AN EXAMINATION OF THE AVAILABILITY AND ACCESSIBILITY OF HEALTH CARE SERVICES IN THE RURAL AREA OF SHONGWENI

BY

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Declaration

I, Ntefeleng Ntoa, registration number 9700865, hereby declare that the thesis entitled **AN EXAMINATION OF THE AVAILABILITY AND ACCESSIBILITY OF HEALTH CARE SERVICES IN THE RURAL AREA OF SHONGWENI** is the result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other University.

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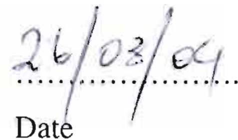
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CHAPTER ONE

1.1 INTRODUCTION

The study examines the availability and accessibility of health care services in rural areas in relation to the right to health. The area that has been selected for the purpose of this study is the Shongweni area in the Province of KwaZulu - Natal. The area is situated on the border of Mpumalanga and Durban Region under the Outer - West City Council.

1.2 MOTIVATION FOR THE STUDY

The majority of the population of South Africa do not have access to basic services of which health services are included.[1] About 50 % of the population of South Africa live in rural areas.[2] The study is significant in that, it is intended to help the Department of Health and other health related sectors, for example, education, sanitation, water supply, electrification, finance, agriculture and small business development, to reconsider the distribution of health care and basic services in rural areas. This can assist in addressing the problems and taking the necessary measures in improving the health of people in rural areas. While one may find that there are health care services in rural areas, indeed most of them are not adequate and accessible for the people residing in these areas. In Shongweni, there is one clinic, which caters for a population of approximately 5000 people.[3] Therefore, resources are obviously not adequate for the people, who have to travel long distances to get to hospitals or clinics in urban areas as an alternative.

1.3 THE RIGHT TO HEALTH CARE SERVICES IN SOUTH AFRICA

The preamble to the Constitution envisions the adoption of the Constitution as the supreme law of the Republic of South Africa in order, to, inter alia, "improve the quality of life of all citizens and to free the potential of each person". According to the Constitution of the Republic of South Africa, Section 27 (1), everyone has the right to

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[1] White Paper on Transformation of the Health System in South Africa (1997) at 4.
[2] A Boulle *Rural Health Care and Poverty – Inextricably linked* (1997) at 356.
[3] Outer – West City Council: Statistics SA, 2001.

have access to health care services, including reproductive health care.[4] Section 27 (2) continues by stating that the State must take reasonable measures within its available resources, to achieve the progressive realization of these rights.[5] Section 27 (3) states that no one may be refused emergency medical treatment.[6]

The clause '*within its available resources*' means that the right to have access to health care services is limited. Access to health care services largely depends upon the availability of resources. The rights created in the Bill of Rights are not absolute; hence there is a limitation clause in Section 36 (1) of the Constitution of the Republic of South Africa.[7]

Section 36 (1) states that the rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:

- the nature of the right;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relation between the limitation and its purpose; and
- less restrictive means to achieve the purpose.

It seems to be a popular conception that the rights in the Bill of Rights are absolute and can be exercised and enjoyed without limitation. This is of course not so. The rights of others also limit the rights. A right extends only so far as the point to where it does not infringe upon another person's right. So, for instance, there is a right to freedom of expression but the rights of others not to be defamed limits it. The right to assemble, demonstrate and picket is limited by the rights of others to access and freedom of movement. A right is also limited where others enjoy the same right and are competing for recognition of such rights.

[4] The Constitution of the Republic of South Africa, Act 108 of 1996.
[5] Idem.
[6] Idem.
[7] Ibid at Section 36.

In *Soobramoney v Minister of Health, KwaZulu-Natal*,[8] the applicant, a 41-year-old unemployed man, was a diabetic who suffered from ischaemic disease and had chronic renal failure. The only treatment, which could keep him alive, was haemodialysis, which was available at the renal unit of Addington Hospital.

The applicant had applied to the hospital for admission and treatment on the dialysis machines but had been refused. The applicant in a Local Division sought an order, inter alia, directing the respondent to cause the rendering of ongoing dialysis treatment to the applicant at the hospital. The hospital, could not, however, provide him with the treatment he requested. The judge dismissed the appellant's application to the High Court for an order directing the hospital to provide him with ongoing dialysis treatment and interdicting the respondent from refusing him admission to the renal unit.

The appellant then approached the Constitutional Court basing his claim on Section 27 (3) of the Constitution and Section 11, which provides that "everyone has the right to life". However, the Constitutional Court was of the view that the appellant's claim to have received dialysis treatment had to be determined according to the decision of the Constitutional Court. It will be convenient and useful to examine the views expressed in respect of the above decision.

The great disparities in wealth, poverty and the consequences of apartheid have far reaching implications for health and access to health care. Access to specific health treatment also had to be within the context of the health needs of others.[9] Furthermore, adopting a holistic approach to the larger needs of society meant that one could not at times focus on the specific needs of particular individuals in society. In the Court *a quo* Combrink J commented on the popular perception that the rights created in the Bill of Rights are absolute and without limitation. He expressed the view that rights are limited by Section 36 (1), by the rights of others, and also where others enjoy the same right and are competing for recognition of such right.[10]

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[8] Soobramoney v Minister of Health, KwaZulu – Natal 1998 (1) SA 430 (D).
[9] Idem.
[10] Idem.

Sachs J noted that the absence of principled criteria for regulating access to public medical resources was perhaps more open to challenge than the existing one and application of such criteria. In deciding who should and who should not receive the treatment, guidelines, which accorded with these principles, were drafted by the Department of Health of the national government, and applied in KwaZulu-Natal. Any patient having no prospect of recovering, like, Soobramoney, or of receiving a transplant is precluded from treatment.[11] Therefore, it is very important to note that in refusing Soobramoney treatment, the Constitutional Court took into consideration the needs of other people.

Madala J raised the question of whether the context of meeting the designs of the Constitution of the provision of health services solves the problem of attempting to distribute scarce resources.

For Chaskalson, the lack of resources was the context (i) for the ambit within which Section 27 had to be interpreted; and (ii) wherein access to health services had to be situated against the needs of others of access to housing, food and water, employment opportunities and social security. Chaskalson reasoned that if Section 27 were to be inferred from the right to life, this would have the effect of substantially increasing the difficulty of the State to provide health care to everyone within its available resources or prioritizing the treatment of terminal illness over other forms of medical care and medical treatment of persons suffering from non-threatening illnesses or bodily infirmities.[12] It therefore seems that although people have a right to health, it is limited by the availability of health care resources.

According to Ngwena the Soobramoney decision highlights the availability of resources as the crucial consideration when determining the enforcement of a socio - economic right against the state. While the Court reached the correct decision on the lack of affordability of lifelong renal dialysis under Section 27 (2) and (3), it was also unduly deferential to execute assertions about budgetary constraints. While the Court was prudent to be slow to

[11] Idem.
[12] Idem.

interfere with rational decisions made in good faith by the political organs and medical authorities on whom rests the primary responsibility for setting the health care budget, it should not have shied away from its implicit constitutional obligation to inquire sufficiently into budgetary appropriations when dealing with enforcement of socio-economic rights. In this regard, the Court failed to inquire whether priorities within the provincial and national governments' health care budgets were in consonance with its constitutional obligations.[13] Factors that influence the access to health care services will be examined in greater detail in Chapters three and four.

The White Paper on Transforming Public Service Delivery[14] states that relevant to access to health care services and the quality of health is the duty of national and provincial departments to identify, **inter alia,** the following:

- A mission statement for service delivery, together with service guarantees;
- The services to be provided, to which groups and at which charges. This means that services should be accessible to those who have been previously denied the access to health care services and health care services to be affordable to those who cannot afford to pay for such services. Primary Health Care is the programme which is aimed at achieving the above;
- In line with the Reconstruction Development Programme (RDP) priorities, the principle of redirecting resources to areas and groups previously under - resourced, which means that the focus will be on rural areas as they have been previously under - resourced;
- Service standards, defined outputs and targets and performance indicators, benchmarked against comparable international standards.
- Monitoring and evaluating mechanisms and structures, designed to measure progress and introduce corrective action, where appropriate, is vital to monitor and evaluate in order to determine whether there is progress in each and every programme that has been implemented. In respect of Primary Health Care, there is a monitoring and evaluating committee to measure progress. This committee reports to the National Committee on the following: -

[13] Health and Human Rights: An International Journal, Vol.5 No.1.
[14] *White paper on Transforming Public Service Delivery: Batho Pele- People First* (1997) at 4.

- Plans for staffing, human resource development and organizational capacity building tailored to service delivery needs;
- The redirection of human and other resources from administrative tasks to service provision, particularly for disadvantaged groups and areas;
- Financial plans that link budgets directly to service needs and personal plans;
- Potential partnership with the private sectors, non-governmental organization (NGO's) and community based organization (CBO) which will provide more effective forms of service delivery, this means that inter-sectoral collaboration is essential as health problems are caused by different determinants, for example, Department of Health must collaborate with Department of Environmental Affairs, Housing, Water Affairs, Social Welfare and Population Development in order to achieve its goal;
- The development, particularly through training of a culture of customer care and of approaches to service delivery that are sensitive to issues of race, gender and disability.

1.4 PRIMARY HEALTH CARE (PHC)

In order to make health care services available to all, the South African Ministry of Health has adopted the Primary Health Care (PHC) programme. This programme aims at making health care services accessible to all people, acceptable to the community and affordable by the community and country.[15]

According to the White Paper on Health,[16] "*The majority of the population of South Africa has inadequate access to basic services including health, clean water and basic sanitation. The task of improving the health of South Africa's population is not that of the Health Sector alone hence inter-sectoral collaboration is vital*".

Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the

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[15] *Alma – Ata Declaration* - Adopted by WHO and UNICEF in 1978, September, USSR.
[16] *White Paper for the Transformation of the Health System in South Africa* (1997) at 4.

community and the country can afford to maintain at every stage of their development in the spirit of self - reliance and self - determination.[17]

Primary health care (PHC) is part of total human development, social, education and economic. It rests on the principle of equity, which means that health care should be related to the needs of the people. The right to equality is set out in Section 9 (2) of the Constitution of the Republic of South Africa.[18] This Section provides that: Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of person, disadvantaged by unfair discrimination. Most resources need to be given to the disadvantaged to reduce the gap between rich and poor so as to achieve social justice. To achieve equity:

- Health care should be *accessible* to all people;
- Health care should be *acceptable* to the community; and
- Health care should be *affordable* to the community and country.[19]

According to World Health Organization (WHO) the strategies of primary health care are:

- *Prevention* of disease and the promotion of health are seen to be essential activities in primary health care. It is more cost effective to prevent disease than to cure it.
- *Inter-sectoral Collaboration* - primary health care should be set in a context of integrated development to include housing, water and sanitation, nutrition, agriculture, education, community development and women's development.
- *Appropriate Technology* - the fullest use must be made of available resources and relevant technologies such as immunization, oral dehydration solution, and simple weighing scales and ventilated pit latrines. In this regard, funds have been shifted towards promoting healthy communities rather than only providing sophisticated curative hospital services.
- *Community Involvement* - by being involved individually and collectively people are informed and develop the skills and the abilities they need to manage their lives more effectively.

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[17] *World Health Organization*: http://www.Idb.org/iphw/whoconst.htm.
[18] The Constitution of the Republic of South Africa Act 108 of 1996.
[19] *World Health Organization*: http://www.Idb.org/iphw/whoconst.htm.

This acknowledges the right of individuals to make choices and take action to improve their health. Community involvement must provide real opportunity for people to share in decision-making process. Community organizations need to be able to negotiate with other groups and institutions to act together for development.[20]

The primary health care approach is the underlying philosophy for the restructuring of the health system. It embodies the concept of community participation in the planning, provision, control and monitoring of services. There must be improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.[21] Primary health care aims to reduce inequalities in accessing health services, especially in the rural areas and deprived communities.[22]

The primary health care approach requires political will on the part of the government, and commitment from communities, health and allied workers, health policy makers, health service managers and the broad range of health related sectors.[23]

An important principle in the primary health care approach is accountability to community structures at local, district, provincial and national levels. Community participation is another important principle of primary health care.

As envisaged in the primary health care approach, effective community participation means that democratically elected community structures, integrated with representatives of the different sectors and stake-holders involved in health and community development, have the power to decide on health issues. Community participation is an essential element that the National Health System must develop at a local level in order to be fully effective, and is not an entity that can easily be prescribed and legislated into being.[24]

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[20] Idem.
[21] Committee on Economic, Social and Cultural Rights (2000) *General Comment No. 14.*
[22] A Chrondell "Guiding Principles" (1998) *A Vision for Health in South Africa* at 19.
[23] Ibid at 20.
[24] Ibid at 21.

Primary health care is not just a cheaper, simpler approach to the delivery of health care, nor is it simply basic health interventions. It is a concept, which is changing the medical culture. Previously this was centred to health professionals, where the community members – the *"patients"* – were the passive recipients of health services and the doctors and health professionals alone were the dispensers of health. The change will inevitably bring about some radical transformations, not only of the health services and of the training and research institutions, but also of the attitudes of both health providers and those demanding health care services. These transformations will pose a tremendous challenge to the National Health System, to the government and to society as a whole.[25]

Therefore Primary Health Care is an essential programme in making health care services available and accessible to the previously disadvantaged communities, that is, rural areas. It is therefore essential to examine how effective this programme is in making health care services available and accessible to the community in rural areas.

1.5 RESEARCH METHODOLOGY

In evaluating the accessibility and availability of health care services in rural areas in relation to the right to health, the types of research methods that have been used are both the quantitative and qualitative research methods. The quantitative method makes it easier to summarize data.[26] It makes observations more explicit and opens up possibilities of statistical analysis ranging from simple averages to complex formulae and mathematical models.[27]

Interviews have been conducted with respondents on a one to one basis. These interviews were semi-structured in that, respondents were interviewed not only using the structured questions but were also interviewed with the intention of achieving research goals. This technique is of utmost importance in that it provides the researcher with the exact information required for research purposes. The *observation* technique was also used in data collection. The researcher observed the manner in which participants were able to

[25] Idem.
[26] C Bless & C Higson – Smith *Social Research Methods* (1995) at 41.
[27] Idem.

access health care services. The environment was also observed as a determinant for the availability and accessibility of health care services.

1.6 AIM AND OBJECTIVES OF THE STUDY

The aim of the study is to evaluate the availability and accessibility of health care services in the rural area of Shongweni, in KwaZulu - Natal.

The objectives of the study are:

- To evaluate the relationship between socio-economic conditions and available health care services.
- To examine the relationship between the environment and health care needs.
- To evaluate the availability of health care services in conjunction with the right to health in South Africa.
- To evaluate the availability and accessibility of health care services in relation to the quality of health care provision.
- To make suggestions and recommendations inter alia, based on the findings of the study.

1.7 DEFINITION OF TERMS

In evaluating the availability and accessibility of health care services in rural areas, it is essential to define some of the terms used in this study.

- Health is a state of complete physical, mental and social well being and not merely the absence of disease.[28] It is also an expression of a number of factors, all of which need to be monitored and addressed.
- Availability has been defined as factors that make health care services obtainable within one's reach.[29] Functioning public health and health – care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the state party. The precise nature of the facilities, goods and services should vary depending on numerous factors, including the state party's developmental level.[30]

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[28] The Constitution of the World Health Organization.
[29] A. E. Joseph & D. R. Phillips *Accessibility and Utilization* (1984) at 104.
[30] Committee on Economic, Social and Cultural Rights (2000) *General Comment No.14*.

- Accessibility has been defined as the factors intervening between the perception of need and the realization of utility.[31] Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party.[32]

1.8 A BRIEF OVERVIEW OF CHAPTERS

The second chapter focuses on international legislation and public health. It provides a background in understanding the availability and accessibility of health care internationally. The third chapter examines strategies of primary health care, such as prevention, inter-sectoral collaboration, appropriate technology and community participation in relation to health promotion. It also takes into consideration the allocation of resources in South Africa.

The fourth chapter explores the health care service delivery in the area of Shongweni. The research methodology, instruments and techniques used to collect data in the selected area are also discussed in the chapter. The fifth chapter provides recommendations and suggestions for addressing problems encountered in the study and provides a final summation of the study undertaken.

1.9 CONCLUSION

In this chapter it is clear that White Paper for the Transformation of the Health System in South Africa aims to transform the health care provision by adopting Primary Health Care (PHC) programmes. One of the principles of Primary Health Care is that health care should be accessible to all people. This is consistent with Section 27 (1) (a) of the Constitution of the Republic of South Africa, which states that "everyone has the right to have access to health care services, including reproductive health". Delivery of health care services should be distributed equally, which means that attention must also be given to rural areas. The following chapter will discuss international legislation related to the provision of health care.

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[31] A. E. Joseph & D. R. Phillips *Accessibility and Utilization* (1984) at 104.
[32] Idem.

CHAPTER TWO

2.1 INTRODUCTION

This chapter examines the provision of health care resources from an international perspective. It also explores whether the right to health is included in constitutions of other countries. This is of assistance in determining to what extent the right to health is upheld in other countries and how does this compares with the South African situation.

2.2 INTERNATIONAL LEGISLATION AND PUBLIC HEALTH

South Africa is one of the countries, which is bound by both domestic laws and international laws to protect the rights of its people. With the establishment of World Health Organization (WHO), for the first time the right to health was recognized internationally. The WHO Constitution affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

A pre-requisite for advancing human well-being and dignity is the interdependence between human rights and health. Pinet describes this in the World Health Organization, the Resolution on " Health for All by the 2000", and the Declaration of Alma-Ata.[33] Three aspects of the relationship between human rights and health have been identified, namely:

- The way in which health policies and programmes can violate human rights;
- The recognition that human rights violations can have severe health effects; and
- That respect for and the protection of rights and dignity are essential conditions which people need in order to be healthy.

In South Africa, the right to health is envisaged in Section 27 of the Constitution of the Republic of South Africa. Section 27 includes the right to health care, food, water and social security. It sets out the right to have access to health services, including reproductive health care and allows for the provision of emergency assistance. The right to health will be examined in detail in Chapter three.

2.2 ALMA-ATA DECLARATION

WHO and UNICEF adopted the Declaration of Alma- Ata on 12 September 1978. This was an international conference on Primary Health Care.[34] It raised an issue of the existing gross inequality in the health status of the people, particularly between developed and developing countries. The promotion and protection of the health of the people is essential to sustain economic and social development and contributes to a better quality of life and to world peace.

2.3 WORLD HEALTH ORGANISATION AND PUBLIC HEALTH

Improving global health conditions has been one of the most important and difficult challenges for the world community. Despite concerted efforts by international organizational organizations, like the World Health Organization, great disparities in health conditions remain between developed and developing countries, as well as within the countries themselves.

In South Africa, the Department of Health is attempting to equalize the distribution of health care services within the country. There are groups of people who have been affected and suffered as a result of apartheid. The Shongweni rural area is one of the areas that have been affected as a result of South Africa' s apartheid policy.

The World Health Organization has achieved some successes through its Health for All Strategy. It can and has encouraged member nations to enact national and international laws to protect and promote the health status of their populations. The Health for All Strategy will be discussed in collaboration with Primary Health Care in the next Chapter. A comparison to the law making efforts in other areas by international organizations indicates that WHO may have the authority and the means to institutionalize efforts to improve global health conditions.[35]

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[33] S Nadasen *Public Health Law in South Africa* (2000) at 7.
[34] *Alma – Ata Declaration*, 12 September 1978.
[35] A. L. Taylor *Making World Health Organization Work* (1992) at 11.

Reforming national health systems to guarantee universal access to primary health care is an extraordinary global health challenge. Access to primary health care services, although particularly problematic in developing nations, is also of concern in some developed countries, including the United States. The United States does not include any reference to health in its Constitution, yet judicial decisions can be found regarding the State's responsibility to regulate health or its duty to ensure equal access to the beneficiaries of the health and welfare system.[36]

Despite growing public recognition of the importance of universal access to health care, little scholarly attention has been paid to the role that international organizations, like the World Health Organization, can play in encouraging and assisting national development of basic health services. The international right represents an international legal obligation of nations to promote and protect the health of their populations progressively. WHO's role as international advocate of right to health and member nations corresponding legal duties can serve as a powerful command to nations to guarantee universal access to basic health services and resources for their populations.[37]

WHO conditions its involvement with individual countries in promoting Health for All on a national commitment to identify the impediments to effective primary health care, to reassess all available and potential resources in the health sector, and to re-orient plans and priorities as necessary. WHO has convinced some member nations of the validity of the Health for All Strategy and of the importance of acknowledging the duty to provide Primary Health Care programmes as a matter of human rights.

In South Africa, access to Primary Health Care is a basic human right. This programme has been implemented in rural areas. The nature of WHO's country programmes also enhances Health for All's influence on national health policies. Article 16 of the African Charter on Human and People's Rights enshrines the right to the highest possible level of health, to which necessary measures will be taken, while also guaranteeing medical services in case of illnesses.

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[36] H. Fuenzalida – Puelma & H. Scholle Connor, Eds. *The Right to Health in the Americans: A Comparative Consitutional Study* (1989) at 278.

[37] Ibid at 279.

In South Africa, medical services in cases of illnesses are not guaranteed as access to health care resources depend on the availability of resources. According to the Limburg principles, "its available resources" refers to both the resources within a state and those available from the international community through international co-operation and assistance. In the use of the available resources due priority shall be given to the realization of rights recognized in the International Covenant on Economic, Social and Cultural Rights, mindful of the need to assure to everyone the satisfaction of subsistence requirements as well as the provision of essential services.[38] In the Shongweni area, access to health care services is problematic due to certain circumstances like transport facilities and inadequate health care resources in local clinics amongst others. This will be illustrated in Chapter 4.

To evidence the legal obligation necessary to advance the international right to health, the United Nations created two treaties, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. In Article 12.1 of the latter, states parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Covenant also provides, inter alia, that each nation, to the maximum extent of its available resources, undertake the necessary steps to achieve the highest attainable standard of physical and mental health for all individuals, without discrimination.[39] This means that even people in rural areas are not to be discriminated against. They have to enjoy the right to health to the highest attainable standards of physical and mental health.

Therefore, states are as responsible for violations of economic, social and cultural rights. The Covenant on Economic, Social and Cultural Rights impose three different types of obligations on states: the obligation to respect, protect and fulfil. Failure to perform any one of these three obligations constitutes a violation of such rights. The obligation to *respect* requires states to refrain from interfering with the enjoyment of economic, social and cultural rights. The obligation to *protect* requires states to prevent violations of such rights by third parties. The obligation to *fulfil* requires states to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full

[38] www.yahoo.com *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights.*
[39] A. L. Taylor *Making World Health Organization Work* (1992) at 12.

realization of such rights. Thus, the failure of States to provide essential primary health care to those in need may amount to a violation.[40]

Article 12.2 of the Covenant identifies measures to be undertaken by member nations to achieve the full realization of the right to health including those necessary for:

- The provision for the reduction of the stillbirth-rate and of infant mortality and for the health development of the child;
- The improvement of all aspects of environmental and industrial hygiene;
- The prevention, treatment, and control of epidemic, endemic, occupational and other diseases; and
- The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.[41]

While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations, which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind and the obligation to take steps towards the full realization of the right to health. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of Article 12.[42]

The Covenant recognizes that the right to health is an essential element of human dignity. The right to health does not, however, constitute an entitlement to individual good health. It is also not synonymous with the right to health care. The right to health does not necessarily encompass free access to health services, for the Covenant mandates only non - discriminatory provision of services to those who cannot provide for themselves, for example, people living in rural areas. The right to health cannot be isolated conceptually

[40] Masstricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 22 – 26, 1997.
[41] A. L. Taylor *Making World Health Organization Work* (1992) at 12.
[42] Committee on Economic, Social and Cultural Rights (2000) *General Comment 14*.

or practically from other human rights articulated in the International Bill of Rights, including life, food, education and social security.[43]

The Declaration of Jakarta, Indonesia in 1997 also includes an updated conceptualization of health. It also identifies the requirements of its attainment. Those requirements include housing, education, social security, social relation, food, income, the sustainable use of resources, social justice, respect for human rights and equity.[44]

In South Africa, the Government has introduced inter-sectoral collaboration in order to attain the right to health. This means that there should be a multi-disciplinary initiative between departments, and inter-agency collaboration taken whenever possible. Similar to South Africa, The Programme of Action of International Conference on Population and Development in Cairo in 1994 encompasses a guaranteed universal access to reproductive health and family planning services.[45] In the South African context, this access is limited within the State' available resources. In the conference mentioned above, governments formally recognized that the health rights, and well-being of the individual lie at the core of sustainable development.[46]

The 1912 Chilean Constitution explicitly mentions the right to health, distinguishing between guarantees for ensuring the well being of the individual for attaining public health. In the case of Haiti, the right to health is directly related to the right to life in Article 19 of the Haitian Constitution. The Haitian State has the imperative duty to guarantee the right to life, health and respect for the person. In addition, Article 23 establishes the obligations to guarantee the necessary resources to the entire population to protect and regain their health by having an adequate health care delivery system.[47] This is also included in the South African context.

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[43] A. L. Taylor *Making World Health Organization Work* (1992) at 12.
[44] B. C. A. Toebes *The Right to Health as a Human Right in International Law* (1999) at 57.
[45] Idem.
[46] www.yahoo.com. *The Programme of Action of International Conference on Population and Development,* Cairo (1994).
[47] B. C. A. Toebes *The Right to Health as a Human Right in International Law* (1999) at 57.

2.4 CONCLUSION

Although the Covenant imposes international obligations on states to aid other nations in the realization of the right to health, the primary duty to guarantee this right lies with member nations within their own populations. The international acceptance of human rights are seen in the context of the state system, with obligations only upon an individual's own society. A nation's obligation to provide the conditions of health to its domestic population may entail some duty of multi - lateral assistance to the health sectors of other countries.

CHAPTER THREE

3.1 INTRODUCTION

This Chapter focuses on strategies of Primary Health Care. Community participation as an important factor in health promotion is examined in detail. The barriers in community participation will also be discussed. The latter part of the chapter will examine statistics to support the presentation of information. The last part of this chapter focuses on accessibility of health care services in developing countries.

3.2 STRATEGIES OF PRIMARY HEALTH CARE

As discussed in the previous chapter, in the year 2000, the attention of health promoters and primary health care workers around the world was to turn to the question of why the goal for Health For All by the year 2000 was far from being met. There were obstacles, which contributed to achieving the goals of Health for All in a global context. The main health-related goal of governments and the World Health Organization was to ensure that all the people of the world attain a level of health that would permit them to lead socially and economically productive lives. The Alma - Ata conference of 1978 defined the key to achieving the goal of Health for All by 2000 as primary health care.[48]

Primary Health Care in this original definition stresses the importance of equity in access to community-based health services that place emphasis on prevention and on action outside the health sector to promote health. According to the Patient's Rights Charter, Section 3, everyone has the right of access to health care services that include:

i. receiving timely emergency care at any health facility that is open regardless of one's ability to pay;

ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;

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[48] A Chrondell & D Yach *Develop and Strengthen Public Health Law* (1998) at 79.

iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV or AIDS patients;

iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;

v. palliative care that is affordable and effective in cases of incurable or terminal illness;

vi. a positive disposition displayed by health care workers that demonstrate courtesy, human dignity, patience, empathy and tolerance;

vii. health information that include the availability of health services and how best to use such services and such information shall be in the language understood by the patient.[49]

3.2.1 PREVENTION

Health promotion is a programme, which focuses on *prevention* as a strategy of Primary Health Care. Health education and promotion can be considered as an application of preventive health research, a relatively new research tradition with various issues that need attention. These issues pertain to, for example, the relation of health problems with several specific behaviours, the target group, the determinants of unhealthy behaviours, programme development, programme and problem diffusion.[50] Education on sexuality, nutrition, sanitation, life skills and basic health is important for health promotion in public health.

Health promotion is the process of enabling people to increase control over, and to improve their health.[51] To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change, or cope with the environment.[52] Health is therefore, seen as a resource for everyday life, not the objective of living. Health promotion is not just the responsibility of the health sector but goes beyond healthy life-style to well being.[53]

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[49] Patient's Right Charter.
[50] H. De Vries, *ABC's of Health Education and Planning* (1999) at 109.
[51] *Ottawa Charter for Health Promotion*, 21 November 1986.
[52] Idem.
[53] Idem.

It is very important to prevent diseases through health promotion rather than focusing on curing the existing diseases. In South Africa, people have the right to basic needs, which can prevent them from becoming victims of diseases. Those basic needs, fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.[54] Improvement in health and prevention of diseases requires a secure foundation in these basic pre-requisites. In the rural area of Shongweni, people do not have all these basic pre-requisites. Most of the people are uneducated and unemployed and do not have an income. This has had an effect on improving the standard of their health, for example, they do not eat proper food before they take their medication. Although people do have access to some of health care resources, improper diets often lead to deterioration of their health.

Proper diet and nutrition has a positive effect on the standard of health. In Shongweni, there is a high rate of illiteracy, which has a negative impact on health promotion. In order to develop effective health education and promotion activities, a planning model is needed to distinguish the most important phase to plan activities carefully. The language that is understandable to the community must be used for health education. In the Shongweni clinic although most of the posters are written in Zulu, most of the people can neither read nor write.

Good health is a major resource for social, economic and personal development and an important dimension of the quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Therefore, inter-sectoral collaboration is very important in health promotion. In Shongweni, the Department of Health, Department of Social Welfare and Population Development and the Department of Education work jointly to ensure that people have access to health care resources. Each Department identifies people who need assistance from a particular Department, and refers them to that relevant Department. In trying to promote health and ensuring that health care resources are accessible and available in rural areas, these Departments usually conduct joint awareness programmes to enable people to access different services provided by these different Departments. This aims to improve the quality of life of people living in the Shongweni area.

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[54] Idem.

Health promotion action aims at making political, economic, social, cultural environment, behavioural and biological factors favourable through *advocacy* for health.[55] Health promotion focuses on achieving equity in health and in prevention of diseases. It aims at reducing differences in current health status and ensuring equal opportunities and resources to *enable* all people to achieve their fullest health potential. People cannot achieve their fullest health potential unless they are able to take control of those things, which determine their health. This must apply equally to women and men.[56] Health promotion plays a vital role in rural areas. It tries to ensure that health care services are accessible and available in disadvantaged communities.

Health promotion demands co-ordinated action by all concerned, for example, by governments, health and other social and economic sectors, non-governmental and voluntary organizations, local authorities, industries and by the media.

In trying to make health care services available and accessible for people living in Shongweni, voluntary organizations like Community Health Care Workers assist the Department of Health by monitoring patients from home, especially TB patients. There are door - to - door visits to assist them in taking their medication. Professional and social groups and health personnel have a major responsibility to *mediate* between differing interests in society for the pursuit of health and prevention of diseases. Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and region to take into account differing social, cultural and economic systems.[57]

3.2.2 INTERSECTORAL COLLABORATION

Primary Health Care should be set in a context of integrated development to include housing, water and sanitation, nutrition, agriculture, education, community development

[55] Ibid.
[56] Ibid.
[57] Ibid.

and women's development. There should be multi-disciplinary, inter-agency collaboration taken whenever possible.[58]

Different Departments should work together with the goal of promoting public health. Public health will be achieved or promoted through collaboration of the following Departments, namely, Department of Health, Welfare, Housing, Environmental Affairs and other relevant departments.

3.2.3 APPROPRIATE TECHNOLOGY

The fullest use must be made of available resources and relevant technologies such as immunization, oral dehydration solution, simple weighing scales and ventilated pit latrines. These relevant technologies are made available in each and every clinic even in rural areas. In South Africa, children are immunized to prevent diseases such as polio, measles and other diseases. During birth, children are immunized for BCG and Polio. In six weeks they are immunized for 1st Polio and 2nd Diphtheria, whooping cough and tetanus, in ten weeks for 2nd Polio and 2nd Diphtheria. In fourteen weeks they are immunized for 3rd Polio and 3rd Diphtheria and in nine months they are immunized for measles.[59] In Shongweni, the Doctor visits the clinic once a week to see patients in the community. Children are weighed to determine whether their weight is consistent with their developmental milestone. This helps to identify as quickly as possible if the child is malnourished so that the problem can be attended to, through health education to the caregiver of the child. In this regard, the government has shifted funds towards promoting healthy communities rather than only providing sophisticated curative hospital services.

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[58] S Nadasen *Public Health Law in South Africa* (2000) at 29.
[59] KZNPA New Germany Clinic, Pinetown.

3.2.4 COMMUNITY INVOLVEMENT

Community participation is an essential element of Primary Health Care. Community is a group of people living within a defined geographical area who share the same values, interests and needs and within which a sense of community prevails.[60]

Geographic communities are, however, very homogeneous with members frequently having conflicting needs and interests. Consequently, within a geographically defined area, there are frequently divisions between relational communities that form around common interests, needs and values as communities, which form as a result of a phenomenon, for example, poverty, a disability or an event.[61] According to Rifkin, Muller and Bichman (1998) 'at risk' groups are of particular concern to health providers and consequently constitute specific communities that may be targeted for involvement in health care provision.[62] This conceptualization of a community within which there may be divergent and competing interests raises initial question about whose participation is required and how conflict between different perspectives might be negotiated.[63]

In the National Health Bill of 2003, Section 8 (1) it is stated that a user has the right to participate in any decision affecting his or her personal health and treatment. According to Section 8 (3) if a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in Section 6 of the said Bill after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.[64] Rifkin (1998) describes three alternative visions of community participation in health care. The first approach is outlined as the "medical approach" which defines health in terms of an absence of disease. In terms of this understanding community participation is defined as the activities of people, under direction of medical professionals, which are intended to reduce individual illnesses.[65]

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[60] I. Petersen, A Parekh, A. Bhagwanjee, K. Gibson, C. Giles & L. Swartz *Community Mental Health Care: Ensuring Community Participation* (1997) at 56.
[61] Idem.
[62] Idem.
[63] Idem.
[64] National Health Bill, 2003.
[65] I. Petersen, A. Parekh, A. Bhagwanjee, K. Gibson, C. Giles & L. Swartz *Community Mental Health Care: Ensuring Community Participation* (1997) at 56.

The second approach is "health services approach". This defines health similarly to the World Health Organization as the physical, mental and social well being of the individual. The notion of community participation within this is the involvement of community in the delivery of health service itself.

Although the definition of health in this model is broader and includes preventative and promotive strategies, the involvement of communities still remains directed towards the health services themselves.[66]

In contrast to these two models, the third approach is community development approach. This moves beyond purely health or service focus and firmly links participation to social, economic and political development. In this model community participation is perceived as the active involvement of community in addressing these issues at their source, through activities aimed at development.[67] In Shongweni, the people are empowered to participate through community development projects, like, sewing, skills training and job creation to generate income.

Another community development project that is useful in promoting public health is agricultural awareness, which is instilled in the people through the gardening project. This project helps people to grow, nurture and to feed off crops and vegetation planted by themselves. In so doing, it also encourages good nutrition.

The first two models, pursued in isolation, generally produce disappointing results. This is because it is often very difficult to mobilize communities around health care issues as though these were independent of other aspects of people's lives, their predominant belief systems, and existing power relations both within the community and between the community and the professionals involved in health systems.

It is argued that the end product of a model of community participation, which situates itself outside of broader political processes, including development, is a health system

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[66] Idem.
[67] Idem.

which cannot break the dis-juncture between professional interests and the diversity of community needs.[68]

The broad framework outlined acknowledges that participation seems to be more effective when it takes into account the importance of mobilizing target in the community around an integrated approach, which is open to community priorities rather than being located strictly in health care itself. This allows for the reality that health care is often not a priority need within communities. Following from this, community members are able to participate more fully when their own experience of need is acknowledged rather than when they are confronted with pre-planned visions of health care.[69] The community development projects that are discussed above show that people in the Shongweni area have priorities that are not located strictly in health care itself. This means that, they are aware that nutrition plays an important role in one's health. They achieve this through integrated approach between the Department of Health and Department of Welfare and Population development.

The mobilization of communities to participate also seems most effective when the specifities of their involvement are recognized to reflect some of the broader political constraints and issues of power and control. It is also not possible to expect representative and equal participation when the power relations between professionals and community are ignored.[70]

In terms of developing community participation, the critical difference in this analysis is the difference between the first two approaches and the third approach. The first two focuses on health services as the most important factor in health improvements and blatantly or tacitly suggest that health professionals should decide how the programme should progress. The third approach focuses on learning how to decide the ways change can be best achieved by people. The terms 'top down' approach and 'bottom up' planning have often distinguished these two views. While they are not incompatible in

[68] Ibid at 57.
[69] Idem.
[70] Idem.

the same programme, some of the assumptions on which they are based are incompatible.[71]

The 'top down' approach usually has poor results. This is because, health professionals assume what the needs of the people are. They often make orders to the community only to find that the community does not participate fully in distribution of health care services. The 'bottom up' approach gives people a chance to speak out about their expectations and their needs. This approach produces good results because health professionals generally do what the community expects.

One assumption of those who take the 'top down' approach is that health professionals based on their experience and the present state of health technology, can define and solve the existing health problems in a relatively short time.

The assumption of those who follow the 'bottom up' approach is that the solution is not as important as the changes (recognized to come about relatively slowly) in attitudes of both planners and community people as the latter seek to carry out some of the basic health interventions that professionals are trained to do. The differences in views about both the time frame and the expected impact of health interventions have tended to lead to conflicts.[72]

Evidence that prompted the call for primary health care suggested that solutions to health problems involved more than health services alone, yet many attempt to solve such problems by gaining community support to attack diseases. It appears that those who have taken an approach to community participation, which focuses mainly on the delivery of health services, have been disappointed, in their attempts to achieve broad and long-term community participation. In Shongweni, Primary Health Care is used as a strategy to ensure that health care services are available and accessible to the community. This is done through the use of community members like local Councillors and community health care workers to determine the health needs of the community.

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[71] S. B. Rifkin, *Lessons from Community Participation in Health Programmes: Health Policy and Planning* (1986) at 241.
[72] Idem.

3.3 BARRIERS TO COMMUNITY PARTICIPATION

There are several reasons why a programme, which promotes only health and health related services limits community participation.

The first reason is that, as we have seen in the discussion thus far, community participation appears not to be the product of a planning solution to a health problem, but rather a process of changing individual perceptions over time as the dynamics of community interaction change.[73]

The second reason, closely related to the first, is that, health care is not a priority. Most lay people define health as curative services and they want these services only when they are ill.[74] This will not improve public health as health also includes related factors like the welfare of the people.

The third reason is that few lay people have had any experience in providing health care services. They have received services from professionals on payment of a fee, by an act of charity and or by the right given to them by the government; few lay people see any scope for their own involvement.[75]

The fourth reason is that all too often planners and agencies, relying on their expertise, ignore the community's role in planning their own health care programmes. Rather than seeking community views about community problems and learning to discuss possible solutions with different people, they present the community with the problems and give health services as the solution. If planners and agencies have decided that health services are what the community will receive, there is often little scope for the development of active participation.[76]

The reasons for failure of community participation includes the existing dis-empowerment of communities, the pressing need for transformation in material

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[73] I. Petersen, A Parekh, A Bhagwanjee, K. Gibson, C Giles & L. Swartz *Community Mental Health Care*: *Ensuring Community Participation* (1997) at 58.

[74] Idem.

[75] Idem.

[76] Idem.

conditions and the reluctance of mental professionals to relinquish the power invested in their conventional practices. Community involvement cannot be conceptualized outside of the economic and political realities of the communities in which they operate. As discussed earlier in this chapter, community development projects play an important role in improving the economy of the people living in Shongweni. In terms of the development model, these difficulties are perceived not simply as impediments to the involvement of communities, but as the focus of the work.[77] Hence there is more emphasis on community development projects in the Shongweni area. Generally these projects have been well received in the Shongweni area as the community members have been able to realize their benefits and this has encouraged community participation.

In general there are three areas in which the barriers to community participation are most clearly evident. The first area is in the power dynamics, which influences the relationship between professional and members of communities. Health professionals are regarded as people who make orders to the community related to diagnoses and taking of medication. The second refers to power relations within communities themselves, for example, Indunas in the rural communities are the ones who make decisions on behalf of the communities without consulting with their communities. The third area is the absence of mechanisms and structures to facilitate community involvement, for example, there are no community activities or meetings where members of the community can express their feelings regarding decisions which affect their own lives.[78]

In relation to the position of professionals it is important to recognize the power imbalances between this group and the communities with whom they work. In spite of attempts to democratize health within models such as primary health care, quite often the different degree of access to knowledge and the power associated with these differences is glossed over. Within the existing health services themselves, including mental health, where the biomedical system has historically dominated, the hierarchies of power are more obvious. In addition, this system, through conceptualizing sickness as a disease, individualizes the problem and de-politicizes the role played by society in the development of individual distress. The scientific and technical basis of biomedicine calls into relief the differential between health care professionals and the communities

[77] Idem.
[78] Idem.

they serve.[79] Health professionals and communities must shift their mind set from conceptualizing sickness as a disease to enhance community participation and to improve quality of life for those who have been underprivileged and disadvantaged.

Primary Health Care with its emphases on community participation and the socio-economic causes of ill health, appears to provide an alternative to this position through its attempts to democratize both at the level of participation and through access to knowledge. In the rural area of Shongweni, community health workers play a very important role. They visit the community through door - to - door visits and refer people to the relevant service providers.

Binedell has shown how community health workers, precisely because of their low status in the health services, cling even more strongly to the power represented by the biomedical model. This situation is likely to be exacerbated where their lack of status is compounded by the distresses created by the implementation of a new system and their relative lack of knowledge and experience in the field of mental health.[80]

In terms of the barriers to participation operating within communities themselves, the most important issue to address is the diversity within communities. As previously noted, geographically defined communities are not homogeneous groupings. Instead, they comprise heterogeneous groups, defined only through diffuse processes of identification and containing the same complete power relations evident in broader society. Individuals and groups who hold power in communities do not always act in the best collective interests of the community. This phenomenon is particularly problematic when these individuals or organizations function as gatekeepers to community participation.[81] This means that these individuals or organizations act as if they present what is at the best interests of the communities, and as if there is community participation whereas people in the community do not know what is going on.

Women's involvement in health care has been generally acknowledged as crucial given their traditional care-giving role. They are, however, often one of the most dis-

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[79] Idem.
[80] Idem.
[81] Ibid at 59.

empowered groups within communities, which inhibit their capacity to participate effectively. The difficulties of creating effective opportunities for participation become even more complex if it is recognized that while men often hold power in the instrumental domain, they are frequently, through their socialization, denied access to the emotions and care-giving domains of community life.[82]

The objective of the Fourth World Conference on Women Platform for Action held in Beijing, which is in full conformity with the purposes and principles of the Charter of the United Nations and international law, is the empowerment of women. The full realization of all human rights and fundamental freedoms of all women is essential for the empowerment of women. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of states, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms. The implementation of this platform, including through national laws and the formulation of strategies, policies, programmes and development priorities, is the sovereign responsibility of each state, in conformity with all human rights and fundamental freedoms, and the significance of and full respect for various religious and ethical values, cultural backgrounds and philosophical convictions of individuals and their communities should contribute to the full enjoyment by women of their human rights in order to achieve equality, development and peace.[83]

In some communities, power structures remain so rigid as to prevent the voices of these groups from emerging. This is particularly so in rural communities, where the power entrenched in traditional structures constrains the possibility of effectively conveying the needs and interests of less powerful groups.[84] Shongweni is a rural area, which still practices tradition, but what is surprising is that, women are generally more actively involved in community development. They are willing to work, to have an income, and to bring food into the home. The discussion that follows examines the challenge of how to address community participation.

[82] Idem.
[83] Forth World Conference on Women Platform for Action, 4 – 15 September 1995, Beijing.
[84] I. Petersen, A. Parekh, A. Bhagwanjee, K. Gibson, C. Giles & L. Swartz *Community Mental Health Care: Ensuring Community Participation* (1997) at 60.

There is no doubt from what has been discussed above, that community participation is an important factor in making the provision of health care services more effective in rural communities like Shongweni.

3.4 MEETING THE CHALLENGE

With regard to the power differential which exists between professional and community interests, these might best be addressed through a process which simultaneously addresses the need for a process of re-training for health professionals as well as community education on health issues.

This would include:

- The re-orientation of health care professionals to be more familiar with comprehensive primary health care, which regards community participation and community development as central to health care. An important function of health personnel education is socialization and the acquisition of a professional person with a set of values compatible with participatory model;
- The empowerment of communities to exert control over the health care that they receive. This means that communities should have a say in decisions that affect their own lives. For some people, the mechanisms of empowerment may lead to a sense of control, for others it may lead to actual control, the practical power to effect their own lives. Empowerment is easy to define in its absence: powerlessness, real or imagined, learned helplessness, alienation, loss of a sense of control over one's life;
- Community based health care personnel education within a primary health care philosophy thus needs to be promoted by tertiary educational institutions. Students who study health professions as a career must be orientated in primary health care, community participation and empowerment. This has been adopted by the Department of Health Sciences in various Universities throughout the country, including the University of Durban-Westville;
- Re-orientation programmes, which focus on attitude change of existing health care personnel, should be introduced in health care settings across the country.[85]

[85] Ibid at 61.

Furthermore, it is important to recognize that any re-training process that addresses the differences in approach in more than a superficial manner is likely to be slow in producing real change. Rifkin describes two pronged approaches to the transformation of the health care system towards primary health care as advocated. This involves firstly, ensuring the establishment of structures and processes, which facilitate community involvement in health care, second, the empowerment of all groups within communities.[86] In the Shongweni area this can be achieved through the local Councillors and community health care workers working together with different service providers in the area. The projects that were discussed earlier in this chapter including adult literacy are important factors of empowering the community of Shongweni.

According to Oakley there is widespread acceptance of the crucial role that community health workers have to play in promoting community involvement in health as they can serve as effective mediators between professional and community interests.[87]

3.5 RESOURCES ALLOCATION IN SOUTH ARICA

South Africa has a population of over 40 million, of which 73 % are women and children. It is classified as a middle - income country that spends 8.5 % of gross domestic product (GDP) on health care,[88] and exhibits major disparities and inequalities. This is the result of former apartheid policies, which ensured racial, gender and provincial disparities. The majority of the population of South Africa, especially those living in rural areas, have inadequate access to basic health services including health, clean water, basic sanitation.

After 1994, the South African Department of Health tried to rectify the inequality in distributing health care needs and focused its attention on rural areas. This was done through the Reconstruction and Development Programme (RDP).

After the 1994 elections a needs based formula was used to determine budget allocations between the provincial health departments. This formula consisted of the provincial population size, which was weighed. The budget allocation changed after the

[86] Idem.
[87] Idem.
[88] Statistics South Africa www.statssa.co.za.

introduction of the new South African Constitution (1996). The Constitution ensured equal distribution of resources amongst people in South Africa including those in rural areas. According to the South African Constitution (1996), distribution of resources should be effective, efficient, equitable and equal to all citizens. The rural areas have been denied this right by the apartheid government. The democratic South Africa has been attempting to rectify this problem by distributing health care resources equally by paying more attention to rural areas.

In 2000/1 health goals included the following: maternal, reproductive and women's health, child/adolescent health, care of older persons and mental health, nutrition, oral health, environmental health, occupational health, emergency health services, human resource development, substance abuse, sexually transmitted diseases and HIV/Aids, technology and drug policies, health information system and health research.[89]

In order to ensure that health care resources are distributed equally in rural and urban areas, the principles outlined below have been used as guidelines:[90]

- Health care financing and resources allocation policies should promote equity of access to health care services among all South Africans, between urban and rural areas, between rich and poor people, and between the public and private sectors. Policies should also promote the optimal utilization of resources.
- Financial resources should be allocated equitably as outlined by the Constitution of the Republic of South Africa, Act 108 of 1996.
- Physical resources should be distributed equitably.

Sectors responsible for funding of health care in South Africa:

- Private Health Care

1. Medical Schemes (decreasing = about 18 %)
2. Out-of-pocket spending (increasing= about 22%)
   - Co-payments 40%
   - General Practitioner 24 %

[89] babsamod@iafrica.com.
[90] Idem.

- State Funded Health Care

1. National, Provincial and Local Government

- Other Funded Health Care

    1. Donor Agencies
    2. Charities and Religious Groups.[91]

There are three major sources of finance for public health, namely:

- Funding from general tax revenue;
- Local rates, utility sales and taxes
- The user free.[92]

Until recently, capital expenditure was fully funded by the government, now donor agencies have become willing to fund government service. As mentioned above other sources of funding is from donor agencies, charities and religious agencies. General tax revenue collects finance of about 94 % of public health recurrent expenditure.

Before 1994 taxes collected in the former provinces were placed in the State revenue account and taxes collected from former homelands were placed in homeland revenue accounts. All taxes are now credited to a consolidated National Revenue Account.[93] The National Department of Health is responsible for the use of central government health funds. The Function Committee for Health advises it on resources allocation. Until recently budget allocation was based largely on the previous years' budget. The Department of Health plans to rapidly reduce historically regional inequalities in funding. For this reason, the White Paper for the Transformation of the Health System in South Africa has a principle that states that health financing and resource allocation policies should promote equity of access to health services between urban and rural areas, rich and poor and between the public and private sectors.[94]

Local authorities in large metropolitan areas find a higher proportion of expenditure from their own resources when compared with those in small towns or rural areas. The

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[91] Idem.
[92] Idem.
[93] *Supra* (note 27) at 32.
[94] *Supra* (note 1) at 42.

provincial Department of Health funds the balance of expenditure by local authorities in the form of subsidies. The future role of this source of finance depends to a greater extent on the final distribution of the tax authority between government levels under the new Constitution.[95]

User charge fee generates 4.5 % of the income. The health departments of former provincial administrations introduced a uniform fee structure several years ago, but the ex-homelands still have their own fee policies. The level of fees in the uniform fee structure depends on the sophistication of the health facility and on the declared income of the patient. Certain patients and services are totally exempted from fees. There are several reasons why so little revenue is generated from user fees. Fee levels are low, except for private patients. Until recently private patients were not allowed to use public hospitals unless they did not have easy access to a private facility. All fee revenue is effectively returned to the provincial Revenue Account, since each department's health budget is reduced by the amount of fees it collects.[96]

Between 1992 and 1993 general tax income contributed 93 % towards funding for public health care. User charge fee contributed 5 % and local rates, utility rates and taxes contributed 2 %.

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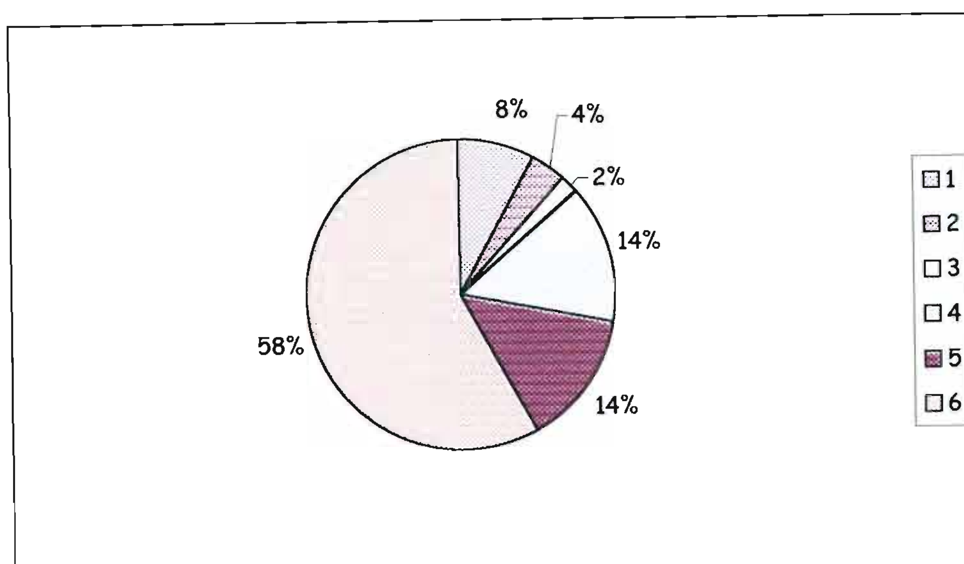
[95] *Supra* (note 27) at 33.
[96] Idem.

Figure 1. Allocation of Financial Resources in the Public Health Sector in South Africa, 1987/1988.



1. Local Authorities – (225 million)
2. Other States Departments – (R399 million)
3. Provincial Administrations – (R3 029 million)
4. Department of National Health and population Development – (R749 million)
5. 'Self – Governing' and Independent States – (R762 million)
6. Own Affairs Administrations – (R188 million)

Source: *Department of National Health and Population Development 1991*

The budget is very important in resource allocation for health care services. Budgetary controls will promote the following:

- Shift expenditure towards primary health care because primary health care is a programme that is used to make health care services available and accessible in rural areas;
- Commissioning of buildings and equipment for the delivery of primary health care services. These include technology for immunization and resources and equipment used for health education, for example, posters, charts and so on;
- Management of patients at the appropriate level of care to enhance community participation;

- Improved efficiency with regard to the use of resources. This will also help in terms of mismanagement of funds;
- Reduced wastage and loss of drugs, that is, appropriate management of available resources;
- Eliminating duplication of facilities and service;
- Limited inappropriate level care in academic hospitals;
- Better use of under-utilized hospitals like public hospitals and clinics; and
- Greater cost recovery at higher-level facilities.[97]

In order to distribute and allocate funds, the Department of Health needs to have the source of funding. Sources of funding are discussed below:

Figure 2 Sources of Finance[98]

Sources of Finance	Expenditure (million rands)	Percentage Contributed (%)
General tax revenue (1)	11,447	38.0
Local authorities	225	0.7
Total public sector resources	11,672	38.7
Medical scheme (2)	12,04	40.0
Medical insurance	923	3.1
Industry	1,162	3.8
Out-of-pocket	4,184	13.9
Total private sector sources	18,333	60.8
Donor funding	145	0.5
TOTAL	**30,150**	**100**

[97] babsamod@iafrica.com.
[98] Idem.

Figure 3 Provincial Health Expenditure/Budgets as a Percentage of Total Provincial Expenditure/Budgets[99]

Province	1996/97	1997/98	1998/99	1999/2000	2000/01
Eastern Cape	18	18	19	22	23
Mpumalanga	15	15	17	18	19
Gauteng	21	18	19	21	21
KwaZulu-Natal	21	18	21	23	24
Northern Cape	16	14	17	18	18
Northern Province	19	18	18	18	19
North West	15	16	17	18	20
Free State	17	17	19	20	21
Western Cape	19	17	17	19	20
Provincial Average	**19**	**17**	**19**	**20**	**21**

As mentioned in Chapter One, Shongweni is located in KwaZulu-Natal Province. According to above statistics, KwaZulu - Natal has the highest population but the amount allocated in terms of the Provincial Budget was far less when compared to those provinces with lower population, like Gauteng for example.

3.6 ACCESSIBILITY OF HEALTH CARE RESOURCES IN DEVELOPING COUNTRIES

Health systems in many developing countries are most frequently geographically centralized and technically sophisticated, with expenditure directed towards high cost urban hospitals. Health services are generally not cost effective, and are neither accessible nor appropriate in the context of the developing world, thus failing to address the health problems affecting the majority of a population, resulting in limited health improvements in many developing countries.[100]

[99] *Funding of Health Care Services* by the Department of Health (1995).
[100] D. R. Phillips *Health and Health Care in the Third World* (1990).

Deficits in rural health provision, particularly in countries in which a significant proportion of the population live in rural areas, reflect rural underdevelopment more generally, and have exacerbated the health gap between urban and rural populations. Groups with poor level of health have the greatest need for health care but, frequently have little or no access to even the most basic of health services.[101]

However, whilst spatial disparities in levels of health are often considerable, particularly between urban and rural areas, it is important to acknowledge that socio-economic inequalities are becoming as significant as spatial inequalities between the health of rich and poor groups in both urban and rural areas are increasingly pronounced.[102]

As a developing country, South Africa has attempted in many spheres to address the issue of inequality. In South Africa, health care services are free to those who cannot afford to pay. Many health problems in developing countries could be effectively addressed with low technology, relatively low cost means, such as basic accessible services, public health measures and disease prevention through immunization and nutrition programme services. Likewise this is done in South Africa and health education is used as a strategy to achieve the above.

A number of developing countries are notable in having achieved impressive improvements in health despite only modest economic growth, such as Sri Lanka, Costa Rica and Thailand. It has been suggested that a significant feature of development in these countries has been education, particularly female education, health care that is appropriate (simpler, rather than vaccination programmes), accepted by the community, and a service that is free or inexpensive to users. Accessible and appropriate health services, as part of a multi-sectoral package, have therefore been a critical precursor of health improvements in many developing countries.[103]

In recognition of the scale of health problems prevailing in particularly low income countries, the WHO established an ambitious resolution which was discussed earlier in

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[101] Idem.

[102] T. Harpham *Cities and Health in the Third World* (1994) at 111.

[103] J. C. Caldwell *Health Transition: The Cultural, Social and Behavioural Determinants of Health in the Third World. Social Science and Medicine* (1993) at 125.

this chapter, 'Health for all by the year 2000'. This was intended to promote improvements in the quality of health care provision, the basis of which was the universal accessibility to health care. Most countries have accepted the importance of the WHO resolution, and many have attempted to adopt the recommendation into health systems policy. South Africa is one of the developing countries, which has adopted the WHO resolution.

Whilst this has led to some improvements, overall success has been limited and inaccessibility problems, especially for poor and or rural groups, continue to prevail. Promoting universally accessible, acceptable and appropriate health care continue to be a key goal for achieving health improvements within the WHO's revised time frame, 'Health for All in the Twenty-First Century', and believing that the same slogan will prevail even in the Twenty-Second Century, reinforcing the need to identify groups with poor accessibility and suggest ways of improving it.

As mentioned in Chapter One, the objective of primary health care provision is the maintenance or improvement of the population's health. The equitable distribution of resources is therefore paramount. The equitable allocation of resources to primary health care presents major challenges especially the allocation in rural areas. In order to ensure that health care resources reach the rural areas, it is important to take into consideration the geographical variations. Shongweni is one of the areas that are located in rural areas. The equal distribution of health care resources in this area may be influenced by the location of the area.

It has been discussed that some of the factors that affect the utilization of health services include, age, sex, social structure, occupation, education, ethnicity and health beliefs. These were distinguished from enabling factors, which encourage or inhibit utilization, such as economic resources of a family.[104] 90 % of the people living in Shongweni are unemployed whereas 10 % are employed and earn low incomes.

[104] P. F. Gross "Urban Health Disorders, Spatial Analysis and the Economics of Health Facility Location" (1972) *International Journal of Health Services* 63.

Although in South Africa, health care services are free, the quality of health care that people receive is not as good as compared to the quality of health care for those who pay for it. Those who earn a high income and can afford to pay for health care services receive a high quality of care.

In South Africa, this is distinguished by private and public health sectors. Private health sectors are expensive and the quality of care is very good whereas public sectors are free but the quality of care is questionable. Patients do not always receive treatment that they require. Public hospitals are usually full and patients have to wait in long queues to be attended to.

It is clear that the location of a particular area plays a vital role in distribution of health care resources. In 1983 Stock conducted a detailed study of the effects of distance on attendance rates at health clinics in Nigeria. The findings were that, the utilization of health care resources were negatively related to the distance between the user and the service, together with the time taken to reach it. In relating Stock's findings to the Shongweni area, what is clear is that even though there is a clinic in Shongweni, more often than not there appears to be a lack of resources. This forces the members of the community of Shongweni to use the neighbouring health care services. The result of this is that people have to travel about 30 kilometers to get to the nearest health care service, that is, either the Pinetown, KwaDabeka or New Germany clinics.

Another finding regarding the factors influencing utilization in Nigeria included the availability of public and private transportation and the costs involved. Importantly, the seriousness of an illness episode also determines the distance an individual is prepared to travel to seek medial attention. In the Shongweni area, most of the people rely on public transport and most of them cannot afford to pay for transport fees. This results in them not being able to have access to health care services.

Carlstein, Parkes and Thrift have suggested that facility opening times and days relative to times when people are able to visit as well as waiting times and queues for consultation, affect accessibility and therefore utilization. Time related organizational factors might

therefore lead to undue inconvenience, hassle and economic cost to users due to poor or inappropriate delivery of services.[105]

3.7 In developing countries there are **determinants of accessibility of health care services.** These include the following:

3.7.1 Transport Availability

Transport availability is clearly an important determinant of access to health care service. As discussed earlier, most of the people in Shongweni rely on public transport to get to the nearest health care services. This usually happens if they did not get assistance from their local clinic or because their particular health problem needs to be dealt with at a hospital.

If the health problem needs to be attended to by hospitalization, people are normally referred to R K Khan hospital as it is the nearest governmental hospital for the Shongweni community. To get to R K Khan hospital, it means that the patient has to travel from Shongweni to Pinetown, which is about 30 kilometers, and from Pinetown to R K Khan, which is about 35 kilometers. In the patient actually acquiring the help depends to a large extent on whether he or she has the money to pay for transport.

3.7.2 Service Awareness

Attitudes to health, personal health values and knowledge about the availability of health care are all known to be determinants of health care utilization.[106] The Shongweni area only caters for African people, most of whom are Zulu speaking. As already mentioned there is a high rate of illiteracy. People from this community experience particular obstacles to accessibility due to linguistic or cultural impediments associated with lack of service awareness.

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[105] J. C. Caldwell *Health Transition: The Cultural, Social and Behavioural Determinants of Health in the Third World. Social Science and Medicine* (1993) at 125.

[106] L. S. Green, M. K. Kreuter, S. G. Deeds & K. B. Partridge *Health Education Planning: A Diagnostic Approach* (1980).

3.7.3 Personal Mobility

Personal mobility exerts an important influence on access to health care services. The young and elderly are seen to be the most restricted in terms of their personal mobility. Those aged 0-15 years are limited by their reliance on parents for transport fees and are accompanied to the surgery. People aged 80 years and over also suffer greater obstacles due to the fact that they are increasingly reliant on assistance to get to clinics.[107]

Townsend et al found that those in lower classes are likely to experience greater difficulties because of their limited financial resources, as it is the case with Shongweni community. Lower social classes in previous studies have indicated higher rates of consultation.[108]

3.8 CONCLUSION

This chapter has highlighted the strategies of Primary Health Care. The importance of community participation as a way of promoting public health was given consideration. It is very important to empower and involve the community in making decisions that affect their own lives. In trying to achieve the goal of community participation, barriers of community participation were discussed and furthermore, the ways of meeting those challenges.

It is clear from the above discussion that rural areas and developing countries have been marginalized and were previously disadvantaged, particularly in regard to the provision of health care. Primary health care is used as the strategy to resolve and deal with these issues so that everyone can have access to health care services. It is stated clearly in the South African Constitution that everyone has the right to health care services. This does not exclude those who cannot afford to pay. There is a concern however when comparing the quality of care given to those who cannot afford to pay to those who are able to pay. This will be discussed further when presenting and analyzing data for the Shongweni area in the next chapter.

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[107] S. Franel *Health Needs, Health Care Requirements and the Myth of Infinite Demand* (1991).
[108] Idem.

CHAPTER FOUR

4.1 INTRODUCTION

This chapter focuses on the sampling techniques and the research instruments used in data collection. The observation method, conducting of interviews and administering of questionnaires have also been discussed as ways of collecting data. The findings of the research will be discussed in this chapter.

KwaZulu-Natal occupies about 92 000 square kilometers, approximately one-tenth of South Africa's land surface. It is the country's third smallest province. KwaZulu-Natal has the largest population of approximately 9.3 million. This is about 20 % of the total population of the country. About 43 % of KwaZulu-Natal's population live in urban areas, while 57 % live in non-urban areas.[109] The rural areas are strongly influenced by traditional authority structures and the communal administration of land and resources are common.

In KwaZulu-Natal there are 36 rural hospitals. The Department of Health introduced the District Health System, which obliges the community to go to their District Hospitals when the need arises for them to use hospitals.[110]. This research focuses on one rural clinic, in particular, the Shongweni clinic.

The specific issues that are researched in this study relate to the accessibility and availability of health care resources and the effectiveness of Primary Health Care in this area. The participants of the study were health care workers and people of the Shongweni community.

According to Statistics South Africa, KwaZulu-Natal employs less than half of the potential labour force in the formal economy. More than one million people are without jobs while 1.57 million people between 15 and 65 years are unemployed. There is a high rate of unemployment in the whole of South Africa. The gap between the per capita income of people living in urban and rural areas is huge. A

[109] Statssa.co.za.
[110] J. Nicholson *Bringing Health Closer to People* (2001).

large percentage of the people living in KwaZulu-Natal, particularly in rural areas, rely on income from family members who are mostly working in the industries around the province.

4.2 DATA COLLECTION

A sample is identified as a subset of the whole population, which is actually investigated by the researcher and has generalized characteristics of the population.[111] The random sampling technique was used for administering the questionnaires. The sample size for the study consisted of 100 respondents of between 25 – 65 years from the Shongweni area.

Stratified random sampling was used and the sample size was divided into three different groups. There was a group drawn from the more educated community, the other from part of the community that were not as well educated or schooled and lastly the health care workers within the community.

Questionnaires, telephonic interviews, observation and face-to-face interviews were the methods of data collection that were used. Interviews involved direct personal contacts with the participants, (who will be referred to as respondents) who were asked to answer questions on a pre-planned questionnaire (See Annexure 'A' attached). This method was used to test the respondent's knowledge and attitude towards the availability and accessibility of health care services in the Shongweni area.

Some of the questions were open-ended whereas others were not. The researcher personally administered the questionnaires. They were designed for the purpose of acquiring information regarding socio-economic characteristics of the respondents. It was also designed for the purpose of obtaining information regarding the availability and accessibility of health care services in the area. The questionnaires were directed at the users of health care services. The environment in which the participants' lived was observed at least three times a month for the

[111] C Bless & C Higson – Smith *Social Research Methods* (1995) at 99.

period from June 2001 to December 2002. The researcher may therefore be described as a participant observer.

As the methods of data collection that were used in this study included administering of the questionnaires, observation techniques, and face to face interviews, the analyses of this data was an evaluation of all the responses. In analyzing the data obtained from this study, percentages, tables and figures were used to illustrate the responses.

4.3 LIMITATIONS OF THE STUDY

Some of the limitations experienced in carrying out the study were that:

- Some of the people were not eager to participate for their own reasons and did not avail themselves to the researcher;
- Not all of the questionnaires were returned;
- Most of the respondents did not understand English, the language in which the study was being conducted, hence, the researcher had to convert some of the questions to isiZulu and transcribe them back into English for data analysis;
- The respondents might not have been entirely honest when answering some of the questions; and
- There was lack of trust of the researcher, as respondents were not sure of what exactly the information was required for.

4.4 DATA ANALYSIS AND PRESENTATION OF FINDINGS

The respondents were mainly between 25-65 years old. The total number of people that were interviewed was 100.

Table 1 An Illustration of the Gender of the Respondents

	Number	**Percentage**
Females	70	70 %
Males	30	30 %
TOTAL	**100**	**100 %**

The table above shows that most of the respondents were females. In rural areas like Shongweni, people who normally participate in community activities are females. This is because women have been empowered to participate in their communities. Unlike the situation that prevailed previously whereby females in rural areas were not involved in community activities, the males would normally be responsible for taking the initiative in matters affecting their communities. Women had to stay at home doing household chores. Empowering women to be more involved in community activities has changed this dramatically. Approximately 90 % of males have lost their jobs and women take the initiative in ensuring that there is food on the table.[112]

Table 2 An Illustration of the Composition of the Respondents

	Percentage
Community Health Workers	10 %
Community Members	90 %
TOTAL	**100 %**

The composition of the respondents was 100%. 90 % of the composition consisted of community members whereas 10 % consisted of community health care workers. It was significant for the researcher to include community health care workers in the study because of their involvement in the community.

[112] Department of Labour – Pinetown.

4.4.1 Availability and Accessibility of Health Care Services in the Shongweni Area

Table 3

Availability of Health Care Resources

Respondents who indicated that health care resources were available	10 %
Respondents who indicated that health care resources were not available	90 %
TOTAL	**100 %**

Table 4

Accessibility of Health Care Resources

Respondents who indicated that health care resources were accessible	20 %
Respondents who indicated that health care resources were not accessible	80 %
TOTAL	**100 %**

As reflected in Table 3 above, only 10 % of the respondents stated that they had adequate health care services in the area. 90 % felt that they did not have adequate health care services in their area. 20 % of the respondents stated that health care services were easily accessible while 80 % felt that the health care services were not. [See Table 4]. Most of the respondents conceived of appropriate health care to include comprehensive primary health care services and family planning.

The community members were of the opinion that health care services that are available whether of a lower quality or high quality will be of assistance to them. They therefore submitted that any form of health care services provided was better than no services at all. Most of the participants indicated that they were not quite aware of the quality of the standard of health care that they were expected to receive as citizens of South Africa.

The respondents identified the following as being factors that contributed to the lack of the provision of health care services:

- The clinic did not have enough resources to cater for all members of the community;
- They had to travel long distance to get to the nearest health care institution;
- There was a lack of public transport to get to the nearest health care institution; and
- There were transport costs involved in getting to the nearest health care institution.

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4.4.2 Adequate Health Care Resources

Table 5

Adequate Health Care Resources	Inadequate Health Care Resources
10 %	90 %
TOTAL=100 %	

About 90 % of respondents stated that the clinic in their area did not have adequate health care resources to cater for the community needs. For many of them, it was preferable to go to the nearest hospital for the same treatment (which was either St Mary's or R K Khan Hospital). Only 10 % stated that health care services were easily accessible to the community.

The reason for this was that there was a clinic and community health care workers were available to provide health care services for those community members who required its services.

4.4.3 Unemployment Rate

Table 6

Employed	Unemployed
20 %	80 %
TOTAL=100 %	

As indicated above, 80 % of the community members were unemployed. This high unemployment rate creates further difficulties and exacerbates the problems experienced. Community members have to travel long distances to get to the nearest hospital, which they choose to use. About 20 % of the respondents stated that they travelled to hospitals to receive health care services whereas 80 % stated that they did not have transport or the means to get to other health care facilities and were therefore only confined to the clinic in the area. The main reason articulated by the respondents for this was that many of them were unemployed and therefore did not have the money needed for traveling costs.

4.4.4 Mode of Transport Used by the Respondents

Table 7

Mode of Transport	Percentage
Buses	40 %
Taxis	55 %
TOTAL [PUBLIC TRANSPORT]	**95 %**
Private transport	5 %
TOTAL [PRIVATE TRANSPORT]	**5 %**
TOTAL= 100 %	

95 % of the community depended on the availability of public transport to get to the nearest hospital. It was stated that they had to travel approximately 35 kilometers to get to the nearest hospital [St Mary's Hospital]. Due to long queues, they sometimes chose to travel to R K Khan Hospital, which is about 60 kilometers away from Shongweni. It was also stated that one had to often make double trips to get to the nearest hospital, as there was no transport that enabled one to travel directly to either R K Khan or St Mary's hospital.

4.4.5 Transport Costs

Table 8

Minimum	Maximum
R 5, 00	R 20, 00

As mentioned above, most of the people in Shongweni have to depend on public transport to get to the health care institutions. They also struggled to pay transport costs mainly due to their financial circumstances. This had a direct bearing on their decisions to get to the health care institutions. The amount spent by the residents of Shongweni on transport costs were R5, 00 for a single trip and about R 20, 00 for the return fare.

4.4.6 Costs Related to Health Care Services

Table 9

Minimum	**Maximum**
R 10, 00	R 100, 00

As St Mary's hospital is a semi-government hospital, (it is subsidized by government), for people to access health care services, a payment of about R 50, 00 is required for consultation and about R 60, 00 for admission to the hospital.

As some individuals may require more comprehensive treatment, such as surgery for example, the consultation costs may actually be much higher. The people in Shongweni have to pay a maximum of up to R 100, 00 for consultation if they require more comprehensive treatment.

4.4.7 Emergency Services in the Shongweni Area

Table 10

Emergency Services: Available	**Emergency Services: Unavailable**
85 %	15 %

About 85 % of respondents indicated that there were ambulance services in the area. However a delay with service delivery was noted. They also stated that they had to wait for an average of about three to four hours for the ambulance to arrive. This is generally due to lack of availability of ambulances and having to wait for an ambulance to be provided from Pinetown which is about 30 kilometers away depending in which part of the Shongweni area one is residing in. As a result, community members sometimes have to turn to their neighbours with cars, particularly in cases of emergency. On the other hand 15 % indicated that there were no ambulance services at all in the area in which they lived.

4.4.8 The Effectiveness of the Department of Health in Health Care Service Delivery

Table 11

Delivery of Services: Effective	**Delivery of Services: Non effective**
40 %	60 %
TOTAL= 100 %	

60 % of the respondents were of the opinion that the Department of Health was not effective enough in health care service delivery and they were not happy with the health care provision in the area mainly because of the kinds of problems articulated above. 40 % of the respondents stated that they were satisfied with Department of Health's attempts at service delivery in the area.

4.4.9 Rating of the Quality of Health Care Provision

Table 12

Rating	**Percentage**
Poor	70 %
Fair	20 %
Excellent	10 %
TOTAL	**100 %**

When asked about the difference with regard to health care service delivery between rural and urban hospitals, the respondents cited the following reasons associated with the difference: poor construction of roads, lack of transportation or expenses associated with transportation, shortage of medical drugs, unfair distribution of health resources, shortage of hospitals and clinics in rural areas.

The community health care workers expressed their concern regarding the differences and the inequality in the distribution of health care services in rural and urban areas. They suggested that the obstacles related to unfair distribution of health care services, which ought to be addressed by the Department of Health. They further stated that the Constitution gives everyone the right to have access to health care services and people in rural areas are no exception. According to them it appeared as though health care service delivery in rural areas was in fact regarded as a privilege and not a right for the people who lived there.

Other concerns were the paucity of community health care workers as they were given some prominence since they were instrumental in health care service delivery in the community. They further stated that an increase in the number of community health care workers would indeed enhance the effectiveness of primary health care in the area.

It was also felt that people in rural areas needed to be involved and consulted in issues that affected their health. It was therefore suggested that a more concerted effort should be made in ensuring that resources are shifted towards rural communities that were previously disadvantaged.

4.4.10 Right to Health Care in South Africa

Table 13

Right to Health Upheld	Right to Health not Upheld
5 %	95 %
TOTAL = 100 %	

95 % of the respondents felt that their right to health care services was not upheld while 5 % felt that their right was upheld. People living in rural areas only know that they have the right to health care services but they do not know that they are legally protected by the Constitution of the Republic of South Africa.[113] In terms of Section 27 (a) of the Constitution of the Republic of South Africa, it is stated that everyone has the right to have access to health care services, including reproductive health care.

Most of the people in rural areas felt that the government is actually not obliged to provide free health care services. Most of them are not aware that there is a Constitution, which protects their rights as South African citizens.

In the case of *Azanian People's Organizations* (AZAPO) v *President of the Republic of South Africa*,[114] the following was said in respect of the accessibility of health care resources:

"...the resources of the state have to be deployed imaginatively, wisely, effectively and equitably to facilitate the reconstruction process in a manner which best brings relief and hope to the widest sections of the

[113] The Constitution of the Republic of South Africa Act 108 of 1996.

[114] Azanian People's Organization v President of the Republic of South Africa 1996 (8) BCLR 1015 (CC).

community, developing for the benefit of the entire nation the latent human potential and resources of every person who has directly or indirectly been burdened with the heritage of the shame and the pain of our racist past".[115]

It was pointed out in the AZAPO case that, difficult choices had to be made by the negotiators for a new dispensation in South Africa. Difficult choices had to be made as far as limited resources were concerned between giving preference to delictual claims of persons who had suffered from acts of murder, torture or assault perpetrated by servants of the state with the need for resources in the crucial areas of education, housing and primary health care.[116]

The right to health represents an international legal obligation of States to promote and protect the health of their populations. The principle legal basis for the right to health is found in the core instrument of international human rights law, the International Bill of Rights. As discussed in chapter two, Article 25.1 of the Universal Declaration of Human Rights proclaims, "everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services.[117] The Universal Declaration does not guarantee a right to health per se, but a right to health incident to the right to an adequate standard of living.[118] This aspect was dealt with in Chapter two.

[115] Ibid at 1038 F – G.
[116] *Supra* (note 12) at 435.
[117] A. L. Taylor *Making the World Health Organization Work* (1992).
[118] Idem.

5. CONCLUSION

From the above information presented, it seems that rural areas are still marginalized in accessing health care services. In comparing health care services in rural areas to urban areas, it is obvious that there are indeed disparities, which need to be addressed.

The findings of the above study reveal that even though there are health care service institutions in rural areas, as is the case in Shongweni, they are not adequate for people residing in the area. What is therefore suggested by way of improvements and recommendations are presented in the following chapter.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Evaluation

In Chapter 2 it was mentioned that the Declaration of Alma-Ata was adopted by WHO and UNICEF. This was an international conference on primary health care. It raised an issue of the existing gross inequality in the health status of the people; particularly between developing and developed countries. South Africa is one of the developing countries, which is willing to balance the gross inequality in health status of the people. The health status of the people in rural and urban areas is unequal. This is also characterized by the standard of health in private and public health sectors. In South Africa, people who can afford it, choose to use private health sectors because the standard of health in private health sectors is excellent as compared to public health sectors. Most people living in Shongweni cannot afford such services and they fall under the category of people who mainly use public health sectors.

The Health For All by the year 2000 had obstacles, which contributed to achieving the goals of Health For All in a global context. Primary health care in this original definition stresses the importance of equity to community-based health services.

The strategies for primary health care are vital for the people living in rural areas like Shongweni, but what is found is that these strategies are not practically implemented. The prevention programmes that are conducted in the area are not enough to reach out to the community of Shongweni. As mentioned in Chapter one, there is a multi-disciplinary collaboration but it is not monitored. Different departments should work together with the goal of promoting public health. Although the Department of Health has encouraged the fullest use of available resources and relevant technologies such as immunization, oral dehydration solution etc., these relevant technologies are not always available in rural areas and certainly not in the Shongweni area.

The people of Shongweni area do not fully participate in issues that affect their health. Most of the people in the area are still used to the 'medical approach' as discussed in Chapter three. In terms of medical approach, community participation is defined as the activities of people, under the direction of medical professionals, which are intended to reduce individual illness.

According to the findings of the study, in terms of the socio-economic characteristics of the people, most people living in Shongweni are unemployed. They do not have a source of income. Those who are employed earn a low income as many are employed as domestic workers.

The findings show that although there is a clinic in the Shongweni area, it cannot meet the needs of the entire community due to lack of resources. This makes it difficult for the community to have access to health care resources.

The people in Shongweni area cannot afford to pay for transport costs when they have to seek alternate help such as hospitals. Transport problems have a negative impact in accessing health care resources. This is because most of the people in the Shongweni area rely mainly on public transport to get to health care institutions. There are usually delays, as the taxis have to be full before departing. They are also expensive. As this is public transport, one has to comply with the rules and regulations no matter how sick the person is.

The long distances that people have to travel usually makes their traveling costs quite expensive. Most of the people in the Shongweni area have to borrow money from either relatives or neighbours to cover traveling expenses. This sometimes results in conflicts between the parties, as most of them cannot afford to pay back the money borrowed. This is because most of the people living in the Shongweni area are unemployed as revealed in the analysis of data in Chapter four.

The clinic in the Shongweni area provides the community with free health care services. People either use the free health care services or pay an unreasonable amount when they wish to use their nearest hospitals. Most of the time, the clinics do not have adequate

health facilities. What is surprising is that most of the people do not have a problem paying for health care services. Their main concern was traveling costs.

On the other hand, some people indicated that it was unfair for them to pay for health care services as Government promised them free health care. They have therefore expressed the view that their right to health care was violated. They also indicated that the Constitution of the Republic of South Africa only protects the rights of people on paper and not in practice. The people in the Shongweni area however acknowledged that they are aware of attempts by Government to protect their human rights.

The findings also show that most of the people who reside in the Shongweni area have maintained that they felt discriminated against. Since despite the fact that the authorities indicated that they were shifting their focus to the previously disadvantaged communities, the services in urban areas were far better than those in rural areas.

According to findings regarding the environment, people living in the Shongweni area were more prone to indoor exposure, that is, smoke caused by ground floor fire. This is because most of them still use ground floor fire for their daily use that is, cooking, etc. This causes lung cancer and bronchitis, which leads to more financial implications. Those who were suffering from these diseases have to get treatment, which in most cases they cannot afford. As discussed in Chapter three, health does not only involve treatment, but it also involves prevention. People have to be educated on environmental issues that can have a negative impact on their health. They also have to be educated on the importance of nutrition to improve one's health. The issue of gardening projects as discussed in Chapter three should be implemented. This will help in administering of treatment and improving people's lives.

5.2 Recommendations

- Firstly, the Department of Health needs to shift the distribution of health care resources to previously disadvantaged communities like Shongweni, so as to ensure that there is equal distribution of health care resources.

- The Department of Health and other relevant stakeholders should be more proactive in identifying the most needy areas, that is, underdeveloped rural areas that do not have adequate health care services like Shongweni area.
- Health care resources should be made adequate to cater for the entire community in rural areas like Shongweni.
- This can be done through enhancing community participation in policymaking and processes, therefore, people have to be consulted and be part of the decisions that affect their lives.
- There should be transparency, community participation and accountability in rural areas if any policy or programme is to be accepted by the community.
- Community participation can be effective if rural people are informed about how and when to participate.
- There should be ongoing programmes of sharing information about health development issues; which is consistent with the right of access to information in the Constitution of the Republic of South Africa.
- Particular attention should be paid to informing people through their traditional leaders in rural areas like Shongweni about the proposed health care policies and programmes.
- The Department of Health should revisit and review the White Paper on Transformation of Health System in South Africa. On paper, the White Paper is excellent as compared to what should practically be implemented in rural areas.
- This is because the White Paper on Transformation of the Health System in South Africa does not assist in clarifying important issues that relate to the transformation of the health system in South Africa. This White Paper has shortcomings because it is a policy that is not enforceable legally.
- Health education on public health issues and prevention of diseases should be a priority. This will empower people to take control of their own health.
- There is a need for emergency services to be located in the Shongweni area.
- To improve the socio-economic status of people living in the Shongweni area, development and income generating projects should be undertaken as a priority. People will then earn proper incomes to improve their health and prevent diseases.
- Compulsory community service for medical students is one of the programmes that benefits the rural areas positively. Several other programmes like this should be initiated.

- Strategies like Health Workers For Change [HWFC] need to be strengthened. This will be very useful especially in rural areas like Shongweni. This is a programme whereby workshops are conducted for health care workers. The health care workers are expected to present back to health workers their own conditions and ask them to reflect on them. It is a process, which encourages health care workers to share experiences with one another and also learn from each other. HWFC workshops would therefore lead to discussions about provider/patient relations.
- People in rural areas have to be taught about their rights and where to seek help when their rights are violated. They should know that they are legally protected by the Constitution of the Republic of South Africa.

A World Declaration on rural health needs to be considered with practical strategies on effective delivery of health care resources in rural areas. From the Durban Declaration, which resulted after the Second World Rural Health Congress in 1997, emerged the following demands:

- the governments must provide adequate infrastructure for rural practice;
- they must improve the status of the health care workers and change the curricula at medical and nursing schools in order to provide training appropriate to the rural context.

The recommendations contained in this Declaration were:

- To redress the inequalities that prevail in rural areas around the world;
- To make health care provision in these areas suit community needs;
- To put health care in the context with housing, sanitation and clean water, that is, improve intersectoral collaboration in rural areas like Shongweni;
- To afford the rural health care workers the same status as the urban health care workers;
- To provide training that will suit the needs of health care workers as well as of rural people; and
- To make rural health care community oriented and more community driven

For all these recommendations to be effectively implemented there must be intersectoral collaboration amongst different departments, for example, Department of Education, Department of Environmental Affairs and Tourism, Department of Housing, Department of

Social Welfare and Population Development should coordinate with one another in ensuring efficient service delivery.

The Department of Health should use all its available resources to realize the recommendations that were made in the Durban Declaration so that people in the rural areas can be able to exercise their right to health as envisaged in the Constitution of the Republic of South Africa. This entails that the national government, provincial government and local government should assist each other in health care delivery. Intergovernmental cooperation is therefore necessary.

Health care delivery in rural areas needs to be monitored by the Department of Health. This will ensure that the standard of care provided for rural people is of a good quality. Establishment of programmes like Medicare Choice Programmes and the Medicare Rural Hospital Flexibility Programme go along way in ensuring that health care in rural areas is efficient. These programmes are geared towards community participation. Although South Africa is a developing country, it does have health care delivery programmes. The problem is that there is no effective monitoring of the implementation of these programmes. This results in a series of health care services delivery strategies that are not implemented or are not practically implemented.

In terms of the Constitution of the Republic of South Africa, the right to health is outlined as a right that every South African should enjoy. There are several initiatives that the government has introduced that are geared towards the realization of this right. Having different health care policies in place are not enough. There is a need for practical implementation of these policies.

The government equity strategies need to be speeded up in order for the rural communities and other under-served communities to realize their right and to have equal access to health care services.

5.3 CONCLUSION

What is apparent from the study is that people in rural areas do not receive adequate health care even though the Government has been attempting to make health resources available to people living in rural areas.

Primary health care is the best strategy to benefit people living in rural areas, but it needs to be evaluated and monitored frequently. The strategies of primary health care should be practically implemented in order to improve the quality of life of people living in rural areas.

The ongoing programmes on sharing of information about health development issues are of utmost importance. These would help people to participate and be included in decisions that affect their lives. South Africa, like most of the countries around the world [developed and developing countries] has prioritized the right to health. People living in rural areas however need to be empowered in regard to their rights, particularly their right to health.

The recommendations provided in this study could help the Department of Health to improve the availability and accessibility of health care resources of people living in rural areas. It is also intended to provide a framework for effecting a distribution of health care resources in rural areas so as to ensure that there is equity in the manner in which health care is administered to people in both rural and urban areas.

APPENDIX 1

QUESTIONNAIRE

RESEARCH TOPIC

An examination of the availability and accessibility of health care resources in the rural area of Shongweni in relation to the right to health.

1. Personal Details

   Name :

   Gender :

   Age :

   Home Language :

2. Occupation

   ____

   ____

   ____

3. Do you have health care service institution in your area? **Yes** or **No**

   ____

   ____

   ____

4. If Yes, what kind is it? e. g. clinic, hospital etc

   ____

   ____

   ____

5. If No, where do you get health care resources? For example, medication etc.

____

____

____

6. Does your health care service institution have enough health care resources to cater for your community needs?

____

____

____

7. Are the health services easily accessible to the community?

____

____

____

8. What do you think are the reasons that contribute to the lack of accessibility of health care resources?

____

____

____

9. Do you have transport to get to health care resources?

____

____

____

10. How far do you have to travel to get to the health care services? For example, 10 km etc.

____

____

____

11. Does the traveling costs influence your decision to go to the health care service institution? **Yes** or **No**

____

____

____

12. If Yes, How?

____

____

____

13. Do you pay for health care services?

____

____

____

14. If Yes, How much?

____

____

____

15. Do you get emergency services in your area, e.g. ambulance etc. **Yes** or **No**

____

____

____

16. If Yes, what kind of emergency services do you get?

____

____

____

17. If No, what do you do in case of emergency?

____

____

____

18. Do you think the Department of Health is effective in health care service delivery?

____

____

____

19. Do you think your right to health care services is upheld? **Yes** or **No**

____

____

____

20. Explain

____

____

____

21. How would you rate overall quality of health care provision in your area? **Poor/ Fair/ Excellent**

____

____

____

22. How would you feel about the difference in health care service delivery between rural hospitals and urban hospitals?

____

____

____

23. Do you have any comments related to health care service delivery in your area?

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BIBLIOGRAPHY

BOOKS

- Baum F. & Saunders D. *Can Health Promotion and Primary Health Care Achieve Health for All Without a Return to their more Radical Agenda*: Oxford University Press (1995)
- Binedell J. *Methods & Madness*: *Researching Community Health Worker's Perception of Mental Illness in Khayelitsha and Nyanga*, Unpublished Master's Thesis, University of Cape Town (1993)
- Bless C & Higson-Smith C *Fundamentals of Social Research Methods*: *An African Perspective,* Lusaka, Zambia: Juta & Co. (1995)
- Boulle A. *Rural Health Care and Rural Poverty in Extricable Linked*, Durban: Health Systems Trust (1999)
- Caldwell J. C. *Health Transition*: *The Cultural, Social and Behavioral Determinants of Health in the Third World. Social Science and Medicine*: Oxford University Press (1993)
- Chrondell A. Yach D. *Develop and Strengthen Public Health Law*, Flinders University, Bedford Park (1998)
- De Vries H. *ABC's of Health Education and Planning*, Cambridge University Press, Cambridge (1999)
- Green L. W. & Kreuter M. W. *Health Promotion Planning*: *An Educational and Environmental Approach,* Mayfield Publishing Company, London (2000)
- Harpham T. *Cities and Health in the Third World* Flinders University, Bedford Park, Australia (1994)
- Joseph A. E. & D. R. Phillips *Accessibility and Utilization*, London (1984)
- Labonte R. *Health Promotion*: *Practice Problematic and the Need for Theory Research*: Toronto, Ontario (1992)
- Nadasen S. *Public Health Law in South Africa*: *An Introduction*, Durban (2000)

- Petersen I., Parekh A., Bhagwanjee A., Gibson K., Giles C. & Swartz L. *Community Mental Health Care: Ensuring Community Participation*, University of Durban Westville (1997)
- Phillips D. R. *Health and Health Care in the Third World*. Oxford University Press (1990)
- Rifkin S. B. *Lessons from Community Participation in Health Programmes*: London (1986)
- Stewart R. & Bhagwanjee A. *Promoting Group Empowerment and Self Reliance through Participatory Research: A Case Study of People with Physical Disability*: University of Durban Westville (1998)
- Tarino E. *Towards a Healthy District: Organizing and Managing District Health Systems Based on Primary Health Care*, Geneva, Switzerland (1991)
- Toebos B.C.A., *The Right to Health as a Human Right in International Law*, London (1997)
- Yach D, *The Emerging Role of Public Health Law in the New Health Policy for the 21st Century,* Presented at the International Conference on Global Health Law, New Delhi (1997)

JOURNAL ARTICLES AND REPORTS

- Gross P. F. *Urban Health Disorders, Spatial Analysis and the Economics of Health Facility Location. International Journal of Health Services* (1972)
- An Article on Funding of Health Care Services by the Department of Health (1995)
- A Vision for Health in South Africa: Guiding Principles
- South African Health Review (Durban Health Systems Trust, 2000
- White Paper for Transformation of Health System in South Africa (1997)
- White Paper on Transforming Public Service Delivery: *Batho Pele* (People First) (1997)

WEBSITES

babsamod@iafrica.com.

http:/www.Idb.org/iphw/whoconst.htm.

www.gov.za.

www.statssa.co.za.

www.yahoo.com

TABLE OF CASES

1. Azanian People's Organization (AZAPO) *v* President of the Republic of South Africa 1996 8 BCLR 15
2. Soobramoney *v* Minister of Health, KwaZulu-Natal 1997 12 BCLR (cc) 1998 15 A 430 (b)

TABLE OF STATUTES

Alma-Ata Declaration – Adopted by WHO and UNICEF in 1978, September, USSR

Constitution of the Republic of South Africa Act 108 of 1996

Constitution of World Health Organization

Health Act 63 of 1997

Ottawa Charter for Health Promotion 21 November of 1986

National Health Bill of 2003

Patients Rights Charter