A DISTRICT HEALTH SYSTEM FOR KHAYELITSHA

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Assignment presented in partial fulfilment of the requirements for the degree of

Master in Public Administration (MPA)

at the School of Public Management and Planning

at the University of Stellenbosch

MARCH 2000

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DECLARATION

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

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SUMMARY

Sharp divisions featured between curative and preventative health care in the Public Health Services of South Africa before the democratisation process. There was fragmentation in authority structures and inequalities between urban and rural areas as well as along racial lines. This resulted in a situation where there was duplication and inequality in the distribution of resources amongst the different levels of health care which led to costly inefficient and ineffective health services.

The introduction of the White Paper Towards the Transformation of Health System in South Africa in 1997, aims at the restructuring of health services towards a unified health system which is capable of delivering quality health care to all in a caring environment. The District Health System (DHS) is featured as the key to ensuring decentralised, equitable Primary Health Care (PHC) to all the citizens of South Africa.

This study looks at the reorganisation of health services in the clinics and the day hospitals which are rendered by the Health Department of The City of Tygerberg and the Community Health Service Organisation (CHSO) of the Provincial Administration of the Western Cape(PAWC) in Khayelitsha with the aim of achieving comprehensive PHC services.

In the absence of legislation for the integration of health services, initiatives for the achievement of quality comprehensive PHC within the district are envisaged.

OPSOMMING

Openbare Gesondheidsdienste in Suid Afrika was voor die demokratieseringsproses gekenmerk deur 'n skeidig tussen kuratiewe en voorkomende gesondheidsdienste. Daar was fragmentasie van bestuurstrukture, ongelykheid tussen stedelike en landelike gebiede asook ongelykheid op grond van ras. Dit het gelei tot duplisering van, en ongelykheid in, die verspreiding van hulpbronne op die verskillende vlakke van gesondheidssorg.

Die Witskrif op die Transformasie van Gesondheidstelsels in Suid-Afrika, 1997, fokus op die her strukturering van gesondheidsdienste en het 'n verenigde gesondheidstelsel ten doel wat daartoe in staat is om gehalte gesondheidsorg in 'n sorgsame omgewing aan almal te lewer. Die Distriksgesondheidstelsel (DGS) word gekenmerk deur gedesentraliseerde, gelykmatige Primêre Gesondheidsorg (PGS) dienslewering aan al die inwoners van Suid-Afrika.

Hierdie studie kyk na die herorganisering van gesondheidsdienste wat deur die gesondheidsdepartement van die Stad Tygerberg en die Gemeenskapsgesondheidsdiens organisasie van die Provinsiale Administrasie van die Wes-Kaap (PAWK) in die klinieke en daghospitale in Khayelitsha gelewer word met die doel om omvattende Primêre Gesondheidsorg-dienste te voorsien.

Weens die afwesigheid van wetgewing vir die integrasie van gesondheidsdienste word inisiatiwe vir die bereiking van gehalte omvattende Primêre Gesondheidsorg binne die distrik beoog.

ACKNOWLEDGEMENTS

I would like to thank my children Sisanda, Babalwa and Nangamso and not forgetting my sister Nosipho and my nephew Ntsikelelo, for their support and understanding during my study years. I am also grateful to my colleagues in the Health Department for their invaluable assistance. A special word of thanks goes to Pat and Funeka for the many hours of typing and the Almighty God for my life for which I am forever grateful.

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1.1 *INTRODUCTION*

Khayelitsha which consists of 3 200 hectares of land, is a rapidly developing peri-urban settlement on the outskirts of Cape Town in South Africa. In 1983 the intention of the Government in establishing Khayelitsha, which was to accommodate about 220 000 people in family dwellings and a further 30 000 immigrant labourers in hostels, was undermined by a combination of events. Those events included the unstoppable migration of people into the Western Cape, international outrage in continued attempts of forced removals, power struggles within the squatter communities of Crossroads and KTC and state-supported violence, which continued unrelentingly until 1994.

Instead of being limited to 220 00 inhabitants in the core-houses, Khayelitsha exploded. In 1996 the population was estimated at an astounding 350 000, an estimate which has derived from the number of shacks and houses multiplied by occupancy.

Like most developing settlements in Africa, the population is generally young with a low death rate, although adult deaths occur violently. Unemployment and consequent poverty, are dominant determinants of the health status of people living in Khayelitsha. The health status is characterised by a high teenage pregnancy rate, a high infant mortality rate and a high incidence of tuberculosis.

Following the 1994 democratic elections of the new South Africa, the process of local government restructuring, culminated in the establishment of municipal local councils in 1996, one of which is the City of Tygerberg. One of the critical roles of the local government as mandated by the Constitution of the Republic of South Africa, is to ensure the provision of services to communities such as Khayelitsha in a sustainable manner. In doing so it is charged with promoting a safe and healthy environment.

Concurrently, one result of the restructuring in South Africa was the reorganisation of the state departments including the Department of National Health. The transformation of the National Health System (NHS) promoted the establishment of health districts as proposed by the *White Paper Towards the Transformation of the Health Systems in South*

Africa (Department of Health, 1997:12) (henceforth the White Paper). During this process the City of Tygerberg was divided into three health districts, one of which is Khayelitsha.

1.2 *AIM OF THE STUDY*

The aim of this assignment is to present a plan for the implementation of the District Health System (DHS) for comprehensive Primary Health Care (PHC) within the municipal and the provincial public health services in Khayelitsha, as set out in the White Paper.

1.3 *RATIONALE FOR THE STUDY*

The Health Act 63 1977, Act 63 of 1977 (Searle, 1984:29) delegated specific health care functions to the three tiers of government, the Department of Health, the Provincial Administrations and Local Authorities, with only a superficial attempt at the co-ordination of these services. One of the outstanding characteristics of the public health sector in South Africa inherited from the previous government, is fragmentation. This fragmented health care system has consequences for coverage and comprehensiveness, as well as efficiency and cost. It also has a potential to render the health system inaccessible. For a democratic country which has recognised health as the right of every citizen (Constitution of the Republic of South Africa, 1996 :Chapter 4), accessible health services are paramount. The public health services in Khayelitsha have been described as inaccessible (Department of Health, 1995 : 15).

The accessibility, availability and acceptability of health services have been the focus of much debate. Accessibility viewed in terms of distance, waiting time, and other economic factors such as the direct and indirect cost of health care, directly affects the lives of people from disadvantaged communities.

Concerns pertaining to the availability and acceptability, which relate to trust and willingness to use certain health services are also often raised. Another pressing problem facing the public health services is the relatively heavy concentration of resources within the hospital sector and the consequent under resourcing of the primary health care services.

Several other problems stem from the historical maldistribution of resources based on racial grounds, which was caused by the apartheid policies of the previous government. The inequitable and inefficient distribution of public health sector resources contributed to the inferior health sector performance that has been manifested in poor health care indicators such as high morbidity and mortality amongst the poor disadvantaged communities.

The effect that these problems have on patients is illustrated by the following report received from a concerned clerk who had been confronted with this information when she investigated why a patient did not return for his treatment in December 1997.

An elderly male resident of Khayelitsha visited one of the provincial clinics called the day hospitals, presenting with breathlessness. When asked about his medical history, he said that he had tuberculosis. On this information he was referred to the municipal clinic which treats tuberculosis. When he arrived at the clinic, the doctor had already left. He was therefore advised to return to the day hospital, which he did. As the patient quota for the day had been reached at the day hospital, the person attending to him informed him to come back the following day. This he was unable to do, as he had died from cardiac failure overnight.

The White Paper (Department of Health, 1997:13) aims at the improvement of the inherited health care system through the development of a District Health System as a vehicle for rendering comprehensive primary health care services.

Specific principles that are enshrined in the White Paper are seen as the appropriate measures for the delivery of quality, and efficient service in a caring environment. These principles aim at overcoming the existing fragmentation, promoting equity, providing comprehensive efficient and effective quality services, access to services, local accountability, community participation, decentralisation, developmental and intersectoral approach and sustainability.

1.4 *ASSUMPTION*

The assumption underlying this study is that the implementation of the DHS and the proposed plan would ensure comprehensive PHC in the rendering of the public health services in Khayelitsha which has benefits which outweigh any benefits that the provincial and local authorities could have individually. Above all, the benefits to the health consumer are numerous. No less than nine of the principles cited in the White Paper can be achieved through the reorganisation of public health services in Khayelitsha. Amongst these are the following :

- the promotion of comprehensiveness;
- the promotion of accessibility through reduced waiting times as services become comprehensive;
- the direct and indirect cost, as affected by the length of time each patient takes away from work or home, will also be reduced drastically;
- the equitable distribution of resources;
- the higher degrees of efficiency will promote job satisfaction;
- the multiple skill development of staff will lead to greater effectiveness;
- this in turn will lead to quality services provision and job satisfaction.

1.5 *THE PROBLEM STATEMENT*

The fragmentation in the public health service delivery in South Africa under the previous Act resulted in each health authority having developed a set of structures, policies, service conditions, procedures and culture independently. The integration of the two health authorities at the primary health care level therefore requires the dismantling of the existing processes and replacement and internalisation of new processes.

If the integration of the public health service is to be successfully implemented the existing processes that support the previous Act must be replaced by processes that support the White Paper.

The integration of the public health services between the two health authorities, the

Community Health Service Organisation (CHSO) under the Provincial Administration of the Western Cape (PAWC) and the City of Tygerberg (COT) has been cited as a method of facilitating the implementation of the DHS for achieving the comprehensive PHC. However, in the absence of an enabling legislation, it has been extremely difficult to integrate the two health authorities, hence the challenge for considerations of alternative methods during the transitional period.

1.6 *STRUCTURE OF THE STUDY*

This study report is divided into five chapters. The first chapter contains the introduction and the rationale for the study.

Chapter two gives the historical background to the present health care system in South Africa as outlined in the Public Health 1977, Act (63 of 1977).

Chapter three presents the goals, the objectives and the underlying principles of the White Paper and reports on the integration of services, with emphasis on the primary health care services.

Chapter four describes the present scenario in public health services in Khayelitsha as evaluated in terms of the ideal public health services.

Chapter five presents the recommendations that could be adopted by the public health services in Khayelitsha in order to comply with the philosophy, principles and the general guidelines of the White Paper. The limitations of this study is that it only focuses on nine of the twelve principles which has been cited as the criteria for the successful implementation of the DHS.

1.7 *CONCLUSION*

Public health services in Khayelitsha portray a typical picture of services in peri urban settings or townships in South Africa. These services are controlled either by the local authority or the CHSO under the umbrella of the PAWC. The control of these services is the source of fragmentation of health services with consequent problems such as inaccessible and poor health services.

The proposals of the White Paper aims at redressing the existing problems through the implementation of DHS. It is envisaged that the DHS will ensure comprehensive PHC to the community. This study looks at the reorganisation of public health services in Khayelitsha to ensure comprehensive PHC services.

2. *DEVELOPMENT OF THE SOUTH AFRICAN HEALTH CARE SYSTEM FROM 1910 UNTIL 1990*

2.1 *INTRODUCTION*

In order to understand why a project such as the reorganisation of the public health service in Khayelitsha is proposed, it becomes necessary to present the development of the present public health care system in South Africa.

Following the Union of South Africa in 1910, each of the four provinces namely, the Cape, Transvaal, Orange Free State and Natal were transferred the responsibilities of the four colonies with regard to health care, while the local authorities continued with the functions entrusted to them in colonial and republican days. "*Each provincial administration autonomously continued to provide public curative services, environmental and preventive health services were still provided by local authorities under the jurisdiction of the Department of Internal Affairs*" (van Rensburg *et al*, 1992 : 56).

It was only in 1918 when the Great Flu Pandemic struck South Africa causing a known 150 000 deaths that the legislators realised that the Union of South Africa lacked the legislative machinery required for coping on a national scale with disasters. A national conference was therefore called to consider the question of legislation at national level to cope with the manifold problems arising from disasters and to work towards positive action for the promotion of the nation's health. The national conference led to the drafting of the Public Health Bill which was presented to Parliament. The Public Health Act 1919, Act 36 of 1919 was subsequently passed by Parliament (Searle, 1984:25).

2.2 *THE PUBLIC HEALTH ACT OF 1919*

This Act aimed to establish uniform control of preventive health services. It also attempted to co-ordinate health care at national level. It created a new Department of Public Health under the Minister of Health which would, at first tier of government and in addition to the provincial administrations and local authorities, be responsible for public health services in South Africa and which would be responsible for co-ordinating health services of the local authorities. Other tasks included the giving of advice to the

other two tiers of government, the control of contagious diseases, district surgeon services and control of institutions for the mentally ill, for TB patients and leprosy patients (Department of Community Health, UCT: 7).

The primary responsibility of the local authorities was the control of the infectious diseases and environmental sanitation in their respective areas of jurisdiction. The Act made provision for refunds by the Government in respect of expenditure incurred by local authorities in carrying out specified health services. Provincial Administrations retained the responsibility for the establishment and maintenance of general hospitals. The Act was in force in South Africa from 1919 until 1977. Although it was necessary to amend the Act and effect changes on no less than 21 occasions, the Act was only repealed in 1977 (Searle, 1984:26). During the 58 years of the Public Health Act 1919, the following amendments became necessary as health needs changed :

- Personal health services such as domiciliary nursing and midwifery service were included in the local authorities functions.
- The provincial administrations were given powers to establish out patient services.
- Psychiatric hospitals were administered by the Department of Interior which kept them out of the mainstream of health care. Later these were handed to the Minister of Health in 1943 to be part of mainstream health care (Searle, 1984:27).

The main features of the South African health care system and its evolution is highlighted in the following paragraph.

2.2.1 Dominance of Curative Health Care

As elsewhere in the world, health care in South Africa has an outstanding feature which is specialisation and super-specialisation of personnel and facilities, technological advances in therapy and highly sophisticated speciality institutions. The increase of chronic degenerative morbidity predominantly among the white population further strengthened the tendency towards institutional care. Attempts to shift the emphasis toward primary, preventive and community health which were propagated by various reports, were all aborted (van Rensburg *et al*, 1992:57).

2.2.2 Expansion of the Structure, Functions and Geographic Fragmentation of Health Care

The legislation of 1919 divided the health care system into three tiers of government, the central, provincial and local authorities. Sharp divisions between the curative and preventive services were noted. The major developments since 1948 during the period of the "Grand Apartheid", aggravated the situation when the homelands and the accompanying ten departments of health which functioned independently, were established in 1970. These ten health departments were coordinated by the creation of another fragment, the Regional Health Organisation of South Africa (RHOSA) which coordinated health in the Bantustans and the RSA(Department of Community Health, UCT:12).

In 1983 the three racial chambers were created, namely, House of Assembly for whites, House of Representatives for coloureds and House of Delegates for Asians . The affairs of these houses were known as "own affairs". Matters affecting the Africans living outside the Bantustans were regarded as "general affairs". Thus South Africa had fourteen ministries of health each with it's own bureaucracy. Over and above this, health care functions were scattered across state departments, police, the prisons and armed forces (Department of Community Health, UCT: 12).

Health Care was affected by this constitutional dispensation in many ways. The own affairs departments which were created in addition to the provincial departments for hospital services created much potential for conflicts of interest, overlapping and duplication in respect of control and functions. Vagueness existed between the own and general affairs. Price *et al* (in van Rensburg *et al* 1992:70) predicted the situation as follows which was later confirmed "*So we may expect little to change except that a whole new network of control, responsibility and administration will be super-imposed onto the already confusing array of authorities. This can only lead to greater inefficiency and cost, and the threat of deterioration of already inadequate services*".

2.2.3 Rural-urban Discrepancies and Inequalities

The increasing urbanisation and apparent concentration of health care resources to urban areas, with under-provision and under-staffing of rural health services was apparent.

Once again because of the apartheid policies, the whites and Asians reaped greater benefits from these urban-based health services (van Rensburg *et al*, 1992:59).

2.3 *HEALTH REFORM AND THE HEALTH ACT OF 1977*

For nearly six decades the Public Health Act of 1919 dictated the organisational framework of South African Health Care. Fundamental problems which the Health Act aimed to address as summarised by the Gluckman Commission were as follows: (Gluckman, 1944 :Chapters XIX&XX).

- disjointed, haphazard and unco ordinated health services on a national basis
- over emphasis of curative health services over preventive and promotive services
- non-availability of health services to all sectors of the population especially the under privileged who needed it most
- inadequate and inefficient health resources to either expand services or to render quality services

The Commission of Inquiry made certain recommendations which aimed at reconstruction of the frame work of the national health system of South Africa as the Commission thought that the structure was the basis of problems of the health system of South Africa (Gluckman, 1944:XXXVIII).

- establishment of the National Health Service which will be directly responsible for personal health and to relieve all other public authorities of this financial burden

- the National Health Services to provide free personal health services to all the sectors of the population with nominal fees payable by the people

- joint service delivery of the National Health Services with the social welfare and voluntary organisations for rehabilitation services for the disabled and injured

- the appointment of the Minister of Health who will be advised by the National Health Council on health policy matters

- development of health regions which will be responsible for carrying out the functions of the National Health Services. The Health Centre to be the nucleus of such services with a Health Centre Council to look after the interest of the community. Local authorities to be allocated the functions of the National Health Services with province in the absence of the former.

2.3.1 **The Health Act of 1977**

In 1977, when the Health Act 1977, (63 of 1977) was passed, the problems highlighted in the Gluckman Report were borne in mind. Specific measures were introduced to reduce these problems. Great emphasis was placed on comprehensive and holistic care, thus integrating the preventative, the promotive and the rehabilitative aspects of health care. The building of community health centres was encouraged. Provision of health by the private sector without the interference from the government was also encouraged.

Two special bodies were established namely, the Health Matters Advisory Committees and the National Health Policy Council to ensure the coordination of health services between the tiers of authorities and to attempt to co-ordinate at national level. Clear definitions of the duties, powers and responsibilities of the respective authorities were delineated (Health Act 1977, Act 63 of 1977: Section 14).

The Health Act delegated the Department of Health functions to coordinate services rendered on a national basis and provision of a variety of services to ensure comprehensive health services. These services included the following : (Health Act 1977, Act 63 of 977: Section 14).

- the establishment of laboratory services;
- the control of a safe environment such as the control of drugs;
- the promotion of family planning;
- the control of the infectious diseases and to carry out all functions of the local authority in its default, failure or absence whereby individuals residing in the jurisdiction of the local authority health were under threat.

Provincial Administrations were delegated the provision of certain facilities required to render health services and the co-ordination of services within the provinces, between the

Department of Health, the provinces and the local authorities.

Other functions included the following:

- the provision of hospital facilities and services;
- the provision of ambulance services;
- the provision of facilities for the treatment of patients suffering from acute mental illnesses, for patients treated for less than 24 hours and the maternity homes (Health Act 1977, 63 of 1977: Section 16).

Functions of the local authorities could be divided into two categories, i.e. those services which local authorities might render on their own behalf and those services which they might render on behalf of another level. The Act made provision for a refund of the latter services. These functions included (Health Act 1977, Act 63 of 1977: Section 20).

- the maintenance of its district at all times in a hygienic and clean condition;
- the prevention of the occurrence of any nuisance, unhygienic condition, any offensive condition or any condition which will be harmful to the health of any persons;
- the rehabilitation of persons and the co-ordination of services rendered by the Department of Health, the provincial administration and itself within its district.

From the abovementioned, it is clear that little of the intentions of comprehensive health care were achieved. Despite the clarity on the fundamental problems that existed before the Act was passed, these following problems continued for many decades to come.

- the fragmentation which in effect remained unaddressed, instead it was perpetuated by the Act of 1977;
- no changes were effected in the health services for the homelands, the Act instead condoned the existing situation;
- white domination continued and was sealed by the introduction of the health departments based on racial grounds;
- services for blacks surrounding the urban areas compared to rural blacks were improved;
- the dominance of curative care continued as reflected in the budgets, services rendered and the training of health personnel, whilst the preventative services existed as a shadow of the curative care (van Rensburg *et al*, 1992 : 74).

2.4 *CONCLUSION*

The problems in South African health care is the problematic provision structure which provide health care services to the population of South Africa in an unequal and discriminatory fashion. Complete lack of planning, coordination and integration of health services is apparent and is the result of racial, functional and geographic fragmentation. Unequal provision, distribution and access on the grounds of race and wealth are features of the health care. The problematic health care system, despite the obvious deficiencies has been enforced by the two Health Acts and the apartheid policies of the South African government.

The perpetuation of the situation resulted in health services which are fragmented on racial, geographic and functional aspects, duplication of services, gaps in service delivery, poor quality service, inefficiency and ineffectiveness, dominance of curative health care over the preventive and promotive health care.

In the following chapter attention is given to the pressures that led to the weakening of the apartheid system and the pressure for a new health care system that addresses the underlying structural problems. The goals and objectives of the restructuring process are discussed and detailed attention given to the principles of the District Health System which are regarded as the crux of the restructuring process.

3. *THE REFORM PROCESS*

3.1 *INTRODUCTION*

In the early nineties, a wave of reform swept through the South African health care system which culminated in the passing of the White Paper Towards the Transformation of the Health System in South Africa. This reform was brought about by calls and pleas from the progressive, academic and professional quarters and from the numerous democratic movements for a national health service which rectifies the structural deficiencies in South African health care (van Rensburg *et al,* 1992:75).
The following section will give a close look on some of these events.

3.2 *THE BROWNE COMMISSION REPORT OF 1986*

A Commission of Inquiry into health services was established in 1980 led by Gerald W Browne. The intentions of the Browne Commission was *" to address the effectiveness of the whole spectrum of health services in relation to the present and future communities to be served, to identify problem areas and to recommend the direction in which the health services should be developed."*

The deficiencies of the health care system which were already known to all were highlighted in the report which included :(Browne G W G, 1986: 18-19).

- under emphasis of preventive and primary health care and over emphasis of expensive secondary and tertiary health care which is in- appropriate to meet the needs of the population of South Africa
- over regulation of private sector in health and the abuse of medical aid schemes
- shortage of health personnel especially non- whites
- inadequate statistical information
- the fragmentation of control of health services and lack of central policy directing
- under-developed health education practise

The Commission made recommendations which were integrated in the National Health

Service Facilities Plan (NHSFP) which aimed at the development of the population in an economic way. The NHSFP proposes six levels, with level 1 aiming at provision of basic needs of the people e.g. water, sanitation, food and housing. Level II aimed at development of the population through health education to maintain a healthy life style and prevention of diseases through immunisation. Level III was the provision of Primary Health Care services. Levels IV, V and VI were hospital services which included the Community, the Regional and the Academic hospitals (Department of Health and Welfare, 1980: 1-20).

Other recommendations were that the Department of Health and Population Development together with the National Health Policy Council be responsible for central management of policy in respect of health services.

- The health authorities be given a greater scope to be responsive to the needs of the people in health service provision and that people be given the financial responsibility for health services received.
- Priority be given to preventative and promotive health services with supporting budgetary allocations towards these services and that community services be expanded in the form of community health centres.
- Private health care be encouraged in the form of private hospitals and outsourcing of some support services in public hospitals. Medical aid schemes to introduce initiatives such as no-claim or minimum claim bonus as well as the introduction of catastrophic cover. Patients were also encouraged to be financially responsible for their own health (Browne G W G , 1986:20-41).
- Training of non-white health personnel and emphasis on nurses as they play a pivotal role on the proposed health care system.

In 1986 the New Health Plan was announced which purported to realise the ideal comprehensive health services for South Africa by centralising the responsibility for policy decision and decentralising the executive responsibility; encourage private initiative and eliminate the fragmentation and duplication. In 1990 another mile stone was reached when the National Policy Act was promulgated. The Minister of National Health And Population Development was given the authority to determine which policy to pursue in the promotion of health of South Africans.

For the first time the responsibility of the individuals for his own health is enshrined in the law.(Department of Community Health, UCT :15).

3.3 *OTHER PRESSURES*

Pressure from the broader social political environments mounted and the government gave new and repeated confirmation of a health care system which has been advocated in the 1980s.

- there were strikes that were organised by the trade unions
- increasing Black opposition to apartheid
- student frustrations with the inferior education system
- political arrests of country and urban Blacks
- 1976 Soweto uprising

The commitment to health care restructuring led to numerous initiatives, to pilot studies, research and exploring ways of reforming the health care system in South Africa. This process reached its momentum with the passing of the White Paper for restructuring of the health care services in April 1997.

Some initiatives were implemented by the government in the 1980s in an attempt to reform the health care system, but when one views these initiatives against the total problems, these initiatives can be regarded as a tip of an iceberg or even meaningless as they failed to penetrate the larger structural problem in South African health care. Van Rensburg *et al* (1992 : 83) had these remarks to make: *"In this sense the reform initiatives were no more than patchwork, again dictated by the framework of the preceding decades."*

3.4 *THE GOALS OF THE RESTRUCTURING PROCESS*

The Government of National Unity brought with it a blue print known as the Reconstruction and Development Programme (RDP). This policy document sets the framework to address the social and economic problems facing South Africans including health issues (Department of Health, 1997 : 11). It is upon these principles of the RDP

that the proposals of the White Paper are based.

The underlying principles of the White Paper, are to redress the imbalances of the past which are manifested by disparities and inequalities in health services delivery. The transformation process envisages comprehensive restructuring of health care in South Africa aimed at the development of a comprehensive, efficient and equitable unified National Health System (Department of Health, 1997 : 14).

The mission, the goals, the objectives and the implementation strategies are articulated in the following guidelines (Department of Health, 1997 : 12).

- The promotion of equity through the development of a single unified health system.
- The focus on the development of a District Health System as a major locus of implementation with emphasis on the Primary Health Care approach.
- An integrated package of essential Primary Health Care is envisaged to ensure the availability of health services to the entire population.

3.5 *THE IMPLEMENTATION STRATEGIES*

The proposed implementation strategies that are contained in the White Paper which aim at improving the existing health care system, are discussed below in a broader national context.

3.5.1 **The Establishment of a District Health System for Decentralisation and Accountability**

The establishment of the DHS has been identified as the core factor in the restructuring process. It is recognised that many functions of the government can be effectively managed by decentralising to smaller geographic and administrative entities which may also be the local level of health care.

According to the World Health Organisation (WHO) the definition of a DHS is : *(*Department of Health, Welfare and Gender Affairs, 1996 : 28*)*.

"A District Health System (DHS) based on Primary Health Care is a more or less self-contained segment of the National Health System. It comprises first and foremost of a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A DHS therefore consists of a large variety of inter-related elements that contributes to health in homes, school, work places, and communities, through the health and other related sectors. It includes self care and all health care workers and facilities, up to and including the hospital at the first referral level, and the appropriate laboratory, other diagnostic and logistic support services."

Specific guidelines for the development of a DHS have been unanimously agreed upon and considered crucial for the restructuring of the health sector at the local level (Department of Health, 1997 : 28). These twelve principles are as follows :

- local accountability
- decentralisation
- overcoming fragmentation
- comprehensive services
- equity
- access to services
- effectiveness
- efficiency
- quality
- community participation
- developmental and intersectoral approach
- sustainability

Most districts have been demarcated and agreed upon by various role players including the health officials from all health authorities and the community. This process involved numerous workshops whereby the concept of the DHS was discussed as well as the boundaries resulting in ten districts in the Metropole of the Western Cape.

The decentralisation of health services to the districts according to the Department of Health, Developmental Welfare and Gender Affairs in Mpumalanga (1996 : 10) is, *"giving districts health managers appropriate powers in respect of personnel and financial control. This will increase responsibility, accountability and efficiency of the service. It will also boost staff morale and encourage local initiative and flexibility in dealing with changing local circumstances".*

The following points identify the purpose of decentralising health services to the district level.

- bringing primary health care services nearer to people and allow decision making at operational level.
- promoting community participation in health service planning and delivery.
- ensuring appropriate responses to health needs of the communities.

About the districts Owen (1995 : 1) makes these remarks *"It has often been said that the health district is where top down approach planning meets bottom up realities."*

Based on the above Butler (1994 : 267) remarks "*the delegation of responsibility increases creative energy".* These ideals were further supported by Walker in Grewe (1998 : 10) "*Department managers perform most effectively if made fully accountable and with full authority for the efficient running of their organisation i.e. let managers be free to manage".*

To emphasise the district as the key concern in the health care developments, the district workshop held for the Western Cape Districts (1998 : 9) proposed that senior managers participate at the district level in order to erase the idea that districts are only "talk shops".

This idea has been supported by the Mpumalanga province in the *Guide to District Based Action* (1996 : 32) with the proposal that the district manager be appointed who is responsible for the development, provision and supervision of health services in the districts. Other functions include the continuous monitoring and evaluation of coverage, efficiency and effectiveness. It is therefore clear that the role of a senior manager at the district level is paramount.

The importance of training of personnel within the districts to ensure successful realisation of the intentions of the DHS is articulated in the White Paper (1997 : 54) as follows : "*Human resource development is a critical factor in the implementation of health and social development. A policy should provide guidelines, design education programmes aimed at developing competent personnel, and promote a new culture of change management in the health sector, based on participatory leadership*".

Because of the new culture in service provision, according to Barron and Zwareinstein (1992 : 14) the focus of training should be on re-orientation of new management skills and styles for district PHC. Emphasis on attitude change training and the promotion of critical thinking is emphasised.

The success of the implementation of the new skills according to these authors, calls for a new organisation which moves from rigid to flexible, reactive to pro-active and creative.

3.5.2 Overcoming Fragmentation and Comprehensive Health Care Services

The White Paper (1997 : 14) aims at overcoming fragmentation by unifying the existing health services at all levels into a comprehensive and integrated health system based on Primary Health Care. The strategy embraces the principles of the RDP which focuses on meeting the basic needs of the people. Embedded in this strategy is a commitment to a system of health care that is accessible and strive to address the socio-economic issues which impact on health.

The WHO defines primary health care as "*essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and the country can afford. It forms an integral part both of the country's health system of which it is the nucleus and the overall social and economic development of the community*" (Cornelissen & Maiolica, 1997 : 68).

The White Paper (1997 : 36) proposed a Primary Health Care package that should be available in each district based on the available resources and implemented in an incremental basis and is sustainable (**Table 1).** The strength of the comprehensive PHC service to the community is supported by the remarks that are made by personnel at Belhar I Clinic in the Western Cape who had a brief experience of rendering such services. *"Clients feel free to attend any day with any problem, cost and time of travelling to big hospitals were less"* (van der Walt, 1996 : 2).

Because of the commitment to comprehensive primary health care services, fragmented health services and vertical health programmes should be integrated into the single delivery of PHC services.

De Villiers (1997 : 6) comments *"It is, however not an easy task to convince health professionals that their vertical programmes should be replaced by a blanket of (perceived) related skills and services"*. These remarks illustrate the difficulty faced by health care providers in moving towards the new dispensation.

Utshudi- Lumbu (1993 : 41) in *Integration of vertical health programmes into horizontal services* has this to say in regard to successful strategy: *"Effectiveness and efficiency can be achieved of a PHC..., the national level of government should take an active role in implementing PHC programme strategy with appropriate delegation of authority to the periphery"*.

Table 1

PHC Services to be provided through the district health system

Services
Personal promotive and preventative services : Health Education Nutritional/Dietetic services Family planning Immunisation Screening of common diseases

Personal curative services for acute minor ailments, trauma, endemic, other communicable and some chronic diseases.
Maternal and child health services: Antenatal care Deliveries Post-natal and neonatal care
Provision of essential drugs
PHC level investigative services: Radiology Pathology
Basic rehabilitative and physical therapy services
Basic oral health services
Basic optometry services
Mental health services
Medical social work services
Services organised and provided at the district level
Health education
Health related nutritional support
Communicable, non-communicable and endemic disease prevention and control
School and institutional health services for children: Oral health Audiology Optometry
Health related water and sanitation services and other environmental health services
Community mental health and substance abuse services.
Occupational health and safety services (*)
Community nursing and home care services including care of the terminally ill
Essential accident and emergency services
Community geriatric services and care of the elderly
Health services support : Epidemiology and health information system Health monitoring Planning and Administration
Basic medico-legal services

Source: **(Department Of Health, 1997:13).**

The successful implementation of vertical programmes depends on the strong political commitment at national, regional and local levels; a strong political commitment of facilities for PHC, equipment and personnel training which lead to redefinition of roles to include the broadened scope of practise; and the continuous support by the experts of the vertical programmes in the implementation, monitoring and the evaluation of the integration process (Utshudi -Lumbu, 1993 : 41).

The importance of training in PHC to equip frontline health care workers with the necessary skills, is emphasised by nurse Hluyako in Schoemandal Clinic in Mpumalanga after she obtained training in PHC (Health Systems Trust 1997 : 7). *"I think every health worker who works at the clinic should be Primary Health Care trained. It is a good tool. It teaches you to solve most of the problems you are faced with at a clinic, to diagnose correctly and to prescribe the correct medicines for minor ailments and if necessary to refer. It feels good to detect illnesses on your own and to manage them instead of referring everything to a hospital. I get job satisfaction and self confidence".*

This calls for a skilled health worker in the variety of services provided because the fragmented services in which health care workers find themselves equip them with skills depending on whether they work for a provincial administration or a local authority.

3.5.3 **Accessibility and Equity**

The White Paper(1997 : 26) commits the health department to the provision of accessible health care services and publicly funded PHC services. This implies that the financial, geographical and other access to PHC services delivered be equivalent for all users. Financial barriers have already been lifted in 1996 when the Minister of Health declared all PHC services free of charge.

Areas that are targeted as priority are the rural peri-urban and urban poor, the aged with an emphasis on the vulnerable. This priority comes in the light of the majority of the population of South Africa which has inadequate access to basic services including health care (Department of Health 1997 : 11).

Harrison (1997 : 22) in *Making PHC work* highlights compelling reasons for improving PHC by stating that "*from a human rights perspective if equity is our goal, then meeting basic needs is a priority....., providing good, accessible PHC will help ease the burden of disease from the most poor and vulnerable*".

Cornelissen & Maiolica (1977 : 68), emphasises that equity with regard to race, class, gender and geographical conditions should be prompt. Physical accessibility is reported as a major problem especially in rural areas where health care facilities are ± 10 km from where people live. Approximately one third of Africans in rural areas travel more than one hour to reach their closest point of health care (Harrison, 1997 : 23).

Another barrier to access cited is language, transport cost and poor organisation of services. Health services rendered by the local authorities are all closed by 17:00 hours because of service conditions. Of the health care facilities that are under the CHSO in Khayelitsha only one facility per district remains open after hours and during week ends. It is for this reason that the Medical Officer for health in Mpumalanga announced that all PHC facilities should remain open from 07:00 - 19:00 (Harrison, 1994 : 24). Comprehensive PHC service also guarantees access to a wider variety of services under the same roof.

3.5.4 **Quality, Efficiency and Effectivity**

The White Paper in proposing the establishment of the DHS highlights specific principles which should be the criteria for the success of the district, amongst which quality, efficiency and effective health services are highlighted.

Quality of care in health services is seldom discussed. When discussed by professionals it is frequently confused with standards, high technology, sophistication, private or expensive services. Crisp in an article *Standards Sophistication and Quality* (1997 : 46) remarks "*It is almost inconceivable that a doctor cannot recognise that the collective aim of decreasing morbidity and mortality (including human suffering) cannot be correlated with increasing sophistication technology*".

Barron and Zwarenstein in *Managing PHC at the district level* (1992:19) note that issues relating to quality of care include continuity of care, and the use of carefully designated protocols which offers the carer the best considered options for patients.

The White Paper (1997:16) in the promotion of quality focuses on the provision of suitably qualified personnel through skills development. The promotion of a new culture of democratic management and a caring and compassionate health sector are determinants of quality health services. *"Health teams and workers at all levels should develop a caring ethos and commit themselves to the improvement of the health status of their communities"* (Department of Health, 1997:13).

The improvement of coverage levels improves effectiveness. In this regard the White Paper proposes the development of a health information system that will facilitate the measurement and monitoring of the health status of the community (Department of Health, 1997:16).

A report about the Northern Province's effectiveness highlights an infant mortality of 60 per 1 000 clearly reflecting poor health service especially with mortality that are due to preventative diseases (Crisp, 1997:47).

The above discussion on quality services calls for the development of a new culture and values. Based on the commonwealth experiences, Karl in Grewe (1998:6) identifies that *"changing values and attitudes is a common theme in civil service reform, the question of attitudes underpins all concrete issues concerning possible civil service reforms. Increasing concern with quality of the service provided to customers has acted as a particular catalyst in developing an organisational culture"*. Also mentioned is the attitude concerning commitment to the job, belief in quality and flexibility. These findings have been associated with many recent developments in commonwealth communities. This gives rise to the view that a new public sector value system is emerging.

To conclude, eight principles of *Batho Pele (People First)* are proposed in the White Paper on Transforming Public Service Delivery (11997:15), six of which are crucial in quality service delivery. These are depicted below.

Table 2

Principles of Batho Pele.

1	**Consultation** Citizens should be consulted about the level and quality of the public services they receive and, whenever possible, should be given a choice about the services that are offered.
2	**Service Standards** Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect.
3	**Courtesy** Citizens should be treated with courtesy and consideration.
4	**Information** Citizens should be given full, accurate information about the public services they are entitled to receive.
5	**Redress** If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response.
6	**Value for money** Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

(White Paper for Transforming Public Service Delivery)

3.5 5 Community Participation

The White Paper (Department of Health, 1997:16) fosters participation across the health sector including the involvement of communities in various aspects of the planning and provision of health services. This is linked to promoting public accountability and encouraging communities to take greater responsibility in health matters. According to Crisp (1997 : 23) specific processes of support need to be created to strengthen community participation at all levels. Loose arrangements in this regard are not adequate.

Because community involvement in health issues is a labourious process, and not very attracting for the community especially the disadvantaged communities, De Villiers (1997 :8) in the article *Integrating Health care at the Community Level,* draws a picture of the difficulties that are experienced in dealing with communities "*Factors that play a role in the sustainability of community participation are the status of the committee, the profile of the role and projects of the committee in the community, the perceptions of representatives that they have no real power through these committees, the many committees, political in-fighting in the community and the fact that there is no remuneration for a job that could be time consuming*".

The eight principles embedded in *Batho Pele* also have a great bearing in community involvement (refer to paragraph 3.5.4).

3.5.6 Developmental and Intersectoral Approach

The Department of Health at national level accepts that it has a significant responsibility for influencing the efforts of all the government departments, the RDP, the private sector as well as NGOs so that they reflect the comprehensive intersectoral approach to the development of the health of the nation. This approach recognises that due to the financial constraints even the implementation of PHC core package should be in phases (Department of Health, 1996 : 7).

3.5.7 Sustainability

The proposal of the White Paper emphasises the issue of sustainability in service delivery. To ensure the implementation of this, aspects such as affordable services for both the service provider and the consumer, the enrichment of the community, the phased approach to service development and efficiency must all be observed. The Primary Health Care approach in itself aims at ensuring sustainability. The White Paper proposing these services, envisage a phased approached aiming at achieving all proposed services over a ten year period(Department of Health, 1997:12).

3.6 *CONCLUSION*

It became apparent over the years that the South African Health Care System does not meet the health needs of the entire population with the underlying factor being the provision structure. Pressures mounted during the eighties and early nineties to restructure the fragmented health care system with calls and pleas for a unified National Health Care System.

The challenges facing health or health care system is the design of a comprehensive programme which seeks to redress the social and economic injustices to ensure that emphasis is placed on health and not on medical care. With these challenges in mind a National Health Care System comprising of a DHS based on a PHC approach as enunciated in Alma Ata in 1978 was established resulting in the passing of the White Paper for the Transformation of the Health System in South Africa.

The DHS is seen as a vehicle and a key factor in the restructuring of health services in addressing the health needs of the entire population equitably focussing on local health needs. The PHC service envisaged covers the whole spectrum of basic services which should be available equitably to all citizens of South Africa.

Twelve principles for the successful development of a DHS have been identified which serve as a measuring yard stick for district implementation. They are as follows : overcoming fragmentation, equity, comprehensive services, effectiveness, efficiency, quality, access to services, local accountability, community participation, decentralisation, developmental and intersectoral approach and sustainability.

Having discussed the ideal health services, the following chapter describes the present public health service in Khayelitsha in the light of the proposed public health services with special attention given to the principles for DHS.

4. *EXISTING PUBLIC HEALTH SERVICES IN KHAYELITSHA*

4.1 *INTRODUCTION*

In order to gain a broader understanding of the implications of the implementation of the DHS and the underlying principles, a description is provided of the public health services in Khayelitsha. An evaluation is also given of the services in terms of the criteria for the successful implementation of the DHS. In the process of evaluating these services the strengths and merits of the services will also be highlighted and emphasis given to the problems, constraints and deficiencies of the public health services. Based on these problems, deficiencies and constraints, recommendations are given on how to reform or reorganise the public health services in Khayelitsha.

It should be noted that the specific problems, deficiencies and constraints identified are closely associated with one another and therefore cannot be seen in isolation.

4.2 *FRAGMENTATION*

4.2.1 **Facilities**

According to van Rensburg *et al* (1992:39), fragmentation occurs when a health care system is divided according to race, authority structure and geographic area.

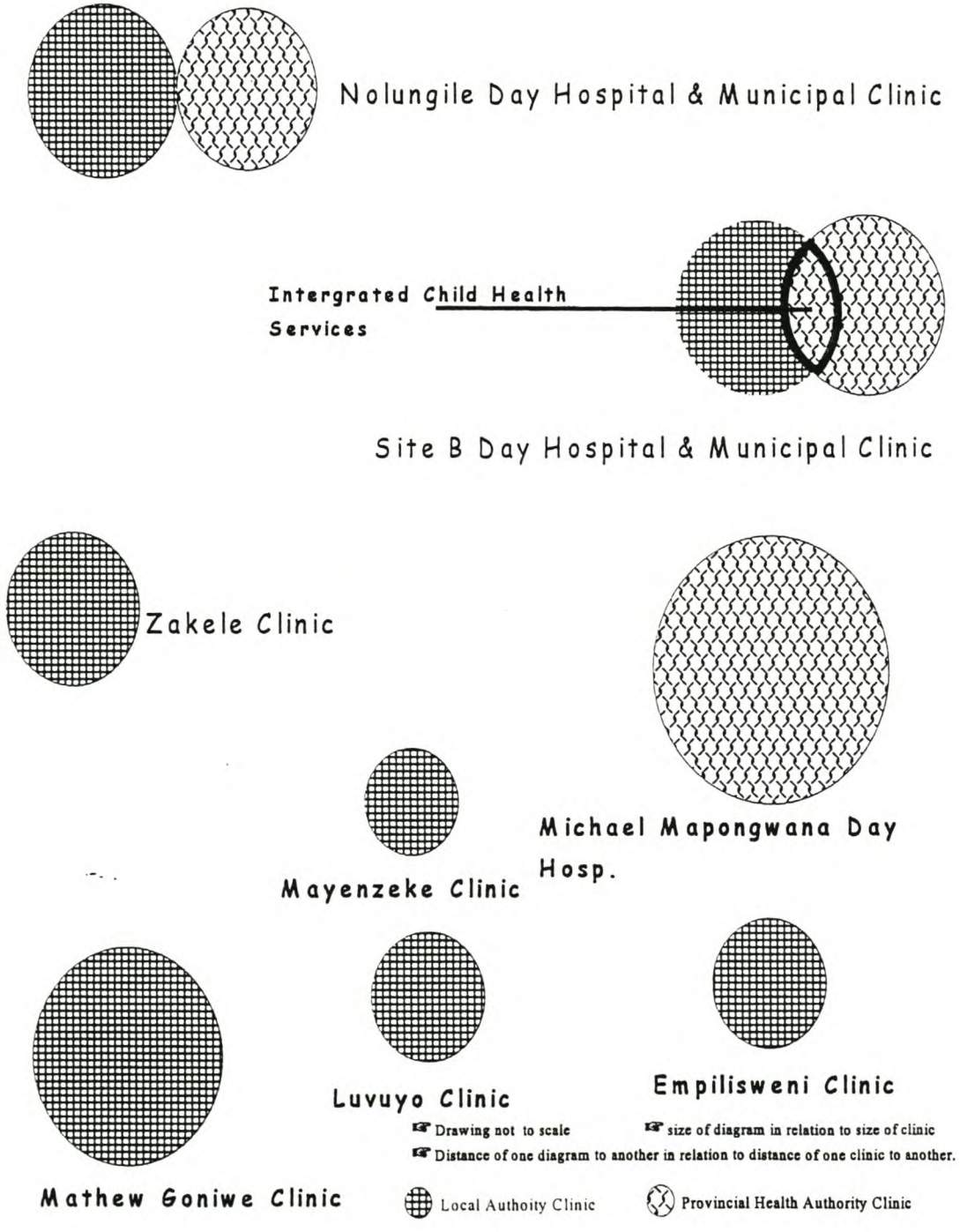
There are eleven public health care facilities in Khayelitsha for the estimated 350 000 people for which public health services are rendered. The management of these health facilities displays fragmentation in the authority structure. Three of the eleven health facilities are under the authority of the Community Health Service Organisation, seven are under the local authority, namely, the City of Tygerberg and one controlled and administered by the Provincial Administration of the Western Cape under the hospital maternity services called Maternity Obstetric Unit (MOU).

Some of these health care facilities under the different authorities share the same ground, others the same building , whilst others are built next to each other. Nolungile clinic is separated from the CHSO facility by a passage, the Khayelitsha hospital share the same

building and the Empilisweni clinic which is a local authority clinic is less than a kilometre away from Michael Mapongwana Day Hospital, a CHSO community health centre. It is for these reasons that the following remarks were made by Abdullah "*There is an astounding duplication of facilities between the local authorities and province with facilities across the road or next to another facility*" (1998:3). **Figure 1** is a diagram showing the spread of health care facilities in Khayelitsha.

FIGURE 1

DIAGRAM : SHOWING HEALTH SERVICE FACILITIES - KHAYELITSHA



4.3 *COMPREHENSIVENESS/FRAGMENTATION OF SERVICES*

Functional fragmentation is another feature of public health services in Khayelitsha. The CHSO in its facilities render community curative health, integrated school health services and community specialised psychiatric health services. All the local government clinics provide the preventative and promotive health services. The MOU and one of the CHSO health care facilities provide maternity services. Table 3 illustrate the different authorities responsible for Primary Health Care Services in Khayelitsha.

Table 3

Authorities responsible for Primary Health Care Services in Khayelitsha in 1998

ADMINISTRATIVE AUTHORITY	SERVICES PROVIDED
Local Government (City of Tygerberg)	**Preventive and Promotive Health Services**
	• Tuberculosis (TB) • Sexually Transmitted Diseases • Well baby clinics including immunisation and growth monitoring • Health education • Nutrition education • Family Planning • Curative under 6 years • Environmental health
Community Health Services Organisation under (PAWC)	**Curative care** **School health services** **Specialised psychiatric services (mental health)** **Antenatal, delivery and post natal care**
Maternity Obstetric Unit (MOU) under (PAWC)	**Antenatal** **Postnatal** **Delivery services**

Minimal coordination of services between the CHSO and the COT takes place and overlapping in service delivery is evident. Duplication with gaps in service delivery is another manifestation of these health services. Owen's remarks are appropriate when he stated that "*Primary Health Care Service are at present provided in a very fragmented and inefficient manner" (1995:1).*

To demonstrate the poor co-ordination of these services and the inconveniency that is experienced by the community, a patient attending one of the CHSO health care facility with an ailment and presenting with a sexually transmitted diseases (STD) problem as well, is attended for the ailment and is referred to the local authority clinic for the STD management. This may result in a patient having to visit the local authority the following day especially if the patient is seen late in the afternoon in the CHSO facility. Gaps in service delivery are demonstrated by the non availability of ante-natal and post- natal care services except in the two facilities which render maternity services.

In an effort to streamline the health care services better, some initiatives were implemented with rewarding benefits for the community. The vertical programmes such as family planning has been integrated successfully in 1990 with the preventative and promotive health services. School Health services have also been incorporated into the CHSO successfully. The reproductive health as a CHSO vertical programme has been integrated in 1997 (Department of Health, 1998:22). Other improvements include an attempt at reducing the existing fragmentation in Site B health facility by integration of child health services for the under 13 years. This initiative brought together resources that are involved with the provision of child health services. Although problems threatened to collapse this service, it is still ongoing two years after the implementation and serves as a learning situation for service providers from both health authorities.

Additional services such as the curative services for the under 6 years has been added to the local authority clinics successfully. Services for children have thus improved and confusion of the community eliminated as it is no longer required of the child minder to take a sick child to a day hospital and visit a local authority clinic for immunisation. These improvements were brought about by the amendments of the Health Act 1977, Act 63 of 1977.

Further implementation of innovative ideas targeted at bringing the two health authorities together to share their resources in an effort to ensure efficiency, have failed because of the difference in governing authority as conditions of employment and services are not the same. Makan and Munro in *South African Public Sector, Provincial and Local Government, Health Personnel, Salary and Benefits for the 1997/8 period: Revisiting and Demystifying. The Parity Debate* (1998 : ix), reflects huge salary discrepancies between the provincial and local authority personnel "*For the majority of nursing personnel, the disparity for the 1995/6 period was estimated at between 12% and 55% higher at Local Government level than the Public Service. However, for the 1997/98 period the disparity had been reduced between - 4% to 20%".*

4.4 *ACCESSIBILITY*

According to van Rensburg *et al(* 1992:30) inaccessibility of health service refers "*to the extent to which services and facilities are open to the clientele".* Problems of accessibility emerges when there are restricting measures or when as a result of specific reasons health care is not open to everyone on equal basis. This links with problems of availability which refers to the presence of the full spectrum of health services, the preventative, promotive, curative and rehabilitative services to the clientele. Another restricting factor to the accessibility of services is the cost of care to the consumer. In 1996 the Minister of Health lifted all financial barriers to Primary Health Care Services by declaring free health care. This step promoted free access to health services resulting in astounding increased workload in curative primary care services of up to 75% (Shung-King M. 1998:37).

The majority of health facilities in Khayelitsha are open on a week day from 07:00 until 16H45. Only two health facilities operate daily on a 24 hour basis, these are the Khayelitsha Day Hospital at Site B and the MOU. The 24 hour service provided by the CHSO is an emergency after hour service predominantly for trauma cases. For a population such as that of Khayelitsha, accessibility of services after hours is a matter of great concern for this community. To a large working population who is employed outside the health district, the majority of which leave their homes before 06:00 and return after 18:00 health services are inaccessible.

Availability of services to any one on an equal basis is hampered by staff shortages. Harrison (1991:43) reports that about 300 untreated patients on a weekly basis are turned away from the Khayelitsha hospital which provides curative primary care services. During week ends access is further restricted by the dominance of trauma patients over paediatric and medical patients. This resulted in inappropriate attendance of children at Red Cross Hospital (RXH), a tertiary level care after hours and during week ends. London and Bachman's study in Shung -King showed that up to 51% admissions and 69% out patients visits to RXH could have been managed at a lower level (Shung -King, 1998: 28). With the down-scaling of Red Cross Hospital, meaning the process where by un referred paediatric outpatients were redirected to primary care level facilities one doctor became available at Khayelitsha Hospital, primarily to see children. However the plight of adult medical patients is still a matter of concern as these patients sometimes leave the health service untreated.

The construction of another community health centre in Khayelitsha, Michel Mapongwana, was intended to relieve pressure on health care workers and congestion from the Khayelitsha hospital, but due to financial constraints the planned 24 hour service has not been effected. Fragmented service is another contributing factor on restricted access to services because of limited scope of PHC services that are available in these facilities. An adult female patient attending a CHSO service for a curative ailment who also requires family planning services is treated, but referred to a local authority clinic for the latter.

The limited scope of practise of health care providers is another restriction on access to services. Nurses are skilled for services which the particular authority renders An accelerated training of nurses on primary clinical skills is being implemented in an effort to deal with this problem. However the situation is not improving, because the personnel trained in the PHC skills are leaving public health services for lucrative pay packets that are offered overseas. Between 1997 and 1998 a total of 12 nurses with primary clinical skills left the employment of the COT for Australia and Saudi Arabia (COT Health Records, 1999). Other services which are not accessible to the community are HIV/AIDS counselling, basic oral health and optometry services. The access to the above mentioned services is limited due to limited resources available to render such services.

The number of health facilities within the population is another determinant for accessible health services. According to van der Morwitz (1997:7) the norm is a health care facility for every 10 000 people. In Khayelitsha this norm is exceeded by far with one health facility for every 35 000 people. The consequent overcrowding of health facilities accompanied by by staff shortages and the restricted accessibility of health services after hours overshadow the accessibility of health services in terms of distance. The national norm for the distance to a health service is 2,5 km. The Independent Development Projects(IDP) reports that in Khayelitsha, except for two groups of communities, the population has less than 2.5 km walking distance to a health care centre. This improvement has been made possible by the Independent Development Trust(IDT) which committed itself to clinic construction (van der Morwitz, 1997:7).

4.5 *QUALITY*

The fragmented nature of the public health services and the accompanying poor coordination of service delivery between the two authority structures, inevitably influences the quality of the health service delivery. Manifestations of inequality are disproportionate distribution of resources in the form of personnel, services and facilities, the unequal provision and availability of services and facilities and the differential quality of services and facilities compared to others (Van Rensburg *et al*, 1992:358). These factors are not isolated but are interdependent.

The heavy client load caused by the rapid expansion of Khayelitsha (it is estimated that 55% of the population in Khayelitsha comes from the Eastern Cape) (Mash B, 1996:6), compromises the quality of services provided. The unemployment rate of Khayelitsha is estimated at 67% with illiteracy levels at 22.7% (Mash B 1996:7). It is an accepted factor that it takes longer to consult an illiterate patient than one who is literate. The high patient work load coupled with the low socio-economic status of the community impact negatively on quality care. When comparisons are made between Khayelitsha and Mitchell's Plain districts, one discovers that for the same number of people and the same number of doctors the patient load is double in Khayelitsha. This has been cited as caused by the social and economic status of patients (Bitalo, 1999). In a study of *Quality of Family Planning Services in Khayelitsha,* the heavy client load was cited as one of the important factors affecting quality of care. (Bachman & Mtwazi 1993:19). The study revealed that 52 clients were seen by one professional nurse as against the norm of 30

clients per nurse per day.

Continuity of services for children and adult patients after hours presenting with medical problems, is scaled down. This is because trauma patients dominate services after hours and during the week ends, consequently, other services such as medical emergencies suffer as they become second priority.

On skills training there are continuous courses arranged for all categories of staff to develop skills as well as in service training to keep abreast with the national and international management protocols for diseases. There are uniform protocols for management of diseases in public services in Khayelitsha, a point which is most welcomed by all service providers. On referrals, clinic emergency response time for transport to get to a clinic for an emergency is more than an hour for Khayelitsha, though South African Health Review reports a less than an hour response time for the Western Cape (HST, 1998:163). On availability of services, dental services are available in one community health centre, laboratory services and after hour x-ray services are not available at all.

4. 6 *EQUITY*

The public health services in South Africa are froth with manifestations of inequity. These inequities are along racial divisions, geographically between regions as well as urban and rural settings and within the hierarchical levels.

In the 1998/1999 health budget for the Western Province the following picture unfolds. Allocation in order of priority were as follows:

LEVEL	AMOUNT
Academic Hospitals	R 1155 254
Primary Health Care Services	R 492 474
Regional Hospitals	R 449 865
Special Hospitals	R 283 129
District Hospitals	R 230 487

(Source : Bletcher M, 1999)

This budget allocation still emphasises the importance that is placed on academic hospitals which are predominantly curative. Having said that one should note that because of the big academic institutions, it will take phasing in the reduction of budgetary allocation to these institutions.

It is sad that towards the end of this century the health budget still show such discrepancies between the preventive and promotive, and curative health care, especially in the light of the slogan of the WHO of " Health For All by the year 2000". It is therefore not surprising to note that personnel in the CHSO health facilities in Khayelitsha are more than personnel employed in the health care facilities of the local authority see (**Annexure 1).**

4.7 *DECENTRALISATION AND LOCAL ACCOUNTABILITY*

The management of health services in Khayelitsha is still centralised. Though both public authority services have middle management allocated and based within the health district, decision making in regard to personnel and financial control lies outside the district where management is based at the headquarters in Woodstock and Libertas for CHSO and COT respectively.

There has been initiatives to empower personnel at the district level through training of low and middle management in management courses and through the establishment of the Health Information System Pilot Project (HISPP) which focusses at collating health information for the district of Khayelitsha. The intention of these initiatives is to ensure that personnel at local levels are empowered to make appropriate decisions .

The establishment of the District Coordinating Teams which consist of senior managers from both public health authorities, has been a step towards decentralisation, unfortunately these task teams do no have scope for decision making, thus issues relating to service delivery, are again decided upon outside the health district.

To promote accountability at local level, in 1995 the then Cape Metropolitan Council introduced a participatory management system which encourages discussions and decision making of staff on issues pertaining to service delivery. Because these structures are perceived as tokenism by the personnel, more work is needed to empower the

participants and render these structures valid.

4. 8 *EFFICIENCY AND EFFECTIVENESS*

Efficiency is defined as the ability to produce a desired product with the minimum effort, expense or waste . On the other hand effectiveness is the ability to produce the desired result (Collier's Dictionary, 1994). From the above mentioned discussions covered under the headings of fragmentation and comprehensiveness which highlight the duplication and overlap in service delivery, it is clear that the criteria for efficiency is not reached.

To measure effectiveness important health indicators as measurement for the health of a nation were developed by the WHO. The Infant Mortality Rate (IMR) in Khayelitsha is reported by the Cape Metropolitan Council to be at 50.3% per 1000 live births in 1986, compared to the IMR of 20.4 per 1000 live births for the neighbouring Mitchells Plain health district (Mash, 1996:21). Though there is the possibility that the IMR for Khayelitsha may be inaccurate because of the denominator distortion which is the result of an influx of sick infants from the homelands, the seriousness of the situation cannot be ignored. However, there has been improvements that have been noted in subsequent years with the IMR dropping to 38.8 per 1000 live births in 1998, though still notably higher than other health districts and within the COT, though this indicator is lower than the Western Cape (53) and South Africa (56), Khayelitsha is still far from the recommended target of 20 IMR per 1 000 live births.

Another important indicator is the morbidity indicator. TB in the Western Cape is reported to be the highest in the world with the COT as having the highest incidence amongst the other six local authorities. In 1996 the incidence of TB defined as an incidence per 100 000 was 604 compared to the rest of the Province which was 702(Mash, 1996:9). Cure rates of new smear positive cases was 62% as against the targeted 85% (COT Health Department Quarterly Repot, April 1999).

Although both indicators could be improved with better health services, one should note that they are both related to poor socio-economic conditions. This is the reason for calls and pleas for co-ordinated planning amongst all government departments, NGOs, the private sector and the community,

4.9 *COMMUNITY PARTICIPATION*

Before the national elections for the democratised South Africa, Khayelitsha district enjoyed a fair amount of community participation. This was in the form of health committees for the different clinics which were involved in matters such as site identification for the construction of a new clinic, tender process, appointment of a contractor, colour scheme, planning of the opening ceremony and appointment of general workers such as cleaners and clerical component for the newly build facility. Four very active health committees were in operation which report to a co-ordinating structure, the Khayelitsha Health and Welfare forum. These committees have not developed to the stage where they determine the objectives for the health care facilities as proposed by the Draft on Provincial Health Plan.

After the 1994 elections which marked the beginning of a new South Africa, community involvement experienced a downward turn with more and more health committees dissolving. This, it was suspected was caused by many factors such as the lack of financial incentive for a trying and demanding job as well political warfare amongst the different parties.

To revive the community involvement the health care professional are once more playing a leading role in reviving these structures, supporting them with administrative needs such as transport to meetings and access to stationery materials and telephones. Training needs are also identified and training arranged. A financial contribution of R1 000.00 was contributed by the health department towards the running of each local committee. Today in Khayelitsha there are six health committees which are active though not as active and developed to the level that is proposed in the Provincial Health Plan Draft.

4.10 DEVELOPMENTAL AND INTERSECTORAL APPROACH

There is a poor intersectoral approach to the development of health services in Khayelitsha. It has been already indicated that between the two health authorities co-ordination is poor because of perceived barriers. Even within the local authority itself there is no co-ordination in service delivery. Other departments within the COT such as housing, environment, sports and recreation, urban planning, that could influence health positively all work in isolation. Thus the benefits of integrated approach to planning

service delivery are non-existent.

The lack of collaboration is just as poor with the private and the non-governmental organisations. Such co-ordination is also poor with other state departments such as the department of education.

4.11 *SUSTAINABILITY*

Services rendered in Khayelitsha, especially by the local authority clinics are mostly nurse based with a medical officer support. This element addresses the element of efficiency and affordable service delivery. The phased approached to service delivery has been adopted through the addition of a component of service, one at a time e.g. the curative and once stability has been obtained, another service. Combining the two health authorities would achieve even greater comprehensiveness and sustainability. This has not been achieved in Khayelitsha or elsewhere because of the absence of the enabling legislation which addresses the integration of these services.

4.12 *CONCLUSION*

Public health services in Khayelitsha are fragmented in authority structure and type of services rendered by each authority. This has consequences for comprehensiveness, quality, equity, access, and sustainability to service delivery.

The following are negative effects of fragmentation on public health services in Khayelitsha.

- Effectiveness and efficiency are not achieved.
- Duplication is resulting in costly services and inequitable distribution of resources.
- Quality of services is compromised
- Access to services is compromised.
- Comprehensive services is not achieved.

The table below summarises the functions rendered by the different public health authority in Khayelitsha as well as service distribution of health facilities amongst the health authorities:

TABLE 4

Authorities, Facilities and Services rendered in Khayelitsha

ADMINISTRATIVE AUTHORITY	ORGANISATION	NAME OF CLINIC	SERVICES PROVIDED
Provincial Administration of the Western Cape	Community Health Services Organisation	* Nolungile Day Hospital * Khayelitsha Day Hospital * Michael Mapongwana Day Hospital	* Curative care * School health services * Specialised psychiatric services (mental health)
Provincial Administration of the Western Cape	Maternity and Obstetrics Unit	* Khayelitsha Maternity and Obstetrics Unit	* Antenatal * Postnatal * Delivery services
Local Government	The City of Tygerberg	* Empilisweni clinic * Luvuyo clinic * Matthew Goniwe clinic * Nolungile clinic * Mayenzeke clinic * Site B clinic * Zakhele clinic * Mobile clinic	* Tuberculosis * Sexually Transmitted Diseases * Baby wellness clinics including immunisation * Health education * Nutrition education * Family Planning * Curative under 6 years * Environmental health

5. *CONCLUSION*

5.1 *INTRODUCTION*

This chapter summarises the findings on public health services in Khayelitsha as evaluated in terms of the DHS principles as outlined in the white Paper. Possible steps which will facilitate comprehensive primary health care services are highlighted.

5.2 *FINDINGS*

- The public health services in Khayelitsha feature structural fragmentation with two main authorities, namely, the municipality of the City of Tygerberg and the Community Health Service Organisation under the Provincial Administration of the Western Cape being responsible for primary health care services.

- Functional fragmentation characterises the primary health care services with the municipality focussing on the preventive and promotive health services and the province focussing on community curative health services

- Access to the services is limited with majority of services being available from 07:30 until 16:45 on week days. Thereafter only trauma and maternity services are available after hours and during week ends. Access is further limited by the functional fragmentation with services provided in a specific facility as determined by the authority which owns the facility. Restriction to access is further exacerbated by inadequate skilled personnel who are not trained to deal with a wider scope of comprehensive primary health care service.

- However access in terms of distance to a health centre from each community has improved greatly with only two communities having a walking distance of more than 2.5 km but less than 5 km.

- Decision making is mainly made at the head offices, at Libertas and Woodstock for the City of Tygerberg and Community Health Services Organisation respectively.

- Quality care is compromised by the long queues which result in the long waiting times which are caused by the heavy clientele workload.

- The restriction to a wider scope of comprehensive primary health care services from all facilities further impacts on quality care.

- A major breakthrough towards quality care has been achieved with the establishment of uniform protocols for the management of common conditions in the Western Cape. These protocols are also implemented in the health services in Khayelitsha.

- The inequitable distribution of resources between the two health authorities is apparent with provincial health services having more nursing personnel in the three health facilities than the local authority clinics for the rendering of health services for the same total population which is estimated at 350 000(**Annexure I)**

- Ineffective services are featured in the poor health indicators of high infant mortality rate, high TB defaulter rates for this district when compared to the health indicators of the other two health districts of the COT and the neighbouring districts (**Annexure II).**

- Inefficient use of resources is more apparent in the duplication of health facilities and uncoordinated health services delivery. Positive initiatives have been introduced in this regard with local and middle managers having regular meetings to explore various ways of integrating the services and building relationships between the two health authorities.

5.3 *RECOMMENDATIONS*

The recommendations that follows look at the promotion of comprehensive Primary Health Care services as the key aspect in improving services. Comprehensive health services also impact on other criteria which are given as guidelines for the successful implementation of the District Health System, namely, over coming fragmentation, the promotion of cost effective services, the promotion of available services, efficiency,

accessibility, quality and effectiveness.

5.3.1 Alternative 1

The best alternative to achieve the comprehensive PHC service as envisaged in the White Paper is to integrate both health authorities. In the absence of enabling legislation which enables these two health authorities to integrate, and the long overdue decision on the governance of PHC within the districts , these services are solely dependant on the willingness and goodwill of the service providers to come and work together. This creates a situation of a fragile base for a service that could be good. The integration of these services has been encouraged at all levels of management, but because of salary disparity and different conditions of service experienced while piloting service integration, there is a very slow movement towards this. With the Unicity being inevitable in the near future, discussions to unbundle the provincial personnel to the municipalities are underway. If this step could be finalised integration could happen and DHS a reality for Khayelitsha public health services.

5.3.2 Alternative 2

In the light of the problems highlighted in Alternative 1, the following recommendations are made :

- That the Nolungile health facility which houses both health authorities, fall under one authority, the COT. All personnel allocated in this facility be employed by the municipality.

  To achieve this , all personnel categories that are employed by the CHSO be substituted by relocating them to other CHSO health care facilities and replacing them by those employed by the COT. Key personnel in the likes of the medical officer and the Sister in charge to remain in the facility for a period of not longer than twelve months. This would also ensure orientation, support and skills transfer.

- All future vacancies be filled with persons who have the skills needed for comprehensive primary health care.

- Management to discuss handover details as regards the equipment, facility and costs allocations. The cost of medication be retained by the CHSO as this is the prevailing agreement between PAWC and the COT.

- The Site B Community Health Centre be under the authority of the CHSO. All personnel in this facility to be under the employment of the CHSO except for personnel who are rendering specialised functions such as Tuberculosis and Family Planning services who should be requested to remain for a period of not more than 12 months for orientation and support purposes.

- Management to discuss handover and management details of the facilities.

- The Empilisweni clinic which falls under the authority of the COT which is less than a kilometre to the 24 hour CHC which is a CHSO facility be closed and the preventive and promotive services rendered in this clinic be integrated into the CHSO Michael Mapongwana Community Health Centre.

- The staff at the Empilisweni Clinic be redeployed to other COT clinics and depending on the need, to the Michael Mapongwana CHC as well. This of course would require intensive negotiations with personnel of both health facilities and the community.

- The Mayenzeke clinic which is approximately a kilometre from Luvuyo clinic (both are COT clinics) be closed and allocate personnel to the Luvuyo clinic and Matthew Goniwe clinic in order to ensure a wider scope of services and to strengthen the comprehensive services rendered in this clinic.

- Luvuyo clinic to serve as a satellite of Matthew Goniwe clinic where complicated cases could be referred.

- Zakele clinic to remain as the satellite of the Site B comprehensive Community Health Centre to which all complicated cases and patients who require services that are not rendered in this clinic can be referred.

- Training of staff in skills for primary health care to be fast tracked and to enjoy the highest priority, this needs to be coupled with incentives to retain trained nurses. This is aimed at ensuring comprehensive services in most facilities and also uniformity within the district.

Annexure III is a diagrammatic presentation of the recommendations.

5.3.3 Service Operation Times

That services be available from 07:00 to 19:00 whilst maintaining a 40 hour week and an eight hour shift daily. Extension to services be extended to Saturday 08:00 to 12:00 (This proposal does not replace the 24 hour service already in place).

6. *SUMMARY OF STUDY*

Following the democratization process of the Republic of South Africa in 1994, a series of events on restructuring ensued. The Republic of South Africa was divided into nine provinces and the local authorities were restructured into local government structures. Many government departments which also involves the Department Health went through a process or transformation. Each local government area was divided into health districts for efficient management of health services. The White Paper for the transformation of health services proposes zoning of local governments into geographical areas called health districts for the efficient management of health service delivery within these districts. The implementation of the DHS for comprehensive PHC services is portrayed as the best alternative in ensuring accessible quality of health care to all the citizens in South Africa in an equitable manner.

Before the introduction of the White Paper with proposals for restructuring, the public health sector rendered health services as enforced by the Health Act No 63 of 1977. This Act which legally still applies perpetuates the proposal of the previous Public Health Act and the subsequent influence of the apartheid era which resulted in public health services being characterised by the domination of curative health care to preventive care, rural urban discrepancies and inequalities, and White versus Black inequalities in health service delivery and care. The situation was exacerbated by delegations of curative care to the province at second tier and the preventative and promotive health care to local authority at third tier of government level.

The White Paper which intends to transform the existing health services has its framework based on the principles of the RDP and envisages a DHS as a vehicle for redressing the imbalances of the past acts. It proposes the implementation of comprehensive PHC which would ensure accessible, efficient health service delivery in an equitable fashion to all South Africans.

These proposals call for the reorganisation of the existing public health services, between the municipal clinics and the CHSO facilities in all districts. This is applicable to Khayelitsha as well. Integration of these two public health authorities into one entity would best achieve the principles of the DHS and will ensure comprehensive PHC.

In the absence of enabling legislation to facilitate the integration and together with problems experienced with attempts to integrate these two public authorities, alternative ways of ensuring that some of the principles of the DHS are implemented are explored. These principles are comprehensive health, accessibility, decentralisation, quality, efficiency, effectiveness, overcoming fragmentation, equity and local accountability.

In an attempt to reduce the conflict that is the consequence of the different conditions of service, policies and procedures, reorganisation of the health services between the two major health authorities in Khayelitsha district is imperative. Each health care facility, it is proposed must be managed by one health authority. Instead of having seven facilities, closing down two clinics is recommended with five structures remaining. This proposal will result in the district having four community health centres rendering a wider scope of the primary health care services, two of which operate on a 24 hour basis, whilst the remaining two render a limited scope of service and referring to the bigger centres.

The closure of the two health facilities that are in close proximity to other health centres will ensure better staffing and thus quality to the affected clinics. While a cost analysis has not been done there are strong indications that this proposal will be much more effective than the present situation.

7. *BIBLIOGRAPHY*

1. Abdulah F, 1998, **Ministerial Task Team on Governance of Health Services,** Department of Health, Cape Town.

2. Bachman M & Barron P, 1996, **"Missed Opportunities for Immunisation in Curative and Preventative Services in a Community Health Centre",** SAMJ volume No 8, August: 847-948.

3. Bachman M & Mtwazi L, 1993, **An Evaluation of Quality of Care in WCRSC Khayelitsha Family Planning Clinics,** Community Health Department, University of Cape Town and Western Cape Regional Services Health Dept.

4. Barron P & Zwarenstein M, 1992, **Managing Primary Health Care in South Africa at the District Level,** MRC/IUPHC workshop.

5. Bitalo, 1999, **Interview with Senior Medical Officer of the Community Health Services in Khayelitsha**, September 1999..

6. Bletcher M, 1999, **Interview with Metropole Region of the Western Cape**, October 1999.

7. Browne Commission , 1986, **Final report of the Commission of Inquiry into Health Services,** RP67/1986, Pretoria, Government Printer.

8. Bupendra M & Munro G, 1998, **Report on South African Public Sector Provincial and Local Government Health Personnel Salary and Benefits for the 1997/98 Period. Revisiting and Demystifying the Parity Debate,** Department of Community Health, University of Cape Town and South Peninsula Municipality.

9. Butler R, 1994, **"Reinventing British Government"** in Public Administration International Quarterly, Vol. 72 (Summer).

10. **Constitution of the Republic of South Africa**, 1996 (Act 108 of 1996)

11. Cornelissen J, 1997, **"Primary Health Care. The Implication for Human Ecology at the University of the Western Cape",** Journal of Dietetic and Home Economics, Vol. 25, No.1 page 67 - 70.

12. Crisp N, 1997, **"Standards, Sophistication and Quality, The Health Balancing Act",** Indicator SA, Vol. 14, no 1 (Summer).

13. Department of Constitutional Development, 1998, **The White Paper on Local Government, no 18739,** 13 March, Pretoria
Department of Community Health, William M Pick, **Working Paper No 2 , The Fragmentation of South African Health Services,** Health Economics Unit, University of Cape Town,

14. Department of Health, Directorate Policy and Planning, 1998, **District Workshop Report on Integrated "One Stop" Health Services, Western Cape**.

15. Department of Health, 1995, **Towards the National Health Care System.** Pretoria

16. Department of Health, 1996, **Official Policy Document on Restructuring the National Health System for Universal Primary Health Care,** Pretoria.

17. Department of Health, 1997, **The White Paper for the Transformation of the Health System in South Africa, No 17910,** 16 April, Pretoria.

18. Department of Health, Metropole Region, **Annual Report April 1996- March 1997** Provincial Administration of the Western Cape.

19. Department of Health, City of Tygerberg, 1999, **Personnel Records, 1999.**

20. Department of Health, City of Tygerberg, 1999, **Quarterly Statistics April 1999.**

21. Department of Health and Welfare, 1996, **Health Care in the Eastern Cape, Implication for Planning.**

22. Department of Health and Welfare, 1980. **National Plan for Health Services Facilities.**

2.3 Department of Public Service and Administration, 1997, **The White Paper on Transforming Public Service Delivery (Batho Pele), no 18340**, 1 October, Pretoria.

24. De Villiers MR, 1997, **"Integrating Health Care at the Community Level",** SA Family Medicine: page 6- 9.

25 Grewe A, 1998, **Making Labour Centres Work,** Unpublished MPA thesis, University of Stellenbosch.

26. Harrison D, 1997, **"Saving the System. Making Primary Health Care Work",** SA Indicator; Vol. 14 No. 1 (Summer) page 22 - 26.

27. Harrison D & Mc Queen A, 1992. **An Overview of Khayelitsha. Implications for Health Policy and Planning,** MRC/IUPHC.

28. **Health Act**, 1977 (Act 63 of 1977).

29. Health System Trust., 1997, **"Policy in Progress. Primary Health Care Training"** HST update issue No. 26, page 7 - 9.

30. Le Roux I.M & Le Roux P.J, 1991, **"Survey of the Health and Nutrition Status of a Squatter Community in Khayelitsha",** SAMJ Vol no 79:500-503.

31. Mangindi V, **Interview with Clinic Clerk of the City of Tygerberg**, 17 December 1997.

32. Mash B, 1996, **"Khayelitsha District Annual Report for 1996",** Health Information Systems Pilot Projects.

33. Mc Intyre D, Chetty K & Ensink K, 1994, **The Utilisation of Health Services in Site C, Khayelitsha,** Working Paper No 8, Health Economics Unit, University of Cape Town.

34. Mpumalanga Department of Health, Developmental Welfare and Gender Affairs, 1996, **Primary Health Care in Mpumalanga : Guide to District Based Action.**

36. National Health Services Commission, **Report on the Provision of an Organised National Health Services for all Sections of the Union of South Africa,** (U. G. 30). Pretoria: Government Printer, 1944.

37 Owen C.P, 1995, **A Policy for the Development of A District Health System for South Africa,** Health Policy Coordinating Unit and Department of Health, Pretoria.

38 Reagon G, 1998**, Workshop on Efficient Cooperative Working within Services shared by the City of Tygerberg and the Community Health Services Organisation,** March page 1 - 81, City of Tygerberg Health Department.

39. Searle C (ed), 1984, **Aspects of Community Health in South Africa,** V& R Printers (Pty), Ltd, Pretoria.

40. Shung-King, 1998, **An Evaluation of the Down- Scaling of Red Cross Children's Hospital Medical Outpatient Department in the Western Cape Metropolitan Region,** Child Health Policy Institute, University of Cape Town.

41. Utshudi-Lumbu A, 1993, **"Integration of Vertical Health Programmes into Horizontal Ones in the South African Primary Health Care Systems",** CHASA Journal Vol 4 no 2:39 - 43.

42. Van der Walt H & Schoeman H, (1996) **Staff's Experiences regarding the Integration of Services in a Comprehensive Health Care Clinic, Belhar I**, page 1 - 13, Medical Research Council.

43. Van Rensburg HCJ, Fourie A & Pretorius E, 1992, **Health Care in South Africa : Structure and Dynamics,** JL van Schaik (Pty) Ltd, St Hatfield, Pretoria.

44. Van der Marwitz J, 1997, .**The establishment of a Comprehensive Primary Health Care Service at the Motherwell Community Health Centre,** University of Port Elizabeth.

ANNEXURE 1

Nursing Personnel in Khayelitsha Health District between the City of Tygerberg, Community Health Service Organisation Clinic in 1998.

NURSING CATEGORY	C.O.T	C.H.S.O
Professional Nurse	68	89
Enrolled Nurses	12	36
Enrolled Nursing Assistant	18	60
Total	**98**	**185**

The staff establishment does not include other health care workers like doctors and support services e.g. radiographers, pharmacist, social workers and clerical admin workers.

ANNEXURE 2

City of Tygerberg

Health Department

Causes of Death amongst infants in Previous Year (97/98) and Current Year (98/99)

Categories of infant deaths as a percentage of all infant deaths in Health Districts

CONDITION CAUSING THE DEATH	Eastern District		Western District		Khayelitsha District	
	87/89	89/99	87/89	89/99	87/89	89/99
Cause Unknown	47%	23%	33%	25%	30%	38%
Related to birth circumstances	28%	39%	27%	15%	15%	8%
Diarrhoea	9%	5%	3%	5%	12%	9%
Chest infections	4%	9%	12%	10%	12%	20%
All other infections	2%	0%	4%	2%	7%	5%
Violence and accidents	2%	0%	5%	3%	4%	8%
Fires	0%	0%	0%	0%	2%	1%
Malnutrition	2%	5%	0%	0%	2%	2%
Congenital anomalies	0%	7%	10%	8%	5%	0%
All other causes	6%	12%	6%	32%	11%	9%
Total	100%	100%	100%	100%	100%	100%
Actual Infant Mortality Rate	**17**	**23**	**19**	**22**	**38**	**41**

ANNEXURE III

Diagramatic presentation of the recommended health care facilities in Khayelitsha