This draft literature review is submitted by the Health Systems Trust in response to the contractual requirement with Soul City: Institute for Health and Development Communication.

<table>
<thead>
<tr>
<th>Report prepared for:</th>
<th>Report prepared by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soul City</td>
<td>Health Systems Trust</td>
</tr>
<tr>
<td></td>
<td>Durban Office (Head Office)</td>
</tr>
<tr>
<td></td>
<td>34 Essex Terrace, Westville, 3630</td>
</tr>
</tbody>
</table>

**Contact Details**

Person Responsible: **Ms Ronel Visser (Acting CEO)**

Tel: 011 312 4524

Email: ronel.visser@hst.org.za

Website: [www.hst.org.za](http://www.hst.org.za)
# Table of Contents

Chapter 1: Introduction ........................................................................................................... 3

Chapter 2: Policy and Legislative Framework for PHC ................................................ 7

Chapter 3: Utilisation of PHC Services ............................................................................... 17

Chapter 4: Clinic Committees .............................................................................................. 25

Chapter 5: PHC Outreach Teams .......................................................................................... 40

Chapter 6: Demand for High Quality PHC ........................................................................ 57

Chapter 7: Implications for the Future and Conclusion ..................................................... 66

Appendix A: List of Stakeholder in PHC Re-engineering .................................................. 69
Chapter 1: Introduction

Even though South Africa has made significant progress with regard to certain aspects of the health system, such as the establishment of a unified national health system and development of progressive public health legislation and policies, the country is still lagging behind with health outcomes and in particular the achievement of Millennium Development Goals 4, 5 and 6. The health sector continues to face significant challenges, which include a quadruple burden of disease, inequitable distribution of health resources, emphasis on curative healthcare, dependence on the public healthcare system by the majority of the population and weaknesses in the areas of health resources and leadership.\(^1\) In addition, there has been more emphasis on the utilisation of facility-based data (through the District Health Information System) for tracking health indicators, instead of population-based data, which is likely to provide a true reflection of the health status of the population.\(^2\) Thus, some transformation efforts are being made towards addressing these challenges, which include the adoption of a “Ten Point Plan” by the National Department of health (NDOH) for the improvement of the national health system; the development of the Negotiated Service Delivery Agreement (NSDA) with four strategic outputs, that is, increasing life expectancy, decreasing maternal and child mortality, combating HIV and AIDS and decreasing the burden of disease from Tuberculosis; and strengthening health system effectiveness.

Furthermore, there has been a recent shift towards the alignment of the objectives of the Ten Point Plan with the NSDA through the development of the primary health care (PHC) re-engineering strategy. The PHC re-engineering initiative was conceptualised as a result of a visit by the Minister of Health, Dr Aaron Motsoaledi, and provincial leaders to Brazil in May 2010, and the renewed global interest in PHC, given the promising evidence from its application in Brazil and Thailand.\(^1\) The PHC re-engineering strategy “seeks to shift the PHC system from a passive, curative, vertically and individually oriented system to one with a more proactive, integrated and population-based approach”.

Soul City Institute has been awarded a grant to develop programme interventions to strengthen community advocacy for quality health services and health care provider accountability as part of PHC re-engineering. The interventions will support the process in:

- Building new skills in methods for engaging communities to define needs, prioritise interventions, monitor services and implement interventions
- Reversing the current pattern of upward accountability to a process of downward accountability
- Experimentation and learning with increased community and public participation and reporting.

In order to be equipped with empirical evidence for these interventions, Soul City has commissioned the Health Systems Trust (HST) to conduct a desktop review, which will focus on the revitalisation of PHC and some key PHC issues. In particular, the literature review will focus on the role of communities in the process of strengthening the PHC system and quality of care. The review will be a desktop-based research activity and needs to draw on the best and most recent evidence from peer reviewed articles, relevant reports and documents from international bodies and any other information that is reliable. This literature review will contribute towards the planning process for the development of the Soul City series 12, as well as the development of Soul Buddyz Clubs materials. The purpose of this drama series is to demonstrate and model greater engagement of communities with primary health service delivery and holding local services accountable. The review will mainly focus on the situation in South Africa, but will draw on international lessons and best practice from similar settings.

The objectives of the desktop review will be to address the following key questions:

**Legislative/policy framework**

1. What are the rights and responsibilities of the public with regard to PHC as outlined in the Constitution, the National Health Act and any other relevant policy or legislation?

2. What is the current vision for PHC and community participation (building on the historical one within the Alma Ata Declaration)?

**Utilisation**

1. What are recent utilisation patterns for PHC services in South Africa’s public sector?

2. What are barriers to utilisation, particularly in rural and poor areas?

3. What are the South African public’s perceptions of PHC delivered by the public sector?
**Clinic committees**

1. What has been the role and value of clinic committees in South Africa and elsewhere?

2. What are the key elements of good functioning clinic committees in South Africa and elsewhere?

**PHC outreach teams**

1. What has been the experience of Community Health Workers or equivalent workers in South Africa? What have been strengths and weaknesses to date?

2. What has been the experience of CHWs and/or PHC outreach teams elsewhere?

3. What contributes to successful PHC outreach teams? How have communities been consulted and how have they received and engaged with PHC outreach teams elsewhere? Refer to Brazil and other experience

**Increasing public demand for high quality PHC**

1. Describe the features of the India model for community based monitoring for health accountability and what resources are required for this? What have been its successes/failures/challenges? What could it do better?

2. How have rural and/or resource poor communities in particular been successful in demanding high quality PHC services in SA and internationally?

This literature review seeks to contextualize revitalisation of PHC as it exists in the form of community participation within a broader PHC paradigm. Some of the factors that influence PHC revitalisation in the South African health sector are discussed and examples of similar initiatives – particularly in developing countries - are offered. The review firstly focuses on the policy and legislative framework for PHC and utilisation of PHC services in South Africa. Secondly, it explores the role of clinic committees and PHC outreach teams as well as the demand for high quality PHC. Then it concludes by providing implications of PHC revitalisation in South Africa in the near future.

The review has been compiled from a wide variety of sources. These include peer reviewed articles, official South African Department of Health documents, reports from organizations working with PHC structures particularly in developing countries, as well as grey literature on the topic. While every attempt has been made to ensure that this review contains the most recent and an exhaustive list of literature, it must be noted that there is a paucity of literature...
on a few issues pertaining to PHC revitalisation in South Africa. For instance, there are very few documented examples of community engagement with PHC outreach teams and best practices on the new initiative, that is, the implementation PHC re-engineering in communities in South Africa, making it difficult to contextualize this study within an established body of work.

References


Chapter 2: Policy and Legislative Framework for PHC

2.1 Rights and responsibilities of the public with regard to PHC

Primary Health Care (PHC) is a philosophy that governs the principles and strategies for the organisation of health systems, around the central focus of health being a fundamental human right. This was proposed by the World Health Organization (WHO) in the Alma Ata Declaration of 1978\(^1\).

PHC is essential health care based on practical, scientifically sound, socially acceptable and affordable methods, made universally accessible to communities through their full participation, in the spirit of self-reliance and self-determination. The strategies of PHC include providing access to good quality health care, preventive and promotive services, inter-sectoral action at local level to address the root causes of ill-health, and enhanced community participation and accountability\(^1\).

WHO describes health as a state of complete physical, social and mental well-being, not only the absence of disease\(^1\). In this context, health is considered as a resource for everyday life, not the object for life. The Ottawa Charter for Health Promotion (1986) emphasizes the role of social factors (such as food, income, education, peace, shelter, social justice and equity), that together permit people to live socially and economically productive lives. This serves to highlight the links between social and economic conditions, the physical environment, individual lifestyles and health\(^2\).

The Ottawa Charter also emphasizes the importance of concrete and effective community action in setting priorities for health, making decisions, planning strategies and implementing them to achieve better health. Related is the concept of community empowerment which occurs when individuals and organizations apply their skills and resources in collective efforts to address health priorities and meet their respective health needs. Through such participation, individuals and organizations within an empowered community provide social support for health, address conflicts, and gain increased influence and control over the determinants of health\(^2\).

2.2 Relevant South African Legislation and Policy

The South African government, which was a signatory to the Alma Ata Declaration, has adopted the PHC philosophy and the WHO definition of health. South African legislation, starting with the supreme law of the land, the Constitution, espouses the values of human dignity, equality, rights and freedoms and social justice in order to ensure accountability,
responsiveness and openness in a democratic society, while seeking to improve the quality of life of all citizens. Section 27 in the Bill of Rights states that “everyone has the right to have access to health care services, including reproductive health care; sufficient food and water; and social security and the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights”\(^3\).

The National Health Act (Act 61 of 2003) is an overarching legislative framework that provides for the establishment of the national health system, and sets out the rights and duties of health care providers, health workers, health establishments and members of the public. The objective is to protect, respect, promote and fulfil the rights of South Africans, with special reference to vulnerable groups (such as women, children, older persons and persons with disabilities). The progressive realisation of the constitutional right of access to health care services is mandated, within the context of available resources\(^4\).

The National Health Act also establishes the governance structures required for community participation. The highest policy making body is the National Health Council, which is comprised of the Minister of Health, Members of the Executive Council (MECs) for Health and representatives of local government and the military. The National Consultative Health Forum (NHCF) is made up of stakeholders in the health sector. The Minister of Health consults and shares information on national health matters with this forum. Similar structures are also created at provincial level – the Provincial Health Councils and the Provincial Health Consultative Forums – the function of which is to facilitate the sharing of information on provincial, district and municipal health issues\(^4\).

The Minister of Health, within the limits of available resources, has to protect, promote, improve and maintain the health of the population by ensuring the equitable provision of essential health services, which at least include PHC services. The public health sector provides free health services to pregnant and lactating women and children below the age of six years, who are not members of medical aid schemes. The duties of the public include adhering to the rules of the health establishment, providing accurate information, and treating health care workers with respect and dignity. The rights of the public include the right to participate in decisions affecting their health, undergoing an informed consent process, and the right to refuse treatment\(^4\).

Chapter 5 of the National Health Act deals with the establishment of the District Health System (DHS), which consists of health districts that coincide with municipal boundaries; and the creation of District Health Councils. The function of these councils is to promote co-
operative governance, ensure co-ordination of planning, monitor the budget and service provision to all residents of that district. The DHS is viewed as the vehicle for the delivery of PHC at the district and sub district level. In keeping with the principles of PHC, these services have to be accessible, of good quality, equitable, comprehensive (not fragmented), and effectively and efficiently delivered. They also have to take into consideration local accountability, a sustainable inter-sectoral approach, and community participation.

Chapter 6 of the National Health Act mandates the formation of health centres (clinics and community health centres) and committees. The committees are required to include one or more local government councillors; one or more members of the community served by the health facility; and the head of the clinic or health centre in question. The Act states that each province has to develop legislation for the establishment and functions for the committees.

The South African government has also recognised the key role of individuals, families, households and communities, in reaching health related goals. The White Paper for the Transformation of the Health System in South Africa (1997) states that “…the people of South Africa have to realise that, without their active participation and involvement, little progress can be made in improving their health status”. The White Paper also provides a number of methods for active participation, in the planning and provision of services, such as including women, children, vulnerable groups and the underserved, and the development of community based information systems that would identify local needs, and monitor service delivery.

The White Paper on the Transformation of Public Service delivery (1997) described the eight guiding principles of Batho Pele (consultation, service standards, access, courtesy, information, openness and transparency, value for money and redress), that set the standards for interactions between the health sector and individuals and communities.

The goal of the government is for all South Africans to “have a long and healthy life”. In order to achieve this, the Negotiated Service Delivery Agreement (NSDA) for Health (signed by the Minister of Health, Cabinet ministers and Provincial Members of the Executive Council) states that, for the health sector, the priority is improving the health status of the entire population. This will only be possible by broadening and deepening the extent and scope of community involvement and social mobilisation in all aspects of health provision at local level.

An important policy document, arising from this, is the National Department of Health’s 10 point plan which is aimed at creating a well-functioning health system capable of producing improved health outcomes. One of the key priority areas is “overhauling of the health care
system and improving its management”. The key activities are to refocus the health system on PHC by developing and implementing a national model for the delivery of health services based on the PHC approach; and to scale up community based promotive and preventive health services (to expand immunisation programmes, antenatal care, postnatal care, nutrition and school health services)\(^9\).

The release of the policy paper on National Health Insurance (NHI) legislation is the first step towards an innovative system of health financing that ensures that all South Africans have access to appropriate, efficient and quality health services. Four key interventions are envisioned: the complete transformation of healthcare service provision, total overhaul of the healthcare system, radical change in management and administration, and the provision of a comprehensive package of care underpinned by a re-engineered PHC\(^9\).

The NHI also makes provision for the Office of Health Standards Compliance (OHSC), which is tasked with the development of standards and norms for quality management at all health facilities. The Revised National Core Standards for Health Establishments in South Africa is the precursor to the OHSC, and has identified six quality improvement priorities: long waiting times, drug availability, nursing attitudes, safety and security, infection prevention, and values of staff. The Core Standards are applicable to all health facilities, including PHC, and are aimed at assessing gaps in order to ensure the delivery of respectful, safe and high quality clinical care with effective support systems\(^7,9\).

The PHC Re-engineering policy is seen as key to the successful implementation of the NSDA, and the National Department of Health’s 10 point plan. This policy seeks to shift the PHC system from a curative, passive, vertical system to a proactive, integrated and population based approach\(^7\). PHC services will be re-engineered to focus mainly on community outreach services to ensure that service delivery extends from health facilities into communities and homes, in a manner that upholds the dignity and decision-making rights of the people\(^9\).

The re-engineered philosophy, in which community health workers form as essential part, will focus mainly on health promotion, preventative care, as well as ensuring that a quality curative and rehabilitative care is provided.\(^9\) All members of the population are entitled to a defined comprehensive package of health services at all levels of care – primary, secondary, tertiary and quaternary with guaranteed continuity of health care benefits. PHC services will be delivered according to three streams: district based clinical specialist teams, school based teams and ward based PHC outreach teams\(^9\).
The approach has a renewed focus on communities, and requires substantial reorientation and reform of existing health systems to “… put people at the centre of health care”. The requirement is for the health system to be responsive to the challenges of globalization, political reforms, changing burden of disease, cultural beliefs, socio-demographics of communities and growing expectations for better performance\textsuperscript{10}.

2.3 Current vision community participation

According to the Alma Ata Declaration (1978), PHC forms an integral part both of the country’s health system and of the overall social and economic development of communities. It is the first level of contact of the individual, family and community with the national health system. PHC uses a holistic approach that addresses the causes of poor health and serves to empower communities in the process\textsuperscript{1}.

Community participation in decision making was endorsed as one of the five original pillars of PHC. The Alma Ata Declaration contained a series of twenty-two recommendations to implement the PHC approach. One recommendation stated that “governments encourage and ensure full community participation through the effective propagation of relevant information, increased literacy, and the development of the necessary institutional arrangements through which individuals, families and communities can assume responsibility for their health and well-being”\textsuperscript{1}.

Looking at the current vision for PHC, it is worthwhile to review the various interpretations of the term community participation, and how it has changed over time. Historically, in the 1950s to 1960s, communities were viewed as passive recipients of health care services, planned and implemented by health care professionals. At this time, there was little scope for self-determination or self-reliance on the part of communities\textsuperscript{11}.

A WHO Study Group Report, defined community participation as the contribution of material or labour, appropriate organisational structures, or the empowerment of communities to manage health matters, enabling them to decide and take action that they believe is essential to their health\textsuperscript{11}. True empowerment is defined as the process and outcome of those without power gaining information, skills and confidence, and thus control over decisions in their own lives\textsuperscript{12}. Thus, community participation is a broader concept that can include many different types and levels of involvement, ranging from passive to active involvement. Table 1 highlights the continuum of community participation from no participation to communities having complete control over all key decisions\textsuperscript{11}.
Table 1: A continuum of community participation

<table>
<thead>
<tr>
<th>Degree</th>
<th>Community Participation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Has control</td>
<td>Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help community at each step to accomplish goals.</td>
</tr>
<tr>
<td></td>
<td>Has delegated power</td>
<td>Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept.</td>
</tr>
<tr>
<td></td>
<td>Advises</td>
<td>Organisation presents plan and invites questions. Prepared to modify only if absolutely necessary.</td>
</tr>
<tr>
<td></td>
<td>Is consulted</td>
<td>Organisation tries to promote plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.</td>
</tr>
<tr>
<td></td>
<td>Receives information</td>
<td>Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected</td>
</tr>
<tr>
<td>Low</td>
<td>None</td>
<td>Community told nothing</td>
</tr>
</tbody>
</table>

Research by WHO has found many examples of passive participation where communities use health service and contribute money, materials, or labour to a project conceived and controlled by government. However, active community participation, in terms of planning and managing health services is very uncommon. The majority of examples fall at the low end of the continuum where policymakers look for the community to advise, consult or receive information about their plans.

While there is widespread agreement as to the need for community participation, there have not been many successes in its implementation. Possible reasons are that establishing community participation is not analogous to building a health facility, it is a complex process that requires clear understanding from policymakers and appropriate support structures. Thus, the manner in which communities are invited to participate in the policy process itself is critically important to its success or failure.

Findings from international literature suggest four preconditions that need to be met before the successful implementation of community participation: political commitment, reorientation of health professionals, development of self-management capabilities of local communities, and the socioeconomic situation in the country being conducive to development.

The benefits of community participation are as follows:

- realises human rights, builds self-esteem, and encourages a sense of responsibility
- ensures the appropriateness of health services for a community's needs
develops a relationship of trust and empathy between providers and the community
encourages a sense of ownership through participatory decision making
creates political awareness, and
ensures accountability of health care workers and managers to communities that they serve

The reasons for failure of community participation in many countries are attributed to:

- preconditions for community involvement were not present
- people were asked to contribute their time and energy, but had no sense of ownership because they were not involved in the planning or implementation of the programme
- health development strategies failed to encourage communities to think and act for themselves
- communities' expectations often outstripped available resources, which caused conflict undermining community involvement
- real structural and political problems and tensions existed within communities
- conventional public health planning was not conducive to community participation. It tended to be top-down and centralised which effectively precluded meaningful participation
- reliance on external funders who wanted short-term tangible results
- a lack of vibrant community-based structures created difficulty in sustaining community participation
- the paternalistic and patronising attitude of health workers did not value the input of communities, particularly if health workers started the process
- community participation represented a threat to governments

2.4 Successful lessons of community participation from international experiences

Cuba

Cuba is an example of the successful implementation of community participation. It involved the integration of the mass democratic movement into formal governance structures, including health. Institutional structures were developed to allow for the participation of communities in decision making and policy processes. Public officials were elected to People Power Assemblies at the provincial and national level to represent community interests. According to the Cuban Constitution, all authority comes from the people and all
accountability comes from the state to the people. Each People Power assembly at each level of government appointed the personnel of the administrative agencies assigned to it. Each health facility had an advisory committee consisting of representatives; management consults with the advisory committee on issues that affect or require participation from the community. Though rarely done, the community has the power to request the removal of health workers.

Cuba developed a unique Family Doctor programme that attaches a family doctor and a nurse to every 120-140 families. These health workers are responsible for all the health needs of that community (including health education, promotion and curative services). This has strengthened communities' understanding of health matters, and promoted the collective discussion and solution of health problems, thereby improving the families and communities' participatory skills. However, a criticism of this approach is that it fostered dependence on medical interventions by the communities.

Brazil

The example of the Unified Health System in Brazil has been the guiding vision behind the South African Re-engineering Policy. Social participation in health is mandated by the constitution to be included in all levels of government (Health councils – 1 national, 27 state and 5500 municipal). The health councils are permanent bodies in charge of formulating health strategies, controlling implementation of policies, and analysing health plans and management reports submitted by their respective level of government. Strong interactions exist between councils, managers, and policy makers, forming a complex and innovative decision-making process. All councils are made up of health care users (50% of members), health workers (25%), and health managers and service providers (25%). Health conferences are held every four years at the three levels. The mandate of these conferences is to assess the health situation and propose directives for health policies, thus contributing to inclusion of themes in the public agenda. Among other democratic mechanisms, the participatory budget adopted by several states and municipalities is also innovative. A proportion of the health budget for a city (municipality) or state is defined on the basis of popular vote; the population of a given city can vote, for example, on whether a new intensive-care unit or more health posts should be built.

2.5 Current vision for PHC in South Africa

As discussed earlier in the PHC Re-engineering policy, the need for the new vision for PHC is premised on the following criticisms of the existing PHC structure: it has a curative, vertical
focus on programmes; it is largely reactive in dealing with major causes of morbidity and mortality, and is weak in addressing the social determinants of disease, and in developing prevention or promotive strategies\textsuperscript{10,13}.

The PHC Re-engineering process was undertaken in order to achieve the following objectives: to ensure that people receive scientifically sound, compassionate, and integrated health care that includes all aspects of promotive, preventive, curative and rehabilitative health care, while upholding the dignity of all, and the rights to decision making about the services provided. The new PHC Re-engineering strategy is seen as empowering members of the public (rather than being passive users) in order to take full responsibility in maintaining their own health. It fully involves families and communities as equal partners, and fosters self-reliance and self-determination in communities\textsuperscript{10,13}.

**Operation Sukuma Sakhe**

The KwaZulu-Natal (KZN) province has introduced Operation Sukuma Sakhe, a model that serves to enhance the implementation of the PHC Re-engineering strategy by shifting the focus from facility based care to community based care, through inter-sectoral collaboration. The aim is to address the key areas of community participation, integrated service delivery, behaviour change, economic empowerment and environmental care, with the outcome of eradicating poverty by growing the economy, creating jobs, and developing communities. Operation Sukuma Sakhe comprises a governance structure that binds together all government departments to deliver services in a coordinated and collaborated manner to maximise their impact, and ensure accountability. This consists of multi-sectoral structures at district, sub-district and community (ward) level that plan interventions based on identified household and community needs, facilitate implementation, and monitor and evaluate the outcomes and impact of those interventions. Delivery of services occurs in partnership between government and community structures. Leadership is provided by the KZN province, the mayors at district and municipal levels, and councillors at ward levels. Community stakeholders include NGOs, community based organisations, youth and women’s groups, religious and church leaders, traditional structures and cultural bodies\textsuperscript{10}.

The ward is considered the lowest level of service delivery, in line with Operation Sukuma Sakhe. Each ward contains a war room, consisting of a team made up of community leaders, representatives from government departments, community health workers and youth ambassadors. The youth ambassadors (appointed in a collaboration between the Departments of Health and Social Development), are seen as responsible for influencing behaviour change among the youth. The youth ambassador programme is an entry level
position targeted at unemployed youth in communities that provides career path opportunities. Community Health Workers or Community Care Givers are allocated a number of households, which they are responsible for profiling. Information from these households goes back to the war rooms that allow the members of the team, including health to identify and quantify household specific needs. This inter-sectoral approach is seen as key to the success of PHC. The community health workers provide care through health education and promotion, early diagnosis and referral to health services. The interaction with the household members is through an identified member or household champion. Higher up, at a clinic or ward level, the school health teams and family health teams are responsible for health promotion and prevention. These feed up to the District Clinical Specialist Teams, that are responsible for the development, provision and monitoring of comprehensive care to individuals, families and communities^{10}.

References

6. Office of the President. Delivery Agreement for Output 2: A Long and Healthy Life for All South Africans.
Chapter 3: Utilisation of PHC Services

3.1 PHC Utilisation in South Africa

Primary health care (PHC) is a public health strategy, which was derived from the social model of health; thus, it is based on the philosophy that health gains are better obtained when people’s basic needs are met first.\textsuperscript{1} The strength of PHC is to respond to the needs of individuals, families and populations at the community level, utilising a comprehensive, inter-sectoral approach.\textsuperscript{1} In South Africa, PHC has been adopted as a basic mechanism to promote health care to her citizens and it is being delivered through the District Health System.\textsuperscript{2} The PHC approach was adopted by South Africa because it was perceived to be the most acceptable and cost effective means of improving the health status of her citizens, especially the less privileged.\textsuperscript{2}

In 2001, a comprehensive PHC service package was developed by the Department of Health. The package outlined some comprehensive PHC services to be available to the population throughout the country within a period of five years of implementation.\textsuperscript{2} This package also provided guidance for provincial and district health authorities on how to optimally provide PHC services, and put together plans to bring services acceptable to national standards. The overall objective was to improve access to high quality health care and diminish inequalities with regard to the provision of PHC services.\textsuperscript{2} The services to be provided include: mother and child care services, antenatal and postnatal care immunization, mental health, treatment of minor ailments and curative services, oral health, rehabilitative services also and the provision of essential drugs.\textsuperscript{2}

It is evident that the implementation of PHC in South Africa has made a positive impact, in terms of increased access to care in comparison to the pre-Apartheid health service delivery.\textsuperscript{2} Over 400 clinics have been constructed and upgraded in South Africa, that ensure that communities now travel shorter distances to health centres, thereby improving the utilisation rate of the PHC services.\textsuperscript{2} The removal of user fees for all PHC services and also for pregnant and lactating women and children below the age of six years who are not members of medical aid schemes, also served to address the economic barrier to accessing health care. PHC visits increased from 82 million per annum in 2000/01 to 122 million per annum in 2009/10, with an average annual utilisation increase of 3.1%.\textsuperscript{3}
3.2 Barriers to PHC Utilisation and Perceptions of PHC services

Even though there are positive reports on improved utilisation of PHC services, there is still a significant number of people who do not have adequate access to PHC services as a result of geographical, physical, economic, population growth, language and other barriers. In terms of geographical barrier, distance to a facility has been found to be a major barrier in some communities in South Africa. In 1998, about 49% of South Africans walked, while 41% used public transport to access health care. A recent study also shows that 43% of Tshwane residents walk, while 47% use public transport to access health facilities. In another study, distance to a facility was reported to be associated with increasing maternal and infant mortality, decreased vaccination coverage and decreased contraceptive use. Therefore, geographic access to a PHC needs to be taken into consideration in health intervention programmes that focus on improving health outcomes.

Other factors, which are found to serve as barriers to PHC utilisation include limited financial resources, influence of family members, family responsibilities, women not realising that they are pregnant and difficulty in obtaining time off from work. Furthermore, socioeconomic constraints (no money for transport to a facility), beliefs about causes of illness (witchcraft), lack of awareness of danger signs (by some mothers), poor quality of care (improper diagnosis and treatment) and the role of traditional healers, are also regarded as barriers to the utilisation of maternal and child health services.

A study conducted by Community Agency for Social Enquiry (CASE) for the Kaiser Family Foundation has also found cost to be the major reason for some South Africans not seeking PHC when needed. Other significant reasons given by participants included financial constraints, unavailability or inaccessibility of services as well as time involved in going for treatment. The qualitative component of the study further emphasized some of the challenges with accessing PHC services in South Africa, as shown in the quotations below:

**On the costs of health care:**

"I went to this other doctor and he told me that the doctor comes back on Monday. I didn't have money for transport, so I didn't go."

**On waiting to be treated at a clinic:**

"The problem is that the clinic only attends to patients in the morning. After 13h00, they don't treat you especially if you are not a school child. They want to rest. If you
were to become sick now and go to the clinic, they would ask you why you didn’t come in the morning. Sometimes you can only go in the afternoon because in the morning you are preparing your children for school.”

**On dissatisfaction with public health facilities:**

“... You won’t like the smell. ... The children’s faeces. ... When you walk through the door you can smell the odour... [When the premier visited] they cleaned the whole day. They cleaned as if Jesus was coming. They went up and down cleaning... It means they are aware of their wrong doings...

“A sick person must stay in clean surroundings... There are cockroaches and they don’t clean the toilets, they say patient must clean toilets... If they admit your baby, you, the mother will sleep outside on a cement floor.”

These quotations show that financial constraints, long waiting times and dissatisfaction with level of cleanliness at health facilities impact on utilisation of PHC services.

Rispel et al. in their study also found overcrowding, long queues of patients, long waiting times, unfriendly and uncaring behaviour of health workers as well as lack of resources as other barriers to PHC utilisation in South Africa. These barriers have therefore negatively impacted on optimum utilisation of PHC services in South Africa.

Harris et al. also concur with Rispel as their study on “Inequities in access to health care in South Africa” revealed that long queues, perceived ineffective care and anticipated disrespectful treatment negatively impact on demand for PHC services. In addition, the study found that desire for respectful treatment influences the health-seeking behaviour of some of the participants. For instance, over half of all respondents felt that patients at public hospitals are “rarely treated with respect and dignity.” Dissatisfaction levels were also high regarding the time taken to receive services, while other factors that invoked dissatisfaction included cleanliness, privacy and confidentiality.

Evidence has also shown that there is high level of dissatisfaction with PHC services, especially in the public sector as this has led many individuals to health care shop or to visit higher level hospitals for primary care. This has therefore resulted in considerable inefficiency and loss of control over efficacy and quality of health care services in many communities in South Africa. According to the study conducted by Nteta et al., participants were satisfied with PHC services and hours of operation; however, a minority of participants stated that they were not satisfied because of long queues and therefore sometimes they go home without receiving health care.
Furthermore, diagnostic procedure, such as X-rays were not always available due to for an example X-rays machine being “forever broken down”.

Another study conducted in rural Limpopo has also found that patients were satisfied with free basic and preventive health care and social services provided; however, they believed that there was still a need to look closely into the interpersonal dimension of the services provided, provision of medication with adequate explanation to patients on the medication given, and on structural aspects. Furthermore, the study identifies three main priorities for enhancing perceived quality of PHC and health policy action, that is, improving drug availability, interpersonal skills (including attitudes towards patients) and technical care. Therefore, the study suggests the need for the government to give support to the clinics to provide adequate services.

Although the South African experience with regard to the utilisation of PHC has revealed some barriers and some negative perceptions of PHC services, the current reforms proposed from the National Department of Health hold promise for addressing these barriers. The reforms include the establishment of the Office of Health Standards Compliance (OHSC) and the development of the Revised National Core Standards for Health Establishments in South Africa which has identified six quality improvement priorities: long waiting times, drug availability, nursing attitudes, safety and security, infection prevention, and values of staff. The other significant reform is the Re-engineering of PHC which would achieve delivery of health services within communities.

### 3.3 PHC Utilisation: The state of the right to health in Rural South Africa

In 2011, the Health System Trust’s flagship publication, the South African Health Review, explored the state of the right to health in South Africa and found that many rural South Africans continue to struggle with accessing health care (see the case study in Box 1).
Box 1: Case study

Sarah (48 years old) lived in Gauteng and had been treated for hypertension. She had a stroke, for which she was treated at a local hospital, and was left with weakness of the right side. She was unable to continue to work, and returned to the rural area where she grew up. She had referral letters from hospital to receive occupational therapy and medication.

Sarah moved into her family homestead where her sister and her children lived, as well as some of her own children and grandchildren. The homestead was situated on a hill about four km from the tarred road, with no piped water and a pit latrine. Sarah had previously provided most of the family's income.

The community caregiver paid her a visit and advised her to go to the local clinic with the referral letters. She explained that Sarah should apply for a disability grant, but said that this would not be easy. It was difficult for Sarah to get to the clinic because of her one-sided weakness, but when she did manage to get there the rehabilitation team was not available and she was given an appointment to return in five weeks’ time. A nurse took the letter but due to unavailability of the prescribed treatment at the clinic, she was prescribed a first-line agent according to the standard treatment guidelines. She indicated that she was not able to refer Sarah for a disability grant as the forms needed to be completed by the doctor – who would come the following week.

The effort involved in getting to the clinic was too great. The family discussed what to do next. They considered traditional medication or a visit to a general practitioner (GP), but to see the doctor at the clinic would have meant at least two more trips. They decided to spend the money on going to a GP, who said Sarah needed to go to the local district hospital with a referral letter stating that she needs occupational therapy and a grant. When they got to the hospital a sister shouted at them for not going to the clinic. Sarah was told to go back to the clinic – and still had no referral for occupational therapy nor a disability grant.

(Source: South African Health Review, 2011)

Even though there have been significant improvements in the health care system since 1994, accessing affordable, good quality and comprehensive health care remains a challenge for many in rural South Africa. While assessment of health care in rural areas is challenged by lack of standardised definition of rurality, marked inequities continue to exist in many rural communities around South Africa. Some of the factors impacting on access to quality health care in rural South Africa are as follows:

Social determinants of health - Issues of education, sanitation, availability of potable water, household income, and food security all have an impact on the health status of individuals and households, especially in the rural areas. One social determinant of disease that has strongly shaped rural health in SA is migrancy. There are high levels of mobility between rural and urban and within rural areas, particularly among the economically active (and healthier) part of the population. Similar to the case study, when falling ill, many people in the economic centres of the country return to their
homes in the rural areas to be cared for within the extended family system, where there are greater challenges in access to health care.

**Financial coverage**- Changes in making access to certain health services free of charge, such as maternal and child care and provision of antiretrovirals, have been critical steps in removing barriers to access to care. However, substantial barriers remain to receiving care, even in the context of free PHC in the public sector. Many families are not able to access healthcare services due to the costs involved. Rural populations are affected to a greater degree due to higher levels of deprivation. An episode of illness within a family with few resources can have a catastrophic impact on the entire family which may be hard to recover from.

**Transport**- Closely related to financial coverage is the need for affordable and reliable transport, particularly when there are large distances and few facilities in rural areas. There is evidence that considerably greater access barriers are experienced by rural compared to urban communities, including distance, time and cost of accessing health services. Rural populations are particularly disadvantaged regarding emergency transport to access healthcare facilities. There are challenges faced by people with physical disabilities in accessing health facilities. There are few public transport systems available for disabled people, particularly people using wheelchairs – and even fewer in rural areas. While transport policies have sought to be inclusive, implementation and regulation of the transport industry has not adequately addressed barriers of access for rural poor and disabled people living in SA.

In addition, to socio-economic factors such as financial coverage and transport impacting on access to health care in rural South Africa, there are also health system-related barriers as follows:

**Rural population coverage by private health care**- Rural populations are not as well provided for in terms of private health care compared to urban populations. The private sector in rural areas comprise mostly of GPs who run cash practices, and either use local public sector hospitals or private facilities in larger towns and cities as referral centres. There are fewer private specialists and private hospitals in rural areas. Rural populations are therefore reliant to a much greater extent on public sector hospitals than urban populations are.

**Rural population coverage by the public sector**- Since 1994 efforts to improve access to PHC facilities in SA have been beneficial for rural populations, as the public
healthcare system provides coverage through a network of community-level care services, PHC facilities and hospitals. However, there is still uneven progress as 15% of poor rural households live more than an hour away from the closest clinic and 20% live more than an hour away from the closest hospital.

**Community-level care** - Community-level care is a sphere upon which government has recently been focusing more attention, as evidenced by the decision to re-engineer PHC. This shift in focus is likely to benefit rural populations by bringing services closer to communities and addressing some of the access barriers. For equity purposes, it will be critical that the current uneven spread of community caregivers be addressed. However, the degree to which community-level care is integrated into the network of PHC clinics is variable across the country, and information from community-level care is seldom used or considered at higher levels.

**Referral system and access to specialist services** - Rural hospitals and clinics form part of a larger referral system, which is not always based on rational planning but rather on historical factors such as location and, perhaps more importantly, availability of services. If regional services are poor or unavailable, a patient from a rural hospital has to be referred to tertiary services, usually even further removed geographically. Emergency services both within and between rural areas and regional or tertiary centres are also typically less resourced than emergency services in urban areas, resulting in long waiting times. In emergencies (particularly obstetric cases) this may be catastrophic, and there is a push to increase capacity for managing increasingly complicated cases in the periphery.

As highlighted, access to quality health care in rural areas is not only compromised by socio-economic barriers but also by health system-related barriers. The inequities of the past have persisted, with inadequate focus on addressing the barriers to accessing health care holistically, including the rural patients’ journey from their dwelling to the point of care. Thus, there is a need for the specific conditions and realities of rural areas to be taken into account when addressing health inequities in South Africa.

**References**


4. Nteta TP. Accessibility and utilisation of the primary health services in Tshwane region. A dissertation submitted in accordance with the requirements for the degree of Master of Public Health (MPH) at the National School of Public Health, Faculty of Health Sciences, University of Limpopo, December 2009.


Chapter 4: Clinic Committees

4.1 Introduction

The principle of community participation is internationally accepted as a desirable feature of any health system. Since its inclusion in the Alma Ata Declaration thirty years ago\(^1\), countries have attempted, with varying degrees of success, to incorporate this principle in their health systems.

There are essentially two main modalities though which communities can impact on their health. The first is informally through participation in health activities within the community; for example, community based health care and attendance of community meetings, and secondly, formal representation on structures which deal with the management of health issues. These structures includes clinic committees “which are accountable to the community and which is part of the governance of the clinic”.\(^2\)

Effective governance of the health system is critical to ensure both access to quality health services and the accountability of the health services to communities. In South Africa, governance structures in the form of clinic committees, hospital boards and district health councils - in line with national policy - are intended to give expression to the principle of community participation at a local and district level. They are intended to act as a link between communities and health services, and to provide a conduit for the health needs and aspirations of the communities represented at various local, district, provincial and national levels.\(^3\)

To bring health decision making process closer to the people, it is envisaged that, the latter would become more involved in identifying their needs and participate more actively in service implementation. Effective community problem-solving emerges from a broadly inclusive group of people engaging in constructive ways. Effectiveness studies show increasing evidence that community participation can improve health outcomes, lead to more responsive care, facilitate people’s involvement in treatment decisions and improve quality and safety.\(^3\)

4.2 Clinic committees

Clinic committees are health governance structures that have been created to provide an avenue for communities to give input and feedback into the planning, delivery and organisation of health services and to play an oversight role in the development and implementation of health policies and provision of equitable health services.
The absence of strong community engagement with health care providers in the planning and monitoring of health services in South Africa has been a limiting factor in strengthening access to and quality of care, especially in disadvantaged areas of the country. Opportunities for meaningful community participation were limited. For example a national survey conducted in 1994 found that only 7% of respondents indicated that there was an elected community health committee through which they could participate. A survey in 1996 suggested that the vast majority of people wanted to be involved in the running of the local clinic - 86% in modifying the negative attitudes of staff; 82% in deciding on clinic opening times; 76% in structuring fees and 55% in appointing staff.

The 2003 Facilities Survey found that while 59% of clinics reported having clinic committees, only 35% were functional and had met recently. In an HST study in 2007, on average, 57% of facilities surveyed reported currently having clinic committees but this ranged from 78% in the Free State Province to 31% in the Mpumalanga Province. An increase was noted in the number of functional clinic committees which is most likely due to the expressed political commitment to governance structures outlined in the National Health Act which legislated for the existence of these committees and delegated a provincial mandate to articulate the terms of references for these committees. Encouragingly, in two provinces, more than 30% of those facilities that did not have clinic committees reported being in the process of establishing a clinic committee. The results also suggest that while most clinic committees meet on a monthly basis, the activities of the clinic committees appear to be mostly confined to problem solving between the community and the health facility, health education and volunteering their services in the facility.

However, simply having a clinic committee in place by no means infers that effective community participation has been achieved. Boulle's study concluded that due to the lack of management and monitoring to ensure that legislation and policies were being implemented in accordance with their original intention, community health centres were in danger of assuming a form that was different to the original intention and could therefore become "socially constructed". In this way, the establishment of a clinic committee could become an end in itself rather than a means for effective community participation in health governance structures.

Whilst the number of functioning clinic committees has increased at primary care level in all provinces in South Africa since the inception of the National Health Act 2003, there are nonetheless a variety of issues that impact on the effective functioning of such governance structures. Some important reasons suggested as to why facilities did not currently have a
clinic committee include: an apparent lack of community interest in forming a committee, that the facility was in the process of forming a clinic committee, a failure on the part of members to attend meetings and a lack of stipends for clinic committee members.\textsuperscript{3}

4.2.1 The roles of clinic committees

The composition of clinic committees should include: the local municipal ward councillor; the facility manager or sister in charge; one person from community organisations (i.e. CBOs, NGOs, traditional healers etc.); and eight community members. Community representatives should constitute more than 50\% of the committee. However, the term "community representatives" is not explicitly defined; therefore it is unclear whether local government councillors or NGO/CBO representatives would qualify as community representatives.

The objectives of the clinic committee are to develop and coordinate relationships and partnerships between the community and the health facility and to ensure that the principles of Batho Pele in service provision are adhered to by facility-based staff.\textsuperscript{6}
Findings from focus group discussions conducted by HST with clinic committees in South Africa suggest that there are a diverse range of understandings of the roles and responsibilities of clinic committee members. These ranged from a purely health promotion

The roles and responsibilities of clinic committees include:

FACILITATE LINKAGES
- Facilitating and advocating transformation in health service delivery
- To act as a link between the community and the clinic management
- To liaise with and share information with other health organisations and facilities within the clinic catchment area

COMMUNICATE WITH COMMUNITIES
- To give feedback to the community on emerging health issues and local health activities
- Giving feedback of information and policy to communities
- To give the community information about the clinic and its roles and responsibilities
- To advocate for their local community
- Assessing community health needs
- Planning action to deal with identified health needs
- Communicating needs of the community to councillor for health and DHC
- Ensuring community participation
- In planning new services and facilities, to consult with communities and feedback to the facility and district

SUPPORT TO CLINIC
- To play an advisory role in the facility
- To investigate administrative complaints and health service delivery problems in a health facility
- To make recommendations to the clinic facility manager and health board regarding solutions to the complaints or problems presented
- To create a suggestion box for the clinic
- To assist in complaint procedures
- To review and comment on facility health plans
- To ensure that resources are used to the best advantage of all in the community
- To monitor implementation of decisions taken by management
- Advise on clinic service rendering (promote equitable, efficient and accessible services)
- Submit written annual reports to the facility manager and the councillor for health
role to a watchdog role over staff. Another review found that these structures appear to engage in a wide variety of activities including mobilizing people for local health events, play an educational function and are sometimes involved in broader socio-economic development issues as well as in advocacy campaigns. A study by HST revealed that 84% of committees reported being involved in problem solving, 47% in health education and also volunteering in the clinic (18%), running community gardens at the clinics (21%), and directly observed treatment (DOT) (26%) and home based care (HBC) initiatives (30%).

In practice, the clinic committees in North West province were reported to function with varying effectiveness. Members of the governance structures visit the clinics. The main purpose of these visits is to see how patients are treated by the staff at the clinic, the opening hours of the clinic and the general well-being of the staff. They are not generally involved in decisions of a technical nature. Items for discussion in meetings include the budget for the facility and the services to be rendered.

The following quotes by FGD participants describe what they see as some of the key responsibilities of their clinic committees:

“Our role is to come here every day to see how the nurses do their work; the time they have to start working and finish; to make the patients enjoy attending the clinic.” (FGD Eastern Cape)

“(Our role is) to see that the clinic is running right and that the clinic is clean; to ensure that staff gets all the support they want from the clinic committee.” (FGD, Free State)

“We see to the wellbeing of nurses and as well as that of the community.” (FGD, KwaZulu-Natal)

4.2.2 The value of clinic committees

Community participation in health is a basic right which develops self-esteem, encourages a sense of responsibility and develops political awareness. Given the limited resources with which many health services operate, community participation is essential to make the health service more responsive and appropriate to the needs and perceptions of local communities.

Some of the benefits of participation include increased and extended coverage of a service and greater efficiency and effectiveness brought about by a coordination of resources and outputs. Equitable outcomes in that those with the greatest need and greatest risk are served and increased self-reliance is achieved when people’s sense of control over their lives is enhanced which resulting in positive health behavioural change.
It is widely documented in the developmental literature that the involvement of communities in interventions is desirable.\textsuperscript{11,14,15} Communities have a good sense of the dimensions of the problems they are facing as well as what solutions are amenable to their community and can be feasibly implemented in their situation.\textsuperscript{16} Sound community partnerships with health establishments lead to the strategic guidance of clinics and improved quality and quantity of operations.\textsuperscript{17} In Zimbabwe, a positive relationship was found between the existence of health centre committees and improved health outcomes even in resource poor communities and clinics\textsuperscript{18}, while in Malawi, communities involvement in planning and managing health facilities at district level resulted in a more responsive health service.\textsuperscript{19} In South Africa, researchers found clinic committees can act as a strategic entry point in facilitating and catalyzing HIV and ARV services.\textsuperscript{20} The research showed that where functional, they have played a significant role in education on HIV and AIDS and facilitating dialogue between the community and health centre. In Zambia, Neighbourhood Health Committees (NHCs) have embarked on income generating projects to provide home based care for HIV affected families, provide health information, food and medicine during home visits.\textsuperscript{19} Community participation therefore provides an opportunity for community members and health care workers to become active partners in addressing local health needs and related health service delivery requirements. Community participation also enables community members and other stakeholders to identify their own needs and how these should be addressed, fostering a sense of community ownership and responsibility.

A study in the North West identified that local level management recognises the value of governance structures, particularly as a communication conduit between themselves and the community. Involvement of the municipal ward structures and governance structures has improved feedback to the community. Informal lines of communication have developed. There is an organised system for reporting back to the community. Health forum members see themselves as being a source of hope for the community that services will improve and they do have some positive impacts on services.\textsuperscript{10}

Members monitor service standards and use of Batho Pele principles and are active in asking questions at the quarterly reviews, which keeps health workers “on their toes” and honest.\textsuperscript{10}

\textit{“And during the reviews they question why things are that way? … the governance structure members were really firing with questions. Why is the cure rate..? You can’t lie. So it’s very good. I mean I see this helping the service.” (District Health Manger)}
Health managers are supportive of community involvement and believe that it can assist with health service delivery. Managers work closely with members of the governance structures, who are useful as they can assess quality of care and attitudes of staff to patients.10

“Our local communities are talking about issues such as health officials not implementing and not honouring the principles of Batho Pele and the Patients Rights Charter... We involved our governance structures to do ad-hoc meetings and inspections and visits to clinic facilities... they have had a very good influence and had a very positive impact. The minute that health workers start seeing that here are people from outside, not our own managers, coming to see what we are doing, we found that people’s attitudes have in a sense started to change.” (Region Health Director)

Some workers were ambivalent as to the role of the forums. Some see governance structures as “watchdogs” to which community members complain about the services. The nurses, in turn, do use the forums to assist with resolving problems. Forum members assisted in one clinic to resolve the shortage of medication.10

Another positive development is that traditional leadership is being brought into the new local governance structures and is represented on the municipal councils. They are supportive of health services, and are involved in the selection process for members of the governance structures. They can offer assistance in encouraging community members to use the services.10

The literature has yielded mixed results with regard to the relationship between health outcomes and the existence of governance structures. In Zimbabwe a positive relationship was found between clinic committees and improved health outcomes.21 Clinics with committees, on average, had more staff, ran more expanded programmes on immunization (EPI) campaigns and reported better drug availability than those clinics without committees. They suggest that this is possibly due to an increased ability to access and absorb health resources. Health indicators were also reportedly higher in areas where clinic committees existed. They found that in general, clinic committees were able to take up community issues and that successful resolution of these were more likely when local resources were mobilized rather than relying on resources from the health department.

The Rogi Kalyan Samiti (RKS) or the Patient Welfare Committee was started in the Indian State of Madhya Pradesh, where government had expressed an interest in increasing community participation in governance structures. Since its inception the RKS concept has been replicated in more than 450 institutions in India and has worked well in both rural and urban areas. A review approximately 3-4 years after the RKS system was instituted, showed
improvements in the efficiency of doctors, reduction in the deterioration of facilities, improvements in the conditions of medical institutions and an increase in the number of patients using the government hospitals. Another study also found that wards without clinic committees have a statistically significantly higher likelihood of not using health services (12.1%) compared to those with committees (9.8%).

It is clear that some of the benefits of community participation initiatives include improved health outcomes, greater efficiency and effectiveness, equitable outcomes and extended coverage of services. Given the mostly individualized and mediatory role played by most clinic committees, it is questionable whether the majority of health facilities with governance structures in the country are directly or even indirectly contributing to the benefits described above. However, some encouraging initiatives were reported by clinic committees. In the Eastern Cape for example, respondents indicated that they had successfully intervened in securing emergency medical transport for patients in their catchment area and had also helped to ensure that there was a more consistent supply of medication at the clinic. In KwaZulu-Natal, respondents reported successfully negotiating with the local chief for land to be used to construct accommodation for nurses working at the facility.

There is a need to encourage and facilitate creative thinking and new understanding of the roles of governance structures to move away from seeing these structures as having purely mechanistic, watchdog functions to reflect a role which embraces a more participatory and developmental approach to health service delivery – borne out of a collaboration between the health services and the community.

4.3 Key elements to ensure well-functioning clinic committees

Despite community participation having been accepted as a desirable and necessary feature of a comprehensive primary health care system, it has not been fully realised. Factors that influence the successful performance of health governance structures (including clinic committees) include: strong political commitment, availability of resources, building capacity of clinic committee members, addressing the attitudes of health workers, defining the roles and responsibilities of the committees, ensuring representative membership, involving communities and addressing non-health contextual issues that may impact on the effectiveness of the committees. These are further discussed below.

4.3.1 Political commitment

Even though the governance structures are legally constituted they often have limited power when it comes to implementing any decisions made or resolutions taken. Political
commitment and local institutional support is critical for the successful functioning of health governance structures.  

4.3.2 Resources and sustainability of governance structures

Clinic committees are beleaguered by a lack of financial and technical support from the health authorities which is exacerbated by the poor socio-economic conditions under which they live. The lack of a stipend or travel allowance to attend clinic committee meetings as well as the lack of a dedicated budget to conduct their activities places a burden on people already living in poverty and hampers the ability of the clinic committee to function effectively.  

In a study of District Health Boards it was pointed out that the capacity of such entities to perform their functions was constrained by inadequate resources. A WHO study reports that community participation flourishes in socio-economic conditions which are conducive to development. This includes adequate staff, logistics and other resources which may be difficult to secure in a resource poor country. Boule in her study of community health committees in the Nelson Mandela Bay Municipality found that there were insufficient resources allocated to provide the necessary support leaving community participation a “neglected component of the health system”.  

Traditionally, the voluntary nature of serving on governance structures can affect the long term sustainability of these structures. This can have negative effects particularly in contexts of high poverty and unemployment, where serving on governance structures can be seen as a means of generating income. Where unemployment and poverty is rife, a failure to reimburse members for transport and other opportunity costs incurred to attend meetings can operate as a deterrent to serving on clinic committees. In addition, the lack of a dedicated budget for governance structures has contributed to feelings of impotence and a limited ability to engage in community outreach projects. This lack of financial or logistical support may in part, explain why some of the reasons offered for the facility not having a clinic committee included lack of community interest and members not attending meetings.

In South Africa, for example, the Health Systems Trust (HST) found that clinic committee members felt aggrieved that members of hospital boards received stipends, while they did not. In a similar vein, but in a different economic context, the South Australian Health Department has cautioned that the voluntary nature of the local health boards is not sustainable due to the added pressures with which these local health boards have to deal.
4.3.3 Capacity and adequate training for clinic committees

Training and capacity building for governance structures is weak or absent. An HST study found that none of the provinces have a coherent and systematic training programme for clinic committee members. This compromises the ability of members to feel empowered to adequately represent the interests of their communities and engage in a meaningful way with the facility staff and the health service planning processes that committee members ought to be a part of. 

The literature confirms the importance of ensuring that community members are provided with training and support to fulfil their roles in participatory structures. There is often a need for long term training and support of community members elected onto governance structures. Where such training does take place, it is usually a once off occurrence which does not involve health facility staff. This can lead to a disjuncture between clinic committee members and health facility staff's understanding of the roles and responsibilities of governance structures as both parties have not been trained on the same issues and would therefore not necessarily have developed a consensual understanding of their respective roles and responsibilities. In the Free State in South Africa, one study reported that while the clinic committee had received training, this had not been determined or planned in conjunction with the community, or had taken into account their training needs.

Training must be ongoing and continuous as it has been found that it takes up to two years for a basic understanding of the district health system and appropriate support systems to be established. Lack of continuity and loss of institutional memory due to resignations, expired terms of office and general attrition can be addressed by developing a sustainable and continuing education programme which will provide updates on relevant issues, refresher courses and initial training for new members of governance structures.

4.3.4 Attitudes of health workers to community participation initiatives

The attitudes of the health facility staff towards community participation and governance structures is an important determinant of the effectiveness of structures such as clinic committees. Constraints to community participation include poor health worker appreciation of the value of participation and a lack of stable planning structures for joint planning between communities and health services. In Zambia while clinic committees were an accepted feature of the health landscape, there was still evidence of resentment from health workers towards these committees. One of the most important factors contributing to the success of community involvement was reported to be the motivation and encouragement of the community by nursing staff. Some of the difficulties associated with the relationship...
between health facility staff and governance structures include poor health worker appreciation of the value of participation, perceptions of being policed by governance structures and little support and direction from the health services.³

Health workers need to embrace community participation. If health workers have paternalistic and patronising attitudes and do not value the input of communities, community participation will fail.

4.3.5 Roles and responsibilities of community members in participatory structures

The HST study has shown that while governance structures do exist, the lack of attention from policy makers as to how they should function and what the focus of their work should be, suggests that many facilities are mechanistically complying with the legislation with little attention as to how to maximise the efficiency and operations of these clinic committees.³ Without formal policy guidance on the roles and responsibilities of clinic committees, there is little standardisation between facilities in how committees are established and what roles they play in governance. The lack of clarity on the range and types of activities that clinic committees are expected to perform and the absence of any national guidelines to this effect has resulted in clinic committees fulfilling mainly a narrow, mediatory and problem solving function between facility staff and local communities.

There are also no official indicators on which to measure clinic committee performance, making it difficult to track whether committees are functioning as legislation intended.

Where roles and responsibilities are unclear and have not been clearly articulated, progress and achievements of governance structures have been slow.⁷,¹⁸,²⁴ Conversely, in instances where there has been clarity on the expected roles of governance structures as in the case of the HCCs in Zambia, these structures have flourished.²⁷

Confusion regarding roles and responsibilities of the clinic committee members had sometimes resulted in strained relationships between health facility staff and clinic committee members. The HST study showed that, due to a lack of communication and guidance on the roles and responsibilities of clinic committees, some clinic committees had attempted to exercise an inappropriate watchdog role over health facility staff with negative impacts.²⁴

The confusion around the roles and responsibilities and a variety of other issues that currently beleaguer the functioning of governance structures could be addressed through the development of a more comprehensive national set of guidelines.³ The existence of such
guidelines could be beneficial for those working at a local level as they could incorporate a transparent and acceptable monitoring and evaluation system which will enable role-players to critically assess the functioning and effectiveness of governance structures. Such a system must also build in mechanisms for soliciting community views and perceptions of the structures being evaluated as their comments will provide objective feedback on achievements and areas for growth. The guidelines should also provide for a remedial plan to address the findings of such monitoring and evaluation exercises.

4.3.6 Representative Legitimacy

Communities are not homogenous groups and are often stratified along race, class, gender and ethnic lines. This diversity poses the danger that in creating participatory structures such as health governance structures, existing power and status differentials could simply be replicated and reinforced, excluding the people whose interests and views most need to be represented. In Colombia, for example, people did not participate in solving problems at a collective level due to amongst others, mistrust of leaders and fear of political manipulation.

The people with the requisite skills and knowledge who are willing to participate may often be perceived by the general population as elites and may not be supported by the public. It is thus important to ensure that all interest groups in the community including the extremely poor and marginalized are represented.

Committee or governance structure positions should be advertised in the media; predefined criteria for eligibility for governance structures should be set and principles of gender parity should be followed. In a similar vein, it has been recommend that people serving on community health organisations should be directly elected from the population and should comprise representation from specified interest groups as well as secondment from local government and or political parties. Similar recommendations were made from a study in Zambia where they found that it was mostly prominent people that served on the DHBs and suggest that selection and appointment procedures for DHBs should be reorientated towards general community members and women.

Transparent and fair policies and procedures for being nominated and appointed onto governance structures which are developed in conjunction with community representatives and are widely publicized will assist in ensuring uniformity in the appointment of clinic committee members. These policies and procedures should be available and displayed in every health facility – in a language that is accessible to the local community.
4.3.7 Non health system issues

The level of community participation can also be influenced by factors that lie outside the health system. Community participation initiatives are mediated by the political and socio-economic contexts under which people live. Community participation is constrained in contexts of poverty and in environments where resources are limited.\textsuperscript{19,30}

Issues such a lack of transport, poor weather, inhospitable topography which makes travelling difficult and long distances from the health facility affect participation in local governance structures.\textsuperscript{3} Community participation was often dependent on the availability of transport, whether or not people felt safe moving about in the community and the amount of free time they had.\textsuperscript{9}

In the HST study, there appeared to be no evidence of any inter-sectoral collaboration or a primary health care approach which locates health within the broader socio-economic determinants of health. For example, none of the clinic committees in the study were reportedly involved in issues related to water and sanitation or the equitable distribution of health services.\textsuperscript{24}

4.3.8 Strong social capital and involving communities

Social capital refers to those features of social relationships such as interpersonal trust, norms of reciprocity and membership of civic organizations which act as resources for individuals and facilitate collective action for mutual benefit.\textsuperscript{31} Social capital in this context refers to the ability of communities to solve problems at a collective level and is thus an influencing factor in the functioning of health governance structures. Civic participation, density of civic organizations and high levels of trust in government are indicators of a community’s social capital.\textsuperscript{32} Establishing and sustaining community participation in health is “facilitated when the community had a history of common struggle, a tradition of voluntarism and a politically supportive environment”.\textsuperscript{13}

4.4 Conclusion

In order for governance structures like clinic committees to successfully carry out their mandates, it is essential that the key issues raised in this review and in recent studies are considered and deliberated by decision makers in the National Department of Health. However, it is equally critical that there is a political commitment not only to conforming to the dictates of legislation but also to an underlying philosophy that recognizes the value and benefit of a truly participative, accessible and responsive health care system.

An important lesson to be learnt from international experience is that a “top-down” approach to community involvement is not effective. Conventional public health planning is not conducive to community participation. It tends to be top-down and centralised which effectively precludes meaningful participation. If government wants to do more than pay lip service to community participation they cannot appear to have determined their agenda and be merely asking people to participate in their pre-set plans. A community’s members are a rich source of energy and commitment to that community and can often mobilise resources that may not otherwise be available. People cannot, however, be asked to contribute their time and energy if they have no sense of ownership because they are not involved in all stages of a programme. If community
members are an active part of identifying needs, and planning, implementing and evaluating activities they will take ownership of both the problem and the solutions, which will improve programme success and sustainability.

References


22. Rogi Kalyan Samiti (undated). Rogi Kalyan Samiti - An Innovative Project for the Management of Public Hospitals through Community Participation in the State of Madhya Pradesh, India


Chapter 5: PHC Outreach Teams

5.1 Community Health Workers – Who are they?

In 1989, the World Health Organisation (WHO) Study Group defined community health workers (CHWs) as “members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organisation, and have a shorter training than professional workers”. In addition, CHWs “must be of the people they serve. The must live with them, work with them, suffer with them, grieve with them, and decide with them”.

According to Lehmann and Sanders, “community health workers” is an umbrella term which embraces a variety of community health aides who have different titles in various countries around the world. Some of the titles include *Agente comunitário de saúde* (Brazil), *Anganwadi* (India), *Kader* (Indonesia), *Activista* (Mozambique), Village health helper (Kenya); Rural health motivator (Swaziland), Community health agent (Ethiopia) and Community health volunteer (Malawi). All these types of CHWs function at the community level and carry out tasks related to health care delivery at the primary and community levels. Moreover, they are trained in some way for the interventions they are expected to perform in order to improve health outcomes.

Even though CHWs are expected to receive training, which is recognised by the health services and national certification authority, their training does not include a tertiary education certificate. Hence, CHWs do not include formally trained nurse aides, physician assistants, medical assistants, paramedical workers in emergency and fire services and others who are auxiliaries, mid-level workers and self-defined health professionals or health paraprofessionals.

The main role of CHWs is to provide preventive, promotional, and in some cases, curative services to households and communities. They may also be required to provide services to clients at health facilities at the primary level, either during a consultation or through follow-up visits in the home. In order for CHWs to perform these services, there is a need for technical and social support from both the community and formal health systems.
At the local level, CHW engagement is expected to diffuse community change to individuals. CHWs are also postulated to reduce disparities through improving access to care; providing culturally competent health education and counselling and sometimes rendering direct health services. As trusted members of the community, CHWs may help to minimise barriers to the provision of quality health care. Furthermore, CHWs serve as a bridge between the community and formal health care system.

**The History of Community Health Workers**

The history of CHWs supports the role that they continue today in providing services to marginalized populations. The earliest records of CHWs date back to a shortage of doctors in early 17th century Russia, where lay people called “feldshers” were trained to render basic medical care to military personnel. Another similar model later arose in China, where farmers with minimal medical training served as “barefoot doctors” to provide basic primary care (e.g. vaccinations and treatment of minor illnesses) to rural underserved regions. This programme is popularly known as “the barefoot doctor programme”. The barefoot doctor
programme was aimed at solving the basic health care problems of rural areas when the nation of China was developing in the early part of the 20th century (see Box 1).\textsuperscript{5}

**Box 1: The Chinese Barefoot Programme**

China’s long struggle with rural coverage for health care goes back to the early part of the 20th century. Although the Government tried to draft private practitioners into the rural medical service corps, delivery of health care was still scarce after 1949. In 1968, the programme of barefoot doctors was introduced by the journal Red Flag as a national policy focused on quickly training paramedics to meet rural needs. Most barefoot doctors, who graduated from secondary school education, practised after training at the county or community hospital for 3–6 months. Hence medical coverage in the countryside rapidly expanded. However, the barefoot doctors, who generated their work points with medical services just like agricultural work (i.e. their income was counted by transferring time for medical service to similar time for agricultural work,) were not at par with the regularly trained doctors and their incomes were 50\% lower.

Despite a low level of service in terms of technique and medical instruments, the barefoot doctor programme effectively reduced costs and provided timely treatment to the rural people. The programme also provided other services, including immunisation, delivery for pregnant women, and improvement of sanitation. Rather than herbs and acupuncture, antibiotics and western medicines were prescribed and even simple surgical operations commonly done. Thus, the arrangement solved the distribution of health-care resources under the urban–rural dual-economic system, and played an important part in modernising health care in rural China. The World Health Organisation regarded China’s barefoot doctor system as a successful example of solving shortages of medical service in developing countries.

(Source: Zhang and Unschuld, 2008)

Lehmann and Sanders note that the concept of using community members to render certain basic health services, to the communities from which they come, has at least a 50-year history.\textsuperscript{2} Partly in response to a global shortage of medical workers and partly in response to the inability of conventional allopathic health services to deliver basic health care\textsuperscript{5}, a number of countries began to initiative the CHW programme. Furthermore, at the International Conference on Primary Health Care (PHC) held in Alma-Ata in 1978, CHWs were identified as one of the cornerstones of comprehensive PHC.

After the Alma Ata Declaration in 1978 many countries, especially in the developing regions of the world, began to establish or strengthen their CHW programmes due to the need for “a shift in attitude from a focus on ill health and hospitals, to a focus on communities and families controlling their own health”.\textsuperscript{6} Then came the economic recession of the 1980s, which seriously jeopardised the economies of developing countries; CHWs programmes were the first to fall victim to the structural adjustment programmes set up by governments, especially in Africa.\textsuperscript{2} Due to these new economic stringencies, most large-scale, national
CHW programmes collapsed. The failure of these national CHW programmes to withstand the economic recession of the 1980s, was also due to the fact that the programmes had suffered from conceptual and implementation problems, as well as “unrealistic expectations, poor initial planning, problems of sustainability, and the difficulties of maintaining quality”.2,7

Even though interest in CHWs waned in the 1980s and early 1990s, the escalation of the impact of the AIDS epidemic in many developing countries caused resurgence in the CHW programme. In addition, the critical shortage of professional health care workers strengthened the need to make greater use of CHWs through task shifting. Task shifting (Box 2) allows CHWs to take on basic PHC services that were previously performed by nurses, thereby permitting the rational distribution of tasks among the health workforce in order to ease bottlenecks in service delivery.

**Box 2: Involving CHWs in Task Shifting**

Task shifting involves extending the scope of practice of existing cadres of health workers to allow for the rational redistribution of tasks among the health workforce in order to make better use of human resources and ease bottlenecks in the service delivery system. When necessary, task shifting can also involve the creation of new cadres to extend the workforce capacity. These new cadres can be trained and deployed much faster than traditional medical doctors and nurses because they receive specific, competency-based training that is designed to equip them to perform clearly delineated tasks.

The task shifting approach has also been used to deploy community health workers (CHW) – non-professional cadres of health workers who undertake short course training and work within their own communities to complement and support the services provided by other health workers. For example, in Malawi and Uganda, the basic care package for people living with HIV/AIDS has been designed to be delivered by non-specialist doctors or nurses supported by CHWs and people living with HIV/AIDS. Similarly, Ethiopia has implemented a plan to hire CHW to expand the current workforce delivering HIV services. The experiences of countries that have deployed CHW in response to the AIDS epidemic have, in many cases, included benefits that extend beyond HIV services and that imply potential for further extending the role of CHW in the delivery of a wider range of health services.

(Source: Celletti F, et al. 2010)

As a result of the need to address the human resources for health (HRH) crisis, many countries have begun to formalise the practice of task shifting for HIV services through the deployment of CHWs. Ultimately, the hope is that task shifting will not only improve the provision of quality health care but also strengthen health systems around the world.
International Experiences of CHW programmes

The utilisation of CHWs, to deliver basic health services at the community level and to act as a stopgap measure for the HRH crisis, has become an increasingly popular strategy in low- and middle-income countries around the world. The HRH crisis continues to be particularly prominent in rural areas, where distances to clinics are excessive and financing for health care workers remains a challenge. Thus, many deaths occur at home before a health facility can be reached; for example data from Bolivia in 1998 showed that 62% of sick children who subsequently died had not been taken to a healthcare. The current interest in CHW programmes is therefore not only rooted in the need to address the lack of skilled workers, but also to deliver PHC at the community level, even in a setting where health facilities are present.

CHWs are also expected to serve as “foot soldiers” in the march towards the achievement of the MDGs, especially the ones that pertain to the reduction of maternal and child mortality. Progress on the achievement of health-related MDGs is far from expectations, especially for the low-income developing countries. An important strategy towards achieving health-related MDG targets is investing in cadres of CHWs, and this has therefore been adopted by many African and Asian countries. With appropriate training, some of the tasks normally performed by professional health care workers can be successfully carried out by CHWs and other cadres of workers like traditional birth attendants, and lay health workers. Thus, engaging CHWs could provide improved access to the basic essential health services and commodities. The current role of CHWs is therefore leaning towards facilitating the delivery of various interventions in community and primary care setting in order to improve MDG outcomes.

A review of global CHW programmes, conducted by the Global Health Workforce Alliance in 2010, has shown that many CHW programmes have been scaled to national levels in countries such as Brazil, Thailand, India, Pakistan, Mozambique, Burkina Faso, Uganda and Ethiopia. The Pakistani Lady Health Worker programme deployed about 90,000 workers in the last decade; while Brazil currently have about 30,000 Family Health Teams and more than 240,000 CHWs across the country. The snapshots of the programmes in Brazil, India, Burkina Faso and Pakistan are provided in Boxes 3-6.
Box 3: Brazil’s Community Health Agents Programme

Program overview
In 1988 the Brazilian government launched the Unified Health System (Sistema Unico de Saúde). The basic initial focus was on universal coverage but later on during the 1990s, the program expanded its horizon into the Family Health Program (Programa Saúde da Família), which encompassed integrated components like promotional and preventive activities, and curative and health care, using a family health team of workers assigned to a specified geographic area. The standard team comprises of one physician, one nurse, nurse aides and 4-6 community health workers. Community health agents are responsible for home visits, in which they collect demographic, epidemiological and socioeconomic information of each assigned family, promote healthy practices, and link families to health services. Their activities ensure the implementation of a community component in IMCI.

Operational aspects and considerations
Ninety Five percent (95%) of these workers are women and are supervised by a nurse who also works full-time in the basic health unit, as part of the family health team. A unique operational aspect of the program is that CHWs are paid health professionals. The state government is paying the salaries of CHWs on agreement of municipal government to also provide a salary for a nurse supervisor.

Coverage and effectiveness
In 1998, 150 municipalities joined hands and 8000 CHWs were deployed in communities. The initiative was expanded in 1994 to the family health program, a team approach to primary health, and adopted at a national level. In 2001, there were 13,000 family health program teams covering 3,000 municipalities, with an estimated coverage of more than 25 million people. Currently there are more than 30,000 family health teams and more than 240,000 CHWs across the country, covering about half of the Brazilian population. Program activities include expanded vaccination coverage, promotion of breastfeeding, increased use of oral rehydration salts, management of pneumonia and growth monitoring. The extended coverage of the Program has been associated with declines in the infant mortality rate.

(Source: Bhuta et al., 2010)
Box 4: India’s Anganwadi Workers (Village Health Guides) Programme

Program overview
The CHW scheme in India was introduced in 1977 with the aim of providing health services at the doorsteps. The title of community health worker has been changed over time from community health workers in 1977 to village health guides (Anganwadi workers) in 1981. In 2002, the village health guides scheme was completely sponsored by family welfare program.

Operational aspects and considerations
The village health guides are the people from community and their main goal is to provide curative, preventive and promotive health care at door steps and to involve rural people in the provision, monitoring and control of basic health services, and to create resource person trusted by the local population who could provide link between primary health center and the local community. They devote and work for at least 3 hours per day.

Constraints in Sustainability
The village health guides program is functional since last 25 years and the program comes under the state government and they are getting financial support from central government, but none of these are willing to take an ownership for its sustainability. The program has encountered number of difficulties, among which is the initiation of perceiving themselves as village medical practitioners.

(Source: Bhuta et al., 2010)
Box 5: Burkina Faso’s Community Health Workers Programme

Program overview
A pilot program in Burkina Faso sponsored by the National Centre for Malaria Control (Centre National de Lutte contre le Paludisme) relies on community health workers who supply anti-malarial drugs at the community level. The CHWs sell the pre-packaged Chloroquine regimens to mothers under a cost-recovery mechanism, in accordance with Bamako Initiative principles. The CHWs are given the first stock of drug packages and are expected to sell the drugs at a pre-approved price.

Operational aspects and considerations
Nurses from the health centers train core groups of mothers, village leaders and CHWs in symptom classification and correct dosage schedules. The core mothers and leaders are then responsible for sharing the messages with other members of the community. The CHWs and community leaders are responsible for providing advice about treatment and referral, acting as intermediaries between the health system and the community. Posters depicting the correct dosage of anti-malarial by age are placed in the villages and are given to core mothers, village leaders and CHWs. Health centre nurses are responsible for supervision of the CHWs through monthly visits and reviewing the sales of packages. Referral is indicated for those patients with convulsions or other neurological complications and for those who are febrile 48 hours after treatment.

Constraints in Sustainability
In a study evaluating this program, it was found that 59% of those children treated with pre-packaged tablets received the treatment over the recommended three days. The correct dosage packet for age was received by 52% of the children, with 31% under-dosed (given a packet for younger child) and 17% over-dosed (with packet for older child).

(Source: Bhuta et al., 2010)
Box 6: Pakistani’s Lady Health Worker Programme

**Program overview**

In 1993, government of Pakistan started a National Program for Family Planning and Primary Health Care and soon the program began to employ a cadre of salaried, female CHWs, called lady health workers, to provide health education, promote healthy behaviours, supply family planning methods and provide basic curative services. Their duties include monitoring the health of pregnant women, monitoring the growth and immunization status of children, and promoting family planning. The lady health workers are provided with a kit that contains materials such as bandages, scissors, cotton, a thermometer, health education posters and a child scale.

**Operational aspects and considerations**

Their training covers the basics of primary health care and comprises both classroom and clinical practice. A supervisory visit to the lady health worker’s community takes place every month, and monthly meetings are held at the health facility. The lady health worker is responsible for recording information about births and deaths in the community, use of family planning methods, immunization of children, diagnosis and treatment of her clients, and pregnancies and care provided. She also refers her clients to next-level facilities if they need further care.

**Coverage and effectiveness**

The program is currently employing approximately 69,000 lady health workers each being responsible for approximately 1,000 individuals. This coverage equals approximately one fifth of the entire population of Pakistan and one third of the target population of the program. External evaluation of LHW program occurs periodically in every 3-5 years and up till now 3 evaluations have been conducted. Program has achieved vaccination promotion coverage of 67% of children under five, modern contraceptive usage of 20% and overall indicators of population served by LHWs were slightly better off than National figures.

(Source: Bhuta et al., 2010)

Some of the lessons learnt from these CHW national programmes in countries around the world, as documented by the Global Health Workforce Alliance, are as follows:

**Planning, production and deployment:**

- The programmes should be coherently inserted in the wider health system, and CHWs should be explicitly included within the HRH strategic planning at country and local level.

- Given the broad role that many CHWs play in primary care, a programme must assure that a core set of skills and information related to MDGs be provided to most CHWs. They should be trained, as required, on the promotive, preventive, curative and rehabilitative aspects of care related to maternal, newborn and child health,
malaria, tuberculosis, HIV/AIDS as well as other communicable and non-communicable diseases.

- The CHW programmes should also give attention to both the content and the timings of delivering interventions at the planning stage.
- Government should take responsibility in making a transparent system for selection and deployment and further quality assurance of the regulated set system.

**Attraction and Retention**

From the outset, programmes should develop village health committees in the community that can also contribute in participatory selection processes of CHWs.

- CHW programmes should continually assess community health needs and demographics, hire staff from the community who reflects the linguistic and cultural diversity of the population served, and promote shared decision making among the programme's governing body, staff, and CHWs.
- CHW programs should also ensure a regular and sustainable remuneration package that is complemented with other rewards and incentives.
- CHW programmes should also provide opportunities for career mobility and professional development. These should include opportunities for continuing education, professional recognition, and career advancement.
- The CHW programmes should support provision of requisite and appropriate core supplies and equipment to enable appropriate functionality of such workers.

**Performance Management**

- The CHW programmes should also ensure that the performance management is based on minimum standardized set of skills that respond to community needs and are context specific.
- The programmes should have established referral protocols with community-based health and social service agencies.
- The programmes should have regular and continuous supervision and monitoring systems in place and supervision should be taught to be undertaken in a participatory manner that ensure two-way flow of information.
- The outline of the country plan of action to develop and improve CHW programmes should be finalised by a working group of relevant multiple stakeholders, including identification of resources needed, indicators and targets, and monitoring tools, and formally authorised by the Ministry of Health.
- Finally, sustained resources should be available to support the programme and workers therein.

**CHW Programme in South Africa**

One of the consequences of the HRH crisis in South Africa is a shortage of capable and motivated health care professionals; this has led to a high rate of emigration, and the resultant impact of HIV and AIDS epidemic, and high burden of disease. Furthermore, South Africa continues to be plagued with poor health outcome indicators, especially maternal and child health indicators, in comparison with other middle income countries such as Brazil and Chile. It is therefore imperative for a paradigm shift to occur in South Africa, in terms of the revitalisation or re-engineering of the PHC approach.

As mentioned earlier, the PHC re-engineering initiative was conceptualised as a result of a visit by the health minister and some health leaders to Brazil, and the renewed global interest in PHC as well as the evidence from Brazil regarding the successful implementation of its Family Health Programme. The initiative focuses on (1) the establishment of district clinical specialist teams to support improved maternal and child health outcomes, (2) strengthening the school health services and (3) implementation of ward-based PHC outreach teams.

The establishment of PHC outreach teams is primarily dependent on the deployment of CHWs to carry out quality health care services at the community level. However, the success of the PHC outreach team programme might be dependent on lessons learnt from documented historical and current experiences of CHWs in South Africa.

**Brief Historical Review of CHW programme in SA**

The history of CHW programme in South Africa is well documented, especially with regard to its response to the impact of HIV and AIDS epidemic. The earliest records of CHWs date back to the late 1920s in apartheid South Africa, where the first CHWs were trained as malaria assistants in Natal and Zululand. In the 1940s, in response to concerns regarding the effects of poor health on black migrant labourers’ and miners’ productivity, the government established health centres, which were staffed by community nurses and assistants who treated and surveyed health problems. However, many of these health centres were closed from 1948, as a result of heightened repression and segregation. Due to lack of commitment from the government, the interest in CHWs waned from 1960s to 1980s.
When the CHW programme gained global support due to the 1978 Alma Ata Declaration, CHW projects, established mostly by individuals or small civic or religious organisations, started emerging in South Africa. From the late 1970s to 1980s, various forms of CHW cadres (e.g. village health workers, lay health workers, first aid workers, etc) were initiated and CHW programmes became to mushroom in communities around South Africa.12

In the 1980s, the CHW programmes flourished due to strong support from international donors; however, they started experiencing financial challenges from 1994 as a result of withdrawal of international donor funds and lack of support from the Department of Health.11,14 By the late 1990s, the need for CHW programmes resurged due to the overwhelming impact of the HIV and AIDS epidemic on facility-based services. Thus, the home and community based care (HCBC) model emerged in South Africa as a way to provide cost-effective and compassionate care to those people infected and affected by the epidemic7 In 1999, Cabinet mandated the Departments of Health and Social Development to lead the implementation of the CHW (and HCBC) programme.16

In the 2000s, there were various initiatives by the post-apartheid government to strengthen the national CHW programme, such as, the release of the CHW Policy Framework (2004); the establishment of the National Community Health Programme and its integration into the National Public Works Programme (2004); and the registration of four community qualifications in terms of National Qualifications Framework (2006).

Due to the current policy shift towards the re-engineering of PHC in South Africa, the national CHW programme is under spotlight again, especially with regard to the deployment of CHWs for the PHC Outreach programme. Ogunmefun et al.16, however, point out that the utilisation of CHWs should not be considered as the panacea for all problems related to the provision of PHC services, without addressing the challenges highlighted in various studies on CHWs in South Africa. Thus, it is imperative for issues regarding the strengths and weaknesses of the CHW programmes in South Africa to be highlighted in this review.

**CHW programmes in SA: What are their strengths?**

Literature on CHW programmes in South Africa has shown that CHWs play an important role in the delivery of basic health services at the community level. The strength of CHW programmes is rooted in their ability to serve as a bridge between the communities and health systems. In addition, CHWs have created a voice for people living with HIV and AIDS, institutionalise notions of volunteering and build lay knowledge and expertise on health issues.8
In spite of limited resources for CHW programmes, CHWs have made a positive impact on the health sector by assisting with some of the most difficult programmes aimed at controlling and improving compliance to treatment of diseases such as tuberculosis, hypertension, diabetes, epilepsy, cancer, HIV and AIDS as well as Sexually Transmitted Infections (STIs). In addition, they have played a role in the reduction of child morbidity and mortality in South Africa by promoting nutrition, breastfeeding, immunisation, contraception and oral rehydration; however, such gains have been reversed by the HIV and AIDS epidemic.

Nxumalo et al. also note that the CHW programmes are very important in the efforts to provide comprehensive PHC services, as they have the potential to be an effective vehicle to ensure that the social determinants of health are addressed by linking communities to multiple sectors. In addition, they have the grassroots legitimacy and knowledge to ensure that marginalised communities have access to multiple sectors. For instance, the CHWs have had an impact on the social development sector where they have been involved in working with disabled children and on inter-sectoral social issues such as poverty relief, food security, water and sanitation, income generation, literacy education, obtaining child maintenance, care dependency grants and documents such as birth certificates.

In addition, the CHW programmes in South Africa are also driven by the passion of those who want to make a difference in an environment of extremely limited and inconsistent resources. This has had a strong impact on the sustainability of many CHW programmes in communities around South Africa.

**CHW programmes in SA: What are their weaknesses?**

Over the years, the CHW programmes in South Africa have been undermined by some fundamental factors that have contributed to their weaknesses. One of these factors pertains to a lack of proper mechanisms for supervising CHWs as the CHW programme entails multiple levels of accountability (or reporting). For instance, CHWs are accountable to the NPO manager, who is in turn accountable to the district health authority. In addition, they are accountable to health facilities for the clinical component of their work. CHWs are also accountable to community-based Facilitators who sometimes help to handle community conflict situations. The multiple levels of accountability sometime have impact on the feedback mechanism channels.
“The facility sometimes does not treat us well. When we report issues to them, at times they do not make any follow-ups” (CHW, North West)

“Other nurses don’t understand the duties of CHWs” (CHW, North West)

“The referral system is very poor because sometimes nurses don’t refer clients to us we just find them at home” (CHW, North West)

Another weakness is the deficiency in the monitoring and evaluation (M&E) system for the national CHW programme. A study conducted by the Department of Social Development (DSD) shows that the current M&E system for community-based services (CBS) is a lengthy paper-based system which involves a time-consuming process of consolidating reports from the CBO level to the provincial and national levels.¹⁰ At the community-based organisation level, the information is paper-based, which is sent to the district level to be captured electronically and later submitted to the provincial office. Thus, the current system creates opportunity for error and does not allow for data verification as well as interrogation of data for rigorous analysis that can contribute to programmatic improvements.¹⁹

The national CHW programme has also been plagued with insufficient funds over the years; this has resulted in the sector relying heavily on a number of unpaid CHWs. Error! Bookmark not defined.²⁰ This has therefore created tension between CHWs who are receiving stipends and those who are not, in addition to poor performance and lack of commitment. Error! Bookmark not defined. In addition, some CHWs who are on stipends believe that the amount is inadequate, thereby resulting in lack of motivation for their work.¹¹

“Caregivers are working very hard… but we can’t get stipends. We go three to four months without any stipends.” (CHW, North West)

“You know, caregivers, immediately the money is not there, they do not work fast. It affects their morale; they do not want to work.” (CHW, North West)

The disconcerting range in the training programmes for CHWs is another major challenge. Although there is a standardised curriculum and training framework for CHWs, there are many CHWs who go through training programmes that are not accredited by approved educational institutions.¹¹,¹⁴ Furthermore, there is lack of cooperation between training providers, and the teaching materials that have been produced are not being adequately disseminated, used and adapted, while existing materials are not consulted before new ones are developed. Error! Bookmark not defined.

All the highlighted factors have contributed to the failure of the national CHW programme over the years; however, efforts are currently made to address these issues in preparation
for the implementation of the PHC Outreach programme. In order to further ensure the successful implementation of the PHC Outreach programmes, there is a need for factors such as community participation, political stewardship and adequate resourcing, as well as infrastructure support to be taken into consideration (Box 7). 12

Box 7: What makes for successful CHW programmes/PHC Outreach teams?

Community participation
Community participation is a vital constituent of successful and sustainable CHW programmes. In most of the cases that show successful community participation, substantial and time-consuming investments were made in: (1) securing participation of communities and (2) involving them in all aspects of the programme, including the identification of priorities and project planning. In other words, community mobilization precedes and accompanies the establishment of CHW programmes.

Political stewardship and adequate resourcing
Successful and sustained large-scale CHW programmes usually have and certainly require significant support from government. They require advocacy, stewardship and direction from political leaders and ministerial officials to be considered an integral part of health sector activities. Attention to reliable and adequate resourcing is crucial. Where government does not create and sustain an enabling environment, CHW programmes run the risk of withering on the geographical, organisation and political periphery.

Good programme management
Management is the one of the crucial, yet often sorely neglected, factors of CHW programmes. Their geographical and organisation location on the periphery, often with ill-defined ownership and accountability, means that they need particularly careful, attentive, and sustained management.

Training/continuing education
The training of CHWs should be competence- and practice-based and located to CHW’s working context. Training materials and activities should be specifically developed for CHWs rather than using training packages developed for facility-based workers.

Supervision and infrastructure support
The success of CHW programmes hinges on regular and reliable support and supervision. Clear strategies and procedures for supervision therefore need to be defined at the outset of programmes and requisite skills need to be taught so that health personnel, CHWs and community health committee members know what is expected of them as supervisors.

Hand in hand with supportive supervision go other forms of support, in particular logistics and infrastructure support. Issues such as the reliable provision of transport, drug supplies and equipment have been identified as crucial to CHW effectiveness.

(Source: Lehmann and Sanders, 2007)
The shift towards the deployment of CHWs for PHC Outreach programme is likely to benefit the South African population, especially those in the rural areas. However, the successful implementation of the PHC Outreach programme is dependent on tackling challenges that have plagued the CHW programme over the years and taken into consideration factors such as community participation, political stewardship and adequate resourcing, as highlighted in this review.

References


18. Nxumalo N, Hlabane S, and Goudge J. The Gauteng Province Community Health Worker Programme: The extent to which it contributes to the provision of comprehensive primary health care. Centre for Health Policy; Gauteng Department of Health; Canada’s University, University of the Western Cape and University of the Witwatersrand, 2011.


Chapter 6: Demand for High Quality PHC

6.1 The India Model for community based monitoring for health accountability

The National Rural Health Mission (NRHM) was launched in 2005 by the Indian government with the goal of improving the availability of and access to quality healthcare for those in rural areas, the poor, women and children. The priority was to strengthen the public health system, with the focus on Primary Health Care (PHC), decentralised planning and community participation. In this regard, the introduction of community based monitoring (CBM) is a significant step towards ensuring service delivery, accountability and transparency at all levels of the health system. The process of CBM requires community members to actively and regularly monitor the progress of health interventions in their areas, and take action (if necessary), with support from community based organisations (CBOs) or local non-governmental organisations (NGOs). CBM is based on locally relevant priorities and issues identified by communities; thereby placing the health rights of the community at the centre of the process.

6.1.1 Resources required

CBM involves recruiting, motivating, mobilising and building capacity in individuals and communities with the purpose of directly giving feedback about the functioning of the health services. CBM is a three-way partnership between healthcare providers and managers in the health system, the community and community-based organisations or NGOs. The emphasis is on the developmental spirit of ‘fact-finding’ and ‘learning lessons for improvement’ rather than ‘fault finding’.

There are 5 stages in the CBM process: preparatory activities, capacity building and training of trainers, community assessment, interface meeting and the evaluation.

Stage 1: Preparatory activities

The first stage involves the identification of stakeholders, and the levels of services for community monitoring. A task force group is set up with representative policy makers from the state, and civil society members for planning, designing, advising and overall monitoring of the community process. CBM entails formation of planning and monitoring committees from the base up, instead of the traditional top down approach (village -> primary health care -> block -> district -> state monitoring committees). Each of these committees is represented by service providers,
Panchayati Raj Institutions (PRI) (elected officials), community and civil society organizations. The committees send a periodic report to the next higher level committee.

**Stage 2: Training of stakeholders**

Training of stakeholders is vital for CBM, as well as building capacity in representatives, community-based organisations and NGOs, who will eventually be providing the feedback. Training areas include accountability building, health rights with clarity of roles and the monitoring of indicators (demand, coverage, access, quality, effectiveness, behaviour and presence of healthcare personnel at service points, possible denial of care and negligence).

**Stage 3: Community assessment**

The core principle of CBM is tracking, recording and reporting the state of public health services in villages as experienced by people themselves. In each monitoring cycle, the information is collected about the health services at village level through group discussions, which emphasize the participation of women and other marginalised groups. Community responses are recorded in a form of rating each service as good, partly satisfactory, or bad. Information collected through this process is presented in a concise form as a ‘pictorial report card’ clearly reflecting availability, regularity, and quality of health services. These report cards rate health services using indicators for which data is generated over a three month recall period. It has three colour codes on the basis of activities completed or on track: green = 75–100%; yellow = 50–74%; red = 1–49%.

**Stage 4: Interface meeting**

This involves feedback in public hearings (*Jan Sunwai*) or public dialogue (*Jan Samvad*). In this forum, local community organisations present individual testimonies and assessment. The official mandate of *Jan Sunwai* has ensured the presence of government representatives at these meetings.

**Stage 5: Evaluation**

This involves evaluation of feedback (data entry and analysis, report submission and review, and documentation). Data collected is complied, collated and analysed in a standardized manner at different levels. Members of the task force monitor the implementation in the field through frequent, regular and planned visits.
6.1.2 Successes

A positive behaviour change in the attitudes of state officials has been described. Compared to pre-CBM, there is a greater effort by officials to understand local dialogue, engage with community perceptions, attend Jan Sunwai meetings and be more accountable to the communities. The Jan Sunwai meetings have been effectively used as a forum for accountability, and have addressed a range of issues (availability of medicine and medical personnel, corruption and illegal charging, instances of denial of health services and a number of policy related issues)\(^2\).

The sense of ownership of public health services has improved in the community “…people have a growing sense that their opinions are being heard by the public health department, and that they have some say in planning and functioning of outreach and PHC services”. This form of empowerment has a spill over effect on the other livelihood issues e.g. people involved with CBM are demanding better service delivery in other areas from officials.\(^2\)

The participation of women in CBM activities has been particularly evident. Coordinators have reported that the responses from women in the village depict a more authentic picture of the local services, when compared to men. This may be attributed to the greater involvement in CBM by women, rather than men.\(^2\)

An evaluation of CBM showed that initially, approximately 48% of health services were rated as ‘good’ by the community. Subsequently, this rating increased to 61% in round two, and to 66% in round three. The average percentage of services rated as ‘bad’ by the community decreased from 25% to 16% and to 14% over three subsequent cycles of monitoring. Improvements in specific indicators e.g. immunisation improved from 69% (rating as ‘good’ in round 1) to 90% (rating as ‘good’ in round three). Health services by primary health centre (for example, 24-hour delivery services, in-patient services, and laboratory and ambulance services) improved from 32% in the first round to 74% in the third round\(^3\).

6.1.3 Failures

While many aspects of the village health services improved, certain services like disease surveillance and village level curative services did not see much improvement, and the status of these health services remained below 50% even after third round of CBM. Moreover, CBM has a limited ability to address systemic and structural issues, and may remain confined to the periphery of the health system outreach services or only services by primary health centres. The lack of interaction between the health department and other governmental departments (such as those concerned with water supply and solid waste...
disposal) could not be addressed by the CBM process, due to the non-involvement of relevant personnel.²,³

6.1.4 Challenges

A major challenge was the tension between traditional vertical power relationships between educated, influential officials and less influential village community members. While CBM is conducted in the spirit of democracy, openness and accountability, there is resistance from those who are expected to be held accountable. Thus, the success of CBM depends on institutional acceptance and responsiveness by all health care providers; which in turn requires multiple interventions at the different levels of the health system. Moreover, it was found that the frequent transfer of key officials weakened the institutional memory associated with CBM. The CBM framework explicitly mandates the key role of PRI representatives in community monitoring. The challenge is that as elected officials, PRI individuals do not view health services as their mandate, and regard CBM as being outside their job descriptions².

The centralised decision making structures in the department rendered the entire process very time consuming. One such example was “...the issuing of the government orders for the formation of PHC, Block and District monitoring and planning committees took six months despite persistent follow up.” ²

Initially, there was poor institutional recognition of the CBM process at the district level. This was due to CBM being identified as a NGO initiative, rather than a major State initiative. This was subsequently addressed at State review workshops that highlighted the importance of CBM, and the inclusion of CBM in State activities. A related challenge was in identifying the appropriate NGOs to work on the project, as selection is based on experience of involvement in rights based work, and a significant community level presence².

Additionally, the reporting by the media posed challenges. In one district, the District Heath Officer was upset about the negative media reports and strongly contested the findings that were mentioned in it. While there is certainly a need for media advocacy, the risk is that sensationalised reporting may alienate officials, that already have some degree of resistance to the process.²

6.1.5 What could it do better?

Since planning for CBM requires a high degree of receptiveness by local officials, the CBM could be included in the District Health Plans. This ensures that CBM is seen as an intrinsic part of the district, and not as an externally imposed structure. A separate and well defined
process of orientation to CBM for health officials would build their confidence and involvement in the programme. This would also create a conducive atmosphere for dialogue and consultations.\textsuperscript{2}

Open training sessions would increase community awareness about CBM, and involve community member who are not part of the committees. One of the most effective mechanisms to ensure sustained community participation in the processes of monitoring is to present feedback to the community about positive changes in the functioning of the health system. Information on the steps taken to correct observed deficiencies should be disseminated at a community level. This would allow subsequent monitoring cycles to outline outstanding issues, and give specific attention to it.\textsuperscript{2}

In CBM, it is important to ensure that the processes of monitoring allow oppressed sections of society to voice their opinions. This is to ensure that a true ‘community voice’ is heard, and not the voices of the most powerful people in the community. It was found that perceptions of people about health services could not always be summarized in the form of ‘Good’, ‘Satisfactory’ or ‘Unsatisfactory’ ratings. There should be a provision for qualitative information emerging during the group discussions\textsuperscript{2}.

6.2 Community participation in Mother to Child Health

Three decades after the 1978 Alma Ata Declaration, high maternal and child morbidity and mortality still remains a cause for concern, especially since a large number of the deaths are preventable\textsuperscript{4}. The World Health Organisation (WHO) estimates that worldwide, 1500 women die every day due to complications related to pregnancy or childbirth. Approximately, 10 000 babies die per day within the first month of life and an equal number of babies are born dead. A disproportionate number of these deaths occur in Africa, which has 10% of the global population, but almost 50% of the total number of child deaths worldwide.\textsuperscript{5, 6}

At current trends, most high burden countries will be unable to meet the 2015 targets set by the United Nations Millennium Development Goals (MDGs).\textsuperscript{4} MDG 4 refers to a two third decrease in the Under 5 Mortality Rate from 1990 to 2015; and the target for MDG 5 in 2015, is to decrease the Maternal Mortality Ratio\textsuperscript{8} (MMR) by 75% from the levels in 1990.\textsuperscript{5}

\textsuperscript{8} The MMR is the number of women dying per year (while pregnant or within 42 days of the end of a pregnancy), due to causes related to the pregnancy, per 100 000 live births for that year.
South Africa is one such country that is not on track to meet the targets set by MDG 4 and 5. Maternal and under 5 mortality is very high, as shown in the National Department of Health’s Report of the Health Data Advisory and Coordination Committee (2011) – MMR is 310 per 100,000 and the Under 5 Mortality Rate is 56 per 1000 live births respectively. By comparison, the 2015 MDG targets for MMR and Under 5 Mortality Rate are 38 per 100,000 and 20 per 1000 live births respectively.\(^6\)

In South Africa, the Saving Mothers Reports identified the leading cause of maternal deaths as infections (such as AIDS), and complications from excessive bleeding and high blood pressure. Overall, 40% of all maternal deaths are avoidable, and are due to community, administrative and clinical factors. Maternal deaths have attendant consequences on the families, communities and the children left behind, often increasing the likelihood that they themselves will die. The commonest causes of Under 5 mortality in the country is deaths related to AIDS, including infections (TB, diarrhoeal diseases and pneumonia) and malnutrition.\(^6\)

### 6.2.1 Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)

In recognition of the burden faced by African countries, and the challenges in reaching MDG 4 and 5, the African Union Conference of Health Ministers launched CARMMA in 2009 under the theme of improving maternal, neonatal and child health. This was endorsed by the African Union Assembly in 2010, in Uganda, which included a list of actions that were committed to by governments.\(^6\) The first action is to “…broaden CARMMA as an advocacy strategy for the promotion of Maternal, Newborn and Child Health … involve all key stakeholders such as the women, children and young people, persons with disabilities, parliamentarians, community and religious leaders, civil society organizations, the media, and the private sector…”\(^6\)

One of the key approaches of CARMMA is to mobilize communities to let them know that everyone has a role to play in improving maternal and child health and to accelerate actions aimed at the reduction of maternal and child mortality in Africa.\(^6\)

The goal of CARMMA in South Africa is to accelerate the reduction of maternal and child morbidity and mortality through the faster implementation of evidence-based interventions essential to improve maternal health and child survival. This will be accomplished by effective advocacy for quality maternal and child health care, collaboration with relevant stakeholders, health system strengthening, and community empowerment and involvement. Key components related to community participation include advocacy and health promotion.
for early antenatal care and attendance/booking, empower civil organisations and communities to demand services, and build the capacity of community health workers to support the communities and health services.

6.2.2 International examples of community participation in maternal and child health

Active community participation is essential for effective community interventions such as those for maternal, newborn, and child health. True community participation is more than mobilising people to accept a health intervention; rather it is a shift from the passive provision of information via health education to health promotion (transformation of attitudes and behaviour) to empower people to have a more active role in their health. Previously, the emphasis on community participation has been focused on poor people in rural areas. However, since a majority of the world’s population now live in cities, there is a need for community engagement in urban areas, as well.

Challenges of this process include the difficulties in engaging individuals, and enabling them to adopt positive health behaviours such as early antenatal booking. Furthermore, in many countries, local-health committees have had little accountability to their communities, and the level of representation of women is low. Representatives themselves can be passive in the face of service bureaucracies because of an absence of local ownership and different perceptions of priorities. Further challenges include the lack of coordination between programmes (horizontal and vertical) and existing health workers, as well as a shortage of trained health staff at primary health settings. Added to this is the lack of common measures and targets across the continuum of care, and conflicting views between community, outreach and facility based strategies.

In India, a participatory intervention that used women’s groups demonstrated improvements in maternal outcomes and the neonatal mortality rate (NMR). The study was held in underserved indigenous communities in two of the poorest states, as shown by 40% of the population living below the poverty line, and high levels of illiteracy (63%). The NMR and MMR in these two states were higher than India’s national standards.

The intervention involved the community forming women’s groups, facilitated by a community member. The facilitator underwent a training course to practice communication techniques, and was supported by the local district coordinators. Community members who

---

1 NMR = Number of deaths in the first 28 days of life per 1000 live births
were not regular group members were also encouraged to participate in discussions. Information about clean delivery practices and care-seeking behaviour was shared through stories and games, rather than presented as key messages. By discussion of case studies imparted through contextually appropriate stories, group members identified and prioritised maternal and new-born health problems in the community, collectively selected relevant strategies to address these problems, implemented the strategies, and assessed the results. Although some strategies were common, each group was free to implement its own combination of strategies. Groups used methods such as picture-card games, role play, and story-telling to help discussions about the causes and effects of typical problems in mothers and infants, and devised strategies for prevention, homecare support, and consultations.9

Health committees were formed for community members to express their opinions on the management of local services,10 village representatives within every cluster met once every two months. As a result, committee members became more knowledgeable about the government health system and assisted with the formation of village health committees as part of the National Rural Health Mission programme (discussed in Section 1). Workshops were provided for the government health staff in the districts, and participants assessed the programme qualitatively at the end of every training session. This resulted in 55% of all pregnant women joining the women's support groups and a subsequent 32% reduction in the NMR.9

Similar findings have been reported in Nepal8, and in Pakistan, which used community mobilisation through group sessions as well as home visits by community health workers. This showed increased rates of skilled birth attendance and facility-based care.4 Other studies in Asia have demonstrated the role of community support and advocacy groups in combination with preventive and therapeutic care provided by community health workers. There is a demonstrated improvement in delivery care and breastfeeding practices, and care seeking behaviour for newborn illnesses, leading to reductions in NMR. There might also be added benefits on female empowerment and family relationships.4 The deployment of women’s groups or community-support groups through trained community health workers offers a cost-effective mechanism for reaching populations at risk and linking appropriate home based and facility base care.10 In Mexico, community-based health promoters have increased exclusive breastfeeding rates and decreased morbidity due to diarrhoeal diseases. In Ethiopia, a study of mother coordinators trained to teach other local mothers to recognise symptoms of malaria in their children and to promptly give chloroquine achieved a 40% reduction in under-five mortality.4
These recent studies greatly add to the global evidence base of intervention and delivery strategies that might improve maternal and newborn outcomes. Although improved maternal emergency obstetric care and health-system interventions to improve access and quality of care remain crucial to improving maternal survival, future strategies to improve maternal and new-born survival need to integrate community-based strategies and facility-based care\(^\text{10}\).

References


Chapter 7: Implications for the Future and Conclusion

7.1 Consolidation of Topics in Review

This review explores the revitalisation of PHC in South Africa by focusing on the role of communities in the process of strengthening the PHC and quality of care. The issues discussed in this review will contribute to the planning process for the development of the Soul City series 12, and the development of Soul Buddyz materials. The overall goal of the Soul City drama series is to demonstrate the need for community engagement with regard to primary health service delivery and holding local services accountable.

The review examines the policy and legislative framework for PHC such as, the National Health Act (No. 61 of 2003), Negotiated Service Delivery Agreement (NSDA), National Health Insurance and the PHC re-engineering strategy. It also defines primary health care as a philosophy that governs the principles and strategies for the organisation of health systems, around the central focus of health being a fundamental human right. This was proposed by the World Health Organization (WHO) in the Alma Ata Declaration of 1978.

The need for community participation is also emphasised; this is defined as the contribution of material or labour, appropriate organisational structures, or the empowerment of communities to manage health matters, enabling them to decide and take action that they believe is essential to their health. The review emphasises that, while there is widespread agreement as to the need for community participation, there have not been many successes in its implementation. Thus, it suggests four preconditions to be met for successful community participation: political commitment, reorientation of health professionals, development of self-management capabilities of local communities, and the socioeconomic situation in the country being conducive to development.

The review also explores the utilisation of PHC services in South Africa. It highlights the barriers to PHC utilisation, such as distance to health facilities, financial constraints, long queues of patients, and uncaring behaviour of health workers. It also emphasises the fact that rural South Africans are more likely than those in the urban areas to face these challenges. The review also discusses how social determinants of health and health system-related issues (e.g. inadequate private health care in rural areas) have impacted on access to health care in South Africa. It points out that the shift towards community-level care is likely to benefit rural population; however, there is a need for the specific conditions and realities of rural areas to be taken into account when addressing health inequities in South Africa.
The role of clinic committees is also discussed. Governance structures in the form of clinic committees, hospital boards and district health councils are intended to act as a link between communities and health services, and to provide a conduit for the health needs and aspirations of the communities represented at various local, district, provincial and national levels. The review focuses on the role of clinic committees and the contribution they make to impacting on health services where they are functional. It further addresses the factors that need to be addressed to ensure effective community participation through a well-functioning empowered clinic committee. This includes political commitment, clarifying roles and responsibilities, dedicating the necessary resources, building capacity for clinic committee members, addressing the attitudes of health workers towards health governance structures, ensuring inclusive representivity of the clinic committee members, involving communities and being mindful of the political and socio-economic context which may also influence the achievements of the committee.

Furthermore, the review provides an overview of the CHW/PHC Outreach programme. It points out that the main goal of the programme is to provide preventive, promotional, and in some cases, curative services to households and communities. CHWs may also be required to provide services to clients at health facilities at the primary level, either during a consultation or through follow-up visits in the home. It highlights the weaknesses of CHW programmes such as insufficient funds, deficiency in M&E, and lack of proper mechanisms for supervision of CHWs, while the strength of CHW programmes is rooted in their ability to serve as a bridge between the communities and health systems and creating a voice for people living with HIV and AIDS.

Lastly, the review focuses on the demand for high quality PHC services. It explores community-based monitoring (CBM) as a significant step towards ensuring service delivery, accountability and transparency at all levels of the health system. It emphasizes that the process of CBM requires community members to actively and regularly monitor the progress of health interventions in their areas, and take action (if necessary), with support from community based organisations (CBOs) or local non-governmental organisations (NGOs). It also points out that one of the most effective mechanisms to ensure sustained community participation, in the processes of monitoring, is to present feedback to the community about positive changes in the functioning of the health system.
7.2 Implications for the future and conclusion

The review shows that community participation is an essential component of the revitalisation of PHC in communities in South Africa. However, mechanisms need to be in place to address challenges pertaining to involvement of community in health systems, such as confusion about roles and responsibilities, inadequate infrastructural support, and lack of participatory intervention. It is also imperative to rectify the inequalities and inequities of the past, especially in the rural areas. In addition, the government of South Africa needs to work with communities in order to play an active role in identifying their needs, planning, implementing and evaluating intervention programmes such as the PHC re-engineering policy and the national health insurance.
### Appendix A: List of Stakeholder in PHC Re-engineering

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Area of expertise</th>
<th>Tel</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yogan Pillay</td>
<td>NDoH</td>
<td>DDG, Strategic Health Programmes</td>
<td>0825519437</td>
<td><a href="mailto:Pillay@health.gov.za">Pillay@health.gov.za</a></td>
</tr>
<tr>
<td>Jeanette Hunter</td>
<td>NDoH</td>
<td>DDG Primary Health Care</td>
<td>0823351764</td>
<td></td>
</tr>
<tr>
<td>Rams Morewane</td>
<td>NDoH</td>
<td>CD: District Health Services</td>
<td>0836280137</td>
<td><a href="mailto:MorewR@health.gov.za">MorewR@health.gov.za</a></td>
</tr>
<tr>
<td>Kethisa Taole</td>
<td>NDoH</td>
<td>PHC</td>
<td>0828730105</td>
<td><a href="mailto:taolek@health.gov.za">taolek@health.gov.za</a></td>
</tr>
<tr>
<td>Bennett Asia</td>
<td>NDoH</td>
<td>Health governance</td>
<td>0825643490</td>
<td><a href="mailto:asiabe@health.gov.za">asiabe@health.gov.za</a></td>
</tr>
<tr>
<td>Yvonne Mokgalagadi</td>
<td>NDoH</td>
<td>Health governance</td>
<td>0823119240</td>
<td><a href="mailto:MokgaY@health.gov.za">MokgaY@health.gov.za</a></td>
</tr>
<tr>
<td>Peter Barron</td>
<td>NDoH</td>
<td>PHC Re-engineering</td>
<td>0733682129</td>
<td><a href="mailto:pbarron@iafrica.com">pbarron@iafrica.com</a></td>
</tr>
<tr>
<td>Nhlanhla Ntuli</td>
<td>NDoH</td>
<td>HMIS</td>
<td></td>
<td><a href="mailto:NtuliNH@health.gov.za">NtuliNH@health.gov.za</a></td>
</tr>
<tr>
<td>Hasina Subedar</td>
<td>NDoH</td>
<td>Consultant to NDoH: PHC outreach teams</td>
<td>0832734567</td>
<td><a href="mailto:hasinas@telkomsa.net">hasinas@telkomsa.net</a></td>
</tr>
<tr>
<td>Elroy Paulus</td>
<td>NDoH</td>
<td>Consultant to NDoH: PHC outreach teams</td>
<td>0827485621</td>
<td><a href="mailto:elroy@blacksash.org.za">elroy@blacksash.org.za</a></td>
</tr>
<tr>
<td>Helen Schneider</td>
<td>UWC</td>
<td>Researcher and M&amp;E: PHC Outreach tams</td>
<td>0832750277</td>
<td><a href="mailto:hschneider@uwc.ac.za">hschneider@uwc.ac.za</a></td>
</tr>
<tr>
<td>Uta Lehmann</td>
<td>UWC</td>
<td>Researcher: CHWs</td>
<td></td>
<td><a href="mailto:ulehmann@telkomsa.net">ulehmann@telkomsa.net</a></td>
</tr>
<tr>
<td>Tanya Doherty</td>
<td>MRC SA</td>
<td>Researcher and mHealth: PHC Outreach tams</td>
<td></td>
<td><a href="mailto:tanya.doherty@mrc.ac.za">tanya.doherty@mrc.ac.za</a></td>
</tr>
<tr>
<td>Sarah Rohde</td>
<td>UWC</td>
<td>Researcher and M&amp;E: PHC Outreach tams</td>
<td>0761551799</td>
<td><a href="mailto:sarahrohde@me.com">sarahrohde@me.com</a></td>
</tr>
<tr>
<td>Irwin Friedman</td>
<td>SEED consulting</td>
<td>Researcher: PHC Outreach tams, CHWs, mHealth</td>
<td>0836018235</td>
<td><a href="mailto:Irwin@seedtrust.net">Irwin@seedtrust.net</a></td>
</tr>
<tr>
<td>Bernhard Gaede</td>
<td>UKZN CRH</td>
<td>Researcher: PHC re-engineering</td>
<td>0849033557</td>
<td><a href="mailto:Gaedeb@ukzn.ac.za">Gaedeb@ukzn.ac.za</a></td>
</tr>
<tr>
<td>David Sanders</td>
<td>UWC</td>
<td>Researcher: CHWs</td>
<td></td>
<td><a href="mailto:sandersdav5845@gmail.com">sandersdav5845@gmail.com</a></td>
</tr>
<tr>
<td>Name</td>
<td>Institution</td>
<td>Area of expertise</td>
<td>Tel</td>
<td>Email</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------</td>
<td>--------------------------------------------</td>
<td>-----------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Richard Cooke</td>
<td>Wits CRH</td>
<td>PHC re-engineering</td>
<td>0842403857</td>
<td><a href="mailto:Richard.Cooke@wits.ac.za">Richard.Cooke@wits.ac.za</a></td>
</tr>
<tr>
<td>Jack Lewis</td>
<td>Community Media Trust</td>
<td>PHC outreach teams</td>
<td>0824671621</td>
<td><a href="mailto:idoljack@iafrica.com">idoljack@iafrica.com</a></td>
</tr>
<tr>
<td>Andrew Robinson</td>
<td>NW DoH</td>
<td>DDG, North West DoH</td>
<td>0183883785</td>
<td><a href="mailto:arobinson@nwpg.gov.za">arobinson@nwpg.gov.za</a></td>
</tr>
<tr>
<td>Rahab Senokwane</td>
<td>NW DoH</td>
<td>PHC re-engineering champion, North West DoH</td>
<td>0712457020</td>
<td><a href="mailto:rsenokwane@nwpg.gov.za">rsenokwane@nwpg.gov.za</a></td>
</tr>
<tr>
<td>Muzi Matse</td>
<td>HST</td>
<td>Support implementation: PHC outreach teams</td>
<td>0834462162</td>
<td><a href="mailto:Muzi@hst.org.za">Muzi@hst.org.za</a></td>
</tr>
<tr>
<td>Waasila Jassat</td>
<td>HST</td>
<td>Support implementation: PHC outreach teams</td>
<td>0827830773</td>
<td></td>
</tr>
<tr>
<td>Tumelo Mampe</td>
<td>HST</td>
<td>Support implementation: PHC outreach teams</td>
<td>0716843656</td>
<td><a href="mailto:tumelo.mampe@hst.org.za">tumelo.mampe@hst.org.za</a></td>
</tr>
<tr>
<td>Catherine Ogunmefun</td>
<td>HST</td>
<td>Researcher: PHC outreach teams</td>
<td>0829462959</td>
<td><a href="mailto:Catherine.ogunmefun@hst.org.za">Catherine.ogunmefun@hst.org.za</a></td>
</tr>
<tr>
<td>Rhulane Madale</td>
<td>HST</td>
<td>Researcher: PHC outreach teams</td>
<td>0829462871</td>
<td><a href="mailto:Rhulane@hst.org.za">Rhulane@hst.org.za</a></td>
</tr>
</tbody>
</table>