Accountability in Progressive Primary Health Care

Alex Clinic

Medicins du Monde

Critical Health

Underprovision of services, overworking of staff, and bureaucratic procedures, amongst other problems, have been the experience of many black people when seeking health care.

However, people have not been passive recipients of these harsh conditions. Over the years progressive doctors, nurses and community health groups have set up democratic appropriate primary health care projects as an alternative to that provided by the apartheid regime. The commitment to democratic principles in the provision of health care has engendered a feeling, amongst users, of the project belonging to the community. Often these health centres have served as centres of protection for political activists and people injured by state and right-wing violence. However, none of these alternative service providers have sufficient resources, labour and financial, to overcome the paucity of state health provision.

This political role, and the care health workers took to ensure that there was some community involvement in their projects hinted at the potential for accountability people are keen to see in their health services. However, it must be remembered that such projects arose in a time where there was also little space for mobilization. As such, many projects' structures did not have a strong sense of engagement of the principles of comprehensive PHC and its relation to community participation and accountability. Because of the powerful position that doctors had, for example, they assumed too many responsibilities with little delegation of roles to others. The projects could not necessarily function democratically or necessarily have been truly accountable (see CH#39 - "Progressive Structures, Doctors and Leadership"). Thus there also existed the potential to turn a project into a meaningless statement of rhetoric.

Alexandra Clinic

One attempt to go beyond the rhetoric of accountability is that of the Alexandra Clinic. In spite of the lack of democratic local or national government, the clinic has managed to establish a strong form of political control which takes the form

of a democratically elected clinic board. This is achieved at an annual general meeting at which every adult resident is entitled to vote. The result has been that in less than five years, a majority of the clinic board is now made up of residents, with the Alex Civic Organization in effective control of the clinic.

Accountability is also ensured by health workers participating in community events, and might include health workers providing first aid at political rallies or provide important information to community organisations on the impact of violence or child abuse on the health care of such victims. Health workers could also make their facilities available to the community they serve, provide support for community initiatives in health care, assist in community based research and also request community assistance in the work of progressive health workers.

Alexandra Clinic. *Photo: Critical Health*

However, even this form of accountability has its limitations. Apart from the danger that this local control could be used by the government as a strategy to entrench racial inequality and block the development of an equitable health service, this type of control does not in itself protect user interests. Representatives elected at a district or local government level from a constituency of upwards of 50 000 people are often drawn from a political or economic elite. One of the results

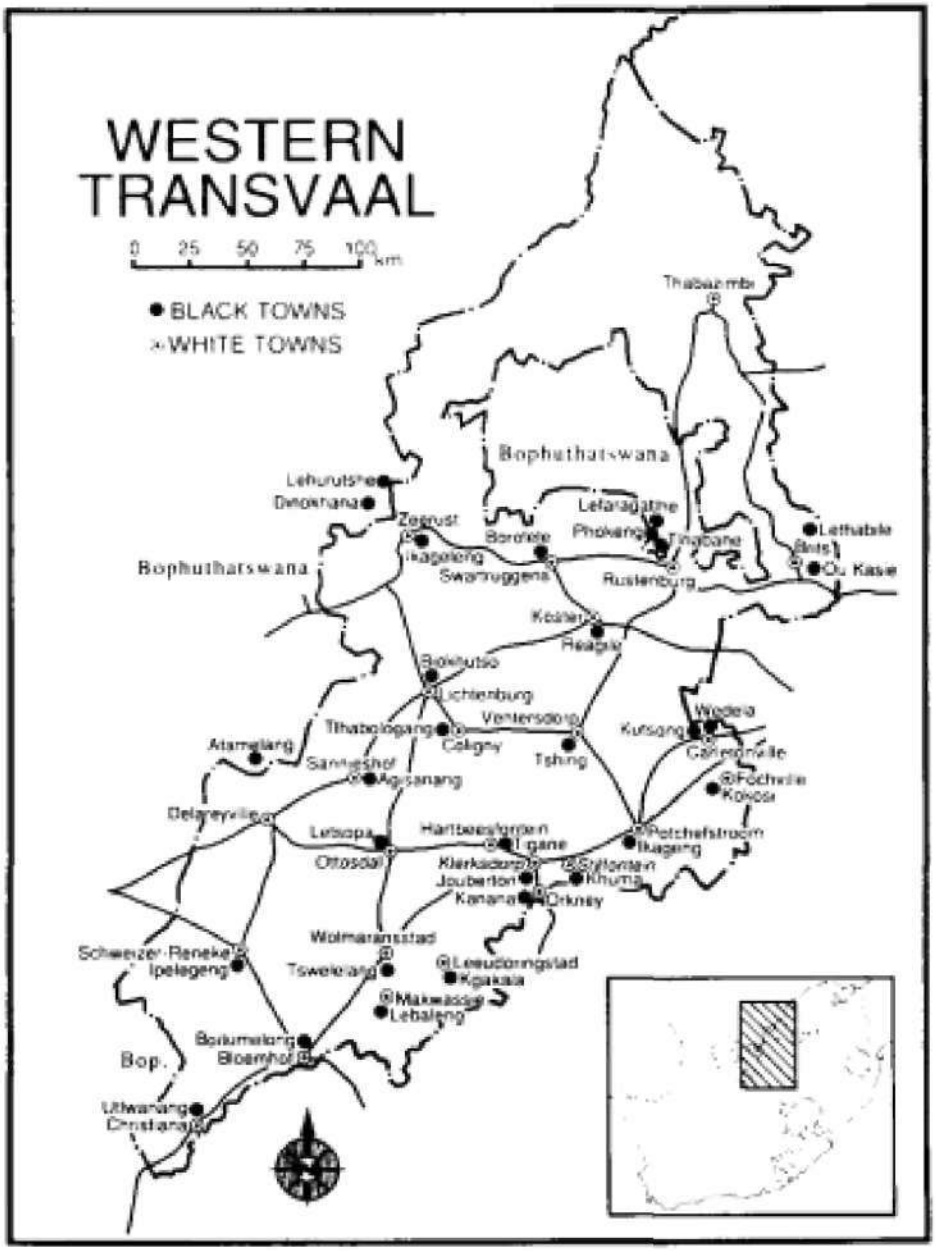
of this is that the democratically elected health service representatives are not necessarily service users and are subsequently not subject to the inefficiencies and inconvenience of the system directly. As a result, their participation often lacks the sharpness by which feedback from direct users can be characterized.

This has been reflected in the Alex experience where the recent establishment of a Civic Health Desk with representatives elected from area committee level has resulted in much more vibrant user feedback. An area committee is made up from a subdivision of the township containing 10 000 to 20 000 inhabitants. Following the establishment of a health desk with representatives from each of the area committees, there have been threats of mass action, demands for particular services and demands for training of community volunteers.

This health desk corresponds to Community Health Committees in the British National Health Service which are made up of representatives elected at ward level (a ward in the British system would correspond roughly with an area in the Alex context). As is the case in Britain, these essentially advisory structures nevertheless have significant influence over their representatives through their members' participation in sub-local authority structures like area committees or wards. Here ordinary residents are familiar with their representatives, know them personally and are not intimidated by them. This improved access means that ordinary residents have much more control over their political representative and an increase in capacity to hold them accountable.

Accountability in Rural Projects

Two field workers of the French Medicines du Monde, a non governmental (NGO) health agency which has four projects in South Africa, expressed a similar view. According to these workers, community participation and accountability work best at projects set up in smaller communities. Residents of these communities tend to relate closely, and have a keen sense and knowledge of many things which affect the community. In some cases, this close association among members of these communities is backed by strong traditions of political resistance and organization against apartheid. Such organization facilitates efforts by health workers to engage these communities' (or at least that of their chosen leaders') interest in their health projects.



Strong Organization Oukasie

The Medecins du Monde workers compared the situation at two communities to illustrate their point. One of these, Oukasie (near Brits), is a peri-urban settlement with a population of about 9 000 people. The Oukasie community is one of the few surviving freehold settlements (or so-called "black spots") and has resisted forced removals since 1953. Oukasie borders on the white town of Brits, whose population is about 22 000. While little growth is predicted for Brits, it has been projected that within five years, the population of Oukasie will be 24 000. This community has an unemployment of approximately 60%. It consists mainly of shacks, and has one tap per 50 households.

At present, besides the community clinic which offers part time curative

Walking down the path of development ? The IDT is financing 1 600 sites in Oukasie. *Photo: Critical Health*

services, Oukasie has a small local authority clinic providing some preventative care. The Transvaal Provincial Authority (TPA) hospital in Brits has 52 beds and 6 maternity beds, but is only available to Oukasie residents with referral. Most patients are in fact sent to the Ga-rankuwa hospital, 15 kilometers away. There is one ambulance serving Brits and one shared between Oukasie and Lethlabile, another settlement, 25 kilometers away. The health committee identified early in 1992 curative and maternity services and transport as priorities.

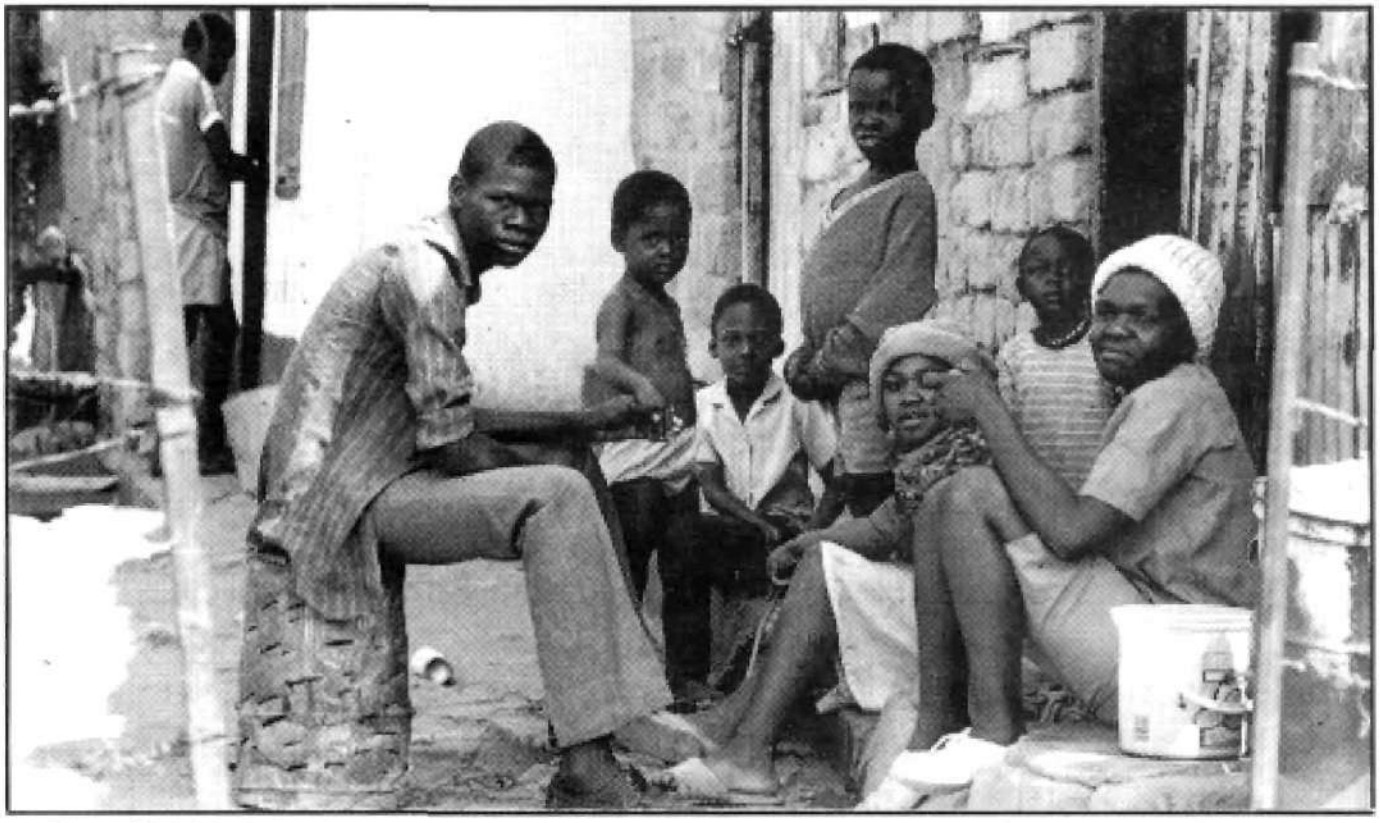
The Structure of the Civic

Today, Oukasie has a strong elected civic association with various sub-committees accountable to it. These sub-committees each specialize in education, transport, finance, health and creche facilities. The community also has a development trust to which these sub-committees are answerable. The development trust consists of people from the community and includes outside agencies from government and non-government organizations, and from local industries. Accountability is ensured by the civic association, which in co-operation with the development trust (including the Independent Development Trust (IDT)), holds a

meeting every six weeks. All the sub-committees report to this meeting. In addition, if a sub-committee deems it necessary, it may invite the chair of the civic association to a meeting on a specific issue related to its work. Direct reportage to the community occurs in the form of public meetings, held every six weeks. Sub-committees may also call on the community's support on important decisions. For instance, when Medecins du Monde approached the civic to assist in their health work, the organization was introduced at one of these public meetings. People welcomed the organization by voting in favor of their working in the community. To facilitate participation of the community at these public meetings, they are held in Tswana.

The Health Committee

The health committee's draft constitution stipulate that it should consist of ten members; two of whom represent outside service agencies and the rest of whom are elected from the community. It meets weekly. This committee has appointed one community health worker (CHW), who works at the community clinic. The responsibility of the CHW is to visit homes regularly to educate people and also to find out the needs of the community as regards their health and other problems. She also works in the community clinic two days a week, with a Medecins du Monde doctor and volunteer students from the medical school at Medunsa.



The CHW visits homes regularly to educate people and find out their health needs. *Photo: Critical Health*

Health Negotiations

In May 1992, the TPA called the Oukasie Civic to a meeting to discuss their own plans for health services in Oukasie. The meeting was also attended by representatives from the Department of National Health and Population Development, Brits City Council and the Regional Services Council.

The health committee invited advisors from Medecins du Monde, Alexandra Health Centre and the Department of Community Health of the University of Witwatersrand to a follow up meeting in June. A new structure for the delivery of preventive care was proposed by the TPA planner, Dr. van Niekerk, with the aim of correcting "unhygienic and uncontrolled behavioral patterns" in the township. Funding for capital and running costs remained unclear. What did become obvious, however, was that the TPA still regarded Oukasie and Brits as two separate entities in terms of health service planning and delivery.

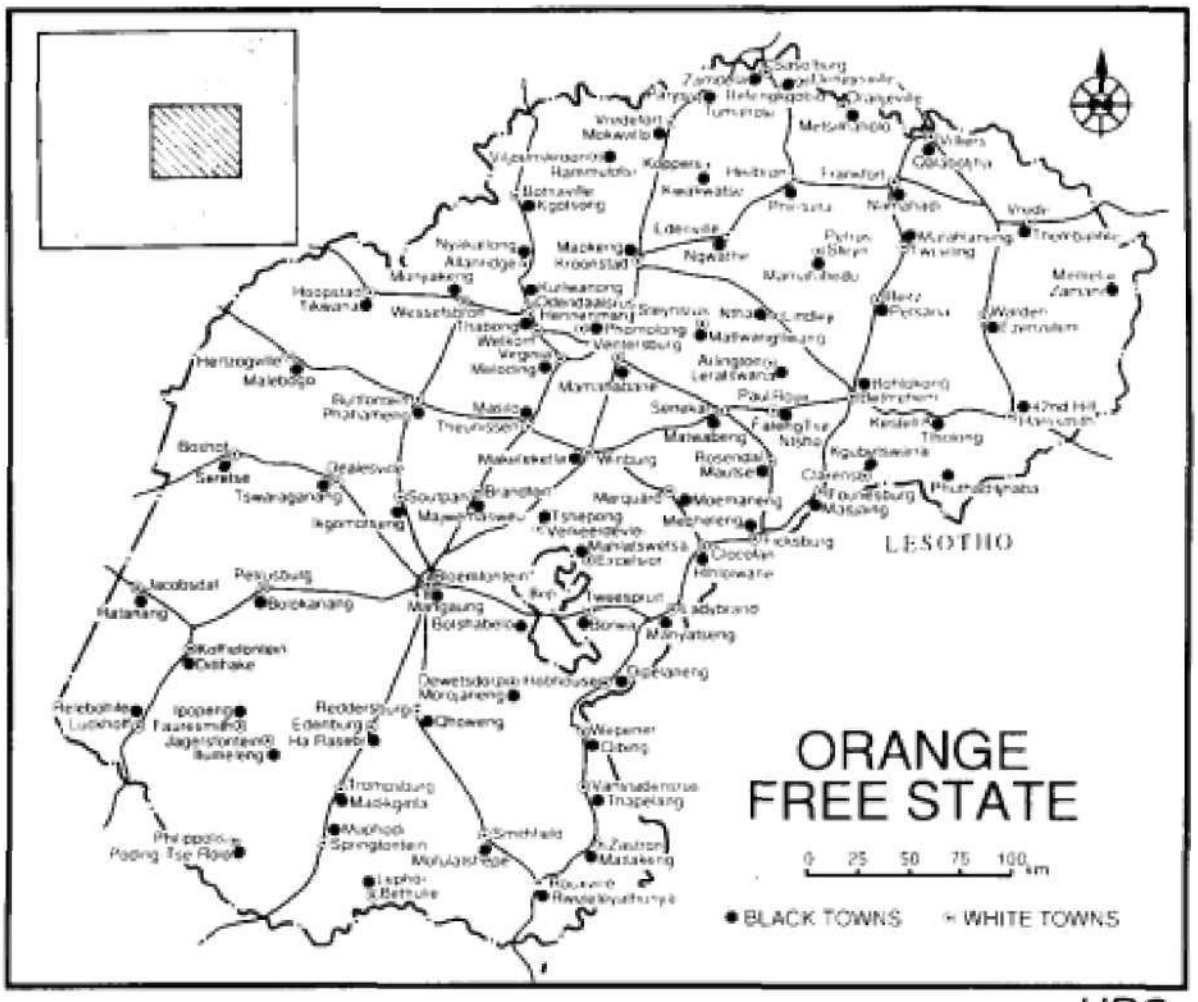
The health committee, with the assistance of its appointed consultants, responded by drawing up guidelines for integrated health service delivery in the Brits district. The TPA then postponed the next meeting indefinitely. At present, both the health committee and representatives from the Dept. of National Health are urging for these negotiations to be resumed.

In the meantime, the community clinic continues to function. Efforts have been made to strengthen the health committee by inviting the Community Based Development Programme (CBDP) to run workshops on organizational and negotiating skills in Oukasie.

Civics with Problems Botshabelo

By contrast, Botshabelo (in the Orange Free State), which was established as an apartheid dumping ground for farm workers forcibly removed from the land, is a less cohesive community. It is occupied by a dislocated population of about 250 000 from various backgrounds. A non-governmental community clinic employs 13 community health workers, an expatriate nurse and a doctor. Medecins du Monde pays their salaries.

However, because of the weak civic structures, this project has been difficult to sustain in a manner that clearly defines its accountability to the community. The community health workers are not elected by the community, although they do extensive house visits to educate and to learn from the community. The civic association was approached in November 1991 by Medecins Du Monde to assist in the restructuring of the health committee. This failed at the



time. Mismanagement and talk of corruption within the civic caused it to be dissolved early in 1992, and an interim civic committee was established until elections were held in June 1992.

In an attempt to channel skills and resources into the civic, there have recently been preliminary meetings in view of establishing a Botshabelo Development Trust. It is hoped that the skills gained through the trust will assist in restructuring the health workers' relationship to the community. One of the organisations involved in discussions around the formation of a community trust is the Kagiso Trust.

These examples from the Alexander Clinic, Oukasie and Botshabelo concern, in general, attempts to develop formal structures of consultation and accountability to the community. From the accounts presented above, the community structure best suited to facilitating this process is the civic association, which emerged in the early 1980s as a rejection of apartheid local authorities. Not only are civic associations elected bodies, but they also lead and represent communities in their struggle.

However, in circumstances of political upheaval, effective accountability can be conceived without such formalized structures. In these circumstances, people perceive accountability in terms of health workers' commitment to supporting their struggles and activities.

Protest Clinics
Braklaagte

When Medicines du Monde first started working in South Africa, for instance, it did so in the form of protest clinics, which developed in an adhoc way, either in response to police brutality or, in the case of the Winterveld clinic, as part of wider political protests. The Winterveld community established a small clinic in the 1970's, which served not only as a health centre, but also as a means of mobilizing people to protest against their incorporation into Bophuthatswana.

Another example of a protest clinic is the one established by the Braklaagte community which was incorporated into Bophuthatswana on 31 December 1988. Braklaagte is a small rural community of 10 0000 to 15 000 people. In an effort rejecting this forced incorporation, people refused to use services provided by the Bophuthatswana government. In addition, the Bophuthatswana government having appropriated the clinic that the community had built for itself in the early 1980's, people resisted, reestablishing an independent one.

In 1990, the community experienced extreme intimidation from the Bophuthatswana government culminating in January 1991 with the killings of several community members. They took temporary refuge at Zeerust (in "South Africa"), where they occupied churches until July 1991. In February 1991, Medecins du Monde was approached by the African National Congress' (ANC) health department and the National Medical and Dental Association (NAMDA) to assist the community in establishing a health care centre. Medecins du Monde employed a nurse to do relief work. It also sent two community health workers elected by the refugees for training at the Winterveld clinic. They returned in July 1991. The community provided their own facilities for the clinic, including a two roomed house from which the clinic operates.

The community has developed its own structures to run the clinic, consisting of an elected health committee made up largely of elected traditional community elders. One of these elders is a chief. Their accountability to the community is acknowledged by the leading role they perform in resisting incorporation into Bophuthatswana. All of these traditional leaders are members of the ANC. They act, through the health committee, as a key organ for ensuring health workers' commitment to the community. One of the two community health workers trained by Medecins du Monde showed disinterest in his work and was called to a meeting

Immunisation on a Thursday at Winterveld clinic. *Photo: Critical Health*

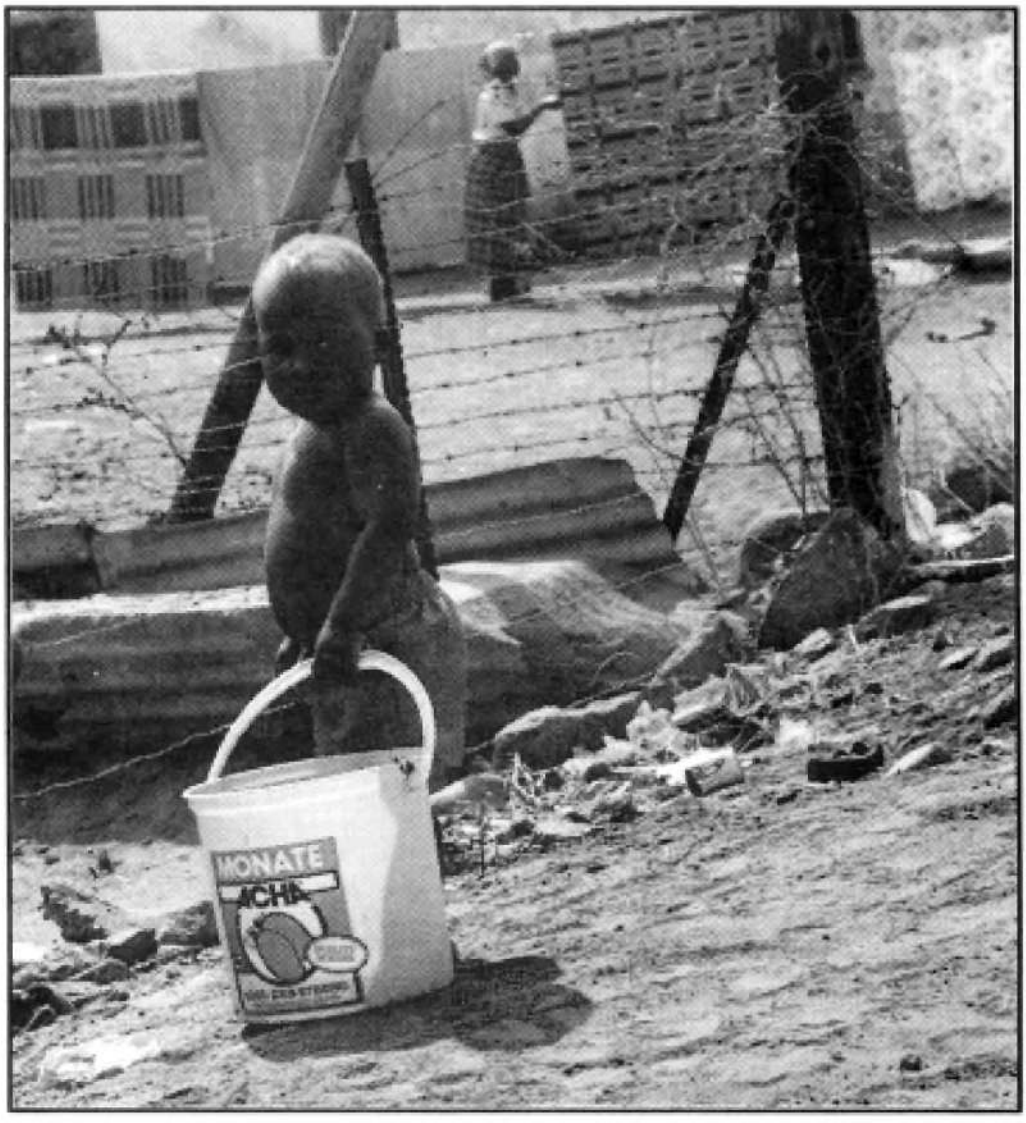
of the health committee. The worker did not attend that meeting, and the committee consequently decided to terminate his services. In another instance, a voluntary community worker decided, without consultation, to prescribe penicillin to patients. Community workers are not allowed to prescribe antibiotics. The committee received word of this from patients, and effectively disciplined that voluntary worker. When people are not happy with the service they receive, they approach the committee.

The Bophuthatswana government has persisted in intimidating health workers at the clinic, claiming that the clinic is illegal. It has attempted to dampen resistance by offering the community a state run clinic. In principle, according to Jane Mathieson, the Medecins du Monde coordinator, people would like to have

the resources such a clinic could provide. However, they have indicated to the Bophuthatswana government that they would accept its offer only if the clinic were accountable to the present health committee and if their own clinic could continue to function unhampered.

Conclusion

These experiences of progressive service providers demonstrate the importance of local control. Accountability at this level has its limitations and dangers. However, the level of consultation and accountability which has been engaged in makes a difference to user experience of services. As a result this approach is of central importance to any future democratic dispensation. On the basis of these experiences it also seems that for meaningful participation in decision making to occur, constituency sizes of not more than 25 000 in the urban context and even smaller sizes in rural areas are necessary for election of any representatives.



Around here everyone works. *Photo: Critical Health*

In addition, there are greater possibilities of exploring different and more flexible forms of accountability at local government level where constituencies are smaller. Various combinations of participation of the community in health activities, and of health workers in community activities are possible at a local level. This can deepen accountability significantly and in important directions. Accountability at central level, however, is generally not possible.

The role of central state then is rather to constructively allocate resources to local government to correct racial imbalances. Because of the scale of the problem, formulae of prioritizing or weighting budget allocation will have to be devised. However, there is still a danger that too much centralization can occur with the result that democracy and accountability to local level can become nothing more than tokenism. By implementing weighted formulae as a primary role of central government it can ensure that it is the only thing that lies outside of local control. In other words the local structures have almost total control on how the resources are used in an area. The weighted formulae ensures that central state is obliged to provide the necessary funds or resources. How these formulae are devised, however, has to be the subject of another discussion.

While centralization of political power in the South African context is necessary at a national level to guarantee the correction of historical injustices, the role of metropolitan and regional government is less clear. They can also be seen as expressions of the centralization of power. They, too, are largely inaccessible and thus have the potential to block any meaningful control from the ground. It is for this reason that they require particular analysis. With this issue is only just emerging in political debate, the contribution of health service experience may have implications, not only for the health sector, but more broadly for all forms of government service, social and otherwise.

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