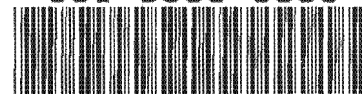


The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.



139

**SHOULD COMMUNITY HEALTH  
WORKERS BE INCORPORATED IN TO  
SOUTH AFRICA'S NEW NATIONAL  
HEALTH SYSTEM?**

**A case study investigating the roles of  
community health workers, and illustrating  
the attitudes of residents to local healthcare  
services in an informal settlement near  
Cape Town.**

**DISSERTATION FOR M.A. IN PRACTICAL ANTHROPOLOGY BY  
COURSEWORK AND DISSERTATION  
MARCH 2000**

**CAROLINE DRUMMOND-HAY  
DEPARTMENT OF SOCIAL ANTHROPOLOGY  
UNIVERSITY OF CAPE TOWN, SOUTH AFRICA**

## EXECUTIVE SUMMARY

This paper explores the role of community health workers in community health, and argues that community health workers should be a part of South Africa's new National Health System. Research was conducted in the community of Masiphumelele, a semi-urban settlement in the Western Cape's Southern Peninsula Municipality, with a population of approximately 15,000. Health care, provided by a municipal clinic, is limited to curative and promotive care for children up to the age of six, family planning, and adult curative care for Tuberculosis patients and those with Sexually Transmitted Diseases. For all other health services Masiphumelele residents must travel to the District Hospital in Fishoek.

South Africa's new National Health System is aimed at providing a health service based on primary health care, that is to be equitable, accessible, and emphasises community involvement. It also aims to empower people to take greater responsibility for their own health - aims which this research shows have not yet been achieved. The National Health System is lacking in financial, structural, and human resources. A significant proportion of the research sample expressed dissatisfaction with health care services in Masiphumelele. However, community health workers are playing an important role in over-coming some of the difficulties and complexities patients experience when encountering the health system.

There are four community health workers operating in Masiphumelele. Despite not being recognised by the government as professional health care providers, these community health workers are delivering some of the prime objectives and achieving the founding principles of the new national health system. They advise residents on health issues and social problems, administer basic medicines and first aid, provide health education and information, advocate for community involvement in health, encourage people to seek medical attention, and work as facilitators to improve access to health resources.

Using ethnographic research methods, this paper demonstrates that community health workers are bridging a gap that exists between health care providers and users in Masiphumelele. In addition, through their activities they are advocating for community involvement in health, and empowering the people of Masiphumelele to make informed decisions and thus take greater responsibility for their own health.

## ACKNOWLEDGEMENTS

There are several people without whom this research would not have been possible. Firstly, Tanya Doherty and Chantelle Juby, the two nurses who founded the Masiphumelele Community Health Project, for whom I conducted this research as an internship, and compiled a report based on my findings. My thanks also go out to Pumla Gobololo, Ayanda Mhlambiso, Kholiwe Jokiwe and Skolweni Zelanga, the community health workers in Masiphumelele. Also to Zukiswa Sidlayi, my research assistant, translator, and now a friend. The sisters at Nomzamo Clinic. Lauren Muller at Health Systems Trust, for information on South Africa's new District Health System. Brian Charlton at Southern Peninsula Municipality's Housing Planning Department, for providing street maps of Site Five. To Tessa Dowling, for her patience in teaching me Xhosa. And all the people of Masiphumelele who gave up the time to respond to questionnaires and to talk to me. Finally my supervisor, Dr. Lesley Fordred, from the Department of Social Anthropology, University of Cape Town.

## TABLE OF CONTENTS

	PAGE
<b>EXECUTIVE SUMMARY</b>	1
<b>ACKNOWLEDGEMENTS</b>	2
<b>TABLE OF CONTENTS</b>	3-4
<b>TABLE OF PHOTOGRAPHS</b>	5
<b>ACRONYMS</b>	6
<b>1. INTRODUCTION</b>	7-15
– Importance of community-based healthcare services	7
– Primary Health Care	7
– What is a Community?	8
– What is Community Participation?	9
– Implementation of Community Involvement in Health	11
– CIH in South Africa	13
– The Importance of Community Based Health Workers	13
<b>2. HEALTH CARE IN SOUTH AFRICA</b>	16-25
– Health and Development	16
– Health Policy in South Africa – the new DHS	17
– Background to Masiphumelele Community Health Project	22
Map of Southern Peninsula	26
Street Map of Masiphumelele	27
<b>3. DESCRIPTION OF STUDY COMMUNITY</b>	28-44
– General community data	29
– History	29
– Geographic setting	30
– Demographic data	33
– Educational facilities, attendance, literacy rate	34
– Health resources data summary	35
– Nomzamo Clinic	35
– SHAWCO	36
– Private Doctors	36
– Masiphumelele Community Health Project	40
<b>4. METHODOLOGY</b>	47-52
– Rapid Assessment Procedure	47
– Sample selection	48
– Techniques	49
– Participant observation	49
– Household interviews	49
– Focus groups	50
– Field notes	50
– Research timetable	50
<b>5. RESULTS</b>	53-64
– Household Data	53
– Descriptions of households	53
– Knowledge and use of health services	54
– Attitudes to health services	55
– Healthcare resources	61
– Clinic activities	61
– False Bay Hospital	62

–	Community Health Workers	64
<b>6.</b>	<b>CONCLUSIONS AND DISCUSSION</b>	<b>68-73</b>
–	Gaps in the New Health Care System	68
–	Are The Masiphumelele CHWs Fulfilling Their Objectives?	69
–	Interaction Between Health Care Users and Providers	71
–	Can the work of the Masiphumelele CHWs be improved?	72
	<b>APPENDICES</b>	<b>74-77</b>
I	Respondents Complaints Regarding Health care Services in Site Five	74
II	Philisa Health Project Mission Statement	75
III	Household Interview Questionnaire	76
IV	Household interview data summary	77
	<b>BIBLIOGRAPHY</b>	<b>78-79</b>

University of Cape Town

## PHOTOGRAPHS

1	Masiphumelele viewed from Ou Kaapse Weg, looking south-west across the Noordhoek Valley	P. 32
2	View along one of the main roads in Masiphumelele	P. 32
3	Children at the crèche	P. 38
4	Women selling sweets and chips at the school gates during lunch time	P. 38
5	Ukhanyo Primary School	P. 39
6	Nomzamo Clinic	P. 39
7	Community Health Workers: Kholiwe Jokiwe & Ayanda Mhlambiso.	P. 46
8	Community Health Workers: Skolweni Zelanga & Pumla Gobololo with her children	P. 46
9	Zukiswa Sidlayi, my translator and research assistant	P. 51
10-13	Some residents of Masiphumelele who were interviewed as research informants	P. 52

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based organisation
CDR	Committee for the Defence of the Revolution (Cuba)
CHW	Community health worker
CIH	Community Involvement in Health
CWB	Catholic Welfare Bureau
DAG	Development Action Group
DHC	District Health Council
DHS	District Health System
DOTS	Direct Observation Treatment System
FBH	False Bay Hospital
FP	Family Planning
GEAR	Growth, Employment and Redistribution
GNU	Government of National Unity
HIV	Human Immune Deficiency Virus
HST	Health Systems Trust
NGO	Non-government organisation
NPPHCN	National Progressive Primary Health Care Network
OT	Occupational Therapist
PHC	Primary Health Care
RDP	Reconstruction and Development Programme
SPM	Southern Peninsular Municipality
STD	Sexually transmitted disease
TB	Tuberculosis
VDP	Valley Development Project
WHO	World Health Organisation

## INTRODUCTION

Historically, health care has been a site of great inequality in South Africa. During the Apartheid era health care was inequitable, inadequate, and racially based; it was a privilege rather than an equitable and accessible service. The Government of National Unity (GNU) is attempting to redress these inequalities, thus South Africa's health system is undergoing a radical process of transformation. The aims of the new National Health System (NHS) are to promote health and health knowledge, to provide an equitable, accessible, and appropriate health service, and to empower people to take greater responsibility for their own health, through community participation and a primary health care approach. This paper explores the role of community health workers (CHWs) in community health, and argues that community health workers should be a part of the new NHS.

This thesis is divided into two parts. The first part explores the importance of community based health care services and of community involvement in health; examines the current state of health care in South Africa; and provides a review of the Department of Health's *White Paper for the Transformation of the Health System in South Africa*. Having examined the framework on which South Africa's national health system is based, and discussed the aims of health service delivery in South Africa, the second part of the paper looks at a specific case study in order to compare health policy with practice. The case study is of an African shack settlement, Masiphumelele, in Cape Town's Southern Peninsula Municipality. A Community Health Project was established in Masiphumelele in December 1998. The study found that the community health workers (CHWs) in Masiphumelele are fulfilling an important role by bridging a gap that exists between health care providers and users. In addition, they have eased the pressure on the limited resources of the community clinic, and are contributing to the development of the community by improving people's standards of living through health education and empowerment.

In the case of Masiphumelele, it is the community health workers, and not the government-funded health services, who are achieving the aims and objectives of South Africa's new National Health System – equity, accessibility, and appropriateness of health services, as well as health education and empowering people to take greater responsibility for their own health.

### The Importance of Community Involvement in Health

#### Primary Health Care

The concept of Primary Health Care was adopted at the Conference of Alma Ata in 1978, and was fully embraced by South Africa's Government of National Unity in the *White Paper for the Transformation of the Health System* (1997). The Reconstruction and Development Programme (RDP) states that "the way to real development is through democracy which allows everyone the opportunity to shape their own lives and to make a contribution to development." It contends that people who are affected by decisions must take part in making these decisions, and must be given the knowledge and the power to do so in an informed manner.

*“Development is about active participation of people and growing empowerment. The strengthening of individuals, forums and community based structures by addressing the development of human capabilities, knowledge and know-how is essential to the ever-growing demands for the eradication of poverty and underdevelopment. Creating the mechanisms for the community voice to be heard, and for the inclusion of the community input in integrated development strategies is one of the first steps toward building the capacity of our people.”<sup>1</sup>*

Community participation in decision making is one of the fundamental principles of primary health care. Primary health care (PHC) takes a holistic approach to health, reflecting the belief that health can not be attained only through improvements in formal health service delivery. PHC is seen and implemented as part of a wider development strategy, promoting inter-disciplinary and inter-sectoral collaborative teamwork for development. A progressive PHC approach not only provides comprehensive quality healthcare, including preventative, promotive, curative, rehabilitative and palliative services, but also addresses the causes of poor health, encourages community empowerment, and prioritises those who are most disadvantaged, ensuring that healthcare is accessible, equitable and affordable to all.

South Africa's decision is an international landmark for primary health care. During the 1950s and 60s community involvement in health was virtually inconceivable. There was an international trend towards modern health facilities, high technology, and big hospital complexes. ‘Communities’ were viewed by the health sector as “passive groups of individual recipients of healthcare services planned and provided by healthcare professionals”.<sup>2</sup> Although there was widespread recognition of the importance of primary health care and community involvement in health, implementation at a national level would require complete restructuring of the healthcare system. Consequently primary health care initiatives were usually implemented at a local level by non-government organisations and church groups. But restructuring the national health system is exactly what the White Paper proposes, and what the government has undertaken in its development of a District Health Service (see chapter 2).

### What is a community?

It is important at this stage to clarify what is meant by “community”. The word ‘community’ is a misleading term. It suggests an isolated group of people, living in a place with demarcated boundaries, of which membership is exclusive. This is clearly unrealistic. Boonzaier and Sharp (1988) question the very existence of communities, and conclude that they do exist because people believe in them, desire them, and act as if they do exist as clearly bounded, homogenous social units. At the same time, they acknowledge that boundaries are porous, and that within the ‘community’ individuals may have multiple identities. They suggest a community be understood as “an image of coherence, a cultural notion which people use in order to give a reality and form to their social actions and thoughts.”<sup>3</sup> And in a sociological context,

<sup>1</sup> Masiphumelele Community Needs Assessment, December 1997, Preface - p. iii

<sup>2</sup> <http://www.healthlink.org.za/pphc/idasal.htm> p.6

<sup>3</sup> Boonzaier, E., & Sharp, J., 1988, p. 38

the “existence of communities is founded on more or less intense social interaction among their members, which inevitably produces social boundaries defining them and giving them identity”.<sup>4</sup> A community is not a closed group; it is dynamic. People come and go, and many belong to more than one community simultaneously. People can have multiple identities.

For example, many occupants of Masiphumelele have come from the Transkei or Eastern Cape to Cape Town in search of employment, and return to their place of origin to visit their families each year. Just because they have moved to Cape Town to look for work and are now part of a community here, does not mean they ceased to be members of their original community in the Transkei or Eastern Cape. Similarly, a man might fulfil different roles in the communities. He might be a father and a husband in the Transkei, and in Masiphumelele a worker who sends money home to his family. He has different identities. In the current context, ‘community’ refers to a diverse group of people who have something in common, in this case that they live in the same geographical location – Masiphumelele. Within that geographical location further groups can be distinguished, for example by age, gender, language, religion, income level, education, etc., which interact with each other in a complex manner, and within these groups every individual is also different. Competing interests and power dynamics also exist and are generated within this setting, and further contribute to the complexity of relationships. So there is little that is homogenous about most groups of people identified as communities.

#### What is community participation?

*“The aim of community participation is to increase people’s involvement and contributions at the local level. This results in a process where the people play an active and direct role in the development of appropriate services to maintain the conditions which promote better well-being and empowerment. ...The process is based on the view that development of the poor cannot occur unless the poor themselves control the process through the experience of participation.”<sup>5</sup>*

Whilst there is general agreement that it is important for communities to participate fully in the health system, there is little consensus as to what this actually means. Community participation is variously understood. It may be seen as (a) passive participation - the contribution of money, material or labour; (b) appropriate organisational structures; or (c) empowerment of communities to make informed decisions and take actions they believe to be necessary regarding their health.<sup>6</sup> In its ideal form, community participation is a partnership between individuals, groups, health organisations and health professionals, so involves many different levels and types of involvement. The Declaration of Alma Ata endorsed “active community participation in healthcare decision making”. This means empowerment of individuals and communities to make decisions about their own affairs and to participate in planning and management of health services.

<sup>4</sup> Boonzaier, E., & Sharp, J., 1988, p. 38

<sup>5</sup> Irwin Friedman (NPPHCN), Community Participation, in Department of Health’s *Handbook for District Managers*, July 1998, p. 147

<sup>6</sup> <http://www.healthlink.org.za/pphc/idasa1.htm> p.5

The impact and benefits of community participation depend on the extent to which individuals are empowered. Amongst any group of people it is almost inevitable that hierarchies will develop. Power relations and power struggles exist, resulting in more powerful individuals gaining greater access to resources (such as information, education, healthcare, and power) than others. People who have the least power also tend to have diminished access to resources. It is these people that 'community involvement in health' initiatives are designed to empower. In previous efforts elsewhere in the world<sup>7</sup> attempts at community involvement in health have failed because they have attempted to organise and mobilise entire 'communities' to participate in the health sector, but did not empower individuals to use resources available to them and to take increased control of their own lives, nor did they encourage the sharing of control between provider and empowered participants. For community participation to succeed the approach should move away from compliance and contribution towards empowerment and self governance.<sup>8</sup>

What are the potential benefits to be gained from actively involving members of the public - healthcare recipients - in their health and the health system? The benefits of community involvement in health are far wider reaching than one might at first imagine, and even when weighed against the costs, the importance of community involvement is clear.<sup>9</sup> Let us start with the benefits:<sup>10</sup>

- In a democracy, individuals have a fundamental human right to make decisions regarding their own lives, including health decisions;
- Effective, active participation in health care can give people insight into the causes of ill health, thus empowers them to make informed decisions regarding their health and lifestyle;
- Taking personal responsibility for one's health is vital for a healthy lifestyle;
- Community involvement in health encourages a sense of responsibility and thus builds self esteem;
- Community involvement in health helps develop a relationship of trust between healthcare providers and consumers;
- Community involvement in health ensures the appropriateness of health services for a community's needs;
- Community involvement in health encourages a sense of ownership through participatory decision making;
- Community involvement in health creates political awareness;
- Personal involvement in health lessens dependency on healthcare professionals, so can reduce the need for health services;
- Consumer awareness improves accountability of health personnel, and hence quality of care and cost effectiveness of health services.

In short, it is the only way to sustain a truly democratic healthcare system, and the only way South Africa can achieve the goals it has set itself, namely to create a comprehensive health system that is equitable, accessible, and appropriate.

<sup>7</sup> <http://www.healthlink.org.za/pphc/idasal.htm> p. 6 Also see case study of Quebec Province, Canada, on page 12 of this paper.

<sup>8</sup> Friedman, I., 'Community Participation' in Department of Health's *Handbook for District Health Managers*, July 1998. P. 151.

<sup>9</sup> Friedman, I., 'Community Participation', in Department of Health's *Handbook for District Managers*, July 1998. P. 149

<sup>10</sup> <http://www.healthlink.org.za/pphc/idasal.htm> p.12

There are of course costs involved. Community participation involves costs and financing by both the health system and care providers, and by the recipients of that healthcare. It is not a magic bullet. Considerable changes are needed in government, health and other development sectors in order for participation to be effective. There must be community-based training and support, and health professionals must be prepared to listen to what the public have to say and be guided by it. This requires a reorientation of health professionals, who must be adaptable to new approaches and improvements.

### Implementation of Community Involvement in Health

Political commitment to primary health care and community involvement in health is one thing, but implementation is another. That is why ethnography is so important; ethnography is a tool with which to examine how policy becomes practice. Internationally, the majority of efforts have involved low levels of community participation. For example, the organisation presents its plans to communities in an effort to develop support and acceptance, but expects compliance and will only make changes if absolutely necessary. It is difficult to find international examples where active participation has been attempted on a national scale and has succeeded, but the cases of Cuba and Quebec are instructive.

#### **Case Study 1: Cuba<sup>11</sup>**

Cuba spent many years developing institutional structures that involve the people in decision making and policy processes. Committees for the Defence of the Revolution (CDRs) were developed, originally to prevent acts of terrorism. At one time eight out of every ten Cubans were 'voluntary' members (how much choice they had in the matter is not clear). Each CDR also had areas of involvement that included health, education, social services, housing, police, and others, and were responsible for stimulating community participation in the discussion of all policy and legal documents, and implementation of mass campaigns. At a provincial and national level, public officials were elected to People Power Assemblies in order to represent 'community interests'.

Provincial authorities were responsible for secondary and tertiary level health facilities, and municipalities for municipal hospitals and health centres. Every facility has an advisory committee consisting of community representatives or mass organisations, whom hospital management must consult on all issues that affect or require community participation.

Cuba also has a unique 'Family Doctor Programme', which assigns a family doctor and a nurse to every 120-140 families. As well as being responsible for all the health needs of those families, the family doctors carry out health education and promotion. There is disagreement among researchers as to whether or not the Family Doctor Programme is empowering to the people. On the one hand it is argued that it has succeeded in training individuals and groups in health related topics, so has strengthened the people's participatory skills. On the other hand due to the large surplus of doctors in Cuba people have become too dependent on medical professionals, and health education is actually disempowering people from taking

---

<sup>11</sup> <http://www.healthlink.org.za/pphc/idasa1.htm> p.11-12

responsibility for their own health. The surplus of doctors has also lessened the demand for community-based health workers, who were better at addressing health issues in their broader socio-economic context than medical doctors are.

### Case Study 2: Quebec<sup>12</sup>

A major goal of the 1971 health reforms in Quebec Province, Canada, was to increase community participation in the health system. The existing elite hospital boards were replaced with “democratic” hospital boards, supposedly representing each of the hospital’s major interest groups. Two representatives had to be users of the hospital, two had to represent the major economic groups of the community, and four were representatives of the Hospital Corporation. The rest of the Board was made up of one hospital professional, one physician, one non-professional staff member, one resident, and a representative from a local referring clinic.

However, hospital managers effectively controlled the selection process, and attempted to re-elect upper-income members. In addition, new members were limited by their lack of experience and lack of understanding of their new role. They were given no formal training, but were instructed by Hospital Managers as to which issues they should discuss. Hospital managers found that the new boards slowed down their decision making process, as well as feeling threatened by having employees on the Board, so they moved a lot of Board business outside of formal Board meetings. Thus the purpose of the new Boards was defeated. Although the new legislation had institutionalised members of the public on Boards, it did not empower people or ‘communities’. Instead it decreased the authority of hospital boards, and concentrated the power of hospital management.

Cuba created a position for healthcare users in the governance of the healthcare system, as well as refocusing the role of health professionals to become public health officers for the community. Whether or not this has empowered communities (groups of individuals) is still under debate. In Quebec a ‘top-down’ approach to Community Involvement In Health was implemented. There are several reasons why it failed. Firstly, the government asked people to participate in their pre-determined agenda. Secondly, they failed to provide any formal training to empower new Board members about their role in ensuring accountability to communities. Thirdly, there was no mechanism to link Board members with the broader community. Quebec has subsequently instigated another restructuring of community participation in health, this time emphasising community empowerment.

These two cases show that Community Involvement in Health is difficult to establish and to maintain. It is a process that needs constant evaluation to ensure its relevance and sustainability. South Africa must take note of lessons that can be learned from international experience. Community Involvement in Health requires not only political commitment, but also a socio-economic situation that is conducive to development, reorientation of health professionals, and empowerment through education and training of local communities.

---

<sup>12</sup> <http://www.healthlink.org.za/pphc/idasa1.htm> p. 9-10

## Community Involvement in Health in South Africa

In 1994, Community Agency for Social Equity (CASE) conducted a national survey for the National Progressive Primary Health Care Network (NPPHCN) in order to establish whether or not South Africans actually wanted to become actively involved in managing their health system. The results indicated that the vast majority did want to be involved, particularly in deciding on clinic opening times, appointing staff, modifying negative attitudes of staff, and structuring fees. At that time only 7% of the survey population said there was an elected community health committee in their area which enabled them to participate in local affairs.<sup>13</sup>

The *White Paper for the Transformation of the Health System in South Africa* gives three principles for involving the community in the health sector:<sup>14</sup>

1. All South Africans should be equipped with the information and means for identifying behavioural change conducive to improvement in their health.
2. People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services.
3. The Department of Health should provide the public with regular updated information on progress, results and emerging issues related to its work, and should ensure that people participate in the development of national policy.

Suggested implementation strategies include: creating clinic, health centre, hospital and community health committees (a) to act as advocates of positive behavioural change in their communities, and (b) so that service users can participate in the planning and provision of health services and facilities. The creation of health committees should ensure accountability to the people (health service users), and should result in the committees having real power, unlike the experience illustrated above in Quebec.

In their *Handbook for District Managers* (1998) the Department of Health present a 'model of community participation in health for South Africa'.<sup>15</sup> This portrays Community Involvement in Health as an essential element of the new national health system in order for it to be fully effective at a local level. Community health structures will be democratically elected, and communities will assist in the management of community health centres, clinics and health posts. They will also be involved at a district level, by serving on hospital boards and participating in the regulation of independent primary care providers. At a local level general functions will be performed by the local health authority and inter-sectoral development committees. The Department of Health recognises that for the new system to work the roles of the community representatives must be clearly defined, and that considerable capacity building of trained personnel is still required.

## The Importance of Community (Based) Health Workers

Community health workers (CHWs) are defined by the World Health Organisation as being "members of the communities where they work; should be selected by the

---

<sup>13</sup> Irwin Friedman (NPPHCN), Community Participation, in Department of Health's *Handbook for District Managers*, July 1998, p. 150

<sup>14</sup> Department of Health, *White Paper for the Transformation of the Health System in South Africa*, 1997, p. 33-36

<sup>15</sup> Friedman, I, 'Community Participation', in Department of Health's *Handbook for District Health Managers*, July 1998. P. 154-158

communities; should be answerable to the communities for their activities; should be supported by the health system but not necessarily as a part of its organisation; and have a shorter training than professional workers". The National Progressive Primary Health Care Network's (NPPHCN) definition was: "Community health workers are non-professional, elected by the community, live in the neighbourhood that they serve and respond to the health needs of their community".<sup>16</sup> They have since dropped the word '*non-professional*', because although community health workers do not receive tertiary education, many are 'well trained and proficient'.<sup>17</sup> Many are paid, and they belong to a group of skilled people all doing the same work. Although there is at present no national association of community health workers, they are certainly not 'unprofessional'.

Community health projects first emerged in South Africa in the late 1970s in response to the inequitable, inadequate, racially-based health service at the time. Most were managed by non-government organisations and community-based organisations. In 1994 an NPPHCN survey recorded 7047 CHWs in South Africa.

With the emergence of the New South Africa members of NPPHCN hoped that the Government of National Unity would give formal recognition to CHWs. Yet in spite of the emphasis on primary health care and community participation in health, the South African government has made no provision for CHWs in the new District Health System. That is not to say they do not recognise the importance of CHWs. The Reconstruction and Development Programme states:

*"... The system must encourage the training, use and support of community health workers as cost-effective additional or alternative personnel."*<sup>18</sup>

In her 1994 budget speech the Minister of Health stated:

*"A human resource question for South Africa that is not resolved is the employment of community health workers in the health care system. The human resource committee ... is examining the role of community health workers in service delivery. ... Before the National Health Ministry can take a policy decision on this matter we will have to know the financial implication on the health care system. ... I believe that community health workers have a role to play at local level. They may be employed by local authorities or non-governmental organisations."*<sup>19</sup>

But community health workers will not be the responsibility of the new health districts; there is no national policy referring to them, and they have no formal place in the National Health System.

Community health workers are important for several reasons. Firstly, health services in many rural areas and informal settlements are inadequate. Secondly, because they live in and are part of the community they are serving, they experience the same problems – problems that an outsider might not necessarily pick up. As an insider, they are able to promote community organisation against the basic causes of

<sup>16</sup> NPPHCN, *Policy Guidelines for CHWs in South Africa*, 1997, p. 3, section 3.1

<sup>17</sup> NPPHCN, *Policy Guidelines for CHWs in South Africa*, 1997, p. 10

<sup>18</sup> *Reconstruction and Development Programme*, 1994, 2.12.5.7

<sup>19</sup> NPPHCN, *Policy Guidelines for Community Based Health Workers in South Africa*, 1997, p. 2

ill-health. Thirdly, they are accessible and available to the community at all times, especially when doing home visits. And fourthly, health knowledge that was previously held by health professionals is made available and accessible to the people.

An economic evaluation of community health worker programmes in Western Cape Province in 1996 revealed that 80% of respondents knew the community health worker in their area, and 82-93% supported CHW activities. Those respondents who had seen community health workers had better knowledge about burn treatment, oral rehydration therapy, and tuberculosis. When the cost of knowledge impact was compared to the cost of treating burns, dehydration and tuberculosis, it was found that prevention through CHW education saved treatment costs, therefore the community health worker is an effective intervention. CHW interventions are lower cost than clinic visits or outpatient visits at the community hospital, so community health workers were found to complement the formal health services.<sup>20</sup>

This is not to say community health workers are a trouble free magic bullet to the South African Health Service. In South Africa and around the world community health workers have identified and experienced multiple problems.<sup>21</sup> These include low salaries or no salaries at all, and job insecurity; lack of a career structure; inadequate support and supervision; long hours and no way of getting away from the community they serve, since they live there, so they are effectively on call twenty-four hours a day, which can cause stress; possible dangerous working conditions; lack of communication between CHWs and local health services, and between CHWs and government; fragmented health service; poor inter-sectoral collaboration; lack of acceptance in some communities and by some health professionals; and a perceived need for certification, uniforms and identity cards.

It is important that all these issues are addressed in the planning phase of a community health project. The other major issue that must be clarified is that of accountability. Are community health workers accountable to the people they serve, or to the funding body? The answer is both. In cases where funding comes from an agency outside the local community, one possible solution is for the funding to be directed through a community representative structure, such as a community health committee, to whom the community health workers are accountable. However, even if the role of the community health committee is clearly defined, and members trained accordingly, this does not solve the problem of powerful interest groups inside, who may use the community health committee to exercise control. As mentioned earlier, complex power struggles exist within so-called communities.

Community health workers are more than just health care providers; their curative work provides an opportunity to engage people in educational discussions about health promotion and prevention of ill-health. So their work also includes development and welfare roles.

---

<sup>20</sup> Bupendra Makan and Dale McMurphy, Dept. of Community Health, UCT, 1996. Quoted in NPPHCN, *Policy Guidelines for Community Based Health Workers in South Africa*, 1997, p.9, section 5.3

<sup>21</sup> NPPHCN/ SAHSSO Policy Conference, 1992. Quoted in NPPHCN, *Policy Guidelines for Community Based Health Workers in South Africa*, 1997, p.9, section 3.3-3.4

## HEALTHCARE IN SOUTH AFRICA

### Health and Development

*"For poverty reduction strategies to be effective, the poor must be sufficiently empowered to initiate, design and implement what they perceive to be good for them. This requires political, social and economic empowerment within the overall framework of sustainable development that combines growth with poverty reduction and protection of the environment."*<sup>22</sup>

Van Rensburg, Kruger and Barron (1997) describe the intrinsic link between health and development.<sup>23</sup> Not only is improved human welfare and health a goal of national development, but health is also a precondition for development. Improvement of health is part of a nation's social development, and health indicators (life expectancy, infant mortality rates, etc.) are used to judge a population's development status. In South Africa, there are wide disparities between population groups. Certain groups, namely rural dwellers, women, children, and Africans, have a far lower development status than others. These groups have lower literacy rates, lower incomes, higher levels of unemployment, and are more vulnerable to disease and ill health.

Under the apartheid regime in South Africa, human development was neglected in favour of technological and economic development. Development was something that was imposed on people's lives; they were not consulted. Since the 1994 elections emphasis has been on community-driven development, equity, accessibility, and acceptability. However delivery has been slow, since policies had to be re-written, infrastructure put in place, and governance and management structures established.

Health reforms were launched as part of the Reconstruction and Development Program's (RDP) war against poverty. But the RDP failed to deliver all that it had promised, and in 1996 was severely downgraded with the launch of GEAR (Growth, Employment and Redistribution). GEAR is based on a different ideology – one more concerned with economic growth and job creation than social development.

This is not to say that development has ceased<sup>24</sup>; a great deal of development work in South Africa is being carried out by non-government organisations (NGOs). They make important contributions in areas where the government has failed to deliver. NGOs also ensure diffusion of power by (a) widening participation in government decision making, and (b) operating at a community level, thus eliciting support and enthusiasm for and participation in development projects. Non-government organisations are effective because they can work autonomously, but at the same time in co-operation with one another and government and business.

---

<sup>22</sup> Deng, L. A., 1996, Poverty Reduction: Lessons and Experiences from Sub-Saharan Africa, In L. A. Deng & E. N. Tjonneland (eds.) South Africa: Wealth, Poverty and Reconstruction. Chr Michelsen Institute/ Centre for South African Studies, p.170-203. Quote taken from *South African Health Review 1997*, Health Systems Trust, p.20.

<sup>23</sup> Van Rensburg, D., Kruger, E., & Barron, P., 1997, Health and Development, In Health Systems Trust's *South African Health Review 1997*, p.17-27.

<sup>24</sup> Van Rensburg, D., Kruger, E., & Barron, P., 1997, Health and Development, In Health Systems Trust's *South African Health Review 1997*, p.26.

## Health Policy in South Africa

*“The health status of the South African population must be viewed within a historical, social and economic framework. Poverty, and poor physical and social conditions, such as lack of adequate access to safe water and sanitation, and poor housing, have impacted negatively on health status. Whilst a minority population enjoyed fairly high standards of health and health care, a large proportion of the population was seriously disadvantaged through grossly inequitable access to health services and health related information. In addition, health programs have been vertical, disease-focused and based on theoretical frameworks that are not always sympathetic of community perspectives”.*<sup>25</sup>

The *White Paper on Reconstruction and Development*, published by the Government of National Unity in 1994, outlined the need to develop a national health system. However no national health bill has passed through parliament. Legislation forms the legal basis for the implementation of policies, and in the absence of a legislative framework many Provincial Health Departments have begun their own restructuring processes.<sup>26</sup>

However in 1997 a white paper was published for the ‘Transformation of the Health system in South Africa’. In this the Ministry of Health committed itself to developing the District Health System. Consequently, a complete structural and organisational transformation of South Africa’s healthcare system is under way. Previously, some healthcare services were controlled by provincial government and others by municipal or local government. This led to an overlap or even duplication of some services, and a deficiency in others, as well as a complicated referral procedure. There was no overall planning, and the services were run in an inefficient manner. A district health system is:

*“... the vehicle for providing quality primary health care to everyone in a defined geographical area. It is a system of health care in which individuals, communities, and all the health care providers of the area participate together in improving their own health”.*<sup>27</sup>

Considerable international experience was drawn upon in planning the new system, and the transformation is being co-ordinated and facilitated by the Health Systems Trust, a Durban-based non-government organisation. The goals and objectives of the new national health system (NHS) as stated in the White Paper (1997) are:

- To unify fragmented health services at all levels into a comprehensive and integrated National Health System
- To promote equity, accessibility and utilisation of health services
- To extend the availability and ensure the appropriateness of health services
- To develop health promotion activities
- To develop the human resources available to the health sector

<sup>25</sup> White Paper on Health, 1997, p. 178

<sup>26</sup> Stuurman-Moleleki, J., Sait, L., & Long, P., 1997 Health Legislation. In Health Systems Trust’s *South African Health Review 1997*, p.29.

<sup>27</sup> Harrison, D., 1997, p.3

- To foster community participation across the health sector
- To improve health sector planning and the monitoring of health status and services.

The fourteen health departments inherited from the previous government, which were divided on the basis of race and ethnicity, have been amalgamated and divided into forty-eight health regions and 180 health districts nationally. Health districts are well-defined areas, with an average population in South Africa of 200,000 people.<sup>28</sup> Their boundaries coincide with local government boundaries, and as far as possible are inter-sectoral (i.e. the same as those for other sectors, e.g., welfare, housing, education). They also have to take into consideration geography (in terms of access to facilities) and socio-economic conditions, and contain facilities including clinics, community health centres and district hospitals.

The development of a district health system marks the decentralisation of South Africa's health system. A single district health authority is responsible for primary health care, including community-based services, clinics and district hospitals. This allows local health problems to be identified, and services to be prioritised accordingly. Decisions about healthcare for each district are made by the district's health authority and not a higher level of the health department. In the past, management was centralised, with very little authority, responsibility or accountability being devolved to regional and facility managers.<sup>29</sup> Managers at national level made decisions regarding local healthcare services, such as how budgets would be spent and the planning of new services. This led to big inefficiencies. The new system requires decentralisation of power and devolution of resources. It gives local people control over their budget and decision making. This should also reduce South Africa's large and complex health bureaucracy, shifting the focus from health service administration to implementation and improved quality of services.

In the past the people who used healthcare services had little or no say in the decision making process, even over matters which concerned them. The new district health system is designed to allow real community involvement in healthcare planning. Not only are communities encouraged to say what they think about local services, but formal structures of participation are being set up in the form of clinic committees, and local leaders and councillors are encouraged to become involved in improving local services. In addition it is hoped that non-government organisations (NGOs) and community based organisations (CBOs) working in the healthcare field will become part of the new district teams.

The district health team is supposed to include all the health providers, including health workers who work for the provincial health departments, for the local authorities, for NGOs and CBOs, as traditional healers, and as private practitioners. This has not yet been achieved, as some parties - community based health workers and traditional healers - are not yet included as active members of the district health team. However the new system embodies a shift in emphasis from curative medicine to preventative medicine and promotion of health, so the mix of health personnel employed will also be re-assessed.

The World Health Organisation's Alma Ata Declaration, 1978 called for "Health for all by the year 2000". Although the South African Government is

<sup>28</sup> Naidoo, S., 1997 Local Government in the move to a District Health System. In Health Systems Trust's South African Health Review 1997, p.58.

<sup>29</sup> Pillay, Y., Mzimba, M., & Barron, P., 1998, p.4.

unlikely to meet this deadline, they are committed to a health service based on primary health care. In the past primary health care services were under-funded while the majority of health expenditure was used to fund the hospital services. By committing South Africa to a national health system that focuses on primary health care health services will become more accessible and equitable. However, limited resources mean South Africa can only afford the most efficient health service. And it is a misconception that primary health care is cheap healthcare for the masses. So money must be spent wisely. The district financial management team must therefore keep close track of budgets, and be able to weigh-up expenditure against performance for the different services within the district. Above all, the new system provides a single management structure, and managers are held accountable not only to the district's governing structures (the District Health Authority), but also to the people in the district. Combining the existing health services will not be an easy change, since people do not like giving up power or authority.

The South African government envisages maximum community participation in planning, management, delivery, monitoring, and evaluation of health services. Each 'community area' is represented by a Community Health Committee, which is elected by the local people, and should exclude people employed by the health system. Committee members are the 'users' of health facilities. Their role is to participate in needs analysis, planning, implementation, and education of primary health care in the area. They are part of the governance structure of local health facilities, and have either advisory or decision-making powers over these services. They also elect representatives to Hospital Boards and the District Health Council.

The District Health Council is made up of representatives of all the Community Health Committees in the district, political representatives from the local authorities, members with business and financial experience, the chairperson of the District Hospital Board, and the District Health Manager. Their role is to decide on policy issues and oversee resource allocations; make decisions or advise on financial matters, provision of pharmaceuticals, revenues, personnel and services; and to form sub-committees and co-opt expertise when required.

The District Hospital Board is composed of elected representatives of the Community Health Committees, representatives of the Local Authorities and the District Health Council, representatives from private providers working within the District and using the hospital, members with business and financial expertise, the Hospital Manager, District Health Manager, and the District Welfare Manager. The Board's role is to ensure that hospital facilities and services are appropriate for all people in the District; to advocate on behalf of communities, to participate in the management of the hospital; to raise additional funds for the hospital; and to ensure co-ordination between the hospital and other facilities in the district.

At each level, so the White Paper says, there will be a national training programme to empower representatives and ensure that they know and understand their responsibilities and roles. Community Development Forums are also proposed in the White Paper, in order to develop and empower communities, and Community Based Organisations are encouraged.

The White Paper for the Transformation of the Health System describes a national health system that incorporates the government, NGOs, the private sector, and end-users of the health system. For this to be possible, communication (defined by Health Systems Trust as "sharing ideas, knowledge, feelings or thoughts with each

other”<sup>30</sup>) is essential. Communication is the only means of achieving goals such as patient compliance, professional support, referrals to hospitals, and ordering drugs and supplies. It also enables health service users to convey their feelings about health services to the people who can do something about it; communication enables health workers to work as part of multi-disciplinary planning teams alongside people from fields such as education, welfare, agriculture, and transport; and communication enables health workers from the public and private sectors and NGOs to talk to each other and work together. This recognition of the importance of communication has necessitated the development of a basic communication infrastructure throughout the country. The aim is for even the most rural hospitals and clinics to have a computer linked by electronic mail to the *HealthLink* network, thus ensuring all health workers have a reliable way of talking to other people in the district and to district management.<sup>31</sup>

As proposed in the Declaration of Alma Ata (WHO, 1978), South Africa’s district health system is part of a wider development strategy. Addressing the causes of ill health is the way to achieve a sustainable health service, and is only possible with co-operation with other sectors. This is the path to wide-reaching sustainable development.

So in summary, the benefits of district based primary health care are:<sup>32</sup>

1. The service responds to health needs. It requires a clear understanding of local health problems, and on-going appraisal of services being offered.
2. The service views people as a whole, not as body parts. This requires re-organisation of existing services, integration of primary health care programmes, and treating the patient as a person, with care and respect.
3. The service is concerned with people’s health – not just disease. The service includes promotion of good health, prevention of disease and trauma, cure of illness, rehabilitation, and palliation (relief of pain and discomfort).
4. The service includes district hospital care.
5. There are clear systems of referral, ensuring that patients are treated by appropriately trained personnel, and that health workers have support and back-up when required, since most local clinics are staffed by nursing staff and not doctors.

Although the government has given its commitment to the new District Health System, implementation is still lagging behind policy. Infrastructure, management systems and support mechanisms are not yet in place. There is still much to be done in the form of capacity building – training both healthcare professionals and communities in healthcare delivery.

The complicated new referral system that is now in place is responsible for many people’s complaints about health services. In her paper ‘Being Chronically Ill and Engaging With the New Health Care System: A Cape Town Study’, Diana Gibson examines “the transition in the health care provision, and of the sick consequently traversing a hierarchy of health care facilities interspersed with long waiting periods before being accorded full status as patients”<sup>33</sup>. In the results of this study, frequent referrals and long waiting times at the clinic and hospitals are

---

<sup>30</sup> Harrison, D., 1997, p.19

<sup>31</sup> Harrison, D., 1997, p.21

<sup>32</sup> Harrison, D., 1997, p.27-34

<sup>33</sup> Gibson, D., 1999, P.1

reported, together with users' negative experiences and perceptions of healthcare workers as being 'uncaring' and lacking in concern for disadvantaged patients. Under the new system, ill people must negotiate this complex hierarchy before they are even classified as a patient at a health care facility. First they must report to their local clinic or community health centre, where the emphasis is on primary health care. From there, if they are classified as 'seriously ill', they are referred to a secondary hospital. And if they need more specialist care the secondary institution will refer them to a tertiary hospital. At each level the sick person must wait to be seen by a doctor, be examined and reclassified, and if referred, must find a means of getting to the next level. Time spent waiting is time when the sick person is between levels of care; they have not yet been afforded full patient status at that institution, yet they have been separated from the community and entered the controlled space of the hospital.

In Diana Gibson's study, severely ill patients from Khayelitsha reported delaying seeking medical attention as a direct consequence of previous difficulties experienced when they had engaged in the health system. At weekends patients could wait for between four and six hours to be seen by a doctor, which some perceived as lack of care, so they did not seek help until their condition had become an emergency, when it was often too late. Seeking medical attention earlier could improve many patients' chances of survival. But they and their families were not prepared to confront the obstacle course of the health care service until there was no other choice, thus "illness was no longer a process, it became a crisis event aggravated by the hospitalisation dynamics, and sometimes the harrowing experience of being close to death."<sup>34</sup> It is not negligence or poor care that are to blame. It is technical, financial, structural and staff shortages, within a health system undergoing radical change. Due to financial constraints, ambulance services are few and unreliable, thus increasing waiting times further, and other means of transport can be too costly for many patients.

The community level clinic or day hospital is the entry point in to the healthcare system; the "interface between the formal and the informal, the institutional inside and the communal outside."<sup>35</sup> In the year ending mid 1998 visits by outpatients to clinics and day hospitals in the Western Cape increased by 29%, but there was no comparable increase in staff or equipment levels – the budget allocated to community health was only increased by 4%. This understaffing of community health centres means they often can not cope with the number of patients, resulting in long waiting times and a perceived attitude of non-caring amongst the staff caused by working under stress. When working under pressure, staff are forced to prioritise patients in order of the seriousness of their condition. The nurses make a cursory diagnosis, and on the basis of that decide which patients will see the doctor. Thus patients are depersonalised, and medicalised – their bodies become medical objects. The patient's perception of the relative urgency of his or her condition may be very different to that of the nurse – they have different understandings of medical problems. The patient may think that her condition is an emergency, but the nurse fails to prioritise her, so the patient feels that the nursing staff do not care about her. This can create patient dissatisfaction and even dispute.

It is not only the primary health services that have been effected by the changes. With the new emphasis on primary health care there have been budget cuts in the secondary and tertiary hospitals too. Wards and beds have been closed, and

---

<sup>34</sup> Gibson, D., 1999, P.23

<sup>35</sup> Gibson, D. 1999, P.17

staff numbers reduced, in spite of the growing number of patients. Due to financial constraints, equipment has not been replaced or updated. So again, prioritisation must occur. The doctors must decide which of the patients that require expensive technology and tests will actually receive it, since resources are so limited. This decision will be made on the basis of the seriousness of their condition, and the economic justifiability of treating that individual.

Members of the National Progressive Primary Health Care Network (NPPHCN - a national non-governmental health advocacy organisation) are aware of the deficiencies and problems in South Africa's health system, and have been working since 1987 to advocate for a national health system based on the principles of primary health care. With offices in eight provinces, and a membership of well over one thousand health and development programmes, NPPHCN is in a strong position in its work supporting active community involvement in all aspects of health and healthcare.

The Network has no party political or religious affiliations, but "affirms values and approaches which recognise universal human rights and are supportive of the promotion of comprehensive, equitable and accessible health for all."<sup>36</sup> NPPHCN works at both a grass-roots level, to provide groups and individuals with primary health care and community skills in order to become health workers, and at a national level in advocacy and policy formulation. Their mission statement is to promote Primary Health Care through.<sup>37</sup>

- Advocating (influencing, mobilising and lobbying) for a national primary health care policy and its implementation
- Transferring appropriate skills to community based organisations
- Bringing together members to share information, skills and experiences
- Providing practical support to members.

NPPHCN have been involved from the outset in the development of South Africa's new District Health System. And they are not afraid to highlight things that the Department of Health have overlooked. Firstly, there is no structure for community involvement in health above district level, so there is no community representation at a national level. Secondly, and most relevant to this research project, the Department of Health does not see a role for Community Health Workers in the new National Health System. They recognise the important contributions community health workers make to the health of certain communities, and in providing a link between the formal health services and communities, yet state that they should not be incorporated into the formal health sector. Thus the only community health worker programmes will be those run by non-government organisations and community-based organisation.

### Background to Masiphumelele Community Health Project

Masiphumelele Community Health Project was founded in 1998. Most community and development projects in the Noordhoek Valley are co-ordinated by the Valley Development Project (VDP). The Community Health Project in Site Five (renamed Philisa Health Project by the community health workers) is not part of this. It was conceived, planned and founded by two nursing students from University of Cape

<sup>36</sup> <http://www.healthlink.org.za/pphc/intro.htm> p.1

<sup>37</sup> <http://www.healthlink.org.za/pphc/mission.htm> p.1

Town, Tanya Doherty and Chantelle Juby. They had been working in the community with the SHAWCO mobile clinic for two years, and realised the need for a community health care service. In 1998 they obtained funding from the Department of Architecture at Birmingham University, England, to develop a Primary Health Care Programme in the Masiphumelele. The Department of Architecture received a National Lottery Grant for the extension to the clinic in Site Five, and agreed to fund the community health project as well.

The selection process for the community health workers was a lengthy one. Firstly, a steering committee was established to discuss the possibility of a community health project in Masiphumelele with local residents. When it was agreed that there was a need, and funding had been secured, four individuals were selected from the community to be trained as community health workers. The selection was not easy, and involved applications and interviews. The successful applicants were all fully literate and bilingual in Xhosa and English, lived in Masiphumelele, and had shown previous initiative in the community.

The trainer from NPPHCN who trained the new community health workers did not initially approve of the selection process. She recommended that community health workers be selected by the people at a mass community meeting. However this was discussed with local residents and the community health committee, and they felt that such a mass meeting would develop in to an excuse for a political agenda. They also feared that powerful individuals and families would take control, and the process would not be democratic.

Certain members of the community health committee (which is in fact inactive, and is made up largely of members of one influential family) felt that members of their families were entitled to be community health workers, and became very upset when their relatives were not selected. They expressed their disapproval of the whole application and interview process, and one member of the health committee stepped down from the selection panel.

The four individuals who were finally selected were sent on a nine week training course with NPPHCN, along with sixteen other prospective community health workers from the Cape Town region. After every three weeks of theoretical training, the four community health workers returned to Site Five to do one week of practical, in order to practice doing home visits and the like.

Although a National Core Curriculum for community health workers was adopted during a national workshop in 1994, NPPHCN design training programmes to respond to the health needs of the community that each CHW will serve.<sup>38</sup> In their "Policy Guidelines for CHWs in South Africa" NPPHCN describe the roles of CHWs as follows:<sup>39</sup>

- Resource Person: links the community with resources and services
- Advisor: disseminates health information, reports on health problems
- Advocate: mobilises people to identify causes of disease, to determine health needs, motivate for resources and to take health into their own hands
- Educator: raises awareness about disease and develops the knowledge, skills and attitudes necessary for the comprehensive improvement of personal and community health

---

<sup>38</sup> Community Health Worker Curriculum, NPPHCN Training Centre, 1997, p.1

<sup>39</sup> Policy Guidelines for CHWs in South Africa, NPPHCN, 1997, p. 4, section 3.2.2

- Service provider and health visitor: identifies sicknesses, counsels, treats minor illnesses or refers patients to appropriate services; performs follow-ups on people who suffer chronic illnesses
- Specialist activities: rehabilitation, malaria, nutrition, etc.
- Facilitator: enables people to discover their potential and generate their own further learning, acts as an agent for development, encourages self-worth, shares knowledge or skills and promotes networking
- Liaison: Liases with primary health care centres and health and development stakeholders, policy makers and decision makers.

The training programme is designed to equip potential community health workers with the skills, knowledge and attitudes to adequately perform their roles. It is a learner-centred programme, in which learners are posed with problems relevant to those they will experience, and must focus on how best to solve those problems. It is an action oriented and outcomes based programme, so participants are motivated to do something to overcome the problems that face them in order to achieve their aims and objectives, and it is based on self-discovery, so situations are created that enable the learners to discover for themselves through their own experience and reflection.

Ideally training would be twelve months. After the initial nine week course participants should work as trainee community health workers, with ongoing training, regular competency assessments, and follow-up support. Because the Philisa Community Health Project is new, there are no existing community health workers for the new trainees to work with and gain knowledge from. But NPPHCN do act as a support network, and performed at least one competency assessment during the course of my research.

The training programme was divided in to four modules. The first module was 'Being a Community Health Worker'. In this course participants were taught what to expect from the programme; the history of community health workers from a local, a South African and an international perspective; community expectations of community health workers and their relationship to community structures; what the responsibilities of community health workers are, and an ethical code of conduct. The module also included life and interpersonal communication skills, including observation skills, attitudes, listening and interviewing skills, facilitation, conflict resolution, counselling, and empowerment. The community health workers were told why and how to conduct home visits and how to record data; advocacy skills; local government structure, services, laws and policies, and networking and referral skills.

The second module, 'The Community', covered how to do community needs assessments, community development skills, community health workers' roles in relation to community development, and specific social problems including child abuse, substance abuse, unemployment, family problems, and teenage pregnancy, and what they can do about each of them as community health workers.

The third module was 'Health.' Here traditional beliefs about health and illness were discussed, and the Primary Health Care approach fully explained. Health promotion skills were taught, covering the topics of child health and development, nutrition, reproductive health, CTOP, post-natal care of mother and new born baby, oral health, mental health, environmental health, and geriatrics and care of the aged.

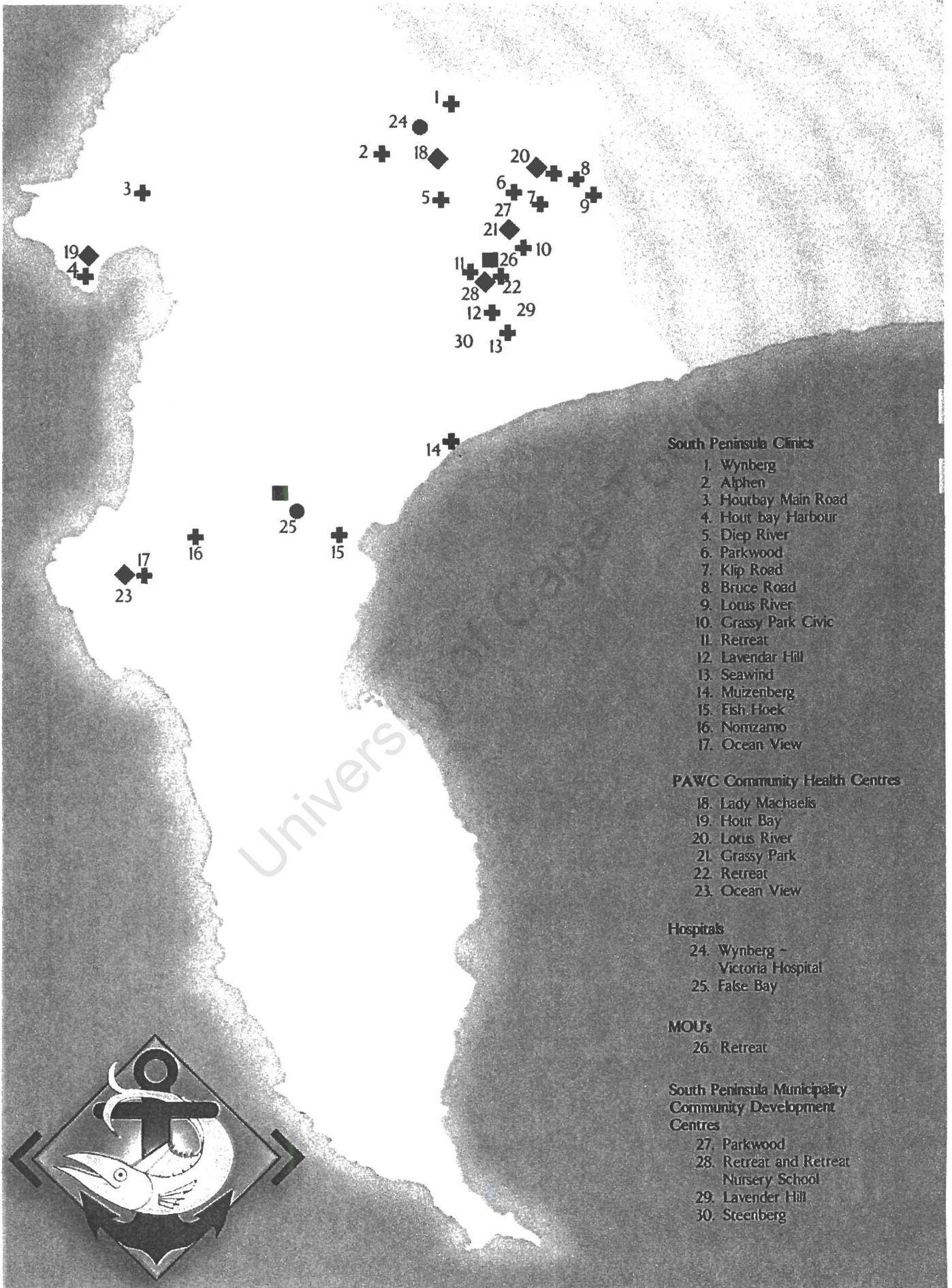
The fourth module, 'Common Health Problems', looked at how to manage specific sicknesses: diarrhoea, eye problems, ear nose and throat conditions, respiratory problems, worms, skin problems, communicable diseases (including TB,

STDs and HIV), non-communicable diseases, and disability and rehabilitation. Instruction was also given in first aid, and the use of basic medicines.

The new community health workers began work in December 1998. Their actual work is discussed in Chapter 3.

University of Cape Town

# MAP OF SOUTHERN PENINSULA



### South Peninsula Clinics

1. Wynberg
2. Alphen
3. Houtbay Main Road
4. Hout bay Harbour
5. Diep River
6. Parkwood
7. Klip Road
8. Bruce Road
9. Lotus River
10. Crassy Park Civic
11. Retreat
12. Lavendar Hill
13. Seawind
14. Muizenberg
15. Fish Hoek
16. Nomzamo
17. Ocean View

### PAWC Community Health Centres

18. Lady Machaelis
19. Hout Bay
20. Lotus River
21. Crassy Park
22. Retreat
23. Ocean View

### Hospitals

24. Wynberg - Victoria Hospital
25. False Bay

### MOU's

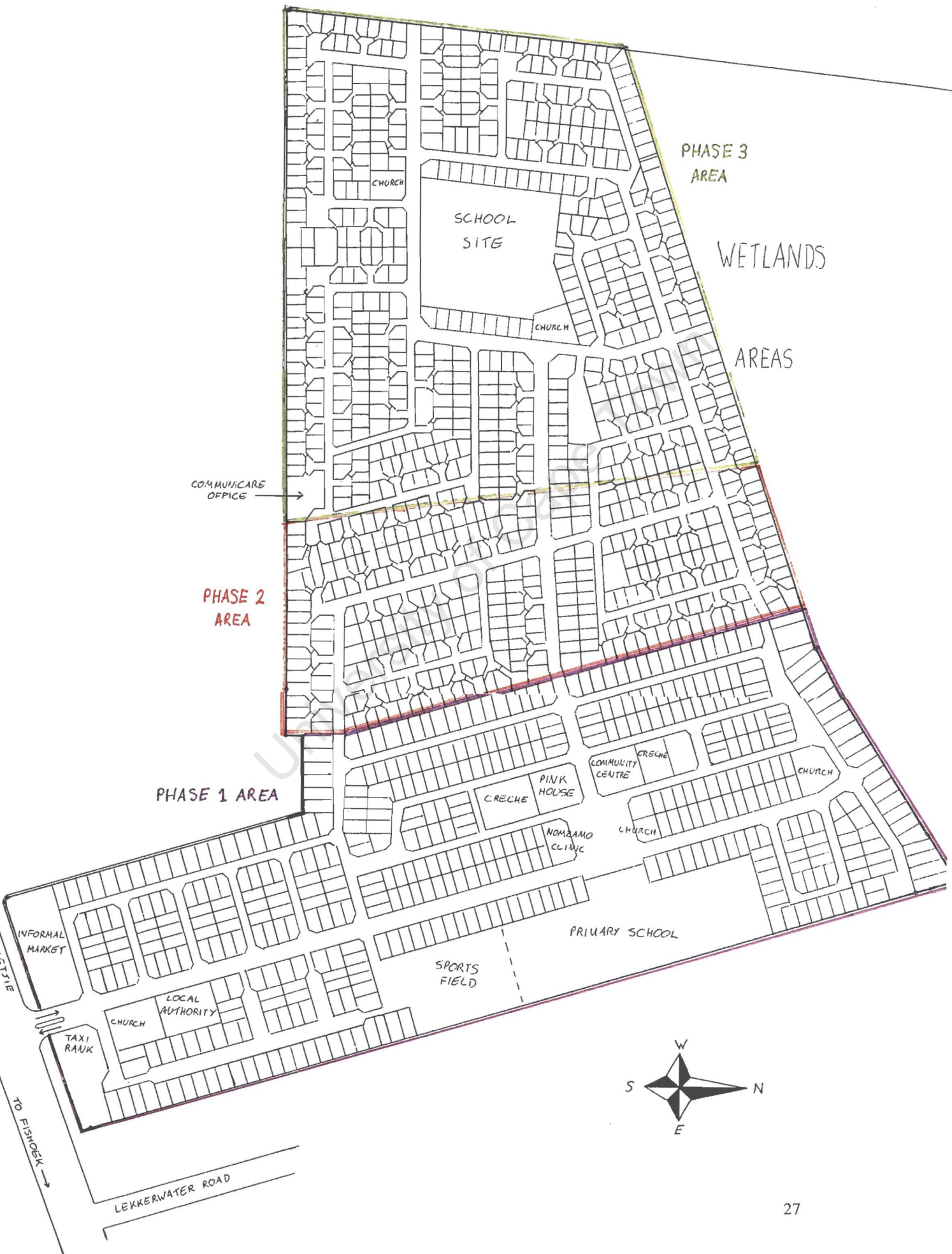
26. Retreat

### South Peninsula Municipality Community Development Centres

27. Parkwood
28. Retreat and Retreat Nursery School
29. Lavender Hill
30. Steenberg



# STREET MAP OF MASIPHUMELELE



## THE STUDY COMMUNITY: MASIPHUMELELE

*"On my first visit to Masiphumelele I accompany the health workers on their rounds. In the first house we visit the patient is not there. The four men in the house are drunk; they say they think he is still in hospital, having his second leg amputated, but didn't know when he will return. In the second house there is a young mother with a baby on her back, another woman, and another two children. One of the children is deaf and dumb. Her mother has left her here and they don't know where she is, so recently she has not been attending the special school in Langa where she used to go. There is also a boy of six (who should be at school), whose mother also lives somewhere else. He has sores on his head and needs to be taken to the clinic to have them cleaned. Then a young woman walks in, with a huge bandage on her right knee. She removes the dressing to reveal a huge gash in the back of the leg, apparently caused by jumping through a window. As she lifts her skirt to show us we can see where she has had a skin graft on her thigh. There are staples in the wound that should have been removed over a week ago, and the dressing has not been changed. She claims she cannot afford the bus fare to get to the hospital – two Rand.*

*We then go to find the mother of the boy with the sores on his head. She is naked in bed with a man and a baby girl. Grudgingly, she gets up and partially dresses. The baby is filthy. Apparently she is nineteen months old, but she is tiny, and cannot yet walk. She usually stays in the house where we found her brother, and both are neglected. The mother was told by the health worker she must take both to the clinic today, so the boy can have his sores cleaned, and she can have a developmental assessment, and be referred to Red Cross Children's Hospital.*

*The last house we visit is that of a mother and her three month old twins. The mother is an alcoholic, so they were very premature. When this household was first visited by the community health workers, the twins had not had milk for three days. Now she gets milk formula for them for the clinic, but today has run out again, so they have only had water. It is obvious from the bruises and swellings on her body that she has been beaten up. Her boyfriend claims that when he goes out to look for work she gets drunk, so when he returns he beats her. She now faces the threat of the police being called, being arrested, and losing her children if she continues to drink and to neglect them."*

Field notes from my first visit to Masiphumelele, 22<sup>nd</sup> February 1999.

## 1. GENERAL COMMUNITY DATA:

### History:

Masiphumelele has a remarkable history. It was the first piece of land in an exclusively white area in South Africa to be allocated to black people. In addition, some of the people who settled there were actually involved in the selection of the site.

In the 1950s the apartheid government declared the Southern Peninsula a white group area.<sup>40</sup> Whilst all 'Coloured' people living within the area were moved to the new dormitory town of Ocean View, no provision was made for the many Africans who had settled there. Only those men employed by the Regional Services Council Road Works, the Cape Point Nature Reserve or on local farms were allowed to continue living in the single-sex hostels, separated from their families. The rest were forcibly removed to Khayelitsha. Some stayed there, and suffered the 30 km daily journey to work in the Southern Peninsula each day, whilst not surprisingly, others settled illegally on vacant land near their old homes.

These families living in the bush around Hout Bay, Noordhoek, Fishoek, and Kommetjie were constantly hounded by police, arrested for trespassing, and their shacks demolished. And each time they would return and build again, because they were employed there and could not afford the travel costs from Khayelitsha. Development Action Group (DAG) reported that in 1987, facing the reality of forced removal to Khayelitsha, a group of these soon-to-be-displaced people asked DAG for their help in drafting a proposal for permanent settlement and the provision of services in the Noordhoek/Kommetjie area.<sup>41</sup> (It is unclear whether these displaced people actually approached DAG, or whether this is merely how DAG portray it in their report; it could have been DAG who approached the people, offering their services and assistance. There is no evidence to support either claim).

An attempt to evict the families in April that year was aborted, thanks to DAG's efforts to ensure that press, embassy officials, and welfare agencies were present. However on the morning of 2<sup>nd</sup> December, 600 families were woken at dawn at gunpoint, ordered to dismantle their shacks, and forcibly moved on the back of trucks to Khayelitsha. This time the press and welfare organisations were kept away by road blocks. But DAG and the people who were removed did not give up their struggle. This set-back made people angry, and united those who had lost their homes. With the help of the Surplus People Project and lawyers, a Supreme Court Application was put together. The lawyers argued that the forced removal of the squatters was unlawful, and for the right of low-income people to live near to economic opportunities. In April 1988 Judge Howie of the Supreme Court Division ruled in favour of the displaced families of the Noordhoek Valley<sup>42</sup>, who returned triumphantly to rebuild their homes. But they were still squatters. They had not been granted the right to land. That fight was yet to come.

Inspired by their initial victory, the Noordhoek Valley 'squatters' joined forces with other groups in the Southern Peninsula who were also fighting for land rights. It was a long battle, but finally in December 1990 an area of land selected by the communities was allocated for the informal settlements of the Southern Peninsula.

---

<sup>40</sup> Manchip, S. (DAG), 1996, p.3

<sup>41</sup> Manchip, S. (DAG) 1996, p.4

<sup>42</sup> Manchip, S. (DAG) 1996, p.6

(By 'communities' I mean all the so-called 'squatters' living in the Noordhoek, Fishoek, and Kommetjie region). The residents named the new settlement Masiphumelele, meaning *let us succeed*,<sup>43</sup> though it is commonly known as Site Five. During the building of the new settlement Development Action Group and the Surplus People Project helped and encouraged the people living there to contribute to its design, as well as providing support and assistance aimed at empowering the people of the community with new skills and resources.<sup>44</sup> They moved to the new site in November 1992. The demarcated area of land was divided into 708 plots, for 2800 people.<sup>45</sup> Despite endless lobbying attempts, no money was available to build brick houses, but each plot was provided with a tap of clean running water and a flushing toilet. Tarred roads were laid, and street lights put up. Electricity was not provided. A 1997 survey<sup>46</sup> showed that 44.5% of houses had access to electricity, though most only use electricity for lighting purposes. Paraffin was the most popular source of household energy, used by 76.9% of households for cooking, 58% for heating, and 53.9% for light. Paraffin use is associated to some respiratory problems, especially in houses that lack proper ventilation.

### **Geographic Setting:**

Masiphumelele is situated in the Noordhoek valley, 60 kilometres from the centre of Cape Town. Masiphumelele lies between the white settlements of Noordhoek and Kommetjie, and is accessible from the Kommetjie Main Road.

Site Five's eastern boundary, and part of the southern boundary, are marked by a high wall, designed to (a) keep the residents of Masiphumelele in, and (b) to screen the development from adjacent landowners. The contrast either side is striking. Inside the walls the land is barren; sand and dust fill one's shoes, and permeate the rudimentary shacks built from wood and corrugated iron. Over the wall can be seen the roofs of expensive suburban houses, many of which have swimming pools and large irrigated gardens. The local ratepayers demanded:

*"A buffer zone of minimum width thirty metres must be established around the township. This zone should be in the form of a berm, of minimum height five metres to minimise visual and audible effects, should be planted with trees, and must be enclosed by a fence of minimum height 1.8 metres along the outer perimeter to contain any potential unrest incidents within the township area. This buffer zone must extend along the western and eastern borders of the proposed township. ...the local residents insist that larger plots be established adjacent to the buffer zone to support higher quality housing and thus ease the geographic transition..."<sup>47</sup>*

The response of some of the residents of Masiphumelele to this plan was:

---

<sup>43</sup> Manchip, S. (DAG) 1996, p.8

<sup>44</sup> Manchip, S. (DAG) 1996, p.9

<sup>45</sup> Kell, C., 1994, p. 13

<sup>46</sup> Masiphumelele Community Needs Assessment, December 1997, p. 9

<sup>47</sup> Chasmay, Lochiel and Lekkerwater Residents, Comments on the VKE Township Plan, June 1991.

Quoted in Manchip, S. (DAG) 1996, p.36

*"We are not criminals, we do not need to be barricaded in like prisoners with walls and fences."*<sup>48</sup>

However the local authorities were very concerned about what the local ratepayers thought, so the fence was built, and only one access road into and out of Site Five was allowed, further isolating the residents from the surrounding community.

There is still no formal housing programme. The Catholic Welfare Bureau (CWB)'s attempted to initiate a brick-making co-operative, and a demonstration sandbag house built by the Valley Development Project (VDP), however Sandy Dowling from the VDP reports that residents will not commit to house-building projects because they believe the government will eventually provide houses for them.<sup>49</sup> In a community needs assessment survey, better housing emerged as the number one need in Site Five.<sup>50</sup>

In 1996, with the building of Phase 2, the site was enlarged considerably with the creation of 811 new plots, most of which have three or four houses on. However, there is still a large un-serviced area to the north, on the wetlands. Here there are no demarcated plots, and no roads. There is a row of communal toilets on the edge of the area, which are unclean and in disrepair, and there are communal water taps. People run cables from houses in the serviced area in order to get electricity, resulting in a hazardous web of live wires sprawling between the shacks. The shacks in this area are very small, most only a single room, and very close to one another. They are built in the bush, and in winter they flood. The area is more densely populated than the serviced areas, and disease and ill-health are rife. Whilst efforts are being made to find a new area in order to relocate the inhabitants of the wetlands, the area is still growing rapidly.

Additional facilities in Masiphumelele include a civic centre, two crèches, a primary school, clinic, several churches (Zionist, Baptist, Methodist, Jehovah's Witness, and Catholic, among others), a library and several informal spaza shops.

---

<sup>48</sup> Quoted in Manchip, S. (DAG) 1996, p.22

<sup>49</sup> Manchip, S. (DAG) 1996, p.33

<sup>50</sup> Masiphumelele Community Needs Assessment, December 1997, p. 14-16

*Photo 1: Masiphumelele viewed from Ou Kaapse Weg, looking south-west across the Noordhoek Valley:*



*Photo 2: View along one of the main roads in Masiphumelele:*



## Demographic Data:

Masiphumelele has a total population of approximately fifteen thousand people – the exact number is not known. There were 708 plots in the original area, and an additional 811 were created in the Phase II and III areas, so there is a total of 1,519 plots, which means there is an average of 9.9 people living on each plot. Many plots have up to four shacks on, particularly in the new area, which is much more densely built on. The actual number of households is not known. Average household size is 4.89 people, considerably higher than the provincial average of 3.9, and a national average of 4.4 people per household.

In 1997 a 'Needs Assessment' was conducted in Site Five.<sup>51</sup> Questionnaires were administered to a random sample of 312 households, and a great deal of demographic data was elicited. The mean age of the head of the household is 35, and for other members of the household 19 years. Masiphumelele is a relatively young community, the greatest age cohort being 30-34 years. 49% of households are male-headed, compared to 46.5% which are female headed, and approximately half of the female-headed households are single parent households.

The rate of unemployment is very difficult to measure in Masiphumelele, because many people who do not have steady jobs manage to eke out a living through various casual labour and self-employment opportunities. It is not clear whether, in a survey, one would count these individuals as working or unemployed. For example, cutting wood and sitting by the road to sell maybe one or two bags a day at fifteen Rand each; selling sheep heads and offal; selling home brewed liquor; selling sweets and chips to the school children at lunch time; or sitting at the 'four-way stop' each day in the hope a prospective employer will pick you up for a days labour. The most common types of work done by respondents and their partners are labour and construction work, and domestic work.

I asked various people about the rate of employment (nurses, teachers, shop owners, health workers, and other residents), and none of them could give me an actual figure, except to say that it is very low, and that the majority of people who are employed are earning less than eight hundred Rand per month. This is confirmed by the 1997 survey, which shows that 55.7% of households have a total combined income of less than R 500 per month, and a total of 91.3% of households have incomes that do not exceed R 1500 per month. In 1996 the unemployment rate for the Western Cape was 17.9, and the average for south Africa was 33.9.<sup>52</sup> The 1997 Community Needs Assessment for Masiphumelele found 37.5% of heads of households to be unemployed, and a further 17.6% to be seasonal or temporary workers, suggesting an unemployment figure amongst head of households of 55.1% at certain periods. In addition, only 28.9% of partners of head of households were employed.

For the period 01/07/98 – 30/06/99 there were 168 live births and 3 still births recorded at Nomzamo clinic. That is a crude birth rate of 11.4 per year per 1000 population. Twenty-four (14.4%) of those births were from teenage pregnancies, and twenty-two (13.2%) of the new-born infants were recorded as having low birth-weight (under 2500 g).<sup>53</sup> Ideally, low birth weight rate should not be more than 10%. Teenage birth rate recorded at Nomzamo Clinic is 13%, which is considerably higher

<sup>51</sup> Masiphumelele Community Needs Assessment, December 1997, p. 2-3

<sup>52</sup> HST, *South African health Review 1998*, p.204

<sup>53</sup> Data supplied by Southern Peninsular Municipality.

than the target for Southern Peninsula Municipality of 8%.<sup>54</sup> Teenage pregnancy increases the risks to both mother and child. In addition, teenage mothers<sup>55</sup> are more likely to drop out of school, have diminished access to employment opportunities, and are likely to be stuck in a cycle of poverty.

Data for death rate and infant mortality rate were not available for Masiphumelele, and data for the Southern Peninsular Health District is of little relevance since the district includes a wide range of income groups.

Key health problems in Masiphumelele are tuberculosis, diabetes, high blood pressure, skin conditions, common childhood illnesses, and substance abuse. Environmental health needs are a problem, for example lack of proper housing, overcrowding, absence of ventilation in some shacks, lack of sanitation and running water in the wetlands area. Poverty associated social problems, including teenage pregnancy, violence and substance abuse are enormous. When, in a household survey, residents were asked to indicate which social problems were experienced in Masiphumelele, excessive drinking, drug abuse, child abuse, domestic violence, gang violence, illiteracy, unemployment, TB, HIV/AIDS, and teenage pregnancies were all identified as serious problems.<sup>56</sup> However, when asked which of these problems they experience in their own households, only unemployment was regarded as a serious problem (53.9% of households). So either respondents exaggerated regarding community problems, or did not give reliable answers regarding their household problems.

Street committees were set up soon after the move to Site Five. Every street has a street committee, which meets twice a month, to talk about local issues and problems. They report things that need to be done to the municipality. They also act as an internal conflict resolution body, only reporting disputes and cases to the police if they cannot resolve them themselves. When respondents were asked whether they thought they were doing enough to improve conditions in Site Five, the majority (43.9%) were not sure, and 28.5% thought they definitely were not doing enough. When asked about their involvement in community organisations, it emerged that community (81.7%) and church-related (64.7%) activities enjoy the greatest level of support. However relatively few people reported being 'active participants' (11.5% of those involved in community activities, and 12.5% of those involved in church activities).<sup>57</sup>

### **Educational Facilities:**

There are two crèches in Masiphumelele, and a primary school (Ukhanyo Primary School). There are 950 pupils enrolled at the school, and attendance is generally about eighty percent, though it drops drastically when the weather is bad. Nineteen teachers teach Grades One to Eight (equivalent of Sub. A to Standard Six), and class sizes vary between forty and sixty pupils. Students range in age from six to twenty-one, and there is approximately a 75% completion rate. Of those that complete their primary schooling here, most do go on to high school.

The overall literacy rate in Masiphumelele is low, which has a negative impact on employment capabilities. In the December 1997 'Community Needs Assessment'

<sup>54</sup> Southern Peninsula Annual Health Report for the period July 1997 to June 1998, P. 15

<sup>55</sup> Defined as under 18 years of age

<sup>56</sup> Masiphumelele Community Needs Assessment, December 1997, p. 18

<sup>57</sup> Masiphumelele Community Needs Assessment, December 1997, p. 19

the literacy rate was 60.9%.<sup>58</sup> (The 1996 literacy rate for Western Cape Province was 78.7%, and the national average was 65.8%.)<sup>59</sup> The 1997 survey showed that 51.0% of the population had only primary or lower qualification, the number of persons who passed matric was 8.2%, and only 0.1% of the population had a post-school qualification.<sup>60</sup>

### **Health Resources Data:**

The South Peninsula has its own local authority sub-structure within the Cape Metropolitan area, and has been allocated as a health district under South Africa's new District Health System. The South Peninsula has a population of 347,000 (1996 census). There are fairly large municipal and provincial health infrastructures in the region, which are still being managed separately. However a District Development Task Group has been formed to establish greater collaboration, and ultimately to facilitate the creation of a district management team.

Masiphumelele has a municipal clinic, Nomzamo Clinic. For services that are not available there (see below) residents of Masiphumelele must go to the district hospital, False Bay Hospital in Fishoek. The regional referral hospital is Victoria Hospital in Wynberg.

#### **Nomzamo Clinic:**

Nomzamo Clinic is situated at the junction of the main access road into Masiphumelele and the main road into the new area, opposite the primary school. The official clinic hours are Monday to Friday, 08:15 to 16:45, however the staff leave at 15:50 in order to return their cars to the municipal compound in time, and on Fridays there is no official consultation time – the clinic staff do their administrative work on Fridays. There are two professional nurses, a staff nurse, and two general assistants. There is very little difference between the responsibilities of the three nurses, except the staff nurse cannot prescribe medication and family planning. The general assistants clean up, make tea, and act as translators (none of the nursing staff speak Xhosa, though they are attempting to learn). One of the assistants also acts as a clerk, and some of the young women talk to her about their problems, especially HIV patients. She tells the senior sister, who wants her to be professionally trained as a counsellor. There is also a doctor who visits the clinic once a week, on Wednesday mornings, to provide curative care for children up to the age of six. An occupational therapist visits once a month, and someone from TB Care comes twice a month.

Services at the clinic, all of which are free, are limited to preventative, promotive and limited paediatric curative care. They offer immunisation, family planning, dressings, treatment for burns, removal of sutures, PAP smears, and child curative care. Clinic staff report child abuse cases to the police and the district surgeon. There is a malnutrition section where chronically ill and aged people get

<sup>58</sup> Literacy Rate measured using the UNESCO definition for functional literacy of the number of persons 14 years and older who have completed seven years formal schooling – grade 7

<sup>59</sup> People age 20 years and more with no schooling or some primary schooling are illiterate. Figures taken from: HST, *South African Health Review, 1998*, p.204.

<sup>60</sup> Masiphumelele Community Needs Assessment, December 1997, p.4

porridge and mealy-meal, and children get pollagen. They provide emergency first aid, and transport to hospital in emergencies. A mobile X-ray machine is brought to the clinic once a week. The only adult curative treatment is for TB and STD patients.<sup>61</sup>

The most common problems that people go to the clinic for are TB, STDs and HIV, and in children coughs, colds, and burns.

The workload of the nurses at Nomzamo Clinic is greater than at any other municipal clinic in the Southern Peninsula Municipality. They see an average of 51 patients each per day. Waiting times vary, from ten minutes on a Friday, when there is no official consultation time so very few people bother to come, to over two hours on a busy morning. There is no television or radio in the waiting room, and only hard wooden benches for patients to sit on. However in the mornings there are often education sessions in the waiting room. People do not go to the clinic specially to hear the education sessions, but those who are there do show interest. A lady from MOSAIC in Cape Town comes every Monday morning, when the clinic is usually very busy, to talk about domestic violence. She speaks in Xhosa, and uses clear visual aids. She is very animated, and talks with passion. In addition to the education sessions, she provides advice and counselling, and follows-up individual cases.

Health educators also come here from the Southern Peninsular Municipality, and the Community Health Workers give educational talks at the clinic, on subjects such as TB and HIV/AIDS. All the education sessions are aimed at the empowerment of women – empowering them to take control of their own health and their own lives. This gender bias is due to the fact that the overwhelming majority of patients at the clinic are women or mothers accompanying children.

#### SHAWCO:

In addition to the municipal clinic, the SHAWCO mobile clinic visits Masiphumelele once a week during university term-time. They operate out of Nomzamo Clinic on Monday nights from seven o'clock. Because there are often communication problems caused by a language barrier, two of the CHWs go to the SHAWCO clinic each week to translate for the doctors, as well as to help make record cards for the patients.<sup>62</sup> Residents can pay two Rand to see a doctor. This provides the only opportunity for most adults to visit a doctor without having to travel far or pay for a private consultation. However patients are encouraged not to become reliant on this service.

#### Private Doctors:

The other alternative is to go to a private doctor. Some residents reported going to private doctors in Sun Valley Mall, and in Fifth Avenue in Fishoek. However the majority of the residents of Site Five cannot afford a private doctor's fees and the transport costs to get there.

Doctor Peter Jacka opened a practice at the Pink House in Site Five in June 1999. He charges patients fifty Rand for a consultation, which unlike the other private doctors, includes medicines, ultra-sound scans, and follow-ups if necessary.

<sup>61</sup> From interview with Sister Moutom.

<sup>62</sup> Field notes, 04.03.99, P.11

When I met him (August 1999) he was not very busy, working from 08:30 to 12:30, and seeing five or six patients a day. He expected business to pick up as the word spread, because those patients he had seen have come back or sent friends and relatives.

His patients represent a cross-section of local residents. Common problems he sees include infectious diseases, viral infections, and pelvic infections and STDs in women. Apparently they prefer to see a private doctor because they believe it is more confidential. Also, at the clinic STD patients are given a blood test and are tested for HIV, which a lot of women do not like.

Doctor Jacka is not in competition with Nomzamo Clinic. In fact before he opened his practice the first thing he did was to visit the clinic and talk to the staff to establish (a) whether there was a need for a doctor in the community, and (b) to make sure that he would not upset the other health care workers in Masiphumelele - he hoped to work in co-operation with them, and not as competition. He refers TB patients to the clinic because they can get tested for free, and it is very expensive to get tests done privately.

#### Occupational Therapist:

There is an occupational therapist (OT) from the Community Health Services Organisation who does house visits with the CHWs one day every two weeks. The service she is providing is aimed at decentralising healthcare, and bringing healthcare services to the people. In other words, her work is not institution-based, like most physiotherapists. Instead, the CHWs keep a record of the people in the community who they feel need and could benefit from her help, and when she comes to Masiphumelele she visits them in their homes with the CHWs. She works in a region that includes fifty community hospitals, and there are only four OTs and ten physiotherapists for the whole region, so one day a fortnight is all she can manage in Masiphumelele.<sup>63</sup> There are many people in Masiphumelele who could do with her help.

---

<sup>63</sup> Field notes, 15.03.99, P.16

*Photo 3: Children at the crèche:*



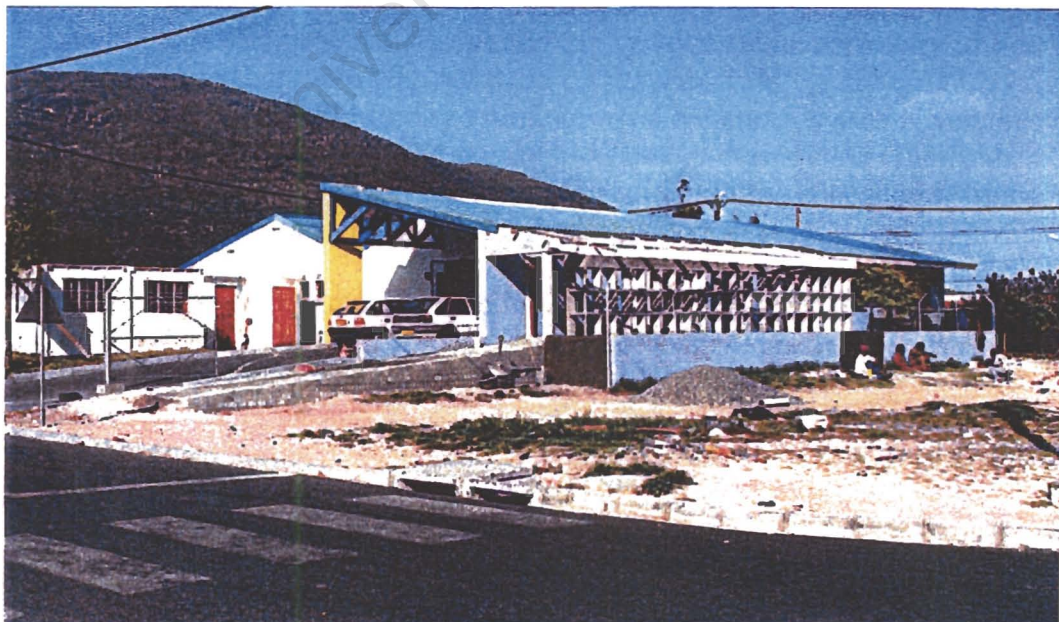
*Photo 4: Women selling sweets and chips at the school gates during lunch time:*



*Photo 5: Ukhanyo Primary School*



*Photo 6: Nomzamo Clinic*



## 2. MASIPHUMELELE COMMUNITY HEALTH PROJECT:

### Masiphumelele Community Health Project:

Since December 1998 there have been four Community Health Workers in Masiphumelele. They have been trained to give advice on health as well as social problems. They can administer basic medicines and first aid, write letters of referral for patients who need to see a doctor, and they can call an ambulance from False Bay Hospital in an emergency. (See previous chapter for selection and training procedures).

Here the Masiphumelele Community Health Workers are introduced in the order in which I met them.

### Pumla Gobololo

Pumla is thirty-five years old. She comes from East London, and has lived in Masiphumelele for four years. She came to Cape Town in search of employment, and to Masiphumelele because she had family living there. She completed standard ten at school, and has done courses in home care and basic computing. Before she became a community health worker she was working for the National Parks Board, on the alien vegetation clearing programme. She also volunteered as secretary for the local residential committee.

The reason Pumla says she applied for the job of Community Health Worker is that she wanted to help her community. There may be additional professional and personal reasons why she wanted to be a community health worker, but if so she chose not to share them with me. It is possible that the health workers gave me the answers they thought I wanted to hear, but that is impossible for me to confirm. Pumla told me that working with people was her dream, so she particularly enjoys doing home visits. She says it gives her an opportunity to communicate with people and to really help them at a fundamental level. She says she sees her relationship with the people she visits as a partnership, building trust so they can work together to solve their problems. One can see she enjoys doing home visits by the relaxed and friendly way she interacts with the people she is visiting. And she is very thorough in following up problem cases

At the same time Pumla is a wife and a mother. She is a practical person, with a wonderful sense of humour. One particular story she told me that had me in fits of laughter springs to mind: We had been talking about the misuse of medicines, when she told us a story about a friend of hers. A friend of hers called her to come over urgently. So she went rushing over, and found her friend sitting at home with a can of Doom. She explained that she had pubic lice, and was about to spray them with Doom to kill them! Although Pumla advised her against it, she went ahead and Doomed her pubic area, then was in such agony she couldn't walk all day, as well as getting a horrible rash!

### Ayanda Mhlambiso

Ayanda is the only male community health worker. It was decided by the community health committee and the selection committee that there should be at least one male CHW because some people prefer to talk to a man about their problems than to a woman. Ayanda is twenty-eight, and has also lived in Masiphumelele for four years. He came here to look for a job, and a better future than he thought he could

achieve in the Transkei, where he was brought up. He matriculated from school, and did a computer course. Before he became a community health worker he was teaching at the computer literacy centre in the valley.

Ayanda had considerable previous experience in community work. He is an active member of St. John's Apostolic Church, and was involved with church youth work. He also worked as a volunteer helping to build the community library, he is the secretary of his street committee, and he used to volunteer as a translator for various development agencies who visited Site Five (now he does not have much free time). He told me the reason he applied to be a community health worker was because at the time he was working as a volunteer at the SHAWCO clinic, and he really enjoyed working with the people. He also saw it as an opportunity to learn, and to give something back to the community. Ayanda is animated and lively, and is particularly interested in working with the youth. He really enjoys talking to people, and sharing knowledge.

### Kholiwe Jokiwe

Kholiwe is thirty two. She comes from East London, and has lived in Masiphumelele for seven years. She also came to Cape Town in search of work, and moved to Site Five because her sister and cousin were living there. She completed standard nine at school, then completed courses in home nursing care, first aid, and basic primary health care. Before she became a CHW she was working as a char in Fishoek, and nursing in Kenilworth. She was also on her local street committee, and worked as a volunteer for the Southern Peninsula Municipality, filling in forms for every new structure in Site Five.

She told me she knew her nursing experience and community work would be valuable when she applied to be a CHW. She particularly enjoys what she calls "being a resource person", by which she means linking local people with resources. She sees herself as a helper to the local people, and appears by nature to be a very caring person.

Although Kholiwe was the last of the CHWs to be selected, she has become the unofficial spokesperson for them all. She is very well spoken (all four of them read, write and speak English), and puts a point across clearly.

### Skolweni Zelanga

Skolweni is thirty years old. She was brought up in the Transkei, has lived in the Noordhoek Valley for nine years, and in Masiphumelele since it was established. She completed Standard nine at school, did an adult education teaching course, and a leadership skills course. She taught adult education from 1991 to 1995. From 1995 to 1997 she worked for the Valley Development Project, two days a week as a food aid worker, distributing food parcels to the very poor and the sick, and the other three days as a volunteer. At weekends she worked at Pick n' Pay.

The reason Skolweni gave for wanting to become a community health worker was because she likes working with people. She had worked as a volunteer for many years, so is well known by local people. She really enjoys the education side of being a CHW, as well as doing home visits, because it allows her to meet lots of people and to help those who have problems.

What the community health workers told me must be evaluated reflexively. It is possible (even likely) that who I am and the nature of my research (a white British, female student at UCT, conducting research on behalf of the people who founded the

community health project and created their jobs) influenced the answers the community health workers gave to my questions.

The Masiphumelele CHWs' mission statement is to:<sup>64</sup>

- Serve all the people of the community (Masiphumelele)
- Promote the health of the community through:
  - Education
  - Skills development
  - Workshops
  - Initiation of projects
  - First Aid
- To co-operate with other resources in the community to promote collaboration
- To diagnose and treat common ailments with the use of basic and essential medicines
- To provide primary level care and to refer to other services as and when appropriate.

The community health workers make house calls throughout Masiphumelele, to assess health and nutritional status. I accompanied them on many of their visits. For each household they create a record card, on which they record the name, age, and any medical problems of each person who lives there. Every visit they make to a house is recorded, along with any advice they give and referrals they make.

They make appointments for members of the community to see the doctor at False Bay Hospital, and write letters of referral when necessary. They deliver prescriptions and test results, and assist compliance with taking prescribed medicines. There is a project known as DOTS – Direct observation treatment short-term – especially for tuberculosis patients. The patient must come to the community health worker's house each day and be supervised taking their medication to make sure they do not default. This system is usually used with people who have defaulted treatment in the past. From what the health workers told me DOTS is very effective, but I did not get the opportunity to observe it for myself because I was never in Site Five in the evening, when they administer the medication. However the clinic staff support the health workers in this project, and also claim that it is effective.

The community health workers are also concerned with infant and child health. When they visit a household they routinely ask to see the 'Road to Health' cards<sup>65</sup> for all children in the household. They check that babies have been weighed at the clinic and are not showing symptoms of stunting or wasting, and that all children are up to date with their vaccinations. Once a month the community health workers also visit the crèches and the primary school in Masiphumelele, and look out for the children. Pumla told me she is particularly worried about infectious diseases amongst children. Because there is so much movement between Masiphumelele and the Transkei there is always the risk of children arriving with an infectious disease and infecting the other children. The community health workers hope to stop the spread of infectious diseases. They also play quite a different role in child welfare, reporting children who are not attending school to the headmistress.

---

<sup>64</sup> Appendix II

<sup>65</sup> 'Road to Health' card is a child's medical card, on which all vaccinations are recorded, weight and height are plotted on a graph, and any additional visits to a doctor or nurse are recorded.

When I began my research in Site Five the community health workers did not administer any medicines. However in April 1999 Tanya and Chantelle brought the first delivery of basic medicines for them to dispense. Their stock includes:

Panado Syrup – for children  
Multivitamin Syrup – for malnourished children  
Calamine lotion – for itchy rash on children  
Benzyl benzoate – for scabies  
Gentian Violet – for grazes and oral thrush  
Painmol – paracetamol tablets for adults  
Whitfields – cream for treatment of ringworm  
Thermo-rub – for arthritis and rheumatism  
Pipirizine Syrup – for worms  
Savlon Antiseptic – to clean cuts and scratches, also to clean stitches  
Dermadine – antiseptic cream for dressings  
Swabs, band aids and dressings.

The medicines the CHWs have in stock reflects the nature of their work. They are all what those of us who have the power and knowledge to take control of our own health would consider basic remedies. They are medicines one can buy over the counter at the pharmacy to treat conditions that we can identify ourselves. However most of the residents of Masiphumelele have a world view that is very different from that which the white middle-class South African experiences. There exist different understandings of the body and illness, and different geographic, social and demographic groups are exposed to different risks. In addition, when one barely has sufficient income to feed one's family, one is not going to spend money on a cure for a headache. Medicines are expensive. This inventory of medicines kept by the community health workers - pain killers, first aid, and simple treatments for common illnesses – defines their approach to primary health care. Helping people to help themselves, and to realise their basic right to health.

The next question was whether or not to charge people for the medicines, and if they do charge, how much should they charge?

*“The CHWs decide to put a nominal charge on the medicines, not to make a profit, but so people realise they can't get it all for free, and so value it more highly and are more likely to use it correctly. However nothing is more than two Rand, and the CHWs may waive the fee if they feel it is a particularly deserving case who cannot afford the price. They are particularly worried about the misuse of Calamine lotion. Some women like to smear it on their faces, especially when it is hot – they think it protects them from the sun and keeps them cool. So the CHWs will try and make sure they only give it for the treatment of children with itchy rashes. They talk for a long time about how much to charge for each of the medicines. Pumla seems to want to cover the costs, but they do not need to because the price has been budgeted for. She and Skolweni get most involved in the discussion; I don't think Ayanda wants to rock the boat, and Kholiwe's mind is elsewhere – her husband has just been arrested.”<sup>66</sup>*

---

<sup>66</sup> Field notes, 13.04.99, P.25

In addition to all this, the community health workers are running a health education programme in the mornings at the clinic, and on Tuesday nights there is a health education session for members of the youth choir. Ayanda teaches the youth choir, so has a certain amount of prior influence over them.

The health workers and the clinic staff tell me there is a lot of domestic violence in Masiphumelele. One morning when I was listening to the counsellor at the clinic and observing her audience, she suggested organising a workshop for the women, and a lot of them seemed enthusiastic. Pumla was also keen, and volunteered to help organise it. Pumla told me just that weekend a 'business man' had shot and killed his wife.<sup>67</sup> I came across so many stories of domestic violence during my time in Site Five, many of which involved young children:

#### Case 1:

22<sup>nd</sup> February 1999. *"The last house we visit is that of a mother and her three month old twins. The mother is an alcoholic, and the twins were very premature. When this household was first visited by the CHWs, the twins had not had milk for three days. Now the mother gets milk formula for them from the clinic, but today has run out again so they have only had water. It is obvious from the bruises and swellings on her body that she has been beaten up. Her boyfriend claims that when he goes out to look for work she gets drunk, so when he returns he beats her. She now faces the threat of the police being called, being arrested, and losing her children if she continues to drink and neglect them."*<sup>68</sup>

9<sup>th</sup> March 1999. *"Ayanda takes me to check up on the twins that I was introduced to on my first day. My heart sinks as I notice a two litre plastic wine bottle on the floor, but mercifully it is only full of water, and the mama appears to be sober. The twins are clean and dressed, and have half-full milk bottles beside them on the bed. Their mother got two tins of milk powder from the clinic yesterday (every Monday – she has no income). Their charts show that they only weighed 2.8 kg and 3 kg at two months. They are due to go to the clinic again on Monday 15<sup>th</sup> March."*<sup>69</sup>

12<sup>th</sup> April 1999. *"I ask Ayanda if he has seen the twins recently, and how they are. He tells me that one of them is dead. I am shocked. What happened? Rumour has it that the mother was drinking again over Easter Weekend. Her boyfriend came home and found her drunk, so started abusing her because he says why is she drinking when she must look after the children? The neighbours say they heard fighting, and people suspect that the baby was killed while the parents fought. The CHWs have told the sisters at the clinic as well as the social worker. Hopefully they will take the other baby away in order to protect it. The parents are certainly incapable of looking after it."*<sup>70</sup>

27<sup>th</sup> July 1999. *"The surviving twin is still with the parents. I find this hard to believe. One child was killed during a fight, and the other one*

---

<sup>67</sup> Fieldnotes, 15.03.99, P.16

<sup>68</sup> Field notes, 22.02.99, P.1

<sup>69</sup> Field notes, 09.03.99, P.13

<sup>70</sup> Field notes, 12.04.99, P.22

*is not taken into care. Not only is the child neglected much of the time, but what is to say that it too will not be injured or even killed? When I ask the CHWs about this, they tell me it is her child, so what can they do? Surely it is better off with its mother, they say.”<sup>71</sup>*

This case illustrates many aspects of the community health workers' work in Site Five. During a routine home visit they discovered the twins were neglected and malnourished. They advised and persuaded the mother to take them to the clinic to be checked and to get milk powder. They also taught her how to feed and clean the babies. They reported the case to the social worker in an attempt to control the mother's drinking problem, and continued to visit the household regularly to check up on both the mother and the twins. Sadly the efforts of the community health workers did not prevent the death of one baby, and they seem unable to do much to protect the other. The mother's alcoholism is a real problem, and one which the community health workers cannot control. However it is realistic to speculate that both babies may have died from neglect shortly after birth had the community health workers not intervened. The second baby is still with the parents, and the health workers visit the house regularly to check on its well-being.

Another case of domestic violence, this time handled by Skolweni, illustrates some of the other functions of the community health workers.

#### **Case 2:**

*“Yesterday Skolweni took a child to the hospital who had been abused. She is one year and five months old, and had blood around her vagina. The mother went with her. The parents run a shebeen – I don't know which one. They think it was a stranger who did it. Apparently the shebeen was packed from Friday afternoon until Sunday night – it is open all weekend and is always full. The parents and grandmother all live there and claim to have been there with the baby all the time, but none of them know anything about what happened. Skolweni tells us the child didn't even cry. She just sat there in the hospital in silence. Chantelle tells her the child must have therapy – she is obviously badly affected by what happened if she is not talking. She tells Skolweni she must get the social worker involved, and Skolweni says she will also tell Jo, who works with abused children in the valley. I nearly cried as I heard the story. The police have opened a case, but the child is back home with her parents. How on Earth are they going to protect her? There is nothing to stop the same thing happening again.”<sup>72</sup>*

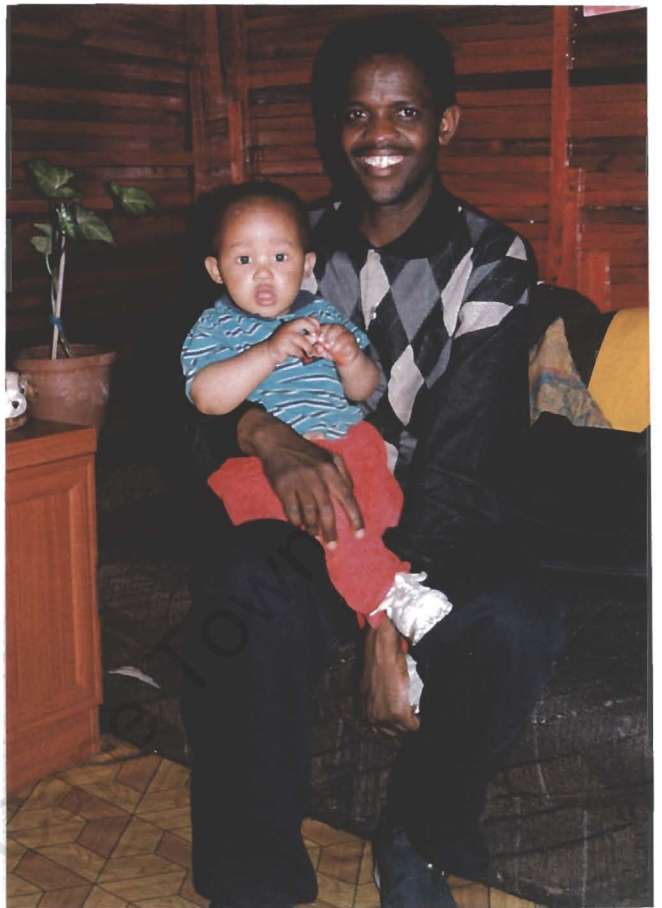
Traditionally, cases such as these would go unreported, or be dealt with internally by the street committee. However, in this case the mother went to find one of the community health workers (Skolweni) to ask for advice. Consequently the proper procedure was followed – the child was taken to hospital and examined by the district surgeon, and a police case was opened. Being unsure of what to do next, Skolweni approached one of the project co-ordinators, Chantelle. They discussed the case, and Chantelle advised Skolweni on how to proceed – the little girl must have therapy, and the social worker must be contacted in order to try and protect the child in the future. In addition, Skolweni contacted Jo on her own initiative.

---

<sup>71</sup> Field notes, 27.07.99, P.31

<sup>72</sup> Field notes, 09.05.99, P.26

*Photo's 7a & b: Community Health Workers (left to right): Kholiwe and Ayanda.*



*Photo's 8a & b: Community Health Workers: Skolweni and Pumla.*



## METHODS AND METHODOLOGY

The methodology I used for this research is based on Scrimshaw and Hurtado's (1987) 'Rapid Assessment Procedures for Nutrition and Primary Health Care'. Three important requirements for this piece of research were that it be done quickly, cheaply, and well, since it was a short internship, the work was unpaid, and the collection of valid and reliable data was essential. The aim of Rapid Assessment Procedures is to meet the demand for "cost-effective and timely tools for programme evaluation".<sup>73</sup> It is a method for quick and good work, hence its appropriateness for this investigation. As an anthropologist, I would still have liked to have spent considerably longer in the field, in order to really get to know the community I was studying, however as with much contemporary anthropological research, that was not possible. (It should be noted that in this case, the anthropological ideal of fully immersing oneself in the community one is studying, would not have been feasible. Among other considerations, it would not have been safe for me to do so.) RAP does not claim to provide all the information full social immersion in the field could provide, but it can produce a lot of it.

### Rapid Assessment Procedure:

RAP procedures, developed during the 1980s, have been widely used in social-science research in health and disease control programmes, and also in Rapid Rural Appraisal, Rapid Epidemiological Appraisal, and rapid assessment procedures for anthropological studies. Because these procedures produce highly focused sets of information, they are used both as an evaluation tool and a method of collecting baseline data.

During the 1970s and 80s, the KAP (knowledge, attitudes and practices) survey was widely used to gather data for large, statistically representative populations, especially within family planning and epidemiological research. Today it is recognised that survey data require verification by other methods – a process known as triangulation. It is this process of validation (ensuring that the data accurately reflects the social reality) that Schopper, Doussantousse, and Orav (1993) describe in their work in Uganda. Validity is not the same as reliability. Reliable data is data that another researcher can go back to the field and, using the same techniques, can get the same results. Anthropologists pride themselves on the validity of their data, though we are often criticised for lack of reliability, i.e., our work is not replicable. This is because much of the research done by anthropologists produces qualitative data, which is not as easy to reproduce as quantitative data, since it tends to be subjective.

Triangulation is the process of looking at one issue from various perspectives in order to reach an "intersubjective account". In other words, it is a method of cross-checking data – a very important exercise in rapid assessment procedures, where, by the very nature of the methods, it is not possible to check one's findings through extensive participant research. RAP is a very focused research method. The time spent in the field may mean that certain things are overlooked, for example

---

<sup>73</sup> Manderson & Aaby, p. 839

seasonal variations, or interviews with key members of the community who are absent at the time of research.

KAP surveys rely on questionnaires to gain information regarding knowledge, beliefs, attitudes, opinions, and reported behaviours and practices. Most KAP surveys use quantitative methods only. One problem with KAP surveys is that of representativeness. They run the risk of being more representative of government than community concerns, since the questions are often designed to answer questions formulated by the government in line with their policies. The validity and appropriateness of social information gathered by KAP is therefore questionable.

The Rapid Assessment Procedure was developed out of community diagnosis methods, in response to the inadequacies of KAP surveys. RAP emphasises community participation, so employs local people as research assistants, encouraging the transfer of social science skills to the community in order to encourage dialogue and collaboration between them and the policy-planners/decision-makers. The methods used are more varied than KAP, involving a mixture of qualitative and quantitative methods, and data collection and analysis is more flexible and innovative. The quantitative data is often collected from existing sources, so the aim of the field research is to collect complimentary qualitative information. This drawing on local knowledge and expertise is one way of tackling the problems that arise from the short time spent in the field. The use of in-depth discussions with the community is seen as very important. It has tones of postmodernism about it – the notion of producing ideas from within, rather than imposing outside ideas.

A positive feature of RAP is that researchers do not necessarily require copious prior disease-based research skills, or training in qualitative research skills, since the manuals provide methods training and support. It also has advantages over KAP in that it combines several methodologies – in-depth interviewing, focus groups, and observations – making triangulation possible and thus improving the validity of the data.

Although rapid assessment procedures have their shortcomings, they demonstrate the usefulness of applied anthropological research, and emphasise integration with other disciplines. We hear a lot about the merits of interdisciplinary research, especially in health care and development projects, and RAP provides one way in which this goal can be achieved.

### **Sample Selection:**

In order to discover what members of the community think of the Community Health Project and of the other healthcare facilities available to them, I conducted random household interviews. The number of residents of Masiphumelele is not known, but there are 1519 plots, the majority of which have more than one shack on. Households were selected on a random basis, though it was not possible to do this using a random number chart, since houses are not numbered consecutively throughout the area. Instead, each day I visited a different area of the community or a different street, and randomly selected houses to visit. The selection process was constrained by whether or not there was anyone at home. Consequently my sample may reflect households with a higher rate of unemployment, because it only reflects the households where someone was at home during the day. Over the course of my fieldwork I conducted a total of 64 household interviews.

In addition I carried out in-depth interviews with all four of the CHWs, the senior sister in the clinic, who is also the clinic manager, and Doctor Peter Jacka, a private practitioner working in Masiphumelele.

### **Participant Observation:**

When I first arrived at Masiphumelele I faced the problem of access. I had to find a way to get to know the community. So for the first few weeks, and at intervals thereafter, I accompanied the Community Health Workers on their daily home-visits. This afforded me the opportunity not only to get to know the CHWs, but also to go into people's homes and learn how to interact with people in their own environment. A home visit lasts anything between ten minutes and one and a half hours, depending if it is a first visit to the household or a follow-up, and is also determined by the extent of the problems in the household. In the case of first visits, the health workers would introduce themselves and me, and describe the work they do. Then an assessment of the household would be carried out and recorded on a record card. When follow-up visits are done any changes are recorded on the household's record card.

Accompanying the CHWs on their home visits, and visiting people in their homes with my translator to perform interviews, allowed me to make detailed observations. For example, I could see for myself what the informants' standard of living was like; I could observe relationships and family interactions in the home; I watched food being prepared; and I could see for myself the condition of the members of the household, and make notes of their nutritional and health status.

### **Household Interviews:**

A household interview lasted for anything between fifteen minutes and an hour, but averaged twenty minutes. I tried to keep them a standard length, and always asked for the same level of detail, but inevitably some people were more verbose or more willing to talk at length, whilst others were busy performing household tasks such as cooking, feeding children, cleaning or doing laundry, so had less time to talk.

The majority of the population of Masiphumelele are Xhosa speaking. Whilst I did make an effort to learn the language, I was not fluent enough to conduct interviews in Xhosa. So for those interviews that could not be conducted in English I needed a translator. However I did not have funds to pay a translator, which meant finding someone was not easy. The first person who translated for me turned out to have planning skills that are more than a little wanting. Day after day I would turn up at the pre-arranged time, only to find she was in a meeting, or had to go somewhere. After a few weeks she disappeared off on holiday for three weeks without telling me, so I had to look for someone else. I asked Zukiswa Sidlayi. Zukiswa is twenty one years old, and teaches computer literacy at the local training centre. She lives in Masiphumelele, and is well known in the community because she often helps her mother out working at the community kitchen in the Pink House. She speaks beautiful English, and is enthusiastic and eager to learn.

When we entered an informant's house, I would introduce myself and Zukiswa in Xhosa, and find out whether that person was happy to converse in English or would prefer to speak in Xhosa. The interviews were structured, though I did

allow room for deviation and discussion. (See appendix III for copy of interview questions).

It was very important for me that my translator and I should influence or bias responses as little as possible. This was a real issue and a problem initially. When interviewees were slow to answer my translator would suggest possible answers to them, so I was not eliciting their own thoughts and opinions. So I explained again to Zukiswa the importance of gaining uninfluenced, unbiased and detailed answers, and I no longer had a problem. Of course my very presence - who I am, where I am from, and the nature of the questions I was asking - also influenced people's answers. It is in the nature of many people to say what they think you want to hear. Unfortunately there is little one can do to overcome this problem, except to always be aware of it.

### **Group Discussions:**

I did not arrange any formal focus groups, but I did experience spontaneous group discussions, when neighbours and family members joined in household interviews. Participants felt relaxed and comfortable enough in their homes to speak openly, so I let the conversation become open, only asking questions to prompt the conversation when necessary.

### **Field Notes:**

Whilst in the field I kept field notes. I took brief notes on observations, conversations and impressions. At the end of each day I expanded on these notes, adding details.

For the in-depth interviews with the CHWs and the clinic staff I used a tape recorder, and transcribed the interviews fully. However when interviewing people in their homes I did not use a tape recorder. I decided it would be too intrusive, and it was not vital that I recorded every word exactly. There was also the language barrier - some of the interviews were conducted in Xhosa through a translator. Since she was unpaid and working on a voluntary basis, I could not ask her to translate and transcribe recorded conversations for me. Instead I took brief notes while I listened to the respondents talking, and wrote them up more fully later in the day.

### **Research Timetable:**

Research was carried out over a four month period, though I was not in the community every day since I was dependant on a translator who had another part-time job. During the first three weeks I conducted no interviews. Instead I went on house visits with the CHWs, and spent time observing in the clinic, in order to gain access to the community and to help me formulate questions.

In week four I began household visits with my first translator. From the beginning she could only manage a couple of hours at a time, and every other day. Then other things got in the way, like meetings cropping up, or when she went on leave for three weeks without informing me. From her endless excuses I realised that she did not enjoy the work, so I started looking around for another translator.

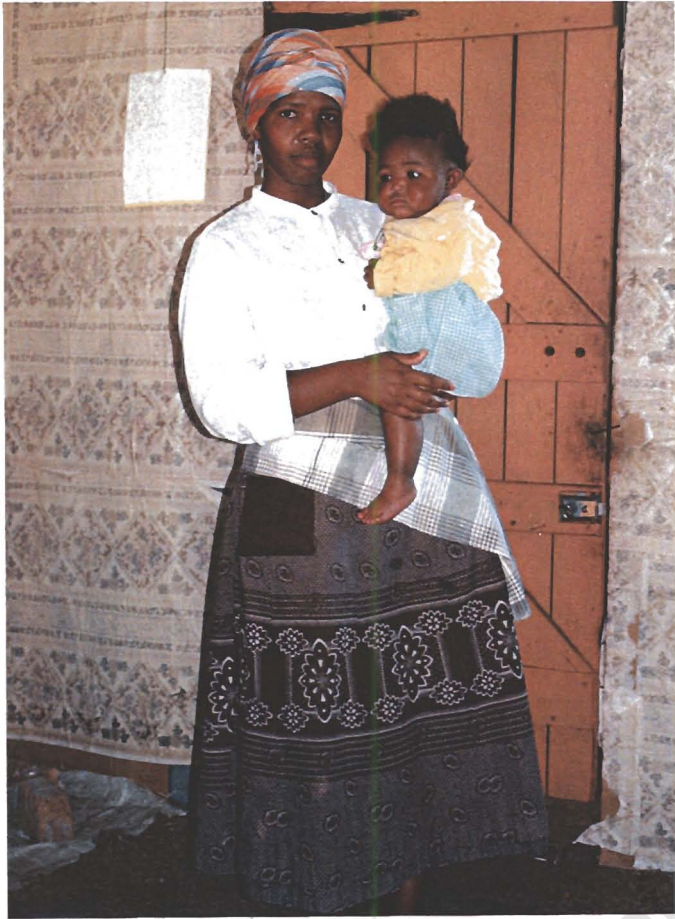
Zukiswa Sidlayi began working with me in the tenth week, and we worked together usually three half days a week for six weeks.

In the eighth week I carried out long, in-depth interviews with the CHWs and in the final week with the manager of the clinic.



*Photo 9: My translator and research assistant, Zukiswa Sidlayi.*

*Photo's 10-13: Some residents of Masiphumelele who were interviewed as research informants:*



## RESULTS

### 1. Household Data

#### Description of Households

The total number of households interviewed was 64. The following results are based only on those households where I conducted interviews.

As mentioned earlier, each plot has a flushing toilet and a tap with fresh running water, and several of the plots now have more than one shack built on them. In some cases different families share a plot, in other cases they are shared by large or extended families. Several shacks I went into had an extra bedroom built outside as a separate building. Number of rooms in each shack varies between one and seven, and the average number of rooms is 3.19.

A lot of shacks are very sparse – a single room with no windows, containing a bed propped up on bricks or crates, a rough, home-made side table with a gas stove, and a couple of pots, bowls and cups on, and maybe a box with the occupants' clothes in. There might be yellowed newspaper lining the draughty walls, and a piece of torn plastic over the roof to keep out some of the rain. A couple might live here with one or more children.

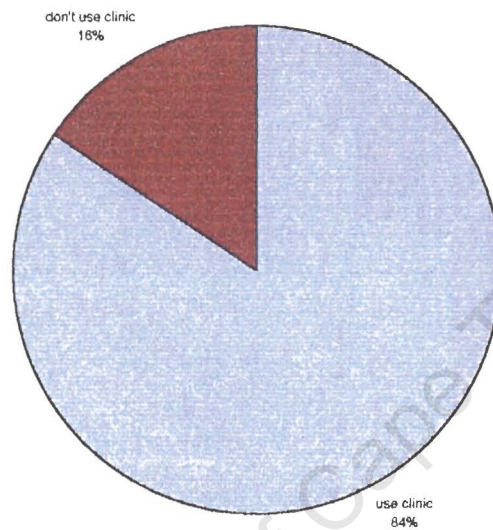
There were other shacks that surprised me by their permanence. I went in to shacks with as many as seven rooms. In the kitchen there was a stove, refrigerator, freezer, work units and storage cupboards. In the living room there was a large screen colour television, video recorder, hi-fi, telephone, couches, armchairs, dining-table, carpet, wall paper, and pictures and mirrors on the walls. When the bedroom(s) were separate rooms I rarely saw in to them. Some people had also incorporated the toilet into the house, but that and the single cold tap were usually the only plumbing. So the difference in dwelling structures is enormous, varying from one room with five occupants, to five rooms with four occupants. But there is little economic segregation within the area; in other words, to find a tiny, sparsely furnished single-room shack next door to a spacious, solidly built, and well equipped six room structure is not uncommon.

The number of persons per household varies between one and twelve, and the average is 4.89. The average number of persons under the age of sixteen per household is 1.69, and varies between zero and six. It is not the norm for households to be made up solely of a nuclear family. A middle-aged couple may have their adult children staying with them, or nephews and nieces. There is a high teenage pregnancy rate, so often a teenage girl and her child will stay with her parents, siblings, or parents' siblings. Sometimes a household is made up of friends who have come from the same area in the Transkei, or two or more families will live in separate shacks on the same plot. The average number of people per household who are employed is 1.17, ranging from none to four. Fifteen point six percent of households interviewed have no-one working.

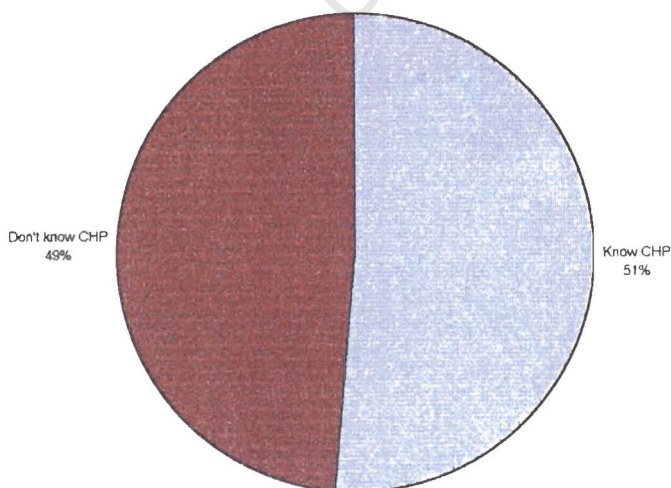
## Knowledge and Use of Health Services

Of the 64 households questioned, 54 (84.4%) said they use Nomzamo Clinic. When asked about the Community Health Project, 59.4% (38) of interviewees had heard about it, and 45.3% (29) had actually met the CHWs.

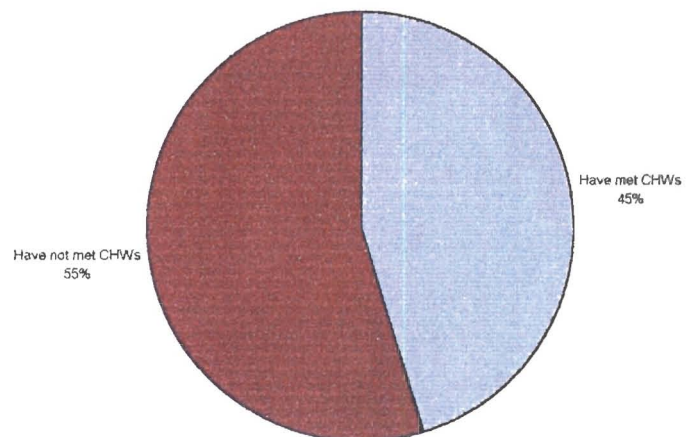
Number of Interviewees who use Nomzamo clinic



Number of Interviewees Who Have Heard About the Community Health Project

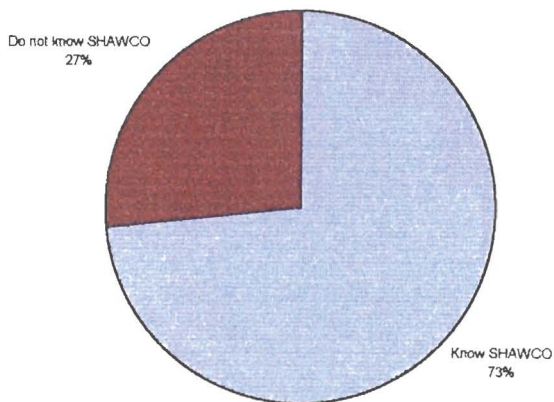


Number of Interviewees who have met the community Health Workers

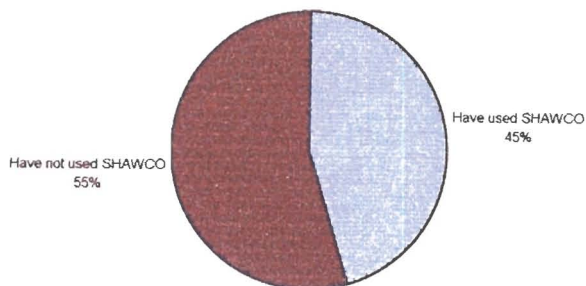


Although 73.4% (47) of interviewees have heard of the SHAWCO clinic, only 45.3% (29) have actually used this service. That is 61.7% of those who know about the service have actually used it.

Number of Interviewees who Know the SHAWCO Clinic

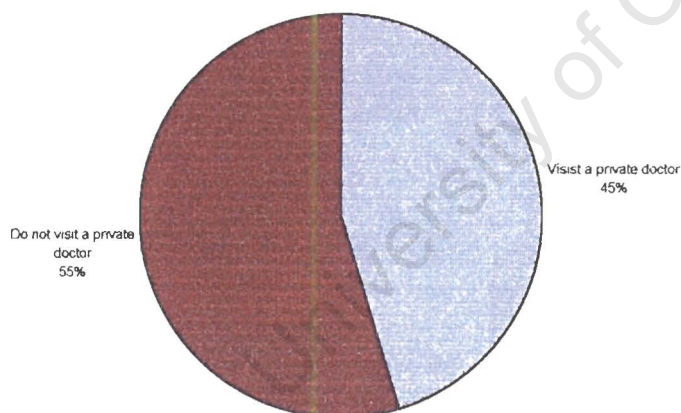


Number of Interviewees who Have used the SHAWCO Clinic

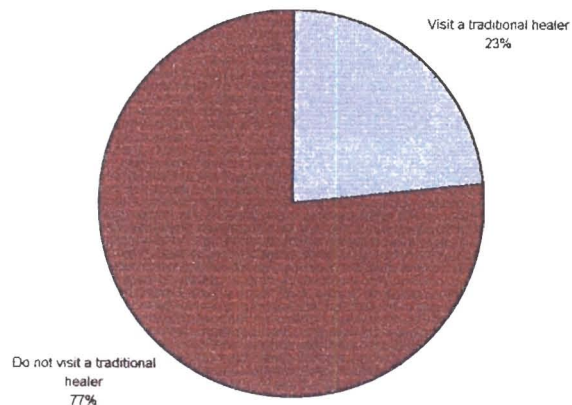


45.3% of interviewees (29) go to a private doctor, and 23.4% (15) go to a traditional healer.

Number of Interviewees who go to a Private Doctor



Number of Interviewees who Visit a Traditional Healer



### Attitudes to Health Services

When asked what they thought of healthcare services in Site Five, 20.3% of interviewees (13) gave a positive response. These were mostly young, healthy people, without children:

- *"It is alright for me"*<sup>74</sup>
- *"I think it is good"*<sup>75</sup>
- *"There is not a problem at the moment"*<sup>76</sup>

<sup>74</sup> Household interview, 01.03.99

<sup>75</sup> Household interview, 20.04.99

<sup>76</sup> Household interview, 19.04.99

45.3% (29) gave negative answers. Most of these dissatisfied individuals were people who had been seriously ill or had family members who had been, and they had found it very hard to get medical help so felt let down by the healthcare system:

- *"There is no healthcare in Site Five"*<sup>77</sup>
- *"Healthcare here is not good because at the clinic they don't have the medication. They always refer us to False Bay Hospital"*.<sup>78</sup>
- *"It is not good because they always refer you to FBH"*.<sup>79</sup>

31.3% (20) had mixed feelings. These comments reflect the inadequacy of the range of the healthcare services provided at Masiphumelele Clinic:

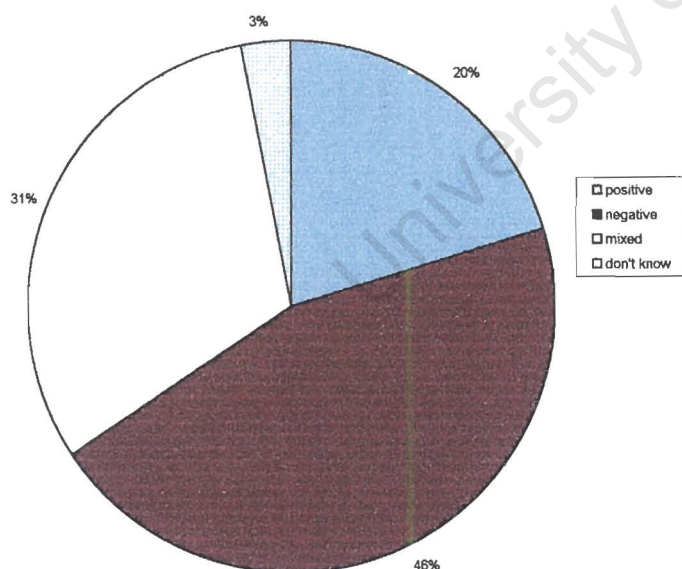
- *"For the Children it is alright, but for me it is not good. They always refer me to False Bay Hospital when I am sick."*<sup>80</sup>
- *"It is good for the kids but not for the adults."*<sup>81</sup>
- *"It is good, except if you go for your injection you have to wait for too long."*<sup>82</sup>

Only 3.1% (2) did not have an opinion, and these were people who had not needed to make recourse to the health system in Site Five:

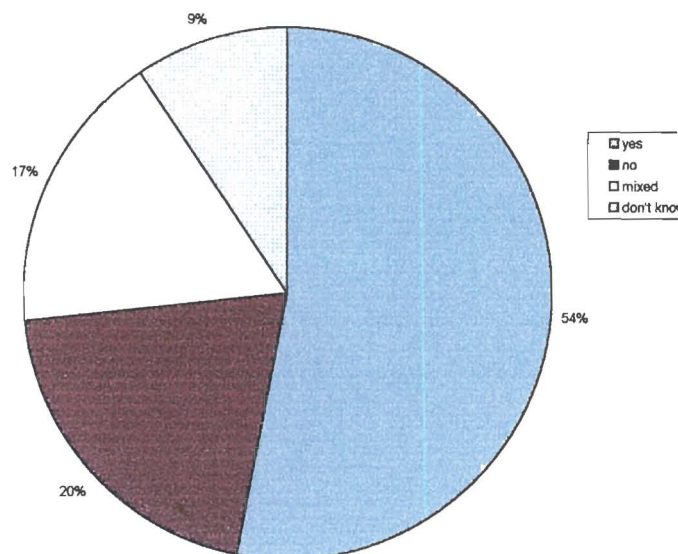
- *"I have not been sick since I am living here, so I don't know, but I have never heard any complaints."*<sup>83</sup>
- *"I don't know about the health care because most of the time I am at work"*.<sup>84</sup>

Lengthy waiting times at the clinic are also a point of dissatisfaction, and are a direct result of the clinic being under-staffed and under-funded. Several respondents complained that the clinic regularly runs out of medicines too.

ATTITUDES TO HEALTHCARE SERVICES IN MASIPHUMELELE



ARE CLINIC STAFF EASY TO TALK TO?



<sup>77</sup> Household interview, 29.04.99

<sup>78</sup> Household interview, 27.04.99

<sup>79</sup> Household Interview, 14.04.99

<sup>80</sup> Household interview, 29.04.99

<sup>81</sup> Household interview, 14.04.99

<sup>82</sup> Household interview, 27.04.99

<sup>83</sup> Household interview, 19.04.99

<sup>84</sup> Household Interview, 28.04.99

Respondents also had mixed feelings regarding the staff at the clinic. When asked whether they found the clinic staff easy to talk to, 53.1% (34) said they were, 20.3% (13) found them difficult to talk to or thought the staff did not care about them, 17.2% (11) had mixed feelings, and 9.4% (6) said they did not know. The majority of people had no complaints about the clinic staff, but amongst those who did the main reason for dissatisfaction was the language barrier. There are no Xhosa-speaking sisters at Nomzamo Clinic, so if necessary and when possible the nurses use a translator. However many patients feel their confidentiality is threatened by the presence of a translator, so will struggle on their own in broken English or Afrikaans, which frequently leads to misunderstandings, and appears to be the basis of the perception that the nurses do not care.

- *"They (the sisters) are not interested in our problems".<sup>85</sup>*
- *"They take their time. They spend too much time drinking coffee"<sup>86</sup>*
- *"I haven't experienced any problems with them, but I have heard of other people who have had a problem."<sup>87</sup>*
- *"They are not easy. They move up and down looking for people to translate. They can't communicate with our people."<sup>88</sup>*
- *"They are not easy to talk to because they are bossy. It is like they look at your face, and if they know you they may be nice. Like me. When ever I go there they are rude. I always go to get condoms. They tell me this is not clinic time, and I didn't even say if I am going for clinic".<sup>89</sup>*
- *"They are friendly, but language can be a problem. They must learn to speak Xhosa, because we have misunderstandings, and they get very annoyed."<sup>90</sup>*
- *"Yes, they are easy to talk to."<sup>91</sup>*
- *"Some of them are good - they are friendly, and listen to my problems, but some of them are always cross. They do not smile."<sup>92</sup>*
- *"They are always nice to me. I am happy to talk to them".<sup>93</sup>*

Of the 29 interviewees who have been to the SHAWCO Clinic, 23 thought it was a very good service (35.9% of total interviewees):

- *"They are very good. The way they work - their approach. They are very patient. It is very rare you go there and don't get better. And if they cannot help you they send you to other doctors, like False Bay, and at least they explain to you why they send you there."<sup>94</sup>*
- *"SHAWCO clinic is much better. They are helping. It is safe to get sick on Monday, otherwise you can die in this place."<sup>95</sup>*

6.3% of interviewees (4) had negative attitudes to SHAWCO:

- *"Once I went there when my back was sore, and they gave me a Disprin. They did not help me".<sup>96</sup>*

<sup>85</sup> Household Interview, 10.03.99

<sup>86</sup> Household interview, 10.03.99

<sup>87</sup> Household interview, 10.03.99

<sup>88</sup> Household interview, 27.04.99

<sup>89</sup> Household interview, 29.04.99

<sup>90</sup> Household interview, 16.03.99

<sup>91</sup> Household interview, 14.04.99

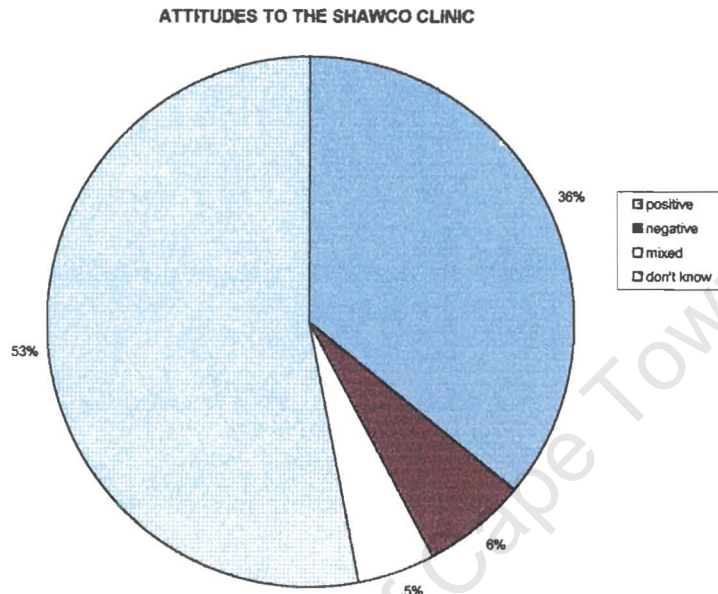
<sup>92</sup> Household interview, 20.04.99

<sup>93</sup> Household interview, 14.04.99

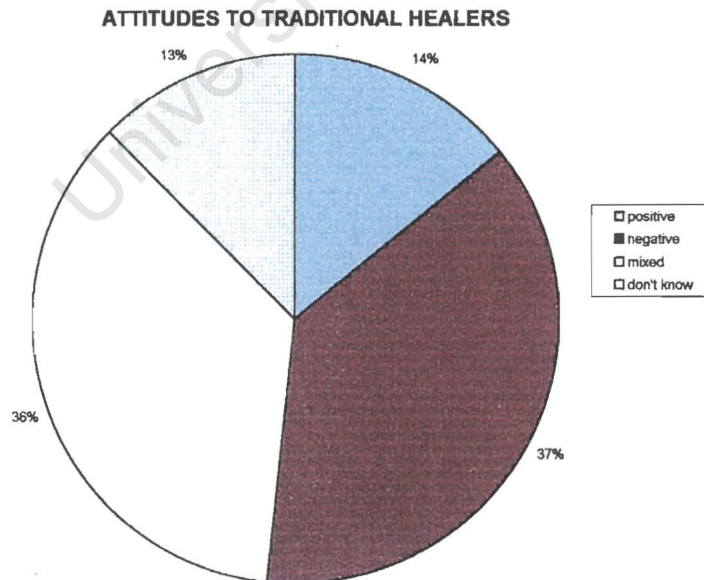
<sup>94</sup> Household interview, 29.04.99

<sup>95</sup> Household interview, 14.04.99

- *I don't think it is good, because I had tonsillitis and they didn't help me.*<sup>97</sup>
- 4.7% (3) had mixed feelings,
- *"I only went once, so I don't really know it. But at the clinic they do not care about us, and I think SHAWCO is better".*<sup>98</sup>
  - *"I think it is a good service, but they could not help me. They checked me and still sent me to False Bay"*<sup>99</sup>
- and 53.1% (34) didn't know because they had never been there.



Attitudes to traditional healers were quite varied:



<sup>96</sup> Household interview, 16.03.99

<sup>97</sup> Household interview, 15.04.99

<sup>98</sup> Household interview, 16.03.99

<sup>99</sup> Household interview, 19.04.99

- *"I am a sangoma, so I think very highly of them! I cannot help everyone who comes to me, and I tell them if I can't help them. Sometimes the people go to a doctor first; it depends on the problem. I cannot treat myself, so I go to another sangoma who is a friend."*<sup>100</sup>
- *"I do not go to a traditional healer. To other people it is good, but to me, no. When you go there they tell you is because of somebody you are sick. So you remain hating somebody, while he or she is really innocent."*<sup>101</sup>
- *"I am to be a sangoma, but I do not want it. I never go to the sangoma; If I am sick I go to the doctor. But I was called to it, so I must go to my home in Kimberly to learn. Nothing will go right for me until I answer my calling."*<sup>102</sup>
- *"I go to the traditional healer for some of my sicknesses, like emotional problems – traditional sicknesses. Like nightmares, or when you see dead people, or if your neighbour is doing something bad."*<sup>103</sup>
- *"I sometimes go to the traditional healer, because there is no other way. Of course we are scared of them, but we must go to them. I do not believe in traditional healers, because I am a church member. Sometimes they can give me medicine to stop my pain, but sometimes they do not give me medicine."*<sup>104</sup>
- *"I do not trust the traditional healers; their work is bad. I only trust the professional doctor. Today's traditional healers do not help you. They lie a lot, and they are just making business out of you."*<sup>105</sup>

A few people declared great faith in traditional healers, and believe that they can help them when a professional doctor has failed. In my survey 14.1% (9) expressed a positive attitude to traditional healers – these were mostly women over the age of forty. A lot of people have mixed feelings about them, and think that they can sometimes help other people, but they would rather go to a professional doctor if they are sick. Thirty-five point nine percent (23) have mixed feelings, 37.5% (24) have a negative attitude, and do not trust traditional healers, and 12.5% (8) do not have an opinion – all people who have never been to a traditional healer. Several people told me they go to a traditional healer when in the Transkei, but here in the City they do not trust them, and would rather go to a medical doctor. The issue of traditional healers is not an easy one to get people to talk about. I am sure that some of my informants were trying to give me the answer they thought I wanted to hear, which, because I am white, is that they don't trust traditional healers and would rather go to a medical doctor. From speaking to a couple of sangomas in Site Five I know that they have a lot of patients, and that they fulfil a role somewhat different to western doctors, solving disputes and spiritual problems as well as administering to physical ailments.

In response to the question 'Do you think the CHWs will help the community?', 81.2% (52) thought they could be of benefit, 18.8% (12) had mixed feelings, and none

<sup>100</sup> Household interview, 10.03.99

<sup>101</sup> Household interview, 16.03.99

<sup>102</sup> Household interview, 16.03.99

<sup>103</sup> Household interview, 14.04.99

<sup>104</sup> Household interview, 14.04.99

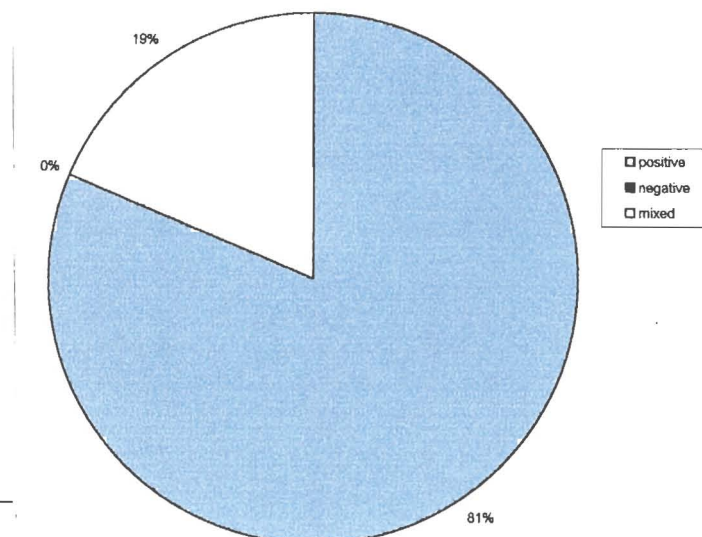
<sup>105</sup> Household interview, 27.04.99

thought they would not help at all. This huge majority reflect the appalling state of healthcare in Masiphumelele. All those interviewees who had mixed feelings were people who had not heard of the Community Health Project before my visit. They thought it sounded good, and that there is definitely a need, but had no experience of it as yet. Here are some examples of what people who had met the CHWs thought about the project:

- *“I think they can really help the old people, because it is difficult for them to go to the clinic. And I think if I have any kind of problem I can go to them.”<sup>106</sup> (An unmarried man in his late twenties)*
- *“I think they can help the community, because there are a lot of people, like TB people, who don’t go to treatment. Maybe they (the CHWs) can find those people and make them go to treatment.”<sup>107</sup> (An unemployed girl of twenty, living with her parents)*
- *“Even if someone doesn’t want to go to the doctor they can force them, like I saw a woman who refused to go to False Bay for treatment for asthma. Even when the ambulance came they wouldn’t go, but they (the CHWs) persuaded her to go.”<sup>108</sup> (A young mother, early twenties)*
- *“I think they are doing good work, but there are very few of them to help the whole of Site Five. There are so many people here who are sick. But they are trying. I always see them walking around.”<sup>109</sup> (A mother aged about 30)*
- *“They can help by doing regular visits, especially to the people who are very sick, and maybe they can give them medicines and arrange transport to the hospital for the people who cannot afford it.”<sup>110</sup> (A man in his thirties, unemployed)*

Again, it is possible that respondents were giving me the answer they thought I wanted to hear. Some may have thought that I was there to advocate for the community health project, whilst others will have been influenced simply by who I am – a white, British, female, university student conducting research.

ATTITUDES TO COMMUNITY HEALTH WORKERS



<sup>106</sup> Household interview, 16.03.99

<sup>107</sup> Household interview, 16.03.99

<sup>108</sup> Household interview, 29.04.99

<sup>109</sup> Household interview, 29.04.99

<sup>110</sup> Household interview, 04.05.99

## 2. Healthcare Resources

Several important issues, related to real or perceived inadequacies with healthcare services and facilities, came to light during the course of my research. In this chapter those issues are discussed in three sections. The first deals with issues that arose during research that are connected to activities at Nomzamo clinic – major health problems in Site Five, and perceptions of the service provided by the clinic; the second deals with issues related to False Bay Hospital, including access and waiting times; and the third is a discussion of issues relating to the community health workers, including the issues of professionalism, power relations, knowledge, and attitudes. Many of these issues are already being addressed and overcome by the community health workers, demonstrating that community health workers are fulfilling a vital role in bridging a gap that exists between health care providers and users in Masiphumelele.

### Clinic Activities:

During the time I spent observing in the waiting room at the clinic I saw very few men. I was concerned that because TB and STDs are the only things men can be treated for at the clinic, men might feel embarrassed or stigmatised to be seen there. I asked Pumla if this was the case, and was surprised by her answer:

*“It is not usually a problem. If they are sick they know they must go to the clinic for treatment. But on Monday I went with the SHAWCO clinic. I translate for the doctors. A man came, and he said he did not want to talk to a woman, so I had to go and find Ayanda, and he helped him. But it is not usual.”<sup>111</sup>*

Health education sessions at the clinic are a good idea, and people appear to listen with interest – many ask questions and offer answers to the educator’s questions – but it is difficult to know how much impact they will have on people’s lives. I listened to several of the sessions in the clinic, and thought they were well presented. The message is always clear, direct, and simply stated. There are usually visual aids and sometimes videos to enhance understanding, and there are question and answer sessions. However, people do not go to the clinic specifically to listen to them. They merely listen because they are there. The question remains as to whether or not they practice what they are taught when they go home. The other problem is that the education sessions at the clinic exclude members of the community who do not ever go to the clinic. Merely from the household interviews I conducted, ten informants (15.6%) said that they never go to the clinic. The majority of the people at the clinic in the mornings are women, especially mothers, so the education sessions are tailored to be relevant to them. But the rest of the community appear to miss out. This is one area where the community health workers are making a difference. On their home visits they are providing informal education specific to each household’s individual needs and/or problems. This way health education is being brought to people who do not attend the clinic.

HIV is a growing problem in Masiphumelele. At the end of 1998 there were 28 registered patients, 13 (46%) of whom registered in that year. A further 17

<sup>111</sup> Field notes, 25.02.99, P.2

patients were registered in the first three months of 1999, bringing the total to 45. More patients were registered HIV positive in the first three months of this year than in the whole of last year. These patients are seen by the visiting doctor. However none of the nursing staff at the clinic are fluent in Xhosa, so they and the doctor are usually assisted by the clinic's general assistant or a volunteer acting as a translator. This results in a loss of doctor-patient confidentiality, which inhibits some people from seeking counselling and support. Recently the community health workers have been working as translators at the clinic, which some patients are happier with than having a lay person there.

Everybody I interviewed said they would be happy discussing their problems with the community health workers. However HIV/AIDS is a difficult issue. Despite AIDS awareness campaigns, it still has a stigma attached to it, and people are reluctant to discuss it. For example, I visited a house with Kholiwe and Skolweni where the mother had defaulted on TB treatment.<sup>112</sup> She denied that she had TB, and had severe weight loss and skin problems. The health workers suspected HIV, but she avoided giving straight answers to their questions, as if she was hiding something. It is very difficult to deal with cases like this when patients do not wish to co-operate. In this case Kholiwe decided to speak to the woman's husband, and to try and motivate him to allow them to both be tested. If they agree, she will also provide counselling for the couple. This case is another example of the community health workers identifying problems and providing solutions. If they had not visited this woman she would not have sought help. Now they will educate her, counsel her, and encourage her to seek medical help.

A lot of informants complained that the clinic is closed too much of the time. On Friday there is no consulting time. If a child gets sick on a Friday, Saturday, or Sunday, they must be taken to False Bay Hospital, where people claim you can wait up to twelve hours to see a doctor. Waiting times at the clinic can also be long – up to three hours. When asked how they thought healthcare services could be improved, a lot of people replied that they need a doctor at Nomzamo Clinic every day, to care for adults as well as children. A lot of people also claimed there is a need for a twenty four hour facility. If there is an emergency at a weekend, some respondents reported that they will find a community health worker to help them, since they live in Masiphumelele and are always on hand. They can administer basic medicines and first aid, or will call an ambulance to take patients to False Bay Hospital. These are important services in a densely populated area that has no full-time 'professional' health workers, making healthcare more accessible to people.

#### False Bay Hospital:

One major source of dissatisfaction with False Bay Hospital (FBH) is that patients can not make appointment times. Everyone is told to be there by seven o'clock in the morning, and they may sit on the benches all day without seeing a doctor, only to be told to come back tomorrow. Such treatment has resulted on many people feeling neglected by hospital staff, and several patients told me they feel that the staff at FBH do not care about them.

---

<sup>112</sup> Fieldnotes, 04.03.99, P.11

There is an emergency department at False Bay Hospital, but at weekends and at night it is difficult to get to Fishhoek because taxis run infrequently (if at all) and to get a private taxi can cost up to R60.00 each way, which few people can afford.

Another reported problem is the whole system of referral. Patients find it time consuming, inconvenient, impersonal, and confusing. For the period 1 July 1997 to 1 June 1998, 1041 patients were referred from Nomzamo Clinic to secondary or tertiary health facilities. They go to Nomzamo clinic, and are referred to FBH to see a doctor. From there they may be referred to Victoria Hospital or Groote Schuur, and a child might be sent to Red Cross. This shunting of patients from one institution to another takes time – time some critically ill patients do not have. The following case was recorded when I accompanied Kholiwe on a home visit. I was speaking to a middle-aged woman:

*“... She tells us she is angry because she had a baby girl, who kept collapsing. So she took her to the clinic, but the sister hardly looked at her. It was as if she wasn't interested. She merely gave her a letter of referral to FBH. So she took her baby to FBH, and the doctors told her she was dying. She is disgusted with the service from the clinic, saying that the sisters do not care, and that they do not need to care, because they know they will get paid at the end of the month regardless of the quality of the work they do.”<sup>113</sup>*

Her daughter died, and she blamed it on the staff at Nomzamo Clinic who had not helped her. In fact they could not help her, and realising it was serious they referred her straight to False Bay Hospital where there is a doctor. But this was interpreted by the mama as a lack of caring by the clinic staff.

Getting to appointments at FBH is not easy, and entails considerable expense for someone who has no income, and at each level the patient and family members who accompany them must wait. First they are seen by a nurse, who will then decide if they need to see a doctor, and if so, how urgently they need to see him, compared to other patients who are also waiting for his attention. Often the nurses assessment and the patient's own assessment of the severity of their condition differs, due to different understandings of illness. Because some patients only seek medical attention when they perceive their condition to be severe, they and their family believe s/he needs urgent and timely attention when s/he arrives at the hospital. Consequently any delay is perceived as a lack of caring by the medical staff, when in fact it is due to technical, financial, structural and staff shortages, within a health system undergoing radical change.

In response to these problems, the community health workers area advocating for a day hospital in Masiphumelele. However it is acknowledged that that will take time. In the mean time they visit patients to remind them to attend hospital appointments (many do not go because it is too difficult and costly to get there), and help patients arrange transport to hospital appointments, calling an ambulance from Fishhoek if necessary. Thus the community health workers are improving accessibility to health resources.

---

<sup>113</sup> Field notes, 01.03.99, P.7

### Community Health Workers:

The four community health workers have already been introduced, and attitudes of residents of Site Five to them have been discussed, but it is important to also look at their individual knowledge and attitudes concerning their work and the community they serve. During the course of my research several issues arose concerning the community health workers.

The first issue is that of professionalism. Community Health Workers are not currently afforded professional status. CHWs are trained, are paid, and belong to a nation-wide group of people who have received the same training and are doing similar work, so there is no reason why they should not be afforded professional status. The issue of professionalism is of concern to the community health workers in Site Five. I first became aware of it during a discussion with the four of them and Tanya and Chantelle. The health workers asked when they would be receiving their uniforms. They will all have navy trousers, a warm coat, shoes, and a work bag.

One can understand that they require warm coats, because they do their house visits on foot, and in winter it can be very cold and windy in the valley. But I asked them anyway why they wanted to wear uniforms, because I was interested in their own reasoning. The answers they gave were as follows: They all want to save their own clothes; the women are particularly concerned about preserving their shoes, as shoes are expensive. Ayanda said he wants people to be able to recognise them as the CHWs. For shoes the women want clogs, because they are tough. When I pointed out that clogs will not keep their feet dry in winter, they were quite insistent that those were the most practical shoes because they are hard wearing. As for bags, Skolweni recalled a story to justify them needing official bags. One day Sandy Dowling (from the Valley Development Project) saw her walking with a Pick n' Pay bag and thought she had been shopping, when in fact she was on her way home from the clinic and the bag was full of DOTS medicines. Being questioned by Sandy and having to show her the contents of her bag made Skolweni feel uncomfortable, and all four of them felt that if they had official bags, such incidents would not happen again.

Here we encounter different understandings of the term 'professional'. Community health workers should be afforded professional status based on the facts that they have received nationally recognised training, and belong to a nation-wide group of people who have received the same training and are doing the same job, fulfilling a vital role within the national health system. To the Masiphumelele community health workers, however, being 'professional' means doing their job well, but also entails elevated status, and recognition from the people amongst whom they live and work. One of the most important defining characteristics of a community health worker is that they belong to and live in the community in which they are working. There is a risk that uniform clothing would serve as a barrier between them and the rest of the community (although I recognise there is a need for warm coats, tough shoes, and a bag). There is a danger that they would no longer be seen as equals by those they serve, but rather as a professional elite, merely because they have chosen to dress in an official way. This is not merely a hypothetical issue, but is based on experience from other community health projects. Problems also arose when uniformed nurses from the clinic used to visit TB patients in their homes. Patients were very against these visits because they were afraid people would suspect

they had TB when they saw a nurse at their house. Now these visits are carried out by the community health workers, and it is not longer a problem.

An alternative to uniforms would be for the community health workers to receive a clothing allowance, which they must use to buy clothes for work, but not all the same. This would save their own clothes and mean they have tidy clothes for work, whilst eliminating the risk of the them alienating themselves from the people they work with.

A second issue that arose is that of power relations amongst the CHWs. I witnessed a couple of events – power struggles - that indicated they do not necessarily consider one another absolute equals. For example, they use an old freight container outside the clinic as their office, which is kept locked. One morning when they arrived they had a discussion and disagreement as to who should keep the key to the container. At the time Ayanda had it, because he holds the youth choir there on Tuesday nights. But the others were not happy with him having it – it seemed that they thought him unreliable. Kholiwe, who emerged on more than one occasion as the self-appointed leader, wanted to keep the key at her house; she said there is always somebody there, so even if she is out one of the others can fetch the key. In the end a compromise was reached. Ayanda would keep his key, and share it with Pumla, and another key would be cut and given to Kholiwe, which she must share with Skolweni. Ayanda and Kholiwe were by far the most involved in this power struggle.

When the community health workers have an issue to raise with Tanya and Chantelle, they often get Kholiwe to do the speaking. The other three do contribute, but mainly to prompt Kholiwe to say things she may have forgotten, rather than raising an issue themselves. This is what gives her the air of leadership, though it may simply be that she is more confident speaking English than the others. It would be naive of project planners to assume that the relationship between community health workers will not be hierarchical.

A third issue is that of the community health workers' attitudes to the people they visit. The CHWs appear to have a very positive attitude to their clients. When interviewed individually they all talked about building friendships, and how important trust is. Pumla referred to her relationship with her clients as a 'partnership', in which she and the people she visits work together to solve their problems. This sentiment is visible when she enters a house. Whenever I accompanied any of the community health workers on home visits they were polite, and never pushy (I am sure there are instances when they get irritated, but I never witnessed any). The health worker introduces him or herself, and describes the work the four of them are doing, before starting to ask questions. People usually welcome them; never once on any of the visits I did with the community health workers were they turned away or even made to feel unwelcome. The CHWs are usually offered a seat, and sometimes tea, or a cool drink. And many people really open up to them. I was amazed at how quickly people start talking about their personal problems. Some people are surprised, and genuinely happy that someone cares enough to take an interest in their problems, and that they might actually be helped. However, one cannot generalise about the feelings of the entire population from these results. All the community health workers reported that they are sometimes made to feel unwelcome, especially in the homes of elderly people, who ask them a lot of questions, and want to know if they are properly trained. But Pumla told me they persist, and visit these houses

again and again in an attempt to build a relationship, since these are often people who need their help.

A fourth issue relating to the work of the community health workers is that all four of them said that they want further training. This could reflect either a lack of confidence, or conversely, a passion and commitment to their work. When accompanying them on their home visits, they all seem very confident in their work – an observation that was also made by the assessor from NPPHCN. However they clearly all feel the need for more knowledge. This would not be at all surprising, given that they only received nine weeks training before taking on their roles as community health workers, and the considerable responsibility that goes with the job, and there is no one senior to them working in Site Five from whom they can learn. As they have got to know their job, and become happier in their work, they have each realised what their personal weaknesses are and where there are gaps in their knowledge. It shows an understanding of their responsibilities, a secure grasp of the aims of the project, and a commitment to their work that they are confident enough to admit they need more training, and to be able to identify exactly what skills they require. They all expressed a desire to improve the service they are providing to the people of Masiphumelele.

During in-depth, one-to-one interviews with each of the CHWs, I asked them how they would like to see the Philisa Community Health Project evolve. All of them mentioned further training. Pumla said that she would like training in leadership skills. She would also like the four of them to run workshops in the community to advise people on health issues, in order to empower them to take greater responsibility for their own health, and she suggested creating support groups for some patients, e.g., disabled people, TB patients, people who are HIV positive, etc. She believes the project will change over the next few years – the community health workers will take on more roles and duties, and she would like them to be involved in any new projects that are initiated in Masiphumelele.

Ayanda would like to focus on the youth. He suggested running youth groups in co-operation with the clinic, and doing role plays around health-related issues. He also said he would like to change his relationship with his clients, in order to “build togetherness and confidence”. In the future he hopes the community health project will have sufficient funds that there will be a community car which the CHWs can use to take people to the hospital, and that they get a permanent office with a telephone, as it is expensive and inconvenient phoning the hospitals to make appointments for patients from a public telephone. Like Pumla, Ayanda hopes that other projects will develop from this one, in order to improve the lives of the people in Masiphumelele.

Kholiwe does not think the community health project will change much in the foreseeable future. Her only hopes for it are that it becomes sustainable, and that it empowers the people they are working with. She thinks the community health workers need more training, especially in nursing skills. She also hopes for some acknowledgement and recognition for the work she is doing.

Skolweni also wants more training, and for people to come and advise them in their work. She does not think the project is going to change much, though she thinks they need to do some fund-raising in order to train some more community health workers. Site Five is a large, densely populated area, and the four of them are not enough. She thinks the project would be more effective if there were more health workers.

That all the community health workers see the Philisa Health Project evolving, and that they wish to broaden their knowledge and their roles, shows a commitment to the project.

A fifth issue that arose amongst the community health workers was a feeling of isolation, due to the absence of a permanent support structure. Tanya and Chantelle try to visit them once a week, accompanying them on home visits and discussing their work and any problems with them, and the nursing staff at Nomzamo Clinic are always happy to advise them, but they are essentially on their own.

In March (i.e., when the community health project was only 3 months old) I attended a meeting between the community health workers and Tanya and Chantelle, during which the CHWs questioned the two nurses about accountability. They said they wanted a contract (which was at that stage still in the process of being drawn up), and a clear job description. They all seemed unclear of their duties, and exactly whom they were accountable to. They appeared to be feeling slightly disoriented, and in need of clarification. Tanya and Chantelle, who co-ordinate the project, tried to be completely up front with them, and told them the project only has funding until the end of the year 2000. They hope to secure further funding, but as yet nothing is confirmed. As for accountability, the project is funded from overseas. Although it is not part of the Valley Development Project, VDP does their administration and controls the money, so does have some responsibility for the project. Tanya and Chantelle told the community health workers they do not want to take control. They want the CHWs to take as big a role as possible in managing the project, because ultimately the community health workers are accountable to the people they serve.

In light of these insecurities, I was surprised when I interviewed the community health workers individually that none of them said they feel isolated. This was about two months after the above discussion took place. It could be that that discussion resolved their earlier problems, or cleared up what were merely misunderstandings. The community health workers reported a good working relationship with the clinic staff, and that for problems that are to do with the project and not a patient they can always contact Tanya or Chantelle. In addition, they can contact the trainers at NPPHCN for advice, and they speak to other community health workers who they met during training and again at a conference for CHWs held earlier this year. It appears their confidence and their independence is increasing all the time.

## DISCUSSION AND CONCLUSIONS

### Gaps in the New Health Care System

The new reformed National Health System (NHS) is based on the notion of equity, and involves a shift in emphasis and redirection of resources away from hospital services to primary health care, and from curative to preventative services. Policy changes are aimed at improving access to health services, and removing historical inequalities. Although the new policies sound very desirable, the resources and facilities to fulfil them are not yet fully in place. Many structures of the old regime still remain, and the new fully-reformed National Health System is not yet in place. There is still an uneven distribution of health care services and facilities between more and less privileged sectors of society. Due to the changes, combined with severe financial constraints, there are gaps in the service people are currently experiencing.

As explained earlier, South Africa's health system is under severe pressure. People complain of long waiting times. Medical staff report having to prioritise patients in order of seriousness. This is an important issue - prioritising lives requires ethical choices to be made. Who is to be helped first: a young mother with a complicated birth, a boy with a stab wound, or an old man with a history of smoking and alcohol abuse who has had a stroke? Is anyone qualified to make these decisions, and to place a relative value on the lives of others? And if so, against what criteria will the value of a person's life be judged: relative youthfulness, health, reproductive potential, family, productivity, usefulness? Prioritisation reflects a complex set of power relations. Within the Western bio-medical model, doctors typically hold the medical knowledge and skills. When patients from Masiphumelele enter the health system they are depersonalised; they are categorised in terms of the severity of their condition – they become a medically interpreted body. They are also disempowered; they place their lives in the hands of medical professionals, who hold the knowledge required to cure them. Patients become objects in the realm of medicine.

One of the key aims of South Africa's new health policy is to empower people, through education and community involvement in health, but the anticipated positive results are not yet visible. The planning of health services must take into consideration the experiences and the expectations of patients. As a result of the historical legacy of apartheid medicine, together with severe financial constraints, inequalities still exist between population and income groups, as well as geographical areas. In emphasising greater access to healthcare, South Africa's new health policy also has to pay close attention to the financial implications. This has impacted on patients and practitioners in many ways. In the context of this discussion, practitioners no longer view patients purely from a biomedical understanding, but must adhere to social constructs of health and worthiness to receive treatment. In terms of power dynamics, it may be argued that, in response to financial constraints, the power held by medical professionals is now being employed on behalf of the provider to the disadvantage of patients.

## Are The Masiphumelele Community Health Workers Fulfilling Their Objectives?

It is important to look at the activities of the community health workers in terms of the NPPHCN guidelines on the roles of CHWs<sup>1</sup> (as described in Chapter 2: Health Care in South Africa), in order to assess whether they are fulfilling their aims and objectives. The roles of community health workers include:

**Resource person:** The community health workers in Site Five link the local residents with resources. They identify health problems and make appointments for people to see a doctor, social worker, or occupational therapist if necessary. Previously many residents of Masiphumelele (and from my results it would appear to be the majority) were not aware that some of these services are available to them. Others failed to seek medical attention when they were sick, either because they were not aware of the seriousness of their condition, or because they had had previous bad experiences when encountering the health system.

The community health workers arrange for ambulances to take people to hospital in emergencies. Many people complained that if there is an emergency it is difficult for them to get help, because outside of clinic hours they must go to False Bay Hospital. At night and at weekends there is little public transport, and a private car is expensive. The community health workers are never really off-duty – people can go to them at any hour of the day or night if they require assistance. People are very grateful for these services. Clearly the community health workers are making health services and facilities more accessible to the people.

The community health workers also encourage mothers to have their children vaccinated – many women, due to lack of education, do not realise the importance of childhood vaccinations, so this is also an important service the CHWs are performing, that will improve the overall standard of health for individuals, families, and the residents of Masiphumelele as a whole.

**Advisor:** When the community health workers visit people in their homes they disseminate health information and report on health problems. They advise about any problems people may have, social as well as physical, and also of the health services available to them. By disseminating information about the range of health services available, the community health workers are playing an important role in empowering people to take responsibility for their own health. Also in their role as advisors, the CHWs report problems such as Tuberculosis to the sisters at the clinic, so patients who are not receiving treatment can be tested and treated, thereby further improving the standard of health for the residents of Masiphumelele.

**Advocate:** The community health workers are encouraging people to take responsibility for their own health, by teaching them about the causes of disease, and also what courses of action to take when they have different problems. This is empowerment of previously disadvantaged people.

**Educator:** The community health workers are raising awareness about disease, through formal education sessions at the clinic and with youth groups, and informal education in people's homes. Educating people in their own homes when conducting home visits is particularly important, as it reaches those who do not visit the clinic often. Some of these people are woefully ill-informed about the causes and management of different illnesses, health practices, and health care services. The

---

<sup>1</sup> Policy Guidelines for CHWs in South Africa, NPPHCN Training Centre, 1997, P.1

community health workers are trying to develop the knowledge, skills and attitudes necessary to improve community health. They also have plans to run educational workshops with specific groups in the community, on subjects such as domestic violence, Tuberculosis, HIV and AIDS, and sexually transmitted diseases. Knowledge is essential to be able to make informed decisions, and in order to redress traditional power relations between health care providers and users, so the community health workers are empowering the people of Masiphumelele through education.

**Service provider and health visitor:** The community health workers make home visits, in order to identify sickness, counsel, treat minor illnesses, and encourage health-promoting practices (see list of medicines used by CHWs, P. 42). In more serious cases, they refer people to appropriate services. They also perform follow-up visits to people who suffer from chronic illnesses, providing counselling and support. In many cases they are helping people who would not otherwise have sought help for their health problems. By providing simple solutions and cures they are teaching by example, thus encouraging people to help themselves in the future.

**Specialist activities:** At this early stage the Masiphumelele community health workers are not involved in many specialist activities. However they do run a DOTS programme (direct observation treatment short-term) for Tuberculosis patients, and they act as translators for the SHAWCO doctors – both very important activities. TB is the biggest health problem in Site Five, and the DOTS initiative identifies and helps those who have defaulted on treatment. Their role as translators is vital in light of the complaints voiced by respondents about the language problem in the clinic.

**Facilitator:** The community health workers share their knowledge and skills with the people they serve, thus breaking down the usual power relations that exist between medical professionals and their patients. They are encouraging people to seek medical attention in cases where they might not have bothered in the past until it was too late. These are important activities as far as empowerment of individuals is concerned. In one-to-one interviews each of the community health workers also expressed a desire to be involved in other development activities in the community, and to act as agents for development.

**Liaison:** The community health workers liaise with staff at Nomzamo clinic, with the Valley Development Project, and with other community health workers in the Cape Town region. They do not at present liaise with policy and decision makers. This is an area in which they hope to get involved in the future. It is not easy at the present moment – the community health committee in Masiphumelele is not active, and the regional health management system is undergoing a complete structural transformation.

From the results of my research and the above summary analysis, it is clear that the Masiphumelele Community Health Workers are fulfilling all the roles described in the NPPHCN 'Policy Guidelines for CHWs in South Africa'. When this research was conducted the Philisa Community Health Project was still very young, so understandably some of the health workers' roles (as described by NPPHCN) were being carried out more fully than others. Kholiwe, Ayanda, Pumla and Skolweni are fulfilling their personal aims and objectives as defined in the Philisa Community Health Project mission statement<sup>2</sup>, and in addition the residents of Masiphumelele think their work is worthwhile and beneficial.

---

<sup>2</sup> See Appendix II

## **Interaction Between Health Care Users and Providers**

This report has shown the nature and extent of interactions between healthcare users and providers in Masiphumelele, as well as people's perceptions and experiences of the various health care services. Of the research sample, 84.4% (54) make use of the clinic, 45.3% (29) have attended the SHAWCO clinic, and 45.3% (29) have met the community health workers. It is encouraging to find how many people use the clinic, because the staff at the clinic suspect that a lot of people rather go to a traditional healer than seek a biomedical solution. It emerged that relatively few people (23.4%, or 15 respondents) use a traditional healer, because they no longer trust them. Several informants remarked that the local traditional healers do not always help the people, but are merely trying to make a profit from them.

One might be surprised at how few people have met the community health workers. However, it is a reflection of (a) the high number of people living in Site Five (c. 15,000) relative to the small number of CHWs (4), and (b) the fact that in many households there is not always someone home during the day, so even if the community health workers did visit there was no one there. The health workers anticipated it would take them a year to visit every household in Masiphumelele, if they are to perform the necessary follow-up visits in problem households as well. So the fact that in five months 43.3% of the sample population had already met them shows they are actually slightly ahead of target.

A very low percentage of the sample population (20.3% - 13) had a positive attitude towards the healthcare services in Site Five. There are many reasons for this high level of dissatisfaction. Firstly, the limited range of services offered at Nomzamo clinic, restricted to paediatrics, treatment for adults with Tuberculosis and sexually transmitted diseases, and contraception/family planning. The adult population of Masiphumelele believe they should be able to obtain medical attention at their local clinic. I asked respondents how they thought health care services could be improved, and 41 (64%) said that they need at least a day hospital that is open seven days a week, with permanent doctors, in Site Five. Another suggestion was for a doctor to work at the existing clinic every day, seven days a week, to serve adolescents and adults as well as children. There is clearly a need for further improvement of health care services in Site Five.

Another reason for the low level of satisfaction with the state health services is communication failure. None of the sisters in the clinic nor the doctors at False Bay Hospital speak Xhosa, so for patients who do not speak English or Afrikaans a translator is used. Some patients see a translator as a threat to their confidentiality, so refuse their assistance and struggle on their own in English, resulting in misunderstandings. In contrast, everyone who has met the community health workers reported that they are easy to talk to. Not only is the local language, Xhosa, their first language, but they are also fluent in English, so can and do accompany some patients to the clinic or to False Bay Hospital. They talk to the sister or doctor for the patient, explaining the patient's problem as s/he (the patient) perceives it, and relating information back to the patient in terms that they understand, and in their own language. This is a vital role. The community health workers are making existing health facilities more accessible to the people of Masiphumelele, bridging a gap caused by something as simple as language.

That such a high percentage of the sample population have positive attitudes towards the community health workers (81.2% - 52 respondents) is very encouraging.

Although a few people have mixed feelings, the fact that none of the respondents expressed a negative attitude towards them is important. Although the research sample does not reflect the whole population of Site Five, this result does reflect the appropriateness and the need for such a project. Every person I interviewed said they would welcome the community health workers into their home. I was surprised by this at first – I thought that some people might find it an invasion of their privacy. But even the people who had not yet met the CHWs said they would welcome them, because they felt they could help them in some way, either now or in the future. It is thought they will particularly be able to help elderly and disabled people, who are unable to or have difficulty in walking to the clinic.

It would be valuable to measure the impact of the community health workers' education initiatives - something that should be considered for future research. Such a project would present a challenge to research methodology. One approach would be to conduct an initial survey of health knowledge, attitudes, and practices, then divide the research sample into two groups. One group could be exposed to education health sessions, and the control group denied access to health education. Then another survey could be conducted to reassess knowledge, attitudes and practices, and the results compared to see if education made a difference. It would be useful to know whether people modify their behaviour as a result of current health education initiatives, or whether approaches to education need to be changed in any way to make them more effective.

As mentioned previously, the community health workers have a very positive attitude towards their work and their clients. They enjoy their work, and gain support from one another. They are gaining in confidence all the time, becoming more independent, and taking greater control of the project.

### **Can the work of the Masiphumelele Community Health Workers be improved?**

The Philisa Health Project can definitely be improved upon in the future. For example, it would be beneficial to the people of Masiphumelele for the community health workers to facilitate workshops with the traditional healers living there, in order to make the traditional healers aware of the work of the community health project, to educate them in basic health practices, and to encourage co-operation.

It would also be desirable and beneficial if in the future the community health workers become more involved in policy and decision making. They are in a strong position to act as advocates for policy transformation. They have earned the respect and trust of the people of their 'community', and know first hand what the issues, problems and needs of the people of Masiphumelele are. The community health workers are therefore in a position to represent them in an informed and reliable manner in health and other social issues.

However, even though the Masiphumelele Community Health Project is an unquestionable success story from which much can be learned, one can not generalise from it. One can not assume that similar projects would work elsewhere, as every 'community' has a unique set of health and social problems and issues. In addition, certain preconditions are necessary for such a project to be sustainable and for community health workers to succeed. Factors that are essential to the success of community health workers include the support of the local population, the support and co-operation of local health officials and medical practitioners, careful selection of community health workers from and by the population in which they are working,

adequate training for community health workers, and full commitment from the CHWs to the people they are serving and to their work. If community health projects are to work “medical and government bodies must commit themselves and the resources they control to supporting such efforts and helping them to expand.”<sup>3</sup>

As was hypothesised at the beginning of this paper, the four community health workers in Masiphumelele are fulfilling an important role by bridging a gap that exists between health care providers and users. That gap is a product of historical inequalities and a national health system in the process of transformation, that is lacking in human, structural, and financial resources. There is no government policy pertaining to community health workers, and they are not currently regarded as professional health care workers. However it is they who are delivering some of the prime objectives and achieving the founding principles of the new National Health System: community involvement in health, health education, and empowerment of disadvantaged people to take greater control and make informed decisions regarding their own health. Thus it is wrong that community health workers are not formally recognised by the South African Department of Health as professional health workers, and as an integral part of the new National Health System. Community health workers are working at a grass roots level to improve people’s quality of life, and are contributing to South Africa’s development and democratisation process.

---

<sup>3</sup> Corrine Shear Wood, *Maori Community Health Workers: A Mixed Reception in New Zealand*. In Coreil and Mull, 1990. P. 132

## APPENDIX I

### Respondents' Complaints Regarding Health Care Services in Site Five:

#### Nomzamo Clinic

- Waiting times can be long.
- Services are too limited – the only adult curative services are for TB and STDs.
- There is no service at weekends, and there are many accidents and injuries at weekends due to the high level of alcohol and drug abuse.
- They sometimes run out of medicines.
- None of the nursing staff speak Xhosa.
- Translators are perceived by some as a threat to patient confidentiality.
- There is only a doctor at the clinic for half a day per week.
- The ambulance service (to take critical patients to FBH) is very limited, and unreliable.

#### False Bay Hospital

- It is expensive to get to FBH – there are few ambulances, and if you do not have a friend who will drive you it can cost up to sixty Rand each way for a private taxi.
- You cannot make an appointment time, so must arrive very early in the morning if you hope to be seen by a doctor that day.
- There are long waiting times – sometimes patients are even told they must come back the next day.
- You will not be seen by a doctor with out a letter of referral.
- None of the doctors speak Xhosa.
- Due to a lack of resources, staff prioritise patients on the basis of the seriousness of their condition, and often refer patients to other secondary or tertiary hospitals.

# **PHILISA HEALTH PROJECT**



## **MISSION STATEMENT**



**THE COMMUNITY HEALTH WORKERS AT  
MASIPHUMELELE SERVE ALL THE  
PEOPLE OF THIS COMMUNITY**

**WE AIM TO PROMOTE THE HEALTH OF  
THIS COMMUNITY THROUGH:**

- ◆ **EDUCATION**
- ◆ **SKILLS DEVELOPEMENT**
- ◆ **WORKSHOPS**
- ◆ **INITIATION OF PROJECT**
- ◆ **FIRST AID**



**WE STRIVE TO CO-OPERATE WITH  
OTHER RESOURCES IN THE  
COMMUNITY TO PROMOTE  
COLABORATION**

**WE ARE ABLE TO DIAGNOSE AND  
TREAT COMMON AILMENTS WITH THE  
USE OF BASIC AND ESSENTIAL  
MEDICINES**

**WE PROVIDE PRIMARY LEVEL CARE  
AND WILL REFER TO OTHER SERVICES  
AS AND WHEN APPROPRIATE**

## APPENDIX III

### RESIDENTS QUESTIONNAIRE:

House Number:

Number of rooms:

Number of occupants:

Number of occupants under the age of 16:

Number of people in household who are working:

1. Do you go to the clinic ever? What for?
2. What do you think of the health care facilities in Masiphumelele?
3. Is it easy to get treatment when you are sick?
4. Where do you go to first when you are sick?
5. Would you seek advice from anyone before you go to a doctor?
6. How do you decide when to go to a doctor?
7. What problems do you go to a doctor for?
8. Is the service provided by the clinic good?
9. Do you find the sisters in the clinic easy to talk to?
10. Do you know about the SHAWCO clinic?
11. Have you ever been to the SHAWCO clinic?
12. What do you think of this service?
13. Do you ever go to anyone other than a medical doctor when you are sick?
14. Do you ever go to a traditional healer?
15. What problems would you go to a traditional healer for?
16. What do you think of traditional healers?
17. Have you ever been anywhere outside of Masiphumelele for health care treatment?
18. If you had to see a doctor where would you go?
19. Have you ever been to the clinic in Ocean View?
20. Have you heard of the Masiphumelele Community Health Project?
21. From where did you hear about the project?
22. Have you met the Community Health Workers?
23. What do you think of these people?
24. Do you feel happy talking to them about your problems?
25. Do you listen to what they tell you?
26. Did they tell you that you must go to the clinic or see a doctor? Did you go?
27. What do you/ would you think of the CHWs coming into your house?
28. Do you think the CHWs will help the community? How?
29. Do you think the CHWs will help you and your family? How?
30. How can health care services in Masiphumelele be improved?

## APPENDIX IV

### Household Interview Data Summary

<b>Total No. Households:</b>		64	100%
<b>No. who use clinic:</b>		54	84.40%
<b>Attitudes to health care services:</b>	positive	13	20.30%
	Negative	29	45.30%
	Mixed	20	31.30%
	Don't know	2	3.10%
<b>Are the clinic staff easy to talk to?</b>	Yes	34	53.10%
	No	13	20.30%
	Mixed	11	17.20%
	Don't know	6	9.40%
<b>People who know about the community health project:</b>		38	59.40%
<b>People who have met the CHWs:</b>		29	45.30%
<b>Attitude to CHWs:</b>	Positive	52	81.20%
	Negative	0	
	Mixed	12	18.80%
<b>People who know about SHAWCO:</b>		47	73.40%
<b>People who have used SHAWCO:</b>		29	45.30%
<b>Attitudes to SHAWCO:</b>	Positive	23	35.90%
	Negative	4	6.30%
	Mixed	3	4.70%
	Don't know	34	53.10%
<b>People who visit a private doctor:</b>		29	45.30%
<b>People who visit a traditional healer:</b>		15	23.40%
<b>Attitudes to traditional healers:</b>	Positive	9	14.10%
	Negative	24	37.50%
	Mixed	23	35.90%
	Don't know	8	12.50%

## **BIBLIOGRAPHY**

- Anon** December 1997, *Masiphumelele Community Needs Assessment*.
- Boonzaier, E., & Sharp, J.** 1988 *South African Key Words: the uses and abuses of political concepts*. Cape Town: David Philip.
- Coreil, J. & Mull, J. D.** 1990 *Anthropology and Primary Health Care*. Boulder: Westview Press.
- Department of Health** 16<sup>th</sup> April 1997 White Paper For The Transformation of the Health System in South Africa. In *Government Gazette*, Vol. 382, No. 17910, Notice No. 667 of 1997. Pretoria.
- Gibson, Diana** 25<sup>th</sup> May 1999 *Being Chronically Ill and Engaging with the New Health Care System: A Cape Town Study*. Seminar paper presented at UCT/UWC Departments of Social Anthropology seminar, at UWC.
- Harrison, D.** 1997 *A pocket Guide to District Health Care in South Africa*. Durban: Health Systems Trust.
- Health Systems Trust** 1997 *South African Health Review 1997*. Durban: Health Systems Trust.
- Health Systems Trust** 1998 *South African Health Review 1998*. Durban: Health Systems Trust.
- Kell, C.** 1994 *An analysis of Literacy Practices in an Informal Settlement in The Cape Peninsula*. (Dissertation in partial fulfilment of the requirements for the Degree of Masters in Philosophy). Cape Town: UCT.
- Manchip, S.** 1996 *Masiphumelele: A Case Study of the Role of The Development Action Group in the Informal Community of Noordhoek*. Cape Town: Development Action Group.
- Manderson, L., & Aaby, P.** 1992 'An Epidemic in the Field? Rapid Assessment Procedures and Health Research'. In *Social Science and Medicine*, Vol. 35, No. 7, pp. 839-850.
- Ministry in the Office of the President** 15<sup>th</sup> November 1994 White Paper on Reconstruction and Development. In *Government Gazette*, Vol. 353, No. 16085, Notice No. 1954 of 1994. Cape Town.
- National Progressive Primary Health Care Network** 1997 *Community Health Worker Curriculum*.
- National Progressive Primary Health Care Network** 1997 *Policy Guidelines for Community (Based) Health Workers In South Africa*. Draft 12, June 1997.
- National Progressive Primary Health Care Network** <http://www.healthlink.org.za>

**Ong, B. N., Humphries, G., Annett, H., & Rifkin, S.** 1991 'Rapid Appraisal in an Urban Setting, an Example From The Developed World'. In *Social Science and Medicine*, Vol. 32, No. 8, pp. 909-915.

**Pillay, Y., Mzimba, M., & Barron, P.** 1998 *Handbook for District Managers*. Pretoria: Department of Health.

**Schopper, D., Doussantousse, S. & Orav, J.** 1993 'Sexual Behaviours Relevant to HIV Transmission in a Rural African Population'. In *Social Science and Medicine* Vol. 37, No. 3, pp. 401-412.

**Scrimshaw, S. C. M., & Hurtado, E.** 1987 *Rapid Assessment Procedures for Nutrition and Primary Health Care*. California: UCLA Latin American Centre Publications.

**Southern Peninsula Municipality** 1998 *South Peninsula Annual Health Report* for the period 1 July 1997 to 30 June 1998.

University of Cape Town