National Situation Analysis of the Health Sector:
Perceptions of Communities and Health Workers

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This article focuses on the indepth participatory situation analysis, including the methods used, common themes, perceptions of and attitudes towards the conditions of the health services held by some health workers, community members and organisations.

Constraints and Limitations

The main constraints that hampered the complete achievement of the objectives set for the situation analysis in some of the areas were :

1. The time allocated for the fieldwork was inadequate. There was limited time for thorough consultation with community leadership in some of the communities, and there was reluctance by some community members to participate.
2. Some of the communities identified to participate in the situation analysis were experiencing turmoil at the time. Instability is a common feature of informal settlements.
3. The lack of tangible and immediate benefits (intervention) that members of the community could associate with their participation, resulted in reluctance and disinterest in some instances.
4. The situation analyses did not enjoy maximum participation of the members of the organisations (NPPHCN and SAHSSO).
5. The limited resources from the national office to the regions, especially financial, hampered the fieldwork considerably.

Methodology
A) Study population

Four areas were identified by the National Policy Sub-committee for the analysis. They were :

- an informal peri-urban area within the Durban functional region, Natal;
- a rural area in the Mhala-Mapulaneng district in the north eastern Transvaal (N/E Tvl);
- the informal settlement of Botshabelo in the Orange Free State which emerged from forced removals in the past; and
- a dense township dwelling in Soweto, southern Transvaal (S/Tvl).

B) Research Teams

In each of these areas, fieldworkers were employed for periods ranging from 3 to 4 months to conduct 'focus group' discussions and interviews. The fieldworkers received training in interview techniques, methods and analysis, prior and during the period of the situation analysis. Each fieldworker was attached to a research centre/unit which served a supervisory role.

C) Focus Groups (FGs), Interviews and Workshops

These were the main methods used. Most of the focus groups were drawn from communities and a few from health workers. They served the purpose of directly eliciting the perceptions and attitudes of some community members and health workers on needs and problems with health services. The interviews were held with key informants, mainly, health workers. Table 1 summarises details about the focus groups, workshops and the interviews.

Summary of Themes
A) Community participation

There was lack of common understanding of what community participation means. However, the following explanations of what community participation could involve, were given :

- Many health workers believed it is the basis of making people do things for themselves.

Table 1.

AREA	NUMBER	SIZE	TYPE & COMPOSITION
NATAL	2 FGs	12 - 26	Mixed (16-38 yrs.,civics, youth) Health Committee (Females, 21-43 yrs.)
	3 Workshops	15 - 32	Members of the policy committee
	9 interviews	9	Health inspectors Community nurses Member of family
NE Tvl.	4 FGs	7 - 10	Mixed (drawn from forum of 45 people representing 17 organisations
	3 FGs*	5 - 10	Matrons (local hospital) Professional nurses (local hospital) Community Rehabilitation Worker Trainers
	4 interviews	4	Professional Nurse Former Matron Director Wits Rural Facility Director: Human Services Development Unit
OFS	10 FGs	6 - 12	Mixed and female (17-48 yrs drawn from political organisations, mothers, civics, a self-help project, church youth groups)
	3 FGs*	3 - 14	Community Health Workers, Community nurses, Chief professional nurses, social workers
	13 interviews	13	Superintendent, Family planning nurse, PHC nurse, 2 Pharmacists, Occupational therapist, Health education advisor, Director for Housing (PAO), Social workers (PAO)[1], Community based project coordinator, Unionist manager -SADTC[2]
S. Tvl.	7 FGs	6 - 10	Separate (old aged women, young mothers, youth below 25 years)
	6 interviews	6	Nurse, 3 Teachers, Shopkeeper, Youth leader

- Some of the health workers saw it as including compromise by communities, and the lowering and subsequent matching of their expectations with what is possible and available. They also saw participation as a form of health education, for instance, whereby mothers would be taught about matters such as sexual education and hygiene. They, in turn, would teach their own families.

Problems such as poor leadership, high mobility of some communities caused by seasonal migration, the lack of a common history and tradition especially in informal settlements, were mentioned as major hindrances in the attainment of successful community participation.

B) Problems in Health Services

The situation analysis identified a number of common problems communities faced, in terms of their access to health facilities. A summary list of these problems is as follows:

- There was a perpetual deficiency in emergency (ambulance) services, caused mainly by historic imbalances and inequalities. Where these services are available, they are poorly equipped and staffed, particularly in rural areas. The need for these kinds of services has been heightened by problems associated with violence, especially in informal settlements.
- Most health services (clinics) in communities are not adequately accessible. Most of them function only during working hours. They are closed after hours and during week-ends. The services are also inadequate, especially maternity services, which are non-existent at some of the clinics. This causes many pregnant women to travel long distances. They are often compelled by these circumstances to give birth unattended.
- The quality of clinical care was often seen to be unsatisfactory, by community members. A review of the qualifications of health workers providing primary health care, indicated a widespread inadequacy and inappropriateness of the training of health workers. This explains the constant demand from communities for professional categories of health workers, such as doctors. This point is further illustrated by the high referral rates from clinics located in communities, whenever such referrals are possible. However, most of the community health workers felt they were adequately trained, and were positive about services rendered.
- There are persistently long queues and waiting times before patients are attended to. This is often contrasted to the prompt, though expensive services rendered by private doctors (GPs).

- The attitude of health workers was perceived as negative, 'victim-blaming, rude and insensitive' in most cases.
- Malnutrition was seen as a major health problem. There is, therefore, a need to develop short and long term strategies to deal with this problem and other drought related crises. Clear guidelines on what structures should be responsible for implementation of programmes that emanate from these must be carefully worked out.
- There was a general appreciation of Community Health Worker (CHW) programmes, from communities in which they existed. In those communities from which they were absent, a desire was expressed for their introduction.

C) Socio-economic conditions

The most overwhelming problems in all the areas studied were - poverty, unemployment, poor levels of education and adverse environmental conditions. This includes lack of water supply and sanitation, refuse removal, over-crowded and congested housing. Some of these problems were seen as requiring national and long-term solutions. Some could be addressed through constitutional and legislative changes, for example, giving people ownership rights to land, credit facilities for housing development and access to natural water resources.

Inanda, Durban: one of the fastest growing informal settlements.
Photo: Omar Badsha

However, there are those requiring urgent and vigilant health service interventions from other sectors. These include water supplies, sanitation and refuse removal. The reasons for failure by the present ministry of health to assure the necessary input from other sectors must be analysed, and new policies and interventions be developed. Other social problems identified were alcohol and drug abuse, teenage pregnancies and child abuse.

D) Non-government Organisations (NGOs)

The role of non-government organisations in rendering health and welfare services was considered to be positive and substantial. These organisations were seen as serving communities, because of the government having neglected its responsibilities to those communities.

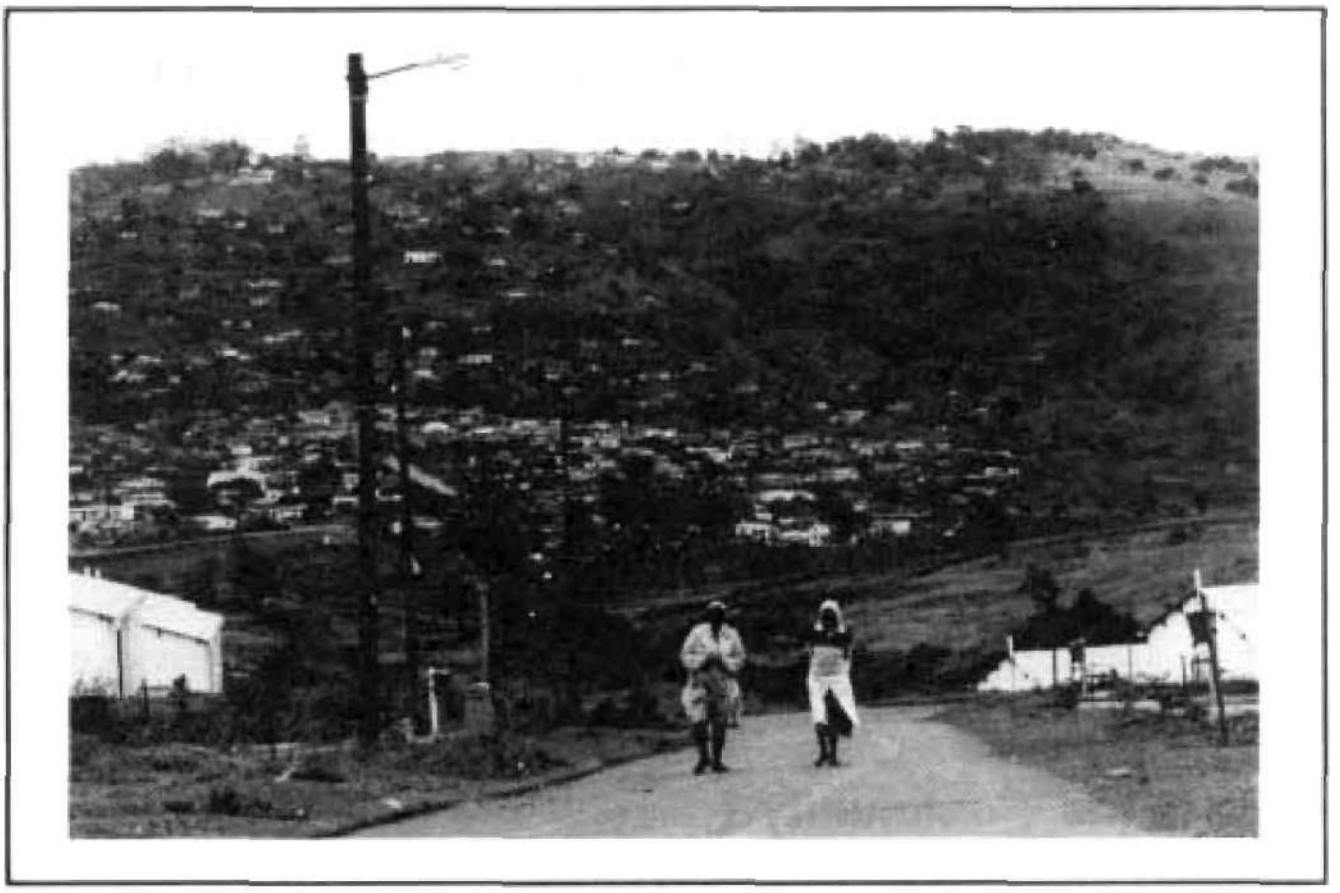
An Assessment of the Situation Analysis

In general, the quality of the in-depth analyses was high. The information gathered will be of value to communities and health planners. However, there are areas that may need further consideration.

Perceptions of communities and health workers of health services continue to vary. Could this be the result of a wide gap between health workers and the communities they serve, and a lack of contact and communication between these interest groups? The notion of community participation (widely accepted as crucial for the attainment of equitable health services) is far from being understood. Not only are health workers confused by this, but also communities are unable to articulate what role they want to play in the rendering of health services.

Does the imminent change, from an uncaring to a possibly more responsible and democratic government, require a review of the roles of NGOs? One of the objectives of the situation analysis was to build capacity within NPPHCN and SAHSSO and their memberships. This has, however, not been as successful as expected. The situation analysis has raised expectations within communities. What can the NPPHCN and SAHSSO do about such expectations in the short-term and long-term?

Moreover, although the situation analysis gives a sense of the range of problems likely to be found in the country, it cannot be used to view very clearly the problems of any particular community. The problems arising from the fragmentation of services, and the issue of incorporating community participants in decision making need to be addressed urgently. As a consequence of the



How will prioritisation of resource allocation in a country of such widespread poverty be decided? *Photo: Ismail Vawda*

scarcity of resources, even after a democratic government has taken over, prioritising resource allocation to deal with specific health problems (such as sanitation, water supply or health education) is essential. Some communities, especially in rural or informal settlements, will require more attention than others. There should be re-training and re-orientation of health workers in order to improve the quality of health services in communities.

Footnotes

* These focus groups consist of health workers only
1. POA - Provincial Authority of the Orange Free State
2. SADTC - South African Development Trust Corporation

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