Community Empowerment Through Municipal Service Delivery: A Proposed Operational Framework

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Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and has not been previously in its entirety or in part been submitted at any University.

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Summary

Legislation encourages local government/ municipalities/ local authorities in South Africa, to fulfil a development role. One of the main objectives of municipalities performing a development role is to empower communities, especially previously disadvantaged communities. This study argues that the services delivered by municipalities are an essential component of a development orientation. In view of this fact, the study proposes an operational framework, whereby community empowerment can be achieved through municipal service delivery.

The operational framework suggest that for community empowerment to be achieved through municipal service delivery, requires that the empowerment enabler (municipalities or departments within municipalities) should assure that: disadvantaged communities have access to services, services must be delivered in a non-discriminatory manner, the community should understand the rationale as to why the service is delivered, opportunity should be given for community participation in the delivery process, there should be a constant information channel between the giver (enabler) and receiver of services, and human resources from the local community should be utilised where possible in the delivery process.

Lastly, a descriptive evaluation is undertaken of the health department's approach (at the Stellenbosch Municipality) to the delivery of primary healthcare services and service infrastructure. The purpose of the evaluation is to ascertain whether the principles as proposed in the operational framework are present in the health department's approach to service delivery. The evaluation reveals that most of the proposed principles of the operational framework features in the health department's approach to the delivery of primary healthcare services and services infrastructure. Thereby, concluding that the health department follows to a certain extent an approach to service delivery that could ultimately lead to community empowerment.

Opsomming

Wetgewing vereis dat plaaslike regering/ plaaslike owerhede/ munisipaliteite in Suid-Afrika, 'n ontwikkelingsrol moet vervul. Een van die doelstellings van 'n ontwikkelingsrol vir munisipaliteite, is om gemeenskappe te bemagtig, spesifiek gemik op agtergeblewe gemeenskappe. Hierdie studie argumenteer dat die dienste gelewer deur munisipaliteite 'n essensiële komponent vorm van 'n ontwikkelings-orientasie. Gevolglik, stel hierdie studie 'n operasionele raamwerk voor, waarvolgens gemeenskapsbemagtiging bewerkstellig kan word deur middel van munisipale dienslewering.

Die operasionele raamwerk stel voor dat om gemeenskapsbemagting deur dienslewering te bewerkstellig, vereis dat die bemagtiger (munisipaliteite of departemente binne munisipaliteite) moet toesien dat: agtergeblewe gemeenskappe toegang het tot diente, dienste moet gelewer word op 'n nie-diskriminerende wyse, die gemeenskap moet verstaan waarom die diens gelewer word, geleentheid moet geskep word vir gemeenskapsdeelname aan die diensleweringsproses, 'n kommunikasie kanaal tussen die ontvanger en leweraar (bemagtiger) van dienste, moet geskep word en laastens moet daar van plaaslike arbeid (waar moontlik), in die diensleweringsproses gebruik word.

Laastens word 'n beskrywende evaluering onderneem na die Gesondheidsdepartement (by die Stellenbosch Munisipaliteit) se benadering tot die lewering van primêre gesondheidssorgdienste asook diens infrastruktuur. Die doel van die evaluering is om te bepaal of enige van die faktore, soos beskryf in die operasionele raamwerk, teenwoordig is in die gesondheidsdepartement se benadering tot dienslewering. Die resultate van die ondersoek toon aan dat die meeste van die faktore, soos voorgestel in die operasionele raamwerk, wel teenwoordig is in die gesondheidsdepartement se benadering tot dienslewering. Gevolglik kan daar afgelei word dat die gesondheidsdepartement wel tot 'n mate, 'n benadering tot dienslewering volg, wat kan lei tot gemeenskapsbemagtiging.

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Abbreviations

CBO	:	COMMUNITY BASED ORGANISATION
CHC	:	CLOETESVILLE HEALTH COMMITTEE
CMC	:	CAPE METROPOLITAN COUNCIL
IMF	:	INTERNATIONAL MONETARY FUND
NGO	:	NON-GOVERNMENTAL ORGANISATION
PHC	:	PRIMARY HEALTH CARE
RDP	:	RECONSTRUCTION AND DEVELOPMENT PROGRAMME
TB	:	TUBERCULOSIS
WCRSC	:	WESTERN CAPE REGIONAL SERVICES COUNCIL
WHO	:	WORLD HEALTH ORGANISATION
WPLG	:	WHITE PAPER ON LOCAL GOVERNMENT
WPTPS	:	WHITE PAPER ON THE TRANSFORMATION OF THE PUBLIC SERVICE

Chapter One

Background and Statement of the Problem

"If Local Authorities do not work, many projects such as the RDP, delivery of houses, health and services cannot be realised, spelling disaster for the Government", Joshua Raboroko, in "Obstacle in Progress", Sowetan, 30 May 1999.

1.1 Introduction

The practice of community empowerment (or popular participation, as it is often referred to in development circles) as the outcome of development intervention is relatively new in South Africa. For instance, De Beer (1996:67) states that examples of communities undertaking development on their own are very rare in the literature.

According to Taylor (in Mayo and Craig 1995:170), the need for community empowerment in South Africa should to be understood within the broader struggle for liberation from political oppression and material deprivation. She is of the opinion that, within this framework, redress is not about basic needs provision, human resource development and changing institutional frameworks only, but that it is centrally related to the development of the capacities of people in ways which make a qualitative difference to racial, class and gender imbalances. To achieve the objectives expressed by Taylor, it is important that the majority that was disempowered and oppressed under the former apartheid system be empowered.

Freire (quoted in Bailey 1995:378) is of the opinion that oppression defines people's reality and what they are capable of achieving. Oppression occurs through a process of cultural invasion, which is the consequence of colonialism, imperialism and apartheid. By imposing the norms, values and culture of the dominant group, it devalues the culture of the oppressed. This causes oppression to be internalised, which signals the acceptance of the oppressor's culture, which in turn may lead to a loss of identity, alienation and powerlessness. South African society represents the classical example of

cultural invasion mentioned above. Empowerment raises people's awareness and consciousness around structural problems. This allows the oppressed to link their oppression to their socio-economic reality. Empowerment can thus be seen as a possible mechanism (strategy) that would enable the majority of South Africans to break out of the shackles of powerlessness.

According to Bryant and White (1982:16-17), powerlessness is an obstacle to the development and progress of people in two ways:
Firstly, it affects the distribution of benefits: " Events have shown that benefits usually go to those in power. The fact that those who are poor are also powerless has to do with the inequity that continues to exist. Powerlessness reduces the demands on political leaders, and without such demands leaders are unlikely to focus on distributional issues. Therefore the gaining of power and the empowerment of poor people demands a refocus on the distribution of resources in society. Secondly, development is about increasing people's capacity to make choices about their future. Without personal efficacy, without an awareness of where to go with their demands, individuals can hardly develop such a capacity" (See also Chambers 1989; Wallerstein 1993).

Promoting empowerment as the outcome of sustainable development can be utilised to overcome obstacles of powerlessness. Empowerment is useful in the sense that it allows stigmatised groups in society, such as those living in poverty, victims of racial abuse and other disenfranchised groups, to assert themselves politically, socially, economically and psychologically.

To support the need for community empowerment in South Africa, Ramphele and Wilson (1990:262) state that "the existing myriad of welfare organisations have gradually led to a hand out sickness/mentality which is now very difficult to cure, both as far as the giver and the receiver is concerned." When this happens, Ramphele and Wilson argue, it cannot be equated with empowerment but rather with a process of co-option, whereby those that are powerless are rendered even more powerless and dependent on outside assistance, which are exactly the opposite to empowerment objectives of self-reliance and independence. This is the typical style of development that was

promoted under apartheid. Ordinary people had little or no input in development processes. In this regard, development plans were pre-determined and drawn up by state agencies and NGOs. Participation by beneficiary communities was limited. Swanepoel and De Beer (1998:21), for instance, stated that "an earlier version of participation, especially used in connection with self-help projects in South Africa, saw it as a means to mobilise the labour input of the poor. Knoetze refers to this as ***sweat equity.***"

To move away from this type of paternalistic, dependency development initiatives, a number of authors have suggested that legislation in South Africa should encourage development projects and programmes that focus on increasing the capacities of communities to promote self-reliance and rely on their own initiatives (See Nkulu 1994; Roodt in Graaff and Coetsee 1996; Reddy in Reddy (ed.) 1999; Loots 1997; Marschall 1998 and Nel 2000).

In view of the above introductory thoughts concerning the need for empowerment in South Africa, it is apparent that the South African state has adopted a deliberate approach through various policies that encourage the empowerment of disadvantaged communities in South Africa. For instance, in the context of local government in South Africa, the Constitution of South Africa (Act 109 of 1996)[1], the White Paper on Reconstruction and Development (1994)[2], as well as The White Paper on Local Government (1998)[3] and the subsequent follow-up legislation to the White Paper on local government, namely the Municipal Systems Act (Act 32 of 2000)[4], encourages municipalities to empower communities within their area of jurisdiction. Empowerment efforts must be aimed at those groups in society who have for historical reasons been systematically marginalised and disempowered through the former apartheid system (Systems Act 2000:14).

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[1] Hereafter referred to as the Constitution.

[2] Hereafter referred to as the RDP.

[3] Hereafter referred to as the White Paper.

[4] Hereafter referred to as the Systems Act.

This study argues that local government in South Africa can promote the empowerment of disadvantaged communities through its service delivery role. It is further argued that, if service delivery is to be utilised as a mechanism for community empowerment, it is necessary for local government to adapt their service delivery functions accordingly. In other words, the enabling institution (which in the case of this study is the operational entities of local government, namely municipalities or departments within municipalities) should adopt an approach to service delivery that makes community empowerment possible. This study will propose an operational framework whereby municipalities can adapt their service function to be orientated towards community empowerment.

To propose the operational framework, the study will conceptualise what is meant by community empowerment, and secondly, what community empowerment should entail in the context of local government service delivery. From this combination, the operational framework for community empowerment through service delivery will be proposed. The principles of the operational framework will also be illustrated through case studies. In particular, it illustrates how municipalities seeking to empower disadvantaged communities have successfully implemented these empowerment principles.

For research purposes, this study will evaluate the approach to service delivery adopted by a department within a typical South African municipality. In this regard a descriptive evaluation of the health department's approach (at the Stellenbosch Municipality) to the delivery of primary health care (PHC) services and service infrastructure is carried out. The rationale for the selection of PHC services will be discussed in Chapter 4. The purpose of the descriptive overview is to evaluate whether the principles that will be proposed in the operational framework are present in the health department's approach to service delivery.

The following section discussed in this chapter deals with the background to the service delivery role of local government as mandated by legislation in South Africa. This will lead to the statement of the problem, followed by the

objectives of the study, the methodology employed, the limitations of the study, the time frame and, lastly, the structure of the chapters to follow.

1.2 Background to the Service Delivery Role of Local Government

The main purpose of any government, be it at the national, regional, or local level is to ensure that those that reside in its area of jurisdiction maintain a proper quality of living. Meiring (1988:7) contends that a government authority must be able to promote both the quantitative (tangible) as well as the qualitative (non-tangible) dimensions of a good life, i.e. it must be able to create and establish happiness and prosperity amongst those over whom it has authority. Therefore a local authority in the context of the local environment needs to be able to create a stable and sustainable environment, which is compatible with and conducive to satisfying the needs and aspirations of those that reside in its area of jurisdiction. One means of achieving happiness and prosperity is through the services provided by municipalities.[5]

In view of the above, the Constitution, the RDP and the White Paper assigns two broad roles to local authorities, namely to deliver services and to perform a development role. This role, in Burger's (1997:79) opinion, has been under-performed and only applied to a limited extent in South Africa. These two roles will be discussed in turn.

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[5] A local authority or council as it is commonly known, refers to the elected representatives from the jurisdictional area of a municipality. They have the power to make by-laws and are also responsible for the formulation of policy at the local level. A municipality refers to the performing entity. It is responsible for implementing the council's policies through officials employed by the municipality. Local government refers to the third tier of governance in South Africa. For purposes of this study, the terms local authority, municipality and local government are used interchangeably, unless otherwise stated.

1.2.1 Developmental Local Government

According to Theron and Burger (1996:48), development is a concept that has been researched, conceptualised, and debated for many years. In most instances, it means different things to different people. As Burger (1997:80) states: "In the private sector of more affluent societies, development is related to glamorous physical projects. Different sectors of the public sector also attach different meanings to the concept." Consensus as to the precise meaning is therefore very difficult to attain.

Davids (1999:5) on the other hand, is of the opinion that it does not matter how development is interpreted; in the context of South Africa's Reconstruction and Development Programme, the interpretations of the term should all have one thing in common, namely **people.** Therefore, for the purpose of this study, development is interpreted from a people-centred perspective. From official government documentation such as the RDP, it is evident that government has committed itself to a people-centred development approach.

The definition of a people-centred development approach, as put forward by Burkey (1993:35-39), suggests that development is about the personal, economic, political and social development of people.[6]

- [6] "Personal development: This is a process whereby individuals develop self-respect, become self-confident, self-reliant, co-operative and tolerant of others through becoming aware of his/her shortcomings as well as his/her potential for positive change. Therefore it is a process of consciously becoming aware of oneself.
- Economic development is a process whereby individuals or through joint efforts boost production for consumption and have a surplus to sell for cash.
- Political development is a process of gradual change; whereby people increase their awareness of their own capabilities, gain knowledge as to what their rights are. In doing so, people start to organise themselves in order to acquire real political power.
- Social development is a process that leads people to increase awareness of their own capabilities, decide on solutions, organise themselves for co-operative efforts, and maintain their own social services and institutions in the context of their own culture, as well as political system".

Therefore, development from a people-centred perspective is an integrated process that starts with the awakening of people towards realising their potential. According to Davids (1999:7) the aim of such an approach is to empower people. People-centred development means exactly what it says: It is the development of people for people.

People are therefore the object as well as the subject of development from a people-centred approach. People are at the centre of this development strategy. Empowerment is thus a central concept in a people-centred development strategy.

This brief overview has introduced the importance of empowerment and how it relates to the development process and specifically, the relevance of the concept in terms of a people-centred development strategy. The next section will look at the development role of local government.

The WPLG (1998:17) defines developmental local government as: "...local government committed to working with people and groups within the community to find sustainable ways to meet their social, economic and material needs and improve the quality of their lives." The Systems Act (2000: 14) defines development as: "...meaning sustainable development, and includes integrated social, economic, environmental, spatial, institutional, organisational and human resource upliftment of a community aimed at: -

(i) Improving the quality of life of its members with specific reference to the poor and other disadvantaged sectors of the community,

(ii) [Ensuring] development serves present as well as future generations."

The definitions of development as outlined in the legislation are very much in accordance with the people-centred development definition outlined above. Several conclusions can be drawn on the basis of this definition:

- A local government that seeks to promote development can only be successful in achieving it by actively involving the communities in its area of jurisdiction in the decision-making process concerning their

needs and how to satisfy those needs; citizens need to be consulted regarding their needs and they need to play an active role in satisfying those needs.

- Traditionally, local government in South Africa has been characterised as a regulator in the delivery of services (Burger 1997:80; Meyer *et al.* 1997). In these instances local authorities satisfied people's material needs. The above definition confirms that services are an essential part of a developmental local government, but only as one component in a range of broadly defined needs.

According to Burger (1997:79), the political transformation in South Africa has given rise to an increasing emphasis on issues of development and the responsibility of the public sector in this regard. In conjunction with this, the Constitution, the RDP, and the White Paper, call on local government to take on a Development-orientation.

The Constitution (article 152(1)(b)(c)(e)), specifies the specific development role of local authorities in South Africa as:

- Providing services to communities in a sustainable manner
- Promoting social and economic development
- Encouraging communities and community organisations in matters pertaining to local government

Article 153(a)(b) specifies how local government can restructure itself in order to be developmentally orientated:

- Structure and manage its administration, budgeting and planning processes to give priority to the basic needs prevalent in the community;
- Participate in national and provincial development programmes.

The Reconstruction and Development Programme forms the cornerstone of government's commitment to eradicating past deficiencies in terms of service backlogs and as a development vision for South Africa. It is aimed at

transforming the heritage of the past (see Coetzee 1994; RDP 1994; Davids 1999).

The RDP consists of six interrelated principles, which form the basis of a new vision for South Africa. The principles state that, amongst others:

- The RDP must follow a sustainable and integrated approach.
- It must be people-driven.
- It recognises the need for peace and security.
- It aims at nation building.
- Reconstruction and development should be linked.
- The final principle on which all the previous ones depend is the idea of creating a democratic society.

The second principle of the RDP, that it must be a people-driven process, is of particular relevance to this study. It connection with this, the RDP (1994:8) states that***: " Development is not about the delivery of goods to a passive citizenry. It is about involvement and growing empowerment" [my emphasis].*** Because the RDP is primarily concerned with eradicating service backlogs and creating services and infrastructure in areas where these are particularly lacking, the mentioned principle implies that the disadvantaged community's needs must be part of the delivery process. This statement also implies that communities are not the recipients of services only, but they themselves deliver services.

Due to the fact that the RDP addresses service projects and programmes that are in line with the type of services delivered by municipalities, the RDP (1994:18) states, that local government needs to be at the forefront of implementing the RDP. (In this regard see also Wessels' (1994) analysis of the congruence between service projects that the RDP promotes and services delivered by local authorities). To illustrate this point, Moller and Jackson (1997:170) estimate that, of the R7.5 billion allocated for the 1996/97 fiscal years, the largest expenditure was for urban renewal (R1.5 billion), municipal services (R1.2 billion), classrooms (R1 billion) and rural water and sanitation

(R817 million). This gives an indication that the services delivered by local authorities are also high on the agenda of the RDP. In addition to this, the RDP also urges those (local authorities) who are responsible for implementing the RDP to take on a development-orientation and, in particular, a development strategy aimed at increasing the capacity of communities and at the same time empowering communities.

The WPLG (1998:18) highlights four aspects that should give local government in South Africa a developmental thrust. These include:

- *Exercising municipal powers and functions in a manner which maximises their impact on social and economic development*

Different means are available to local government to promote social and economic development. In this instance the provision of household basic infrastructure, coupled with service provision is central to the well-being of those communities that reside within the local government's area of jurisdiction. The WPLG (1998:19) also notes that functions such as art and cultural facilities, recreational facilities, especially in areas where it was not available during the Apartheid era, can go a long way in creating well-being amongst people/communities. In terms of economic development, Sinnett (in Reddy, 1995:39) is of the opinion that local authorities can boost this in their areas of jurisdiction by creating employment opportunities, especially for those marginalized under apartheid. The enormous backlog in services makes it possible for local authorities to make use of partnerships with small businesses, which, in turn, would be required to make use of local employment. Labour intensive capital projects would provide another possibility for creating employment.

- *Playing an integrating and co-ordinating role*

In Daniels' (in Graham, 1995:54) opinion, the breakdown and delay in projects and programmes, regarding the provision of services is largely due to a lack of co-ordination between the various agencies and role players. At the local level there are different types of pressure groups, all of them with different needs. These, inter alia, include civic organisations, small business,

community based organisations, and communities. In these instances different stakeholders want local government to address the issues raised by them. Unfortunately this is not an easy task. Consequently choices should be made. Because all the issues cannot be addressed at the same time, local government can co-ordinate as well as integrate these issues and, with the various stakeholders decide what the priority needs are in the community and what the best available means are to address it. In this way there will be a structure in terms of the priority needs. It also allows for greater participation by different role players in local government.

The WPLG (1998:19) states that greater co-ordination can be achieved through Integrated Development Planning (IDP). Integrated development planning also allows for participation by the community in the planning and development of their respective areas. Mudzanani (1999:47) supports this statement when he states that greater coordination and integration at the local level can be achieved through development planning that involves communities.

- *Democratising development, Empowering communities and Redistribution issues;*

These aspects of developmental local government are crucial in terms of future sustainability, as well as legitimacy of municipalities. First, it provides a forum whereby citizens at the grassroots can directly participate in the decisions that govern their lives. For example, if something is wrong in their neighbourhood it allows citizens to participate by complaining to a local authority. The WPLG (1998:20) states that: "Municipal Councils play a central role in promoting local democracy. In addition to representing the community and its interest within the council, municipal councillors should promote involvement of citizens and community groups in the design and delivery of services". This principle fosters legitimacy of the whole process of decision-making at the local level.

Apartheid left many communities powerless. Promoting empowerment within marginalised communities, provides an opportunity for those in society that

are less fortunate to play an active role in their own development, which would most probably not have been the case otherwise. Promoting community involvement provides a forum for the community to become aware, through their participation, of the needs in the community and to partake in seeking solutions.

The White Paper, (1998:21) states that there are several methods whereby empowerment can be linked to the redistribution, which is so important in the South Africa context. These include:

- The provision of service subsidies to the poor.
- Technical as well as financial support to the poor.
- Empowerment that needs to be directed to those most marginalized in communities, for example women, children and the disabled.

- *Building social conditions favourable for development*

  In terms of this aspect, municipalities need to create the necessary environmental conditions conducive to development. Developing political leadership, working together with interest groups in the area of jurisdiction, and making knowledge available can achieve this. The most important principle for local authorities to remember in terms of this feature is not to try to dominate and regulate people's lives. This can be achieved by building partnerships with community organisations, as well as other relevant stakeholders in local government.

In addition to the above features, the White Paper highlights the possible outcomes on which a development orientation must be focused, namely:

- providing household infrastructure and services;
- creating liveable, integrated cities and towns and rural areas;
- promoting local economic development;
- furthering community empowerment and redistribution.

For local government to fulfil its development duty successfully, municipalities need to be encouraged to change their modus operandi. By implication, municipalities must learn to work in collaboration and partnership with the beneficiaries of services and other stakeholders. It also requires staff to be trained and prepared to accept change and move away from the rigid, bureaucratic attitudes that have come to be synonymous with public officials.

Although this section has not described the new development orientation for local government in detail, it has outlined what is expected of municipalities in South Africa. The following section will look at why and how municipal service delivery can be transformed.

1.1.2 Municipal Service Delivery

Boot (cited in Meyer *et al.* 1997:69) conceptualises local government services as indicated in table one as follows:

Table One: Local Government Services

Classification	Type of Service
Community service	Recreation facilities, community hall, municipal health, roads and streets, storm water drainage
Security services	Roads and streets, civil protection, traffic control, law enforcement
Subsidised services	Ambulance, libraries, museums
Commercial services	Electricity, gas, produce markets, abattoirs, urban transport, water
Environmental services	Pollution control, conservation refuse removal/garbage collection
Services of convenience	Nature reserves, pools
Economic services	Housing, building control licensing, sewerage cleaning

Public services such as delivered through municipal services (as mentioned in Boot's classification) provide a means whereby people's living conditions and quality of life can be improved. The Constitution of the Republic of South Africa (Act 200 of 1996) supports this notion, and is quite clear with regard to the services that residents are entitled to in the areas in which they reside. In this regard, Section 175(3) of the Constitution prescribes that all persons residing within a municipal area of jurisdiction shall, to the extent determined by an applicable law, have access to water, sanitation, transportation facilities, electricity, primary health care services, education, housing and security (Constitution of South Africa, Act 108 of 1996). In addition, Sections 4 and 5 of the Constitution also list a whole range of services that citizens are entitled to (See also Thornhill 1995). Therefore, the challenge to the newly elected government structures, be it national, regional or local, is to ensure that the constitutional guarantees in terms of services are upheld.

Particular emphasis is placed on local government as the essential institution to deliver services that are promised in the Constitution. In this regard, the opening quotation to this study is very relevant, insofar as it states that successful service delivery will largely depend on successful local government or a workable local government.

Stressing the link between successful local government and service delivery in South Africa, Harris (1999:184) states in his article: "I do not know if Valli Moosa has been asked what his three priorities for South African local government are, however, I imagine that his answer would be delivery, delivery, delivery, unless it is development, development, development." To understand the reasoning behind so much emphasis on local government as the service delivery vehicle for South Africa it is important to understand the history thereof.

In South Africa, municipalities have a long history in terms of delivering services. Botha (1993:291) and Heymans (1993:16) attribute this to the fact that local authorities are closest to people. This enables them to determine

best what the needs and aspirations are of people that reside in their area of jurisdiction.

Unfortunately, local government did not escape the inequalities of the former apartheid system. Meyer *et al.* (1997:47) raises the notion that, during the apartheid era, unlike today, the system of local government had no constitutional guarantees/safeguards. Therefore local government had to manage its affairs within the apartheid framework.[7]

Within the apartheid framework, local government was expected to play an instrumental role in the implementation of the former National Party's policies of separate development. In Planact's (Ismail & Maphai 1997:5) view, this gave rise to a system of local government characterised by many distinct features. These included control of urbanisation, racial segregation of settlements, racially divided local authorities and gross inequalities in access to services and houses.

Swilling and Boya (in Fitzgerald 1997:166) state that apartheid resulted in two images of South Africa when describing the development of the typical apartheid city: "Opulent white suburbia with commercial and municipal service standards comparable to societies whose Gross Domestic Product (GDP) is several times higher than South Africa's, present one image. Sprawling black townships on the peripheries of towns and cities with uniform housing units, poor services and ever widening bands of informal houses erected by the homeless, present another." The eradication of this deep-rooted inequality and contradictory images is the key challenge faced by local government in the foreseeable future. (For an appraisal of the system of local government and the features of the system during apartheid, see Meyer *et al.* 1997; Botha

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[7] It must be categorically stated that apartheid was not the start of the exploitation and the gross inequality that are prevalent in South Africa today. In fact, this started long ago with the colonialisation and the exploitation of the locals at the time. For an overview of local government in South Africa, see Ismail (1997), in particular Chapter 4, which deals with local government development from 1652-1991.

1993; Ismail 1997; Swilling 1996; Zybrands 1998; Corrigan 1998; IESR 1994; Urban Foundation 1993; Reddy 1995; Cameron 1993, 1996; Ismail and Maphai 1997; Heymans 1993; Heymans and Totemeyer 1988, as well as Cloete 1994).

For reasons explained above, most of the services mentioned in Boot's classification were either absent or of an inferior quality for the majority of South Africa's population. The result of this situation is that, with the democratisation of local government, much emphasis has been placed on the delivery and development of services and service infrastructure to communities that either did not have access to these, or where they had, it was of an inferior nature. More importantly, the WPLG, the RDP and the Systems Act encourage municipalities to promote the involvement of communities in the affairs of local government. In other words, communities should be involved in the service delivery process.

Currently, concerted efforts are under way to transform public services in South Africa. In this regard, the ANC led government claims that, since coming to power: [8]

- Running water was delivered to more than three million people;
- Electricity was connected to two million households;
- Improved health care for the poor saw over five hundred new clinics built or upgraded, and free medical care for children under six years and pregnant women; and
- Nearly three million people have been housed, with 750 000 houses built or currently under construction.

Khosa (2000:2) is of opinion that these impressive facts and figures raise more questions than answers. For example, to what extent will infrastructure and services be sustained within the context of fiscal constraints? Or what are the differential social and ecological impacts of service delivery on the part of the beneficiaries? Who are these beneficiaries and how have they been

[8] Source: Khosa (2000:1)

targeted or selected? To what extent are the newly created delivery mechanisms empowering the poor or private sector infrastructure deliverers? In essence, Khosa is of the opinion that the figures mentioned above do not necessarily reflect the qualitative difference it is making to people's lives. In other words successful delivery cannot only be judged on impressive figures without considering the potential impact it has on people's lives.

Besides ensuring access to services, transforming service delivery will also depend on transforming delivery mechanisms. This implies that local government, as an essential institution for delivering services also needs to transform its delivery mechanism. In the past, service provision at the local level was delivered in-house and was mainly seen as an administrative task, with little or no input from other stakeholders such as the intended beneficiaries. In this regard, Nong (1999:13) calls for a shift away from the inward-looking, bureaucratic systems, processes and attitudes, and a move towards new ways of working which puts citizens first (See also Daniels, in Graham 1995:53).

Initially, the White Paper on the Transformation of the Public Service (WPTPS) formed the basis on which public services in South Africa were transformed. The WPTPS (1997) provides policy guidelines whereby government departments and institutions such as local government can transform and improve service delivery to the inhabitants in its jurisdictional area. This document is also popularly known as 'Batho Phele'[9] or "People First". Batho Pele is based on eight principles, which must always be considered in the delivery process, as indicated in Table two.

[9] Batho Pele is a Sesotho word meaning 'people first' (WPTPS 1997:13)

Table Two: The Batho Pele Prinicipies[10]

Consultation	Citizens should be consulted about the level and quality of services they receive and should be given a choice concerning the services that are offered, if possible.
Service standards	Citizens should be told what level and quality of service they would receive so as to know what to expect.
Access	All citizens should have access to services to which they are entitled.
Courtesy	Citizens should be treated with courtesy and consideration.
Information	Citizens should be given full and accurate information about the services that they are entitled to.
Openness and transparency	Citizens should be told how services are run, how much it costs, as well as who is in charge.
Redress	Citizens should be offered an apology and explanation and an effective remedy when promised services are not delivered. They should also receive a sensitive hearing and a positive response when they complain.
Value for money	Citizens should get the best value for money when receiving services.

The successful implementation of the 'Batho Pele' principles will depend on the willingness of public servants, as well as departments, to change attitudes and adhere to and implement the above principles. The above principles allow citizens to feel that the municipality or whatever institution provides the service is interested in them. This in itself can generate feelings of belonging, happiness, motivation, self-esteem and respect. In essence, it can enhance feelings of empowerment, for the receiver as well as the provider of services.

[10] Source, Nong 1999:16-18

The principles of 'batho pele' are also in line with how services can be transformed to be more developmentally orientated.

From the above discussion it can be deduced that there are many challenges facing democratic local government in South Africa. These include making access to social and economic opportunities available to those that have been disempowered and marginalized in the previous dispensation. A development orientation for local government can contribute to this. Making communities part of the development process through their active participation in needs identification and seeking for solutions in collaboration with municipalities and other stakeholders will build self-esteem and confidence. This is a crucial component for the psychological well being of the community. It also fosters legitimacy of a local authority, something that has been lacking in South African local government.

1.3 Statement of the Problem

Two important points have emerged. Firstly, one of the main objectives of the new development role for local government is to ***empower disadvantaged communities***. Secondly, municipal services are integral components of a development-orientation for future local government, but as Burger (1997:81) states: "...many of the services delivered by local authorities will continue but these must be focused on building capacity and growing empowerment". Khosa (2000:3) shares Burger's view when he states that "At the heart of any infrastructure and service delivery programme, there should be a deliberate effort to empower relevant beneficiaries, curtail excessive powers of global and corporate stakeholders and establish meaningful institutional arrangements and resources to ensure sustainability and service affordability." As indicated, one of the primary objectives of a development orientation for municipalities is to empower communities. Municipal service delivery forms an integral component of a development orientation. How can municipal service delivery contribute to empowering communities? This study intends to answer this question.

1.4 Aims of the Study

To answer the question posed at the end of the preceding section, this study will, as its primary objective, attempt to propose an operational framework for community empowerment and to suggest how it (community empowerment) can be achieved through municipal service delivery. The second objective of this study is to give a descriptive evaluation of the health department's approach to service delivery. The adopted approach will be assessed in terms of the proposed operational framework. If an approach to service delivery that could empower communities has been adopted, it is expected that most of the principles of the operational framework would have been implemented in the delivery process. This would determine the extent to which the delivery process is geared towards community empowerment.

1.5 Methodology

This study is exploratory as well as descriptive in nature. It employed qualitative research methodology. To propose an operational framework for community empowerment, a thorough literature review was undertaken. Relevant information was obtained from books and research articles, as well as legislation.

To ascertain the approach to the delivery of primary health care services and infrastructure, data was primarily collected through interviews. Interviews were conducted with municipal officials responsible for the delivery of the above-mentioned service. Interviews were also conducted with members of the community based health committees.

1.6 Time Frame

This study looks at the approach to primary health care as adopted by the health department during the period 1995-2000. The rationale for selecting this period stems from the fact that 1995 was the time at which the RDP was implemented. Another reason relates to the fact that local authorities were elected on a democratic, non-racial manner in the Western Cape in 1996. Therefore it was pertinent for local authorities to alter their modus operandi.

1.7 Value of the Study

The study suggests the outline of an operational framework for community empowerment and how municipalities can promote it through its services. It is believed that this will have practical value, especially for development practitioners but, more importantly, for local level (municipal) officials, who are expected to be at the forefront of empowering disadvantaged communities through its role of service provision. The principles of the proposed operational framework will also provide a checklist whereby officials can determine to what extent departments are successful in empowering communities.

1.8 Limitations of the study

This study will not be able to make any generalisation. It will not be able to conclude that the Stellenbosch Municipality follows an approach to service delivery that allows for community empowerment, because of the fact that the research will only focus on one department, which is not representative of services delivered by or of departments of the said municipality. Generalisations can also not be made with regard to other municipalities in South Africa.

1.9 Structure

Chapter One has outlined the framework for this study. It stated (in previous sections) that municipalities should empower communities. This study suggests that community empowerment can be achieved through the role that local authorities fulfil in delivering services. If municipalities want to empower people in their jurisdictional area, it has to adopt an empowerment approach to service delivery. In order to achieve the objectives of this study as outlined above, the rest of this study will be divided into four chapters. The contents of the various chapters are as follows:

Chapter Two: This chapter will discuss the concept community empowerment. It will look at the concept in a global context, particularly from a development perspective, and will attempt to analyse the concept from such a perspective. It will argue that empowerment of communities cannot start as

a process on its own and that the empowerment enabler needs of necessity to experience a reduction of its power. It discusses the role that an enabler should perform.

Chapter Three: This chapter proposes a possible operational framework that can be utilised by Stellenbosch Municipality especially to empower previously disadvantaged communities through its role of service provision.

Chapter Four will evaluate the health department's approach to the delivery of PHC services. The department's approach will also be assessed in terms of the operational framework.

Chapter Five: This chapter will summarise and conclude the study and offer suggestions for future research.

Chapter Two
Community Empowerment: A Development Perspective

"What has been happening to poverty? What has been happening to unemployment? What has been happening to inequality? If one or two of these problems have been getting worse, especially if all three have, it would be strange to call the result development, even if per capita income doubled"(Seers, quoted in Friedman 1992:1).

2.1 Introduction

The introductory chapter to this study argued that there is a need for disadvantaged communities in South Africa to be empowered. It proposed that communities could possibly be empowered through the service delivery function of municipalities. This chapter explores the concept community empowerment from a development perspective. The reason being that service delivery is a development intervention aimed at addressing the causes of underdevelopment. It is expected of municipalities in South Africa to fulfil a developmental duty.

But what is empowerment? What does empowerment entail for poor people, how can disadvantaged people be empowered? The questions raised here are very relevant to this study. To address these questions, this chapter will present a theoretical background relating to the rise of the concept community empowerment within development discourse in a global context. The term community empowerment will then be conceptualised. Lastly, the chapter will discuss the role that enabling organisations and institutions (such as municipalities) should fulfil to empower disadvantaged communities.

2.2 Theoretical Background

As the world moves into the 21st century, academics, practitioners, governments, financial institutions such as the World Bank and the International Monetary Fund (IMF) as well as Non-Governmental Organisations (NGOs) are still grappling with the phenomena of poverty,

underdevelopment and all its manifestations, which are probably as old as mankind itself. Realistically, it is a phenomenon that will by all means never be eradicated permanently. Especially now, with the recognition of the fast depletion of natural resources and the competition for resources; a competition between those that possess power and those that do not. For those who do not possess power, gaining power and their empowerment is the only realistic means of competing on an equal footing. Although these comments may sound very philosophical, value laden, biased and subjective, favouring the socially excluded (powerless) in a global context, it is also the current reality experienced by millions.

In a global context, the focus on the concepts 'community empowerment' and 'participation' within the confines of development discourse, is firmly embedded in what Friedman (1992:1-13) and Titi & Singh (1995:6) refer to as 'alternative development'. De Beer and Swanepoel (1998:9-10) as well as Burkey (1995:30), refer to it as 'another development'. The idea of another development has its roots mostly in Third World countries due to the failure and inability of purely conventional development strategies of technocratic growth and modernisation to eradicate poverty and the perpetuation of inequality and underdevelopment. Or, as Elkins (quoted in de Beer and Swanepoel 1998:9) asserts: "Another Development has emerged as a clear and coherent system of development analysis to contrast the top-down, finance orientated economism of conventional strategies."

Earlier development thought saw economic growth as a mechanism that would lead to economic development. In turn, the potential benefits would trickle down to the poor. This never materialised. In addition, Mayo and Craig (1995:3) state that the structural adjustment programmes advocated by the World Bank and the IMF, were intended for Third World countries to promote market-led development were failing the intended beneficiaries (poor) in particular. What these programmes did instead was to cut government spending in order to be market-orientated. The consequences were that social welfare programmes aimed at eradicating poverty had to be reduced. In fact,

what this did was to exclude vast numbers of people, both politically as well as economically (Friedman 1992:14).

Despite the fact that the economic growth strategy has not been successful in the emancipation of the world's poor, it would be totally disastrous to discard economic growth as a development strategy (Friedman 1992:34). Instead, Friedman suggests that an alternative development strategy should foster an integrated process, whereby growth would be used as a strategy to encompass inclusive democracy, gender equality as well as inter-generational equity. In essence, growth must be utilised as a mechanism that allows for those socially excluded classes in society to be incorporated into the broader processes of societal development.

Over the years, several variants under the alternative paradigm have evolved at the grassroots level. Some of the most important included the ***Basic Needs Approach, The Social Learning Approach,*** and more recently, the ***People-Centred*** or ***Bottom-up approach*** to community development. (For a more detailed account of the origins of these various approaches, see Swanepoel and de Beer 1998; Roodt in Graaff and Coetzee 1996 and Keeton 1984). For purposes of this study, the people-centred approach is central. The reason for the centrality of the people-centred approach stems from the fact that the South African state has adopted a development approach that emphasises the development of people. As mentioned previously, this is well illustrated by the RDP.

Whereas earlier development thinking focused on the economy as a vehicle for development, people-centred development focuses on micro-level solutions to address development. People are viewed as the object as well as the subject in development. People are therefore the most important resource in development (See definition of people-centred development by Burkey in section 1.2 of chapter one). Development is promoted in this way when people realise their own potential while seeking solutions to their development deficiencies in conjunction with outside agents, be it government departments,

NGOs or financial institutions such as the World Bank and the IMF. The aim of this approach is to empower people (Davids 1999:9).

The idea of community empowerment characterised as an aggressively participatory approach to development has its origins in the people-centred variant of alternative development. In relation to this, Titi and Singh (1995:13) write that: "Within development discourse the concept of empowerment has evolved in conjunction with the bottom-up approach otherwise known as people-centred development. This can be related to the miserable failings of past strategies of growth, and modernisation at alleviating dependency and large-scale inequality. Instead of empowering people, these strategies only made the poor more dependent upon development aid and outside agents determining their (poor) development" (See also Onex and Benton quoted in Christianson 1998:21).

The above serves as a guideline to position community empowerment in a global context by investigating its origin within development discourse. The following section will give a more detailed account of its meaning. Apart from giving meaning to the concept, the following sections also discuss the possible role outside agents could play when they ought to promote community empowerment.

2.3 What is Community Empowerment?

The term community empowerment is a combination of the concepts 'community' and 'empowerment'. In order to proceed to a meaningful conceptualisation of community empowerment, a useful starting point would be to discuss the two terms separately and progressively build a constructive conceptualisation of community empowerment.

2.3.1 Community

Community at first looks like a straightforward concept but it can become very complex and disputable in reality. It depends on the context in which it is used.

Swil (1982:10) for instance, distinguishes between three categories of communities:

- Geographical communities, which refer to all the individuals, machines, institutions, etc. that are geographically distributed within a specific boundary. These communities are subjects of an aerial view and examples would be cities such as Johannesburg or suburbs within cities such as Soweto and Saxonworld in Johannesburg.

- Geographical/Functional communities focus on the different parts or fragments of a geographical community in interaction. The essential characteristic of this type of community is the structure of the relationship between these communities that arises from the bases of commonality, but is still contained within a certain geographical boundary. Examples of this type of community are pupils at a particular school and homeowners in a specific neighbourhood.

- The last types of community are those that stress common life and can be regarded as functional communities. The feature of this community is emphasised by the lack of any geographical boundaries and its exclusive focus relates to commonality. Examples here would be the Muslim community, which shares a bond no matter where they live in the world.

De Beer and Swanepoel (1998:18) come to the conclusion that the term 'community', when used in a development context, contains the inherent assumption of closeness to people, shared needs or interests, a certain level of poverty and a need to take part in development are present. This need not necessarily be the case, as illustrated by Burkey (1995:41) when he states that "communities are composed of individuals and groups with different and often opposing interest." In support of Burkey's views, Wallis (in Reddy 1995:35) is of opinion that the idea of a community sharing a common interest in a given locale is a rather utopian notion and may be seriously off the mark.

This is especially true in relation to communities within which political conflict reaches a point at which acts of violence are common.

The Shorter Oxford Dictionary describes the word community as "a body of people organised into a political, social or municipal unit." The term 'municipal' is particularly useful for purposes of this study.

From the above definitions, and according to Davids (1999:4), it becomes clear that there are certain characteristics of a community which, inter alia, include:

- People: communities consist of people/individuals;
- Membership: communities involve the idea of membership in the sense that people live in some spatial relationship to one another; and
- Locality: communities share a common locality or geographical area.

A community therefore cannot exist without people, because a community comes into existence when people (as individuals or as groups) join other people (membership) within a specific geographical area (locality) in order to satisfy their common needs (Davids 1999:4).

For purposes of this study, the term community as conceptualised in community empowerment refers to the people living within the geographical /jurisdictional boundaries of a municipality. In other words, people that live within the jurisdictional area of the Stellenbosch Municipality constitute the Stellenbosch community. However, it must be borne in mind that there are various sub groups within a municipal area, such as those living in neighbourhoods and distinctive areas, which also have the features, that conform to a community.

2.3.2 Empowerment

According to Tandon (in Titi and Singh 1995: 29), empowerment is a very complex and misunderstood concept. Trying to define it can be very problematic. Titi and Singh (1995:13-14) are of the opinion that to try and

define empowerment in precise terms might not yield any significant insight into the concept and its utility. This can be linked to the extensive use of the term in the social sciences, as well as the different dimensions, -political, social, economic or psychological connotations- attached to the term. The concept does not impact on the social sciences only, but also to a large extent on economic as well as managerial sciences, all looking for ways whereby their respective disciplines can contribute from their perspectives as to how empowerment can be employed as a strategy for social inclusion, whether for the unemployed, the poor, the disabled or any other stigmatised groups in society (See Foster-Fisherman 1998; Perkins 1995; Dominelli 1999; Fawcett *et al.* 1995; Forrest 1999; Lee 1994; Mondes and Wilson 1994; as well as Friedman 1992 for an overview of different perspectives within the various disciplines).

Christiansen (1998:260) states that it is a term that has become relatively well known throughout academic circles, as well as among community activists, yet paradoxically it is a term that is very difficult to define. Schuftan (1996:260) also shares this view when stating that it is very difficult to really say what is empowering within the context of community development. In Schuftan's *(ibid)* view: "Any attempted operational definition will always carry a certain bias, depending on the conceptual glasses one is wearing."

To evolve the paradoxical nature of the term empowerment as put forward by Christiansen as well as Schuftan, Forrest (1999:95) argues that the paradox exists due to a contest over the meaning of empowerment. On the one hand it is a tool being used by the 'new' type of managerialism that moves away from the traditional hard, bureaucratic style of management. It allows for greater control of individuals in the workplace and decentralisation of responsibility. On the other hand it has been used consistently as a symbol for resistance to poverty, racism, alienation and oppression. Or, as Craig and Mayo (quoted in Forrest 1995:2) ask in the context of third world countries: "....is empowerment the human face of structural adjustment programmes in the wake of global economic recession, or a tool for democratic transformation?"

One way to offset and recognise the contradictions that exist is to note the following assumptions of empowerment made by Foster-Fisherman *et al.* (1998:509) and empirically established by Forrest (1999). The assumptions are that:

- Empowerment theory assumes that empowerment takes on different forms for different people (different levels of empowerment, be it individual, group, community, organisation). In layman's terms what might be empowering to one individual might not be the same for the next. This applies to a community as well. A community (as shown earlier) is not a homogeneous construct, with people living in peace and everyone sharing the same problems. Coherence and co-operation is important. To use Bartunek from (Foster-Fisherman *et al.* 1998:509) as an example: "...newcomers to a participatory decision-making process were more likely to define a directive leader as empowering while those more experienced in this process needed real influence over decisions to feel empowered."

- Empowerment is context specific. What might be empowering in one context might have the opposite effect in another.

- Empowerment is dynamic in nature. What might have been empowering in a specific time frame might not be in another. It is constantly in a flux.

According to the Oxford Dictionary, 'to empower' means to authorise or to enable. The latter meaning is of particular relevance to this study and will be further explored towards the end of this chapter.

Conger and Kanungo (1988) investigated the empowerment process within the context of the workplace. Their focus was on the manager/subordinate relationship. They came to the conclusion that empowerment leads to a situation in which an individual's power needs are met (needs referring to both concrete and abstract aspects).

These power needs are met when individuals perceive that they have power or when they believe that they can adequately cope with events, situations and people they confront. On the other hand, these power needs are frustrated when an individual feels powerless or when he/she believes that they are unable to cope with the physical and social demands of the environment (Conger and Kanungo 1988:473).

Closely related to this perspective, Neighbours *et al.* (in Powell 1990:205), summarises the concept empowerment as "a process of increasing personal, interpersonal as well as political power, so that individuals or collectivities can take action to improve their life situation".[11]

Friedman (1992:33) describes empowerment in the context of the household, as involving three kinds of power:

- Social power that is concerned with the household's access to productive and reproductive resources such as skills, material goods, information and finance. As access to such resources increases so to does the family's ability to actively pursue its objectives;

- Political power concerns itself with the involvement of individuals in the decision-making process, which affects their lives.

- Psychological power relates to the individual's sense of potency, that is, to what extent an individual believes he/she is able to influence the situation around them

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- [11] Personal empowerment refers to an internal process in which one develops a feeling of increased power or control.
- Interpersonal empowerment allows the individual to function effectively and independently in social situations by having the ability to ward off the controlling influence of others.
- Political empowerment attempts to deal with direct blockages to power such as inadequate resources and denial of opportunities by social institutions. (This level of collective empowerment is initiated when powerlessness is externally imposed and reinforced).

From the above definitions it can be deduced that empowerment deals with the satisfaction of needs, both concrete and abstract. Within the confines of a community, it refers to the satisfaction of the community's collective needs. The gaining of power can satisfy these needs.

A literal translation of the word "empower" means to give power, which raises serious questions as to what kind of power as well as to how much power? This question raises inherent difficulties:
Firstly, who determines needs within the context of the individual? Surely, the need for power differs from individual to individual. In the context of community, which consists of individuals, who determine the community's needs? Individuals within the community certainly have different power needs.

Secondly, who gives power or enables those who do not have power? This raises a third issue namely, are those who possess power willing to share or relinquish their power? In Titi and Singh's (1995:13) view: "Empowerment as a process of enabling implies the transfer of ownership to the affected community". In community work, it implies that the community worker needs to share or relinquish his/her power. Or as De Beer (1995:349) states: "A trainer (community worker) or official who trains in the interest of empowerment should of necessity experience a reduction of his/her power."

The concerns raised above have direct bearing directly on the power relations between those that possess power and those that do not. Unfortunately, the scope of this study does not allow going into such deep-rooted difficulties and complexities. Forrest (1999:99) mentions in this regard: "In a libratory context empowerment is a concept which gives meaning to the challenges of established power relations between men and woman, black and white, young and old, parent and child, professional, client and employee."

Based on the above definitions and interpretations, empowerment can be defined as a process of gaining power over the forces that shape one's destiny. It is a process whereby individuals as well as communities gain an

understanding of the forces that shape their reality and, in turn, develop strategies that positively influence the processes that shape their destiny.

In the context of development, empowerment is aimed at groups and people living in poverty, as well as in a state of underdevelopment. It is important to note that empowerment is a process. In other words, it implies that, for empowerment to be achieved, certain steps need to be taken to constitute the process. These steps are not necessarily linear in nature but, rather, it is integrated.

2.3.3 Community Empowerment

The previous section on the concept empowerment has illustrated the wide use and also the ambiguity attached to the concept. This section deals with what empowerment entails in the context of the community. In order to avoid the ambiguity and limitations of a definition, De Beer (1996:71) suggests that the main features and characteristics of the concept should be looked at.

According to de Beer *(abid.),* Titi & Singh (1995:13) and Perkins (1995:770), community empowerment is characterised as:

- A process that satisfies concrete as well as abstract human **needs**. The earlier definitions of empowerment have clearly illustrated this. Concrete needs refer to tangible needs while non-tangibles such as a need for self-esteem, self-respect, autonomy, and dignity may evolve at the same time.

- Empowerment is a **learning** process. In this instance, learning is not just about the ability to read and write. It is about gaining knowledge, which enables communities to become critically aware of the structural political and economic forces that shape their lives. In development projects, it refers to the ability of impoverished or beneficiary communities to identify their own needs and shortcomings and to seek solutions to these problems by their own means. Titi & Singh (1995:13) argue that empowerment goes beyond notions of democracy and human rights to include:

- Enabling people to understand the reality of their environment, be it political, social, economic, ecological or cultural;
- As people become aware of this reality, they critically reflect on these forces that shape their environment;
- In doing so, they take steps to effect change to improve their situation.

- Empowerment is **collective action**. Poor people cannot realise a process of empowerment on their own because they do not possess the necessary capacity or resources to start such a process. According to Perkins (1995:770) it is difficult to find unmediated and independent community action in practice. Community development programmes are either concerned with traditional growth and macro economic strategies or rely heavily on centralised bureaucratic structures. From an empowerment perspective, those that aim to promote development and empowerment such as NGOs and the state should not usurp local initiative but should rather enable or support the poor/beneficiaries of empowerment.

- Empowerment is action at **grassroots level**. Decisions cannot be made in a top-down fashion. This implies that a development enabler such as a municipality cannot pre determine development plans and projects. In other words, if the objective is to empower communities, blueprint development planning becomes nullified.

- Empowerment creates **self-awareness**, which in turn addresses abstract developmental needs. The work of Paulo Freire in this regard is of particular relevance. According to Freire's view (quoted in Mayo and Craig 1995:6) empowerment allows the oppressed and powerless to become active and reflective about their reality and struggles to transform this reality. This is also known as a process of conscientisation.

Several case studies from the literature (de Beer 1996; Bailey 1995; Singh 1999; Christianson 1998) illustrate how the above characteristics of community empowerment can be successfully applied in practice: In this

regard, the Mapayeni project illustrates how the characteristics of empowerment can be put in practice (see De Beer 1996:72). The Mapayeni project was initiated by a small group of rural woman who identified a **concrete** need for food and translated it into an **objective** for a food garden. Through **collective action** they overcame obstacles such as continued drought, as well as lack of knowledge, to achieve their objective. The success they achieved over a short period substantially improved their **self-esteem,** as well as **self-awareness**.

From the above characteristics of community empowerment, it can be deduced that there are many similarities between the characteristics of community empowerment and the 'Batho Pele' principles discussed in Chapter one. The commonalities are as follows:

- Firstly, community empowerment occurs when abstract human needs are transformed into tangible benefits. Access to services and services infrastructure provides tangible benefits.
- Secondly, community empowerment is collective action between the enabler of empowerment and the beneficiary community. Municipalities and communities should jointly deliver services.
- Community empowerment is action at the grassroots level. In other words, initiative for action must stem from the community. Communities must participate in the delivery of services.
- Community empowerment is a learning process. Communities should be informed of the quality, the quantity, and the types of services that are delivered. Information regarding this should be easily obtainable.
- The enabler of community empowerment must of necessity experience a reduction of his power. Rather than decide for people, decide with people. Staff training to change attitudes must accompany services that are delivered. The purpose is to listen to people and discover what their needs are, instead of ignoring people's views.

In view of the above congruence, community empowerment through service delivery, for purposes of this study, is conceptualised as a process whereby a

community, as defined within the borders of a municipal area, determines its collective needs in terms of services in collaboration with/in partnership with a development enabler/service provider (local government), and together determine the best means possible to satisfy it. This becomes possible when a community, through a process of participation and critical learning, identifies its needs. As a collective they decide on what action /decisions needs to be taken in order to satisfy the felt needs. This requires active participation from all parties involved, from the beneficiary group, right through to all other stakeholders involved.

When community empowerment is defined in this manner, how can municipal officials as enablers of empowerment contribute to the empowerment of communities?
The next section 2.3 will discuss the supportive role enablers such as municipalities can play in an empowerment process.

2.4 The Role of the Enabler

Earlier in this chapter the author stated that empowerment is a process of 'enabling'. This is relevant because those who do not possess the capacity or the power, and who are supposed to be the intended beneficiaries of an empowerment process cannot start or realise such a process on their own. Therefore outside assistance, usually by those who do possess the necessary capacity and power, is of crucial importance. When the objective of an empowering process is for people/communities to gain real leverage, as Theron and Burger (1996:61) state, the role of enabling organisation is to facilitate/enable, rather than impose the values that suit them (enabler). All too often there is a tendency among outside agents such as NGOs, governments and institutions such as the World Bank and the IMF to impose their type of thinking and plans. Needs are determined by these institutions without consulting those that are the intended beneficiaries.

An empowering strategy, if implemented correctly, sets out to avoid such tendencies. All too often outside agents believe that, by delivering tangible goods to impoverished communities, they have empowered people. On the

contrary, an empowerment strategy sets out to avoid this because material goods do not equal empowerment. This also creates dependency on the part of the beneficiaries and such a process can be particularly damaging, especially when one considers to what extent it is sustainable.

So the question remains; what type of outside intervention is appropriate in an empowerment strategy? Racelis (cited in de Beer 1998:23) is of the opinion that outside assistance should be in terms of skills and organisational training, credit, income-generating schemes, appropriate technology, education and access to basic services. In essence, Racelis is saying that enablers must be able to create the necessary environmental conditions that are conducive to communities realising their potential, which could lead to their empowerment.

Forrest (1999:97) also identifies the role of the enabler, but in the context of the workplace. In this instance the enabler needs to be able to spend more time with people, relinquish control, encourage decision making, stressing innovation, allow risk taking, provide support, increase motivation and gives feedback. This allows an individual to develop self-esteem, confidence and believe him or herself (See also Bailey 1995:379).

Another pertinent issue relating to the role of the enabler already touched on above, is the whole idea of who should be in control of decision making in the development process or, for purposes of this study, the service delivery process. In this regard, de Beer and Swanepoel (1998:24) state that "decision making must truly be returned to the people, who have both the capacity and the right to inject into the process the richness including the subjectivity - of their values and needs. Decision processes should be fully informed by whatever analysis available experts can provide, but only as one of several data inputs available to the many participants." Thus, the enabler must not be dominant or try to be. To achieve this, the enabling organisation should adjust its institutional framework to be compatible with empowerment thought. In this regard, de Beer (in Liebenberg and Steward 1997:29) states that the organisation that is attempting to empower people need to be able to be more adaptive and more flexible.

This can be achieved by adopting the following principles:

- Embrace error: unavoidable (learn from mistakes)
- Plan with people (avoid top-down know-it-all type planning)
- Link knowledge building with action.

Organisations should therefore let go of hard bureaucracies and inward looking to become adaptive administrations or, as Dennis Goulet so aptly, states: "It must become institutionally vulnerable" (De Beer and Swanepoel 1998:8). (See also Swanepoel 1996:100.)

In addition, De Beer (1996:73) is of opinion that, if the public institutions in South Africa, be it on a national, local or provincial level, are to fulfil the empowering/supportive role, then it is necessary for the institutions as well as its personnel to meet specific institutional requirements. In this regard there must be:

- Commitment by government
- Administrative support
- National planning and programming
- A capacity for co-ordination, or that such a capacity is developed.

In South Africa, there is no doubt that government will perform a pivotal role in the social upliftment of communities. If government wants to realise its vision of a people-centred society as envisaged in the RDP, which will ultimately lead to empowered communities, it needs to position itself strategically in order not to dominate the development process. At best, government should create the necessary environmental conditions and institutions should adapt accordingly to enable sustainable development to proceed. A top-down, bureaucratic process should be avoided. Wilson and Ramphele (quoted in De Beer, 1996:75) have focused on the fact that "Development efforts in many African countries became a shambles because of the eagerness of governments to direct everything from the top." It thus is imperative for government, if it is serious about creating a people-centred society, to plan, to

implement and evaluate projects and programmes with the beneficiaries of development efforts in South Africa.

2.5 Conclusion

In this chapter 2 the term community empowerment has been discussed from a development perspective. It was argued that the emergence of the concept within the confines of development discourse is embedded in the alternative development school to contrast the inability of purely macro economic development strategies, such as growth and modernisation to eradicate poverty on a global scale. In contrast to technocratic growth, alternative development focuses on micro-level solutions to people's development deficiencies. In light of this it views people as the most important resource for development. Community empowerment has its origin in the people-centred strategy of alternative development. It was argued that, if enablers want to empower communities, they must of necessity experience a reduction in their own power in favour of the intended beneficiaries of an empowerment process. In view of this, this chapter discussed the role enablers of empowerment, such as municipalities need to fulfil.

The following chapter will propose an operational framework for community empowerment through service delivery.

Chapter 3

Community empowerment: A proposed operational framework

3.1 Introduction

Chapter one of this study stated that local government, through its operational entities (municipalities), could empower communities through its service delivery function, as compelled by the Constitution, the RDP and the White Paper on Local Government. Chapter two of this study discussed the concept community empowerment from a development perspective with regard to the fact that municipalities need to perform a development role, in other words, promote the participation of disadvantaged classes in society in the social, economic and political processes that influence them. A second relevant aspect of importance, discussed in this chapter, referred to the role enablers, such as municipalities need to perform if they are to fulfil the development role, which would ultimately lead to community empowerment.

This chapter will propose a possible operational framework for community empowerment through local level service delivery that can be implemented by line function departments within municipalities.

3.2 Toward an operational framework

Burger, in writing about the new development orientation of local government in South Africa, makes a very important observation in terms of services. He states (1997:81) that "Many of the service rendering functions of local government will continue, but these activities and others must be focused on increasing capacity and empowering people". This statement relates directly to the problem statement in the opening chapter. The question is how?

In answer to this, Christianson (1998) and Schuftan (1996) provide useful frameworks to indicate how communities can be empowered through services.

Christianson (1998:24), in seeking practical solutions as to how black communities in the United Kingdom can be empowered, provides the following framework:

- Empowerment, in practice, should be sensitive to gender/race/class and other aspects of humanity and interaction where social inequality can emerge.
- Existing resources in the given locale/area should be used in a productive manner.
- People who live and work in the community should play an active role in the decision-making process relating to the delivery of services.
- The delivery of services must be accompanied by the measures of accountability, i.e. those that receive services must not be passive but active and should be given or demand a role of responsibility.
- Training and re-training is encouraged, with the aim of improving the competency of staff.
- Empowerment also entails an open flow of information regarding services between giver and receiver, in order to ensure equal partnership in the planning and delivery (along with the evaluation) of services.
- Empowerment in practice means that the organisation should aim to reflect the broader society in their workforce. In the context of blacks in the U.K it entails visibility of blacks at all levels in the workforce.

According to Schuftan's (1996:261) classification, community empowerment through service delivery entails:

- Providing services in a gender sensitive, as well as cultural sensitive way.
- Using existing local human resources wherever possible.
- Ensuring that most people in the community understand the rationale behind the service being delivered/offered.
- Participation by community representatives in making decisions about the services being delivered.
- Training of staff is mostly competence-based, in-service, aimed at behavioural change and followed by regular support supervision.

- People ceasing to be passive recipients of services delivered by government and others, (people) demanding a role of responsibility for themselves, especially in determining the type, quality, quantity, place and focus of such services, partaking in both decision making and delivery mechanisms.
- Assuring a flow of information between the providers and the end users of such services, enabling them to be equal partners in the planning, delivery, management and evaluation of the services.

3.3 An operational framework[12]

The afore-mentioned classification of Schuftan and Christianson in conjunction with the 'Batho Pele' principles (as discussed in Chapter one) envisaged for government departments in South Africa, as well as the general characteristics of community empowerment, has provided useful insight as to how services can contribute to empowering communities in South Africa, especially those disempowered under the previous dispensation. If local authorities want to promote empowerment of communities in their area of jurisdiction through municipal services, it is suggested that their strategy must take cognisance of the following principles:

- Municipal services should be accessible to communities, especially to disadvantaged communities, or those who have no access to services. In many parts of South Africa, the most basic services are still lacking with regard to a substantial number of people. Therefore it is pertinent that everybody is given access. Access to services, though, will not necessarily guarantee an improved quality of living. An example here would be housing provision whereby the supposed beneficiaries in a housing project experienced a drop in the quality of their living

[12] This is a broad framework. The intention is to inform the reader that each of these principles must be interpreted in the context of a particular service. In other words, a certain factor that might be of more importance in one service might not be so important in the delivery of another. Some services are technical in nature, which allows for limited community input while others are open to community participation.

standards in RDP houses (Friedman 1997:187). Access must be accompanied by quality of provision, accountability and participation by the beneficiaries, which is one of the important principles to follow. For purposes of this study, access in terms of services is measured in terms of financial; distance, availability and discrimination constraints to services.

- Services need to be delivered in a way that is **non-discriminatory** in terms of gender and race. This implies that cognisance must be taken of situations where inequality can arise. In this regard, the Constitution of the Republic of South Africa (1996:3), Principle 1(b), quite categorically indicate non-sexism as well as non-racialism as two core values of the South African state. In the context of this study, non-discrimination therefore requires municipal services to be delivered in a non-sexist and non-racist way.

- The beneficiary community should participate in the service delivery process, especially with regard to decision-making processes. In theory, it is easy to state that communities should participate in the service delivery process. However, the fact that communities should participate presents more questions than answers. For example, how should communities participate? What is their expected role? Why should they participate? Is it not easier to leave delivery to the professionals? It is suggested that community based organisations as well as NGOs serve as representatives of community interest in decision-making. In this regard community members need to be at the forefront to identify their service **needs**.

  Various methods are available for ascertaining needs in the community. It would be useful for municipalities to conduct annual surveys to determine service needs. Note must also be taken of citizens who do not have the capacity for or are illiterate. In this regard it is pertinent that members have access to community forums where

issues such as needs identification can be obtained. There is also a danger of people being overwhelmed by the idea of more research and filling in of questionnaires. Dockery, in Watt (2000:122) states: "In my experience some communities are refusing to participate any further in such research as they feel they have been 'needs-assessed to death' without any tangible response in terms of resource allocation." This illustrates why it is important that needs assessed by the community must to be turned into tangible benefits, otherwise needs assessment is of no use.

Daniels (in Graham 1995:54) makes the comment that local authorities need to look externally to the community they serve, to learn of the problems faced and the impact of services provided in terms of their (communities) experience or non-experience in utilising it.

According to Arnstein's framework in Gouden and Merrifield (1994:94), community participation ranges from non-participation, manipulation, tokenism, information, consultation, placation and partnerships to complete citizen control, which leads ultimately to community empowerment. One of the main features of community empowerment is self-reliance and self-control. It can therefore be assumed that, when citizens gain control over service provision, the stage of community empowerment has been reached. Gouden and Merrifield *(abid.)* also state that movement along the continuum of participation also implies a shift in the significance of delivery agency, where the ultimate responsibility of delivery moves from the external development enabler/agency (local government) to the beneficiary group once they are empowered.

Therefore the ideal end result for community empowerment through municipal service provision implies that the community itself is responsible for the delivery of services itself. It must be borne in mind that this is the ideal situation, and is a long-term process. This situation should be striven for.

Participation should therefore move beyond the limits of purely needs identification and consultation as called for by 'batho pele'. for. In this regard, Watt *et al.* (2000:121) are of the opinion that many levels of government are keen to promote consultation and often the use of this word in policy statements seems to imply the expectation of a resultant social equity. Arnstein, (cited in Watt *et al. abid.*), also argues that consultation is nothing more than a degree of tokenism and that **partnership** would be a much more appropriate route to citizen empowerment.

Bernstein (in Graham 1995:6), on the other hand, suggests that different forms of participation are needed at different stages of the governing process. This involves consultation and involvement in decision making and design of services and mobilisation during implementation. The intended beneficiary community must also participate in decisions regarding the **type** of services to be delivered, the **quality** and the **quantity** of services to be delivered. It is also suggested that, due to the difficulty of consulting each member in a community, it would be useful to include community representatives in the decision-making process.
Therefore communities need to participate in:

- Identifying service needs;
- Planning of services and service infrastructure;
- Implementation of services and service projects;
- Evaluation of services.

- The **rationale** for the service being delivered needs to be explained to the intended beneficiaries. Communities do not always understand or have an idea as to why services are delivered. Daniels (in Graham 1995:53) states that many citizens are not knowledgeable about the workings of a municipality and are therefore not able to derive maximum benefit from the services that such authorities deliver.

  Research by the Mashakane office in Stellenbosch has shown that people do not participate or take responsibility for municipal services

due to a lack of knowledge of the structures of the municipality and especially, of why it is necessary to pay for such services. In other words, people do not understand the service delivery process (September 2000:11).[13] Therefore one of the enabling conditions required of a local authority is to fulfil the role as educator.

Morris and Barnes make an important comment with regard to why it is important for communities to understand the service delivery process. In their opinion (1997:207), it is important to highlight the policy parameters within which communities can make demands. Knowing and understanding this can eliminate irrational demands. Secondly, educating communities in the dynamics of service delivery can enable them to play a significant role in the service delivery process. Therefore municipalities need to be instrumental in educating citizens, especially those that are less knowledgeable, about the services being delivered. There are several mechanisms that municipalities can follow to implement this, that is for instance, by making information of the line department responsible for a service available through having a policy statement, by providing information on who the personnel are, supplying information regarding the service itself in terms of objectives, and projects that the municipality are planning to implement.

- A constant flow of **information** regarding services needs to be channelled between the community and the local authority. This can ensure accountability, as well as legitimacy. This also implies that communities should have easy access to officials and councillors. In this regard it would be useful for municipalities to produce a newsletter regarding services delivered, the type and quality and, basically, what to expect. This can be done on a quarterly basis, seeing that limited resources are available to municipalities.

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[13] September, A. 2000. Building the nation with Masakhane. Viva Newsletter. February 2000. Stellenbosch: Stellenbosch Municipality.

- Existing **human resources** should be used in a given locale. This implies that those that are under the jurisdiction of the local authority need to be preferred when it comes to employment opportunities or in service projects, especially where it involves the delivery of service infrastructure. It is important that local people from the beneficiary community are contracted to do the job. Seeing that privatisation and outsourcing has become the current practice in local authorities, services that are labour intensive as well as not so technical in nature can be outsourced to communities, especially disadvantaged communities. In this regard, see Smit 1997; Policy Business Unit 2000; Janse van Rensburg 1998; Livine 1984; Raphaelson, A.H. 1998. The municipality can provide training, new skills can be acquired and community capacity can be increased at the same time.

The above-mentioned principles should be supported by a staff training programme, whereby training is not limited to the technical knowledge required of officials to deliver services. It is important that training should also focus on developing a customer orientation towards service delivery. Lupton and Hall (quoted in Watt *et al.* 2000:123) concluded from a study of user involvement in one social service department that there was a "need for widespread attitudinal change on the part of staff at all levels within the organisation. Rather than hope this change will occur by central directive, [respondents] emphasised that the development of consumer involvement may need to be supported by a systematic programme of staff training and development."

Therefore, it is important that the capacity of municipal officials should be increased to deliver services in a development manner. This can be obtained by training officials in how to:

- Think cross-sectorally rather than only concentrate on the objectives of their line departments.
- Understand the local issues, and economic and political conditions of their neighbourhoods that help define service needs and the impact on delivery.

- Work with CBOs, i.e. learn to listen to citizens as they express concerns, and complaints and offer solutions.
- Identify emerging leaders from the various neighbourhoods and help them to become more effective advocates and community mobilisers.
- Solicit support from CBOs in identifying neighbourhood problems.
- Empower neighbourhood groups to accept their responsibilities with regard to implementation.

For purposes of this study, it is suggested that service delivery processes that adhere to the above-mentioned principles can contribute to an improved and effective delivery system. It will allow members of the society to play a more meaningful role in their own and in their community's development. In other words, it is suggested that implementing these principles in the service delivery process can enable community empowerment.

3.4 Illustrations of good practices: Community Empowerment initiatives through services in Practice: Case Studies[14]:

The following case studies illustrate community participation and empowerment in the service delivery process in partnership with local authorities, and Community Based Organisations (CBOs). The case studies also illustrate the principles of empowerment as suggested in the operational framework.

Case Study 1: Capacitating CBOs to undertake waste management and recycling:

This case study represents an example of how a metropolitan government (Durban North Central Council) in partnership with a CBO operating within the council's area of jurisdiction successfully manages waste and recycling.

The objective of the partnership is to capacitate communities and their organisations in waste management and recycling to ensure that waste is removed weekly. Community organisations identify **local people** from the

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[14] All case studies were obtained from the Internet site: Http//www.local.gov.za/DCD/dcdindex.Html-13.09.2000

community to collect waste and the council pays these individuals for the service delivered. The council's long-term plans are for the CBO to manage all aspects of waste management. Because of this, the council established a Section 21 company that carries out training of local people in environmental management and waste removal. In the council's view, this form of area based management and service delivery is empowering (materially as well as organisationally), it is cost-effective and socialises a new understanding of roles, responsibilities, duties and obligations in a development manner. Thus, the partnership facilitates community empowerment and also educates the community to value their environment and assets.

Case Study 2: Meeting the housing and infrastructure needs of the poor through participatory decision making

This case deals with a partnership between the East London Municipality and the Buffalo Community Development Trust (CBO). The aim of the partnership is to meet community needs through the provision of housing and infrastructure while ensuring full community participation. A third stakeholder (The Eastern Cape NGO coalition, in particular Afesis-corplan), supports the Trust to achieve its aim of delivering cost-effective and quality products by the community by way of training and capacity building programmes. On the other hand the Trust, with the assistance of the NGO, provides community advice, supports housing association activities, manages the housing project, ensures that the municipal funds for construction are sensitive to, and informed by, community needs and that local labour is used.

Case Study 3: Matching municipal funds for latrines - Cambre, Brazil:

A parish priest and the community association leader initiated an agreement with the mayor of Cambre to conduct a socio economic survey of the community in order to better match local government funds with real needs in the community. The community association assessed the needs of 1200 families in the area, using a 52-question survey. The survey revealed that the community's main priority was better sanitation services. To satisfy this community need, the municipality applied for federal funds to build 400 latrines. Funds were used to manufacture cement blocks and purchase other

construction materials. The neighbourhood association registered households in need of toilet facilities. They also conducted a health campaign to show how latrines and vaccinations protect everyone against contagious diseases. Families contributed the labour of one person to help construct bathrooms. The neighbourhood association did the bulk of the construction, supervised by a municipal foreman. Three hundred and fifty new bathrooms were constructed. The neighbourhood association also taught recipient families hygienic practices.

The above case studies suggest that certain crucial elements are necessary for empowerment initiatives to succeed under South African local government. The fact that two of the case studies are South African gives an indication that municipalities are serious about their expected developmental role. All three cases illustrate the importance of co-operation and the building of partnerships between municipalities, communities and community-based organisations, the advantage of training the beneficiaries in the development process and, lastly, educating people in the possible benefits of understanding service delivery and the purpose of its delivery as aptly illustrated through case study three, where the CBO educated the recipients of toilets in the benefits to health and hygiene.

To summarise this chapter: In terms of the operational framework, it was suggested that if service delivery ought to empower communities, communities need to have access to services and they need to participate in the delivery of service infrastructure and the development of services. In particular, communities should participate in identifying service needs. In planning to satisfy those needs, communities must be part of the implementation of plans, and they need to participate in the evaluation of services. A third factor that was addressed is the role of education about service delivery: Providing information is a means of increasing knowledge. Local human resources (if possible) should be used in the implementation of services or the provision of service infrastructure.

The following chapter evaluates the approach to service delivery as adopted by the Health Department in the town of Stellenbosch. The purpose is to ascertain the extent to which the approach adopted by the health department is aimed at empowering communities.

Chapter Four
Evaluating Community Empowerment

4.1 Introduction

Chapter three proposed an operational framework whereby community empowerment can be achieved through municipal service delivery. This chapter evaluates the approach employed by the health department of Stellenbosch Municipality to the delivery of Primary Health Care (PHC) services and service infrastructure in the town of Stellenbosch. Before addressing the central theme of this chapter, it is important to clarify what is meant by evaluation and the interpretation thereof for purposes of this study.

Mark *et al.* (2000:3) defines evaluation as "sense making about policies and programmes, through the conduct of systematic inquiry that describes and explains social policies' and programmes' operations, effects, justifications and social implications. The ultimate goal of evaluation is social betterment, to which evaluation can contribute by assisting democratic institutions to better select, oversee, improve, and make sense of social programmes and policies." From this broad definition, it is clear that the authors are of the opinion that evaluation or policy evaluation encompasses different approaches, methods and diverse purposes.

In addition, Cloete (in Cloete and Wissink 2000:211) lists a number of definitions from different authors relating to policy or programme evaluations. These definitions indicate that the purposes of evaluation differ. For example, evaluation can be used to learn more about a policy, about the effectiveness of a particular programme or policy, or if the stated objectives of a policy have been achieved with regard to the outcome. Policy evaluation can therefore have an array of objectives, depending on the context and the purpose for which it is used. (For a more detailed discussion/appraisal of policy evaluation see also Pawson and Tilley 1997; Meenaghan and Kilty 1994; Verdung 2000; Dunn 1994; Shaw 1999; Clark and Dawson 1999; Mohr 1995; Shaw and Lishman 1999 and Rossi *et al.* 1989).

From the definition (and importantly for purposes of this study) various methods of inquiry can be employed, depending on the purpose of evaluation. Mark *et al.* (2000:15) lists four modes of inquiry that are of particular relevance to policy evaluation as illustrated in Box one:

Box One

Four inquiry modes of evaluation practice

1. **Description**: methods used to measure events or experiences, such as client characteristics, services delivered, resources, or client's standing on potential outcome variables
2. **Classification**: methods used for grouping and for investigating the underlying structures of things, such as development or application of taxonomy of programme subtypes
3. **Causal Analysis**: methods used to explore and test causal relationships (between programme services and client functioning, for example) or to study the mechanism through which effects occur
4. **Values inquiry**: methods used to model natural valuation processes, assess existing values, or dissect value positions, using formal or critical analysis

The mode of inquiry applied in this study is descriptive evaluation. It describes the approach adopted by the health department to the delivery of PHC services. The description of the health department's approach to service delivery will then be assessed in relation to the proposed operational framework for community empowerment. The author believes that this would give insight with regard to the extent to which the health department's approach is compatible with the proposed operational framework for community empowerment. The following section will address the rationale for the selection of PHC services.

4.2 The rationale for the selection of Primary Health Care services

The selection of primary healthcare (PHC) services in Stellenbosch was influenced by the following factors:

- The service under study is community-orientated and does not primarily focus on the individual. It aims to improve people's social conditions, which is pertinent for social and human development to proceed.
- As some communities were within easier reach of social facilities and services than others, the Department of Planning and Development (1996: 30) at the Stellenbosch Municipality identified the imbalance in the distribution of social facilities across the town, as an issue that needed to be addressed. For some communities access to community facilities is limited by affordability and mobility constraints.
- The 1995 local government elections determined that the satellite towns of Kylemore, Johannesdal, Klapmuts and Jamestown be incorporated into the jurisdictional area of the Stellenbosch Municipality. With the incorporation of the satellite towns into the jurisdictional area of Stellenbosch, service infrastructure (which was either lacking or of an inferior quality) was delivered to these sub-communities. This is another reason why research was undertaken in these satellite towns. If the municipality had adopted an approach to service delivery that allowed for community input and participation, it was expected that most of the factors that compromise an empowerment approach as outlined in section (3.3) would have been adopted in the delivery of service infrastructure, such as clinics, in these areas.
- The delivery of community facilities and the provision of service infrastructure were identified as key issues in the spatial development framework for Stellenbosch (Stellenbosch Municipality, Department of Planning and Development 1996:6).
- Kendall (1991:113) has stated that "[p]ublic services that have very little to do with emotional and psychological needs such as roads, construction, sewerage plants and electricity supply can be provided on whatever scale makes most sense in terms of efficiency and cost-saving. However, services that require human caring and concern, like education, health and

welfare, should be planned and carried out with local communities wherever possible." Primary healthcare services can be classified under the latter categories mentioned by Kendall. The service selected for this study is suitable for community participation, which is a key feature of an empowerment approach.

4.3 Data Gathering

4.3.1 Study Area

Research for this section of the study was undertaken in the jurisdictional area of the Stellenbosch Municipality.[15] Table three indicates that the town of Stellenbosch had a population of approximately 67850 inhabitants, in 1995 (Department of Planning and Development, Stellenbosch Municipality, 1995). It is estimated that the town's population, excluding the student population, would increase to almost 90000 people by the year 2015 as indicated in Table four. Table three also provides for a breakdown of the population by area or neighbourhood. The neighbourhoods are characterised by racial clusters. This implies that neighbourhoods can still be distinguished in terms of white, coloured and black occupation. (Table five provides a breakdown of income for various neighbourhoods and areas in Stellenbosch). In addition, the satellite towns of Kylemore, Johannesdal, Jamestown, and Klapmuts (all identifiable by predominantly coloured occupation) were incorporated into the jurisdictional area of the municipality at the time of the 1995 local government elections.

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[15] Research for this study started prior to the December 2000 local government elections. Therefore the jurisdictional area of Stellenbosch Municipality for this study compromises the area as determined by the 1995 Local Government elections. Considerable changes to the jurisdictional area of Stellenbosch Municipality have transpired with the December 2000 local elections, which saw the towns of Stellenbosch, Franschoek and Pniel amalgamating to form a new single municipality, named Stellenbosch Municipality. Due to the difficulties of the amalgamation process, relating to matters such as the consolidation of various budgets and accounts, as well as integrating personnel of the three formerly independent municipalities, the administrations of the various towns still function independently. This process could take some time to finalise. The use of the old jurisdictional area of Stellenbosch Municipality is justified until such time that the new municipality functions as a single unit.

Table Three: Total Urban Population of Stellenbosch[16]

Area	Population
Cloetesville	13216
Idas Valley	8427
S/B Town	29990
Jamestown	1960
Johannesdal	320
Kayamandi	10007
Klapmuts	1130
Kylemore	2800
Total	**67850**

These satellite towns previously were the responsibility of the now defunct Western Cape Regional Services Council (WCRSC) and, with its demise, of the Cape Metropolitan Council (CMC).

Table Four: Projected increase in the population of Stellenbosch[17]

Year	1995	2000	2005	2010	2015	%Growth
Population	+/_57400	+/_64300	+/_72000	+/_90450	+/_90450	2.4

[16] Source: Department of Planning and Development, Stellenbosch Municipality (February 2001).

[17] Source: Department of Planning and Development, Stellenbosch Municipality (1996:44). The above population figures exclude university and college students.

Table Five: Average Monthly income of households in various neighbourhoods[18]

Areas	Average monthly income in R's
Kayamandi	828
Cloetesville	1146
Idas Valley	1604
Town Centre (North)	1654
Simonswyk	4621
Uniepark	3836
Onder Papegaaiberg	4612
Town Centre (South)	1828
Mostertsdrift	4812
Die Boord	6217
Dalsig	5059
Paradyskloof	6002

Because this study argues that communities in disadvantaged areas should be empowered through the delivery of services and service infrastructure, research focused on the delivery of the above-mentioned services in the Coloured neighbourhood of Cloetesville, Kaymandi (a township dominated by African occupation) as well as the satellite towns of Kylemore, Klapmuts and Jamestown, which can all be classified as disadvantaged due to past policies.

4.3.2 Data

Data was gathered through unstructured interviews.[19] Seven interviews were conducted. Three were conducted with municipal officials. These included interviews with the Head of the Health Department; the Manager of Clinic Services (Primary Health Care) and the Senior Nursing Sister in charge of the Cloetesville Clinic. The other four were conducted with members of the

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[18] Department of Planning and Development, Stellenbosch Municipality (1996:49). The average income of people living in the satellite towns of Kylemore, Jamestown and Klapmuts is not available.

[19] See Babbie (1998: 290) for an overview of unstructured interviewing.

community-based health committees for the areas of Cloetesville, Klapmuts, Kylemore, and Jamestown.

The following persons served as respondents:[20]

- Mr Harmse, Head of the Health Department, Stellenbosch Municipality
- Mrs Weideman, Manager of Clinic Services, Stellenbosch Municipality
- Mrs Coetsee, Senior Sister in Charge, Cloetesville Clinic
- Mr Isaacs, Chairperson: Cloetesville Health Committee
- Mr Davidse, Chairperson: Jamestown Health Committee
- Mr Carolissen, Member: Kylemore Health Committee
- Ms Fabriek, Member: Klapmuts Health Committee

4.4 Approach to the delivery of PHC services and infrastructure

4.4.1 Background

Primary Health Care services form the basis on which the health care system in South Africa is shaped. According to the White Paper on the Transformation of the Health System in South Africa (1997:28) the rationale for this choice is based on the fact that primary health care is the most efficient as well as the most cost-effective means of improving the population's health. Swanepoel and De Beer (1997:107) state that: "PHC is a type of essential service which is based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community as well as the country can afford." In other words, PHC services promote the involvement of the potential beneficiaries in the delivery process.

According to the WHO (1978:16-17) PHC is based on the following principles:

- Universal coverage of the population, with care provided as needed.
- Services should be promotive, preventative, curative and rehabilitative.
- Services should be effective, culturally acceptable and manageable.

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[20] All 12 interviews were conducted in Afrikaans

- Communities should be involved in the development of services so as to promote self-reliance and reduce dependency (See empowerment conceptualised).
- Approaches to health should be related to other aspects of development.

In addition, the Alma Ata Declaration[21] states that the objective of PHC should be (Koesoebjono-Sarwono 1993:7):

- The promotion of proper health
- Adequate supply of safe water
- Basic sanitation
- Maternal and child health care, including family planning
- Immunisation against major infectious diseases
- Education concerning prevailing health problems and the methods of preventing and controlling them
- Appropriate treatment for common diseases and injuries
- Provision of essential drugs.

PHC is therefore an approach to health care aimed primarily at those sectors in society that lack access to professional health care, due to their socio economic circumstances. It is an approach to health care that allows for community participation and it views educating the beneficiaries of these types of health services as an essential element in the provision of the service. These factors are all crucial for community empowerment as well.

In South Africa, efforts are also under way to make PHC services more accessible to people, especially people in rural areas. In this regard an extensive clinic-building programme has been launched to improve access to PHC services (See Khosa 2000). As in the rest of South Africa, the provision of primary health services and infrastructure has also been on the agenda in Stellenbosch.

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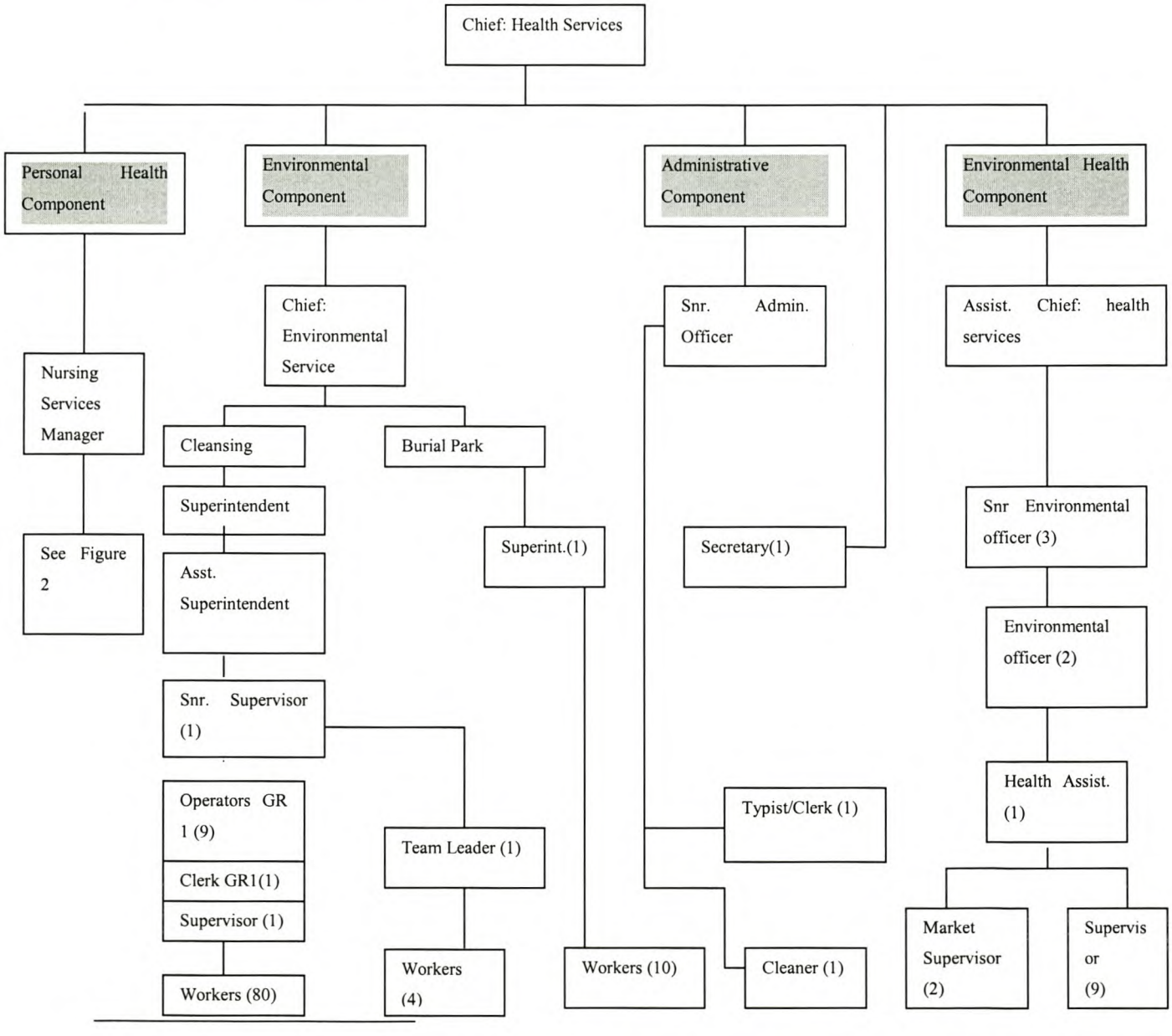
[21] The WHO and Unicef organised an International Conference on Primary Health Care in Alma Ata in 1978, which produced the Declaration of Alma Ata.

4.4.2 PHC services in Stellenbosch

In Stellenbosch, the health department of the local municipality is responsible for the provision, maintenance and development of PHC services and infrastructure. The health department is divided into four functional components. These include a personal health component; an environmental health component; an environmental component; and an administrative component, as illustrated in Figure one.

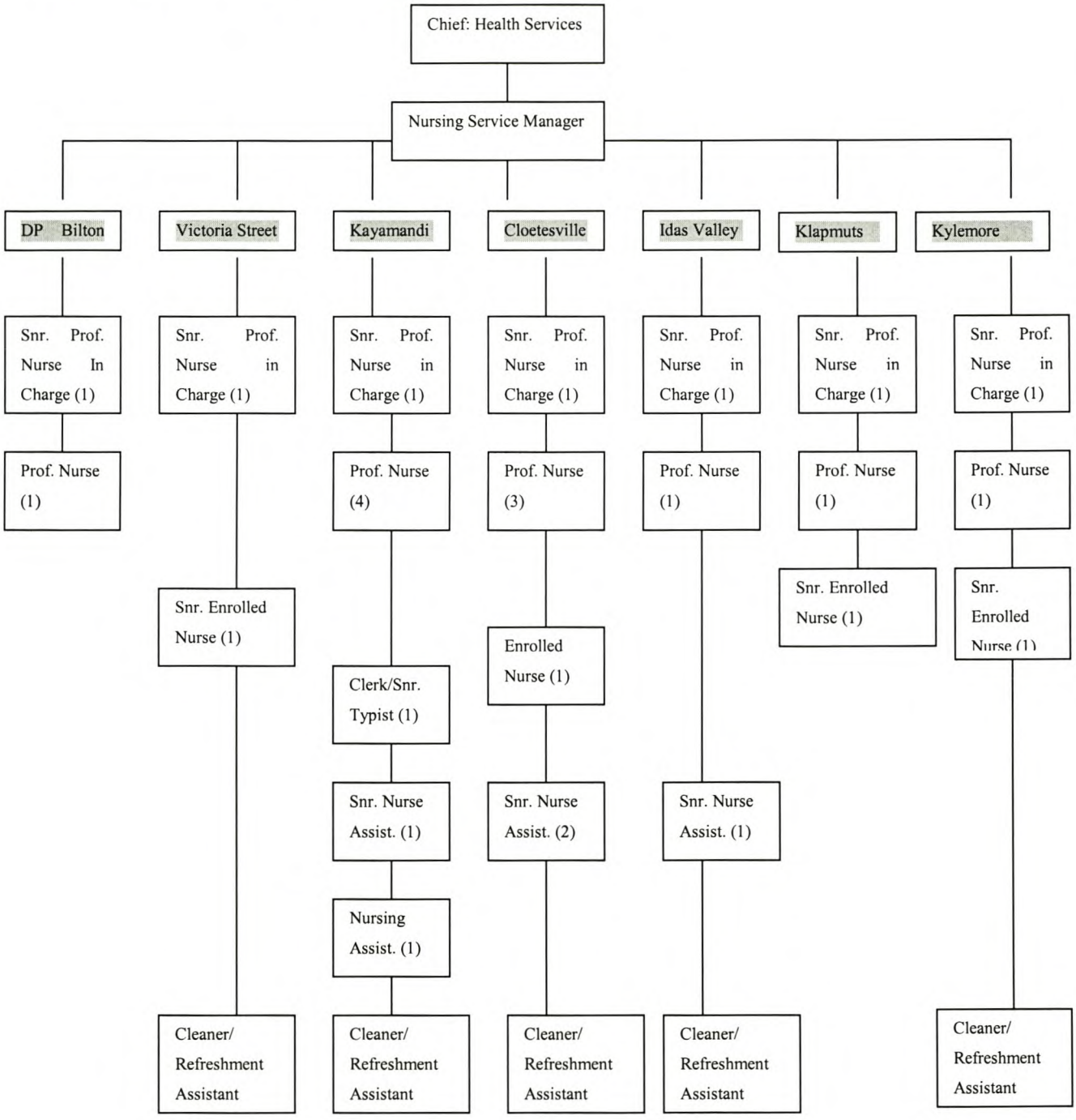
Figure 1: Department of Health Services[22]



[22] Figure 1 as obtained from the Health Department, December 2000. Figures in brackets indicate number of personnel

Each component is responsible for delivering various health related services. Primary health care services are categorised under personal health care services, as illustrated in Figure 2.

Figure 2: Personal Health Component[23]



[23] Figure 2 as obtained from the Department of Health, December 2000. Figures in brackets indicate number of personnel

Figure 2 illustrates that Stellenbosch has seven clinics that provide primary healthcare services. The clinics are located in the areas of Kylemore, Klapmuts, Jamestown (DP Bilton), Cloetesville, Idas Valley, Kayamandi and the Victoria Street , located in the central business district.

As previously mentioned, the satellite towns of Kylemore, Jamestown, and Klapmuts were only incorporated into the jurisdictional area of Stellenbosch Municipality at the time of the 1995 local government elections. When the municipality took responsibility for the delivery of PHC services in these areas, there was no proper health infrastructure. Jamestown did not have a clinic. The same applied to Kylemore. Klapmuts had a clinic. However, the clinic only provided family planning and pre- and postnatal services. Therefore the lack of proper health infrastructure and services necessitated action to improve access to PHC services in these areas.

To address the lack of PHC services, the health department has undertaken various infrastructure projects in the satellite towns. Since 1995, clinics have been built in Jamestown and Kylemore. The Klapmuts and Kayamandi clinics were upgraded.

The building of the Jamestown clinic was made possible by a donation of R800 000 from the Bilton Household (Bilton was a farmer in the Jamestown area).[24] The donation of R800 000[25] resulted from years of service by members of the Jamestown community. Construction on the clinic started in 1997. Planning and construction of the clinic took two years. The clinic was opened in 1999 at a cost of R559 255. A trust fund was also established for the maintenance of the clinic building (Interview with Mr Harmse).

The Kylemore clinic was completed in 1997, at a cost of about R 551 779. Construction of the clinic progressed swiftly, and took approximately six

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[24] The Jamestown clinic is named after DP Bilton.

[25] All figures relating to the cost of the clinics, as well as the dates of completion, was obtained from Mr. Harmse, Head of the Health Department, Stellenbosch Municipality.

months to complete. A possible reason for the swift completion of the clinic could be that it was a Presidential Building Project.

The Klapmuts Clinic became the responsibility of Stellenbosch Municipality on the 1st of July 1997 when the Cape Metropolitan Council ceased its services. When the Health Department took responsibility for the primary health care function in Klapmuts, extensive renovations and extensions to the existing facility was undertaken. It was completed at a cost of R60 000, in 1998. The upgrading included the addition of two consultation rooms and the enlargement of the clinic chemist. Corobrick donated 35 000 bricks and support was also received from USKOR.[26] Whereas the clinic used to provide only maternal and family planning services, it is now equipped to provide a comprehensive range of services.

The Kayamandi Clinic was completed in 1993, at a cost of R 433 409. This clinic serves one of the most overpopulated and poorest areas by far of Stellenbosch. Planning and construction of the clinic took about two years. As in the case of Klapmuts, the Health Department also undertook extensive renovations at the facility. This resulted in the addition of two consultation rooms and the enlargement of the clinic chemist. Support for the project was also received from Corobrick, which donated 35 000 bricks, as well as USKOR.

From the above it can be deduced that the Jamestown, Kylemore and Klapmuts clinics are relatively new. The fact that the municipality only took control over these areas after 1995 indicates that much has been accomplished to establish health infrastructure in these peripheral towns in a short period of time.

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[26] USKOR is currently known as Matie Community Services/ Matie Gemeenskapdiens

According to Mr Harmse[27], the infrastructure projects described above were not undertaken in isolation of the immediate communities that live in the vicinity of the clinics. In this regard, the Health Department did involve communities through the health committees that were established to participate and influence decisions pertaining to the delivery of the clinics.

4.4.3 The role of the health committees

There is a health committee to serve each of the areas in Stellenbosch where a clinic is situated. The respondents interviewed for this study, cited various reasons for the establishment of these committees. Mr Harmse, for instance, cites the transition to democratic rule in 1994 and subsequent legislation such as the RDP as important reasons for involving communities in the service delivery process. He stated that: *"Wetgewing na 1994 het munisipaliteite aangemoedig om groter gemeenskapsdeelname te bewerkstellig in terme van dienslewering"* (interview: Harmse, 31 August 2001). To facilitate community input and participation in the delivery process, the health department requested that community-based health committees be established for Klapmuts, Kylemore and Jamestown. Besides being mandated by legislation to involve communities in service delivery, Harmse felt that community participation could lead to better co-operation, development and legitimacy of the delivery process.

He (Harmse) further stated that the purpose of the health committees is to serve as a link between the community and the municipality. In this regard it is the responsibility of the committees to channel relevant information pertaining to health services to the community. The health committees were also established to provide the relevant health authorities with information pertaining to the needs experienced in the communities and to educate the community with regard to health issues. Therefore, from a departmental viewpoint, the committees were established to represent the health needs as

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[27] Legislation since 1994 has encouraged Municipalities to achieve greater community participation in terms of service provision (Interview with the head of the health department, Stellenbosch Municipality 31 August 2000).

experienced within the community. By having health committees, it was felt that services could better match service needs experienced in the communities. In addition to the head of the health department's comments, the respondents interviewed as representatives of the health committees also cited reasons for the establishment of the committees.

Mr Isaacs[28] for instance, cites complaints, from Cloetesville residents, about the dilapidated state of the clinic, unhygienic conditions and a lack of understanding service delivery as the main reasons for the establishment of the Cloetesville Health Committee (CHC). He explained that the complaints gave rise to a situation where it was felt that the public needed to be actively involved in the delivery of health services. In his opinion, the members of the health committee are also members of the community. This places them in a better position to identify and access health related needs within the community, which enables the committee to inform the health workers/ nurses of needs.

The general consensus amongst the respondents interviewed for the areas of Klapmuts, Jamestown and Kylemore was that their (committees') existence could be directly related to the lack of access to PHC services experienced in their communities. They were of the opinion that the absence of a clinic in their areas severely disadvantaged their communities, especially elderly people and people living on the surrounding farming areas, as did the degree of poverty that exists within the communities. Due to the socio economic circumstances prevalent within their communities, most members in these communities are seldom in a position to afford professional health services. Therefore, their function was to ensure that a clinic was constructed in their respective areas.

[28] Interview with the chairperson of the Cloetesville Health Committee, 8 January 2001

In this regard Mr Carolissen[29] stated: *"Die oorspronklike funksie was om 'n kliniek te bou. Verder het dit ook gegaan om insette te lewer oor waar die kliniek moes kom, hoe groot dit moet wees, watter tipe diens nodig is en na die kliniek gebou was, om in samewerking met die munisipaliteit te kyk na die tipe diens wat gelewer moet word sowel as die kwaliteit van die diens en laastens om terugvoering te gee aan die munisipaliteit in terme van hoe die gemeenskap oor die diens voel. Basies moes die komittee dus 'n kontak wees tussen* die *munisipaliteit en die gemeenskap."*

Mr Davidse[30] and Ms Fabriek[31] of the Jamestown and Klapmuts health committees, respectively, confirmed that the establishment of health committees partially resulted from a request from the health department and Mr Harmse, in particular, when the planning commenced for the clinic building projects in their areas.

4.4.3. (i) The selection of the committees

The interviews with the members of the health committees also revealed that different methods were used in the selection of the various committees. For instance, the Kylemore health committee is a representative structure, consisting of delegates that represent various organisations and interest groups within the community, as illustrated in Figure 3.

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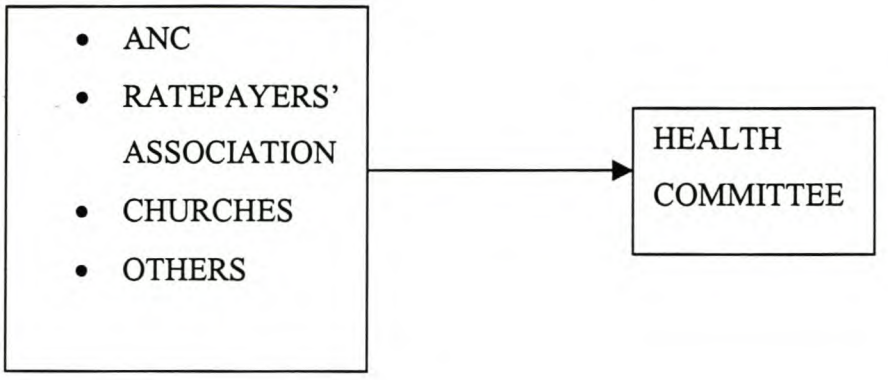
[29] The original function was to build a clinic. It further involved input concerning where the clinic had to be placed, how large it had to be, what type of services was required and, after the clinic was built, to cooperate with the Municipality to determine the type of service to be delivered and the quality of the service and, lastly, to provide feedback to the Municipality with regard to how the community experienced the service. Basically, the committee therefore had to provide a contact between the Municipality and the community (Interview with the member of the Kylemore health committee, 10 December 2000).

[30] Interview with the chairperson of the Jamestown Health Committee, 18 January 2001

[31] Interview with the member of the Klapmuts Health Committee, 08 February 2001

Figure 3: Composition of the Kylemore Health Committee



With the selection of the committee, each organisation was given the opportunity to nominate two delegates from their organisation to represent them. The onus is upon the delegates selected to the health committee to report back to their constituencies. In other words, the two delegates each from the various organisations are given the responsibility to report on decisions taken by the health committee. According to Carolissen, this method of representation ensures that the widest possible audience is involved.

In Cloetesville, Mr Isaacs stated that the health committee is selected on a yearly basis at the annual general meeting. The procedure followed is relatively straightforward. People are nominated to serve on the committee. Each community member on the committee is then given the opportunity by voting, to select members nominated to serve on the committee. A feature of these meetings is that they are not well attended.

In contrast to the above more open and transparent selection procedure, the health committee of Jamestown was not elected but rather appointed by the head of the health department. The reason for the appointment relates directly to the lack of co-operation (to be discussed later) that the health department experienced among the larger Jamestown community during the beginning stages of the planning for a clinic in the area. It is therefore, questionable whether this committee is a representative structure of the Jamestown

community although Mr Davidse is of the opinion that the committee has the approval of the community.

Another observation of interest in terms of the health committees, is that women account for most of the membership. With regard to the seven original members of the Klapmuts committee, Ms Fabriek indicated that six are women, Mr Carolissen pointed out that over seventy percent of the Kylemore committee are female. According to Mr Isaacs, the same trend is followed in Cloetesville. Only the Jamestown committee is dominated by men (nine males and two females) as pointed out by Mr Davidse. It can only be speculated that a possible reason could be related to the fact that women are more concerned with issues such as health that affect the immediate family and community.

From the above views it can be deduced that mechanisms were created (through the establishment of health committees) for communities to influence service delivery. The next section will try to establish the extent to which the committees have influenced service delivery in Stellenbosch.

4.4.4 The health department's approach to delivery

In response to the question whether everybody in Stellenbosch has access to PHC services, Harmse[32] commented that the seven municipal clinics provide the same comprehensive (both curative and preventative) range of health care services[33] free of charge. Mrs Weideman[34], (Manager for Clinic Services) and Mrs Coetsee[35], (Senior Nursing Sister in charge of the Cloetesville Clinic) confirmed this.

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[32] Interview, 29 August 2000

[33] The services provided at the clinics provide for both curative as well as preventative services. Of the most important services delivered include, family planning; pre-; as well post natal care, immunisation, counseling, nutrition, provision of essential drugs and medicine, health education, consultation services.

[34] Interview, 31 August 2000

[35] Interview, 31 August 2000

They stated that national legislation requires that every person within a radius of 5km should have access to a facility that provides primary health care services. The clinics are located strategically throughout the municipal area. Before 1995, Stellenbosch only had four clinics, as indicated earlier. This resulted in access problems for people living in the peripheral areas of town. In Mr Harmse's opinion the addition of the Kylemore and Jamestown clinics and extensive renovations to the Kayamandi and Klapmuts clinics have improved access considerably for the communities living in these areas.

In addition, the head stated that the health department has adopted a policy based on equality for all. Therefore every person is entitled to be treated in the same manner at the clinics. Mr Harmse further stated that the rationale for building most of the clinics in disadvantaged areas has to do with the fact that middle to high income earners, who in the case of Stellenbosch are mostly white, can make use of professional services. Clinics are built in areas where there is a need in terms of people's socio-economic conditions. This does not imply that the more affluent sectors in Stellenbosch cannot make use of these facilities. However, the service specifically targets sectors in society that cannot afford professional health services. Unfortunately, in Mrs Weideman's opinion those that are able to afford professional services still exploit the PHC service provided.

Legislation also requires a ratio of 1:30/40 patients (implying that each nurse should, on average, attend to 30-40 patients per day). In this regard Harmse stated that the department has accomplished this target. The size of the personnel at the clinics is also proportional to the population size of the various areas. For instance, Cloetesville and Kayamandi have more personnel than the other areas, because of the larger population counts in these areas.

According to Mrs Coetsee and Mrs Weideman, the nurses are relatively well trained and the department does provide additional staff training. Training also is not limited to the nursing profession. In this instance the personnel are compelled to attend a training programme called 'free to grow' which deals

with how to treat clients of service delivery. The programme also focuses on personal growth of employees.

The respondents from the health committees that were interviewed, commented that they are relatively satisfied with the health department's efforts to make PHC services accessible to their communities. Ms Fabriek for instance stated that the old clinic (before renovations) only delivered pre- and postnatal as well as family planning services. The implications of the limited services available to the Klapmuts community were that the majority of the community had to travel to the nearest town (Paarl) to access medical services. This severely disadvantaged the elderly people in the community as well as those that were not able to afford the transport. In Fabriek's opinion the upgraded facility with its broader range of services has therefore improved access considerably.

Mr Davidse was also of the opinion that the opening of the Jamestown clinic has improved access to health services, especially for elderly people and people from the surrounding farming areas.

Although Carolissen shared the above views, he is of the opinion that more can be done to make clinic services even more accessible, especially if the health departments reconsider the clinic hours. Services provided at the clinics are usually available from between eight and nine o'clock in the morning until four o'clock in the afternoon, from Mondays to Fridays. For Carolissen this potentially excludes some members in the community that, due to work commitments, are not able to frequent the clinic during this period. The clinics are also closed on weekends, thereby still excluding working people. Thus Carolissen feels that: *"Die behoefte van die gemeenskap moet gebou word rondom die kliniek, instede dat die behoeftes in die gemeenskap gebou word rondom die reëls en regulasies van die burokrasie."*[36] In other words the clinics should be more flexible with regard to

[36] The needs of the community should be established around the clinic, instead of the needs in the community being built around the rules and regulations of the burocracy.

the needs experienced in the community instead of always being rigid and unbendable.

4.4.5 Community participation in the infrastructure projects

As previously mentioned, Harmse commented that the health department's approach to service delivery allows communities to influence the delivery process through the health committees. In this regard the health committees have fulfilled a prominent role in the delivery of the health infrastructure projects. The committees were consulted and participated extensively before, and after the commencement of the infrastructure projects. In Harmse's view the committees were instrumental in assessing the needs of the community, with regard to what type of services they wanted, and where they wanted it. The committees were also involved in the planning as well as decision-making processes. The interviews with the respondents of the various health committees indicated that they were given the opportunity to participate in the infrastructure projects.

According to Mr Carolissen, planning for a clinic in Kylemore started in 1992. During this period, the WCRSC identified the need for a clinic in the area and according to Carolissen, the idea of community input was theirs (WCRSC). He cited several possible factors that might have influenced why the WCRSC wanted communities to partake in the building of the clinic. In this regard he states: *"Op die stadium was daar op plaaslike regering vlak, wat ons nou noem, die 'discredit bestuurskomitee' wat nie werklik die gemeenskap se belange verteenwoordig het nie en binne die gemeenskap self was daar ander drukgroepe soos die belastingbetalersvereniging wat 'n sterk 'lobby' gehad het asook 'n groot basis en so het die WCRSC miskien besef dat dit 'n goeie idee sou wees om gemeenskapsinsette te kry in lyn met die demokratiese denkrigting van die dag."*[37] Carolissen was also of the opinion

[37] In local government, at that stage, there was the 'discredited Management Committee' that did not represent the interest of the community. In the community, there were other pressure groups such as the Ratepayers Association, which had a strong lobby and the support of the community. This might have

that a further contributing factor could be related to the fact that there was a Dr Newman in the Ratepayers Association[38] who had strong ties with the WCRSC and they 'valued' his opinion in particular.

In the project phases that followed, the Kylemore Health Committee was involved in the planning and in the type of services that they wanted the clinic to deliver. Initially, the WCRSC identified a sight for the project and the idea was to construct a pre-fabricated building (with the limited financial resources available at the time) that would be utilised as a clinic. This was not acceptable to the committee. The committee was not satisfied with the site allocated for the clinic, citing that it was too small. Secondly, the committee was not satisfied with the original plans for the facility. Instead, the health committee wanted a facility that would provide for both curative, as well as preventative services, in other words a facility that would deliver a comprehensive range of quality services. After extensive consultation between the committee and the WCRSC, the committee became responsible for identifying the new site that would be appropriate for the clinic and gave input into the revised final plans of the clinic building. The committee also played a significant role in the appointment of the project consultant.

Although planning started as early as 1992, the clinic was only completed in 1997. During this period (in 1995) the satellite town of Kylemore became the responsibility of Stellenbosch Municipality and overseeing of the building of a clinic, the responsibility of the health department. Most of the planning for the clinic had been done when the WCRSC ceased to be responsible for Kylemore. However, Mr.Carolissen indicated that, when Stellenbosch Municipality took responsibility for Kylemore, the activities of the health committee did not cease. In fact, in his opinion the health committee was

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led to the decision of the WCRSC to allow for input from the community, in line with the democratic process at the time.

given a more 'sensitive ear' at Stellenbosch municipality as the need for a clinic in Kylemore grew. During this period, additional funding was also obtained from the provincial RDP fund. Members of the health committee were also part of the delegation that negotiated with provincial authorities for additional funding. The end result was that Kylemore eventually got its clinic, which delivers a more comprehensive service than was initially planned.

In the case of Jamestown and Klapmuts, the committee members pointed out that they fulfilled a prominent role in overseeing the building of the clinic. For instance, the committee gave input with regard to the appointment of the project consultant, the planning of the facility, as well as decision making. They also had input regarding the plans for the facility.

In addition to the communities giving input during the initial planning and decision-making phases of the projects, Harmse stated that another feature during the implementation was the employment of labour from the respective communities. The respondents representing the health committees confirmed that local labour was used. In this instance, Mr Davidse pointed out that, with the construction of the Jamestown clinic, the committee insisted that people from the local community be employed in the construction of the clinic. Carolissen of Kylemore agreed and stated: *"Die kontrakteurs het uit die vallei gekom en dan natuurlik moes hy (kontrakteur) gebruik maak van die plaaslike arbeid. Dit is ook 'n pertinente riglyn wat gekoppel word aan presidensiële bouprojekte in die land".*[39] Ms Fabriek also pointed out that members of the Klapmuts community were involved in the upgrading of the clinic. The committee was also responsible for providing the building plans of the clinic.

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[38] According to Mr. Carolissen, Dr. Newman had extensive knowledge of health services, due to the fact that he had considerable experience, having worked in clinics as well as hospitals in the Cape Peninsula.

[39] The contractor was from the valley and in turn he had to employ labour from the local Kylemore community. This is also a guideline attached to presidential building projects in South Africa.

In addition to participating in the infrastructure projects, members of the health committees said that they were relatively satisfied with the information provided by the department with regard to the projects. In other words, the consensus was that, when the infrastructure projects were undertaken channels of communication between the committees and the health department were open.

Harmse also pointed out that participation by the health committees was not limited to the infrastructure projects. Under his leadership a health forum was established, consisting of representatives from the health department and two delegates from each health committee (health committee chairpersons and one additional member from each committee). According to Harmse, the purpose of this forum was to inform and update the committees regarding issues relating to PHC services. Meetings were, thus, mostly used to provide the committees with information pertaining to the delivery of PHC services. The delegates representing the committees were also given the opportunity to discuss matters relating to health issues that were of concern to them. He further stated that the health committees were responsible for communicating the information to their respected constituencies. It was therefore the responsibility of the committees to supply the rest of the community with information.

Mr Davidse indicated that topics that were discussed at these meetings were related to changes in health care; the administrative side of health care, as well as the financial side, was discussed. The extent to which these committees could influence decisions taken at these meetings could not be detected. However, Davidse pointed out that: *"...mens moet wel onthou dat jy 'n gesondheidskomitee het, maar jy het nie soveel mag om te sê nie omrede jy nie direk verbonde is tot die administratiewe deel nie en ook nie soveel kennis het nie. So jy is in 'n mate maar net daar omdat jy daar moet wees"*[40].

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[40] You can have a health committee but this does not necessarily mean that you have the power to influence decisions taken, because you are not directly involved in the administrative side and also due to a lack of knowledge. Therefore you are only there because you need to be there.

Therefore it is doubtful whether the community-based health committees had influence at the forum.

Unfortunately, these meetings abruptly came to an end. Most members interviewed cited the December 2000 elections as a possible reason for the lack of interest. At the time it was uncertain whether the municipality would continue to be responsible for the provision of the PHC function or whether it would be transferred to the 'new' district municipalities that were planned after the local government elections of 2000. In this regard Davidse stated: *"Die onsekerheid oor wie verantwoordelik sou wees vir die gesondheidsfunksie het dalk daartoe gelei dat die entoesiasme wat bestaan het oor deelname vanaf gemeenskapkant deur middel van die kommittees afgeneem het".*[41] Although an attempt was made to establish a forum, it was not sustainable.

4.4.6 Lack of co-operation

Despite the health department's attempt to involve the health committees in the delivery process (the infrastructure projects and the health forum that were established), Harmse pointed out that relations between the health committees and the health department were not always good. In his opinion, some of the committees are largely dysfunctional and they are sometimes disruptive regarding service delivery. In his view, some of the community-based health committees are highly politicised. The implications of politicising are a lack of co-operation, understanding and trust between the committees and health officials. Instead of **supporting** *[my emphasis]* decisions taken by the department, the committees usually want to derail every decision the health department takes.

Examples would be the Kayamandi Health Committee who wants to sit in on meetings to appoint staff at the clinics, which in Harmse's view involve an administrative function, which is not the responsibility of the health

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[41] The uncertainty as to what authority would be responsible for the health function after the 2000 local government elections, might have led to a decline in the enthusiasm, relating to participation of the community-based health committees that existed.

committees. In the case of Jamestown, certain members in the community were opposed to the site located for the construction of the clinic[42]. This considerably delayed the project. In the case of Klapmuts, the committee wanted their meetings to be conducted at the clinic in the evenings, which, according to Harmse, is not always feasible, seeing that schedule five medicines are kept in the clinic. Although these claims might sound petty, it is also the reality at the local level. Issues such as these can have serious consequences. Most of these claims were confirmed by members of the various health committees in the areas mentioned above.

In view of the above claims, Davidse confirmed that, with regard to the building of the Jamestown clinic, there were certain members within the community who were opposed to the site allocated for the clinic. Reasons given at the time were that it would devalue the properties in the area. This also led to the establishment of the health committee for Jamestown.

Ms Fabriek indicated that the reason for holding meetings in the clinic relates to the fact that Klapmuts does not have any suitable community halls. The primary school in Klapmuts is the only suitable venue for meetings. Unfortunately there are so many community-based committees in Klapmuts, that everybody uses the school. She also stated that the idea of holding the meetings at the clinic came from Harmse.

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[42] The establishment of the Jamestown health committee is as a direct result of the difficulties the health department experienced in convincing the Jamestown community that the site allocated was the best alternative. Certain members of the community wanted the facility away from the residential area, siting that a clinic in the area would devalue their properties. According to Harmse the problem with the site arose when municipal officials from the planning and engineering departments informed members of the community that a site on the outskirts was available for the building of the clinic. Harmse explained that these officials unfortunately, did not know at the time that the site was on proclaimed provincial ground and that it would be impossible to construct a clinic there. In order to proceed with the project, Harmse requested that a health committee be established for Jamestown, whereby co-operation could be achieved.

Mr Isaacs commented that the lack of co-operation between the committees and the health department could be related to the rigid and bureaucratic attitudes that still persist within the health department. In his view, the health department wants to dictate to the health committees what they can and cannot do. He said: *"Ek gaan nie name noem nie, maar toe ons (Cloetesville Health Committee) ons eie grondwet wou opstel en aan die gang sit toe wou die munisipaliteit se gesondheidsdepartement voorskryf hoe ons die grondwet moes opstel. Dit doen jy mos nie. Die komitee het by wyse van eie inisiatief self riglyne gekry soos byvoorbeeld die 'Ottawa-charter' om by die tema te bly hou by die daarstelling van PHC of anders gestel, om gesondheidsorg op die vlak te bring sodat die gewone man in die straat kan verstaan."*

Although relations between the committees and the health department have not always been good, the consensus amongst the members of the health committees is that relations between the committees and the personnel of the clinics are reasonably good.

4.4.7 Concerns

Despite fulfilling a prominent role in the delivery of infrastructure in their respected areas, the general consensus among the members of the various health committees interviewed was that participation or input from the health committees in the delivery process has not been that forthcoming since the completion of the clinics.

The consensus amongst the respondents for the committees is that they have little to no influence with regard to services delivered or quality thereof. Carolissen, for instance, feels that nothing is being done to ask the community how they feel about the services, how it can be improved, how the community experiences the delivery, whether they understand it. For Carolissen the lack of functionality implies that the committees have no influence over the type of service delivered. In other words, neither the health department nor the clinics have mechanisms whereby the committee or the community can evaluate the quality of the services being delivered. Additionally, he stated that*: "die diens is so goed of sleg soos die gemeenskap se dit is".* Implying that services can

be delivered efficiently and effectively, but if it does not carry the approval and satisfaction of the community, it loses community support.

The consequences of the lack of interest and involvement resulted in the committees becoming non-functional. Carolissen, for instance, stated that the committee currently only exists in name. Fabriek and Davidse expressed the same sentiments.

Although the members of the health committees are of opinion the that the general level of service quality is good, a common criticism against the health department's approach has been the lack of educational programmes pertaining to health issues and problems. Carolissen feels that the clinics and their operations are under-utilised. He stated: *"Natuurlik dink ek dat die kliniek 'n meer agressiewe rol moet speel in die totale diensleweringsopset want die transformasie van die gemeenskap verg dat 'n gebou wat 'n 'community asset' moet wees na 16h00 in die middag nie nog toestaan nie. Daar is geen programme vir vaders, kinders asook ouers en dienste meer nie. Dis die enigste munisipale gebou in die omgewing. My idee sou wees dat die kliniek 'n 'multi-purpose' identiteit moet aanneem. Dit word slegs vir 'n bepaalde tyd gebruik. Die res van die tyd is dit 'n wit-olifantjie. Die kliniek kan ook dien om gesondheidsprogramme aan te bied. Tans byvoorbeeld is daar nie 'n vigsprogram nie, wat 'n burning issue is op die oomblik."*[43]

According to Fabriek, there is an urgent need for educational programmes relating to health issues in Klapmuts. She stated that many people in the community are illiterate. Many children in the community are undernourished.

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[43] Naturally, the clinic should have played a more agressive role in the service delivery process. Tranformation of the community requires that a 'community asset' cannot be only used for a limited time and the rest of the time it is closed. After four o'clock there are no programmes for fathers, children and adults and no services. It is the only municipal building in the area. Therefore it should take on a multi-purpose identity. The clinic can also serve as a facility that provides health educational programmes, for example, there are no aids programme in Kylemore, currently, which is a burning issue.

Problems relating to health are further exacerbated by the high rate of Tuberculosis (TB.).

Davidse is of the opinion that many people in the Jamestown community are not knowledgeable about health issues. In this regard, he feels that education can prevent many problems within the community. Examples here are the lack of a sense of responsibility and ignorance of teenagers and teen pregnancies.

In response to the criticism, Mrs Weideman (Manager of Nursing Services) pointed out that the health department has two 'councilors' that regularly visit schools in the vicinity. The purpose of the visits is to increase people's (especially the youth) awareness of health issues. In addition the clinics do provide educational and consultation services. She also admitted that the services provided are not sufficient and that more needs to be done to deal with health issues in Stellenbosch.

Despite the department's lack of an educational approach, Harmse feels that it is the responsibility of community-based institutions such as schools, churches and groups such as the health committees to fulfil the role of educator. In his opinion education starts in the community. He further argues that to address health problems and issues requires a more integrated and holistic approach, instead of looking at it sectorally. For instance, health issues cannot be separated from the socio-economic environment. Poor housing and service infrastructure are also responsible for health problems. Therefore, he argues that health education would not necessarily improve the health status of a community unless it is accompanied by an integrated process to change the quality of the living environment.

4.4.8 Action from the health committees

Despite the general view of the respondents from the health committees that they were non-functional regarding input into the services delivered at the

clinics, initiatives from some of the committees to address health related problems as experienced in their communities were launched.

Ms Fabriek, for instance, stated that the health committee in collaboration with the Klapmuts clinic has launched a feeding scheme to alleviate the problem of undernourished children in Klapmuts. Fabriek commented that the committee is responsible for the preparation of the food. To support the scheme, the committee is responsible for lobbying surrounding businesses for donations. The clinic staff is responsible for the identification of malnourished children. These children are then referred to the committee. Currently, the feeding scheme provides for two meals per day at the school for children who are referred from the clinic. According to Ms Fabriek the long-term plans are to extend the feeding scheme. In her opinion many other malnourished children in Klapmuts are not necessarily referred to the committee by the clinic.

Besides organising the feeding scheme, the committee, with the assistance of the clinic personnel, has also been responsible for the training of health volunteers in the community. For instance, to deal with the alarming Tuberculosis (TB.) rate, volunteers have been given DOTS training (training in the identification of the various medicines for TB. patients). According to Fabriek, TB. presents a curable problem. However, the level of literacy or awareness amongst TB. patients, are relatively low. If volunteers were not trained to address the problem, TB. patients would simply not bother to take their medicine.

In Isaacs' opinion, the lack of understanding service delivery amongst the Cloetesville residents has necessitated that the health committees play an educational role. He stated that : *"Opvoeding, opvoeding en nogmaals opvoeding is die mees belankrikste funksie van die gesondheidskomitee in Cloetesville".*[44] To raise the level of health awareness among Cloetesville residents, the committee has adopted a strategy whereby public meetings are

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[44] Education, education and again education is the most important fucntion of the Cloetesville Health Committee.

called. During these meetings health topics are raised and discussed. Pamphlets aimed at increasing people's awareness surrounding topics discussed in the meetings are then distributed in the community. For instance, during winter, illness usually associated with this season, such as colds and flu, are discussed and the pamphlets issued contain information on how to prevent such illnesses. Isaacs pointed out that despite the efforts of the health committee, a worrying feature of the meetings is the lack of interest and poor attendance of these meetings by the general public. As in the case of Klapmuts, the committee, in collaboration with a health NGO (Progressive Primary Health Care) is responsible for DOTS training for volunteers.

In summarising this discussion, it can be stated that the health committees did attempt to address health problems within their communities.

4.4.9 General

An issue that was not sufficiently addressed relates to the question of whether it is worthwhile to place such a great deal of emphasis on community participation as the basis for community empowerment in the delivery process. Is community participation not perhaps an obstacle to efficient and effective delivery? For instance, the preceding overview clearly illustrated that many of the projects were delayed because of a lack of co-operation between the health authorities and the community-based health committees. The answer to the above questions is that it is not always easy to engage communities in service delivery, especially where tension and animosity on account of past injustices still prevail. However, it is important for people to participate for the mere fact that, without such mechanisms, the service delivered would simply not be focussed on issues surrounding service quality and what the people are rightfully entitled to. It boils down to choices between an efficient delivery system that is not effective or an effective, quality driven system that is sustainable without necessarily being efficient.

The general impression of the respondents interviewed reveals that very few people in the communities are willing to participate in community initiatives. Communities are apathetic and they are not willing to engage in projects or

community activities that could have a positive impact on the overall quality of their lives. People expect facilities and services but are not willing to engage in activities that could promote these. It was also noted during the interviews that the members of the health committees are reasonably well informed regarding the PHC practices in general and the fact that municipalities need to create avenues for community participation.

The following section will assess the delivery of health services in Stellenbosch in terms of the proposed operational framework for community empowerment.

4.5 Assessment

The purpose of this assessment is to analyse the approaches to service delivery as adopted by the health department in relation to the proposed operational framework.

In the operational framework as outlined in Chapter 3, it was suggested that, if enablers (health department) want to empower disadvantaged communities through service delivery, the following principles should be adopted in their (enablers') approach to delivery: Firstly, enablers should ensure that disadvantaged communities have access to services and service infrastructure, if required. Discrimination as an impediment to access should also be removed. Secondly, the beneficiary community should be able to participate in the delivery process, be it in terms of infrastructure delivery or in the development of services. It was suggested that beneficiaries should participate in identifying service needs, help take decisions on how to satisfy the needs in the planning and implementation phases, and that the enabler should create mechanisms for community participation and input in evaluating the quality of the delivered service. Thirdly, it was suggested that mechanisms should be created for the regular channelling of information between the enabler and the beneficiaries of services. Fourthly, the enabler should develop awareness regarding the importance of the services and the potential benefits. In other words, it should educate citizens with regard to the services and the delivery process. Lastly, skills pertaining to the services should also

be taught to the community. The potential benefit of imparting skills to the community fosters greater self-reliance and independence. These factors will be discussed in relation to the health department's approach.

(i) Access

On the basis of the views expressed by the respondents and the evidence presented in the descriptive overview above, it can be stated that the health department has considerably improved access to PHC services in the disadvantaged areas of Stellenbosch. Since 1995, the health department has constructed two new clinics and two existing ones were substantially upgraded to improve access. Three of these projects were undertaken in the peripheral areas.

The proliferation of clinics in the peripheral areas of Stellenbosch has ensured that distance as a constraint to access has been removed. The services provided at the clinics are free, which have removed financial constraints on poor people, who would not have been in a position to access health services. Another positive feature relating to clinic services is that it is open to anyone who wants to make use of the services provided. In other words, discrimination as an impediment to access has also been removed.

An issue that needs to be addressed in terms of access is the possibility of extending clinic hours. Consideration should be given to the problem of persons who are not able to access the clinic services during the prescribed clinic hours. If the municipality is committed to providing quality service, it becomes necessary to re-evaluate the possibility of extending hours. This would require extra financial resources as well as personnel, which is not always feasible, considering the already under-capacity in terms of staff and financial viability of municipalities in general in South Africa. Careful consideration should be given to this proposal.

Apart from this problem, it can be stated that the health department has succeeded in making PHC services more accessible to communities in Stellenbosch with the additional clinics that were constructed.

(ii) Community Participation

In terms of this principle, the views expressed by the respondents in this study indicated that the health department did attempt to introduce an element of community input and participation in the delivery process during the process of making services accessible The community-based health committees that were established bear testimony to this fact. It is important to ascertain the extent to which the committees were allowed to influence the delivery process. The reader should remember that it was mentioned in the operational framework that there are various levels of participation, which range from token participation at the lower levels to partnerships at the highest level of participation. This will give an indication of the health department's commitment to community participate in the delivery process.

The members of the various health committees interviewed indicated that they were given the opportunity to influence the planning and decision-making processes during the construction of the clinics. In their view, the committees, in co-operation with the health department, gave input regarding the type of facility they wanted, the building plans of the facility, as well as the appointment of the project consultant and various other related activities.

Another feature was the employment of local labour from the various communities. In other words, skills available in the local community were utilised. It can therefore be deduced that the health committees participated at various stages in the delivery of the clinic, from the identification of the need for a clinic until the completion of the structures. Thus it can be assumed that the infrastructure projects (clinics) were undertaken **with** the community-based health committees rather than **for** the community. This is a key feature of an empowerment process. **Plan and do with people rather than for people.** It can therefore, be stated, that the health department genuinely attempted to get communities to influence the delivery of infrastructure in their respected areas through the health committees.

In contrast to the active participatory role that the committees fulfilled during the delivery of clinic infrastructure, a concern identified by members of the

various health committees related to the fact that, since the completion of the clinics, contact between the health department and the committees has not been sufficient. The fact that the respondents from the health committees indicated that they are currently inactive and only exist in name implies that they have no input or influence with regard to the quality of the service delivered.

A criticism that was raised against the department's approach is the absence of an evaluation mechanism. However, despite attempts to establish a health forum, the active role that the health committees played during the infrastructure projects has come to an end since the completion of the projects. In other words, co-operation and **input** from the side of the community with regard to the delivery process have not been sustainable. Therefore the health department's commitment to community participation as showed during the infrastructure projects can be questioned, considering the limited influence the committees have regarding the development and delivery of services. The head of the health department also stated that the role of the health committee is to **support** decisions made by the department. This could imply that he views participation as a form of presenting information to the community instead of participation whereby the health committee has the opportunity to influence decisions concerning health services. The sincerity of the health department in allowing communities to influence the delivery of PHC services is therefore questionable.

(iii) Educational Approach

Footnote 12 of this study indicated that the application and importance of each empowerment principle would vary from service to service. Education and health education, in particular, is critical to an effective PHC system, as indicated earlier in this chapter. Health education reduces dependency and encourages self-reliance. If the community has the knowledge that pertains to particular services, measures can be introduced whereby the community themselves can take responsibility for the delivery of services.

The overwhelming majority of respondents regarded the lack of health education programmes at the clinics as one of the major criticisms against the health department's approach to delivery. It must be borne in mind that the clinics do provide health education. However, these services are aimed at the individual users and are not necessarily presented in a community context.

(iv) Information Flow

In the descriptive overview, there is evidence to suggest that the health department did attempt to create a communication channel between the communities and the department. Here, again, the health committees were to serve in this function. The general view expressed by the respondents was that information and communication was relatively good and open during the infrastructure projects. The health forum that was established is another example of the health department's attempt to create an open flow of information between the committees and the department. The extent of the health committees' influence at the health forum could not be determined. It could also not be determined if the information pertaining to PHC services that was provided to the delegates were ever channelled to the community by the representatives. The fact that the forum and its activities have stagnated, indicates that the communication channel that was created has not been sustainable.

(v) Skills Development

Did the department train or make use of skills existing in the communities? Earlier it was indicated that labour from the respective communities was utilised for the infrastructure projects. A second aspect of relevance is the fact that the clinic personnel have assisted the health committees in providing training for volunteers, especially DOTS training to care for TB. patients. Unfortunately involvement from the clinics has been limited to these activities.

In summary, it can be stated that most of the empowerment principles as proposed in Chapter 3 have been introduced in the delivery process. Regarding empowerment, the health department focused on the lack of health infrastructure in disadvantaged areas and there was consensus amongst the

respondents that the clinics did improve access considerably. Communities, through the establishment of the health committees, did have the opportunity to influence the delivery of the infrastructure projects. However, in terms of the development of services and the evaluation of services, community input has been limited and non-existent, to a certain extent. The health department did also attempt to introduce a health forum to serve as a communication channel between the department and the community. Unfortunately, this forum was not sustainable. A criticism against the department has been the lack of an educational approach, especially in relation to health education in a community context. Lastly, labour from the respected communities was utilised in the construction of the clinics. The department did also assist in providing DOTS training to volunteers. In this regard, an educational role was fulfilled.

In conclusion it can be stated that the expected result (the ideal outcome) for community empowerment through PHC services is that the community is in a position to be able to provide the services themselves. The community should have gained knowledge on how to prevent and overcome major diseases and infections. Actions to address health related issues must also stem from the community. The descriptive overview indicated that some of the communities did launch their own initiatives to address health-related problems in their communities. Although (in my opinion) the communities are not yet in a position to deliver services themselves (ideal outcome) the health department definitely created the foundation for communities/ health committees to fulfil a prominent role in the delivery of PHC services in future.

Chapter Five
Summary and Conclusion

5.1 Introduction

This chapter is divided into four sections. Section 5.2 will summarise the previous chapters. Based on the findings and assessment in Chapter 4, section 5.3 will suggest recommendations to be implemented by the health department. Section 5.4 will present an overview of topics in the field of local government and development that might be useful for future research. Section 5.5 will conclude the study.

5.2 Summary

Chapter 1 of this study argued that, in terms of policy directives such as the Reconstruction and Development Programme (1994), the Constitution of the Republic of South Africa (1996), The White Paper on Local Government (1998) and the Municipal Systems Act (Act 32 of 2000), municipalities in South Africa need to perform two broad categories of functions. They should firstly be responsible for providing services as assigned by legislation. The second function requires municipalities to promote social and economic development in their jurisdictional areas. Therefore, municipalities should perform a general development role. It was argued that the objective of a development orientation for local authorities is to empower communities in their jurisdictional areas, as outlined in the legislation mentioned above. The Municipal Systems Act in particular emphasises the development and empowerment of communities that were historically disadvantaged. It was also stated that the development role assigned to local government is relatively new. This chapter also suggested that, if municipalities wanted to fulfil the development role successfully, municipalities should move away from the bureaucratic, top-down, rigid approach that has come to be synonoumous with local governance in South Africa.

Unfortunately the above policy directives do not provide for concrete strategies that can be utilised to empower previously disadvantaged

communities. They (the policy directives) only refer to the roles assigned to local government as possible catalyst for empowerment, but do not provide a concrete strategy that can be employed by municipalities. Therefore this study, as its primary objective, proposed an operational framework for community empowerment and how empowerment can be obtained through the process of municipal service delivery.

Chapter 2 of this study presented a discussion of the concept community empowerment from a development perspective. It was argued that the extensive use of the term has led to conceptual confusion and that the context within which it is applied is detrimental to its meaning. It is context specific. In a development context, it was argued that, the rise of the concept empowerment could be related to the failure of purely technocratic growth strategies that did not trickle down to the poor as it was thought it would. Empowerment in this context is seen as a means for underdeveloped and disadvantaged sectors in society to gain power and respect and challenge established power positions. It was suggested that empowerment could only proceed when formerly oppressed people participated and were responsible for their own development, with the assistance of an outside enabler. This chapter also looked at the role that enablers such as municipalities must fulfil if they ought to empower disadvantage communities. In particular it was suggested that enablers should of necessity experience a reduction in their decision-making power in favour of the intended beneficiaries of empowerment. In other words, decisions cannot be made for people but rather with people.

Chapter 2 also indicated that there are similarities between the characteristics of community empowerment and the principles of transformed service delivery as outlined in the 'Batho Pele' principles discussed in chapter 1.

Chapter 3 proposed a possible operational framework for how municipalities could contribute to empowering communities through the provision of services and service infrastructure. It suggested that, if municipalities are committed to empower disadvantaged communities in their jurisdictional areas, the

principles of the proposed operational framework should be implemented in the service delivery process. These principles include, inter alia: making services and service infrastructure **accessible** to disadvantaged communities, enabling communities to **participate** in the service delivery process (both in infrastructure delivery as well as the development of services), making use of **human resources** from the community in which service projects are undertaken, ensuring that **skills** pertaining to the service are **learned/gained** and that the people understand the delivery process, **information** must be easily accessible in order to promote openness and transparency.

If the purpose of service delivery is to empower communities, participation by beneficiary communities moves beyond purely consulting communities with regard to the delivery process and communities become part of the whole process, from needs identification, to planning, as well as decision making regarding services and evaluating the quality of the services provided. Secondly, an approach should be adopted that educates communities about services and the delivery process. Studies have shown that communities do not always understand why services are delivered and, in turn, why they should pay for it. Education can also contribute to sustainable delivery. Information pertaining to services should be communicated to the intended beneficiary community on a regular basis. People need to be informed and kept up to date about performance indicators, how money is allocated, and about service projects to be undertaken.

Chapter 4 evaluated the health department's approach to the delivery of PHC services and service infrastructure. The purpose of the evaluation was to determine the extent to which the approach encompasses the principles of the proposed operational framework for community empowerment. Findings based on the descriptive overview of the health department's approach to service delivery indicated that most of the proposed principles as outlined in the operational framework have been implemented to a certain extent. There are areas that can still be improved upon. Based on the findings in Chapter 4, the following section will make some recommendations that could increase

the potential of the health department to make community empowerment a reality.

5.3 Recommendations for delivery

Based on the evaluation and assessment in Chapter 4, it is suggested that, if the health department is committed to empowering disadvantaged communities in Stellenbosch, cognisance should to be taken of the following recommendations.

- *Reviving the health committees and health forum*

The above research has indicated that the health committees, as representatives of the various communities, have made an impact during the planning of the clinics. Unfortunately, after completion of these health care facilities, most of these committees have become non-functional. It is suggested that the health committees should be revived because they provide an indispensable link between the health department, the clinics and the community in the sense that it can identify health needs within the community and thereby bring problems to the attention of the relevant authority.

- *Improve accessibility*

If the health department of the Stellenbosch Municipality is serious about promoting services that take cognisance of the needs of people and place people first, the issue around accessibility, especially in terms of clinic hours, needs to be re-evaluated. It is suggested that clinic hours either be extended or at least be accessible for a couple of hours on a weekend. Consensus in this regard should be obtained from the community, through the health committees and in collaboration with the health department.

- *Promote health education.*

Currently, health education and counselling is limited to the clinics. Besides the limited counselling at the clinics, little else is done to promote health education at community level. Exposure to health education can improve awareness of health issues and thereby decrease or prevent diseases. This

function should be delegated to the committees, in collaboration with the health authorities. This can be done by providing regular workshops and training sessions to members within the health committees, as well as by training volunteers. Other types of health-related education should be the responsibility of the health committees, with technical expertise provided by the clinic staff, and the health department. The potential impact of these community initiatives should be evaluated on an annual basis.

- *Evaluating service delivery*

No process is complete if it does not have an evaluation component. In the case of health service delivery, there is as a clear lack of evaluation components to ascertain the level of customer satisfaction with the services and service infrastructure. Currently, there is no concrete mechanism to evaluate the quality of service delivery and the potential impact that delivery has on communities. It is suggested that evaluation strategies be sought jointly between the health department and the health committees. It is recommended that surveys be conducted on an annual basis. It is pertinent that the views of the people should be known in order to improve service delivery and work on areas that might be needed to be improved upon.

- *Continues flow of information*

Information regarding service quality should be more accessible to the public.

5.4 Topics for future research

With the many challenges facing democratic local government in South Africa, it is imperative that continued research be carried out in this arena. The topics that will be suggested were chosen with specific emphasis on relevance and their contemporary nature with regard to the grassroots level of governance in South Africa. The following topics might provide useful future research:

(i) Community empowerment through outsourcing municipal services

Research should focus on the various options whereby community-based organisations or communities in disadvantaged areas can be utilised to

deliver services on a contractual basis for the local authority/municipality. The potential benefits include the possibility of the creation of employment opportunities, community capacity building and empowering of communities in the process. More debate and research is required.

(ii) The IDP process in Stellenbosch: A case study

Municipalities in South Africa have been mandated by legislation to prepare short- and long-term development plans for their respective jurisdictional areas. This process has also become commonly known as integrated development planning or the IDP process. One of the objectives of IDP is to allow as many stakeholders as possible, be it CBOs, NGOs, businesses, and the general public and disadvantaged communities to participate in the planning of the municipal area. This is also a potential mechanism for empowering previously disadvantaged communities to influence decisions relating to future development initiatives. However, at the end of the initial IDP process in Stellenbosch, the previously disadvantaged community of Kayamandi indicated that they did not have any real influence to affect decisions taken. It would be interesting to explore **why** they have this opinion.

(iii) The current study on *'community empowerment through municipal service delivery'* should be explored further. It is suggested that emphasis should be placed on a quantitative approach, for example survey research, to establish the views of the general public regarding service delivery and the role the public play in the delivery process.

5.5 Concluding remarks

Many people do not realise or understand the significant role local government is playing in order to consolidate South Africa's young, and still fragile, democracy. Governance at local level is where ordinary people have an opportunity to influence aspects affecting them on a daily basis. However, the responsibility is on the enablers (municipalities) to create and allow the necessary conditions for communities to participate in the affairs of local government. It must be remembered that, if the objective of service delivery is to empower communities, then participation does not mean merely consulting

communities on predetermined delivery plans or service projects, but it involves participation whereby communities are part in the decision-making processes to determine development plans. Therefore, genuine participation is participation that builds the capacity of communities in a way that could lead to their (the community's) empowerment. Empowered communities will not be the result of an event, action or happening. It is about gradual change, consisting of multiple actions such as learning and the gaining of skills to increase the capacity of communities to become self-reliant. The success of empowering communities will largely depend on the commitment of the enabling institution. If the enabling institution does not have the commitment and willpower, community empowerment will not become a reality.

In conclusion, it is sincerely hoped that this study will contribute to debate on critical issues and challenges faced by democratic, developmental local government in South Africa. Without debate accompanied by action, the initial freedom experienced by millions for the first time in 1994, will not be sustainable.

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Mr Isaacs, Member of the Cloetesville Health Committee, 8 January 2001.

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