 2010:10).

Step 4: The participants must receive a response either later or at a later time.

- Individual emails or letters
- Local newspaper ads;
- Community radio ads;
- Text messaging (SMS) via cell phone databases;
- Posters and bulletin boards
- Pamphlets and brochures;
- • Loud hailers

5.14.2 When initiating a project at a specific community

Before beginning a project at a specific location, a provincial department is required to consult the affected community and other pertinent parties and to report on the outcomes of all interactions. When presenting a project to a community, the following procedures have to be followed:

Step 1: In the designated community, perform a situational exploration of all the impacted individuals and role-players.

Step 2: Consultation is included. The provincial government should, if appropriate, collaborate with the local and/or district authority when offering services to that specific community.

Step 3: Give civil society the freedom to organize by utilizing the efficient local organizations already in place.

Step 4: Explain the principles of dedication to set an example in situations where opposition and contestation may arise.

Step 5: Get the public to agree in principle. Create a Memorandum of Agreement outlining the terms and conditions that have been agreed upon with the communities.

The Community Involvement team will suggest appropriate protocols or methods to be used for phases 2, 3, 4, and 5 from the lists provided in 3.2 above, after consulting with the relevant Department (RSA, 2010:12).

5.15 Boards and Committees of Western Cape Health Facilities Act (No. 4 of 2016)

The Act emphasizes the importance of responsive and accountable governance for health facilities, including clinics, hospitals, community health centers, treatment facilities, and other health services. The Western Cape Facility Boards Act (No. 4 of 2016) delineates the subsequent protocols for legislative intentions in Section 3:

(a) The creation of statutory Health Facility Boards that are accountable and representative.

(b) The management of health facilities' accountability to the community and their responsiveness to patients' and families' needs.

(c) Community involvement in and support of health facilities and their initiatives.

(d) Accountability for the medical facilities' financial administration.

(e) The effective and efficient use of resources at the hospital level.

(f) Health Facility Boards are given a foundational set of clearly defined responsibilities and authority by the Western Cape Facility Boards Act, No. 4 of 2016, which may be progressively expanded in the public interest as a Board's capacity increases.

According to Section 6 of the Western Cape Facility Boards Act (No. 4 of 2016), the minister must appoint a minimum of 8 and a maximum of 14 members, with the following exclusions: (a) people who speak on behalf of the community or communities that the health facility or facilities serve. The Minister may, by subsection (2), appoint persons to a Board in addition to those chosen under subsection (1).

(g) one or more elected council members, proposed by a local council committee concerned with health issues.

Working with communities is important for all workers in PHC, including those who deliver clinical services. Many health workers offer their professional knowledge and expertise, and tell the community or patients what is best for them to do, rather than enabling them to make decisions themselves. When engaging with communities about health issues, we should learn to step back from being experts and learn how to listen to and share power with the members of the community (Sherry, 2018:52). Health professionals ought to encourage the community's sense of agency over matters pertaining to their health and well-being. This can be extremely challenging but when communities decide and act for themselves, rather than doing as they are told by outsiders, the changes they make are more meaningful and more likely to be sustained.

Understanding local history, culture and the way communities function is vital to understanding how to engage communities on health issues. Building positive and trusting relationships is equally important, and this begins with the process of community entry (Sherry, 2018:52).

5.15.1 Different forms of community involvement

Participation in the health of the community can take many forms at different times and places. The numerous intricate variables at play mean that no one approach can be effective in every situation.

Community involvement can be divided into opportunities created by the government in which the citizens are invited to become involved (known as invited spaces), and those in which the community takes the initiative themselves (known as claimed or invented spaces). Who initiates involvement, and where and how it takes place, can affect who holds genuine power through that opportunity (Sherry, 2018:52).

5.15.2 Opportunities created by government: Invited spaces – Health facility boards

As part of the nation's democratic transition, several public-sector organizations in South Africa underwent modifications starting in 1994 to encourage citizens' active participation. School governing bodies were created to include parents and other community members in the administration of education, and community police forums were created to allow communities to work with law enforcement in the fight against crime (Sherry, 2018:52).

Health Facility Boards (HFBs) are "invited spaces" in the public health system that were established to provide communities a say in the management of health services and programs.

Laws mandate that hospitals have parallel hospital boards and that each clinic have a committee composed of elected community members and staff representatives. These committees ought to convene regularly to discuss grievances pertaining to facilities and local health issues that the community is concerned about. They should also plan events for health advocacy and awareness campaigns, among other things (Sherry, 2018:52). While HFBs assist health managers in reaching consensus on how best to allocate resources and organize services, these forums ought to take into consideration the services that ought to be offered in specific locations. In order to implement health strategies, community representatives can mobilize available resources. Contributions in the form of cash, land, labor, or resources can be made to the construction of facilities or the management of services.

There are several challenges to the effective functioning of HFBs. First, there is no definition of their role in different situations and they do not have legal powers to act where there are problems. Second, there is little training or support in place, and many members of these

boards do not have the knowledge and skills to ensure their effective functioning, especially in less educated and less affluent communities.(Sherry, 2018:52).

5.15.3 Opportunities created by communities: Claimed spaces

Regrettably, there is frequently a disconnect between the goals and assurances of governmental policies and the actual state of affairs. The invited spaces described too often are controlled by state employees themselves and give too little power to community members. Because such systems do not always work, citizens often find ways to hold the state accountable for health programmes and services. Social accountability is an approach initiated by citizens themselves in which spaces to engage with the government are 'claimed' using the government's policies and commitments (Sherry, 2018:53).

According to Altee (2013:1), there are three ways to understand democracy: (i) The power perspective: democracy is viewed as an attempt to strike a balance between social power, where power is allocated as widely and fairly as feasible. (ii) the involvement perspective, which views democracy as an activity through which citizens participate in their community—a basic human need and a natural outgrowth of our nature—wherever it must be concentrated, it is made constitutionally answerable to those over whom it is exerted; and (iii) The intelligence perspective, which views democracy as a component that fosters the application of collective intelligence, which refers to society's ability to adapt as a whole to changing conditions, to seize opportunities creatively, to express and follow goals and objectives, and to develop as a culture. Local knowledge, resilience, and grassroots social capital are important factors (Mchunu et al., 2016:164).

5.16 Local Government Municipal Systems Act (No. 32 of 2000)

Municipalities must set up policies, procedures, and processes that permit local communities to participate in local governance matters in accordance with the Municipal Systems Act (No. 32 of 2000). This Act's Chapter 4 is devoted entirely to community involvement. The Act provides information by stating

> ….A municipal council's duties include promoting community involvement and engaging in dialogue with the local populace, all while adhering to the municipality's financial and administrative constraints and taking pragmatic factors into account about:

- The accessibility of service preferences; and
- The value, diversity, control, and quality of municipal services rendered by the municipality, either directly or through other service providers (Mubangizi, 2016:204).

According to Cloete and Mmakola (2018:123), municipalities are required by the Local Government Municipal Systems Act (No. 32 of 2000) to encourage participatory budgeting, participatory performance management, and integrated development planning in order to strike a balance between representative and participatory democracy.

5.16.1 Community involvement: A legislative requirement

The Municipal Systems Act (No. 32 of 2000), Chapter 4, provides extensive information on community involvement in local government. The chapter requires municipalities to cultivate a ethos of community involvement and describes various procedures for community involvement and the enabling environment, which is necessary for involvement to take place.

The local community must be more involved in municipal affairs in order to develop opportunities and tools for community contributions as well as to create, implement, and evaluate the Integrated Development Plan (IDP), the budget, the performance management system, and strategic decisions about the provision of municipal services (MSA, No. 32 of 2000).

It is noteworthy that the Municipal Systems Act's section 4 outlines a municipality's obligations going forward. The local community must first be encouraged to get involved and consulted regarding the extent, caliber, scope, and effects of municipal services. The municipality must notify the community about accessible options for basic services, according to Pypers and Bassuday (2016). Section 16 requires the municipality to use the efforts of its employees and council members to support the community's capacity-building efforts. Participation in municipal governance must be made through political formations, specifically ward committees, in accordance with the protocols and guidelines. According to Sections 17 (1) and (2) of the MSA, No. 32 of 2000, other avenues for community involvement include ward councillors, petitions, public comment processes, public meetings, inquiries, consultation sessions, and feedback.

The community's rights and responsibilities, the municipality's policies, procedures, and processes, topics where community involvement is encouraged, and municipal governance,

management, and development are all subject to information sharing by the municipality. Section 18 (MSA, No. 32 of 2000) states that consideration must be given to the needs of the illiterate as well as their preferred language.

All regular and special meetings of the council (Section 19) must also be announced to the public, according to Sections 20 (1) and (3). The public and media are welcome to attend all council meetings, with the exception of those when the conduct of the business justifies their exclusion. All meetings of the council are open to the public and the media, except when the nature of the business reasonably requires the public or the media to be excluded. Cloete (2018:141) deliberates that in any 21st-century democracy, the media constitutes a very powerful force that exercises a significant influence on public opinion. The role of the media, which includes print, visual, audio, and electronic (internet and social) media, is to inform and educate the public (Cloete, 2018:141).

Section 20(2) states that the public and media are not allowed to be excluded from the council meetings when it is discussing draft bylaws, the budget, the IDP, the performance management system, or whether to sign a service delivery agreement (MSA, No. 32 of 2000).

5.17. Integrated Development Plan (IDP) July 2022 – June 2027

According to the City of Cape Town (2022:12): “It is required of the Municipal Systems Act 32 of 2000, which defines the IDP as a municipality’s principal strategic planning instrument that guides all municipal planning”.

5.17.1 People

The population of Cape Town increased gradually to about 4,68 million by 2021. However, the rate of population growth is decreasing annually. The population of Cape Town is relatively young; about 25% of its citizens are under the age of 14. It is projected that as the city's population ages, a larger proportion of its residents will be 65 and older. According to CoCT (2022:22), the old-age dependence ratio is anticipated to increase from 10% in 2021 to 14% in 2030 and 18% in 2040.

5.17.2 Health

The health of Capetons is still improving, with a decreasing infant mortality rate and a consistent rise in life expectancy (CoCT, 2022:25). Both sexes' average life expectancy at childbirth in the Western Cape has been rising steadily. Men were 64,3 years old and women were 69,9 years old from 2011 to 2016; from 2016 to 2021, the ratio was 64,9 years for men and 70,3 years for women. Although this points to improved health care services, in 2021 the pandemic also resulted in a shorter life expectancy. HIV/AIDS and tuberculosis tendencies in

the City increased prior to the pandemic because of better patient monitoring and support systems as well as easier access to basic services (CoCT, 2022:25).

5.17.2.1 Primary health care initiative

The City of Cape Town is a key partner in the provision of personal primary healthcare (PPHC), which prioritizes maternity and early childhood care in addition to encouraging healthier lifestyles. Primary and tertiary healthcare in Cape Town is provided by the Department of Health of the Western Cape province. In order to guarantee that health services are provided through a network of clinics, especially for the most vulnerable and underprivileged, the province and the city will collaborate. The review of the PPHC practical consignment will be given top priority by the city and province in order to reduce redundancy, boost service effectiveness, and create sustainable governance structures. Additionally, in order to maintain health services, the province, the city, and other partners will keep up their effective response to the COVID-19 pandemic (CoCT, 2023:84).

5.17.3 IDP Objective 16: Capable collaborative city government

To maintain the municipality's long-term financial viability, the City must limit fees and place a strong emphasis on fulfilling its primary responsibilities. Proactive risk management, performance management, responsible financial stewardship, and robust internal administrative structures and procedures are the cornerstones of long-term fiscal health and administrative efficacy. The City maintains its equitable cross-subsidization regime and indigent claim procedure to guarantee low-cost access to a package of basic services and to guarantee entry to a reasonable set of basic services (CoCT, 2022:109).

5.17.4 Community engagement and partnership programme

A responsive, comprehensive, and considerate government is built on the foundation of community engagement, as outlined in IDP objective 16.7, which gives communities a voice in decisions that affect them. The City has a duty to establish processes for making decisions that allow the public to participate in local governance. The City acknowledges that while partners are better equipped to achieve results in some domains, it can execute certain roles and meanings effectively. Over the next five years, resolving complex disputes and advancing Cape Town will require meaningful cooperation with the populace. Cape Town is dedicated to improving its partnership with communities in order to turn it into a City of Hope (CoCT, 2022:116).

5.17.5 Public engagement project

IDP Objective 16.7 A states that the City will improve its processes for community engagement and consultation so that locals can offer input on matters that directly affect them. Increasing local community participation in planning and budgetary processes, as well as in the development and implementation of government projects, will be a primary focus. The City will train its staff and obtain the tools required to reach a wide range of stakeholders, making the most use of digital meeting platforms, to efficiently facilitate community consultation procedures (CoCT, 2022:117).

Table 5.3: Public engagement

City role	Accountable directorate
Partner: Enable	Future Planning and Resilience

Source: (CoCT IDP, 2022:117)

5.17.6 Public partnership project

According to IDP 16.7 B, the City will engage in meaningful collaboration with the community to effect change and identify causes for recurring problems that communities face. Policies, instruments, and regional frameworks for decision-making that support enduring, mutually beneficial ties between the City and its citizens will be used to achieve partnership. Staff members from the city will be equipped to handle disputes and maintain positive, long-lasting relationships with local stakeholders. Another pressing issue is increasing the accessibility and openness of city statistics (CoCT, 2022:117).

Table 5.4 Public partnership

City role	Accountable directorate
Partner: Advocate	Future Planning and Resilience

Source: (CoCT IDP, 2022:117)

5.17.7 Local needs service delivery coordination initiative

IDP objective 16.7 C states that sub-council managers will assess how the current local spatial, infrastructure, and service delivery plans align with the local requirements that were

discovered during the IDP's expansion. Subcouncil leadership will receive quarterly reports based on this, and a localized list of priorities for service management or improvement will be built upon it. The city manager will receive a quarterly progress report detailing issues related to critical service delivery that require attention, as well as additional resources and procedures needed to address them (CoCT, 2022:117). In legalese, a subcouncil is "an entity that has the power to make recommendations on any matter affecting the area; can also be given delegated powers or be instructed to perform any duty of the Council," according to Buire (2015:216). Subcouncils are essentially a vehicle for endorsing and enabling the implementation of metropolitan decisions, even though their purpose is to act as a conduit for communication between the ward-level daily requirements and the metropolitan-level decision-making bodies (mayoral committee, party caucuses, technical portfolios) (Buire, 2015:218).

Table 5.5: Local needs

City role	Accountable directorate
Partner: Advocate	Future Planning and Resilience

Source: (CoCT IDP, 2022:117)

5.18 Performance management

Performance management is crucial for the municipal administration to guarantee that plans are carried out with the intended development outcome and that resources are used efficiently. Consequently, a performance management system that is connected to the priorities, objectives, indicators, and targets of the IDP must be established.

The municipality must oversee its operations in a way that is accountable, effective, efficient, and economical, as required by Section 38. Announcements about upcoming meetings and policies for promoting the town's public engagement initiatives are included.

Community involvement is mentioned in other chapters of the Systems Act; later sections of this policy will incorporate the provisions found therein. Community engagement tools, protocols, and methods are provided in Sections 17(1) and 17(2). The municipality must receive and manage community complaints, process them, and report back to the local communities—this is in addition to holding consultation meetings with recognized community organizations and, when necessary, traditional authorities (Craythorne, 2006:314).

5.19 Municipal Structures Act No. 117 of 1998

Part 4 section 72 (3) states that the ward committee's objective is to improve participatory democracy in municipalities. The ward is composed of a maximum of ten additional members who fairly represent women and the disabled, as well as representatives from the following sectors: youth, sports, education, environment, arts and culture, business, community-based organizations, faith-based organizations, safety, and security organizations, and designated vulnerable groups (CoCT, 2023:1). In addition, the ward councillor chairs the committee.

5.19.1 Ward committee

The ward committee is authorized by the Act to express gratitude on any issue pertaining to its ward. Ward committees may recommend members to the executive committee, municipal council, executive mayor, or appropriate metropolitan sub-council through their ward councilors.

Each ward is assigned a committee, which is made up of the ward councillor and ten or fewer other ward members.

Women must be represented equally in the council's membership, and the variety of interests represented therein must be taken into account.

The Constitution stipulates that since municipalities are the arm of government that deals with the public most directly, each municipality must encourage its citizens and community organizations to get involved in local government operations. To address the need for structured community involvement, the council can work with the ward or sub-council participatory systems of government, which facilitate community involvement in municipal affairs. Ward committees may be established under the municipal government's ward participatory system to help this kind of community involvement. Additionally, ward committees can help the local community and the municipal council communicate better. Additionally, they can assist in classifying community needs and modifying municipal programs to better suit regional conditions. Residents now have more influence over the management of their neighborhoods. It enhances participatory democracy in the municipality by providing a means for local communities to address the municipal council with their needs and opinions.

Like communities, wards have a wide variety of needs and interests. Being essentially advisory committees, ward committees are empowered to recommend actions on any issue that arises in their wards. They provide the ward council members with a framework and a sounding board. The competition intends to make sure that the ward participation system functions in a way that highlights the different needs and advantages that are present in a

given ward as tools for community and community organization consultation. Section 19(2) of the Municipal Structures Act mandates that municipal councils perform an annual assessment of the following:

The community's needs;

- The urgency with which those needs must be met;
- The mechanisms by which the community's needs are organized and delivered;
- The community's overall enactment in accomplishing its objectives (Monaheng et al., 2016:233).

As per the Local Government: Municipal Structures Act (1998), Section 19(3), "a municipal council must develop mechanisms to consult the community and community organizations in performing its functions and exercising its powers" (RSA, 1998) when using its powers.

Involvement in the community allows citizens to participate in the governance of their communities, which is an essential component of democracy. The Local Government: Municipal Structures Act No. 117 of 1998 states that, among other things, local governments must develop mechanisms that allow them to consult with community organizations and communities when implementing their mandates and exerting their influence. Often called ward committees, these groups serve as a vital conduit between the ward council, the community, and the local government. They make it possible for residents to have an impact on city planning in a way that most fairly takes into account their needs (Tau, 2022).

5.14.3.1 The role of the ward committee

By using a report, a ward committee can commend the executive mayor, sub-council, or ward council member on any issue that impacts the ward (CoCT, 2022:3). The goals of the ward committee should be:Support the ward councillor in addressing issues in the ward and providing feedback to Council and the residents;

- Serve as a grassroots advisory body to advise Council on matters affecting communities in the ward;
- Serving as a planned channel of communication between the sub-council and the community;
- monitoring routine forecasting and application;

- helping to prioritize community needs brought up in public meetings;
- supporting the council in carrying out its mandate for community involvement in the following areas: IDP, municipal bylaws, policy formulation, and performance management systems;
- To foster and facilitate the growth of a partnership and a sense of co-governance between the council and the community; and
- To encourage and facilitate the community's active participation in council governance matters as they relate to the ward (CoCT, 2022:3).

These kinds of committees can only be formed by municipal and metropolitan governments. Round configurations allow for the creation of both ward committees and subcouncils. A ward committee's goal is to improve local government's use of participatory democracy.

These committees, which are led by the council, consist of the following members:

- The ward councillor, who also serves as the group's chair, and up to ten more elected members make up the group.
- The council must set rules for selecting these ten members, considering two important considerations: the need to fairly represent women and the need to represent a variety of interests within a ward.

  The reference to “a diversity” (and not “the diversity”) must be understood as a connotation that not all interests need to be represented, presumably referring to rights. The instructions made by the council must also deal with the filling of vacancies and the frequency of meetings. The term of office of a member of a ward committee is of the same duration as the term of office of the council, and vacancies must be filled by a procedure determined by the council. The 10 members of a ward committee must fulfil its objectives. A ward committee differs from a subcouncil in that no provision is made for an equitable financial framework for ward committees. Tau (2022) states unequivocally that the ward committee may recommend to the ward councillor, and via the ward councillor, to the municipal council, the executive committee, or the support committee, on any issue impacting the ward. The ward committee is recognized by the municipal council as the statutory structure that serves as both a consultative body and a channel of communication for matters pertaining to the ward. These matters may include, but are not limited to: representing the community in the creation and execution of the Integrated Development Plan; maintaining a positive and harmonious relationship between the municipality and the community; handling all issues that

impact and benefit the community; operating in the community's best interests; and guaranteeing the community's active participation in the municipality's budgetary process (Tau, 2022).

5.20 Summary

In this chapter, the legislation has been discussed that directs community involvement in health. This includes the South African health sector adhering to international law. A single facet of the process involves planning with communities on matters that affect their health. Following this conversation, health services were put into place to help the communities that needed them the most.

CHAPTER SIX:
RESEARCH METHODOLOGY: THEORY

6.1 Introduction

Within the context of universal health care, the basic health care laws of South Africa were explained in the previous chapter.

The research design and methodology utilized to look into the research question are covered in this chapter. This study employs both qualitative and quantitative research methods. It also provides an overview of the various research designs and supports the use of case methods to address the research question. The methods and tools used for data collection are described in order to allay worries about the validity of the responses and the dependability of the data.

Finally, it draws attention to the data exploration methodology that was used to extract interpretations.

6.2 Research approaches: Quantitative and qualitative research

When understanding, exploring, or describing people's behavior, themes in behaviors, attitudes, or trends is your aim, you will employ qualitative techniques like participant observation, in-depth interviews, or textual analysis. Apart from the observation that quantitative researchers employ measurement, whereas qualitative researchers do not, there seems to be minimal distinction between the two forms of research initially. However, the division of business research into qualitative and quantitative categories is a useful acronym for organizing different strategies, techniques, and procedures (Bryman et al., 2018:30). For example, use quantitative methods to extrapolate from a sample of people to a larger population, explain the significance of quantities, degrees, and relationships of quantities, or predict and control future outcomes.

You will have some guidance in this regard based on the goal, purpose, and aim of your research.

6.3 Research approach: Qualitative research

Working with people has made researchers aware of the limitations of quantitative research in certain areas and the necessity of using real-world settings to examine many of the challenges they face; experimental designs are just not practical in these situations. In these circumstances, scientists ask specific questions that again require different methods. As a result, when a phenomenon is poorly understood or has unclear boundaries, or when little is known about it, qualitative methodology is employed (Brink et al., 2015:120). To understand how people see the world is the aim of qualitative research. While qualitative research can be done in many different ways, most approaches are flexible and focus on preserving nuanced interpretations of the data. They entail gathering and assessing non-numerical data (text, audio, or video, for instance) to comprehend concepts, opinions, or firsthand accounts. They can be applied to generate new research philosophies or to acquire comprehensive understandings of an issue. Numerous qualitative designs, often mentioned to as qualitative methods, are used and often there are several thought schools in one particular approach, for example, in phenomenology. Phenomenological studies explore anthropological knowledge through the descriptions that are delivered by the individuals involved, responding to the question “What is it like to experience this or that?” We refer to these encounters as "lived experiences." Therefore, the goal of phenomenological research is to characterize people's experiences with particular phenomena and how they interpret those experiences or give

meaning to them. According to Bless et al. (2013:15), the more modern philosophical views that truth is arbitrary and that knowledge is created by humans gave rise to qualitative methods. Put another way, our preconceptions, biases, and assumptions shape the way we perceive the world. These are pretty radical philosophical stances. The majority of social scientists today hold that shared knowledge can still be created to help people understand our world and find solutions to problems that impact our communities, even though people are unable to study themselves and their environment objectively (Bless et al., 2013:16). Rather than description and extrapolation, consideration is the goal of qualitative research.

In order to obtain an insider's perspective, the researcher must adopt a position and give the research participant's voice a voice. Furthermore, because of the complexity of human life, the phenomenon frequently necessities to be examined from various angles. The phrase "qualitative research methodology" encompasses a broad spectrum of investigative techniques and strategies used to examine social action phenomena that are not fully understood by us. Many different approaches are referred to as research designs within the category of qualitative research; each has a specific focus and knowledge-acquisition goal. Qualitative methods are, as their name suggests, centered on the qualitative aspects of experience, comprehension, and significance. By using these methods, one can examine human experience from the viewpoint of research participants in the setting in which the action occurs. This is referred to as a "insider's view" or a "emic perspective" (Brink et al., 2015:121).

When attempting to describe the lived experience, researchers focus on the individual's perspective, taking into account what is happening in their life, the significance of the knowledge, and any necessary adjustments. In this manner, the participant's definition of "health" and "caring" can be understood by the researcher (Brink et al., 2015:122).

The following are some of the most widely used qualitative techniques:

- Observations: Make careful field notes that include every thing you have heard, seen, or encountered.
- Direct questioning of people in one-on-one meetings is known as an interview.
- Focus groups: asking questions and encouraging discussion among members.
- Surveys: distributing forms containing open-ended inquiries (Bandari, 2020).

According to Bless et al. (2013:16), the qualitative method is frequently used when the issue has not been previously researched. Smaller sample sizes are usually used in this approach, and the outcomes offer a clearer understanding of the phenomenon being studied. The research plan is more circular and flexible in the qualitative approach. The researcher looks into an issue by learning about the respondent's opinions and feelings regarding a specific

occurrence or problem. Stated differently, reality is understood through the lens of the respondent.

6.3.1 Data collection

The success of a study greatly depends on the data collection process. In the absence of superior methods for gathering data, the accuracy of the study findings is merely challenged. Therefore, it is imperative that the researcher is knowledgeable about the various methods of gathering data, including the benefits and drawbacks of each, in order to choose the method that best suits the study's objectives, its intended setting, and its target population. The goal of qualitative research is to understand emotions, perceptions, social situations, or phenomena as they occur in the real world and, as a result, to investigate them in their natural environments (Kelly, 2014:287).

6.3.2 Qualitative research ethics

It is a common misconception that ethical considerations and reviews do not apply to qualitative research. Arguments include the conversational nature of the approach and the fact that data analysis aims to maintain the accuracy of the information gathered. Nonetheless, subjects in qualitative research have the same rights to respect and safety as subjects in quantitative research. Qualitative interviews should only be carried out with informed consent, explicit confidentiality agreements, and the application of a rigorous analytical process in order to ensure that trustworthy and legitimate conclusions are reached. Compared to most quantitative methods, qualitative interviews have a far greater potential to cause participants' subjective distress; this must be carefully addressed in the protocol's risk/benefits section (Wassenaar, 2014:76).

6.3.3 Questionnaires

As the subject of analysis, the respondent fills out a questionnaire by writing their answers to questions that are printed in a document. If the participant is educated, it is easy for them to respond to a well-designed questionnaire. The researcher can administer and grade it in a practical manner. But creating a questionnaire like that is challenging. Every component has the ability to affect a respondent's response, including the color of the paper used and each question. Because of this, the researcher has to think carefully about how to build or expand the questionnaire.

The objectives of a well-designed questionnaire should be met, its contents should fit the research problem and aims, it should obtain the most accurate and comprehensive data possible, and it should do so within reasonable time and resource constraints.

These are crucial considerations for researchers to make when creating a questionnaire:

1. Enumerate the specific research topics that the questionnaire will address. determined goals and objectives, or study
2. Verify that you comprehend the pertinent literature in its entirety.
3. Examine the types of data required to investigate the research questions.

Here, you can be aided by the use of a description matrix of the numerous content areas in which queries covering explicit circumstances are necessary. Having recognized the areas, you must select what quantity of questioning time to assign to every feature of the content. For instance, if you are fascinated in the knowledge of and attitudes towards the use of limits for hospitalised elderly patients, the specification matrix may be similitude of table provided in

Table 6.1. With the help of this matrix, you can create 10 questions for each cell, for a total of 40 questions in the questionnaire. This fairly straightforward matrix illustrates the researcher's view that each feature is equally important.

Table 6.1: An example of a specification matrix

	Chemical restraints	**Mechanical restraints**
Knowledge	10	10
Attitudes	10	10
An example of a specification matrix		

Source: (Brink et al., 2015:121)

1. Formulate the exact questions and check each one for appearance accuracy, objectivity, relevance, suitability, and chance of being answered.

Now, let's look at the various aspects of designing questionnaires. The way the questions are written is crucial for the researcher to get the right kind of response. They could opt for a long, detailed response that reflects the individualism of the participants, or they could choose for a shorter response selected from predefined categories. Put another way, the researcher has to choose between using open-ended, unstructured questions and closed-ended, structured questions. In the former case, the respondent is free to respond as they see fit, while in the latter case, they are required to select from a list of options. Closed-ended questions include straightforward "yes" or "no" inquiries, multiple choice questions, checklist-style inquiries, "true" or "false" inquiries, and questions that are identical.

The following are some instances of open-ended questions:

• What major issues do you believe the health sciences education field is currently facing?

• Are there any situations where legalizing the use of cannabis is appropriate?

Examples of closed-ended questions are as follows:

- Are you involved in decision-making?
- Please specify your yearly salary grade for the preceding year with a tick alongside the applicable number:
    - R000,00 to R49 999,99.
    - R50 000,00 to R99 999,99.
    - R100 000,00 to R149 999,99.
    - R150 000,00 or more (Brink et al., 2015:155).

6.3.4 Interviewing

Interviewing people is a more common way to work with people than assigning them to complete a form, take a test, or complete an experiential project. For this reason, it is a good fit for the interpretative exploration approach. It enables us to become highly acquainted with individuals, enabling us to comprehend their thoughts and emotions. Interviews are, on the one hand, just regular conversations, but they are also extremely skillful performances (Kelly, 2014:297). The study may be more environmentally valid if interviews were used as a follow-up method after the initial questionnaire survey, as opposed to studies that merely use more official data collection instruments. By using a second method to validate the results, this triangulated approach aims to counterbalance the shortcomings of the first one. Cross-sectional studies cannot be easily divided into those that employ either quantitative or qualitative methods, as this example of mixed-methods research makes clear (Brink et al., 2015:28).

6.3.4.1 In-depth-interviews

You can find out more about respondents' opinions, beliefs, and comprehension of a specific phenomenon by asking targeted questions during an in-depth interview, a qualitative data collection technique. Open-ended questions are used in interviews, which are a type of conversation with the main goal of gathering information.

When done well, interviews are excellent informational tools that let you decipher and comprehend the meaning of participants' responses to particular questions. During in-depth interviews, you can also ask a respondent to clarify a point they're making and provide a more thorough explanation of something they're saying, like how they feel about a specific question you asked. Because of your ability to delve deeper into the topics that fascinate you as a researcher, the research process can be more flexible.

You have access to nonverbal cues from participants as they respond to your questions, which is an extra source of information for your analysis and interpretation. Three distinct interview types can be distinguished:

4. You don't ask specific, pre-planned questions during casual, conversational interviews; instead, you let the conversation flow naturally. With this kind of interview, you can respond to the interviewee's answers with as much openness and flexibility as possible.
5. A conversational approach is used throughout the interview when the general interview approach is used. The interviewee is given a great deal of freedom, even though predefined questions cover certain themes. This is a very flexible method that enables the researcher to change the interview's focus as needed.
6. The goal of standardised, open-ended interviews is to ask every participant the same set of open-ended questions. The data collected is easier to analyze, and this format makes it possible to compare participant notes on their perspectives and opinions in a more structured way (Strydom & Bezuidenhout, 2014:188).

Key considerations

When conducting in-depth interviews, a researcher should take into account a number of factors in order to maximize the benefits. Interviews for qualitative research are conducted in one location. For these kinds of interviews, a voice recorder is advised. It can take a while, particularly if comprehensive answers are required (Strydom & Bezuidenhout, 2014:190).

When setting up the interviews, don't forget to consider these factors. Consider the questions you want to ask:

- There should be a shift in the questions' focus from wide to specific. Start by posing wide-ranging, general questions about the subject. The respondent will provide an answer that might hint at additional information that needs to be found. These cues should serve as the basis for your more targeted follow-up questions, which should be crafted to elicit as much information as possible from the participants.
- It's best to let the interview develop naturally and flow like a conversation rather than depending solely on prepared questions.
- Make sure the participants understand exactly what you are expecting of them when you ask a question by crafting concise, straightforward questions. Don't ask one question while thinking another.

- Ask truly open-ended questions. Do not ask questions that lead the participant into answering in a certain way. Open-ended questions allow the participant to give varied opinions and responses that are not influenced by predefined cues provided by you.
- You must exercise caution when posing suggestive queries. Rather than posing a probing query like "Did the experience make you happy?" Instead, inquire as to "What was your experience like?" This will enable the participants to communicate their actual feelings rather than just what they believe you should hear.
- Avoid posing questions with two questions. One aspect at a time should be the only focus of your questions. A participant may become confused and the response may only partially address the question if you attempt to get multiple answers from a single question. For instance, if you want to know if office supplies are available, you could ask, "When did you receive a new laptop and printer?"

To obtain the information that you truly want, you need to listen carefully to what the participants are saying:

- Refrain from reading your interpretations and viewpoints into their answers.
- Pay attention to any underlying or hidden subtext.
- Verify that the context in which you understand and interpret the response matches the context in which participants are responding to the question.
- Never assume that you understand participants' intentions completely; instead, ask them to elaborate on their response when they give a particular response.

When you need to elicit personal information from participants about specific aspects of their lives and experiences, keep their feelings in mind. By letting you interview them, they are helping you with your research, so you should be considerate of any limitations they impose. Do not press a participant to respond if they are reluctant or uneasy about moving forward with a particular topic (Strydom & Bezuidenhout, 2014:190).

6.3.5 Interview planning

You should ask yourself what kind of interview you need to conduct before you begin. There are numerous forms of interviews, just as there are numerous types of casual chats and lengthy political arguments that occur in daily life. One helpful way to approach this is by considering the ideal structure for the interview. If all you need from someone is some basic information, a very structured interview would work just fine. This kind of interview would basically consist of a list of standard questions. On the other hand, if you want people to talk

to you in-depth about their experiences or emotions, you should set up an unstructured interview. Prepare some questions ahead of time and, at the very least, make a list of the feelings and experiences you'd like to know more about. Semi-structured interviews are the most popular kind, where an interview schedule and a list of major themes and possibly subthemes are prepared in advance (Kelly, 2014:298).

6.3.6 Setting up the interview

Make sure you have a sufficient amount of privacy during the interview and that you won't be unduly disturbed. If you're recording, make sure the background noise won't overpower your recordings. To ensure that they can give the interview their full attention, make sure the interviewee has scheduled the necessary amount of time (Kelly, 2014:298).

6.3.7 Recording ins and outs

The majority of people don't mind if you videotape or record an interview, but make sure you first obtain their permission. The benefits of recording are clear: you can maintain an exhaustive record of the interview without being sidetracked by taking thorough notes. Additionally, it conveys to the interviewee your seriousness about what they have to say (Kelly, 2014:299).

6.3.8 Interview start

Giving a brief overview of the topic of the interview at the outset could be a smart idea. After that, you could ask an open-ended, non-threatening question to start the interviewee talking and help them feel more at ease. Recall that the purpose of an interview is to learn more about each other.

6.3.9 Interview itself

It's a good idea to jot down any questions or points of view that come up during the interview, even if it is being recorded. Understand your interview schedule well enough to avoid having to constantly refer to it, which would break the rapport and natural flow of a well-done interview. Put simply, have a discussion rather than a Q&A session. The following actions should be taken by interviewers:

- Pay closer attention when someone is speaking, speak less, follow up on what they say, and ask questions when you understand.
- Request further information on a topic,
- Investigate without probing
- Ask open-ended questions without presuming an answer, and steer clear of leading questions (Kelly, 2014:299).

6.4 Research approach: Quantitative

Quantitative research, according to Bryman et al. (2018), is a popular research methodology that involves gathering statistical data, considers the relationship between theory and research as deductive, supports positivism and other natural science approaches, and embraces an objectivist interpretation of social actuality. Brink et al. (2015) state that positivism is a systematic method of conducting research that places a strong emphasis on observable facts.

The fact that the research approach is described as quantitative does not mean that it is only different from a qualitative research approach in that social life's characteristics are quantified. It suggests that there is much more to it than just the occurrence of statistics because of its unique ontological and epistemological stance (Bryman et al., 2018:31).

Gathering and evaluating numerical data is the process of conducting quantitative research. It is useful for determining averages and patterns, formulating hypotheses, examining causality, and extrapolating findings to larger populations. It contrasts with qualitative research, which gathers and examines non-numerical data (text, audio, or video, for example).

The natural and social sciences—biology, chemistry, psychology, economics, sociology, marketing, etc.—both heavily rely on quantitative research.

Examples of quantitative research questions include:

- What was Singapore's 2020 demographic composition?
- In what ways has the global average temperature changed in the past century?
- Does the abundance of honey bees depend on environmental pollution?
- Does productivity increase for those who have long commutes when they work from home? (Bandari, 2020).
- With the quantitative approach, the researcher tries to be as neutral and objective as possible by collecting data (measurements or frequencies) by a very specific set of steps, just as natural scientists do. Statistical techniques are used to analyse quantitative data so that results can be extrapolated from a small sample to continue being as impartial and objective as you can. Statistical techniques are used to analyze quantitative data so that conclusions from a small sample can be applied to the entire population.

The differences between quantitative and qualitative research in terms of the three mentioned areas:

Table 6.2: The difference between quantitative and qualitative research in terms of the three mentioned areas

Areas	Quantitative	Qualitative
Principal orientation to the role of theory in research	Deductive empirical testing of theory	Inductive, generation of theory from data
Epistemological orientation	Natural science model, in particular, positivism	Interpretivist
Ontological orientation	Objectivism	Constructionist

Source: (Bryman et al., 2018:31).

The following are typical characteristics of quantitative research methods:

- Put a strong emphasis on quantification when collecting and analyzing data;
- Follow a logical approach when relating theory and research, giving theory analysis priority.
- Adopt a viewpoint that regards social authenticity as an external, objective reality.
- Incorporate the methods and standards of positivism in general and the natural sciences model in particular.

In contrast, the qualitative research approach

- rejects positivism in general and the methods and standards of the natural scientific model in particular.
- It views social reality as both ever-changing and emergent, as experienced by individuals.
- It places more emphasis on words than numbers when gathering and analyzing data.
- It favors an inductive approach to the relationship between theory and
- research, where the creation of theories is prioritised over the validation of existing ones (Bryman et al., 2018:31).

6.5 Mixed-methods research: Combined quantitative and qualitative research

Research that blends or integrates quantitative and qualitative research methodologies within a single project is referred to as mixed-methods research. It is not enough to use quantitative and qualitative research methods separately; rather, a combination of the two should be used. This implies that the quantitative and qualitative data from mixed-methods research should be mutually illuminating, as previously explained. By utilizing a combination of methods, the researcher could potentially leverage each method's advantages while mitigating its drawbacks. However, not every writers on research approaches agree that this integration is either desirable or feasible. Nevertheless, since the early 1980s, mixed-methods research has grown in popularity, especially in the fields of business and management (Brink et al.,

2015:155). This pragmatic approach is the foundation of much of modern social science and many researchers combine quantitative and qualitative methodologies to develop knowledge about the world that can be used to improve the quality of life.

Occasionally, the situation or the issue being studied necessitates the use of both approaches in the same study to support or further develop each one (Bless et al., 2013:16).

For example, a mixed-methods study might consist of the following elements:

- structured questionnaires for quantitative data and open-ended interviews for qualitative data;
- quantitative surveys and qualitative case studies; or
- quantitative surveys and qualitative observations.

6.5.1 Be persuasive

The research writing up is not simply a matter of commentary on your findings and presenting some conclusions. When writing you constantly need to refer to the literature you drew on, expound how you did your research, and outline how you conducted your analysis. Simply saying, “This is what I found; is it not interesting?” is not suffice. Your writing must be persuasive so that your readers regard your findings and conclusions as significant, plausible, and credible.

6.5.2 Open or closed questions

One of the most significant contemplations for numerous researchers is whether to ask a question in an open or closed set-up. This issue is applicable to both structured and self-administered questionnaire studies, although the qualitative or quantitative nature of a project often leads to questions being either open or closed respectively.

When a question is presented as open-ended, participants are free to answer in any way they choose. When asked a closed question, participants are given a list of predetermined options from which they must select the best response (Du Plooy-Cilliers & Cronje, 2014:159). The two parts of the closed-ended questions are the item, which is the statement, and the evaluation, which asks the respondent how much they agree or disagree with the statement.

6.5.3 Variables

Variables are more specialized and detailed than concepts and theories, claim Brink et al. (2015:28). Additionally, they suggest that since the concept is so precisely defined, it is feasible to obtain particular observations and, as a result, amounts.

6.5.4 Philosophy

In the literature, "philosophy" is used in a variety of contexts. In this context, it can be used to refer to a Weltanshaung, or worldview. It represents our standards, beliefs, and expectations regarding the nature of reality, knowledge, and ways to acquire it, as well as our own well-being, the health sciences, the environment, and ourselves (Brink et al., 2015:26).

6.5.5 Model

The writings also contain inconsistent usage of this word. Although it often looks the same as the word "theory," some authors make a distinction between the two and consider a model to be the precursor of a theory.

Symbolic descriptions of reality are standard definitions for models. It presents a diagrammatic representation of specific interactions between phenomena and denotes concepts with charts or symbols. A model helps us organize the way in which we can comprehend a situation, an occurrence, or a population. A model can offer an ordered framework or assist in defining and directing particular health sciences research tasks (Brink et al., 2015:26). Models aid in the identification and illustration of the most significant theoretical concepts as well as the dynamics of the relationships between them. With the use of models, a researcher can more easily explain something that is difficult to visualize. Models are limited in their ability to explain the "why" behind a theory's concepts, but they are useful in illuminating the "what" and "how" of complicated ideas. As a result, they are primarily utilized to show how a theory's concepts relate to one another and cannot be used by themselves to explain a theory (Bezuidenhout, 2014:48).

6.5.6 Development of theory

Getting familiar with the structural and functional elements is the first step in creating a concept. Assumptions, ideas, constructs, variables, and propositions make up the structural components, whereas the theory's field concepts and their appropriate application—that is, their description, elaboration, forecasting, or regulation—make up the functional components. "Assumptions" are the basic beliefs we accept as true without question or evidence, or that we take for granted. They necessitate reflection and a solid foundation of knowledge in the field of research to be uncovered because they are frequently ingrained in behavior and thought patterns. They establish the characteristics of ideas, meanings, goals, and connections. These are the fundamental underlying truths that theoretical reasoning starts with. Research assumptions affect the study's rationality because they are ingrained in the logical framework of the study's design, outline, and justification of findings.

"Concepts" are the semantic labels we give to things or occasions. They've been referred to as the conceptual building blocks. The abstract characteristics of the subjects under study are

what some writers perceive as constructs of specific human behaviors and traits. The degree of abstraction in concepts varies. The abstract and highly complex concepts of managing and self-esteem are two examples. It is challenging to assign a value to these. Less abstract concepts, like blood loss and being overweight or underweight, are simpler to measure empirically. In general, the difficulty of the researcher in producing reliable and valid empirical indicators increases with the complexity and abstract nature of the concept.

In day-to-day work, ideas are not defined or made clear. For instance, you might be able to understand a patient based solely on their description if they identify as depressed and you know why they could be experiencing that (Bryman et al., 2011:43). However, you would need to define, characterize, and elucidate the emotion if you were to undertake a thorough analysis of the concept of sadness. Our use of terms becomes more consistent when we define them. When a concept is explained in a way that raises the possibility of its observation and quantification, it is considered a "construct". A concept linked to the concept of pain could be discomfort, encompassing both mental and physical aspects. To enable most healthcare providers who work with them to know precisely what to measure, observe, control, or search for in the real world, constructs are intentionally non-specific when compared to laws.

Because they show that a concept has been defined precisely enough to allow for accurate observations and, subsequently, measurements, "variables" are more precise than concepts and constructs. Table 6.3 displays the connections between concepts, constructs, and variables.

"Propositions" are claims that imply a particular relationship between two or more formations or concepts. Occasionally, they are called "relational statements." There are several ways in which the relationship can exist. Certain theories may have one or more connections to other ideas. Others are unrelated to one another and operate independently. Positive or negative relationships can also exist between concepts.

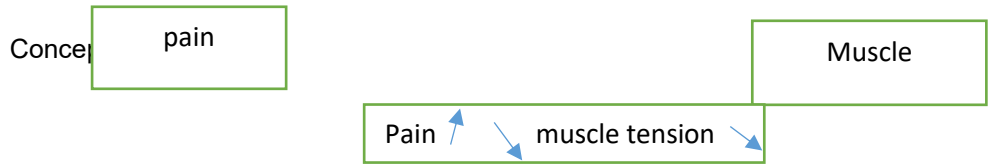
When considered collectively, propositions give a theory its structure and content.

Table 6.3 How a proposition could be developed

	Example 1	**Example 2**	**Levels of abstraction**
Concept	**Pain**	**Anxiety**	**Abstract**
Construct	Physiological and Psychological discomfort resulting from internal or external stressors	Emotional response	Abstract
Variable	The score obtained on the pain inventory self-test	Palmar sweating	Concrete

Figure Concept-construct-variable

Proposition: As pain increases, muscle tension increases



Source: (Bless et al., 2013:162)

6.6 Research population

The population is the entire group of items or people that the research project is focused on and about which the researcher needs to gather certain characteristics. It could be a population of all the cars assembled at a particular factory during 2005, all the houses in a town, or all the primary school teachers in the country. The population as a whole is divided into 50 homes in that town or 100 primary school teachers chosen from a list of trade union members, depending on the nature of the research (quantitative studies whose features will be generalized to the entire population). A car, a house, or a single primary school teacher e up an element or unit of analysis in each sample.

Population parameters are particular numbers or values that apply to the entire population, such as the average age of primary school teachers. Sample statistics are defined as the corresponding values or quantities that are extracted from the sample, e.g., the average age of the 100 teachers that make up the sample. Accordingly, estimates of population parameters constitute statistics (Bless et al., 2013:162).

The population is the collective term for the research study participants. If the study's participants were chosen at random, the findings might be seen as typical of a wider population. For instance, 57% of 1,015 randomly chosen retirees in a recent Gallup Poll (Van Derhei, 2012:9) stated Social Security was a "major" source of their income. Based on the responses of the population surveyed, it can be concluded that the majority of retirees in America depend on Social Security.

Any grouping of individuals or non-human objects, time periods, geographic locations, wheat prices, educational institutions, or individual salaries is referred to as a population. It is the entire range of occurrences, people, or objects to which the study's conclusions are intended to be applied.

6.6.1 Target population

Identification and agreement on the target population are necessary before research can start. The entire population, or group, that a researcher is interested in studying and analyzing is known as the target population. Stated differently, we must determine which viewers we can actually reach. The choice may be made to concentrate on residents of the same province because it may be simpler to get in touch with them (Pascoe, 2014:132).
If the goal of the study was, for example, to estimate the proportion of parents who read a particular newsletter article, then all parents whose children were enrolled in that school would be the target population. The school could then provide a list of parent contact details as a sampling frame, with individual parents serving as the target units.

A few examples of target populations are patrons of a company, citizens of a country, students at a particular university, or people who live in a housing association. The idea that every member of the population should have at least one explicit trait related to the research question should be kept in mind (Davis, 2014:132). When it comes to qualitative research, the findings provided cover every aspect of the population that was studied.
Accurately describing the target population is crucial. The best way to accomplish this is to specify the properties that need to be analyzed in detail (Bless et al., 2013:164).

6.7 Sampling

The review of the literature identifies a number of factors that influence primary healthcare when the City of Cape Town provides health services. Decisions made by officials in management positions have a major impact on the process of providing health services, and the best way to gather meaningful data is to measure perceptions and obtain an insider's perspective. The mixed research approach, which combines interviews and a questionnaire survey, has been chosen specifically for this reason.

A 100% sample was used in the study because all managers in the Eastern City Health Area of the City of Cape Town were surveyed using a questionnaire.

Stratified random sampling was utilized as a starting point for the interviews, and purposive sampling was then employed to ascertain which respondents could provide the data required for the research. The fundamental idea behind stratified random sampling, according to Bless et al. (2013:169), is to divide a population into multiple groups, or strata, so that each member of the population is exclusive to one stratum. Then, random sampling is done within each stratum using either the simple or the interval sampling method. Even though there are numerous samplings, only a small population is sampled for each one. According to Pascoe (2014:139), stratifying the population into smaller groups is the initial step. Strata, from which

the singular form is stratum, are collections of elements that are part of the population and share similar characteristics. Ward committees serve as a direct conduit in this instance between the local community and the City Council.

Strata, from which the singular form is stratum, are collections of elements that are part of the population and share similar characteristics. Ward committees serve as a direct conduit in this instance between the local community and the City Council.

A random sample was chosen from each ward after the manager's office of City of Cape Town's subcouncil 21 provided the ward committee membership count.

Purposive sampling, according to Bless et al. (2013:172), is predicated on a researcher's assessment of the qualities of a representative sample. Based on what the researcher deems to be typical units, a sample is selected. The ability of the candidate to supply the information required to address the research question will be the deciding factor in deciding who will be interviewed. For this reason, 12 ward committee members are representative community leaders in respective wards across subcouncil 21. See Annexure 9, which outlines the agenda item for the interview that followed. Interviewees' consent was requested before the voice recordings were made. The recordings were an indication of the information sensitivity and value of the interviewees with the researcher. Sampling is the process of choosing which group to use for data collection in your study. For instance, you may survey a sample of one hundred students to learn more about the opinions of your university's students. Sampling in statistics lets you test a hypothesis regarding a population's characteristics.

The plan is to choose units that are thought to be the most typical in the population being studied. An example of a typical school student would be someone who is "12 years old, male, Catholic, and has parents who work in the clerical profession." Only pupils who fit these requirements would be included in the sample.

According to Pascoe (2014:135), representative sample drawing is typically necessary for quantitative research. Like a blood sample, a representative sample has the same features as the broader population. As a result, their responses to your study ought to be extremely similar to what they would have been had the entire population been included.

A sample is a smaller, more manageable portion of a larger group. It is a subset that includes characteristics from a larger population. Samples are used in statistical testing when population sizes are too large to include every possible participant or observation.

The process of choosing a subset, or smaller number, of units, from a population that is representative of the entire population or that shares particular characteristics with it, is known

as sampling in the quantitative paradigm. The sample should reflect the features of the entire population in the same proportions and relationships as the entire population. How frequently you could anticipate finding similar results if the survey were to be repeated is what the confidence level principle refers to. 10% of the population constitutes an adequate sample, according to Pascoe (2014:136), suggesting that the sample is then regarded as representative. It's critical to comprehend representativeness and how it relates to generalizability.

Only when it is conceivable that the observations made in the sample of subjects would likewise be made in any other group of subjects from the population can the results of a study be considered generalized. A sample is a subset of measurements or a subset of elements taken from an interest population (Strydom, 2021:229).

6.8 Advantages of using samples

Sampling is done primarily for representativeness and feasibility. It is rarely feasible to reach every member of a population of interest, such as drug addicts, child abusers, or elderly people with children living abroad, in order to provide complete coverage of the entire population. Finding, contacting, and studying every member of the pertinent population may be feasible in theory, but time and financial constraints typically make this an impractical endeavor. As a result, using samples may yield, as previously indicated, more accurate information than studying the entire population could have. This is true because resources like time, money, and effort can be better allocated to creating higher-caliber studies, better tools, more detailed data, and more skilled interviewers or observers when there is a sample.
A phenomenon would require a great deal of time and effort to observe or study in its entirety. This would result in a large volume of data that would be challenging to process, analyze, and interpret. Furthermore, access to the complete set of entities that make up the population may not always be possible due to the nature of the practice or research problem in which you are interested. It's possible that the population is too large to study or that you don't have enough time or resources to finish the task. Studying a sample or a subset of the population would then be possible.

Owing to time constraints in large studies, the problem is sometimes faced that the phenomenon changes over time and does not give a real picture of the situation (Strydom, 2021:229).

6.9 Data-collection instruments

The fundamental tools used by researchers in their work are data. Data are derived from observation and can be expressed in words (qualitative data) or numbers (numeric or

quantitative data). A researcher needs reliable data to analyze and interpret to come to meaningful conclusions from a study (Durrheim, 2014:51).

When doing scientific research, collecting data in an accurate and organized manner is essential. It enables us to gather the data we wish to about the study objects we are looking at. Depending on the kind of research being done, different techniques are employed to gather data. These techniques might include document review, observation, questioning, measuring, or a combination of techniques.

6.10 Questionnaire

A questionnaire, which consists of a list of questions and extra prompts, is a tool used to gather data from respondents. Reactions may also be impacted by the sequence in which questionnaire items are presented. First, the answers provided to one question can influence the ones that follow. If, after several questions about the dangers of gangsterism to the Manenberg (Cape Town) community, there is an open-ended question asking respondents to volunteer what they think are threats to the community, gangsterism will receive more citations than it would otherwise. It is best to start this conversation with open-ended questions in this case (Babbie & Mouton, 2001:243).

Checklists, rating scales, and closed-ended questions are frequently used in questionnaires. These devices are very useful because they simplify and quantify responses, which is very helpful since most people prefer to check boxes rather than write or type out lengthy answers. The following things need to be considered when developing a questionnaire:

- Don't forget to start a survey with an introduction outlining who is conducting it and why.
- When at all possible, give the respondents a compelling argument for why it will be worthwhile for them to complete the questionnaire.
- Assure responders of their privacy or anonymity, as appropriate.
- State how long you think the survey will take to finish.
- Sort questions on related subjects into groups and follow a logical order.
- Limit the number of questions you ask. Shorter questionnaires are easier to fill out by respondents than longer ones. So, a higher response rate can be guaranteed by asking fewer questions. Additionally, limit your questioning to what your research question (or hypothesis) asks.

- Take into account requesting demographic details at the conclusion. People frequently lose interest in surveys if you start them off, but it won't be a big deal if they don't finish them if demographic information isn't crucial to the study.
- Always express gratitude to those who answered your survey.
- Ensure that your questionnaire is comprehensible and unambiguous by conducting a pre-test (Du Plooy-Cilliers & Cronje, 2014:152).

6.11 Steps required to design and administer a questionnaire

1. Define the research's objectives.

2. Determine who the intended responders are and 3. Provide contact information

4. Questionnaire design 4. Pilot experimentation

5. Completing the questionnaire

6. Analysis of the findings

6.12 Defining objectives of the study

The researcher should be able to gather the most accurate and comprehensive data in an orderly manner by using a questionnaire. This is carried out in order for the intended observations to produce trustworthy results.

A well-designed questionnaire should minimize unanswered questions, which are a common issue with many surveys, and achieve the research goal and objectives.

6.13 Define the target respondents and methods to research them

It is important to define clearly the target and study populations from which the researcher collects data and information.

Direct communication, focus groups, mail-based online questionnaires, and phone interviews are the main ways to get in touch with the respondents.

6.14 Data analysis

Data must be arranged and verified for accuracy and comprehensiveness after collection. Following this procedure, the researcher will characterize the sample data and extrapolate from this data set to the population from which the sample was drawn using a variety of statistical and mathematical tests (Bless et al., 2013:22).

6.14.1 Data collection and analysis

In qualitative research, data collection and analysis usually take place concurrently or as consecutive steps in a cycle. Qualitative data includes things like written and spoken words,

images, videos, and artifacts. When conducting interviews, video cameras and audio tape recorders may be used as part of the data collection process. Additional literature research that results from data collection and analysis can make the process even more cyclical and flexible (Bless et al., 2013:22). Tape recording was the suggested method in this case questionnaire survey and the standardised interviews, respectively, in light of the mixed research approach the study employed. According to Sarantakos (2000:328), the following significant events—which are succinctly described—are involved in the data analysis process in quantitative research:

• Data preparation, which entails checking and creating tables, coding, and classifying answers to open-ended questions.

• Counting, which records the occurrence and frequency of certain responses

• Grouping and presenting, which entails collecting related objects into sets

• Relating, which uses statistical tests and cross-tabulations to explain why relationships occur.

Sarantakos (2000:328) agrees that careful examination of the data provides researchers with the knowledge they need to comprehend results and report on how the findings affect society. Computers are now widely used in research to examine data, particularly in quantitative studies (Cronje, 2010:155). The data collected for this research project was analyzed using the quantitative tool in SPSS (Statistical Programme for Social Sciences).

6.15 Triangulation

The process of using multiple sources to confirm the accuracy and veracity of data collected and conclusions drawn from it is known as triangulation. Without a doubt, the researcher can learn details about the phenomenon by taking a broader view of it than would have been possible with a single measure. Two important objectives are achieved by the multiple-method approach: cross-checking the validity of the findings and confirming the dependability of the data collected. According to Erlandson et al. (1993: 115, in Vos, 2004: 341), triangulation provides multiple insights into the phenomenon being observed and is characterized by the use of multiple sources for observation. This line of reasoning is continued by (Patton1990: 244, in Merriam, 1998: 137), who asserts that multiple sources of information are more trustworthy than single sources. The researcher is in a far better position to confirm the validity of the findings and ensure the data's reliability by using multiple sources of measurement. Jick (1983:145–147, in Vos, 2004:342) states that triangulation is advantageous for qualitative research in certain situations. Cronje lists three advantages (2010:155).

The first is that it focuses on the validity of the results. Stated differently, the degree of subjectivity has been minimized because multiple sources of measurement have been utilised. Second, by using more than one measurement, new insights become apparent that would not have been possible with just one. The different points of view present challenges to the analyst, but in the end, the result is a rich description of the phenomenon. The subject of theory synthesis is finally brought up by Cronje (2010:156), who also proposes that using a variety of sources (methodological triangulation) is a means of applying a variety of theories (theoretical triangulation) to investigate a phenomenon. Most importantly, every author on the previously mentioned list concurs that triangulation improves the validity of the conclusions drawn and the dependability of the data gathered. This viewpoint guides the researcher, and a variety of methods are used in this approach to guarantee the reliability of the data collected and the validity of the findings.

The research question serves as the foundation for the logical flow that underpins the study's use of triangulation. Therefore, triangulation is a kind of focused methodological approach that is used to try and answer the research question rather than a vacuum. By combining the quantitative approach—in the form of a questionnaire survey—with the qualitative approach—in the form of a semi-structured interview—this research project employs triangulation (Cronje, 2010:156).

6.16 Summary

This chapter provided a viewpoint on the research methodology used to answer the research question. The rationale behind integrating the quantitative and qualitative research paradigm approaches was examined in this field of study.

In order to address the research question: "What elements play a role in the general public's discontent with primary healthcare? What actions ought to be performed to resolve the circumstance?" Using both quantitative and qualitative research methods was appropriate.

The circumstances in the City of Cape Town Municipality are covered in the following chapter. The three main themes that were previously covered in the questionnaire guide discussion serve as the foundation for the analysis. The municipality will use a model for health and well-being in the first theme, which describes how primary health care (PHC) will be delivered. The second theme investigates the legal framework governing community involvement. The third theme looks at the factors supporting PHC and assesses how well they are implemented.

CHAPTER SEVEN:

RESEARCH METHODOLOGY: DATA ANALYSIS AND INTERPRETATION

7.1 Introduction

The preceding chapter covered the theory underlying the mixed approach of quantitative and qualitative techniques used in this research study. This chapter covers the data collection, analysis, and interpretation. The information obtained from the questionnaire is first presented, and then a review of the data obtained from the interviews with Subcouncil 21 ward committee members is presented.

7.2 Data analysis questionnaire

The questionnaire was given to the subdistrict's management team, which is made up of eight clinic managers and seven senior professional nurses. Out of the fifteen surveys distributed, fourteen were returned, resulting in a 92% response rate. The biographical information that was covered in the first section of the questionnaire is reported next. Refer to the section on the questionnaire in Annexure 8 (A1–A4).

7.2.1 Dependent variables

The replies to the numerous groupings are reflected in the form of a diagram.

Table 7.1: Dependent variables

		Age group	Gender	Marital status	Highest education qualification	Total work experience	Govt. work experience and work experience with local government
N	Valid	14	14	14	13	14	14
	Missing	0	0	0	1	0	0

The 14 participants comprise seven clinic managers and seven senior professional nurses.

Table 7.2: Age group

		Frequent	Percent	Valid percent	Cumulative percent
Valid	25–39 years	4	28.6	28.6	28.6
	40–49 years	4	28.6	28.6	57.1
	50–59 years	6	42.9	42.9	100.0
	Total	14	100.0	100.0	

The diagram above indicates that 57% of the staff falls in the age group of between 25 and 49.

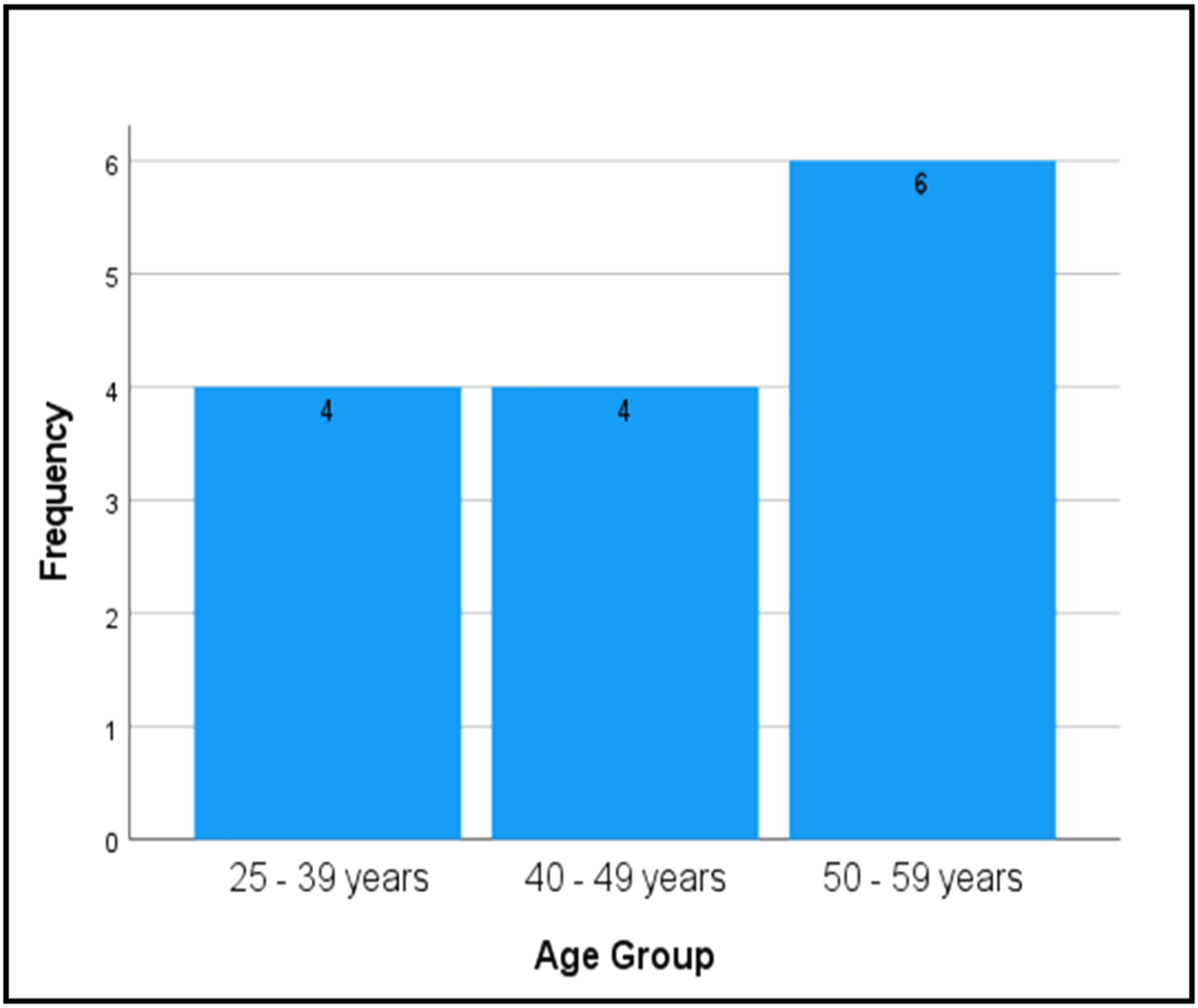


Figure 7.1: Age group

Table 7.3: Gender					
		Frequency	Percent	Valid percent	Cumulative percent
Valid	Female	14	100.0	100.0	100.0

The diagram indicates that 100% of the target population are females.

Table 7.4: Marital status					
		Frequency	Percent	Valid percent	Cumulative percent
Valid	Never married	1	7.1	7.1	7.1
	Married	10	71.4	71.4	78.6
	Divorced	2	14.3	14.3	92.9
	Widowed	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Of the population, 79% are married.

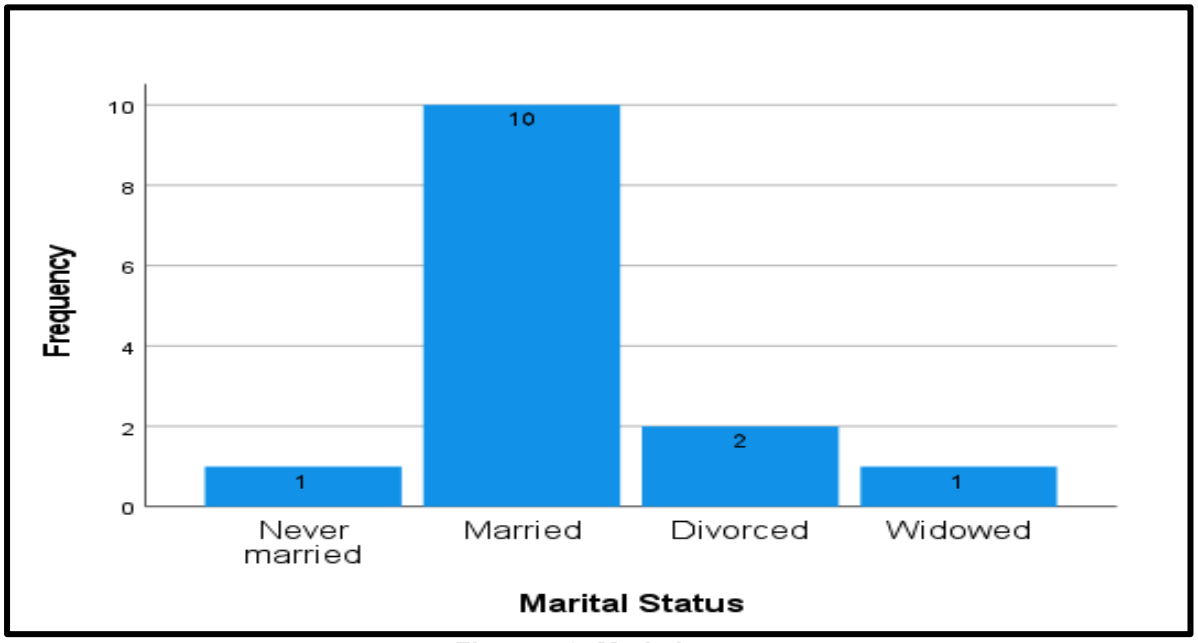


Figure 7.2: Marital status

Of the management staff, 80% are married.

Table 7.5: Qualification highest educational qualification					
		Frequency	Percent	Valid percent	Cumulative percent
Valid	Master's degree	1	7.1	7.7	7.7
	Honours degree/ Advanced Diploma	3	21.4	23.1	30.8
	Degree	4	28.6	30.8	61.5
	Diploma	5	35.7	38.5	100.0
	Total	13	92.9	100.0	

There is 100% post-matric qualification in the population group.

Table 7.5: Highest educational qualification					
		Frequency	Percent	Valid percent	Cumulative percent
Missing	System	1	7.1		
Total		14	100.0		

There is 100% post-matric qualification in the population group.

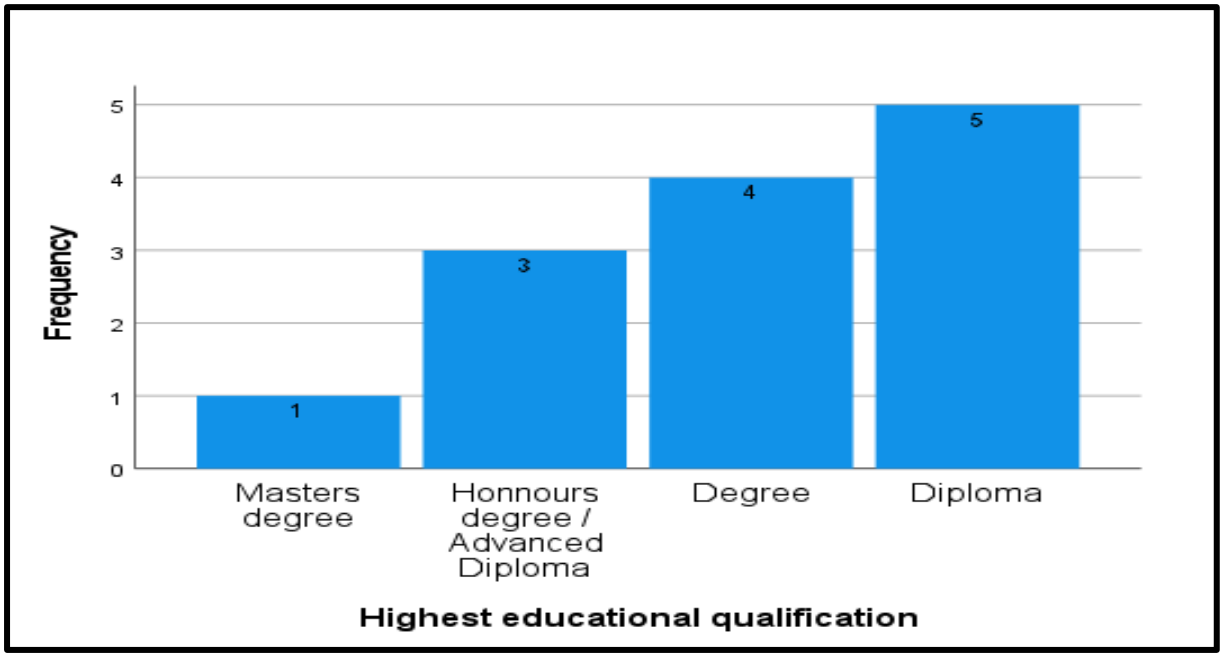


Figure 7.3: Highest education qualifications

Of the staff, 100% possess a post-matric qualification.

Table 7.6: Total work experience					
		Frequency	Percent	Valid percent	Cumulative percent
Valid	1–5 years	1	7.1	7.1	7.1
	6–10 years	3	21.4	21.4	28.6
	11–19 years	5	35.7	35.7	64.3
	20–29 years	2	14.3	14.3	78.6
	30 years or more	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the staff work experience, 36% range between 11 and 19 years.

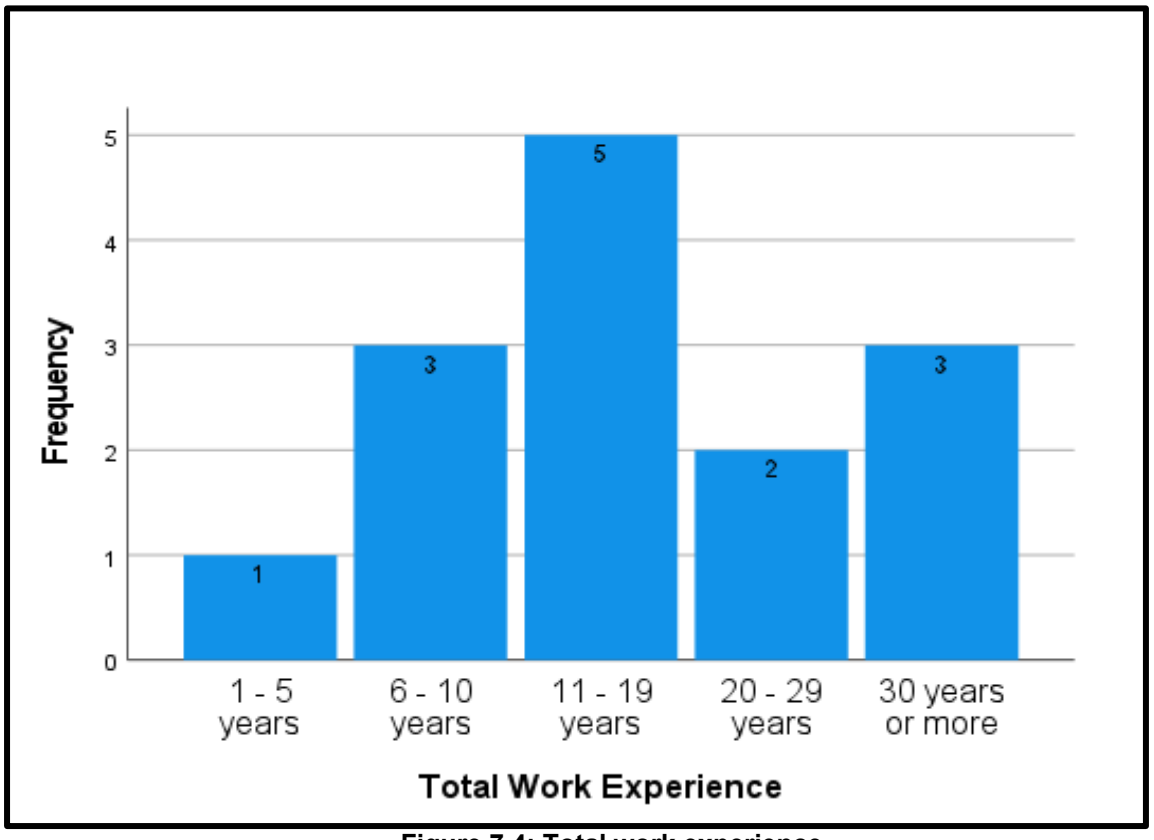


Figure 7.4: Total work experience

The average work experience of 40% is between 11 and 19 years.

Table 7.7: Work experience within local government					
		Frequency	Percent	Valid percent	Cumulative percent
Valid	1–5 years	3	21.4	21.4	21.4

	6–10 years	5	35.7	35.7	57.1
	11–19 years	3	21.4	21.4	78.6
	20–29 years	2	14.3	14.3	92.9
	30 years or more	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Of the staff in the target population, 79% have acquired their experience (between 6 and 30 years) within local government.

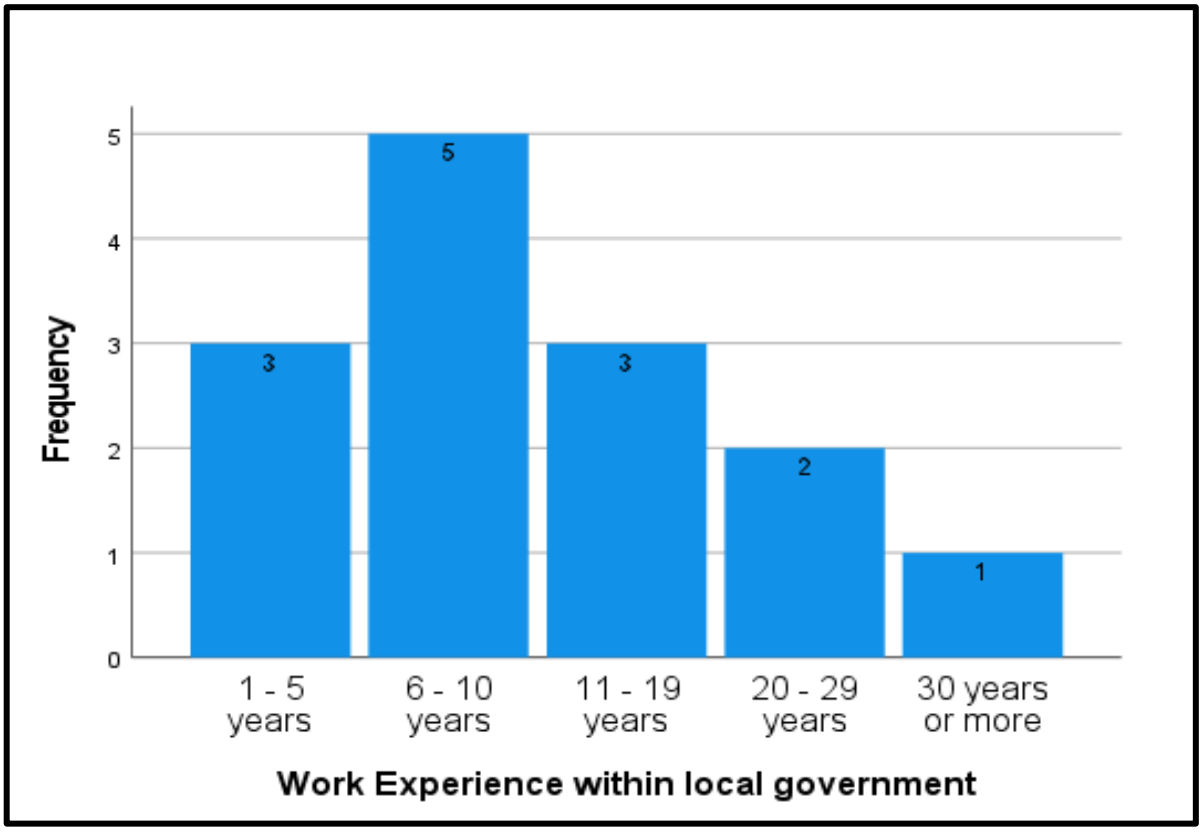


Figure 7.5: Work experience within local government

Of local government work experience, 45% average between 6 and 10 years.

7.2.2 Independent variables

Respondents were asked to rate their opinions on a set of statements in the second section of the questionnaire. The following are the answers to the different statements:

Table 7.8: Health problems identification

Q 1 Primary health care (PHC) is about community members helping the clinic to identify health problems.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	11	78.6	35.7	78.6
	Neutral	1	7.1	7.1	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 79% strongly agree that PHC is about community members helping clinics to identify health problems.

Table 7.9: Solving health problems

Q 2 PHC is about community members developing approaches to solving health problems.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	11	78.6	35.7	78.6
	Neutral	1	7.1	7.1	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 79% agree that PHC is about community members developing solutions to problems.

Table 7.10: PHC success

Q3 PHC success depends on full community involvement.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	7	92.9	50.0	92.9
	Neutral	1	7.1	7.1	100.0
	Disagree	14	100.0	100.0	
	Total				

Of the particioants, 93% agree that PHC is about community members developing approaches to solve health problems.

Table 7.11: Community involvement platform

Q4 Clinic management's role is to create a platform for community involvement.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	14	64.3	64.3	100.0
	Total	14	100.0	100	

There is 100% agreement that clinic managers must create a community-involvement platform.

Table 7.12: Health service demand

Q 5 Community involvement increases the demand for health services.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	13	92.9	64.3	92.9
	Neutral	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Of the participants, 92.9% agree that community involvement increases health service demand.

Table 7.13: Informal settlement record

Q6 Each informal settlement is recorded in our clinic.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	8	57.2	42.9	57.1
	Neutral	3	21.4	21.4	78.6
	Disagree	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the participants, 57% agree that informal settlements are kept on record at clinics

Table 7.14: Planning programmes

Q7 The community is involved with our planning of programmes.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	5	35.7	28.6	35.7
	Neutral	3	21.4	21.4	57.1
	Disagree	6	42.9	42.9	100.0
	Total	14	100.0	100.0	

Of the particpants, 43% disagree, saying that communities are not involved in planning health programmes.

Table 7.15: Implementing programmes

Q8 The community is involved in our implementation of programmes.

	Frequency	Percent	Valid percent	Cumulative percent

Valid	Agree	5	50	35.7	50.0
	Neutral	5	35.7	35.7	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the particpants, 50% agree that communities are involved in the programme implementation.

Table 7.16: Programme outcomes

Q9 The community is involved in the outcomes of our programmes.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	5	35.7	35.7	50.0
	Neutral	6	42.9	42.9	78.6
	Disagree	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the participants, 43% are neutral about communities being involved in programme outcomes.

Table 7.17: Provincial social development agreement

Q10 Our clinic has a partnership agreement with Provincial Social Development.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	9	86	64.3	86
	Neutral	3	21.4	21.4	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 86% agree that the clinic and provincial social development has a partnership agreement.

Table 7.18: Community health issues

Q11 Civil society organisations often represent community health issues at our clinic.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	8	57.2	57.2	71.4
	Neutral	1	7.1	7.1	64.3
	Disagree	5	35.7	35.7	92.9
	Total	14	100.0	100.0	

Of the participants, 57.2% agree that civil society issues are represented at clinics.

Table 7.19: Information accuracy

Q12 Community-based organisations provide accurate information on community needs.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	9	64.3	64.3	78.6
	Neutral	1	7.1	7.1	71.4
	Disagree	4	28.5	28.5	92.9
	Total	14	100.0	100.0	

Of the particpants, 64.3% agree and 29% disagree that there is information accuracy provision from community-based organisations.

Table 7.20: Poorest communities profiled

Q13 The poorest communities are profiled in our clinic.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	5	35.7	38.5	61.6
	Neutral	7	50.0	53.8	92.3
	Strongly Disagree	1	7.1	7.7	100.0
	Total	13	92.9	100.0	
Missing	System	1	7.1		
Total		14	100.0		

Of the participants, 50% are neutral about clinic community profiling.

Table 7.21: Quarterly interventions

Q14 Quarterly health interventions are held at informal settlements in our catchment area.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	6	42.9	42.9	57.2
	Neutral	2	14.3	14.3	57.1
	Disagree	6	42.9	42.9	100.0
	Total	14	100.0	100.0	

Of the participants, 43% disagree that quarterly interventions are held in informal settlements.

Table 7.22: Clinic openness and transparency

Q15 Involvement enhances our clinic openness.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	11	78.6	50.0	107.2
	Neutral	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the participants, 50% agree that involvement enhances openness.

Table 7.23: Clinic accountability

Q16 Involvement enhances our clinic's accountability.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Strongly Agree	5	35.7	35.7	35.7
	Agree	5	35.7	35.7	71.4
	Neutral	4	28.6	28.6	100.0
	Total	14	100.0	100.0	

Of the participants, 36% Strongly agree that involvement enhances clinic accountability.

Table 7.24: Ward councillor familiarity

Q17 Our ward councillor is known by all staff.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	3	21.4	21.4	28.5
	Disagree	11	78.6	78.6	64.3
	Total	14	100.0	100.0	

Of the particpants, 43% disagree and 36% strongly disagree the ward councillor is known to staff.

Table 7.25: Social conditions recorded

Q18 Knowledge regarding local social conditions are recorded at our clinic.

	Frequency	Percent	Valid percent	Cumulative percent

Valid	Strongly Agree	4	28.6	28.6	28.6
	Agree	4	28.6	28.6	57.1
	Neutral	2	14.3	14.3	71.4
	Disagree	4	28.6	28.6	100.0
	Total	14	100.0	100.0	

Of participants, 29% strongly agree and 29% disagree that social conditions are recorded.

Table 7.26: Community health risks identified

Q19 Health risks in our community are identified.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Strongly Agree	4	28.6	28.6	28.6
	Agree	8	57.1	57.1	85.7
	Neutral	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 57% agree that community health risks are identified.

Table 7.27: Community health risk discussed

Q20 Health risks with our communities are discussed.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	3	21.4	21.4	35.7
	Neutral	4	28.6	28.6	50.0
	Disagree	7	50.0	50.0	
	Total	14	100.0	100.0	100.0

Of particpants, 43% disagree that health risks are discussed with community leaders.

Table 7.28: Community engagement

Q21 Our clinic is familiar with community engagement.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	10	71.4	71.4	92.8
	Neutral	2	14.3	14.3	85.7
	Disagree	2	14.2	14.2	92.9
	Total	14	100.0	100.0	

Of the participants, 50% agree that clinics are familiar with community engagement.

Table 7.29: Quarterly engagement

Q22 We engage quarterly with our communities.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	6	42.9	42.9	57.2
	Neutral	1	7.1	7.1	50.0
	Disagree	7	50.0	50.0	100.0
	Total	14	100.0	100.0	

Of the participamnts, 50% disagree stating that they are not engaging quarterly with communities.

Table 7.30: Engagement precedes decision-making

Q23 Engagement precedes clinic decision-making.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	5	35.7	41.6	50.0
	Neutral	3	21.4	25.0	66.7
	Disagree	4	28.6	33.3	100.0
	Total	12	85.7	100.0	
Missing	System	2	14.3		

Of the participants, 36% agree that engagement precedes decision-making.

Table 7.31: Health values

Q24 Health values that are most important are prioritised.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	11	78.6	78.6	107.2
	Neutral	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the participants, 79% agree that health values are prioritised.

Table 7.32: Primary health care trends

Q25 PHC clinic trends are investigated quarterly in our community.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	6	42.8	42.8	64.3
	Neutral	5	35.7	35.7	78.6

	Disagree	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the partici[pants, 36% are neutral and 21% disagree that primary health care trends are investigated in our community.

Table 7.33: Clinical data

Q26 Data are used to resolve specific health problems in our clinic catchment area.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Strongly Agree		28.6	28.6	28.6
	Agree	13	92.9	92.9	100
	Neutral	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Of the participants, 93% agree that data are used to resolve specific health problems in clinic catchment areas.

Table 7.34: Clinical data in community

Q27 Data are used to resolve health problems in specific communities in our clinic catchment area.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	13	92.9	92.9	100.0
	Neutral	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Of the participants, 93% agree that data are used to resolve health problems in specific communities.

Table 7.35: Vulnerable populations

Q28 Nurses are advocates for vulnerable populations.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	12	85.7	85.7	121.4
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 86% agree that nurses are advocates for vulnerable populations.

Table 7.36: Ideal Clinic impact

Q29 The Ideal Clinic has brought about an improved effect on our populations health.

	Frequency	Percent	Valid percent	Cumulative percent

	Agree	12	85.7	85.7	114.3
	Neutral	1	7.1	7.1	92.9
	Disagree	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Of the participants, 86% agree that the Ideal Clinic has brought about an improvement in the population's health.

Table 7.37: Health committees

Q30 Health committees are a channel we use for participation.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	8	57.2	61.6	92.3
	Neutral	2	14.3	15.4	76.9
	Disagree	4	28.5	30.8	92.3
	Total	13	92.9	100.0	
Missing	System	1	7.1		
Total		14	100.0		

Of the participants, 57% agree that health committees are a communication channel.

Table 7.38: Health committees and ward committees

Q31 There is a difference between health committees and ward committees.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	11	78.5	78.5	100
	Neutral	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the participants, 79% agree that there is a difference between health committees and ward committees.

Table 7.39: Clinic management accountability

Q33 Community involvement in PHC essentially keeps clinic management accountable.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	11	78.6	78.6	92.9
	Neutral	1	7.1	7.1	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 79% agree thatcommunity involvement keeps clinic management accountable.

Table 7.40: Health committee governance

Q34 Health committees are an ideal governance structure.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	9	64.3	69.3	92.3

	Neutral	4	28.6	30.8	100.0
	Total	13	92.9	100.0	
Missing	System	1	7.1		
Total		14	100.0		

Of the particpants,43% agree health committees are an ideal governance structure.

Table 7.41: Health and ward committees familiarity

Q35 Health committee members are known to ward committees in our area.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	4	28.5	28.5	50.0
	Neutral	5	35.7	35.7	64.3
	Disagree	5	35.7	35.7	100.0
	Total	14	100.0	100.0	

Of the participants, 36% are neutral and 36% disagree that health committees are known to ward committees in the areas.

Table 7.42: Health committee members' photos display

Q36 Health committee members' photos should be displayed in our clinic.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	35.7	35.7	57.1
	Neutral	7	50.0	50.0	85.7
	Disagree	2	14.2	14.2	92.9
	Total	14	100.0	100.0	

Of the participants, 50% are neutral about health committee member photos being displayed in clinics.

Table 7.43: Active problem-solving

Q37 Our health committee is active in problem-solving.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	5	35.7	35.7	50
	Neutral	1	7.1	7.1	42.9
	Disagree	8	57.1	57.1	64.3
	Total	14	100.0	100.0	

Of the participants, 36% strongly disagree and 57% disagree that health committees are active in problem-solving.

Table 7.44: Communication tool

Q38 The health committee is also a communication tool within our community.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	8	57.2	57.2	85.7
	Neutral	2	14.3	14.3	71.4
	Disagree	4	28.5	28.5	78.6
	Total	14	100.0	100.0	

Of the participants, 57% strongly agree that health committees are a communication tool within communities.

Table 7.45: Extended emergency clinic hours

Q39 Extended emergency clinic hours are a need in our community.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	11	78.5	78.5	99.9
	Neutral	3	28.6	28.6	85.7
	Disagree	14	14.3	14.3	100.0

Of the participants, 36% agreed to extended emergency clinic hours.

Table 7.46: Vulnerable groups complaints minuted

Q 41 The complaints discussions with vulnerable groups are minuted.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Strongly Agree	3	21.4	21.4	21.4
	Agree	4	28.6	28.6	50.0
	Neutral	5	35.7	35.7	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 36% are neutral about complaints discussions with vulnerable groups being minuted.

Table 7.47: Collective problem-solving

Q 42 Normally we solve our problems collectively with the community.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	8	57.1	57.1	57.1
	Neutral	3	21.4	21.4	78.6
	Disagree	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the participants, 57% agree, 21.4% are neutral and 21.4% disagree that problems are normally solved collectively with the communities.

Table 7.48: Health committee membership by ward councillor

Q 43 Our ward councillor serves on our health committee.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	4	28.5	28.5	35.7
	Neutral	4	28.6	28.6	57.1
	Disagree	6	42.8	42.8	92.9
	Total	14	100.0	100.0	

Of the participants, 43% disagree that ward councillors serve on their health committee.

Table 7.49: Most vulnerable clients

Q44 The most vulnerable clients are known by our clinic.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	9	64.3	64.3	78.6
	Neutral	2	14.3	14.3	78.6
	Disagree	3	21.4	21.3	100.0
	Total	14	100.0	100.0	

Of the participants, 50% agree that the most vulnerable clients are known by the clinic.

Table 7.50: Information shared with leadership

Q 45 Health information sharing with our community leaders are held once per year.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Strongly Agree	2	14.3	14.3	14.3
	Agree	2	14.3	14.3	28.6
	Neutral	5	35.7	35.7	64.3
	Disagree	3	21.4	21.4	85.7
	Strongly Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 36% are neutral that health information is shared annually with community leaders.

Table 7.51: Language strategy

Q 46 Language strategy is in place to accommodate all groups.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	9	78.2	78.7	92.9
	Neutral	3	21.4	21.4	78.6
	Disagree	3	21.4	21.4	100.0
	Total	14	100.0	100.0	

Of the participants, 78.2% agree that a language strategy is in place to accommodate all groups.

Table 7.52: PHC concept

Q 47 People first is central to our PHC concept.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Strongly Agree	6	42.9	42.9	42.9
	Agree	6	42.9	42.9	85.7
	Neutral	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 43% strongly agree that people first is central to the primary health care concept.

Table 7.53: Racial groups infections. PHC concept

Q 48 Particular racial groups have infections more often.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Agree	1	7.1	7.7	7.7
	Neutral	7	50.0	53.8	61.5
	Disagree	4	28.6	30.8	92.3
	Strongly Disagree	1	7.1	7.7	100.0
	Total	13	92.9	100.0	
	Missing system	1	7.1		
	Total	14	100.0		

Of the participants, 50% are neutral about particular racial groups having infections more often.

Table 7.54: Effect of environmental conditions

Q 49 Environmental conditions effect on health of clients.

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Strongly Agree	4	28.6	28.6	28.6
	Agree	9	64.3	64.3	92.6
	Neutral	1	7.1	7.1	100.0
	Total	14	100.0	100.0	

Of the participants, 64% agree that environmental conditions affect clients' health.

Table 7.55: Quarterly clinic interventions

Q 50 Our clinic interventions once per quarter focus on environmental conditions

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	11	78.5	78.5	78.6
	Neutral	1	7.1	7.1	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the participants, 79% agree that quarterly clinic interventions focus on the environment (basic services – drinking water provision and refuse removal conditions). That links to diseases such as diarrhoea and other.

Table 7.56: Cultural health programmes

Q 51 Cultural health programmes remove the barriers to health care in my clinic area.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	4	28.5	28.5	50.0
	Neutral	8	57.1	57.1	85.7
	Disagree	2	14.3	14.3	100.0
	Total	14	100.0	100.0	

Of the particpants, 57% agree that cultural programmes remove barriers to health care

Table 7.57: Quarterly school health

Q 52 Quarterly health programmes are provided in schools.

		Frequency	Percent	Valid percent	Cumulative percent
	Agree	9	64.3	64.3	92.9
	Neutral	4	28.6	28.6	92.9
	Disagree	1	7.1	7.1	100.
	Total	14	100.0	100.0	

Of the participants, 64% agree and 29% are neutral to the statement that health programmes are held quarterly in schools.

Table 7.58: Descriptive statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Q4 Clinic management's role is to create a platform for community involvement.	14	1	2	1.64	.497
Q47 People first is central to our clinic PHC concept.	14	1	3	1.71	.726
Q3 PHC success depends on full community involvement.	14	1	4	1.71	.825
Q26 Data are used to resolve specific health problems in our clinic catchment area.	14	1	3	1.79	.579
Q27 Data are used to resolve health problems in specific communities in our clinic catchment area.	14	1	3	1.79	.579
Q49 Community environment conditions have an effect on many of our clients' health.	14	1	3	1.79	.579
Q5 Community involvement increases the demand for health services.	14	1	3	1.79	.579
Q19 Risks in our community health are identified.	14	1	3	1.86	.663
Q16 Involvement enhances our clinic's accountability.	14	1	3	1.93	.829
Q24 Health values that are most important are prioritised.	14	1	3	1.93	.730
Q29 The Ideal Clinic has brought an improved effect to our population's health.	14	1	4	1.93	.829

Q1 Primary health care (PHC) is about members from the community helping the clinic to identify health problems.	14	1	4	1.93	1.072	
Q15 Involvement enhances our clinic's openness.	14	1	3	1.93	.730	
Q28 Nurses are advocates for vulnerable populations.	14	1	4	1.93	.997	
Q31 There is a difference between health committees and ward committees.	14	1	3	2.00	.679	
Q34 Health committees are an ideal governance structure.	13	1	3	2.08	.760	
Q50 Our clinic interventions once per quarter focus on these conditions.	14	1	4	2.14	.949	
Q52 Quarterly health programmes are provided in schools.	14	1	4	2.14	.949	
Q33 Community involvement in PHC essentially keeps clinic management accountable.	14	1	4	2.21	.893	
Q10 Our clinic has a partnership agreement with Provincial Social Development.	14	1	4	2.29	.994	
Q21 Our clinic is familiar with community engagement.	14	1	5	2.29	1.139	
Q40 The complaints of vulnerable groups are discussed with those affected.	14	1	4	2.29	.994	
Q39 Extended emergency clinic hours are a need in our community.	14	1	4	2.36	1.008	
Q30 Health committees are a channel we use for participation.	13	1	5	2.38	1.325	
Q2 PHC is about community members developing approaches to solving health problems.	13	1	4	2.38	1.044	
Q18 Knowledge regarding local social conditions is recorded at our clinic.	14	1	4	2.43	1.222	
Q41 The complaints discussions with vulnerable groups are minuted.	14	1	4	2.43	1.016	
Q42 Normally we solve our problems collectively with the community.	14	1	4	2.43	1.089	
Q44 The most vulnerable clients are known by our clinic.	14	1	4	2.43	1.016	
Q6 Each informal settlement is recorded in our clinic.	14	1	4	2.50	1.019	
Q46 A language strategy is in place to accommodate all groups.	14	1	4	2.50	1.019	
Q8 The community is involved in our implementation of programmes.	14	1	4	2.50	.941	
Q13 The poorest communities are profiled in our clinic.	13	1	5	2.54	1.127	
Q12 Community-based organisations provide accurate information on community needs.	14	1	5	2.57	1.222	
Q25 PHC clinic trends are investigated quarterly in our community.	14	1	4	2.57	1.089	

Q36 Health committee members' photos should be displayed in our clinic.	14	1	5	2.64	1.151
Q38 The Health committee is also a communication tool within our community.	14	1	5	2.64	1.550
Q51 Cultural health programmes remove the barriers to health care in my clinic area.	14	1	4	2.64	1.008
Q9 The community is involved in the outcomes of our programmes.	14	1	4	2.71	.994
Q11 Civil society organisations often represent community health issues at our clinic.	14	1	5	2.71	1.267
Q23 Engagement precedes clinic decision-making.	12	1	4	2.83	1.030
Q14 Quarterly health interventions are held at informal settlements in our catchment area.	14	1	4	2.86	1.167
Q35 Health committee members are known to ward committees in our area.	14	1	4	2.86	1.167
Q22 We engage quarterly with our communities.	14	1	4	2.93	1.207
Q7 The community is involved with our planning of programmes.	14	1	4	3.00	1.038
Q45 Health information sharing with our community leaders are held once per year.	14	1	5	3.07	1.269
Q32 We do know our ward committee members in our clinic catchment area.	13	1	4	3.08	1.038
Q43 Our ward councillor serves on our health committee.	14	1	5	3.14	1.099
Q20 Health risks are discussed with community leaders.	14	1	5	3.21	1.188
Q48 Particular racial groups have notable infections more often.	13	2	5	3.38	.768
Q37 Our health committee is active in problem-solving.	14	1	5	3.43	1.555
Q17 Our ward councillor is known to all our staff.	14	1	5	3.86	1.292
Valid N (listwise)	10				

7.3 Data interpretation

This section covers the themes that were looked at in the questionnaire and the semi-structured interviews with members of the Ward Committee.

7.3.1 Questionnaire

The questionnaire tested the following themes, which are discussed below:

7.3.1.1 Legislative framework

This variable covers the following important topics:

The poorest communities are profiled in our clinic.

Of the respondents, 50% are neutral and 7% strongly disagree that the poorest communities are not kept in a special clinic file. Since the participants are in managing positions, the expectancy is that they must all be acquainted to the poverty index within its clinical catchment area. Given that poverty is ingrained in South African culture, it is evident that people who live in conditions that are associated with limited and low economic development are less likely to be healthy and happy. The clarification that the PHC justification is based on the equitable provision of health care services subject to the WHO Alma-Ata Declaration was provided during the interviews. Health care resources must be distributed more fairly or with priority to those who are most in need. A notable finding was that coloured communities are very reluctant to participate in clinic health committees and any other health communication structures. Whereas black communities are very active in clinic health committees and health communication structures. This notable and additional information came from one clinic manager's observation while working in clinics that are located either in coloured- or black-dominant communities.

Health risks are discussed with community leaders.

Of the respondents, 50% indicated that health risks are not discussed with community leaders. The other concern is that 29% of the respondents are neutral about the matter. The fundamental tenet of primary healthcare is the WHO Alma-Ata Declaration from 1978. The right and obligation of "the people to participate individually and collectively in the planning and implementation of their health care" is stated in Section 4. It's interesting to note that "health governance structures" have historically been used to refer to clinic committees, community health center committees, hospital boards, and district health councils in South Africa. These institutions have been set up to provide communities with a means of providing feedback and responding to decisions about the organization, planning, execution, and assessment of health care services. They also act as a watchdog on the development and implementation of health policies as well as the delivery of equitable medical services. Importantly, the National Department of Health's policy on hospital boards states that an accountable structure representing South African citizens should be part of a health governance structure.

Our ward councillor serves on our health committee.

From the participants, 36% disagree and 7% strongly disagree that ward councillors serve on health committees. The Western Cape Facility Boards Act (No. 4 of 2016) stipulates in Section 6 that the Minister shall designate a minimum of eight members and a maximum of fourteen members, with the following exceptions: (a) individuals who represent a community or communities that the health facility or facilities serve. In this instance, the ward council member serves as the community representative. Subsection (2) allows the Minister to appoint one or more elected councillors, nominated by a local council or a council health-related committee, to a board (b), in addition to the members appointed under subsection (1) (RSA, 2016).

Working with communities is important for all workers in PHC, including those who deliver clinical services. Many health workers offer their professional knowledge and expertise, and tell the community or patients what is best for them to do, rather than enabling them to make decisions for themselves. When engaging with communities about health issues, we should learn to step back from being experts and learn how to listen to and share power with the members of the community. Health workers should promote a belief in the community's capacity to be responsible for their health and to influence the things that affect them. This can be extremely challenging but when communities decide and act for themselves, rather than doing as they are told to do by outsiders, the changes they make are more meaningful and more likely to be sustained.

Understanding local history, culture and the way communities function is vital to the understanding of how to engage communities on health issues. Building positive and trusting relationships is equally important, and this begins with the process of community entry.

Our health committee is active in problem-solving.

Of the respondents, 57% indicated that health committees are not active in problem-solving at their clinics. In addition, responding to the needs of the public is mentioned in Section 195(e) of the Constitution, which describes the core values and tenets that direct public administration. Nonetheless, transparency must be promoted by providing the public with appropriate, accurate, and timely information (s195(g)), and public administration must be held accountable (s195(f)). Encouragement of public participation in policymaking is necessary (RSA, 1996).

School governing bodies were created to involve parents and other community members in the administration of education, and community police forums were created to enable communities to work with the police to combat crime (Sherry, 2018:52). A recently announced

"invited space" in the healthcare sector, Health Facility Boards (HFBs) will give communities a say in how health services and initiatives are run. Hospitals must have boards similar to these, and every clinic must have a committee made up of elected community members and staff representatives. These committees should meet on a regular basis to address facility complaints and community-affecting local health issues. They ought to organize campaigns for health advocacy and awareness, among other things.

These organizations should be in charge of the services that ought to be provided in specific locations; health managers should make decisions about how best to allocate funds and arrange services with the help of HFBs. In order to implement health plans, community representatives can mobilize available resources. Contributions of cash, land, labor, or materials for the construction of facilities or the provision of services are examples of community involvement.

7.3.2 Interviews

According to section 6.7 of this thesis, purposive sampling was used in the interviews with 12 ward committee members in Subcouncil 21 to test the themes that follow:

.3.2.1 Clinic staff in the subdistrict do not know their ward councillor

Governance system

Two interviewees argued the fact that “clinic staff are residents outside the communities they service. Most definitely they will know their leadership structures within their residential areas. Therefore, their knowledge about community leadership structures and whereabouts will be very limited and would need expansion”. The Alma-Ata Declaration recognizes that a nation's health system evolves over time in response to its political, economic, social, and cultural environment. Thus, many organisations have community consultative councils ensuring that additional voices are heard at the leadership level, as prescribed under the aspect of community governance in the model diagram marked no. 1. These councils deliver constant response, raise concerns, and priorities, and offer direction for organisations. Similar to ward committees that represents communities at municipal level.

According to Section 72(3) of the Municipal Structures Act (No. 117 of 1998), the goal of a ward committee is to improve participatory democracy in municipalities. The Act gives the ward committee the authority to thank anyone on any matter pertaining to the ward. Through their ward councillors, ward committees are able to submit recommendations to the executive committee, the municipal council, the executive mayor, or the relevant metropolitan sub-council.

Another interviewee thinks that the new ward councillor is thew incumbent with a strenuous task to familiarise the area and gain the confidence of the community, taking into consideration that the ward councillor lives outside that particular community.

The Western Cape Facility Boards Act prescribes ward councillors' membership in hospitals, health facilities, community day centres, clinics, and community health-centre committees and forums. The rationale for this committee is to enhance engagement on matters affecting the communities or wards.

Communication

Ward Committee 1 (WC1) interviewee suggested that ward councillors must introduced to clinic staff in a formal manner. The Mayco portfolio member for health should action this. A good example is the Villiersdorp traffic department's impressive communication sheet showing the ward committee (community leadership structure) including pictures, and contact details. Thus, it is essential to share ward committees contact details and portfolios with clinic staff. The Ideal Clinic strategy outlines annual open days. The mere fact that ward councillors are not known to staff, indicates concern or question about the hosting of annual open days at clinics, as prescribed in Chapter 5. For this reason clinics a legislative requirement is that clinics should host open days. The rationale is to link ward councillors and community leaders with the clinics.

Accountability and efficiency

The ward committee 1 (WC1) interviewee referred to two incidents, about one of which he advised the clinic manager. This resulted in an argument. According to the interviewee, the clinic manager's interpretation was that he want to tell her how to execute her duty. According to him, this was not the case. The matter regarded a wheelchair ramp and the risk management of the patient. The second observation is about how senior citizens have to endure early hours – from 06h00 and long periods of waiting outside clinics.

Disengaged staff

According to WC1:

We have picked up most of the clinic staff regards community leaders as people that want to tell them how they need to have to do their jobs. While we are trying to reach out. The big problem currently is most of our staff at our clinics. They don't necessarily live in that community. For them is just a job that is not really about me serving my community.

Interprofessional

WC1 explained:

So what I am saying: The moment you expand, you incorporate your community structures and your leaders. I will promise you that is when people will start to embrace that facility as our facility. It is our colleagues umm, umm colleagues, our staff, it is our people we need to look at. But currently, it is them and us.

It's about relationships, man, Currently there is no relationship between your clinics and the community. Even your local ward councillor. He does not have a relationship them. Because that is an obstacle, the moment you address the relationship. You have that regular engagement. Whatever concerns and issues you can raise within that environment and the moment out of relationships. Trust will grow, respect and everything and I can promise you later on people will go out of their way. If I may use my example. When I was the chairperson of the school governing body. You know just because of my relationship with the school being the chair. I then went out of my way. Because I had certain linkages and contacts. I can take you back to that school today, because they did not have a proper sports facility or field, err lack of classrooms. Even the lack of proper fencing. You can even go back to that school today. We, I secured sponsorship to develop that sports ground properly. Emm, sponsorships to develop extra classrooms not mobile, properly. So out of relationships. I promise you when you engage and they say. We have a lack of staff, lack of resources, and lack of that. That can be addressed. Just because of your relationship with your community structures and stakeholders. That can be addressed because I know. How I am connected elsewhere and I know my other community members also. So at the end of the day. You can have a facility that the community can be proud of and say. I played a, might have been a small contribution so that.

Collaborative approach

WC 1 said the following:

Do it holistically. Include, incorporate, we have academics that does, have done research in varsities, Stellenbosch, UWC, UCT, and CPUT, um all of those academic institutions have done excellent research. Why don't you use most of those recommendations that were made in reports? I mean most of those guys. They are professors and doctors today but I don't see their recommendations implemented. So it's time that government takes those recommendations too seriously. Because it was done by people that have done extensive research. And the other thing is, especially us as church leaders. You know especially with COVID, everything was done. Government has put measures in place err emm measures in place. But have forgotten about us as a community and especially church leaders. Were only able to open our doors to the buildings of our churches to provide food for our community. But we were never really regarded as an important stakeholder to see how can we collectively tackle this issue and, bring us into their confidence and share. Because err, COVID was still unknown. Nobody knew where this came from. That is why we only had to hear from the President on television as to the way forward certain things. But locally, we had things, especially from the government that were put in place disaster. Whatever, whatever, but community leaders, church leaders we were never consulted. My thing is relationships, stakeholders err emm and also beside your academics, civil society that is now the Gift of the Givers. We only hear of them, but there are a million other civil society organisations in our country and especially here in our communities. They need to engage those umm umm structures as well. Because they sit also with umm, umm in-depth experience. And sometimes some of these civil organisations have linkages to other countries. Where some of them even went to other countries to be empowered and have a better idea of how to resolve certain issues. Because currently I think, the government feels he has a budget. He must spend that budget and because he has to account for the sense, he can't involve other stakeholders, err because he is in control of the budget. And that is the mistake emm, err knowledge is power. I believe that there is no single person. God has created us like that. No single person has the answers to everything. But collectively as a community and that is now government, civil society your academics everyone. Collectively we can deal with and tackle issues. Like your HIV and AIDS it. The TAC Zachie Achmat and that, they had to force the government. They had to go to court. Remember TAC was an outside, outside of government. Because the government at that stage did not regard HIV as a crisis as a reality. So it had even civil society had to send people out of the country. (You bring in a good point there as an example because if I look at it err if any other condition. Can be substance abuse you know, that is almost as Pastor is saying. That

model of TAC can be followed by the same root). The government had a stance on HIV, but the TAC we, at that stage, I was involved with the unions together with TAC. Putting pressure on the government saying our people are dying children are dying we need the ARVs. We need the ARV asap. But the government had its stance, so we had to go to court. To force the government. Today there is a policy not because of the government that moves. Because the courts compelled the government to move. So what I'm trying to say. We had from civil society, we had the resolutions the answers to everything. So that is why I'm saying. Government can't think they have all the answers. No. There are a lot of people in our country (WC 1).

7.3.2.2 How are the health matters of the poorest of the poor addressed?

Regarding the health issues of the poor in terms of community profiles at clinics, which comprise the social determinants of their health, 50% of the participants were neutral, and 7% strongly disagreed. Given that Florence Nightingale, a nursing pioneer, believed that both individual and community health are influenced by environmental factors, this is a serious concern. The core of the primary healthcare philosophy, founded on the idea of equity and established by the World Health Organization in 1978, is the poorest of the poor. In answering this query, the participants went into further detail:

Access to health services

WC 1 outlined:

Currently, the poorest of the poor are expected to travel from Kuilsriver to Bellville. I don't have money. Homeless people, no one comes out. I said why don't you look at this building in terms of rolling out as a proper care facility as a clinic? But especially for adults. Yes, we have the one for the children and the babies. But we need somebody because the poorest of the poor and elderly people have to travel to Bellville. And it does not make sense. It does not make sense to me. How do you expect the poorest of the poor? I don't have money. The taxis are so much (WC1).

Ward Committee 2 (WC2) interviewee:

The big issue with the Northern area is the greatest housing developments. Has taken place here in the last 10 years. But you can see housing developments popping up here like popcorn. But the provision of services has not kept up. And that goes across health, schools, clinics imm police stations. It has not kept up. And often the basic infrastructure is the water, the sewerage infrastructure (So there's not a parallel with the development). Far from it. So you gonna get this 1000 plus, you know, residents

coming in. Where are they gonna access schools? The schools are bursting to their seams. There is another out of those 1000 units. Say there are 500 children. Who is gonna come in, where are they gonna go to? They can't go to Khayelitsha how are they gonna get there? Because they want access here. Services and population growth or new housing developments are not 100 percent.

I know for decades people were being advocated for, if I got the right term. What do they call (a community health centre)? A community health centre (so it's like 24/7). What's in Delft, something like that for Kuilsriver? Because Kuilsriver people if they have any crisis. They go to the Delft clinic and then they are referred to Eersteriver. You can't just walk into Eersteriver. So that is being advocated for a long time.

Public safety

WC 2 Interviewee:

There is not a day that has gone by that someone doesn't get robbed on their way to the taxi rank. And if you live in Sunbird Park it's not just a matter of getting to the taxi rank. And if you live in Sunbird Park, there is very little that someone from the taxi will turn down that road in Silversands and drop someone at the clinic. It's not also about taking one taxi; it's about taking two taxis to get to the clinic. And for a mommy with a baby to be at the clinic at 06h00, so that she can be on time, you understand my point? There are a lot of things geographically; the clinic is at a spot, that is not safe for our people to go to. Umm, I don't know what the City planned to build a clinic that is not accessible to people. If I look at the clinic in Blue Downs, then that clinic, that clinic would love many of their clients with young babies or grandchildren. (So it will be a young mother aged 18, 19, 22, or 24 years. so forth. So what you are saying). It's unsafe, it's inaccessible, okay. Due to this unsafety and geographic is this first-hand knowledge?).

Yes, it is. I can say I can tell you that I know of people that stay in Sunbird Park that lies about their addresses just so that they can have access to the clinic. In Kuilsriver. Because it is about it is better accessible, it's one taxi up. You understand my point. Some of the Ubers don't even want to drive there at the back.

Because the CODETA/COTSATA taxis and whatever target them. We, as the people staying in Sunbird Park, can't take a Uber to Shoprite Blue Downs because Uber can't stop them, they target them. With going to social development, they are being targeted by the COSATA taxi, you understand. So it's not that the safety matter of walking to

the clinic. It's the safety hazard of taking your transport to the taxi. (Okay, I see the obstacles). And the cost, it's costly. (So it comes back to what you have said). The premises, (if there is a certain community hall). I can tell you if there would have been a clinic in Old Nooiensfontein that clinic would be full every day. I would like Eerste River because it's accessible and it's a safe road.

That clinic is accessible for Blackheath it's a safe road. That clinic is accessible for Blackheath, Happy Valley to a certain point. And there is a field, which is also not safe. Because if you ask the ladies from Happy valley, why don't you go to the clinic? They say Auntie you need to be there early. And you get robbed walking to the main road and over the field, you need to wait till it's light and wait for someone to walk with you still.

Infrastructure

Interviewees WC1, WC2, WC3 and WC4 all agreed on the matter of lack of infrastructure in informal settments:

Informal housing areas are not easy accessible owing to no infrastructure, such as roads, safety and security and halls. So that clinics can go out and provide services to such. Two interviewees mentioned mobile services in previous years. However, they said the lack of safety and theft will not permit such services. Therefore active planning with all stakeholders is very important and priority must be given to vulnerable groups.

Ward Committee 3 (WC3), Interviewee.

There is a lack of infrastructure in informal settlements and also there is now, sewage in the informal settlements. There is hardly any water in informal settlements. You find the one that has and the next one has been skipped, it is just an interflow of lack of a lot of things that should be basic in communities. And I jotted, definitely the lack of basic infrastructure.

Vulnerable groups

WC 4 stated:

That I bring another thing under your attenttion. Don't think for one minute that is because people staying in this area that they not suffer. The area is what it is, because

of what it was and given in the apartheid years. The people of colour found the area and the houses like this. So, it doesn't mean that we are, because I've seen it in COVID. I delivered packages to people in my area. Even though their house was neat. But nothing was happening in their household; they also didn't have food; they also waited on those packages. They were thankful that the poor of the poorest. That to me was the first time that I realised, the (need) in my community. I found sick people, people with stage four cancer, people who had strokes that were just living quietly in there. But I got it privately, I got private because when I posted we are going to hand out care packs from the Councillor and people must contact me privately, and if there is a need I will come to them. That's when I realised, oh my, I go out to areas thinking. But it's happening right here under my nose. (Something very thoughtful, and insightful for the mere fact, in other words. Bring that back to health a person may stay here, daughter stays on the same premises. But they are dependent on public health services). They don't have medical aid, and half of the people in this area do not have medical aid. Because why, yes they qualify for this house, but the bulk of that money that they have left now is going into that bond. The money that they have left now is for the car, daily living school fees. (They barely make it). They barely make it, but why they decided to rather raise their children in a better area? (Who won't). Who won't? You understand, so that's where I realised, so back to the question. How are the health matters of the poorest of the poor addressed? I, when, let me start with awareness campaigns that I saw on TV already. Those are the things that we, that I normally feed off. If I see anything on the news or a social media platform. I always try and get that information and send it out in the community in general. How has it been addressed? Is it now from my side as a ward member or in general? Because if I just speak in general, what I've seen in the past is campaigns or awareness programmes from NGOs, how they make people aware of what they can do or what is at their disposal in the areas. That I've seen; how effective it is, I don't know. (This point is also explored. (I think you as emm you are in the capacity of a leader. Because that emm like I, you must just correct me if I'm wrong. That spurred you to post this message on social media, because the ward councillor is your primary leader, and you are a subleader because you as a ward member report to her. She had these care packs and you did emm the accountable action by posting it on your residential in your ward. Yes, you did the right thing and you had a response, and now with the response. You discovered, but here amongst my ward is the poorest of the poor.) That's correct, shockingly. (Obviously, I do not expect you to give, emm at this number that number). Yes, that's personal and private. (That made you come in contact with people at your

doorstep). That's correct, ya. So now I tap into people, they will ask me things on the side or find out and I had my list of people that I go to and it's mostly seniors, right? Yes, their bonds are paid but they live on a pension. (Yes, yes). But half of that pension must now pay the utility bills and things, and then they are left with R500-00. (So that made you more empathetic, towards raising your voice in those meetings.

Ward Committee (WC2), interviewee:

Because sometimes, especially in vulnerable communities, sometimes they have to get up at 05h00. They have to travel early; there is maybe no transport money to go fetch the tablets. Umm, some of these seniors, their feet are swollen. They can't even move. A vehicle must be found to take them to the hospital and most of the time in the hospital and most of the time in vulnerable areas these people do not have money to go and even get that early to the hospital at a certain time. They don't get a number which means they have to come back. And these poor people sit there the whole day with their bodies already sick and frail. Then they have to sit there on that hard desk. And if I think of some people who must go fetch their tablets at Reed Street. They must go sit outside and wait for their tablets. (You speak as if you know some of these people). Yes, my mother fetches her tablets at Reed Street. and what we do is my sister goes on her behalf to fetch her tablets and sometimes my sister leaves here at 05h00, and then she comes back at 15h00 at 16h00. So you can imagine if it was my mother sitting. (yes). You mentioned my point, Umm, I mean if I think of Auntie Gairo, just last week she went to fetch her tablets. She has to take a Uber at 06h00. She paid R280-00 to go to Eersteriver, (Eersteriver, is that the hospital?). The day hospital, yes, (or Kleinvlei?). Something like that. But yes, she has to now imagine her son paying that for her. With the pension they get, on the 20th, there is no money. Even during COVID time, the home base nurses went to fetch the tablets. The implementation of that practice was very valuable to the community because people got their tablets. They could drink their tablets. They did not have to wait till the end of the month to go fetch their tablets. (oh, so during the COVID, it was brought to their home, so that Auntie Gairo received her tablets at home). Yes, (so if you see, what you previously said is contrary to the primary health care definition. Because it says here, "to be accessible to individuals and families at a cost that they can afford, but now it was mentioned that the Uber money is R280-00). Only up, because of that time of the morning. You understand. She took public transport, a taxi back which is two taxis to travel to Kuilsriver and from Kuilsriver another taxi. But they booked a Uber that time of the morning. So she can get there early. I mean having your mother, having to walk

down to the bus stop to take a taxi at that time is not safe in context what you are explaining. (That question is also explored).

Public transport and public safety

Ward Committee 2 (WC2) interviewee:

Because they were being robbed and everything; that's why we suggested they wait here. And then the people come and fetch. But I mean it's like walking distance. (I see what you are saying. It comes back to the point if that portfolio is perhaps filled. Then these matters could have been addressed). Yes, exactly. (Maybe a solution can come up like, why my place is here open. I do have a container. Why can't they dispense here?). Exactly (Maybe the 120 people at this specific time, can dispense). And that is what happened if their mother can't make it and the nurses are here? They notify me and say my son when he comes from work he will come to pick it up. Because my feet are swollen or I don't feel well. So thanks. No. 4 is covered

Service inequality

WC2 Interviewee:

*Do you know when they take them on, there is a whole length of paperwork? Can you think of someone that's not educated at all? (*Researcher: *Like really, Councillor Mare). So, if you ask me how are the health matters of the poorest of the poor addressed, I would say poorly. Because the same type of service you receive here is not the same type of service that you will receive in Goodwwod and Vasco. (Why do you, can you? Not to give a long, shortly but). Well, I can tell you when I was married I stayed in Tokai. If I compare the experience of social development or I experience the life of the service when you stay in Kirstenbosch compared to umm. Mfuleni, because I've experienced the other side where money is concerned. Whether it's a public hospital or not, because I was raised in Goodwood, Wallus Street, there where the Libertas hospital is. So I mean, I can clearly remember the type of treatment that I received. The treatment I received at the clinic in Goodwood compared to, you wouldn't see people standing queueing outside in Goodwood clinic, would you? No, you won't, there's an area for them to come and sit. Umm, you don't have to. In those clinics, you don't even sit the whole day also.*

If you compare the service delivery for Kuilsriver clinic, in Kuilsriver compared to Mfuleni would it be the same? Nope, it's not the same. (So you say there is a service discrepancy amongst clinics). Yes, amongst classes, amongst certain areas, there's a difference.

There's a difference. You don't have to look at the clinic, you can go to Shoprite or any SPAR and you will see the difference in service delivery compared to that place compared to the area. (Okay, I will leave it at that. So, lastly you would have seen a different outcome for that particular; they would have been in a formal area or just outside this catchment).

7.4 Summary

This chapter detailed the answers provided by the participants in the semi-structured interviews and questionnaire survey that were administered to the sample, which consisted of Subcouncil 21 ward committee members and clinic managers in the City of Cape Town. The gathered data were examined and evaluated. Tables and statements were used to display the data.

CHAPTER EIGHT:
OVERVIEW OF MODELS FOR PRIMARY HEALTH CARE MODEL AND A NORMATIVE MODEL FOR PROVISION OF PHC

8.1 Introduction

The analysis and justification of the data were covered in the previous chapter. This chapter looks at the models that are currently in place for involving the community in the provision of primary healthcare services.

An overview is given of present models in public participation, an interchangeable term, as outlined in Chapter Two. Arnstein (1969) has conceptualised eight rungs from lowest to highest degree of community involvement, following: 1. manipulation; 2. therapy; 3. informing; 4. consultation; 5. placation; 6. partnership; 7. delegated power; 8. citizen control. Ideally, citizen control occurs when residents can govern a programme, be in full charge of policy and managerial features, and be able to discuss the circumstances under which outsiders may amend them. This factor coincides with the primary health care (PHC) definition which emphasises health care that is universally accessible to individuals and families in the community through their full involvement in a cost-effective method. Therefore, the model for health and well-being is centered on the Canadian concept incorporating determinants of health, community governance, accessibility and accountability, among a total of eight concepts of comprehensive and public health, including for poverty-stricken communities.

8.2 Models

A model is an idea or concept that is represented physically, orally, mathematically, or graphically (Bezuidenhout, 2014:48). Models are created to simplify theoretical concepts or to understand a phenomenon, eliminating unnecessary details, and simplify understanding. The model contains just the necessary points; hence, a comp A model is an idea or concept that is represented physically, orally, mathematically, or graphically (Bezuidenhout, 2014:48). They are mostly used to explain how a concept or theory can be simplified using a model. On occasion, models can be seen as the application of theory, consisting of boundary conditions for a singular group as it serves projections on the related theory. Models assist us to identify and illustrate the most important concepts of a theory and the dynamics of the relationship between concepts, allowing the researcher to depict visually something that is otherwise difficult to explain. Because of their nature, models illustrate the ‘what’ of the concepts of a theory (Bezuidenhout, 2014:48). They are mostly used to illustrate how concepts of a theory are related, and cannot be used in isolation to explain a theory (Bezuidenhout, 2014:48). It captures the important aspects of the thing being modelled from a certain point of view and

simplifies or omits the rest. Models permit the researcher to visually depict something that is otherwise difficult to explain.

Models are broad conceptual structures that provide holistic views and specific foci of administration, nursing or various disciplines (Alligood, 2014:43). They serve as organizational frameworks for specific nursing practice vantage points, such as self-care, interaction, person-environment processes, and adaptation. A model in research is a visual aid that illustrates important ideas. It illustrates the relationship between different types of variables, such as independent, dependent, moderating, mediating, etc., using arrows and other diagrams. A model is a mathematical representation of a firm, a market, or any other entity that is based on economic theory, according to Pindyck et al. (2009:6). For example, we might develop a model of a particular firm and use it to predict by how much the firm's output level will change as a result of, say, a 10-percent drop in the price of raw materials".

An essential component of successful research projects is a theoretical model. Models are frequently used by academics and other practitioners to organize their thinking and aid in their comprehension process. Gaining a basic understanding of them is essential in order to decide which aspects of them to include in your research. These models are outlines created by researchers to plan how to approach a thorough research analysis and to organize a study process. It can help you formulate a clear research goal and develop a well-informed opinion. the creation of a review of research viewpoints. Create a research question first in order to give your theoretical model direction.

Next, decide on a broad topic that piques your interest, and then choose a narrow subset of that subject to focus on. When crafting a compelling research question, make sure there are plenty of options for you to investigate and evaluate in order to form your own opinion. For instance, what elements influence young people's attendance at clinics? To what extent can medication be used to treat migraine headaches? Which marketing techniques boost sales in the spring? Krosel and associates, 2017:3). Brink et al. (2015:26) claim that there is inconsistent use of the term "model" in the literature. Even though the terms are frequently used interchangeably, some writers make a distinction between the two and consider a model to be the foundation of a theory. Most people agree that a model is a symbolic representation of reality. It employs diagrams or symbols to represent concepts and gives a schematic representation of specific correlations between phenomena.

A model helps us organise our ability to evaluate a situation, thing, or people. A model can help us define and direct specific research tasks or provide an organized framework for health sciences research (Brink et al., 2015:26).

8.2.1 Distinguishing between a model, theory and paradigm Model

A simplified representation of a more complex reality, a model can be used to clarify and elaborate on the relationships between variables and, in some cases, even to suggest how something should happen. Consequently, models can be used normatively to convey a preference for a particular value judgment or neutrally to describe something. Models are built around the interactions between specific concepts (Cloete & De Coning, 2018:34).

Theory

A theory is a thorough, systematic, dependable explanation and forecast of the interactions between particular variables (e.g., the theories of democratic and revolutionary change). It is built using a variety of ideas and models and makes an effort to provide a complete explanation as well as forecast future events. Additionally, theories can be applied prescriptively, as in the public choice theory of democratic policy-making, or descriptively, as in the case of the systems theory of the policy process. Theories are usually judged on their ability to predict the future, while models are usually judged on how well they represent reality. However there are often overlaps in the practical applications of these two concepts, which can sometimes make their differences less apparent. Theories function similarly to binoculars, enabling us to see distant objects within our immediate fields of interest. Images are focused, enlarged, and enlarged with binoculars (Bezuidenhout, 2014:37).

Paradigm

A paradigm is an ideological group or pattern that creates a broad, prescriptive intellectual framework or method for scientific endeavors. These ideologies include, but are not limited to, Darwinism, globalism, feminism, fascism, nationalism, liberalism, Marxism, and apartheid.

If a paradigm is widely acknowledged within the relevant scientific community, it is considered dominant. An authoritarian approach to public policy, such as one that favors or opposes evidence-based versus opinion-based policy-making, is known as a policy paradigm. Reducing prevailing confusion about the nature and application of paradigms can be accomplished in part by examining the relationship between policy ideas and paradigms. We depend on the first explanation of policy paradigms and the lessons that can be applied to

policy analysis and assessment when employing this conceptual tool (Cloete & De Coning, 2018:34).

Table 8.1: Levels of conceptual analysis

Paradigms/Ideologies (e.g., positivism, relativism, developmentalism, capitalism, socialism, liberalism, conservatism)
Theories (e.g. of democratic, social, economic, cultural change)
Models (e.g., systems, programme logic models)
Concepts (e.g., poverty, empowerment, equity, sustainability, inputs, outputs, outcomes)

Source: (Cloete & de Coning, 2018:34)

8.3 The ladder of citizen participation

In order to explain the body of knowledge that managers must possess in order to carry out their responsibilities efficiently, the study examined management theories. The current school of thought in public management was also mentioned in the study as a framework for thinking about interventions that would improve performance.

Arnstein released a "Ladder of Citizen Participation" in 1969. As one goes up the ladder, from low to high, Figure 8.1 shows how citizen participation in decision-making processes varies. Its importance in non-American contexts cannot be emphasized, despite its value in America, as it contributes to our comprehension, characterization, and examination of the mechanisms underlying public involvement in decision-making. Citizen power should ultimately result from the governed's participation in matters of governance, as stated by Arnstein (1969:216), which is considered the "cornerstone of democracy." The "have-nots" participate in the decision-

making process through participation. People or groups of people who are typically left out of decision-making processes are known as "have-nots";

consequently, these people are usually the weaker, less fortunate, and poorer people, like Black people, Native Americans, and refugees (Arnstein, 1969:216). Arnstein (1969:216) compares citizen power to highlight the significance of citizen participation. According to her, citizens have the right and the responsibility to engage in decision-making (Connor, 1988:249). Limited or nonexistent participation emasculates the poor because it raises awareness of their deprivation.

***Non-participation**:*

The bottom two rungs of the ladder, (1) manipulation and (2) therapy, make up this phase. According to Arnstein (1969:218), involvement during the "manipulation" phase serves only the authorities' objectives and is not advantageous to the participants. The steps listed above represent the lowest level of involvement. Because it only aims to "educate" or "cure" the participants, there is little expressive citizen participation.

***i. Tokenism**:*

There are three steps involved in this: (3) informing; (4) consulting; and (5) placating. Participants can choose to participate, but they cannot guarantee that their suggestions will be taken into account. Participation from citizens does not yet have the power to alter the status quo. Placation, namly rung number 5, is effectively a more advanced form of tokenism since, although citizens can advise those in charge, those in charge have the last word in decisions, regardless of whether or not they consider citizen advice.

***ii. Citizen power**:*

This is the highest level of citizen participation, consisting of three steps, where citizens have varying degrees of decision-making authority. Citizens can now form partnerships in order to negotiate and interact with those in positions of traditional power. Delegated power and (8) citizen control represent the second rung of the ladder, where citizens maintain the majority decision-making authority while participating in the decision-making process. Decisions are made with input from the public and are under their control (Arnstein, 1969:221). This stage represents the complete detachment of citizens from the process of making decisions.

Because they are a component of the decision-making process, they have a direct impact on public policies (Muronda, 2017).

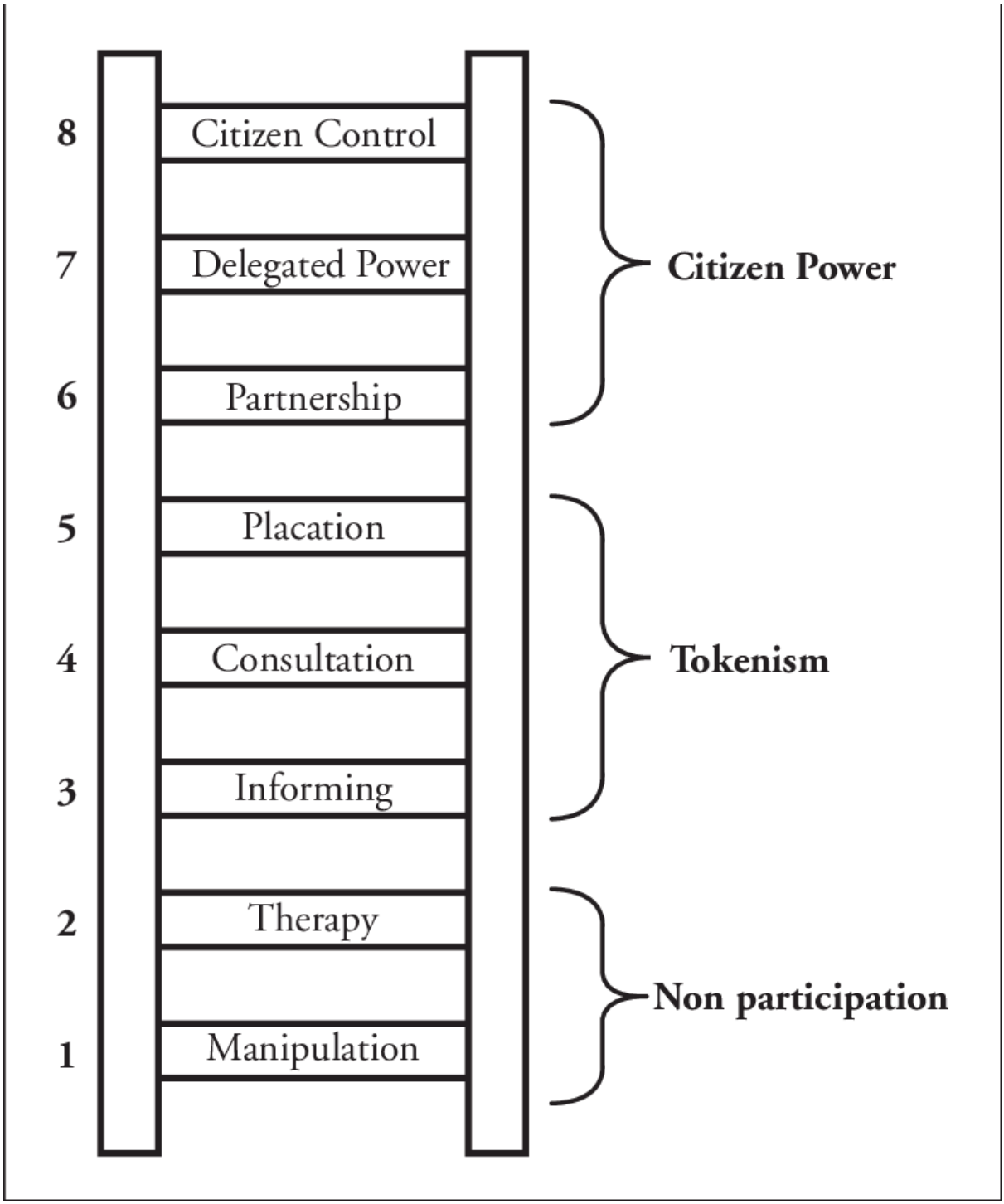


Figure 8.1: Arnstein's ladder of participation

Source: (Arnstein, 1969)

As "pvotal to enhancing a genuine partnership between parties to any development, a partnership which can be construed easily as the highest stage of the working relationship between different people brought together by commitment to common objectives, bonded by long experience of working together, and sustained by subscription to common visions," In order to encourage active citizenship, UN-Habitat (2002:8) highlights the importance of incorporating beneficiaries in the development process.

Put simply, "power with" and "power to" participants are promoted by Arnstein's ladder of citizen participation, which is supported by UN-Habitat. In the same way that it promotes high-level collaborative decision-making, this teaches a true participation process.

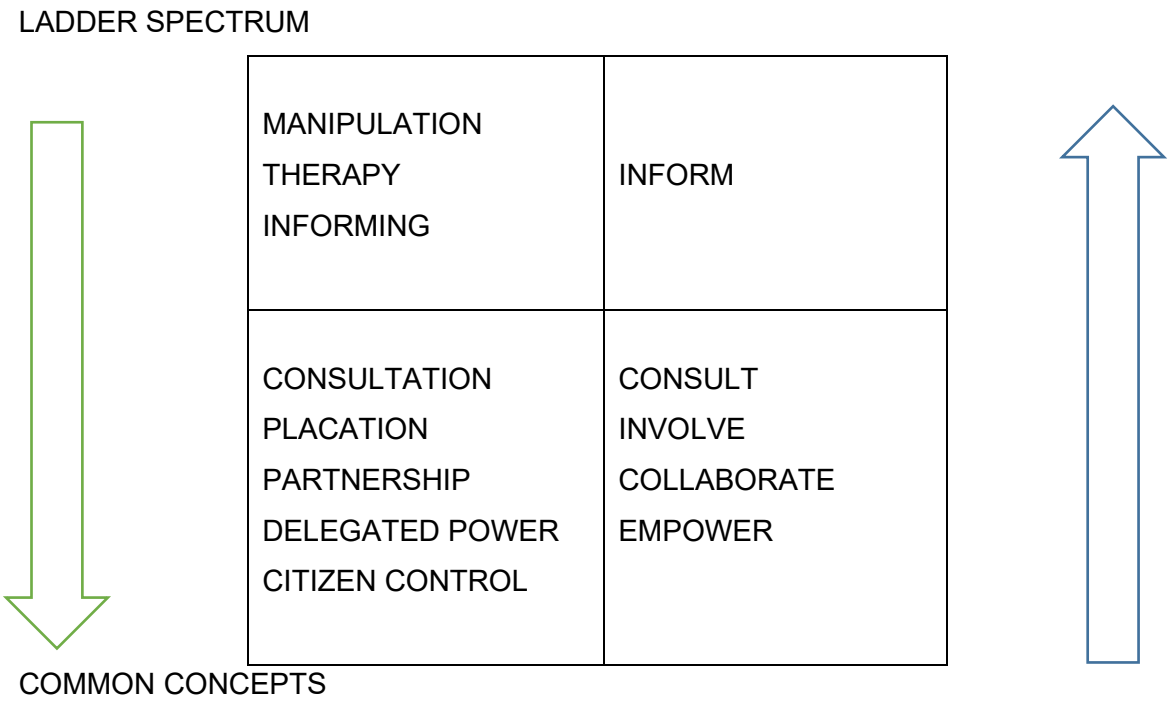


Figure 8.2: Active citizenship

Source: (Mdunyelwa, 2015:25)

It is also claimed that the eight steps of the ladder of participation exist (Simmons et al., 2006: 576). They conceptualize this ladder of participation as having just three steps, as shown in Figure 8.3. These three decisions came about as a result of consultation. Formal mediation, official representation, and self-management are the results of consultation, according to the three ladders of participation. The authors contend that although empowerment and engaged citizenship are necessary for self-management, there is some implicit or implied dependency

between these two processes. However, both theories make it abundantly evident that the ideal higher-order condition is one in which individuals have the autonomy to speak their minds, take control of their surroundings, and shape their own future (Mdunyelwa, 2015:24).

Figure 8.3, which reproduces a best-fit method by adapting Arnstein's ladder of participation, shows that the opportunity for public input to impact or influence the process increases with each level of public participation.

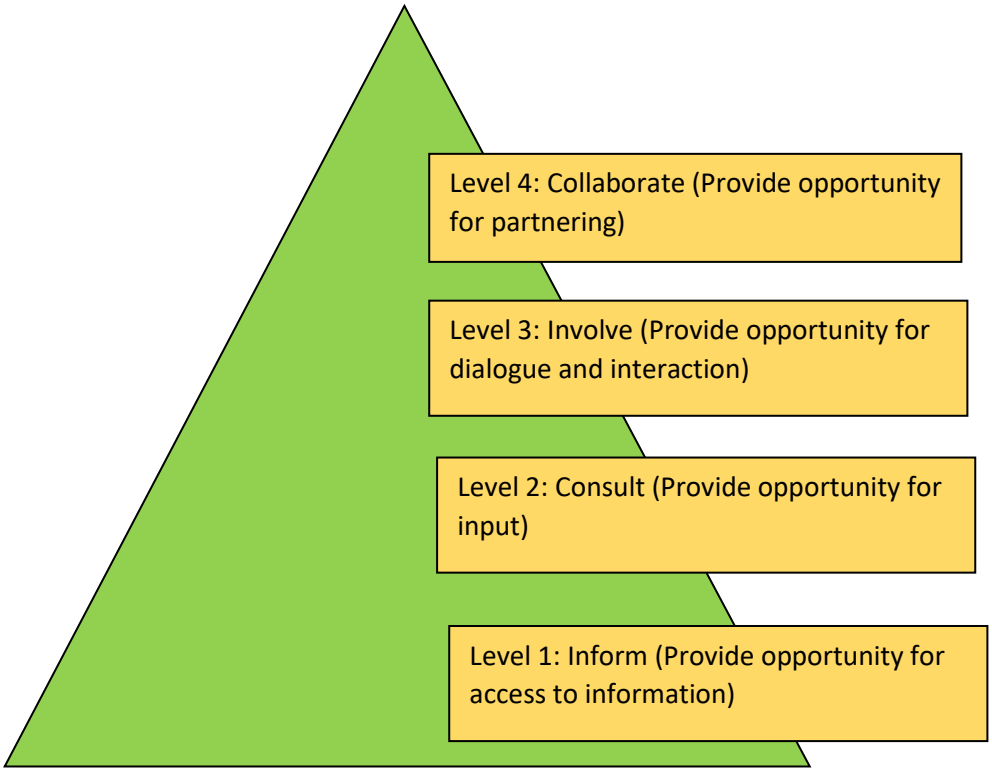


Figure 8.3: Ladder of participation

Source: (Simmons et al., 2006:576)

8.4 The International Association for Public Participation

The International Association for Public Participation advocates a spectrum of participation ranging in the continuum from informing communities to empowering such communities, in contrast to Arnstein's (1969) eight stages of participation. According to the model, empowering entails giving the public the final say in decision-making, while informing calls for the straightforward distribution of reasonable and objective information to assist them in considering the issue, potential solutions, and/or alternatives. In conclusion, the Association

provided a set of fundamental criteria for public participation of some sort so that people and organizations could evaluate adherence to participation values. This standard comprises the following elements:

- People who might be affected by or interested in a decision should be sought out and encouraged to participate.
- Participants should also be asked for feedback on how best to participate, given the information they need to make a meaningful contribution, and
- informed about how their involvement will affect the decision.
- The belief that people who are impacted by decisions are rightful to be involve in decisions. On things affecting the lives.

Table 8.2: International Association for Public Participation:spectrum of public participation

Public participa-tion goal	**Inform** To offer impartial, unbiased information to the public in order to help them comprehend the issue, potential solutions, and/or other options.	**Consult** To get opinions from the general public regarding analysis options and/or choices.	**Involve** To actively collaborate with the public at every stage of the process to guarantee that their goals and concerns are continuously recognized and taken into account.	**Collaborate** To collaborate with the public on all decision-making processes, including developing potential solutions and determining which is the best option.	**Empower** To give the general public the authority to make final decisions.
Promise to the public	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns, and aspirations, and provide feedback on how public input	We will collaborate with you to make sure that the options that are developed accurately represent your goals and concerns, and we will give you feedback	We will seek your counsel and inventiveness when developing solutions, and we will make every effort to incorporate your suggestions and counsel into our choices.	We will implement what you decide.

		influenced the decision.	on how the public's input affected the choice.		
Example tech-niques	*Facts sheets *Websites *Open houses	*Public comment *Focus groups *Surveys *Public meetings	*Workshops *Deliberative polling	*Citizen advisory committees *Consensus building *Participatory decision-making	*Citizen juries *Ballots *Delegated decision

Source: (International Association for Public Participation)

As has been mentioned throughout the conversation, the two highest levels of participation that must be reached for participation to be deemed to have occurred are, in accordance with these theories, citizen control and empowerment. Equal theories support the importance of citizen control as the ultimate goal of active participation. The International Association of Public Participation's theory specifically opposes the two theories against which the beneficiaries' participation will be evaluated through focus groups and empirical research (Nabatchi, 2012).

8.4.1 Inform

This is the highest level of citizen participation, consisting of three steps, where citizens have varying degrees of decision-making authority. Citizens can now form partnerships in order to negotiate and interact with those in positions of traditional power. Delegated power and (8) citizen control represent the second rung of the ladder, where citizens maintain the majority decision-making authority while participating in the decision-making process. Decisions are made with input from the public and are under their control (Arnstein, 1969:221). This stage represents the complete detachment of citizens from the process of making decisions. Because they are a component of the decision-making process, they have a direct impact on public policies (Muronda, 2017). When information is disseminated to the public, it should be as accurate, factual, and objective as possible. The public should also be informed about the rationale behind the choices being made by front-runners, such as elected governments, public administrators, and school administrators, through an information-gathering process.

However, an information-gathering process can become challenging when leaders exhibit ambiguity and omit crucial or required information, or when they present biased information to mislead the public and manipulate opinion. The most dangerous kind of information-gathering procedures are those that are used as management tools to manipulate legitimate public concerns or trick the public into supporting a decision or course of action that is not in their best interests.

8.4.2. Consult

"Obtain public feedback on analysis, alternatives, and/or decisions" is a consultation process's declared goal (Nabatchi, 2012). Participants offer their thoughts, opinions, or preferences during a consultation process, and leaders base their decisions on this information. When implemented effectively, a referral process gives public servants and school administrators a better understanding of the priorities, needs, concerns, and values of people whose decisions will be impeded, which strengthens the decisions made during a decision-making process. A consultation process can, however, become motivating if leaders ask for input from the community but do not act upon it, or if they leave out significant stakeholder groups or constituencies, such as communities of color or young people. When a consultation process is incoherent, it can, at worst, cost the public a lot of money and time while yielding few concrete results, or it can be designed specifically to create the impression that the public has been heard when, in fact, leaders are ignoring—or perhaps never planned to act upon—public recommendations. Public trust in a decision-making process and public institutions generally can be damaged by dishonest or inefficient consultation procedures (Nabatchi, 2012:3).

8.4.3. Involve

"Work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered" is the stated goal of an involving procedure (Nabatchi, 2012:3). In an involving procedure, decision-makers such as public representatives and school administrators organize and facilitate active participation from participants in the decision-making process. A procedure is most beneficial and effective when it involves the public in significant ways, such as training them to be facilitators or giving them some level of leadership authority, like chairing a committee. From the outset of the process—when an issue is discovered and a suggested method to resolve it is refined, for example—to the conclusion—when the process is reviewing its results—the public is also involved.

However, if leaders and coordinators do not give the public participants the information, support, training, or other forms of assistance they may require to participate fully or competently, or if the public participation opportunities are not genuine, then an involving

procedure may become problematic. As an illustration, consider the situations where frontrunners are "forced" by policy to involve the community in a decision-making process, but they only comply or overrule participant decisions they find objectionable (Nabatchi, 2012:4). In the worst case scenario, a procedure involving people could be so badly run, dishonest, or even fraudulent that the public begins to distrust those involved. Alternatively, it could be deliberately and selectively exclusionary, authorizing some people, groups, or perspectives over others.

8.4.4. Collaborate

"Partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution" is the stated goal of a collaborative procedure (Nabatchi, 2012:4). Public employees and school administrators work together with the general public in a collaborative process to identify problems and promote solutions. In order for genuine collaborative processes and corporations to be effective and beneficial, they must put leaders and participants on an equal footing and share some degree of control, management, or decision-making authority with those in positions of authority (Nabatchi, 2012:4).

However, a collaborative process can become troublesome or harmful when leaders abuse their position, influence, or power to take advantage of or dehumanize their partners. For example, leaders may ask friends to do the majority of the work on a project while they generate the majority of the grants, funding, or awards, or they may use a partner's network of supporters to win an election or vote, then renege on their campaign promises.

8.4.5. Empower

"Placing final decision-making in the hands of the public" is the stated goal of an empowering procedure (Nabatchi, 2012:4). In an empowering process, public officials and school managers, for example, may transfer some or all of their authority to manage, control, or make decisions to members of the public. Alternatively, instead of organizational leadership or action on a major issue, the public may organize to support a decision-making process. An effective empowerment procedure gives the public the ability to make decisions, which boosts public confidence. Additionally, it gives the public's members who might not be able to participate without accommodations or support the resources they need (political education, social networks, training, funding, interpreters, transportation, etc.) (Nabatchi, 2012:4).

An empowering process can turn difficult or even destructive, but it can also turn that way when the people or organizations in charge of overseeing it are incapable of managing it effectively or when professionals, experts, and institutional leaders pull out of a process that involves decision-making or problem-solving and necessitates official leadership, specialized

knowledge, or professional skills to get to a satisfactory conclusion. As the previous examples of defective forms of participation demonstrate, all modes of participation require compromises and possibly abuses. Despite this, many academics, researchers, and practitioners have cautioned against viewing empowerment—or any other format of participation or commitment—as universally or categorically good. Nevertheless, empowerment is frequently signified as the peak of public participation in models such as the Public Participation Spectrum.

8.5 Proposed model – based on the Canadian health care model

In Ontario, Canada, there are 14,193,384 people living in 1,076,395 square kilometers. Small towns and isolated communities can be found among population centers, as can Toronto, which is home to over six million people (Rayner et al., 2018). Organizations and individual physicians running private practices that follow different payment and distribution models frequently offer primary care. Health care is normally funded by public sources. "That level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere by others" is the standard definition of PC, which applies to the majority of PC models in Ontario (Rayner et al., 2018). However, most of Ontario's PC provision models do not adequately represent the concept of primary health care (PHC), which is a mode of care that includes services provided to people with an emphasis on disease prevention, equity, and health promotion (Rayner et al., 2018). When policymakers search outside of PC for strategies to maintain health equity through a more comprehensive PHC, they find little to guide their efforts.

Because there are so many different funding and distribution options available, Ontario's PC/PHC landscape is complicated. The system's complexity and heavy reliance on private practitioners—who are not part of a delivery system that spans the entire province—make cooperative long-term planning, performance management, quality enhancement, and group data division difficult.

The PHC approach, which puts community and individual development ahead of funding or service delivery models, is a paradigm shift in the way Ontario's healthcare system is thought of. By centering the patient, this strategy deflects attention from the healthcare providers and can expedite the transformation of the health system into one that is people-centered, as envisioned by the province government's "Patients First" agenda. It also addresses enduring concerns about the proper "mix" of PC funding models in Ontario: a PHC-focused approach

preserves the emphasis on PHC's role in advancing individual and societal well-being as well as population health and health equity while allowing innovative funding models to emerge gradually. Even though Canada is required to provide high-quality healthcare, there is still a great deal of concern about health disparities. The ongoing disparities in health care that marginalized populations must deal with are concerning. Inversely, people with the most social and health issues sometimes have the least access to care.

Reducing equity gaps in Ontario is the goal of Community Health Centers (CHCs) and other community-governed PHC models, such as providing care to populations facing barriers to healthcare access, Community Family Health Teams (CHFTs), Aboriginal Health Access Centers (AHACs), and particular Nurse Practitioner-led clinics (NPLCs) (AOHC, "Membership"). With over 40 years of experience, Ontario CHCs are interprofessional, community-governed PHC organizations that serve over 600,000 patients in 110 communities across the province (AOHC). Hassen and Tyler (2015:11) , in order to fill service gaps for particular communities and demographic groups, AHACs were founded in the middle of the 1990s, and in the early 2000s, CFHTs and NPLCs were created. Interprofessional care from physicians, nurse practitioners, nurses, dietitians, social workers, and other clinical health providers may be provided to visitors to one of these organizations. Health promoters, community workers, and others address health complications caused by social, environmental, or economic factors by offering services, community programs, and support in addition to individual-based care when funds permit. Hassen and Tyler (2015), page 11. In order to fill service gaps for particular communities and demographic groups, AHACs were founded in the middle of the 1990s, and in the early 2000s, CFHTs and NPLCs were created. Interprofessional care from physicians, nurse practitioners, nurses, dietitians, social workers, and other clinical health providers may be provided to visitors to one of these organizations. Health promoters, community workers, and others address health complications caused by social, environmental, or economic factors by offering services, community programs, and support in addition to individual-based care when funds permit.

1. The model of health and well-being (MHWB), an evidence-based road map, was developed by a number of organizations to specify care delivery strategies and raise the bar for healthcare. This model is based on the World Health Organization's guidelines and the 14 social determinants of health, which are underlying variables that impact an individual's health status. Work, education, income, insecurity in housing and food, social exclusion, gender, race, and disability are a few examples of these variables. This MHWB is composed of eight qualities that, when taken together, highlight the significance of an upstream, systemic perspective in the provision of comprehensive PHC. The core principle of the model is that people and communities facing health-related issues should have access to integrated services that address the various, discrete factors influencing their condition. Despite the fact that CHCs created the model, all Ontario Community-Governed Primary Health Care (CGPHC) organizations provide services to a variety of populations according to the needs of their local communities. According to Rayner et al. (2018), they are also among the organizations that have authorized and put into practice the MHWB.

8.5.1 Methods

A group of industry leaders, medical professionals, community developers, and health advocates founded the MHWB in 2013. They began with the World Health Organization's (2009) concept of people-centered health. Several characteristics and criteria were added to a planned model that could be applied at the organizational level as a result of giving the person concept priority. To validate definitions, values, and attributes, a series of face-to-face meetings and interviews with clients and stakeholders preceded this iterative process.

Sector leaders were given access to all versions of the framework, which included definitions, characteristics, and values, to make sure the model was inclusive and appropriately reflected particular practices in the CGPHC organizations. The model's subsequent description was shaped by the scheduled evaluations and comments. It was iterated again and again to make sure it was grounded in data.

8.5.2 Model of health and well-being (MHWB)

The three main objectives of the MHWB are community vitality and belonging, health equity and social justice, and the highest quality people-centered health and well-being. In addition to the primary objectives, eight characteristics define how services are rendered. The definitions of the features are summarized here. Empirical data supports the notion that respectful behavior is crucial for both social and medical services. While the operationalization

of each feature may vary depending on the needs of the community, examples of clearly defined service provision have been provided.

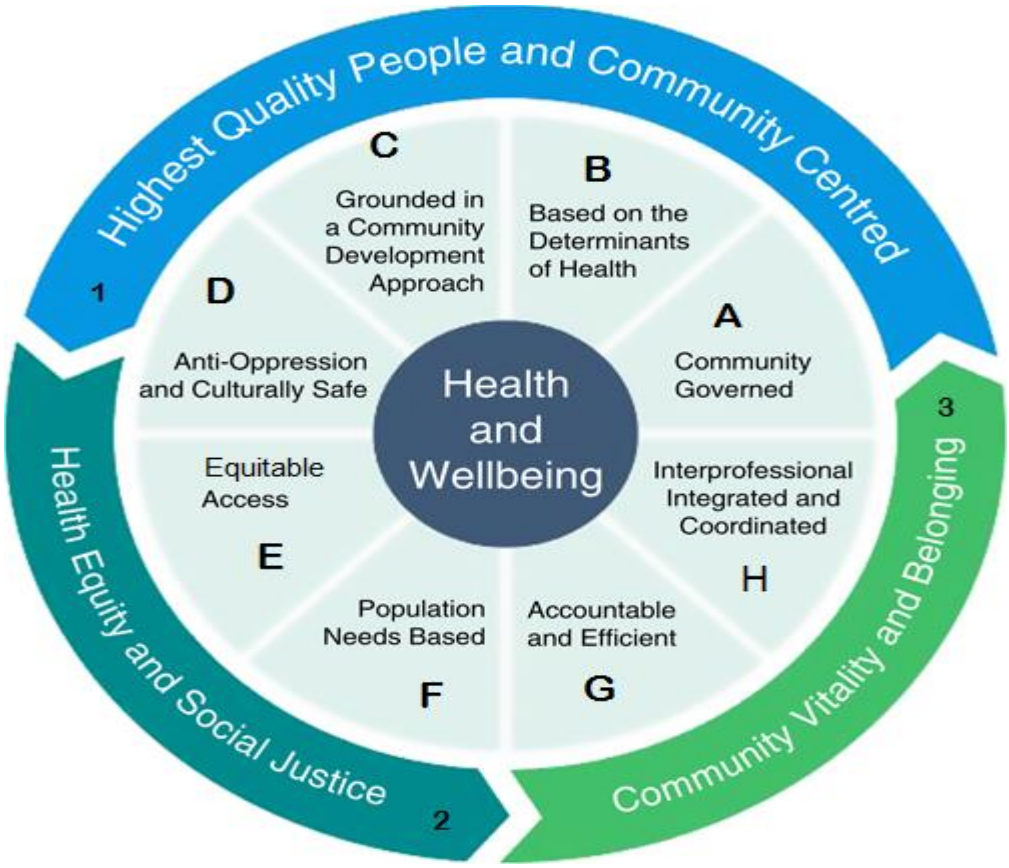


Figure 8.4: Model of health and well-being

Source: **(Rayner et al., 2018)**

8.5.2.1. Highest quality people and community-centred

A. Community governed

MHWB organizations use a range of tools to engage communities, such as needs assessments, board governance, program design, and focus groups. A study by Church et al. (2006) found that CHCs offer a range of opportunities for "citizen participation" that are not found in other parts of the health system. This may lead to improved community capability, increased levels of trust, and higher general satisfaction levels, as well as better services and programs that better meet the needs of the community.

Community-centered PHC applies the principles of epidemiology, PHC, preventative care, and health promotion to systematically identify and address community health needs. The community environment has an impact on people's health, according to Longleat et al. (2001) (Muldoon, et al., 2010). Studies conducted as early as the 1940s suggest that this model may have a substantial effect on community health (Mullan & Epstein, 2002). Haggerty and Martin

(2005) claim that CHCs are the only settings where community-centered PHC is found. Haggerty and Martin (2005) discriminate between people who receive assistance from "community models," where the populations served are determined by local geography, and those who receive assistance from "professional models," where the populations served are the patients undergoing training. The community-centered approach is the most effective, provides the highest quality of services, and offers the best opportunity for cost containment, claim Lamarche et al. (2003).

All of the non-profit organizations that have supported the MHWB are managed by community boards. This enables the organization to promptly address local needs while simultaneously defending democratic ownership and representation at the highest levels. Also, a number of organizations have community advisory councils to guarantee that additional perspectives are taken into account during the management phase. These councils provide organizations with leadership, while also consistently addressing issues and setting priorities. This is in line with the interview that is referenced in Municipal Systems Act No. 32 of 2000, section 7.3.2.1.

B. Based on the determinants of health

One thing that all CGPHC organizations have in common is their awareness of how upstream, non-clinical DOH factors affect the health of the individuals they serve. The factors that influence health have been the subject of an increasing amount of research. These include crucial elements like social standing and financial stability, support systems for others, education, career and working conditions, physical and social environments, coping strategies and individual health behaviors, healthy child development, biology and genetics, health services, gender, and culture. In addition to being significant on their own, these components also have connections to one another. Furthermore, an expanding body of literature describes how the DOH functions at the local and individual levels. Social and economic factors that tend to concentrate in specific communities are responsible for a considerable portion of the health outcomes experienced by Canada's population. In Ontario, thousands of people essentially lack access to the resources they require to maintain their health, which leads to a high rate of preventable illnesses and early deaths. “Because sometimes, especially vulnerable communities. Sometimes they have to get up at 05h00. They have to travel early, there is maybe not transport money to go fetch the tablets” (WC2, 2023:305).

The majority of CGPHC organizations take advocacy, action, and initiative-based approaches to lessen the impact of poverty. Furthermore, many centers offer childcare, transportation, food boxes, and community gardens, which increase access to wholesome food and

transportation. Increasing a person's sense of belonging and reducing social isolation are top priorities for CGPHC organizations, and many of them have initiatives to unite people.

C. Grounded in a community development approach

This feature emphasizes that providing the best possible healthcare also entails treating illnesses while optimizing all the elements that enable people to live, work, learn, and play in their communities. The general health of communities is more likely to improve over time and sustainably when community capacity is strengthened rather than services based on behavior or clinical diagnosis (Hawe, 2009). The deliberate enhancement of a community's social, cultural, environmental, and economic well-being is known as community development.

It's a procedure where community members come together to work together to solve issues and take coordinated action (Frank & Smith, 1999). One of the respondents, who was interviewed by ward committees, or community leaders, said that the poverty index in her neighborhood is very concerning. While delivering food packages provided by the ward councillor, this observation became apparent. The respondent's perception of this neighborhood was greatly affected by this realization since it is thought to be quite elite and well-established. The respondent encountered both stroke victims and sick residents with stage four cancer at the same time. Using a phone appointment as the distribution method, these packages were given to each resident.

It is a process whereby community members come together to take cooperative action and create solutions to problems, according to Frank and Smith (1999). During the interviews (with ward committees, or community leaders), one respondent expressed how deeply concerning the poverty index is in her neighborhood. When delivering food packages that the ward councillor had provided, this observation became apparent. This realization had a big impact on the respondent's perception because this neighborhood is seen as well-established and affluent. The respondent encountered sick residents at the same time, including those suffering from strokes and stage four cancer. Setting up a phone appointment with each resident was the strategy used in the distribution of these packages.

D. Anti-oppression and culturally safe

Adopting a set of nondiscriminatory behaviors or skills as well as maintaining a conscious awareness of one's own prejudices, assessments, and potentially unfair behaviors, as well as how they affect the care that is given, are examples of anti-oppressive practice. A critical first step in reducing the disparities in care that racialized groups encounter is the provider's thoughtful approach. These actions are carried out with the knowledge that discrimination happens in many conscious and unconscious forms in daily life. In addition to numerous overt

acts, a variety of covert cues, including language and imagery, also contribute to the perpetuation of oppression. This approach is a big step in the right direction to lessen the unequal power dynamics that contribute to disparities in health outcomes. Many studies (Human and Wray, 2013; Nestel, 2012) have found that, in a setting where systemic racism is pervasive and cultural safety is valued, indigenous people are frequently refused access to health care. Current population studies show significant differences in health outcomes compared to non-indigenous populations and high levels of systemic racism, despite investments and efforts in the health and socioeconomic sectors within indigenous communities.

Compared to non-racialized Ontarians, members of racialized communities (immigrants and Canadian-born individuals) have a higher risk of developing certain illnesses, including diabetes, heart disease, HIV/AIDS, and some forms of cancer (Human & Wray, 2013; Nestel, 2012). Socioeconomic injustices and barriers, such as poverty, precarious employment, social exclusion, and discrimination, that many members of racialized communities experience exacerbate poor health (Premji et al., 2010; Smith & Mustard, 2009).

To address the health disparities that vulnerable immigrants, refugees, and racialized communities face, we must pay close attention to the DOH. When they initially arrive, immigrants are typically healthier than native Canadians, but this advantage eventually wears off (Setia et al., 2012; Vang et al., 2015). Compared to the general Ontario population, immigrants, refugees, and racialized communities have lower rates of access to specialized care and mental health services (Hyman et al., 2012). Organizations that concentrate on the areas where discrimination manifests itself in daily care can operationalize anti-oppressive practices. The creation of a harm-reduction plan and its implementation for patients is another example of this emphasis on providing nonjudgmental care.

Meeting clients "where they are" is the goal of this approach, which acknowledges that everyone has the right to self-care. This motivates caregivers to acknowledge that the social barriers that bring clients in for care always take precedence over their human dignity. When primary healthcare is provided as intended, the patient is transformed from a presumed "drug

addict" to a person with a substance abuse issue in need of multiple services. The first supervised injection sites in Ontario are currently located in CHCs. Organizations strive to establish a culturally safe environment so that all groups feel valued and included. This includes a look at the actual surroundings, such as poster images, secure locations, food and child care facilities, and awareness. Many CGPHCs offer staff anti-oppression and cultural safety training. Additionally, peer workers and community health workers offer a variety of services. Many CGPHCs offer staff anti-oppression and cultural safety training. Additionally, peer workers and community health workers offer a variety of services.

8.5.2.2. Health equity and social justice

E. Inequitable access

Access, equity, inclusivity, and social justice are all emphasized by accessibility. The Mental Health Workforce Benefits (MHWB) highlights the importance of accessibility outside of regular business hours. Giving access to those who are more likely to face health issues as a result of various racial, cultural, linguistic, physical, social, economic, and geographic barriers is part of this. Offering culturally appropriate programs and services, programs for the uninsured, designing websites that adhere to accessibility regulations, providing extended hours and after-hours on-call services, and selecting the best service locations are all part of the process of removing barriers to accessibility. Despite being written in straightforward English, the materials are frequently translated into several languages. To ensure that everyone can respond, the client experience survey, for instance, is available in seventeen different languages in one metropolitan area. Another example is the provision of transportation services (like volunteer driving programs, transit passes, and mobile units) schools, shelters, and parks regularly provide services (Rayner et al., 2018:237).

F. Population needs-based

"An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups" is the population health approach as defined by the Public Health Agency of Canada (Rayner, 2018:238). This approach emphasizes healthcare delivery to all populations while acknowledging the importance of the DOH. The population health approach acknowledges the importance of intersectoral partnerships between various governmental levels, medical professionals, and other experts who impact health at the local level. The CHPHC collaborates with organizations like youth programs, public health, libraries, shelters, and home support services to operationalize this.

8.5.2.3. Community vitality and belonging

G. Accountable and efficient

Centres must place a strong emphasis on both continuity in quality improvement and the efficient use of resources in order to make the most of the services and resources available. For this reason, accountability and efficiency are highlighted as essential components of the model. Stakeholders that any organization must answer to include the community, funders, and nearby medical facilities. Accountability plans with benchmarks and goals about clinical care, financial management, and service delivery are present in every organization. Every CGPHC organization participates in the annual process of defining and reporting quality improvement targets. The great majority of businesses have accreditation as well. Public outcomes of the accreditation attest to a dedication to training and development as well as to suitable and superior risk management (Rayner et al., 2018:237).

H. Interprofessional intergrated and coordinated

A significant body of research indicates that in-professional teams can enhance health outcomes and access to care for individuals with complex and chronic illnesses (Jacobson, 2012; Katon et al., 2011). When compared to care provided by lone caregivers, these advantages include appreciable improvements in health and wellness for individuals with risk factors and chronic illnesses (Dinh & Bounajm, 2013). Interprofessional teams, by Goldman et al. (2010), develop care plans, attend to patients' social and medical needs, and provide improved care management. Participants who had access to an interprofessional team—primarily those with chronic diseases—were more likely to receive health promotion, disease prevention, and improved coordination of care, according to a study on the impact of PC teams on procedures and outcomes of care. Every organization that has embraced the MHWB collaborates with experts from various domains to form well-organized teams. They also want to fortify their strong partnerships with local services and outside vendors. Contract system navigators are often employed by these organizations to detect and minimize barriers to diagnosis, treatment, and care. These employees identify, anticipate, and remove obstacles related to health to guarantee the efficient, informed, and well-coordinated provision of all internal and external services. The primary attributes that are prioritized are efficiency and accountability, as centers must facilitate ongoing quality improvement and effective resource management to optimize available resources and services. Every organization has to consider the needs of the communities it works with, funders, and local health authorities. Accountability agreements covering clinical care, service delivery, and financial management are in place in every organization. These agreements set standards and objectives.

8.6 Summary

This chapter has explained the elements of model design by emphasizing that models are thought to be the most effective way to analyse organisational behaviour because they represent reality. In the context of community involvement, the use of models has increased dramatically. Arnstein's (1969) model of community of public participation (community involvement) is widely used. However, the ultimate model for the delivery of primary health care (PHC) in the City of Cape Town is the the model for health and well-being (MHWB), which has outstanding features relevant to the health sector-named determinants of health, accountability, accessibility and community development that are applicable to vulnerable communities within the City. The model has been tested in vulnerable areas in Canada, taking into consideration diverse aspects such as language, marginalised groups and specific diseases in relation to specific communities. As opposed to Arnstein's model, which is more generic and applicable to other disciplines, the MHWB is more specific.

CHAPTER NINE:
SUMMARY, FINDINGS, RECOMMENDATIONS AND CONCLUSION

9.1 Introduction

The four objectives that formed the basis of this research project: to explore the legislative framework that governs community involvement; to analyse the philosophical factors that underpin primary health care; to explore community involvement theory subject to primary health care; and to conduct an empirical qualitative survey regarding community involvement in health.

9.2 Summary

The study's background, problem statement, primary questions, numerous subproblems, study objectives that defined the study area, and the particular research methodology that was used were all briefly described in Chapter One. It proved that the study's purview is limited to the health department of the City of Cape Town.

The definition of community, its various manifestations, and the viewpoint on community involvement were all covered in Chapter 2. This chapter gives a lot of weight to the role that community organizations played in South Africa both before and after democracy was established. This chapter describes Imizamo Yethu, a community of informal settlement in Hout Bay, Cape Town, with its diverse ethnicity, language, structural formation, and socioeconomics.

Chapter Three explained the origin of primary health care (PHC) from a philosophical view. In essence, inequitable health care provision with exhuberant cost implications gave rise to the PHC philosophy during the 1970s. Affluent communities had been beneficiaries of technological hospital advancements. However, the return on these investments has been a concern of governments, particularly in terms of the persistent rise of disease as opposed to cost in newly built hospitals with technological advancements. Thus, a conference was convened by the World Health Organization (WHO) in 1978, in Alma-Ata, Kazakstan in Russia.

The conference decided to adopt Health for All by 2000 as the primary healthcare philosophy. The main area of interest is equity in global health. With its emphasis on cause-and-effect realism and self-reliance, as well as complete community involvement in program planning and execution, the PHC definition is quite clear. This chapter highlights the philosophy of Florence Nightingale, the 1800s nursing pioneer, noting that the core of the proposed MHWB model, the concept of social determinants of health, is congruent with how environmental factors impact health care.

Chapter Four discussed the theoretical concept of community involvement in health (CIH), as derived from Oakley (1980). It maintains its relevance within 2011, as adopted by University of Western Cape Public Health academics. The most noteworthy observation is that, although far from being free, CIH is an affordable way to extend a state's health care system to its social and geographic boundaries. Thus, a distinction is made that communities who starting to comprehend their health position objectively instead of fatalistically may be progressed to take a sequence of preventative measures. Involving communities that are especially prevalent among low-income and vulnerable groups—such as women and children—has advantages because their needs might not be sufficiently satisfied by service delivery strategies that do not encourage participation and co-production. Participation of members of marginalized groups in the development and provision of services can increase responsiveness and increase marginalized people's use of those services. To address their disproportionate burden of disease and the complex political, cultural, and economic determinants, indigenous communities in Australia, Canada, and Chile have successfully planned and delivered a range of high-quality, integrated social and health services that are acceptable to their culture (Ghebreyesus & Fore, 2018:19).

Furthermore, it states that if community health workers are well selected they will gain confidence at grassroots level. They are not expected to take advantage of their neighbors and might even be aware of the best ways to get assurances from them. This chapter is a complementary overview of concepts such as accountability and efficiency in the MHWB model.

Community CIH is governed by a legislative framework that is outlined in Chapter Five. As a result, the CIH known as public participation has regional and global roots and is pertinent to the City of Cape Town local government legislation. This thesis combines strategies from the Municipal Structures Act No. 117 of 1998 and the Municipal Systems Act No. 32 of 2000. The National Department of Health program makes suggestions about how communities can get involved in issues that affect their health on a local level. For this reason, a great deal of organizations concentrate on community engagement strategies. One of the great examples that the chapter mentions is the International Association for Public Participation (IAP2).

In Chapter 6, a viewpoint on the research approach applied to answer the research question was provided. The combination of qualitative and quantitative research approaches is explained with a justification. It states that the method is required as a triangulation tool to validate the reliability and correctness of the research findings.

Chapter Seven provided an analysis of the questionnaire survey results and semi-structured interviews with the sample, which included managers from the City of Cape Town's Health Department and members of Sub-council 21's ward committee. 92% of the 15 questionnaires that were distributed were returned, or 14 of them. A stratified random sample that was 100% representative was used to interview the wards of Subcouncil 21.

The principles of model construction were explained in Chapter Eight, where it was noted that models are believed to be the most useful tool for studying organizational behavior because they accurately depict reality. A few that have gained traction in the field of community involvement are the models of health and well-being (MHWB), the spectrum of public participation developed by the International Association for Public Participation, the active citizenship model developed by Simmon et al. (2006), and Arnstein's ladder of participation. These models are explained in order to emphasize the critical role that they play in the field of community involvement health, which is the study's main focus. Nonetheless, MHWB is the best model for providing primary healthcare because it is a public-sector activity. The fundamental presumptions upon which the MHWB is built are discussed, after which the model's methodology is explained and it is suggested that this model be used as a community involvement model for the delivery of primary healthcare services.

9.3 Findings

Several noteworthy aspects of community involvement in primary healthcare and health have been delineated by the research project.

9.3.1 Findings in relation to community involvement, primary health care theory and philosophy

In Chapter Two, the community involvement definition was meticulously outlined from a sociological perspective. This shows how interwoven the meaning and the philosophy of primary health care are in Chapter Three. One author is of the view that a given community may be complex to define, since people who live near one another are likely to share characteristics (for example, living conditions), but may be different from one another in ways that give rise to different needs and priorities (Sherry, 2018:44). An operational definition of a community that consists of the different interconnected points of view is proposed by Visser and Moleko (2014:7).

The MHWB model puts significant focus on the determinants of health, intersectoral partnership, cultural inequities and advisory councils. In a South African context, the advisory

council refers to ward committees that form a mediation between communities and the City of Cape Town Mayoral office. The health matters that affect communities are communicated in a bottom-up approach from the poor to the governance structures.

This is related to the advantages of being involved in the community, as it highlights the fact that community involvement often prompts people to consider alternative options in addition to the tried-and-true, if probably time-worn, methods from the past. A program's likelihood of success or failure can often be determined by the community's availability of critical information about the state of affairs or the best way to carry out a decision.

The third chapter revolves around the genesis of the term primary health care (PHC) and the Alma-Ata Conference of the World Health Organization (1978), which is associated with the theme of Health for All by 2000. The definition states: “PHC is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation. At a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and 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, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service (Sherry, 2018:45)”. Oakley (1989) analysed the definition critically, which eventuated in the following: For PHC to be successful, it must have the maximum degree of community involvement or participation in addition to individual and community self-sufficiency. which is the regular planning, administration, and control of primary healthcare through the utilization of local, state, federal, and other resources along with the engaged involvement of members of a specific kind of social group.

Community members must fully participate (be involved) in the definition of health issues and the creation of strategies to address the comorbidities. The foundation of primary healthcare is found in every community under a government and encompasses every aspect of society.

Thus, the stance from “Nightingale (1946) about nursing, is viewed as a philosophy and serves as an example of philosophy with unmistakably moral foundations. Nightingale’s work stemmed from a desire to serve humankind. She encouraged nurses to attend to the environment of the patient, who could be sick or well (Grace, 2014:53)”. It was necessary to manipulate a patient's surroundings to best prepare them for the effects of nature. To understand the laws of health and put them into practice, one needs to observe, experience,

and reflect on the situation. Nightingale believed that for nature to take its course, nurses needed to confront the social forces that obstructed their ability to provide patients with the best care possible. Her philosophy is evident in her writings and life work.

One of the findings encapsulates inaccessible clinic service for a specific community owing to public safety or to the clinic not being located in conjunction with public transport routes and the residential area. Certain groups are marginalised in terms of health services; thus, a contravention is prescribed in terms of the PHC definition.

Another finding is that communities are not involved in the decision-making, planning, implementation and monitoring of health programmes that affect their lives.

9.3.2 Findings in relation to the legislative framework for community involvement in the City of Cape Town

The legislative purpose section of the Western Cape Facility Boards Act (No. 4 of 2016) outlines the following procedures: (a) the establishment of statutory bodies, representative and accountable Health Facility Boards; (b) Health Facility management will be answerable to the community and sensitive to the needs of patients and their families; and (c) Health Facilities and their programs will be made available to the community. The following commitments were given to healthcare facilities: (d) Conscientious financial management; (e) Resource utilization that is both effective and efficient; and (f) Provision of a basic set of clearly defined functions and powers to Health Facility Boards, which may be gradually expanded in the public interest as a Board's capacity increases.

The ward committee's goal is to improve local government's participatory democracy, according to Part 4 Section 72(3). The ward is made up of a ward councillor who represents the ward in the council, serves as the committee's responsible chairperson, and up to ten additional members who fairly represent women and the disabled in various sectors, including business, arts and culture, education, environment, faith-based organizations, safety and security organizations, sports, and youth (CoCT, 2023:1).

The Municipal Systems Act (No. 32 of 2000), Chapter 4, covers community involvement in local government in detail. The chapter mandates that municipalities foster a culture of community involvement and outlines different methods for involving the community as well as the supportive environment that is required for involvement to occur. The local community's involvement in municipal affairs needs to be promoted, and avenues for feedback on the creation, execution, and evaluation of the Integrated Development Plan (IDP), budget,

performance management system, and planned decisions concerning the provision of municipal services need to be created and reviewed (MSA, No. 32 of 2000). Thus, it is significant that Section 4 of the Municipal Systems Act delineates the duties of a municipality. The extent, quality, scope, and impacts of municipal services must first be discussed with and the local community consulted. The community must also be informed about the options available for basic services by the municipality (Pypers & Bassuday, 2016:2). by the work of its employees and council members, the municipality is mandated by Section 16 to contribute to the improvement of the community's capacity. In compliance with the procedures and rules for participation, political structures—more especially, ward committees—must be used for participation in municipal governance. As per Sections 17 (1) and (2) of the MSA, No. 32 of 2000, involvement can also occur through council members, petitions, public comment processes, public meetings, hearings, consultative sessions, and community reports.

The municipality is required to inform the community's members about their rights and responsibilities, the municipality's tools, policies, and practices, challenges where community involvement is encouraged, and municipal governance, management, and development. According to Section 18, consideration must be given to the linguistic preferences and needs of those who are illiterate (MSA, No. 32 of 2000).

Notification of all regular and special council meetings must also be sent to the public, according to Section 20 (1) and (3) (Section 19). The public and media are welcome to attend all council meetings, with the exception of those when the conduct of the business justifies their exclusion. According to Cloete et al. (2018:141), the media is an extremely potent force in 21st-century democracies that greatly shapes public opinion. Newspapers, visual ads, audio, and electronic (social and internet) media are all considered forms of media. The public is to be informed and educated by the media (Cloete et al., 2018:141).

Section 20 (2) states that when discussing a draft bylaw, the budget, the IDP, the performance management system, or the decision to enter into a service delivery agreement (MSA, No. 32 of 2000), a meeting of the council may not exclude members of the public or the media. Another finding is that managers openly admit their ignorance of the structures and leadership in their communities. The clinic management does not follow up on the health needs assessment because the impoverished communities are not identified.

A further finding is that clinic managers have the perception that community leaders might interfere in their clinic operational management in telling them how to perform their duties. Therefore, community leaders are often referred to the health board to lodge complaints. In contrast, community leaders yearn for the establishment of relationships with clinic managers.

Currently, throughout communities there is no relationship between community leaders and clinics. Relationship building by means of frequent engagements is vital. This is how you expand and the community will automatically embrace the facility: “this is our facility, our colleagues”. But currently it is “them and us”. Of the managers, 100% agreed that a platform must be provided for community involvement.

The poorest of the poor utilize public transportation to get to health care, according to another finding. Communities are thought to be treated unfairly if they are required to pay R20,00 plus for clinic services, as this goes against the primary health care definition. Planning is therefore essential to resolving such issues.

9.3.3 Findings in relation to the theoretical basis for community involvement in primary health care

Participating in community health (CIH) is a basic human right that everyone ought to be able to experience. Participating in choices and actions that impact public health fosters a sense of accountability and increases self-esteem (Oakley, 1989:36). As a standard, CIH has inherent value for community growth and ought to be supported as the foundational approach to health development. Communities that are involved in shaping their own health and healthcare needs can develop their own skills and knowledge, as well as relationships and confidence, which they can use to address issues that affect them (Sherry, 2018:48). Many health services, particularly those in underdeveloped countries, have little financial resources. CIH can be a means to increase the amount of resources available by supplementing what is offered by the official health services with local knowledge and resources. Additionally, it can help lower the total cost of healthcare services and increase their accessibility (Oakley, 1989:36). CIH increases the likelihood that health initiatives and programs will successfully address residents' definitions of health needs rather than the medical needs set by health authorities. When health services are implemented with local assistance and integrate local perspectives on health needs, their programs will have a higher chance of success (Stern & Schaay, 2011: 17). Most of the time, communities are aware of the programs and services that will best meet their needs. By interacting with and serving the community, health professionals and managers can make sure that services are responsive to the conditions and needs at the local level, improve population health, and make better use of resources (Sherry, 2018:48). In addition to breaking the cycle of dependency that permeates most health improvement initiatives, CIH raises awareness among the local populace about their potential to contribute positively to development efforts on a larger scale. In the end, CIH can help people become more politically aware and eager to voice their opinions.

It was found that nursing officials are estranged from community leaders and structures owing to the fact of being resident outside the clinic catchment areas. This factor reiterates the importance of the establishment of interdependent relations with community leadership. This is possible through existing structures within a community. Relationship building with clinics is needed, according to participants, with main aim of collective planning and the implementation of community programmes.

Another finding was that staff safety and security measures must be considered. These are imperative while implementing community health outreaches (mobile health services). One primary reason is that clinics have expensive equipment and mobile clinic vans, which could induce criminal activity that puts the lives of staff at risk. Hence, a multidisciplinary team is needed comprising community members, law enforcement, ward councillors and others, so that high risk areas can collectively be identified. Including communication strategies be applied to alert clinic teams should volatile incidence occur.

9.4 Recommendations

Many recommendations have been made for research, clinic managers, and theory development based on the previously mentioned findings.

9.4.1 Considerations for theory building

The results of the investigation have consequences for developing theories. When applying the model from Chapter Eight as a means of improving process efficacy, care should be taken. Compared to other models, like the systems model, which incorporates previous studies and program implementations in the health sector, the model is comparatively simpler. As a result, it supports a significant amount of futuristic success. It focuses mostly on strategy-related practical issues. Because of its strong collaborative approach, shared decision-making, consideration of social determinants of health, and prioritization of services in specific communities of need, the health and well-being model is pertinent today. Considering the limited resources available, these factors are very important for the City of Cape Town.

Access to services, in conjunction with the MHWB, prescribes that consideration must be given to alternative venues to provide services. Also, the implementation of health committees, proper marketing strategies for such committees, and working in synergy with community leaders. The Ideal Clinic of the National Department of Health programme, specifically pertaining to community engagement, must be an element for thorough consideration.

9.4.2 Considerations for clinic managers

The impoverished communities in the clinic's catchment areas deserve serious attention. These kinds of communities need leadership, and that leadership needs to be exercised in coordination with the relevant ward committee members and the ward councillor. Referring to Chapter Three of this thesis, which discusses the history of nursing from the time of Florence Nightingale in the 1800s to the present, the approach's foundation is philoshophical and is based on the idea of equity. The justification for this is to concentrate on impoverished and vulnerable populations that require primary health care (PHC) services the most. so that the PHC clinic team can reroute resources into these communities, including cancer prevention services, HIV/AIDS, and tuberculosis immunizations. The principles are based on equity, efficiency and effectiveness. Because resources are used where they are most needed, this fact reduces the likelihood of wasting money. The municipality is required to "involve the local community in the development, implementation, and review of the municipality performance," according to Chapter 6 Section 42 A of the Municipal System Act No. 32 of 2000. The theory is outlined in Chapter Two and the proposed MHWB model in Chapter Eight.

9.4.3 Considerations for further research

As noted in Chapter Five, section 5.18, there are 10 representative community leaders for groups including vulnerable groups, women, safety and security and youth, among others. These are components of great significance that can be a support to clinics, honouring the primary health care philosophy. Ethnic communities have varying perspectives regarding community involvement in primary health care (PHC). The empirical study revealed that the perspectives of African and Colored communities regarding community involvement in primary health care differ significantly.

While working in both predominantly African and predominantly colored communities, a clinic manager made this noteworthy observation. African communities always demonstrate active community involvement in clinic committees and communication structures as opposed to coloured communities, which demonstrate no interest in clinic committees or in communication structures. As referred to 7.3.1.1, this is an area for further research to improve upon this finding, particularly in coloured communities.

9.5 Conclusion

- Although community involvement in health has always been important in South Africa, it has gained particular significance since 1994—especially in light of COVID-19—and serves as evidence of the connection between politics and science. Science is the study of epidemiology or disease management, which influences cabinet and

presidential decision-making. This study demonstrates the government's unwavering commitment to establishing legal foundations for community involvement. • Since the beginning of democracy, community involvement has been explicitly stated in the South African Constitution. Provincial laws specify how community involvement should be carried out through media, literature, and communication tactics, as far as practical examples go. The Municipal Systems Act and Municipal Structures Act of the local government incorporate the Integrated Development Plan, which includes major components involving the community.

The study's conclusion was a descriptive model of community involvement in health. This was one of the primary goals of the study. The term "descriptive" emphasizes that forecasting is not meant to be accurate. The description states that staff members should make sure all activities are directed toward the designated community by using the model as a guide. The South African health care system should be taken into consideration when selecting a descriptive model. Notwithstanding the abundance of laws, research indicates that the quality of health care provided falls well short of expectations. This model makes an effort to instruct public servants on how to facilitate the attainment and maintenance of a level of performance that will result in the accomplishment of the main goals of health care.

The study looked at management theories to comprehend the body of knowledge that managers need to effectively carry out their duties. The study also mentioned the current school of thought in public management as a framework for considering performance-improving interventions.

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ANNEXURES

Annexure 1: Questionnaire

Cape Peninsula University of Technology

FACULTY RESEARCH ETHICS COMMITTEE
Business and Management Sciences Faculty
Ethical Considerations Questionnaire (REC 5)

Type of research project/activity [Tick One Box with "X"]

	Staff Project	Postgraduate Project (Masters and Doctoral level)	x	Undergraduate Project (e.g., Diploma and B Tech level)	

Title of Project	A community involvement model in primary health care services in a metropolitan municipality.
Name of researcher(s)	Stanley Sayers
Name of Supervisor(s) (If appropriate)	Dr Stan F Cronje

Type of the study **[Tick One Box with "X"]**

Ethnography	Interview	Focus group discussion	Document based
Case study	Deception	Others specify:	

Describe the sampling design by selecting whatever is applicable to the study

	Purposive sampling		Convenient sampling		Theoretical sampling
	Probability sampling		Mixed Methods sampling	x	Descriptive
Questionnaire and a group interview.					
	Interim Analysis		Multi-centre study		Other specify:

		YES	NO	N/A
1	Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?	X		
2.	Will you tell participants that their participation is voluntary?	X		
3.	Will you obtain written consent for participation?	X		
4.	If the research is observational, will you ask participants for their consent to being observed?			X
5.	Will you tell participants that they may withdraw from the research at any time and for any reason?	X		
6.	With questionnaires will you give participants the option of omitting questions they do not want to answer?	X		
7.	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	X		
8.	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?	X		

Annexure 2: Ethics Clearance

Cape Peninsula University of Technology

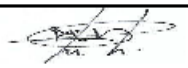
P.O. Box 1906 | Bellville 7535
Symphony Road Bellville 7535
South Africa
Tel: +27 21 4603291
Email: fbmsethics@cput.ac.za

Office of the Chairperson Research Ethics Committee	FACULTY: BUSINESS AND MANAGEMENT SCIENCES

The Faculty's Research Ethics Committee (FREC) on **4 May 2021**, ethics **APPROVAL** was granted to **Stanley Sayers (206249500)** for a research activity for **Doctor of Public Administration** at Cape Peninsula University of Technology.

Title of dissertation / thesis / project:	**A community involvement model for improving primary health care services in a Western Cape metropolitan municipality** Lead Supervisor (s): Dr S Cronje

Decision: APPROVED

	**20 June 2021**
Signed: Chairperson: Research Ethics Committee	**Date**

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the CPUT Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study requires that the researcher stops the study and immediately informs the chairperson of the relevant Faculty Ethics Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, notably compliance with the Bill of Rights as provided for in the Constitution of the Republic of South Africa, 1996 (the Constitution) and where applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003 and/or other legislations that is relevant.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data requires additional ethics clearance.
7. No field work activities may continue after two (2) years for Masters and Doctorate research project from the date of issue of the Ethics Certificate. Submission of a completed research ethics progress report (REC 6) will constitute an application for renewal of Ethics Research Committee approval.

Clearance Certificate No | 2021 FBMSREC 039

Annexure 3: S Sayers Approval

2. **Area/Branch Manager**

Signature Vera Scott
Name .....
Date .....

Comments
.....
.....
.....
.....
.....

3. Director City Health

Signature
Dr Waarisa Farood
Date .....

Comments
.....
.....
.....
.....
.....

Annexure 4: Approval 2

Approval for City Health's own staff initiated research

Name: Stanley Sayers
Staff number: 10008316
Title and MARS number: 9419
(Attach summary of research proposal)

Guiding Criteria	Yes/No	Additional Comments
Research topic/title is sound?	Yes	
Research has clear aim and objectives?	Yes	
Research questions are sound and aligned to the stated objectives?	Yes	
Research methodology is sound?	Yes	
Research aim and objectives aligned to one or more of the CCT's Priority Objectives?*	Yes	
Research aim and objectives aligned to one or more of the CCT's Strategic Focus Areas?*	Yes	
Research outputs/deliverables are clearly defined?	Yes	
Research demonstrates value for money/resource input?	Yes	
Research poses any potential risks to the CCT?	Yes	

***See below for list of objectives and strategic focus areas**

Approval:

1. **Line manager**

Signature
Name ..... Vera Scott Digitally signed by Vera Scott Date: 2021.05.28 13:49:29 +02'00'
Date .....
Comments (e.g. time allocation during work hours and inclusion in WSP)
.....
.....
.....
.....
.....

Annexure 5: Approval Letter

CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

CITY HEALTH

Dr Natacha Berkowitz
Epidemiologist: City Health

T: 021 400 6864 F: 021 421 4894
E: Natacha.Berkowitz@capetown.gov.za

Ref: 28257 2021-06-09

RE: A community involvement model for improving primary health care services in a Western Cape metropolitan municipality.

Dear Stanley Sayers

Your research request has been approved as per your protocol. Please note that telephonic interviews are recommended due to space constraints at acilities. Managers have the right to refuse to be interviewed. All facilities may be contacted.

Eastern & Khayelitsha:

Contact Person: Prof Vera Scott (Area East Manager)

Tel/Cell: 021 360 1258/082 308 8059

Email: Vera.scott@capetown.gov.za

Northern & Western:

Contact Person: Dr Andile Zimba (Area North Manager)

Tel/Cell: 021 980 1230/084 627 2425

Email: Andile.Zimba@capetown.gov.za

Tygerberg & Klipfontein:

Contact Person: Mr Ruberto Isaaks (Area Central Manager)

Tel/Cell: 021 444 0893/078 565 7607

Email: Ruberto.Isaaks@capetown.gov.za

Mitchells Plain & Southern:

Contact Person: Mrs Soraya Elloker (Area South Manager)

Tel/Cell: 021 400 3983/084 222 1478

Email: Soraya.Elloker@capetown.gov.za

Annexure 6: Ward Council Permission

Dear Alesia

I trust that you are well and keeping safe.

The subjoined E-mails and attached E-mail refer.

As the previous Area Director, Dr Mdunyelwa has given permission for Mr Sayers "to approach/consult Ward Committee Members of Ward Committees in Area East" (please refer to the attached E-mail), It would be appreciated if you could facilitate the process with the relevant Subcouncil Managers (SCs 8 and 21) to arrange accordingly with Mr Sayers so that he may consult with the Ward Committee members at the convenience of all parties concerned.

Your support in this regard is appreciated.

Kind regards

Keith Miller
Office of the Speaker

Location: 6th Floor, Podium Block, Cape Town Civic Centre, 12 Hertzog Boulevard, Cape Town, 8001

Tel: (021) 400 2285
Cell: +27 (0) 84 2221351
E-mail address: KeithLeslie.Miller@capetown.gov.za
Website: www.capetown.gov.za

CCT Contacts | CCT Media and News | Report a fault | Account Queries | Water Restrictions

For information regarding our privacy practices, please see our privacy notice

Annexure 7: Empirical Study

Kuilsriver

7580

04 October 2022

Dear participant

I am currently registered for the Doctor of Public Administration degree in the Faculty of Business and Management Sciences at the Cape Peninsula University of Technology. The title of my thesis is 'A community-involvement model for improving primary health care services in a Western Cape Metropolitan municipality'.

Part of the requirements of the qualification is that an empirical study is conducted amongst the respondents identified by the researcher with a view to analysing the existing level of community involvement at primary health care facilities, and the need for effective and efficient community involvement at Primary Health Care Facilities in the City of Cape Town.

Please take note that your participation in the study is voluntary, and that your identity will be kept confidential at all times. You may withdraw from the project at any time, and you will be informed of the findings on completion of the study. The questionnaire should take you approximately thirty minutes to complete.

Yours faithfully

Stanley Sayers

Researcher

021- 903 6899 or 021- 400 2629

060 802 6516

206249500@mycput.ac.za or

stanleysayers@gmail.com

QUESTIONNAIRE

Instructions

Indicate with the mark "X" what is applicable to you

Independent variables

A 1: Age

25–39	1
40–49	2
50–59	3
60 and older	4

A2: Gender

Male	1
Female	2

A3: Marital status

Never married	1
Married	2
Divorced	3
Widowed	4

A4: Highest Educational Qualification

Doctorate	1
Master's degree	2
Honours degree / Advanced Diploma	3
Degree	4
Diploma	5

A5: Total Work Experience

1–5 years	1
6–10 years	2
11–19 years	3
20–29 years	4
30 years and more	5

A6: Work Experience within local government

1–5 years	1
6–10 years	2
11–19 years	3
20–29 years	4
30 years and more	5

Instructions: Please indicate with a cross (X) in the accompanying column on the right the response that resembles your opinion on the statement to the left.

Dependent variables

	Statement	***Strongly Agree 1***	***Agree 2***	***Neutral 3***	***Disagree 4***	***Strongly Disagree 5***
1.	Primary health care (PHC) is about community members helping the clinic to identify health problems.					
2.	PHC is about community members developing approaches to solving health problems.					
3.	PHC success depends on full community involvement.					
4.	Clinic management's role is to create a platform for community involvement.					
5.	Community involvement increases the demand for health services.					
6.	Each informal settlement is recorded in our clinic.					
7.	The community is involved with our planning of programmes.					
8.	The community is involved in our implementation of programmes.					
9.	The community is involved in the outcomes of our programmes.					
10.	Our clinic has a partnership agreement with Provincial Social Development.					
11.	Civil society organisations often represent community health issues at our clinic.					
12.	Community-based organisations provide accurate information on community needs.					
13.	The poorest communities are profiled in our clinic.					

14.	Quarterly health interventions are held at informal settlements in our catchment area.					
15.	Involvement enhances our clinic's openness.					
16.	Involvement enhances our clinic's accountability.					
17.	Our ward councillor is known to all our staff.					
18.	Knowledge regarding local social conditions is recorded at our clinic.					
19.	Risks in our community health are identified.					
20.	Health risks are discussed with community leaders.					

Instructions: Please indicate with a cross (X) in the accompanying column on the right the response that resembles your opinion on the statement to the left.

Dependent variables

	Statement	***Strongly Agree 1***	***Agree 2***	***Neutral 3***	***Disagree 4***	***Strongly Disagree 5***
21.	Our clinic is familiar with community engagement.					
22.	We engage quarterly with our communities.					
23.	Engagement precedes clinic decision-making.					
24.	Health values that are most important are prioritised.					
25.	PHC clinic trends are investigated quarterly in our community.					
26.	Data are used to resolve specific health problems in our clinic catchment area.					
27.	Data are used to resolve health problems in specific communities in our clinic catchment area.					

28.	Nurses are advocates for vulnerable populations.					
29.	The Ideal Clinic has brought an improved effect on our population's health.					
30.	Health committees are a channel we use for participation.					
31.	There is a difference between health committees and ward committees.					
32.	We do know our ward committee members in our clinic catchment area.					
33.	Community involvement in PHC essentially keeps clinic management accountable.					
34.	Health committees are an ideal governance structure.					
35.	Health committee members are known to ward committees in our area.					
36.	Health committee members' photos should be displayed in our clinic.					
37.	Our health committee is active in problem-solving.					
38.	The health committee is also a communication tool within our community.					
39.	Extended emergency clinic hours is a need in our community.					

Instructions: Please indicate with a cross (X) in the accompanying column on the right the response that resembles your opinion on the statement to the left.

Dependent variables

	Statement	***Strongly Agree*** ***1***	***Agree*** ***2***	***Neutral*** ***3***	***Disagree*** ***4***	***Strongly Disagree*** ***5***

40.	The complaints of vulnerable groups are discussed with those affected.					
41.	The complaints discussions with vulnerable groups are minuted.					
42.	Normally we solve our problems collectively within the community.					
43.	Our ward councillor serves on our health committee.					
44.	The most vulnerable clients are known by our clinic.					
45.	Health information sharing with our community leaders are held once per year.					
46.	A language strategy is in place to accommodate all groups.					
47.	People first is central to our clinic PHC concept.					
48.	Particular racial groups have notable infections more often.					
49.	Community environment conditions have an effect on the health of many of our clients.					
50.	Our clinic interventions once per quarter focus on these conditions.					
51.	Cultural health programmes remove the barriers to health care in my clinic area.					
52.	Quarterly health programmes are provided in schools.					

Annexure 8: Kuilsriver Questionnaire

Kuilsriver

7580

Date 15 November 2022

Dear participant

I am currently registered for the Doctor of Public Administration degree in the Faculty of Business and Management Sciences at the Cape Peninsula University of Technology. The title of my thesis is 'A community-involvement model for improving primary health care services in a Western Cape Metropolitan municipality'.

Part of the requirements of the qualification is to conduct an interview amongst the respondents identified by the researcher with a view to analysing the existing level of community involvement at primary health care facilities, and the need for effective and efficient community involvement at Primary Health Care Facilities in the City of Cape Town.

Please take note that your participation in the study is voluntary, and that your identity will be kept confidential at all times. You may withdraw from the project at any time, and you will be informed of the findings on completion of the study. The questions should take you approximately thirty minutes to complete.

Yours faithfully

Stanley Sayers (Researcher)

021- 903 6899 or 021- 400 2629

060 802 6516

206249500@mycput.ac.za or

stanleysayers@gmail.com

Introduction

Before we start with the interview proper, your opinion on a few things is of importance. A questionnaire survey conducted amongst clinic management staff on the topic of community involvement in primary health care.

Some of the responses did not align with expected practice. They are the following on which I would like you to comment.

1. A large percentage said that clinic staff in the subdistrict do not know their ward councillors. Why do you think this is the situation?
2. Many indicated that clinic staff do not know ward committees and health committees. Can you explain this? What do you think the reason could be?
3. Many indicated that health interventions in informal settlements are seldom implemented. Can you explain?
4. As a community leader, how do you engage with your clinic in health matters affecting the women and youth and vulnerable groups in your ward? Are there other approaches you can use?
5. How are the health matters from the poorest of the poor addressed? What can be done to improve this area?
6. As leaders, you have significant knowledge about social conditions in your ward? Elaborate how to address this in a collective manner with clinics?
7. What are the major obstacles in the field? Any suggestions how to overcome this?

Annexure 9: Ward Council Meeting Agenda

CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

Making progress possible. Together.

TO: **MEMBERS OF THE WARD COMMITTEE FOR WARD 108 OF THE CITY OF CAPE TOWN**

Notice is hereby given that the **WARD COMMITTEE MEETING** for WARD 108 of the City of Cape Town will be held in the **KUILSRIVER COUNCIL CHAMBERS** on **THURSDAY, 23 FEBRUARY 2023** from **17:00 until** conclusion, to consider the business set forth in the attached agenda.

*The attention of members of the Ward Committee is directed to the **Code of Conduct** for Members of the Ward Committees.*

AAN: **LEDE VAN DIE WYKSKOMITEES VIR WYK 108 VAN DIE STAD KAAPSTAD**

Kennis geskied hiermee dat die **WYKSKOMITEEVERGADERING** vir WYK 108 van die Stad Kaapstad gehou sal word in die **KUILSRIVER RAADSAAL** op **DONDERDAG, 23 FEBRUARIE** vanaf **17:00** tot aan die einde, om die sake wat in die aangehegte agenda uiteen gesit is, te oorweeg.

Lede van die Wykskomitee *se aandag word gevestig op die **Gedragskode** vir Wykskomiteelede.*

SIJOLISWE: **KUMALUNGU EEKOMITI ZEEWADI EZIZIWADI 108 ZESIXEKO SASEKAPA**

Kukhutshwa kwesaziso sokuba **INTLANGANISO EHLANGANISIWEYO YEKOMITI ZEWADI LWADI 19 zesiXeko saseKapa** iyakuthi ichotshelwe **KUILSRIVER COUNCIL CHAMBERS, eyeSILIMELA** ngomhla weWesithathu- 23 EYOMDUMBA ukususela ngeye-**17:00** kude kugqityiwe, ukuze kuqwalaselwe imibandela equlunqwe kwi-ajenda eqhotyoshelweyo.

Amalungu eKomiti yeWadi akhunjuzwa ngeMigaqo wokuZiphatha kwamaLungu eeKomiti zeWadi.

for CITY MANAGER
Egameni UMPHATHI WESIXEKO
Namens STADSBESTUURDER

Annexure 10:Checklist for a Functional Clinic

Annexure 140: Checklist for element 218 – There is a functional Clinic committee

Use the checklist below to check whether the documents are available as evidence that the clinic committee is functional

Scoring – In column for score mark as follows:

Y (Yes) = present; N (No) = not present

Item	Score
Formal Appointment	
Signed appointment letters from Office of the MEC or delegated person	
Adopted and signed constitution as per provincial guidelines	
Code of conduct for Clinic/CHC Committee	
Training	
Attendance register for orientation and training conducted in the past 12 months	
Services Planning, Monitoring, Evaluation and meetings	
List of community needs as determined by the Clinic/CHC Committee in past 12 months Agendas indicating that community needs and progress against operation plan was discussed at least twice in the past 12 months	
Signed minutes indicating that the Clinic/CHC Committee was informed on the progress against the facility's operational plan at least twice in the past 12 months Current year plan indicating scheduled meetings (at least two within the next 12 months)	
Attendance registers show that meetings held formed a quorum	
Minutes of Clinic/CHC Committee meetings indicate that statistical data on population health indicators are discussed	
Minutes of Clinic/CHC Committee meetings indicate that the clinic's human resources situation is discussed	
Minutes of Clinic/CHC Committee meetings indicate that situation relating to equipment and , supplies is discussed	
Complaints, Compliments and Suggestion Management (check record of the past 6 months)	
Proof that Clinic/CHC Committee took part in opening complaints boxes according to stipulated schedule (signed register)	
Minutes indicate that the management of complaints, compliments and suggestions are discussed at Clinic/CHC Committee meetings	
Accountability and Communication	
Contact details of Clinic/CHC Committee members clearly displayed in reception area	
Total score	
Percentage (Total score ÷ 15) x 100	%

Annexure 11: Editing Certificate

Ricky Woods Academic Editing Services

Editing Certificate

Ricky Woods Academic Editing Services
Cell: +27 (0)83 3126310
Email: rickywoods604@gmail.com

To Whom It May Concern

Cape Peninsula University of Technology

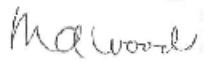
Editing of a Doctoral Thesis

I, Marietjie Alfreda Woods, hereby certify that I have completed the editing and correction of the doctoral thesis: **A Community-Involvement Model for Improving Primary Health Care Services in a Western Cape Metropolitan Municipality** by **Stanley Andrew Sayers.** I believe that the thesis meets with the grammatical and linguistic requirements for a document of this nature.

Name of Editor: Marietjie Alfreda Woods

Qualifications: BA (Hons) (Wits); Copy-editing and Proofreading (UCT); Editing Principles and Practice (UP); Accredited Text Editor (English) (PEG)

MA (Ricky) Woods



23 October 2023