ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH SERVICES IN KWAZULU-NATAL

BY

NDLOVU BASIL SIPHIWE

DISSERTATION

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(Funded by the CSD, HSRC, South Africa)

Supervisor : Professor D Sing

Date Submitted : January 1999

DECLARATION

I hereby declare that the ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH SERVICES IN KWAZULU-NATAL is entire my own work and that all sources used or quoted have been acknowledged.

NDLOVU BASIL SIPHIWE

....

Signature Date

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A BIG THANK YOU TO YOU ALL!

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By

Basil Siphiwe Ndlovu

SYNOPSIS

Supervisor	:	Prof. D. Sing
Degree	:	M. Admin
Faculty	:	Commerce and Administration
Department	:	Public Administration
University	:	University of Durban-Westville

This dissertation focuses on the role of non-governmental organisations in provision of health care services in KwaZulu-Natal. The study had three objectives which were:

- identify the role of non-governmental organisations in the provision of health in KwaZulu-Natal.
- describe mechanisms for enhancing collaboration between the government and non-government organisations.
- investigate mechanisms for redistribution of resources from the public and private sectors to the non-government organisations.

The Nationalist Party government, supported by its apartheid policies created imbalances in the provision of services in South Africa. Generally speaking, inequity in all spheres of life was visible between the white population which was the minority and their counterparts, the blacks which were the majority. Health care services were fragmented and divided in racial lines. The whites who were predominantly located in urban areas had access to curative health care which was affordable to them. The blacks were located in rural areas which were referred to as homelands. The health services were minimal and in most places they were unavailable. Curative facilities provided by hospitals and clinics were situated long distances from where the majority of the population could find them. Transport facilities like roads were not well developed, ambulances and health care workers were not available. Health care facilities was inadequate in these areas.

The health care provided by the apartheid government was inadequate and structures which were outside the government known as non-government organisations were formed. These NGOs acted as the first line of health defence to the marginalised sectors of the South African communities. Non-governmental organisations were also functioning in the province of KwaZulu-Natal and some were comprehensive in approach and did not provide only health services but also training and education, housing, social services and other development activities. The role of these non-governmental organisations involved the following:

- improving health in the most remote and disadvantaged communities, for example, informal settlements, rural and the ultra poor areas.
- providing integrated and comprehensive services, for example, employment generating projects, education and training and housing.
- unifying the different racial groups and breaking down prejudices and assumptions with regard to race and gender.

Although non-governmental organisations operated in South Africa, there was always confrontation between the government structures and NGOs, particularly those which were actively involved in the upliftment of the lives of the previously disadvantaged communities, namely the blacks. These non-governmental organisations provided these services under a variety of unpleasant conditions, characterised by assassinations, tortures

and imprisonment. These NGOs were banned by the government and others operated under restrictive and authoritarian government policies.

The recent political changes which took place in South Africa - the unbanning of political organisations like the African National Congress and the Pan Africanist Congress highlighted the need for transformation in all aspects of life. In 1994 a democratic government which was ANC-led was legitimately elected. The government of national unity was committed to the upliftment of the lives of all South Africans, particularly the provision of health care for all. People were extremely optimistic when the new government (GNU) came into power.

The role of non-government organisations was theoretically non-existence and minimal as the government was aiming at providing health care services to the previously disadvantaged communities. Foreign donors and funders redirected their financial assistance to the government and the funding was between government to government. The personnel from non-governmental organisations was recruited to business and government sectors which also challenged NGOs to replace these dedicated and committed people. The funding problem has become a major challenge to non-governmental organisations and most of them have been forced to shut down. The political transformation has challenged non-government organisations to reposition

themselves and work with government in the upliftment of the lives of all South Africans. The government of national unity is committed to the provision of equitable, preventive, promotive, curative and rehabilitative services at all community levels, particularly the previously disadvantaged.

The researcher has identified two non-governmental organisations as a case study and these NGOs are providing health care services in KwaZulu-Natal. The NGOs are the Health Systems Trust and the Valley Trust. In addition to these two NGOs literature which was relevant to this study was also reviewed.

The researcher reached the following conclusions after the findings of the study were analysed:

- Non-governmental organisations have played an important role in the past in the upliftment of the lives of South Africans.
- Resources have been inequitable been distributed and there is a need to redistribute these resources equally.
- South Africa is faced with health problems which needs all stakeholders to be involve in order to eradicate ill-health.

The study offers a number of recommendations based from the conclusions which can be generalised to non-governmental organisations providing health services.

ABBREVIATIONS

ANC	-	African National Congress
AIDS	-	Acquired Immunodeficiency Syndrome
CBO	-	Community Based Organisation
CHW	-	Community Health Worker
CHESS	-	Centre for Health Education and Social Studies
DHS	-	District Health Systems
EU	-	European Union
GNU	-	Government of National Unity
HIV	-	Human Immunodeficiency Virus
HSRC	-	Human Sciences Research Council
HST	-	Health Systems Trust
IFP	-	Inkatha Freedom Party
IMR	-	Infant Mortality Rate
KZN	-	KwaZulu-Natal
NGO	-	Non-Governmental Organisation
NHIS/SA	-	National Health Information System of South Africa
NHS	-	National Health System
NNP	-	New National Party
NPA	_	Natal Provincial Administration
NPPHCN	-	National Progressive Primary Health Care Network

PHC	-	Primary Health Care
PHID	-	Project for Health Information Dissemination
PSC	-	Public Service Commission
PSNP	-	Primary School Nutrition Programme
RDP	-	Reconstruction and Development Programme
STD	-	Sexually Transmitted Diseases
SWOT	-	Strengths, Weaknesses, Opportunities, Threats
TB	-	Tuberculosis
UNICEF	-	United Nations Children Fund
VHW	-	Village Health Worker
VO	-	Voluntary Organisation
WHO	-	World Health Organisation

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CHAPTER 1

GENERAL INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Access to basic rights such as education, housing, water, electricity, refuse removal, sanitation facilities, nutrition and health, is still beyond the reach of a large proportion of the population. Disadvantaged people do not perceive that health rights are for them. The circumstances of their lives such as travelling distances, long waiting times, lack of money the disrespectful attitudes of health care providers, their lack of knowledge about when, where and how to seek appropriate health services are experienced by many people as very disempowering and dehumanising (NPPHCN Annual Report 1996:20).

The apartheid government was inefficient in the provision of services, particularly in the provision of health care services to the majority of its population and this led to the emergence of the non-governmental organisations which were formed to challenge these injustices. Non-governmental organisations mainly targeted those sectors of South African population which were the most vulnerable, ***viz*;** blacks, rural, poor, women, children and the neglected communities.

NGOs have historically provided local health services under a variety of conditions in South Africa. In most cases NGO services have filled a void created by neglect of health care needs for under served populations. In many instances NGOs have paved the way for development of sustainable health care services at the community level. In other instances NGOs have the capacity to create innovative services which do not fit into conventional health service provision (ANC 1994:72).

It is important to note that the apartheid government through its discriminatory policies created two classes of citizens in South Africa and the population was divided in racial lines. Non-governmental organisations then came into existence to bridge the gap between the wealthy and poor. However, this was a challenging task because NGOs had to operate under restrictive measures which ensured that the ***status quo*** (apartheid) prevailed.

Political changes in South Africa, especially after 1994, when the democratically elected government (ANC-led Government of National Unity-GNU) came into power challenged the role of non-governmental organisations, as Pavlicevic (unnumbered) noted that much has changed in South Africa since the advent of a new democratic government, not least of which is the role of NGOs. Under the old regime (apartheid),

NGOs have a firmly established place in resistance to the government. Because of the involvement of the anti-apartheid movement, they had access to funding as well as both national and international expertise and support.

In this chapter the researcher provides an overview of the whole study which includes objectives, hypotheses, study area, research methodology, terminology, limitations of the study, layout and overview of chapters and finally the conclusion of the first chapter.

1.2 OBJECTIVES OF THE STUDY

The study had three objectives which were to:

- Identify the role of non-governmental organisations in the provision of health services;
- Describe practical mechanisms for enhancing collaboration between the government and non-governmental organisations; and
- Identify mechanisms for the reallocation of resources from the government and private sectors to the NGO sector.

In order to achieve the objectives of this study a number of questions were raised by the

researcher and included among others the following:

- What was the past, present and future role of non-governmental organisations in the provision of health services?
- What was the nature and functions of non-governmental organisations?
- Is there any relationship between government, business and the NGO sector in the provision of health services?
- Where should funding for NGOs be obtained from?
- How should the available resources be equally shared among all health stakeholders?

It was the objective of this study to find possible answers to these questions and the findings of this study are presented in the later sections (chapter five and six) of this study and are not only limited to KwaZulu-Natal but are also important for South African Health.

1.3 HYPOTHESES OF THE STUDY

The study generated three hypotheses which the research was based on and are:

HYPOTHESIS: 1

Non-governmental organisations will continue their role of providing health care services to the disadvantaged communities.

HYPOTHESIS: 2

Many non-governmental organisations will be incapable of sustaining themselves without resources from international donors.

HYPOTHESIS: 3

Non-governmental organisations in South Africa will emerge as developmental activists in the democratic era (after the 1994 general elections).

The three hypotheses that were generated by this study were tested through a research that was conducted in the KwaZulu-Natal province and the findings are also presented in chapter five of this study. The study was aimed at investigating whether these three hypotheses could be substantiated or not.

1.4 STUDY AREA

The study was conducted in South Africa, with particular emphasis in the province of

KWAZULU/NATAL BY DISTRICT

KWAZULU/NATAL PER DISTRIK

Acknowledgement: The detail map is based on co-ordinates provided by the Department of Regional and Land Affairs. Adjustments were made to accommodate the districts of the former TBVC states as well as the so-called self-governing territories.

Erkenning: Die gedetailleerde kaart is gegrond op koordinate wat verskaf is deur die Departement van Streek- en Grondsake. Aanpassings is aangebring om die distrikte van die voormalige TBVC-state sowel as die sogenaamde selfregerende gebiede te akkommodeer.

FIGURE 1: KWAZULU-NATAL MAP

KwaZulu-Natal (Figure 1). There are a number of non-governmental organisations that are operating in this province and they include the RED CROSS and the National Progressive Primary Health Care which are also involved in the provision of health care services. Two non-governmental organisations were chosen for this study and are the Health Systems Trust and the Valley Trust. These two NGOs operate around the province and were chosen because of their relevance and accessibility in terms of resources and scope for this study. The Premier of KwaZulu-Natal (by March 1999) was Mr. Lionel Mtshali from the Inkatha Freedom Party and the Provincial Health Minister was Dr. Zweli Mkhize of the African National Congress.

According to the Health Care (1996:9) the total population of KwaZulu-Natal is 8.5 million with 39% of the total population under 15 years of age. The average population density is 93 people per kilometre ranging across regions from 40 - 1064. Over three fifths of the population (63%) live in areas classified as rural. The health service formerly under the Administration of KwaZulu, the Natal Provincial Administration, the Department of National Health and Local Authorities, need to be brought with the private sector to create one coherent health service. Formerly, the Natal Provincial Administration was responsible for hospitals, curative care and limited preventative care in the area, whereas the KwaZulu Administration rendered all services in all areas under

its jurisdictions.

The KwaZulu-Natal MEC Dr Zweli Mkhize has a daunting task of integrating these fragmented Departments of health into one coherent, efficient and effective health department. The other challenges are to integrate other sectors like the NGO sector as well as traditional healers into the main stream which are arguable the most accessible and affordable sectors to the majority of rural communities in KwaZulu-Natal. Fragmentation of this department created inequity in the provision of health care services and resulted in one group of the society being under served and the other which was over served. As highlighted earlier in this study, one of its objectives was to find mechanisms of reallocation of resources from previously advantaged communities to those who were disempowered.

1.5 RESEARCH METHODOLOGY

As no similar research was previously conducted in KwaZulu-Natal, an exploratory research of both qualitative and quantitative nature was used to collect the relevant information for this study. This study was conducted and completed over a period of thirty (30) months. A study of available literature on non-governmental organisations

that were providing health services was undertaken. Two questionnaires (A1 and A2) were piloted before they were administered to the communities and NGOs, respectively. Visits to the Health Systems Trust, The Valley Trust, local hospitals, libraries and KwaZulu-Natal Health Department were made, to collect more relevant information. The fieldwork was conducted between July 1997 and August 1998 and interviews were scheduled and conducted with the relevant officials and community members. The media (T.V., newspapers and the radio) also provided with the latest developments and relevant information.

1.6 TERMINOLOGY

For the purpose of this study the terminology used will be defined within the Public Administration context and the terms will include: apartheid, district health system, non-governmental organisation, primary health care and reconstruction and development programme which are all important and relevant to this study.

1.6.1 APARTHEID

Fox and Meyer (1995:7) define apartheid as "... the value system which, from 1948 to

1990, was the basis of the official policy of the Union, and later Republic, of South Africa. The most important point of departure of this value system is that race, or acceptance by a racial group, is the basis on which a person's role within the state is defined. The clear ideological component of apartheid is reflected in its philosophical basis and its practical application. Various statutory measures were taken to separate whites and blacks by, ***inter alia***, establishing separate residential areas, transport facilities, educational institutions, public amenities, churches and political representation. During the 1960s the emphasis was placed on **"development"**, and the Nationalist Party's policy was renamed **"separate development"**. This resulted, ***inter alia***, in the creation of political institutions, economic structures and the selective development of human potential.

1.6.2 DISTRICT HEALTH SYSTEM

A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost a well defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private [or]

traditional. A district health system therefore consist of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services (ANC 1994:62).

1.6.3 NON-GOVERNMENTAL ORGANISATION (NGO)

Not belonging to or associated with government (Tullock 1993:1032).

Bonbright and Honey in (Kleinenberg 1994) define non-government organisation as "... civil society refers to all society outside the government sphere of life. It includes the non-government for profit sector which we call business, and the non-government, non-profit sector sometimes called the voluntary or NGO sector".

1.6.4 PRIMARY HEALTH CARE (PHC)

Primary health care is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should

be involved in it (The Valley Trust 1987-1988:78). The National Health Plan For South Africa (1994:20) also states that "... PHC will form an integral part of the country's National Health System, of which it will be the central focus, while the PHC approach will guide the overall social and economic development of the community".

1.6.5 RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)

According to the African National Congress (1994:1) RDP is an integrated, coherent socio-economic policy framework. It seeks to mobilise all our people and our country's resources toward the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future.

For the purpose of this study non-governmental organisations and voluntary organisations will be used interchangeably and will mean the NGO sector as defined above.

1.7 LIMITATIONS OF THE STUDY

Among the problems the researcher confronted, was the refusal from the 'would -be'

respondents to participate in the study. This was experienced mostly in the rural areas, especially from heads of households (usually males) who refused to participate in the study and sometimes did not allow any member of his family to participate. These people thought the study was political and were not interested in political issues, however the researcher explained that the objective of the study was mainly on health-related issues.

The study was limited to the KwaZulu-Natal province. Conducting the study in areas that were under the jurisdiction of traditional leaders (**Amakhosi**) was very unpleasant and frustrating due to restrictions imposed. This is because in rural areas traditional leaders still play an important role in organising and deciding on events and action within the community.

The other problem for this study was that of 'no-go areas' whereby areas were controlled by a particular dominant political group and there was animosity and even violence between the opposing groups and sometimes the views of opposing group/s were unacceptable to the other group and therefore suppressed.

Documents that were important for this study were not disseminated freely and

sometimes the respondents especially those from the non-governmental organisations were not available for the scheduled interviews and this increased the cost burden on the researcher. Lack of transport in some areas was also a problem.

1.8 LAYOUT AND OVERVIEW OF CHAPTERS

This study is divided into six chapters in which the reader is introduced to the study and conclusions and recommendations are presented in the final chapters.

CHAPTER 1

GENERAL INTRODUCTION AND BACKGROUND

Chapter 1 is the general introduction in which the researcher provides the background for this study. This chapter included the objectives of the study, hypotheses, study area, methodology, terminology, limitations of the study, layout and overview of chapters and finally the conclusion of the chapter. This chapter provides the reader of this dissertation with a brief overview of this study.

CHAPTER 2

NON-GOVERNMENTAL ORGANISATIONS:

A THEORETICAL PERSPECTIVE

Chapter 2 reviews literature associated with the NGO sector. The international perspective on NGOs is significant for this study as most local NGOs were financial viable through the support of foreign governments and donors. This chapter discusses the following topics which falls under the non-governmental organisations and are the:

- terminology
- history
- characteristics (both international and local)
- strengths, weaknesses, opportunities and threats
- relationship with government (past and present); and
- summary.

This chapter provides the theoretical background of non-governmental organisations which the study was based on and also provides with a global perspectives on how NGOs emerged and the role they played in their respective communities.

CHAPTER 3

SOUTH AFRICAN HEALTH POLICY

AND NON-GOVERNMENTAL ORGANISATIONS

Chapter 3 discusses the history of the South African health and how it was structured and the fragmentation in the provision of health care services which resulted in the majority of the population neglected by the government. Non-governmental organisations came in to fill the void created by the government. Like any other organisation Pavlicevic states that "... NGOs usually operate within the framework of a constitution, or founding document which outlines the structure of the organisation ...". The chapter discusses how these organisations operated under the oppressive health laws of the past government.

In the past, apartheid laws were oppressive and discriminatory to the majority of the population which marginalised them to an inefficient and ineffective curative health system. Preventative health measures were provided to a minority group and health care services did not reach all the sectors of the South African population. The political reforms that occurred in 1994 whereby the apartheid regime of the Nationalist Party was replaced by a democratic Government of National Unity which is ANC-led, saw a

transformation in all aspects of South Africa. Although there are health policies that have been implemented, the overall process is very slow. This chapter discusses the health plan for South Africa and includes:

- national health plan
- national health bill
- national health act
- provincial health legislation
- reconstruction and development programme and GEAR
- taxation of non-governmental organisations; and
- summary.

CHAPTER 4

ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH CARE: a Health Systems Trust and the Valley Trust case study

Chapter 4 presents the findings of questionnaire A1 in which two non-governmental organisations that are providing health care services in KwaZulu-Natal were selected for the study. Most of the fieldwork for this study was conducted in the Health Systems

Trust and Valley Trust. Research through interviews and observations was conducted in the respective communities of these two case studies. The chapter provides the reader of this text with the role of non-governmental organisations in the provision of health services in KwaZulu-Natal.

CHAPTER 5

RESEARCH FINDINGS: ANALYSIS AND INTERPRETATION OF DATA

Chapter 5 analyses and interprets the findings of questionnaire A1 and A2. The bar diagrams and tables are used to illustrate the findings. The findings in this chapter can be generalised to KwaZulu-Natal because the non-governmental organisations that were studied have been providing health care services (Valley Trust) and disseminating and providing health information and services (Health System Trust) to the population of KwaZulu-Natal.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

Chapter 6 is the final chapter of this study and draws conclusions on the role of non-

governmental organisations in the provision of health services in KwaZulu-Natal. It was the conclusion of this study that non-governmental organisations have contributed significantly to the promotion of better health in the province and as the country is faced with health problems like chronic disease such as HIV/AIDS, cancer, TB and others, the NGO sector has a future role to play for South African health. The study also provided with a number of recommendations which were based from this study.

The bibliography and appendices that were relevant to the study were also included.

1.9 SUMMARY

This chapter has provided the reader of this dissertation with the background and the overview of the non-governmental organisations that are providing health services in KwaZulu-Natal. The chapter included the objectives of the study, hypotheses, study area, research methodology, terminology, limitations of the study, layout and overview of chapters and the summary of the study. The following chapter will discuss the theoretical perspective of non-governmental organisations.

CHAPTER 2

NON-GOVERNMENTAL ORGANISATIONS:

A THEORETICAL PERSPECTIVE

2.1 INTRODUCTION

Organisations are groups of people who come together for a common purpose. There are profit making organisations or business in which people come together to make and sell products or to provide a service in order to make a profit. In a non-profit making organisation the main purpose is to serve people in some way, and not to make money (Pavlicevic 1996:1).

This chapter reviews literature on both international and local non-governmental organisations and organisations that are associated with the NGO sector in order for the reader of this text to theoretical understand the non-governmental organisations. This chapter discusses the following topics of non-governmental organisations:

- terminology
- history

- characteristics (both international and local)

- strengths, weaknesses, opportunities and threats

- relationship with government (past and present); and

- summary of the chapter.

2.2 TERMINOLOGY

It is important for this study to provide the reader of the text with definition of terms that are used in this chapter and they include; non-governmental organisations, voluntary organisations and community-based organisations.

2.2.1 NON-GOVERNMENTAL ORGANISATIONS (NGOs)

Pavlicevic (1992:2) states that there is usually a fairly large group of non-government, non-profit organisations which are funded by members, or donors. In South Africa these are usually called NGOs (Non-Governmental Organisations).

Non-governmental organisations (NGOs) embraces a variety of organisations. A working definition that perhaps proximate all the features ascribed to NGOs is offered

by Bernstein in Reddy (1996:254) "... NGOs are non-profit groups outside of government, organised by communities or individuals to respond to basic needs that are not being met by either the government or the market. Some produce goods; others deliver services; and some of the largest do a combination of both. The groups are either formed at the neighbourhood level, by and for the community, or at a regional level where they have intermediary functions".

These NGOs are non-profit and have the common objective of restoring dignity to the lives of its communities. Sometimes the term civil society is used as in the following definition: Civil society refers to all society outside the government sphere of life. It influences the non-government for profit sector which we call business, and the non-government, non-profit sector sometimes called the voluntary or NGO sector (Kleinenberg 1994:1).

de Beer & Swanepoel (1994:17) also define NGOs as organisations not in any way dependent on or responsible to either the public or private sectors. Usually NGOs come into existence to address specific problems e.g. health (Valley Trust)... they address a number of problems in the field of development.

2.2.2 VOLUNTARY ORGANISATIONS (VOs)

Voluntary-organisations (VOs) are also non-profit organisations. They are defined by Kjaerum (1993:13) as nonprofit and nongovernmental (***sic***) organisations, organised by groups of people in the sphere of civil society, working for a cause for the benefit of society, which very often contribute as well to the development of democracy.

Voluntary organisations usually employ voluntary workers who are not paid or sometimes who are not full-time employees and do not posses the highest expertise of the job. However, this has been changing over the years in such that the voluntary workers are now become highly skilled and can match their counterparts from the private as well as the public sector.

2.2.3 COMMUNITY-BASED ORGANISATIONS (CBOs)

Community- based organisations (CBOs) are non-profit organisation working within specific localities in which they provide services for the local communities. CBOs may include churches, schools and local institutions which are not government structures. These local structures are elected by the people to represent them and provide them with

the goods and services they need (Kleinenberg 1994:3).

The community-based organisation is also known as the popular sector and de Beer & Swanepoel (1994:17) argue that popular sector, ... consists of organisations founded in and run by individuals or groups within communities.

2.3 HISTORY OF NON-GOVERNMENTAL ORGANISATIONS

NGOs vary in size, activity, organisational form, goals and objectives. They range from informal to formal, small or large, rural to urban, conservative to liberal and they differ from place to place. However, they aim at improving the lives of individuals or groups which are being neglected by the government. NGOs range from politically aligned to women, social and those who are providing health care services like those discussed in Chapter four. According to Kjareum(1993:15) NGOs exist for different reasons which may include:

- tension between state and civil society
- ineffectiveness and inefficiency of the government
- competition with the government

2.3.1 OLD NON- GOVERNMENTAL ORGANISATIONS

Carrol (1992:19-20) revealed that the old NGOs were:

- Ranging from baking clubs to women lawyers associations.
- They perform welfare work and are also involved in income generating activities for women which are dominated by white liberal women.
- They support only those activities which could support (or at least not challenge) colonial power and its economic structures.
- The traditional NGOs are generally characterised by weak management and organisational structures.
- Although the NGOs had been implementing income generating projects for women on a large scale.
- These traditional NGOs usually have reinforced women's marginal position by focusing on women's traditional roles as mothers and home-makers only.
- The accountability of many NGOs is no longer to the constituency they represent but rather to the donor agencies who fund them.
- Some NGOs claim that they have evolved from welfare organisations to development. But with the same structures and staff in place, this is questionable.

- These old fashioned income generating projects had not befitted women at all and that it is time to re-address their approaches.

2.3.2 NEW NON-GOVERNMENTAL ORGANISATIONS

Carrol (1992:21) distinguishes between old and new NGOs as follows:

- This type is mainly urban based and tends to take a more activist stand.
- These organisations usually emerged from a group of (women) who came together on a professional basis and who had realised that neither government nor the old NGOs could be expected to work effectively towards women's emancipation.
- They have an advantage over the more traditional organisations as they start off on a more professional basis, often being in a position to learn from the mistakes of traditional NGOs.
- The organisational and management structure is generally more professional.

Carrol (1992:9) uses the terms grassroots support organisations (GSOs) and membership support organisations (MSOs) when referring to non-government organisations (NGOs). He argues that GSOs and MSOs are the two sets of the broad spectrum of NGO and he

also states that NGO term encapsulates hundreds types of organisations which many vary from political organisation to church and sports clubs. However, he maintains that MSOs and GSOs are only those NGOs with specific developmental purposes and also function at a certain level. He also makes a distinction between GSOs and MSOs on the basis of ownership and he states that in the former the members are not the beneficiaries whilst in the latter the stakeholders and the beneficiaries is the members.

(i) GRASSROOTS SUPPORT ORGANISATION (GSO)

A GSO is a developmental body that offers services and support to disadvantaged groups and individuals. It acts as in intermediary between these beneficiaries and often remote levels of government, donor and financial institutions. It may also perform a networking function by providing services to other organisations that support the poor (Carrol 1992:11).

The Valley Trust has been supporting remote areas and communities though projects that were aimed at eradication of poverty, illiteracy and ill-health. These projects have been comprehensive in approach and through the networking of different stakeholders the disadvantaged communities have been reached.

(ii) MEMBERSHIP SUPPORT ORGANISATION (MSO)

MSO also provide support to local groups. An example is local cooperative or trade union. A second-level group will be an association of these base groups. A third-level can also be formed resulting in a national federation. The second and third-level membership organisations are referred to as MSOs (Carrol 1992:1).

In South Africa the membership support organisation can be associated to trade unions like the Congress of South African Trade Union (COSATU) which has be operating in the country and helping communities in different aspects of their lives, particularly in work-related issues like retrenchments and unfair labour practice by employers.

(iii) PRIMARY GRASSROOTS ORGANISATION

These organisations are distinguished from GSOs and MSOs by scope, level, complexity and function. They are the smallest group of individuals or households that engage in developmental activities which are of common interest. GSOs and MSOs operate on a

level above the grassroots organisation providing them with the necessary support (Carrol 1992:11).

These primary grassroots organisations work like the community-based organisations where they organise small projects like bricklaying, adult education and educare. These projects have been successful, especially in remote rural areas whereby infrastructure such as roads, schools and hospitals is unavailable. These facilities have been welcomed by the beneficiaries and have been instrumental in the upliftment of the lives of these communities. The community utilises the available skills and resources to achieve a common goal and the services provided are affordable and every member of the community contributes to the success of that particular project.

FIGURE 2 : GSOs and MSOs within the spectrum of NGOs
GSOs and MSOs are within the boxes (Carrol 1992:10).

PURPOSE

Political action
Advocacy of special interests

Advocacy combined with service or assistance to the base

Charity
Relief
Development

Economic development
Social development
Social business combined with equity objectives

MAIN ACTIVITY

Fraternal, social, recreational
Education

Education combined with development services or direct assistance
Organisational assistance

Research
Research combined with development services
Lobbying

Lobbying combined with development services

Networking

Coordination, brokerage, representation

LEVEL

Local (single primary groups and communities)

Regional
Locality (Grouping of communities)
National

2.4 CHARACTERISTICS OF INTERNATIONAL NGOs

Non-governmental organisations or voluntary-organisations at an international level will differ from local NGOs. Kjaerum (1993:14) is of the view that voluntary organisations have common features which he lists them as follows:

Firstly, voluntary organisations do not belong to the apparatus of the state. They may seek to exert influence on the formation of public policy and they may be financially supported by the state, but they are legally and organisationally independent from the apparatus of the state (Kjaerum 1993:14).

Secondly, voluntary organisations are to be distinguished from commercial and profit-oriented organisations operating in the market place. Special features of voluntary nonprofit organisations are their idealistic mandate and commitment to a cause. Voluntary organisations may provide services for their members on a commercial basis (for example, by charging fees for services), but they do not act as companies or other business entities, striving for profit on the market (Kjaerum 1993:14).

Thirdly, voluntary organisations are conceived by groups of individuals pursuing common interests. Their organisational forms are nonformal in the sense that they are self-imposed (even though the organisational form is often highly hierarchical) and represent non elected groups of people. In this sense they often represent a "minority" in the society as opposed to the majority elected by the people to the national parliament (Kjaerum 1993:14).

Finally it should be stressed that the defining feature is the activity more than their common interest. The very activity of members of sympathisers of voluntary organisations acting in the grey zone between state and market is quite simply their prime resource. This is opposed to the state's legitimate monopoly of power and the capital accumulated in private companies (Kjaerum 1993:14).

Pavlicevic (1996:3) also identifies five characteristics of international non-governmental organisations as follows:

- They meet a non-commercial need by providing services and occasionally material products (like food or clothing) to their members, or to members of the greater community.

- They rely to a large extent on being able to raise money from members, donors or the general public.
- They are accountable to those who benefit from their service, and to the wider community which provides financial support.
- They measure success by how well they meet the need they were set up to deal with.
- They have some form of governing or controlling body which is finally responsible for seeing that the money raised is used for its intended purpose (Pavlicevic 1996:3).

2.5 CHARACTERISTICS OF SOUTH AFRICAN NGOs

Although South African NGOs share many characteristics of international NGOs, they have their unique features which are identified by Cross in Reddy (1996:262-264). The oppressive and discriminatory policies of the previous Nationalist Party regime marginalised the majority of South African in all spheres of lives. There was inequity in the provision of services. The emergence of NGOs in South Africa took its own direction which was sometimes is in contrast with the other parts of the world.

Cross in Reddy (1996:262) argues that many South African non-governmental organisations originated from an anti-apartheid constituency, and therefore viewed the state as an enemy or hostile entity. Therefore, there was great deal of opposition between NGOs and the state.

He continues the argument that many of them (NGOs) developed around charismatic individuals who emerged during the era of mass struggle, who assumed leadership positions, and who now find themselves engaged in development work. In the process an element of possessiveness about their NGOs has taken root. An innate prosperity towards rivalries and "turf wars" between NGOs had also developed. This has become more problematic and intensified as some NGOs constitute a vehicle for the ambitions of particular individuals.

Some NGOs could more appropriately be described as "tribunate" (`claiming to speak in the name of the people') organisations rather than as purely voluntary. They are structures that have a particular political intent with an implicit agenda to capture and manage the process of community mobilisation at an intermediate level. This is the aftermath of decades of political struggle. Such organisations tend to impede the goal of promoting social and economic advancement, as their dominant purpose is to control

the development process in order to benefit from the patronage, status and prestige derived from the delivery of basic social services. Arguably, in the South African NGO context, `populism, development and democracy' have often been viewed as `strange bedfellows' (Reddy 1996:263).

It is important to note that there are a number of different perspectives about NGOs and besides that they differ in activities and sizes. Nevertheless they also have some commonalty in which most of the NGO sector is associated with and that is working towards the upliftment of communities and societies especially those who are perceived as disadvantaged. However, these communities differ from place to place for example, European countries look at the disadvantaged communities as the minority groups whilst African and Asian countries define the disadvantaged groups as the majority who are disempowered. Basically the characteristics of NGOs that are common outweighs the differences of these NGOs. The characteristics of these NGOs are also determined by the role they play and this will be discussed in Chapter four of this study. The characteristics of NGOs providing identical services will also differ from country to country, for example, those NGOs from United States of America that are providing with health care services will differ from those NGOs functioning in Ethiopia because of the difference in needs, resources (human, natural and otherwise) and also because

of the development levels between the two countries. As mentioned earlier the objective will be the same and that is rendering of health care services to the disadvantaged groups.

2.6 ROLE OF NON-GOVERNMENTAL ORGANISATIONS

The role of NGOs is numerous and is ever escalating. Governments are loosing the battle against NGOs, the people are loosing trust of their governments. Even in democratic governments most of the disadvantaged communities are being catered for by the NGO sector especially those who are in remote areas like rural, informal settlements and unproductive areas. The roles of NGOs will also differ from organisation to organisation. Kjareum (1993:15-16) highlighted the following common functions:

- Articulating the demands of citizens;
- Encouraging diversity and growth of opinions;
- Being agents of political mobilisation;
- Being agents of political socialisation;
- Providing early warning mechanisms, on a national as well as international level;

- Being a buffer against the state and against the market.

2.6.1 ARTICULATING THE DEMANDS OF CITIZENS

According to Kjareum (1993:15) a key function of voluntary organisations is their role in the articulation of the demands of citizens and thereby transformed into political process. This process is often fueled by in-depth analysis and monitoring of government policy by NGOs. The so-called "watchdog" function.

2.6.2 ENCOURAGING DIVERSITY AND GROWTH

Voluntary organisations play an important role in encouraging diversity and the growth of different opinions. This is supported by Kjareum (1993:15) when he argues that freedom to join or form an organisation is one of the fundamental democratic rights on a par with the right to vote and the freedom of expression. It is often assumed in democratic theory that this right is utilised so as to facilitate the formation of organisations that compete against each other.

2.6.3 AGENTS OF POLITICAL MOBILISATION

One effect is the facilitation of integration of groups in civil society and into the country's political process. An obvious example is organisations supporting migrant workers and refugees, not to mention their own organisations. These organisations are crucial for migrants and refugees when they want to be heard as a minority and when policies are counter-productive to their integration into the society of the new country. Another effect is that government, in responding to the pressure from all these diverse and mutually competing organisations, can obtain a higher political quality (Kjareum 1993:15).

2.6.4 AGENTS OF POLITICAL SOCIALISATION

According to Kjareum (1993:15) voluntary organisations also function as agents of political socialisation. Through activities in voluntary organisations individuals are trained in the role of ***homo politics***. Organisations working under repressive regimes often reflect undemocratic tendencies in their own structure.

2.6.5 EARLY WARNING MECHANISM

Voluntary organisations also assume the role of being an early warning mechanism. The international network of voluntary organisations is an important factor in disseminating information about undemocratic tendencies or repression in a given state, information that is normally not accessible to government institutions like embassies. An international network also affords protection against repression from the state, since an international reaction can be expected if an organisation does not get the opportunity to work freely within the framework of the state (Kjareum 1993:15).

2.6.6 BUFFER AGAINST STATE AND THE MARKET ECONOMY

Voluntary organisations ***defacto*** perform a protective function, partly because public policies often are implemented through networks of voluntary organisations, and partly because the social acceptance or legitimacy of state policies to a certain extent depends on voluntary individuals. Voluntary organisations also function as a buffer against the market economy (Kjaerum 1993:15-16).

Non-governmental organisations all over the world have been playing a developmental

role. Without the NGO sector the disadvantaged communities will suffer. The governments with their limited resources are unable to fulfil all the needs of its people. The bureaucracy that is involved in government institutions makes the delivery to be ineffective and inefficient. The centralisation of power makes decision-making to be slow.

2.7 STRENGTHS OF NON-GOVERNMENTAL ORGANISATIONS

The strengths of NGOs represent the weaknesses of the public sector. This section will focus on the strengths and opportunities of the NGO sector especially in the health care delivery. According to Brown & Korten (1989:16) NGOs have the following capacity:

- fend for the poor and other groups not served by public or private sectors. This commitment is related to their dedication to helping the poor and other disadvantaged groups;
- ease the mobilisation of local resources and the establishment of private organisations to promote participatory development. NGOs are very versatile and can easily identify and adapt to local needs and circumstances;

- provide basic services at low cost. This is related to the NGOs capacity to galvanise local resources and voluntary labor; and
- find creative solutions to unique problems and to promote successful innovation in the public sector. This capacity is related to 'their small size, administrative flexibility, and relative freedom from political constraints.

The strengths of NGOs in the delivery of health care are identified in the Health Systems Trust (1994:6-8) as follows:

- Filling the gaps
- Involving communities
- Nurturing democracy and equality
- Holistic approach
- Committed leadership and workers
- Responsiveness and flexibility; and
- Optimal use of resources
- Building bridges
- Attraction of funding

2.7.1 FILLING THE GAPS

NGOs usually targeted people and areas which were relatively neglected by the public sector. The unfair provision of services under apartheid had meant that many disadvantaged groups did not even have their most basic needs addressed by the State. NGOs had played an important role in addressing these needs. CBOs had often also provided an affordable service where public services were unaffordable (Health Systems Trust 1994:6).

The apartheid government was providing health care service to a minority group which were whites and the majority of blacks were neglected. Those from the remote areas like rural, informal settlements and the former 'Bantustans' suffered the most.

2.7.2 COMMUNITY INVOLVEMENT

The close relationship that many of the NGOs had with the people they served is demonstrated by the fact that, in many communities, the health committees served as the ***defacto*** public representatives. Often, health was used as the development issue through which communities were organized. Communities often had considerable say in the

management of NGOs (Health Systems Trust 1994:7).

Community involvement is very important for the people to feel ownership of the projects and thereby respecting and being responsible for the property which they are in control of. Involving the community also has its advantage and that of developing the talents and skills the people have.

2.7.3 NURTURING DEMOCRACY AND EQUALITY

Within many organisation, a culture of democracy was engendered. Although clearly not unanimously recognized. NGOs had often played an important role in breaking down prejudices and assumptions, particularly with regard to race and gender. Democracy was important for the NGO sector whereby there is transparency within the organisation and accountability by all within the organization (Health Systems Trust 1994:7).

2.7.4 HOLISTIC APPROACH

As NGOs were confronted by the reality of the entire spectrum of people's needs, they

were often compelled to respond to all of these needs. Consequently, their approach tended to be more integrated and comprehensive than health facility-based intervention. Often, CBOs involved in health care delivery were also involved in other sectoral activities such as educare and employment generation (Health Systems Trust 1994:7).

The ANC (1994:22) supports the comprehensive approach and the view that most NGOs were not only concentrating on the health care delivery only but on other sectors that affected health.

2.7.5 COMMITTED LEADERSHIP AND WORKERS

People working in community-based organizations tended to be visionary and committed. The financial reward of working for NGOs was minimal. These voluntary workers were involved in health care delivery primarily to provide health care services to the disadvantaged and did not expected financial reward for the services because they knew that the people did not have the financial resources to compensate them (Health Systems Trust 1994:8).

2.7.6 RESPONSIVENESS AND FLEXIBILITY

The small size and close proximity to communities often meant that NGOs were able to adjust rapidly to people's changing needs (Health Systems Trust 1994:8).

Unlike their counterparts (government -which was remote and ineffective) and (private sector -which was expensive and unaffordable), NGOs were always with the people and they understood the people's needs and were able to respond immediately with no charge for their services.

2.7.7 OPTIMAL USE OF RESOURCES

NGOs were often able to achieve much with limited resources. Maximum use of people's skills was encouraged, even if people did not have formal qualifications for the work (Health Systems Trust 1994:8).

The active involvement of community members in the health sector is very important as sometimes one finds out that the local community understand the health problem and able to find cure for it. Sometimes these workers like traditional healers have been

serving the local communities for a long time and a culture of thrust had been developed between the users and providers.

Derman & Makanjee (1996:137) state that consistent training has been provided in primary health care for community members to become Village Health Workers (VHWs), and for traditional healers. There is a long established system of referrals between VHWs and traditional healers and ***vice versa***.

2.7.8 ATTRACTION OF FUNDING

At a time when the government was being isolated, CBOs provided an accountable vehicle through which international support for community development could occur. Significant donor funding were ***inter alia;*** European Union, Henry J. Kaiser Family Foundation and the Kellogg Foundation (Health Systems Trust 1994:8).

Successful NGOs focus on one rather than many tasks; prudently choose staff who sympathies and identify with the poor; develop an administrative structure that is modest, more user-friendly, and has more flexibility than the public or private sectors; adopt an `increment alist' and creative approach to development; notice, and respond

sensitively to the needs of clients who also participate in the design and execution of projects; establish linkages to influential forces in the political, public and private sectors; and sensitively merge social issues with technical expertise Cross cited in Reddy (1996:259).

2.8 WEAKNESSES OF NGOs

Non-governmental organisations' weaknesses and threats represent the strengths of public health sector. Brown & Korten (1989:16-17) identifies several reasons for criticism of some NGOs and are summarised as follows:

- they are not able to undertake complex projects. This is related to their limited budgets and small size, especially in terms of staff, pay scales and capacity to attract qualified professionals;
- they are unable to implement successful projects on a regional or national basis. This is because of their limited size and resources, restricted 'administrative systems, intensive focus on a few communities, and in attention to developing real efficiency and expertise in a well defined technology';
- they are unable to establish community organisations that can function

independently. This is linked to the small scale and short-term operations of NGOs, as well as their limited funding. Also, NGOs do not give sufficient attention to sustainability in project planning;

- they often work in isolation, focusing on the micro level, and ignoring the wider context in which they function, as well as the strategic linkages that could be forged with other major actors. Such deficiencies may arise from a combination of 'commitment to locality-specific interventions and a sense of moral superiority that leads to undervaluing the ability and intentions of other organisations'; and
- they have weak administrative, managerial and organisational skills. There are several interrelated reasons for these weaknesses: limited skills, scarce resources and the inflexibility associated with administrative bureaucracies.

The Health Systems Trust (1994:9-10) revealed the following weaknesses of NGOs:

- Dependency on leadership
- Lack of marketing .strategy
- Tardiness
- Tendency to retain unproductive staff

- Slow decision-making processes
- Tendency to empire-build
- NGO culture resistant to change
- Lack of financial accountability
- Erratic feedback to communities; and
- Lack of evaluation.

2.8.1 DEPENDENCY ON LEADERSHIP

NGOs were often managed by dynamic leaders, whose departure from organisations left a large leadership vacuum. Strong individual leadership often created dependency with inadequate managerial skills development in subordinates (Health Systems Trust 1994:9).

2.8.2 LACK OF MARKETING STRATEGY

It is important for any organisation to engage in a strategic planning and to plan in advance so that it could avoid crisis situations. Lack of this (strategic) planning would lead to a collapse of that organisation.

NGOs often lacked the drive to market themselves and their product. They were often resigned to a fate dictated by availability of funding, rather than forward thinking and promotion of their ideas (Health Systems Trust 1994:9).

2.8.3 TARDINESS

The same article states that NGOs had developed a poor reputation regarding punctuality. A lack of commitment to deadlines had undermined their productivity.

2.8.4 UNPRODUCTIVE STAFF

The close-knit working environment of NGOs meant that many found it difficult to retrench unproductive staff membesr ***(sic)***. NGOs ended up carrying a lot of 'dead wood' (Health Systems Trust 1994:9).

2.8.5 SLOW DECISION-MAKING PROCESS

The downside of the commitment to accountable decision-making was that decision-making was often a lengthy and protracted procedure (Health Systems Trust

1994:9). This has been associated with the bureaucratic procedures which are lengthy and unfamiliar to the ordinary citizens. For example, a decision to attend to a seriously ill patient could take over ten hours because of procedures the patient should follow before being attended by a health worker, particularly a doctor. Many cases in which patients have died through these lengthy procedures have been reported to the Department of Health.

2.8.6 TENDENCY TO EMPIRE-BUILD

Personal aspirations, coupled with rivalry for funding, often resulted organizations expanding and developing without regard or consideration for other organizations. Information was often hoarded and there was often a reluctance to share resources. This tendency to empire-build often resulted in fragmentation of services (Health Systems Trust 1994:10).

2.8.7 NGO CULTURE OF RESISTANCE TO CHANGE

Change especially transformation is usually met with resistance and likewise "... NGOs had developed a character and 'culture' of their own which was, at times, as rigid

and resistant to change as any public service bureaucracy (Health Systems Trust 1994:10).

2.8.8 LACK OF FINANCIAL ACCOUNTABILITY

In some organizations, financial management had been poor and had even resulted in embezzlement of funds. This problem was compounded by a reluctance to confront each other for fear of disrupting the organizational dynamics (Health Systems Trust 1994:10).

Donors are only interested to those organisations that have sound financial policies in which their money would be spend on those goods or services for which they were initially budgeted for. Without a responsible management, financial accountability would be impossible and therefore for organisations to receive more financial assistance non-government organisations should engage in vigorous financial management and be accountable.

2.8.9 ERRATIC FEEDBACK TO COMMUNITIES

Although NGOs often claimed to be the voice of communities, they sometimes became remote from the people they served by being too immersed in their own activities (Health Systems Trust 1994:10).

2.8.10 LACK OF EVALUATION

The same article argues that due to time constraints and inadequate skills, there was often little evaluation of either the operations of the organization or its impact. Non-governmental organisations as well as community -based organisations have been working under stressful conditions in which they were directly involved in improving the health of disadvantaged communities like rural and informal settlements. Although the NGOs and CBOs that were involved in providing health care were seen as ineffective by the government, the communities that they were serving saw them as efficient and effective because the government that was responsible was remote to these black communities and was only serving the white communities in urban areas. Therefore one would argue that these 'weaknesses' were actually a success on the part of the NGO sector hence they had a very minimal and limited resources as compared

to their counterpart - the government which was ineffective and inefficient (Health Systems Trust 1994:10).

2.9 RELATIONSHIP BETWEEN GOVERNMENT AND NGOs

The relationship between government and the NGO sector should not be looked at in isolation, hence there are other important influential factors which affect the relationship of government and NGOs. In the South African context these factors are ***inter alia;*** political, social, cultural and otherwise. This section discusses the relationship from:

- Past (pre-elections)
- Present (post-elections)

2.9.1 PAST RELATIONSHIP (BEFORE ELECTIONS)

The relationship of government and NGOs in South Africa was not healthy. The Nationalist Party government with its apartheid policies was seen as an authoritarian regime and thereby an element of antagonism and opposition prevailed. Under very

repressive authoritarian regimes, the nature of that relationship is " ... one largely of opposition and protest" (Carmichael 1993: 1 9). This was the relationship between the past apartheid government and the non-governmental sector. International NGOs were able to communicate directly with local NGOs in all spheres for example; social, political, educational or in health.

NGOs were seen as a threat by the apartheid government and this led to the contrast of interest in which NGOs were assisting in delivery of health care services whereas the apartheid regime was not interested in improving the lives of all its citizens but for the minority group which was white. Carmichael (1993: 1 8) states that NGOs were working under difficult environment which were ***inter alia;*** Many such groups have been closed down by the state, their leaders have been banned, jailed, tortured, even assassinated, and fundraising has been made difficult.

Although the NP government was oppressive, it did allow the NGO sector to function and the NGO sector was able to utilise that opportunity effectively. The apartheid policies encouraged the NGO sector to develop complex networks in which they could operate and deliver health care services to the disadvantaged groups.

During the years of apartheid, public participation and development dialogue were principally conducted through international support to a vibrant and vocal non-governmental organisational sector. This sector in turn supported community-based organisations. Many of these organisations built strong networks that supported family survival through a broad based, multi-sectoral approach which attempted to address all aspects of poverty. Non-government organisations in South Africa have a wealth of experience which should be exploited during the current phase of transition. Their holistic approach recognises that many of the causes of ill- health fall outside of the health sector. For example overcrowding, poor sanitation, lack of water, poor transport and telecommunications all impact on an individual's health status. In contrast government is often constrained in its delivery system and often cannot easily adopt a very community-based approach. The size and delivery scope of some community-based organisations is not adequately recognised in South Africa (South African Health Review 1996:136).

The tension between the past government and NGO sector is also articulated by Williams in Reddy (1996:260) and he argues that the reason for NGOs and government conflict is that they are sometimes forced to compete with each other economically and politically. Many NGOs have displayed an amazing capacity to collect large sums of

money independently of the government. This generates suspicion that some governments would like to tax these resources and/or control the NGOs. Some governments feel threatened by the capacity of NGOs to organise and mobilise the poor around important social issues neglected by the state. However, there are strong grounds to support collaboration between NGOs and governments. For example, 'getting experienced NGOs into national and local policy making, programme design and project formulation may contribute to development that is more sensitive and responsive to the needs of the poor'.

After the unbanning of political organisations the NGO sector increased in number as political exiles returned to the country and seeking alternative jobs, more professionals and academics were drawn into this field and one could say that most opponents of the apartheid regime worked in the NGO sector. As the government was interested in separate development, the NGO sector was for development. Although there was inequity in the provision of health care services the NGO sector with its limited resources was able to offer help to the most disadvantaged communities of South Africa. The tension between the government and NGOs was inevitable.

2.9.2 PRESENT RELATIONSHIP (AFTER ELECTIONS)

The post-election phase is the period after the April 1994 elections in South Africa. This was a change in government - transition from the apartheid regime to a democratic government. The legitimate Government of National Unity (GNU) had to replace the old political order which was an illegitimate apartheid National Party (NP) government. There was change of interest from the government. The ANC-led GNU was committed to a new order in which the lives of all its citizens will be improved particularly those of the disadvantaged majority which were blacks. The GNU would prefer to work together with the NGOs i.e. from antagonism to partnership. As the GNU represented the majority of South African and committed at building a healthy nation it was necessary for the government and the NGO sector to change. However, there are very important factors which need to be considered and partnership would be possible if the following factors articulated by Matlhasedi (1994:18-19) are considered:

- Coalitions
- Partnership
- Co-ordination
- Co-option
- Funding

2.9.2.1 COALITIONS

The aim with this theme is to promote collaboration between NGOs and CBOs, particularly those in the health sector, organised at district, regional, provincial and national levels (NPPHCN 1996:7).

National as well as provincial NGO coalitions is very important. The Western Cape, Eastern Province and KwaZulu-Natal had made a significant progress on NGO coalitions.

NGO coalitions indicate that the organising of an NGO coalition that will effectively and authoritatively represent the NGO sector and thereby be a viable partner for government in development does not take place within such a short space of time (Matlhasedi 1994:18).

This would be welcomed by the Government of National Unity hence coalition of NGOs would reduce the number of NGOs to a single sector which is not as fragmented as that of the past. This would also place these non-governmental organisations in a better position to access state funds or grants.

2.9.2.2 PARTNERSHIP

The GNU would prefer to work in partnership with the NGO sector. The GNU would have to recognise the NGOs and CBOs as partners.

Matlhasedi (1994:18) however, warns that this partnership must not result in a situation wherein government relegates its duties to NGOs, but where a dynamic partnership between government and NGOs are established. The willingness and readiness of both the government and the NGOs to assume responsibility when the other is less capable of performing a certain task or in service delivery must be nurtured within this partnership.

2.9.2.3 CO-ORDINATION

Matlhasedi (1994:18) strongly believes that the NGO/Government partnership should be formed around the co-ordination of works and programmes that are part of a common development agenda, where communities are consulted and part of the process. Organisations should be able to criticise the government's approach in areas of development where they do not agree while working collaboratively in other areas.

Rensburg ***et al*** (1997: 27) argue that the post-apartheid era has seen a wide range of health and development activities in the NGO field. Because of scarce resources, co-ordination among NGOs has become important for strengthening their achievements in development. In order to address the immediate funding crisis, a South African NGO Coalition was instrumental in establishing the Transitional National Development Trust. This Trust is an interim development funder and formal link between government and non-governmental organisations.

It is therefore important for NGOs, donor agencies and the Government to coordinate their activities so as to achieve the common goal of improving the health of its citizens.

2.9.2.4 CO-OPTION

The non-governmental personnel and leadership has been co-opted into government with attractive financial packages which they did not earn in the NGO sector. This has drained the skills, resources, leadership from NGO to the government sector.

Matlhalsedi (1994:19) agrees that although NGOs and CBOs must vigorously attempt to target partnerships with certain units of a new government, especially those

government departments involved in projects that would be of benefit to the communities in which they work, this should not result in the wholesale co-option of NGOs by government.

NGOs should not be forced to operate with the government. NGOs should be allowed to work as watch dogs and not be threaten if they do not co-operate. Many NGOs are prepared to work together with the ANC-led Government of National Unity (GNU) however, they are not prepared to be subordinate but have equally role in the provision of health care service. Even if NGOs are co-opted into government they should continue their role of serving the disadvantaged communities.

2.9.2.5 FUNDING

Matlhasedi (1994:19) maintains that NGOs and CBOs must remain independent of government. Maintaining and strengthening alternative centers of power and democracy outside the formal government structure (even though it is democratic and legitimate) remains an important imperative for NGOs and CBOs.

NGOs, government and the donor agencies should agree on the funding channels and

also adhere to those agreements. These may include ***inter alia;*** taxation, donors/funders, projects and amount of funding.

NGOs are now faced with the problem of funding. With the new democratic and legitimate government in power NGOs would have to compete with the GNU in that donor agencies would now channel their funds to the government.

The European Union (EU) continued to be the single biggest donor within the health sector. However, this funding has been jeopardised by events around the ***Sarafina 2*** AIDS play. The extent of further support by the EU to the health sector remains to be seen (South African Health Review 1996:xvii).

Funding is also directed to health research. The Finance Week (June 1994:14) in an article by Molobi revealed the following about NGOs. Most NGOs are in financial crisis and many have closed down like the Urban Foundation which was also functioning in poorest and remote areas of KwaZulu-Natal. About half of the estimated 54 000 NGOs operating in South Africa could be out of business by 1995. This was

correct as many NGOs decided to close down as they were unable to compete with the GNU and with other powerful NGOs like the Health Systems Trust, The Valley Trust and Kagiso Trust.

Most of the funding comes from the Corporate donors & local foundations which is estimated at R100-R200 million and is channeled mainly to Universities. The other sum is received from the Department of Health (R50 million). The Department of science & technology also contributes up to R50 million. The other contributors are the Department of Education, Foreign donors and Pharmaceutical companies. Both local NGOs and international NGOs also fund some health research (Edwards & Mametja 1996:121).

Competition for foreign funding is not only between the GNU and the NGOs\or CBOs but between the NGOs themselves. It is possible for foreign donors to directly fund the GNU instead of an individual NGO hence the present Government is democratic and legitimate. This is however questionable as the GNU is also not delivering and the RDP is seen as a failure in most communities especially those from KwaZulu-Natal particularly the rural and informal settlements.

2.10 SUMMARY

This chapter has discussed the theoretical perspective of both international and local non-governmental organisations. Organisations that are associated with the NGO sector have been identified. The characteristics of non-governmental organisations differ from country to country as this was the case with South African NGOs, however it was evident in the discussions that the common purpose of all the non-governmental organisations was the upliftment of the lives (health for the purpose of this study) of the disadvantaged communities. It is therefore important to note that the relationship between government and non-governmental sector was different during the apartheid whereby the government policies were based on apartheid. The Government of National Unity is committed to a better health for all which means a positive relationship with government.

CHAPTER 3

SOUTH AFRICAN HEALTH POLICY AND NON-GOVERNMENTAL ORGANISATIONS

3.1 INTRODUCTION

The Department of Health, as a national authority, has the responsibility to determine the country's health priorities and policies. The Department is also ultimately responsible for the delivery of services to South Africa's people (Government Gazette 17910 of 1997:188). However, according to Hindson & McCarthy (1994:147-148) few countries in the world show such racial disparity in health status indicators as South Africa. Health and welfare services are fragmented by racial and spatial divisions. Priorities favor individual care for the privileged rather than adequate care for all, and a strong urban bias exists. Voluminous literature has demonstrated that those who need health care in South Africa have least access to it ... studies show that people most at health risk are:

- the rural poor, especially those far from health and social services
- squatter communities, especially recent arrivals

- people with high migrancy rates; and

- people not reached by primary health care services.

This chapter focuses on the health policy in South Africa and includes:

- history of health care in South Africa from 1910 to 1990's

- national health plan

- national health act

- provincial health legislation

- reconstruction and development programme

- growth, employment and redistribution

- taxation of non-governmental organisations; and

- summary.

3.2 HISTORY OF HEALTH CARE

This section of the study will provide the reader with an overview of the South African health care from 1910 up to the 1990's.

3.2.1 UNIFICATION IN 1910

Naidoo in the South African Health Review (1997:53) explained that "... in the South Africa Act (1910), there was neither special mention of health services, nor did it repeal the previously fragmented colonial health legislation...". Although there was unification, fragmentation of authority for health was visible as Naidoo (1997:53) noted that responsibility for health care was transferred from the four colonies to the four provincial administrators. The four provincial administrations continued to provide public curative services independently, environmental and preventive health services were still provided by local authorities under the jurisdiction of the Department of Internal Affairs.

3.2.2 PUBLIC HEALTH ACT OF 1919

According to Naidoo there were serious health problems in South Africa in 1918 and argues that the disastrous influenza epidemic of 1918 which claimed 142 000 lives was directly responsible for a fundamental reorganisation of South Africa's health care. This epidemic revealed the shortcomings in the organisation and co-ordination of the health services at that time, but also stressed the fact that the State had to assume

responsibility for public health, especially where disease threatened society as a whole. A new dispensation with a definite health policy and clearer authority structures came about shortly after this epidemic ... the original purpose of the 1919 legislation, namely the co-ordinated supply of health care, was lost as provincial administrators continued to have autonomy, exacerbating the polarisation between preventive and curative services. A further critical shortcoming of the Act was that it made no reference to the place and role of the rapidly emerging private health sector (South African Health Review 1997:54).

In 1938 in accordance with Government policy, the Department of Health decided to establish a completely segregated health service for Africans which would be administered jointly by itself and the Department of Native Affairs (van Rensburg ***et al*** 1992:44).

3.2.3 GLUCKMAN REPORT OF 1944

The National Health Services (Gluckman) Commission's report was the culmination of the reformist thinking in health care. Its brief was to make recommendations regarding the provision of an organised national health service, and the necessary

administrative, legislation and financial measures required for this purpose (Naidoo 1997:54).

The Gluckman Commission recommended the following:

- establishment of a national health service for South Africa (a detailed programme to implement such a service was formulated).
- establishment of a single national health authority responsible for all personal health services and for co-ordinating all non-personal health services (this was never implemented).

3.2.4 HEALTH REFORM IN THE 1970's

For nearly sixty years, the 1919 Public Health Act determined the organisational framework of South African health care. It was repealed and replaced by the Health Act of 1977. In essence, the Act reinforced the administrative and functional fragmentation of health care, delegating responsibility for preventive services principally to local government, while retaining provincial control over hospitals. Consequently, local authorities provided a limited range of health services, varying in nature and extent (Naidoo 1997:54).

3.2.5 FRAGMENTATION IN THE 1980's

The shortcomings of the Health Act of 1977 rapidly became apparent as Naidoo (1997:54) noted that a number of plans aimed at streamlining the services were devised (Commission of Inquiry into Health Services 1980, the National Health Services Facilities Plan 1980, and the National Health Plan 1986). However, any efforts at creating a more logical service were stymied by the grand apartheid plan, with further fragmentation due to the homelands policy and the constitutional changes of 1983. The consequence of these policies, evolved over eighty years, was a conglomeration of health providers, each responsible for a limited range of services and with little interaction between them.

3.3 NATIONAL HEALTH PLAN

The plan is based on the belief that every individual has the right to achieve optimal health. Aspects of the plan were clarified in the Reconstruction and Development Programme (which is discussed in the later section of this chapter). According to Dennill (1995:77) the government is responsible for ensuring that health services are

available to all South Africans and the ANC is committed to using primary health care approach as the underlying philosophy to attain this restructuring of the health system.

3.3.1 PRIMARY HEALTH CARE

The World Health Organization has set a target of "Health for all by the year 2000. The means whereby this target is to be reached is Primary Health Care (PHC) which is defined in the Declaration of Alma At. For the developing countries community participation is seen as essential in making PHC available to every person and family. In addition, lay community health workers (CHWs) are seen to be an essential part of such community involvement. This realization led to the introduction of a CHP in several wards in KwaZulu from 1977, an informal basis, and mostly by non-government organizations (Steyn ***et al*** 1991:3).

In order to achieve the goals of the Primary Health care it is important for government to involve and to have confidence in people who are involved in the provision of health care services, for example, the non-government organisations. Health Minister Dr. Nkosazana Zuma said the basic building block for Primary Health Care was the nurse working at the clinic. Community Health Workers (CHWs) could supplement the nurse

but under **no** circumstances could they replace her. "... no health service can be built on CHWs" (Health Systems Trust March 1995:3). The Minister argues that they (CHWs) are selected by, and work in a community, they must be seen as part of the community. They will therefore have to be employed by the community or NGOs or voluntary organisations.

However, one could argue that CHWs are from the community and they understand the problems of the community far better than the nurses from the public sector and the community is free to discuss any kind of problems with the CHWs. Unlike the nurses the CHWs visit the patients in their homes without them (patients) paying for the services.

3.3.2 EQUITY

Dennill (1995:76) argues that health for all cannot be acquired through the supply of equitable health services but through the achievement of equitable social and economic development. The need for employment, education, adequate housing, water, sanitation and electricity are all vital if "health for all" is to be attained.

3.3.3 RIGHT TO HEALTH

This principle is based on the premise that each individual has the right to attain optimal health and the government must provide the environment in which this can be achieved. This is stated in the ANC (1994:14) as follows: every person has the right to achieve optimal health and it is the responsibility of the state to provide the conditions to achieve this. Health and health care, like other social services, and particularly where they serve women and children, must not be allowed to suffer as a result of foreign debt or structural adjustment programmes.

A policy on free health care for children under 6 and pregnant women has been implemented and has shown positive results for the previously disadvantaged communities. This policy was publicised as follows in the Government Gazette Notice 657 (1994:111):

> As from 1 June 1994, free health services must be provided to:
>
> (a) pregnant women for the period commencing from the time the pregnancy is diagnosed to 42 days after the pregnancy has terminated, or if a complication has developed as a result of pregnancy is diagnosed to 42 days after the pregnancy has terminated, or if a complication has developed as a result of the pregnancy,

until the patient has been cured or the conditions as a result of the complication has stabilised;

(b) children under the age of 6 years; non-citizens of South Africa who are in the groups mentioned in par (a) and (b), and who incidentally develop a health problem whilst in South Africa.

Free health services is aimed at disadvantaged communities who are generally in the areas which are predominantly controlled by the NGO sector. The services will be provided at state health care facilities ***viz***; hospitals, community health centers, clinics and state-aided hospitals.

3.4 NATIONAL HEALTH ACT

The Government of National Unity has to pass a National Health Act that would transform the South African health care system. At present (January 1999) the Health Act of 1977 is still legally enforceable and does not give the legal authority for the setting of a district health system which is the cornerstone of Ministry of Health in South Africa. The nine provinces continue to be governed by the previous laws of the

apartheid regime. On the 16 April 1997, the Minister of Health, Dr Nkosazana Zuma published the White Paper on the Transformation of the Health System in South Africa in the Government Gazette No.17910 of April 1997. This document presents the policy objectives and principles of the Ministry of Health in South Africa. The Department of Health ***inter alia*** intends to:

- transform the health care delivery system
- decentralise management of health services
- increase access to services by making primary health care available all South Africans
- rationalise health financing through budget reprioritisation; and
- develop a National Health Information System.

To realise these objectives and principles the Department of Health will have to incorporate all stakeholders ***viz***; government, private sector, NGO sector and the communities. Active participation and involvement of all sectors of South African society in health and health-related activities is essential.

The Government should engage non-governmental organisations in the provision of

health care services so that the most vulnerable section of South African community could benefit. Until new legislation is passed South Africa will remain subject to the Health Act of 1977.

3.4.1 NATIONAL HEALTH BILL

The most important of the proposed legislation for l997 was the National Health Bill. It is very important to understand the procedures that are to be followed when passing a Bill to an Act of Parliament. Wigton (1997:12) describes the process as follows:

Parliament is the legislative branch of the national government lists primary function is to pass governmental laws. Parliament is comprised of two Houses: the National Assembly and the Senate.

Either Houses can introduce a Bill: however, the majority of Bills are introduced in the National Assembly. Most Bills are introduced by Ministers. If a Minister wants to introduce a Bill he or she first requests the State Law Advisors to prepare the Bill in appropriate legislative language. The sponsoring Minister then submits the Bill and its intentions to the Speaker who puts it on the Order Paper, which is a list of business to

be discussed.

The Bill is made available to the public for review (via the Government Gazette), and concurrently, the Minister sponsoring the Bill presents it for a First Reading to the full Assembly. During the First Reading, the sponsoring Minister may give a short overview of the background to, reasons for, and objectives, of the provision of the Bill. One member of each party of the House then may make a three minute response to the Bill.

Next, the Speaker of the National Assembly refers the Bill to the appropriate Portfolio Committee, which conducts hearings or requests information about, and offers amendments to the Bill. The Committee submits a report back to the House which outlines consensus reached, any disputed aspects of Bill, and amendments.

The Bill is put on the Order Paper for a Second Reading. During the Second Reading the Committee presents the Bill with its amendments, the Bill is debated, and a vote is taken on whether or not to "carry" (approve) the Bill. If the Bill is rejected at this point, it cannot be reintroduced into parliament during the same year.

The Bill is then sent to the Senate for review, goes through a similar process, and is

returned to the National Assembly. If the Senate adds amendments to the Bill, these must be approved or rejected by the National Assembly. A Bill passed by one House and rejected by the other is referred to a Joint Committee consisting of members of both Houses. If approved by both Parliamentary Houses, the Bill is sent to the President for signature. The Bill then becomes an Act of Parliament.

The South African government, through its apartheid policies, developed a health care system which was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care (ANC 1994:7).

3.4.1.1 ADVANTAGES OF THE HEALTH BILL

The following positive aspects of the Health Bill have been cited by Toms in the Health Systems Trust (March 1997:9):

- It has a comprehensive framework for transformation of the health services,

particularly the development of a district health system.

- The Bill is a progressive move that will decentralise authority to the local level, thereby making real community involvement far more possible.
- The Bill will definitely improve health because of its progressive nature
- Its major thrust is in the direction of the district health system, and by allowing for intersectoral collaboration it broadens the view of health to cover all the socio-economic factors leading to ill- health.

Another positive aspect of the Bill is that non-governmental organisations that are involved in health care delivery were also invited to contribute on this Bill.

3.4.1.2 DISADVANTAGES OF THE HEALTH BILL

Ntsalumba argues in the Health Systems Trust (March 1997:10) that the major disadvantage of the Bill was the omission of the controversial area of dispensing doctors, however, there was a conscious decision to omit this area as it falls under the Medicines Control Act. This Act covers dispensing doctors, generic substitution, parallel importation and the review of the Medicines Control Council.

The Department of Health has decided to hold public meetings around the country in addition to having written submission as meetings are simpler, particularly for rural and illiterate communities. This will ensure consultation and all stakeholders outside of the government department *viz*; NGO sector and the private sector will be invited. While the New Constitution pressurises the government to begin to improve the health care and social services provided to all South Africans, the Department of Health has passed no national health legislation to give legal substance to these promises for people on the ground. The Department of Health has drafted numerous policy documents and begun implementation on a series of health issues, but none of the proposals has the force of law. These documents serve as guides for public servants within the Ministry of Health for implementation of reforms, but they do not hold force for people outside the Ministry (South African Health Review 1996:197).

3.5 PROVINCIAL HEALTH LEGISLATION

The mission of a provincial health department, as mandated by the Constitution of South Africa within the national policies, strategies and guidelines, is to promote and monitor the health of the people in the province (Government Gazette 17910 of 1997:26).

The provinces are faced with similar problems which the South African Health Review (1996:199) argue that no health related bills have been passed at the provincial level. Without clarity from the national level, provinces have been reluctant to amend and rewrite provincial health legislation. Thus, the health services of each nine provinces continue to be governed by the previous laws of the four pre-1994 provinces, the former independent states, and self-governing territories that existed within provincial boundaries. In some provinces many conflicting statutes exist, making the situation unworkable in the long-term. Even where there are no conflicts, provinces like the national government are operating under apartheid era health laws. With national enabling legislation due in 1997 at the earliest, it could be December 1997 or early 1998 (this did not happen) before provincial health legislation is passed to harmonise previous health laws. It could take even longer to draft and enact new provincial legislation that fleshes out the national framework.

Progress has been made in the Free State Province and The North West in which two pieces of provincial health legislation were passed, the Hospital Act of 1996 and the Health, Developmental Social Welfare and Hospital Governance Institutions Act of 1997, respectively.

3.5.1 KWAZULU-NATAL HEALTH LEGISLATION

The KwaZulu-Natal Srategic Team for Health has made significant progress in drafting a new Health Legislation for the province. The Minister of Health in KwaZulu-Natal, Dr Zweli Mkhize has divided policy issues not two categories, namely;

- matters that should be regulated by the province (KwaZulu-Natal); and
- matters that should be competencies of the National Department of Health.

The KwaZulu-Natal Health Department has prepared new legislation on non-controversial issues and senior provincial officials have expressed a commitment to enact enabling legislation on provincial health matters with or without clear direction from the national level. The KwaZulu-Natal province has been engulfed with controversies, this is because of the different of opinions and interest between the leaders of the province (Inkatha Freedom Party) and the National Government which the IFP refused to participate in.

The most relevant and important aspect (for this dissertation) of this legislation is Chapter three of the discussion document for KwaZulu-Natal legislation which is the

Community participation and contains several aspects of health which are discussed in the following section.

3.5.1.1 COMMUNITY PARTICIPATION

Chapter three of the discussion document for KwaZulu-Natal legislation deals with the following aspects of health:

- organisation of health services
- promotion of non-governmental bodies
- community health forums
- reporting procedures
- voluntary workers; and
- contracting out of services.

(i) ORGANISATION OF HEALTH SERVICES

Public sector health services must be so organised as to enable the community to participate, through appropriate structures at community and health district levels, in the formulation of health policy and the control of its application (KZN 1995:10).

(ii) PROMOTION OF NON-GOVERNMENTAL BODIES

The KwaZulu-Natal Health taskforce has taken a positive direction by recognising the important role of non-governmental organisations (NGOs), community-based organisations (CBOs), churches, schools and clubs in assisting the formal health sector in the delivery of health care services.

Health authorities and agencies in KwaZulu-Natal must promote and support the establishment of non-governmental bodies which have as their objective organised participation in programmes for the promotion and improvement of the public health, and in programmes for disease and accident prevention, disability prevention and the rehabilitation of the disabled (KZN Strategic Team for Health 1995:11).

Government intervention will only be successful if every component of civil society as mentioned above, is involved and given a significant role to play in the provision of health care services at the provincial level. KwaZulu-Natal is faced with the HIV/AIDS epidemic and the involvement of non-governmental organisations is of paramount importance as they act as the first line of health defense to the marginalised communities.

(iii) COMMUNITY HEALTH FORUMS

The discussion document for KwaZulu-Natal states that the political head of the Department may, from time to time by notice in the official gazette, establish one or more community health forums with any health district. The objective of a community health forum is to provide a forum for various community groups working in the field and interested members of the public to discuss health issues relevant to their health district and region and the political head of the Department may issue guidelines in respect of the membership, objectives and terms of reference of community health forums (KZN 1995:13).

(iv) REPORTING PROCEDURES

The political head of the Department may, by notice in the official gazette, establish procedures whereby the public may report to the relevant authorities for example:

- events, acts or omissions that represent a risk or that cause injury to the health of the population
- irregularities or shortcomings detected in health services delivery, and

suggestions for the improvement of health services; and

- the existence of persons requiring health services, when those persons are unable to request assistance themselves (KZN 1995:14).

It is therefore important for the Department to ensure that the above mentioned procedures are widely publicised in all areas of KwaZulu-Natal. This is also supported by the South African Health Review (1995:196) that a summary of the framework was made available for comment to a wide range of interested structures and organisations, as well as the general public via accessible centers such as public hospitals. Notice of the availability of the document was published in 23 local newspapers, as well as on radio services. Both the notice and the framework itself were made obtainable in both English and Zulu (South African Health Review 1995:196).

As the Department of Health reports to the public it would receive tremendous response and the comments would help to improve the Health Bill of the province.

(v) VOLUNTARY WORKERS

Health facilities may utilise the services of voluntary workers. These workers may

collaborate, without remuneration, in assisting persons suffering from chronic diseases, persons suffering from disabilities, and the elderly, in particular by providing company and recreation, by performing simple health care, domestic or social welfare tasks, and by participating actively in programmes of health education and their activities must be co-ordinated by the superintendent of the health facility concerned. However, the activities of voluntary workers must be restricted to what has been ethical principles that guide the activities of the health facility (KZN 1995:15).

Nigel (1992:1) perceived voluntary work as one of the greatest endeavors to which people commit themselves. It harbors an enormous variety of activity, and much of it is altruistic. It is thus, important for voluntary workers to be committed to their work and continue their main objective of improving the quality of life, of individuals or of communities and this is discussed in Chapter four.

(vi) CONTRACTING OUT OF SERVICES

The Department may establish commissions and technical committees, enter into agreements, and formulate joint programmes that are required for the greater effectiveness and efficiency of its duties and functions under this Act, with trade

unions, non-governmental organisations, private health services providers, statutory bodies, academic and research institutions and professional and civic organisations (KZN 1995:16).

The activities of the public, private and non-governmental organisations should be integrated in a manner that makes optimal use of all available health care resources and it should also promote equity. This is also highlighted in the Government Gazette no.17910 (1997:32) as follows: costs of health services and on the efficiency of resource utilisation is a crucial requirement for the cost effective and cost efficient health service delivery.

3.6 RECONSTRUCTION AND DEVELOPMENT PROGRAMME

The Reconstruction and Development Programme (RDP) was the development initiative of the post-apartheid government. The RDP was of the view that NGOs in South Africa have an important role to play particularly in health care, however, the RDP emphasised transparency and accountability for the NGOs to survive.

The Reconstruction and Development Programme (RDP) is an integrated, coherent,

socio-economic policy framework drawn up by the ANC-led alliance in association with other key mass organisations such as NGOs and other research organisations (ANC 1994:1).

Five broad programmes were identified to promote the objectives of combating poverty and were:

1. the meeting of basic needs
2. upgrading human resources
3.. strengthening the economy
4.. democratising the state and society
5. making the state and the public sector more efficient.

Health and development policies of the post-apartheid era have been cast in the RDP mold.

3.6.1 RDP AND NGOs

Apart from the strategic role of government in the RDP, mass participation in its elaboration and implementation is essential. NGOs, as part of civil society are, therefore, expected to contribute to the attainment of national priorities and programmes (Government Gazette 17910 of 1997:189).

However, the Government of National Unity through the RDP has occupied the space that NGOs occupied in previously disadvantaged communities by an illegitimate government. Although there is a new democratically elected Government in South Africa, there is still a need for NGOs to continue providing health services. Poorest provinces like KwaZulu-Natal which is drawn into a political battle between the ANC and IFP still need the NGOs for the upliftment of their standards of living.

The reality of the new political order is that the ANC-led government of national unity must "deliver" development to an expectant constituency (Business Day October 27, 1994).

3.6.2 FUNDING OF NGOs

The Government and its departments are not responsible for the funding of NGOs. Such funding is a matter between donors and the NGOs concerned. Where the Department of Health commissions as NGO(s) to execute some of its programmes, the Department will be responsible for mobilising the financial resources for such a programme (Government Gazette 17910 of 1997:189).

A high percentage of aid monies targeted in the past for anti - apartheid work is now being redirected to government reconstruction and development projects (Finance Week, June 23-29,1994).

The funding battle between government and NGOs has been going on since the election of a legitimate government. There has been drastic changes whereby donors channeled their monies directly to the Government of National Unity complicated by donor attentions shifting away from social concerns towards larger issues of economic growth and trade. In addition, the Reconstruction and Development Programme concentrates overwhelmingly on the delivery of 'hard' products such as water, housing and sanitation. However, it is also vital to fund information services, processes and products

to encourage public participation and allow fundamental needs to be expressed (South African Health Review, 1996:38).

Although there has been shift by donors to fund NGOs, the Henry J. Kaiser Family Foundation (USA) and the Kellogg Foundation remain significant funders of non-government organisations like the Health Systems Trust. It is important for NGOs and CBOs to remain independent of government so as to allow the former to act as a "watchdog".

3.6.3 CLOSURE OF THE RDP OFFICE

On the 28 March 1996 the South African State President Dr. Mandela announced the closure of the RDP office as a result of a cabinet reshuffling. Without the RDP office it was unclear what will happen to all the RDP structures and projects. During its tenure the RDP office expressed difficulties engaging line departments in intersectoral processes.

There was a large scale attempt to improve the physical access to primary level care through a clinic building and upgrading programme. By June 1996, R190 million of the

Reconstruction and Development Plan (RDP) funds had been used to build 60 new clinics, to upgrade 47 more and to equip a further 73. In addition, 142 mobile units have been purchased and general improvements made to a large number of clinics around the country (South African Health Review. 1996:xvi).

The failure of the RDP could be attributed to the following;

- lack of integrated planning
- inefficient delivery
- lack of capacity
- underspending on projects bureaucratic bottlenecks; and
- protracted and inefficient consultation processes (South African Health Review 1997:24).

3.7 GROWTH, EMPLOYMENT AND REDISTRIBUTION

The failure of the RDP saw the government presenting its new Growth, Employment and Redistribution Programme(GEAR) in mid-1996. GEAR was introduced as an integrated, macro-economic strategy for rebuilding and restructuring the economy.

Though GEAR reaffirms commitment to the RDP, the GEAR strategy conveys quite a different message which boils down to economic growth and employment creation.

GEAR is also criticised for not being in the interest of the poor, and that it will not solve the problem of crime because the "trickle down" effects of both foreign investment and free market policies could take a long time to materialise. The general argument then is that GEAR will impose additional hardships on the country's poor rather than alleviating the inequities inherited from apartheid (South African Health Review, 1997:25).

By November 1998 the government agreed that the GEAR policies did not achieve its goals in schedule and there was a need to re-assess the budget allocation of funds (SABC 3: Parliament). The government however, reaffirmed its position of redistribution and the creation of more jobs and health services to the most vulnerable, poor, rural and unemployed South Africans by the year 2000.

3.8 TAXATION OF NGOs

Tax avoidance is not the same as tax evasion. Tax avoidance is the legitimate arrangement of one's affairs in such a way as to pay the minimum amount of tax required by law. Tax evasion on the other hand, has the same motive but implies illegal and dishonest behavior for which the Act prescribes harsh penalties (Emslie ***et al***.1985:3).

This is reiterated by Deloitte & Touche (1996:9) that no one should pay more tax than the law requires of them. The best way of not paying more than your fair share of taxes is through tax planning. Tax planning is **not** tax evasion. Tax evasion is any manoeuvre of which the purpose is to hide income otherwise subject to tax (for example, failing to declare all your interest income). The tax planning involves reviewing your financial goals, and then arranging your activities to achieve these goals at the least tax cost by using tax rules that permit you to reduce or defer taxation, increase deductions, or avoid tax traps. In the apartheid era NGOs were operating under numerous ineffectual Acts, like the Fund-raising Act which was passed in the mid-70s and was seen as an attempt by government to control NGOs. This Act was seen as restrictive and bureaucratic by many NGOs. The past government viewed the NGO sector as a threat and thereby

imposed these restrictive laws to counteract the anti-apartheid organisations. With the new democratic government in place the laws governing NGOs have also changed.

According to Meyerowitz (1997-98:A18) donations tax is payable at a flat rate of 25% on donations made by a person ordinary resident in the Republic or by a domestic company. It is immaterial whether the property donated is situated in or out of South Africa.

It is very difficult for an NGO to qualify for tax exemption, however with the new South African constitution there are NGOs which are entitled for tax exemption.

Strydom (1997:Chapter 10 of the Income Tax) states that non-profit companies or bodies for the promotion of research, health services, social or recreational amenities, or group commercial or professional interest are exempted from tax.

3.8.1 CATEGORIES OF DONATIONS

The Government Gazette (No.17910, 16 April 1997:187-188) states that there are three

categories of donations to NGOs and they are *viz*; financial, technical expertise and other donations.

(a) FINANCIAL DONATIONS

(i) The acceptance of funds donated by external agencies must be in keeping with South Africa's fiscal policy and financial legislation.

(ii) Subject to the general guidelines, the donation of funds should be focused initially on bridging finance for the reconstruction and rationalisation of the health services.

(iii) Funding of recurrent expenditure for predetermined periods should focus initially on priority areas, as identified in the Government document titled "The Health of the Reconstruction and Development Programme" -and other government policies (Government Gazette 17910, 1997:187).

(b) DONATIONS OF TECHNICAL EXPERTISE

The Department will solicit and accept contributions of a technical nature from the donor community. This will only occur if there is a local shortage of such skills, or if

such contributions are geared to enhancing local skills.

Costs related to the provision of international expertise will be supported by the donor agency(ies), upon review and agreement with the Department (Government Gazette 17910, 1997:188).

(c) OTHER DONATIONS

Donations of equipment will be subject to the following principles:

- appropriateness of and need for the particular equipment in South Africa; and
- Adequate and readily available support structures, including:
- expertise, potential for training and availability of suitable health personnel;
- an adequate maintenance service, including the availability of service personnel and parts at a reasonable price; and
- the necessary infrastructure, such as electrical power supply, adequate roads and telecommunications.

Donations of equipment which would replace existing equipment generally should

take preference over the provision of new equipment, as the later would result in an increase of recurrent costs.

Donations involving capital projects should facilitate job creation, capacity building and community development, with particular emphasis on disadvantaged communities. In assessing such projects, one of the fundamental factors is their sustainability in the medium to long- term (Government Gazette 17910, 1997:188).

3.8.2 GUIDELINES FOR DONORS

The conditions attached to donations are as follows:

(i) acceptable to both the donor agency and Government;

(ii) in accordance with broad Government policies;

(iii) assist and support the sound planning and management of health services:

(iv) aimed at making an impact on the health services;

(v) promote Intersectoral collaboration and co-ordination; and

(vi) develop South Africa's capacity (at the national, provincial and/or local levels) (Government Gazette 17910, 1997:184).

3.8.3 PRINCIPLES FOR DONORS

According to the Government Gazette (16 April 1997:185-186) there are principles that must be advanced by all donor projects or programmes and these are ***inter alia***:

(i) SUSTAINABILITY

Donations which have recurrent cost implications for Government must evaluated, to ensure that the required financial resources are available to sustain such programmes or projects (Government Gazette 17910, 1997:185).

(ii) EQUITY

Donations must address - the shift to primary health care:

- inequalities between provinces, as well as unequal development within provinces;
- under-served areas, especially rural areas; and
- the needs of specific groups in society, such as women and children (Government Gazette 17910, 1997:186).

(iii) ACCESSIBILITY

Donations should be directed at making health services accessible to all South Africans, irrespective of race, gender, income status or geographic location (Government Gazette 17910, 1997:186).

(iv) EFFICIENCY

Donations should promote the efficiency of health services through different mechanisms, e.g. training programmes for health workers, establishment of sound information systems, technical support initiatives and strengthening community involvement and participation in health services delivery (Government Gazette 17910, 1997:186).

(v) ACCEPTABILITY

Donations should not only be acceptable to Government structures, but also to the community for whom such donations are intended (Gov. Gazette 17910, 1997:186).

3.9 SUMMARY

The aim of the South African health policy should be the rendering of quality health that is accessible and affordable to all South African and the improvement of the health of the community. The transition from apartheid to democracy will have no impact if legislation has not changed. Political transformation should be followed by a change in all other sectors namely; social, economic, educational, health and in other sectors. South African health needs a comprehensive health policy in which all health stakeholders should be involved in matters pertaining to health issues. The new legislation should ensure cooperation between government and non-governmental organisations and should address the fundamental health issues that South Africa is faced with. Although the Government of National Unity introduced the Reconstruction and Development Programme to address the imbalances of the past, the non-governmental sector should also play its role and not hope that government would deliver all goods and services, particularly on health . This chapter has discussed the available health legislation in South Africa with an emphasis on its impacts on the non-governmental sector.

CHAPTER 4

ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH CARE: a Health Systems Trust and the Valley Trust case study

4.1 INTRODUCTION

Non-governmental organisations have played an important role in the provision of health care services in the KwaZulu-Natal. Health care services that were provided by the former Health Department were inadequate and unaffordable to the majority of South Africans. Historically disadvantaged communities in particularly the blacks, rural, poor, women and children were the most vulnerable to ill-health. Many non-governmental organisations emerged in the past as anti-apartheid movements and most of them were committed to the upliftment of the lives of the most vulnerable communities. This chapter will discuss two of these non-governmental organisations which have been chosen for this study and they are: Health Systems Trust and the Valley Trust. Most of the information was gathered through the two questionnaires (Annexure A1 and A2), reports, interviews and observations.

It is important to note that these two successful organisations also provide other health stakeholders around South Africa with health-related information.

4.2 THE HEALTH SYSTEMS TRUST (HST)

The Health Systems Trust (HST) is an independent non-governmental organisation established in 1992. The HST was officially launched on the 1st of April 1993. It is funded by the Henry J. Kaiser Family Foundation, Commission of the European Union, Rockefeller Foundation, the Kagiso Trust and the National Department of Health, whose funds are channeled through the Medical Research Council (MRC). The HST was initially located on the 5th floor of corner of Smith and Field Street, however due to business demands it has been relocated to Maritime House on the 4th Floor in KwaZulu-Natal, Durban.

The HST has a very explicit agenda with regard to research, namely; to understand and support health systems research which will help clarify health policy options and lead to improvements in health care delivery. The HST was established to support the restructuring of health care in South Africa, primarily through health systems research.

The HST invites funding proposals for projects which will further its mission (Harrison 1998: interview).

4.2.1 HST MISSION STATEMENT

The Health Systems Trust is committed to a health care system which meets the needs of all South Africans. It seeks to help realise this vision through independent support for research and skills development aimed at improving policy and planning at all levels, as well as other strategic initiatives which move us toward this goal (HST Annual Report 1996:1). (Refer also to Annexure B 2).

4.2.2 HST - ORGANISATIONAL STRUCTURE

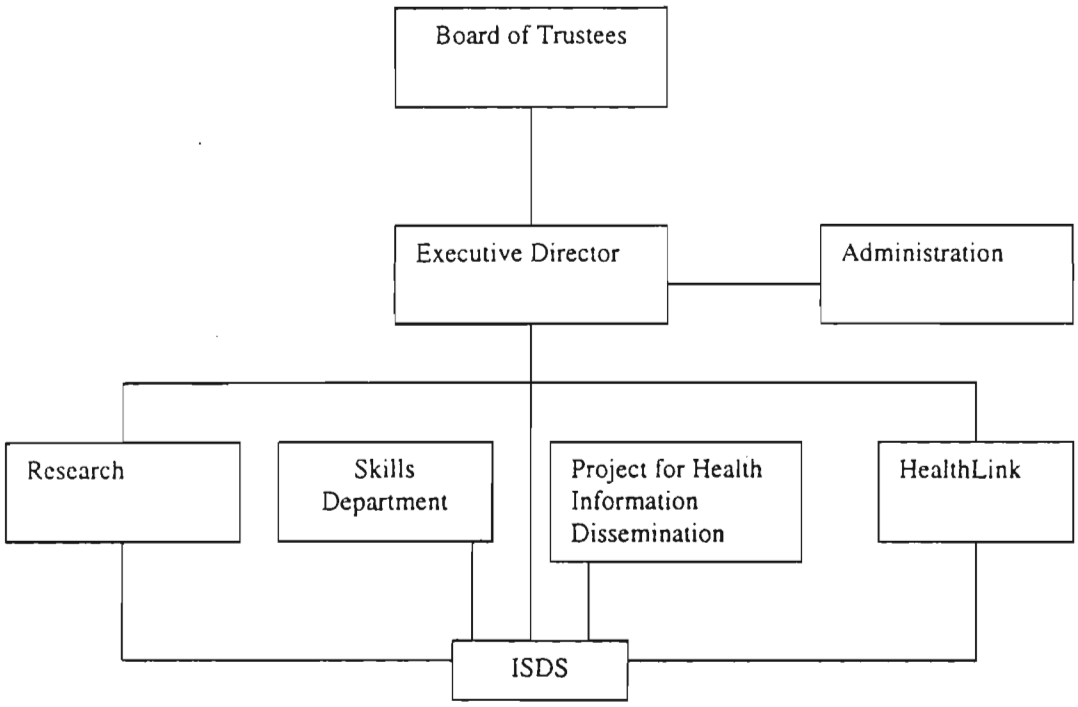
The HST is governed by a Board of Trustees which is responsible for policy setting, and the overall management and disbursement of funds. The secretariat under the leadership of an executive director is responsible for the implementation of the programmes of the Trust. (Figure 3) is an illustration of the HST's organisational structure.

The Board of Trustees consists of eleven members. The Board is committed at maintaining and developing the Health Systems Trust as a successful independent non-governmental organisation supporting health systems reform in South Africa. Reddy (1996:5) in the HST Annual Report maintains that this would be achieved by focusing on the following:

- bringing our programmes closer to implementation, particularly at the lower levels of the health system as the current transition phase plays itself out;

FIGURE 3: HST - ORGANISATIONAL STRUCTURE

(Adopted from the HST Annual Report 1996:97)



- providing independent and critical review and assessment of health policy developments;

- in partnership with other NGOs, strengthening smaller and more localised NGOs to ensure effective community participation in health care;
- nurturing individual and institutional capacity development already started within health services, historically black institutions and other non-governmental organisations.

The HST is under the leadership of David Mametja who has taken over from David Harrison who stepped down as Executive Director. The Administrative staff is dedicated to the success of the HST.

The Health Systems Trust has five programmes which are:

- Research
- Skills Development
- Project for Health Information Dissemination
- HealthLink; and
- Initiative for sub-district support

4.2.2.1 RESEARCH

HST has two mechanisms for funding research. Namely in response to submitted proposals, and commissioning research around key issues. The main criteria for selection of any research project are: its relevance and potential impact on health systems reform; envisaged skills transfer and development; and involvement and endorsement by the relevant health authorities (HST information brochure: undated).

HST has funded over 120 research projects, large and small dealing with both national and local issues. A special fund, the Reproductive health Research Fund was established to focus on research related to adolescent sexuality, sexually transmitted diseases, family planning and termination of pregnancy. An estimated R6 million budget over two years with equal contributions from the national Department of Health, the Department of International Development and the Kaiser Family Foundation has been allocated for this fund (Radebe, 1998 : interview).

Presently, priority areas for research support are:

- Human resource development

- District systems development and decentralisation
- Informatics support to health care
- Drug policy
- Health financing and economics
- Nutrition
- User fee policies.

HST funds and promotes high quality research that addresses priority issues and policy relevant health systems research. The trust is proactive in developing research agendas and at helping to produce targeted research outputs. Institutions like UNITRA (which has not been active in health research) is encouraged to get involved and relatively stronger institutions like University of Natal are encourage to work with the relatively weaker ones like the University of Zululand on research into school health services. Skilled researchers are also encouraged to take their skills outside the metropolitan areas to rural areas of the previously disadvantaged communities of KwaZulu-Natal like Vryheid, Ndwedwe, KwaNyuswa and Maqadini (Radebe 1998: interview).

4.2.2.2 SKILLS DEVELOPMENT

The Skills Development Programme aims to equip a core of South Africans, particularly those previously disadvantaged, with skills in health systems research, planning and management, programme monitoring and evaluation, documentation and presentation. These skills are developed through participation in problems-based training and development programmes, research internship projects and exchange placements with other developing countries. Short courses and workshops are considered as part of these projects and programmes. Special emphasis is placed on developing skills of teams rather than individuals. The programme is targeted at prospective trainees operating the public health sector within districts, in historically black institutions, NGOs and CBOs, particularly in rural areas (HST information brochure: undated).

According to Radebe (1998: interview) a Skills Development Programme was essential to:

(i) strengthen health systems research as a discipline

(ii) build institutional capacity, focusing particularly on historically black

universities, the health services and non-government organisations

(iii) build individual capacity, with particular emphasis on black South Africans

(iv) redirect funding towards geographical areas previously neglected.

4.2.2.3 PROJECT FOR HEALTH INFORMATION DISSEMINATION

The Project for Health Information Dissemination (PHID) aims to provide a reliable source of information about health and health policy developments in South Africa and to serve as a channel through which health systems research results and recommendations can be shared.

The main outputs of this project are:

- South African Health Review;
- Monthly newsletter of policy developments and HST activities (HST Update);
- Directory of Health Systems Research in South Africa and a resource centre that collects, collates and disseminates reports, journal articles, monographs and grey literature (Radebe 1998: interview).

(i) SOUTH AFRICAN HEALTH REVIEW

It is co-published by the Health Systems Trust and the Henry J. Kaiser Family Foundation. It remains the most comprehensive review of health and health care in South Africa. The South African Health Review is a culmination of hard work by many individuals, a task that has significantly grown in complexity over the years. The Review covers ***inter alia***; Health Status, Health and Development, Legislation, Financing and Expenditure, Research, Health and Media, HIV/AIDS and TB (Radebe 1998: interview).

(ii) HST UPDATE

The HST is the main vehicle for reporting research results and recommendations of HST funded and commissioned research. It is increasingly being used as a channel for communication with policy makers, particularly in spelling out the efforts at health sector restructuring. It provides up to date information on debates that have dominated the health sector during each month. Update is now distributed to approximately 3 600 readers, including health workers in clinics and hospitals nationally. The full text of Update is disseminated electronically on the Internet through Healthlink. There was a

tremendous increase in the number of people interested in receiving the newsletter. Commercial advertisers were encouraged to advertise for a minimal fee (HST Annual Report 1996:25).

HST Update is a monthly gazette which documents policy developments and serves as a platform for policy debate.

(iii) HST RESOURCE CENTRE

The resource centre maintains a rich collection of up to date research reports that emanate from HST funded and commissioned research. There is also a wide range of publications and periodicals, annual and newspaper clippings (HST Annual Report 1996:26).

The centre is managed by Cynthia Mfayela and it collects and disseminates information to students, researchers, hospitals and to NGOs.

4.2.2.4 HEALTHLINK

HealthLink is funded by the Henry J. Kaiser Foundation with commitment of resources (human, technical, physical) by the Department of Health. Its mission is:

"to address the communication and information needs of managers, providers and consumers of health care using appropriate technology" (HST Annual Report, 1996:28).

There are three areas of HealthLink activities that feed into the support for the Initiative for Subdistrict Support (ISDS) and are:

- Information resources
- Technical infrastructure; and
- User support.

Information resources is under the leadership of Candy Day (July 1998). In 1997 the World Web server became operational and started to provide services for clients. HealthLink is a project of the Health Systems Trust established to help meet the

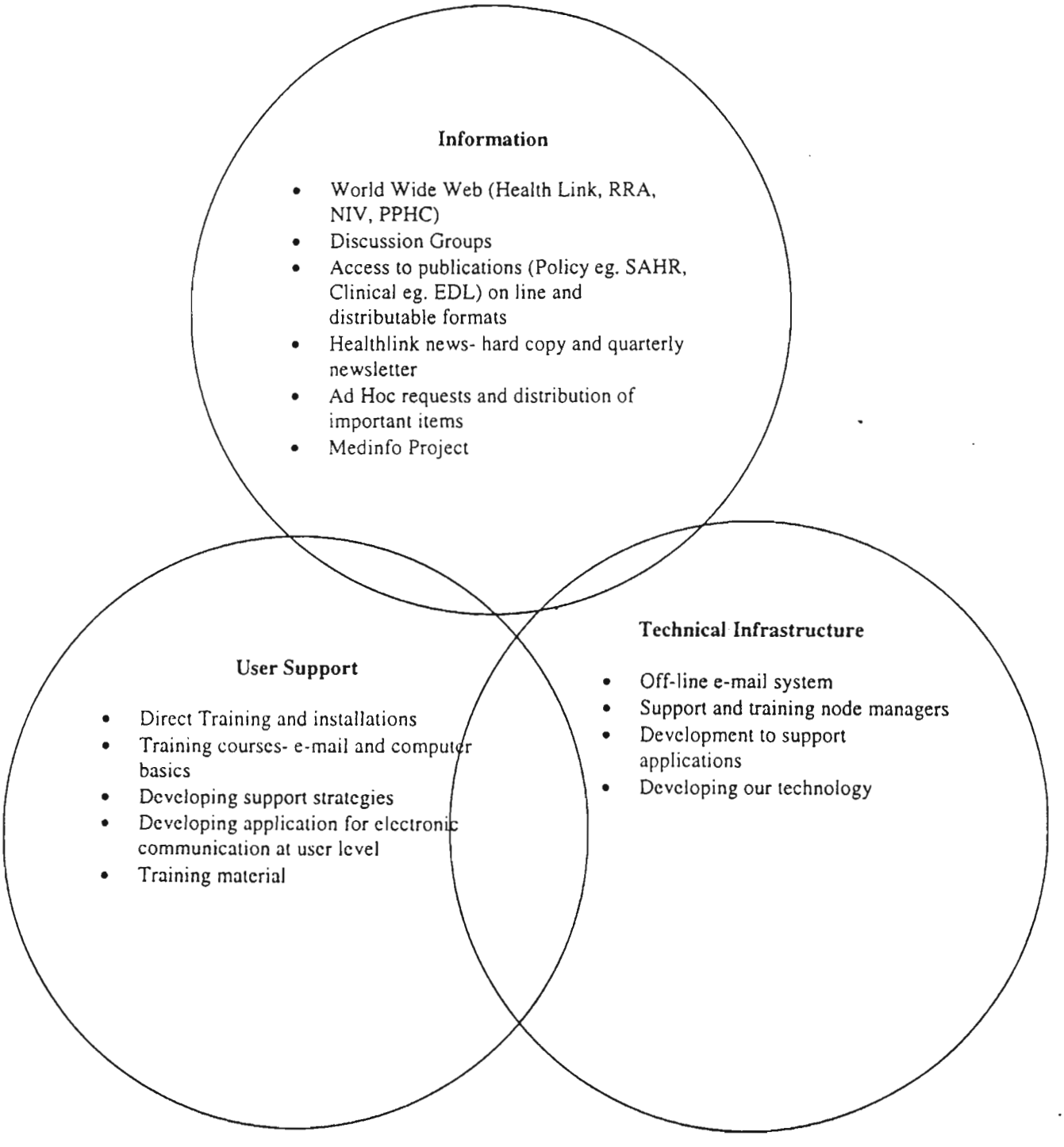
communication and information needs of health workers in South Africa (Day 1998: interview).

The Technical infrastructure is now established and supports users in every province, many of whom would have no other access to this medium without HealthLink.

The User support is a vital component of HealthLink functioning and this initiative is focusing on health facilities where HealthLink would particularly like to make a contribution (Radebe 1998: interview).

FIGURE 4: HEALTHLINK OF THE HST

(Adopted from the HST Annual Report 1996:29)



4.2.2.5 INITIATIVE FOR SUB - DISTRICT SUPPORT

The District Health Systems (DHS) is recognised as the fundamental building block of South Africa's unified health system. The Initiative for Sub-District Support (ISDS) aims to demonstrate improved standards of primary health care by providing sustained, systematic and comprehensive support to selected sub-districts. In other words, ISDS hopes to improve service delivery by identifying those factors which affect health care at local level, and developing practical ways of changing these factors for the better (Radebe 1998: interview).

The purpose of this initiative is to demonstrate the impact of a process which:

- deliberately and systematically addresses factors affecting the quality of care at local level;
- supports and strengthens the capacity of both public sector and non-government health providers;
- strengthens the capacity of communities to participate in governing and managing health services; and
- harnesses technical resources, both local and distant, to support health systems

reform at local level (Radebe 1998: interview).

4.2.3 HST - SWOT ANALYSIS

Strengths, weaknesses, opportunities and threats that were faced by the HST in the previous years are highlighted in this section, however detailed analysis is in chapter five of this study.

4.2.3.1 STRENGTHS AND OPPORTUNITIES

The strengths and opportunities of an organisation are very critical to its overall success, however if they are not realised and taken the organisation would not develop and prosper. Radebe (1998: interview) highlighted a number of factors that have been critical to the development and success of HST and are summarised as follows:

(i) FINANCING

Although there has been funding problem for the NGO sector for the past four years,

the HST has been receiving funds from both the national Department of Health and the Henry J. Kaiser Foundation.

This partnership has an active interest in the activities of HST by the Department of Health, and has an active interest in the funding from a number of other agencies which are ***inter alia***; Rockefeller Foundation, Commission of the European Union and Independent Development Trust. HST has solid support from key funders (Radebe 1998: interview).

(ii) FLEXIBILITY

Bureaucratic organisations like those in government are heavily criticised for their "top-down" approach in decision making and the process is a lengthy one. As an NGO the HST is flexible and respond quickly to needs and requests of users and providers of health care services both national and local. Radebe (1998:interview) emphasised that the organisation is "... not bogged down by bureaucratic structures...".

(iii) HEALTHLINK

According to Radebe (1998: interview) it (HealthLink) "... is a project of the Health Systems Trust established to help meet the communication and information needs of health workers in South Africa...". The evolution of HealthLink has provided a means of linking these information sources to rural and otherwise isolated health workers in the public and non-government sectors. The HST as an independent organisation is a resource for other NGOs. HealthLink also helps in introducing health workers to information technology.

(iv) RESEARCH

According to Edwards - Miller (1997:115) "... Health Systems Research focuses on issues related to the delivery of health care and it therefore cuts across the various health problems...". Radebe (1998: interview) states that HST has two mechanisms for funding research. Namely in response to submitted proposals, and commissioning research around key issues. The main criteria for selection of any research project are: its relevance and potential impact on health systems reform; envisaged skills transfer and development; and involvement and endorsement by the relevant health authorities.

The HST funds and promotes high quality, policy relevant health systems research. HST assists researchers in; proposal development, through protect support and implementation, through support for skills development, to dissemination and application of results and recommendations (Radebe 1998: interview).

(v) CAPACITY BUILDING

The HST has an explicit commitment to capacity building and skills development. This includes an internship programme, and support for short courses. The HST also provides methodological support for individual researchers. Around 10 interns per year are fully funded and are placed at institutions where they will be adequately supervised. Other research organisations, such as the Centre for Health Policy, also fund and train interns (South African Health Review 1997:115).

Funding for capacity-building which has enriched HST's research programme and enabled support for health services to move beyond planning toward support for implantation (Radebe 1998: interview).

4.2.3.2 WEAKNESSES AND THREATS

The weaknesses and threats an organisation has to faced has to be understood as challenges for that particular organisation and should be overcome in order to meet the goals and objectives of the organisation. Radebe (1998: interview) explained that there were challenges that were facing the HST and she cited the following:

(i) FUNDING

Although this has been cited earlier as one of the strengths of the HST Radebe (1998: interview) highlighted the fact that foreign government aid has become bilateral after the political transition in 1994 whereby government directly funds another government and that was the main difficulty. The support of NGOs by donors and funders have been detoriating and most NGOs have been forced to 'shut down'. The HST is no exception to this and is also faced with funding problem. The trust is faced with numerous task but has limited resources in term of finance, human and equipment to provide services to the under served communities. The task of disseminating information to users and providers of health is expensive and the trust needs more resources in attaining the set goals and objective of the organisation. The trust has

survive these difficult times through forged partnerships with the Department of Health and with important stakeholders like the J. Kaiser Family Foundation. The HST "...works alongside Government - not in competition but complementary..."(Radebe 1998: interview).

(ii) DISTRICT HEALTH SYSTEMS

The implementation of the district health system is a threat to the HST. KwaZulu-Natal has not made any progress towards the creation of districts. The implementation of district health system is impossible without district boundaries. Although there is a strong political will and commitment to the creation of a decentralised health system based on districts there has not been the same commitment in the KwaZulu-Natal province (Radebe 1998: interview).

(iii) RESEARCH

The HST is faced with conducting research that will be of national interest. The shift by donors and funders from directly funding the HST to funding the government limits the resources (human and financial) available for conducting research. Research is

expensive and without proper research conducted, the limited resources that are available would not be appropriately utilised (Radebe 1998: interview).

It is clear that South Africa is still in a phase of transition, and support for planning and policy development needs to translate into support for implementation if that transition is to be complete. There is a need for continuing independent review and assessment of health policy development. Many non-government organisations have failed to survive the transition. HST has demonstrated that non-government organisations can continue to play a critical and constructive role. Together with other NGOs within the health sector, HST has a particular responsibility to strengthen smaller and more localised NGOs to ensure effective community participation in health care. HST recognises that individual and institutional capacity building is a medium to long - term strategy, and the seeds which have been sown within health services, historically black institutions and non-government organisations need to be nurtured (South African Health Review 1996:123).

In the past research has focused almost exclusively on basic and bioclinical research. Research into the delivery of health care has been neglected and funding for this type of research remains negligible. A well-structured health systems research programme

is essential to future health policy and to adequate monitoring of the national investment in health services (South African Health Review 1997:115).

In the view of the Health Minister, Dr Nkosazana Zuma (HST Update February 1997:21) HST has an important role to play for "at least another ten to fifteen years" and the Health Systems Trust must continue to demonstrate that "things can be done differently". The flexibility and responsiveness of a non-governmental organisation like the HST should be fully used by the Department to make thinsg (***sic***) happen as quickly as possible.

4.3 THE VALLEY TRUST

The Valley Trust is a non-government organisation (NGO) founded in 1953 as an initiative of visionary medical doctor Halley Stott and was probably the first primary health care programme in South Africa then. The Valley Trust is located on the edge of the Valley of a Thousand Hills at Bothas Hill, KwaZulu-Natal. The Trust is within easy reach of both Durban and Pietermaritzburg. It is set in attractive grounds and offers accommodation for up to 44 trainees, and a variety of well-equipped venues for meetings, workshops and seminars.

The Valley Trust is an independent socio-medical protect that takes a holistic approach to development. It encourages self-help projects driven by basic needs. The Valley Trust like many similar non-governmental organisations throughout the world is not aligned to any political, religious or sectarian interest group. The trust has been providing health care services to the Nyuswa tribe. Although it works primarily in the Valley of a Thousand Hills outside Durban, an area of 250 square kilometers and some 100 000 people, it applies principles that can be used in other underdeveloped areas and share its experience by encouraging and publishing research and by a visitor and trainee programme. Health care is at the core of the trust, as it sponsors the training of community health workers, first aid stations, mobile clinics, home deliveries and HIV/AIDS programme. The trust also provides consultancy services to business, other non-government organisations, government departments and community organisations. The Valley Trust with more than 40 years of experience is respected both nationally and internationally for highly innovative work in health promotion and sustainable development. However, its efforts are not immune to an illogical state bureaucracy, as this is the case with other non-governmental organisations (Mthembu 1998:interview).

4.3.1 THE VALLEY TRUST MISSION STATEMENT

The mission of the Valley Trust is to promote the complete physical, mental and spiritual well-being of the individual and communities emphasising their dependence upon and responsibility towards the environment. It strives to uphold universally-accepted humanitarian values. The Valley Trust's philosophy is to encourage self-reliance and participation applying principles that are innovative, non-sectarian, ecologically sound and scientific (The Valley Trust Annual Report 1996:1). (Refer also to Annexure B 1).

4.3.2 AIMS OF THE VALLEY TRUST

The Valley Trust has set its aims and objectives and are summarised as follows:

(i) innovate, evaluate and replicate

(ii) strengthen local impact

(iii) become a national reference centre

(iv) promote self-reliance and sustainability at the organisational and community level

(v) improve educational and community levels

(vi) influence national policy-making

(vii) encourage the application of ecological principles within the organisation direct programmes towards those vulnerable groups with the least resources (i.e. the poor)

(viii) improve communication

(ix) improve impact on key groups (i.e. youth, women and decision makers); and

(x) integrate as far as possible the work of sections as a component of holistic work of The Valley Trust (Valley Trust Information Brochure 1997:1).

These strategic aims of The Valley Trust can be achieved through the holistic approach whereby all the factors contributing to health are taken into consideration and these factors are ***inter alia***; socio-economic, cultural, recreational and educational factors.

4.3.3 THE VALLEY TRUST ORGANISATIONAL STRUCTURE

The organisational structure of The Valley Trust consists of a board of trustees, a management committee, an executive director and a board of management controlling

various sections. The restructuring of The Valley Trust had been taken into its third and final phase by the end of 1997. There were three additional departments which were created, bringing the total number to nine. These departments are graphically illustrated in Figure 5 and are:

1. Administration
2. Community Development and Outreach
3. Conference Centre
4. District Health and Finance
5. Education
6. Engineering
7. Marketing
8. Social Plant Use; and
9. Training

Each of the nine departments has clear objectives against which achievement is measurable in terms of verifiable indicators.

FIGURE 5: THE VALLEY TRUST ORGANISATIONAL STRUCTURE

(Adopted from the Valley Trust Annual Report 1997:70)

4.3.3.1 ADMINISTRATION AND FINANCE

The overall goal of the Finance and Administration Department is to provide effective support to The Valley Trust as a whole, to assist in enabling the attainment of the mission of offering quality education, training and associated resources in the fields relating to comprehensive primary health care and sustainable development to strengthen the capacity of individuals and communities to improve their quality of life. Planning and evaluation for the department resulted in further rationalisation and restructuring which resulted in the Conference Centre having autonomy (Mnyeni 1998: interview).

4.3.3.2 COMMUNITY DEVELOPMENT AND OUTREACH

Working with representative committees is central to the empowerment of communities (The Valley Trust Annual Report 1994/95:9).

Meetings were held between the Development Committees, **Amakhosi** (traditional leaders) and The Valley Trust Board of Managers to improve and strengthen good relationship and prioritise a way forward. Community representatives from Kwa-

Dedangendlale emphasised a desire to engage projects themselves and highlighted the crucial role required by The Valley Trust (Mnyeni 1998: interview).

The community capacity building has led to various key areas of progress which are ***inter alia***:

(i) Simunye Farmers Association

(ii) Hlanganani pre-school Association

(iii) Khanyakhwezi Adult Basic Education Association

(iv) Community Health Committees; and

(v) Community Development Committees (Mnyeni 1998: interview).

4.3.3.3 CONFERENCE CENTRE

The department has accommodation, venues, and the canteen. There has been improved security, catering, grounds maintenance, housekeeping and accommodation. A reservation and arrival procedure has been developed to ensure customer satisfaction. The KwaZulu-Natal government is faced with a challenge to use NGOs' skills and experience in project delivery (Mnyeni 1998: interview).

4.3.3.4 DISTRICT HEALTH AND FINANCE

Health care in The Valley Trust has been re-defined and the approach to health has been that of community-orientated Primary Health Care (PHC) in which district health would be achieved. In the past the Government's approach to health was more curative as opposed to the comprehensive approach in which all the stakeholders (doctors, community health workers, health promotion staff, community, nurses and leaders) are recognised and work together towards the eradication of factors that contribute to ill-health (Mnyeni 1998: interview).

A fresh commitment to a patient-orientated service, highly practical in-service training, and a new reciprocal working relationship between The Valley Trust and Don McKenzie Centre have contributed to a good standard of Primary Health Care at the Halley Stott Health Centre (The Valley Trust Annual Report 1994/95:3).

There are some areas of progress which can be identified in this section and are highlighted as follows:

(i) Health promotion

(ii) Improvement in community health indicators

(iii) Elimination of malnutrition in its acute form; and

(iv) Increased AIDS awareness.

Health promotion through district health system is now well established and there is a co-ordinating committee which provides useful forum for exchange of ideas around identified health issues. A system of governance for the District Health System which conforms with the proposed National Health Plan is moving ahead. An innovative protocol was drawn up and funding secured for research to develop a Health Information System. There are challenges which need to be addressed immediately and are ***inter alia***: bureaucracy which prevents independent decision-making and implementation of goals. Funding is not yet available to staff and manage proposed health services full time. The uncertainty surrounding the role of Traditional Authorities in local government development (Mnyeni 1998: interview).

Improvement in community health indicators continued to show progress in that five Community Health Facilitators (CHFs) were chosen to undergo training in facilitation skills and health issues. Although Community Health Workers (CHWs) are currently not recognised as formal public sector employees, there are still about 1 500 CHWs

who continue to be employed by the State (South African Health Review 1996:88).

Elimination of malnutrition in its acute form has been one of the pillars on which The Valley Trust's reputation was built and is a priority of the District Health Service. In KwaZulu-Natal, the Department of Health has approved the expenditure of R40 million for the implementation of The Valley Trust Nutrition Education Programme in 3 500 schools (South African Health Review 1997:208).

Increased AIDS awareness has been a national priority for the past three years. Educative AIDS/HIV programmes have included peer training, youth workshops, condom distribution, AIDS awareness days and workshops with traditional healers and community health workers. An AIDS awareness club for taxi drivers has been introduced and meets weekly (Myeni 1998: interview).

4.3.3.5 EDUCATION

The establishment of The Valley Trust as a centre of learning excellence in the field of integrated rural development requires a competitive and commercial ethos whereby income generated requires a training and consultation could lead to self-sustainability

in the future. The staff are to be complimented on their adjustment to this new ethos. The organisation was restructured to give effect to this new focus. A training department was established with four teams, each specialising in specific training needs. The health section worked progressively closer with the Department of Health and the Halley Stott Health Centre. A support services department was created to ensure that the environment, both administrative and infra structural, enables effective delivery of training and health promotion (Myeni 1998: interview).

A culture of learning in the Valley was emerging whereby teachers and learners were prepared to work together. Assistance to both teachers and youth to upgrade their skills was provided through centres like:

(i) IKHWEZI EDUCATION RESOURCE CENTRE

Secured four (4) computers and educational software for both school and community development, with the assistance of Kearnsney College (Mnyeni 1998: interview).

(ii) BUILDING AND EQUIPPING OF SCHOOLS

Four new pre-schools were built to address accommodation backlogs and these are Inhlakanipho and Thuthukani in Nyuswa. Phaphamani in Ngcolosi and Mbuyazi in Lower Nyuswa. Fifteen new classrooms were added to six primary schools in the Qadi-Nyuswa area (Mnyeni 1998: interview).

(iii) NUTRITION EDUCATION IN SCHOOLS

National policy states that nutrition programmes should be integrated, sustainable, environmentally sound, people and community-driven, and should target the most vulnerable groups, especially children and women (McCoy ***et al*** 1997:207). The Valley Trust's School Nutrition programme has enjoyed a lot of support from government personnel and has been funded by the IDT. The underlying sustainable theme of the project is that the final responsibility for feeding children properly belongs to the parents. Through the programme, pupils are motivated to bring food to school to supplement the snack provided by the Primary School Nutrition Programme (Mnyeni 1998: interview).

4.3.3.6 ENGINEERING

Key activities of Engineering Services were geared to contribute to the unfolding the Reconstruction and Development Program. Practical projects enable The Valley Trust to interact with relevant community committees, providing current information, training, equipment and encouragement at a very hands-on level. Road construction of 15 network roads, 24km of bus/taxi routes and major access roads, has been successfully completed. These projects maximise local labour opportunities and involve the community committee as 'client' to the contractor (Mnyeni 1998: interview).

The organisation contributed to a national water and rural sanitation document commissioned by Mvula Trust, as well as two national workshops and a special committee of the Department of Water Affairs and Forestry (The Valley Trust Annual Report 1994/95:17).

4.3.3.7 MARKETING

Marketing has been difficult for the Trust since local and foreign donors have withdrew

their funding for non-governmental organisations. Funders have been cautious not to commit themselves and the Government of National Unity has published in the Government Gazette No. 17910 (1997:186) that it will only fund those NGOs which have been assigned by the government to work on a specific health project (Mnyeni 1998: interview).

4.3.3.8 SOCIAL PLANT USE

The work of the Eco-Agriculture Section has been redefined as the Social Plant Use Programme (SPUP). This arose out of a concern that concepts such as "food production" and "social forestry" are too narrow to capture the way in which plants contributed to the livelihoods of people, their health and development. One aspect of the SPUP which gained particular relevance during the year was food security (Mnyeni 1998: interview).

The SPUP is gaining considerable attention and interest both provincially and nationally, given that it is action orientated and people centered. The Simunye Farmers Association executive committee received assistance with strategic planning. The committee restructured, and tribal garden committees have received training. Practical

work with community gardeners (mainly in Ngcolosi) has resulted in garden innovation and increased production practices through terrace stabilisation with vetiver grass, compost making and mixed planting of vegetables (Mnyeni 1998: interview).

Training of community health facilitators, community health workers and traditional health practitioner around three health posts, focusing on both food production and medical plants has taken place. Traditional health practitioners have also visited Silverglen nursery to access plant material and learn more about plant propagation (The Valley Trust, Annual Report 1996/97:13).

4.3.3.9 TRAINING

According to the Valley Trust Annual Report (1997:15) training at the Valley Trust has been approached within the context of four major challenges to improvement of health care in South Africa and these are:

- Shared understanding
- Necessary skills
- Personal and organisational change; and

- Intersectoral collaboration.

(i) SHARED UNDERSTANDING

Although Primary Health Care and its implementation through the District Health System (DHS) is accepted policy, there is not necessary shared understanding of the concepts among the major stakeholders. It is therefore important for the Valley Trust to understand that PHC is most appropriate when it takes into account local needs and people are involved in the decision-making process that affect their health (The Valley Trust 1997:15).

(ii) NECESSARY SKILLS

The necessary skills for the implementation of PHC and DSH are often lacking. The health stakeholders especially, the government should make it a priority to gradually introduce these skills (Mnyeni 1998: interview).

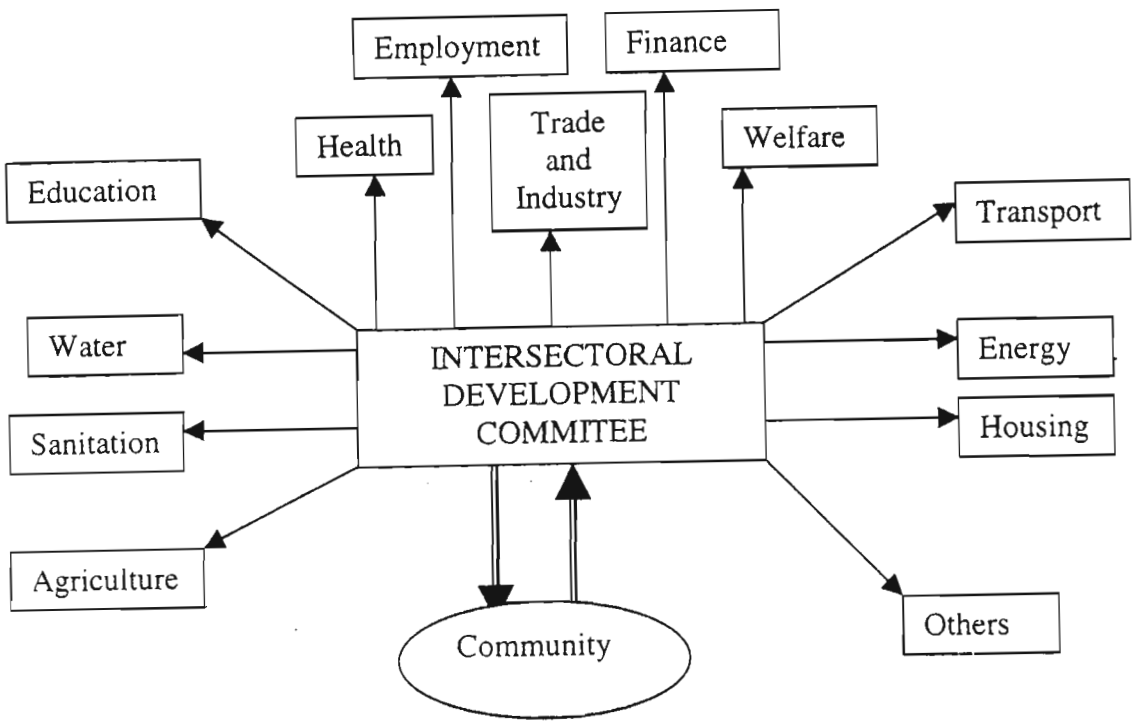
(iii) PERSONAL AND ORGANISATIONAL CHANGE

Mnyeni (1998: interview) argues that the necessary changes in understanding and implementation will not come about without all role players recognising the need for both personal and organisational change.

(iv) INTERSECTORAL COLLABORATION

Different sectors have the different resources, skills and technology necessary for the attainment of a healthy community (Dennill ***et al*** 1995:8). There is a need for a more holistic approach to PHC, recognising the importance of aspects such as food security, water and sanitation, poverty, and environmental degradation as depicted in Figure 6.

FIGURE 6: INTERSECTORAL COLLABORATION (ANC 1994:23)



The Valley Trust with the 44 years of experience is an ideal position to inform the many processes of change currently under way within the country, through training, consultancy, information and skill sharing.

4.4 ROLE OF NON-GOVERNMENTAL ORGANISATIONS

The hypothesis of this study was that non-governmental organisations played an important role in the provision of health services in KwaZulu-Natal. This study through the research instruments (questionnaire A1 and A2) that was administered to the non-governmental organisations and the beneficiaries of these services concluded that NGOs had a role to play in the past, present and in the future of health care in KwaZulu-Natal.

4.4.1 PAST ROLE OF NGOs

Progressive non-government organisations played a vital role in communication with marginalised and disenfranchised communities. In many instances, these organisations were the only support available to many disadvantaged communities. Health organisations have often been pivotal in articulating people's needs - and health, in particular has served as a rallying point for political mobilisation" (Derman and Makanjee 1996:13).

The findings of this study (which are analysed in chapter five) indicates that the main role in the past was to challenge the apartheid regime and to protect the rights of disadvantaged South Africans. Non-governmental organisations like the RED CROSS, Health Systems Trust, Valley Trust and others outside the health sector voluntarily provided basic comprehensive services to communities who were marginalised by the past government of the National Party. KwaZulu-Natal was the most neglected province by the previous regime. Curative facilities (hospitals and clinics) provided by the government were situated long distances (urban areas) from where the poor were. Transport facilities (ambulances and public) were not available and were not well developed. There was no equity in the provision of health in the province, whereby one group (minority) was receiving efficient, quality and affordable health care whilst the other group (majority) was receiving the most inferior, inefficient, inadequate and unaffordable health care services and often not receiving any service at all.

The NGO sector was required to provide health services to the disadvantaged communities which were the responsibilities of the government. The former Natal Provincial Administration (NPA) was inefficient and ineffective, it could not provide health care services to most rural communities because of lack of planning. Available resources were misused, there was corruption and maladministration. The health

officials were not responsible because they were not accountable. Non-governmental organisations then provided basic services to most disadvantaged communities at very minimal price or at no charge. Many NGOs in the province were able to provide services which the government could not provide. NGOs were able to fill the void created by the inefficiency of the government. These NGOs were able to operate in areas where there was political instabilities, and places where there was no infrastructure (clinics, electricity, roads and schools) and remote places where the government did not bother to provide health services.

The non-governmental organisations that operated in KwaZulu-Natal gained a lot of respect and thrust from local communities. This was because of community involvement. The people were consulted and were given the opportunity of taking decisions on matters affecting their health. The local communities felt that the services were provided for them, controlled by them and evaluated by them. There was a good relationship between NGOs and the local people. The donors and funders of NGOs were supportive of the course persuaded by the NGO community. Funding of these structures was not problematic and well-established and recognised NGOs like The Valley Trust were largely funded by foreign donors. Although they were able to fundraise, the government imposed restrictive and oppressive policies to these

organisations that were improving health in disadvantaged communities especially in rural and informal settlements. This often involved confrontation with the apartheid regime nevertheless NGOs were able to survive and continue their role of improving health in disadvantaged communities.

The past role of non-governmental organisations was very challenging and there was always confrontation between government and NGOs.

4.4.2 PRESENT ROLE OF NGOs

The transition from apartheid to democracy in South Africa challenged the NGO sector to review its role. The confrontation of the past between government and NGOs has to change to partnership and co-operation. The Government of National Unity now occupies the space that NGOs occupied in communities denied resources by an illegitimate government. Through government initiatives ***viz***: Reconstruction and Development Programme (RDP) the government is providing health services to the previously disadvantaged communities. The projects which are ***inter alia***; building of new clinics and free health care are aimed at eliminating health problems amongst South Africans. These health care services were normally provided in the past by the

NGO sector.

4.4.2.1 HIV/AIDS.

Care of people with HIV/AIDS is imposing an increasingly large burden on health service resources in South Africa. One estimate suggests that there will be between 3.7 and 4.1 million HIV infected people and 200 000 adults with AIDS by the year 2000 (SAJPH November 1996:1484).

Despite efforts to raise awareness, the HIV infection trend generally continued along the trajectory of the "worst case scenario". The 1995 survey of women attending antenatal clinics showed that 10.4% were HIV positive, with the figure rising to 18% in KwaZulu-Natal. The survey also showed an average of 10% of teenage girls visiting antenatal clinics across the country were infected with the HIV (South African Health Review 1996:xviii).

The NGO sector has a significant role to play especially in KwaZulu-Natal. The Health Department alone will not solve the problem, however, with the NGO sector and other stakeholders being involved in finding a solution, there are better chances to fight this

epidemic. The experience of NGOs in working with communities especially the disadvantaged will help in informing the communities about the disease. However, funds that are allocated to HIV/AIDS awareness campaign should be properly accounted for, unlike the controversy over the funding of *Sarafina 2* on the AIDS awareness play. The report alleged "... Zuma 'negligently and recklessly' omitted to stipulate a limit on the cost of the controversial musical and that her actions led to the loss of R10.5 million (Sowetan November 16 1998:2).

The government expressed its willingness to defend Health Minister Nkosazana Zuma who faces civil claim by Judge Willem Heath's anti-corruption unit over the funding of the AIDS - awareness musical *Sarafina 2*.

It is therefore important for the government to consult with all stakeholders who are involve in health care delivery like the traditional healers who know the community and their experiences, NGOs who have been working well with the communities in the past and also the community health workers who are trusted by the community. However, KwaZulu-Natal MEC Dr. Zweli Mkhize warned the traditional healers "... not to raise the hopes of residents with HIV as it is harmful to the community to claim that there is a cure that is not based on scientific evidence..."(City Press September 20 1998:1).

4.4.2.2 TUBERCULOSIS

As in other countries, Tuberculosis is being affected by HIV. It has been estimated that there were 160 000 TB cases in 1996, of which 42 000 cases could be attributed to HIV. The prevalence of HIV in adult TB patients in the Hlabisa health district of KwaZulu-Natal has risen from 36% in 1993 to 58% in 1995. The disease case load in the service has risen 3 fold and the clinical features of the disease are different. Furthermore, the HIV infected patients were 3 times more likely to fail to complete their treatment (South African Health Review 1997:10).

It is evident from the studies conducted that TB accounts to more deaths in the province and most victims are those communities with poor housing, lack of clean water, sanitation and those who cannot afford to pay for hospitals and the clinics. These communities are mostly from the rural areas. The slow delivery of the government through the RDP is seen as inefficiency on the side of the communities. Many communities in KwaZulu-Natal have lost trust in government structures because of the "election promises" that are not fulfilled. NGOs and CBOs that were

providing health care services to the disadvantaged communities have been struggling to compete with the government because of lack of funding by foreign donors.

Community Health Workers have an important role to play in the provinces. They have developed a sense of trust in their communities. They speak the local language and are acquainted with cultural norms. These groupings should be more pro-active in taking the process forward on community level (South African Health Review 1997:135).

Non-governmental organisations have a very critical role to play in the provision of health services in KwaZulu-Natal in order to supplement the provincial government in improving the health of the people of this province.

4.4.2.3 MALNUTRITION AND POVERTY

Poverty in South Africa is extensive and is predominantly associated with Blacks, especially those in rural areas, informal settlements and townships.

Poverty usually breeds ill-health because of poor nutrition. The eradication of poverty is one of the priorities of the government. However other stakeholders should also be involve in solving this problem.

The Department of Health has developed a comprehensive set of policies and objectives in order to address the problems of poor nutrition. There is now a clear policy framework for provincial Departments of Health and other relevant role players in the country (McCoy & Saasa-Modise 1997:212).

School nutrition programmes have been implemented all over the country, however there are problems that are encounter such maladministration, inefficiency of project managers and in other places the food does not reach the intended recipients (children). It is therefore important that these projects be administered and implemented by people with the necessary expertise and skills. Non-governmental organisations through the community-based organisations have a vast experience in nutrition programmes and in the eradication of poverty. The government should ensure that these nutrition programmes are sustainable and should target the

most vulnerable groups of society especially those in the previously disadvantaged communities. In KwaZulu-Natal, the Department of Health has approved the expenditure of R40 million for the implementation of the Valley Trust Nutrition Education Programme in 3500 schools (McCoy & Saasa-Modise 1997:208).

4.4.2.4 ALCOHOL AND DRUGS ABUSE

A study of all traffic-related trauma patients (drivers, passengers and pedestrians) presenting to Addington Hospital, Durban, assessed 530 patients for alcohol intoxication and marijuana use at the time of presentation to the hospital. The results indicated that 52% of all the patients were over the legal limit for alcohol, 35% had traces of marijuana in their urine and 19% were positive for both substances. A study on fatally injured pedestrians indicated that of the 60 cases examined, 78% were BAC (blood alcohol contents) positive and of these latter 47 cases, 30 (64%) tested positive for cannabis and/or Mandrax as well (Butchart & Peden 1997:218).

From the above findings it is evident that people misuse alcohol and drugs. The government alone would not solve the problem. However with the involvement of non-governmental organisations who can reach the communities through educational and awareness programmes on the harmfulness of these substances could eradicate the problems. As unemployment level is high these people tend to resolve to crime and this increase the burden of the government who spends a lot of money on rehabilitation.

The funding problem of non-governmental organisations, limits their role in the provision of health care services. NGOs have experienced difficulty in securing funding as traditional donors have chosen to redirect their funds to the government. Foreign doctors recruitment has also posed another dilemma for the NGO sector. These doctors are operating in areas that were traditional the NGOs territories. In cities there is one doctor to every 700 people, while in rural areas there is one doctor to every 10 000 to 30 000 people. This emphasise the need for more health providers (Ntsalumba 1997:7).

This should be viewed as a short-term measure to address the problems of inefficiency and unavailability of doctors in the rural areas. Therefore foreign doctors and other health providers must not be seen as a threat to local NGOs especially in KwaZulu-Natal as there is a need for health care providers. Free health care services for pregnant women and children under the age of 6 that came into effect as from the 1st of June 1994 should not be seen as a threat by non-governmental organisations although these people (women and children) are the major recipients of the services they are rendering.

Although in theory it should be possible to have a user fee system that exempts the poor and disadvantaged, this does not generally happen in practice. This is mainly due to lack of administrative capacity which is aggravated in high volume facilities where there may be even less time, space and privacy to identify those people who are exempted from fees. Other problems include a reluctance amongst staff to grant exemptions and a reluctance amongst patients to request exemptions despite being eligible (South African Health Review 1996:158).

4.4.3 FUTURE ROLE OF NGOs

Although NGOs are faced with the funding problem and the commitment of the government to the provision of equitable health care for all, NGOs have an important future role to play in the provision of health care services.

However the government will not afford to ignore the crucial role of the NGO sector as it is aiming at providing health care for all by the year 2 000.

4.4.3.1 RESEARCH AND EDUCATION

Non-governmental organisations need to conduct research and education in health related issues and illnesses like STDs, HIV/AIDS, TB, cancer, drugs and alcohol abuse and other infectious diseases. Edwards-Miller (1997:113) argues that "... skills need to be developed to ensure that rigorous and appropriate research methods are applied to these priorities. Health services, historically disadvantaged institutions and black researchers who were largely excluded from the research process in the

past, need to be financially and technically supported to build their research skills and capacity within priority health research areas ...".

4.4.3.2 DISTRICT HEALTH SYSTEM

A district health system is the vehicle for providing quality primary health care to everyone in a defined geographical area. It is a system of health care in which individuals, communities and all health care providers of the area participate together in improving their own health (Harrison1997:3).

Health care needs to take into account local needs and should be managed by the local people in order to be successful. Community-based organisations which have been successful in implementing changes in health care should continue their role with the financial assistance from the government. Harrison (1997:5) has identified 5 important reasons for district health care and are:

(i) HEALTH CARE NEEDS

In the past health services were only provided only to those who came to clinics, hospitals and those who could not afford were denied. The district health care try to meet the health care needs of all South Africans (Harrison 1997:5).

(ii) SIMPLE LOGICAL SERVICE

The health services need to be integrated and different health providers in the departments need to work together. Fragmentation of health care services also contributes to unnecessary delays (Harrison 1997:5).

(iii) DECISION-MAKING

Local people who know local needs best must have control over budget and decision-making and not by remote national or sometimes provincial governments (Harrison 1997:5).

(iv) COMMUNITY INVOLVEMENT

Harrison (1997:5) argues that local people who receive health care should be involve in improving the services they use. This has been achieved as community-based organisations participated vigorously in the formulation of health forums which are a forerunner of the District Health System. Workshops were also held on various policy issues e.g. strategies to involve males in HIV/AIDS.

(v) IMPROVING HEALTH

District health care is meant to shift the focus from administering health services to really improving the quality of care (Harrison 1997:5).

The involvement of non-governmental organisations is an advantage because they do not limit their services to particular individuals but they provide health care services to all those who need it. The communities would then support the role played by non-governmental organisations. It is important that the donor funds that are available should be used to

eradicate poverty and solve the health problems. However some non-governmental organisation officials have enriched themselves. Poor people should be supported to improve their standards of living and thereby improving their health status. Health care services provided to these communities should be improved.

4.5 SUMMARY

This chapter has indicated the role played by non-governmental organisations in the provision of health services with particular emphasis to the case study of the Valley Trust and the Health Systems Trust. These NGOs have played a significant role in the past in improving health in disadvantaged communities. KwaZulu-Natal has benefitted from these health care services. Although this involved confrontation with the apartheid health structures these NGOs managed to survive.

The future role of NGOs is ernomous as South Africa is faced with problems such as HIV/AIDS epidemic, cancer, TB, alcohol and drugs abuse however the NGO sector is faced with the problem of lack of funding.

CHAPTER 5

PRESENTATION AND ANALYSIS OF DATA: ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN HEALTH PROVISION

5.1 INTRODUCTION

The focus of this study was on the role of non-governmental organisations in the provision of health services in KwaZulu-Natal. This chapter introduces the reader of this text to the most important aspects of this study- the findings. The chapter includes: objectives of the study, research methodology, study sample, research instruments, interpretation of research findings, hypotheses and conclusion of the chapter.

5.2 OBJECTIVES OF THE STUDY

The three objectives of this study as set out in chapter 1 are to:

- Identify the role of non-governmental organisations in the provision

of health services;

- Describe practical mechanisms for enhancing collaboration between the government and non-governmental organisations; and
- Identify mechanisms for the reallocation of resources from the government and private sectors to the NGO sector.

In order to achieve the objectives of this study a number of questions were raised and included:

- What was the past, present and future role of non-governmental organisations in the provision of health services?
- What was the nature and functions of non-governmental organisations?
- Is there any relationship between government, business and NGO sector in the provision of health services?
- Where should funding for non-governmental organisations be obtained from?
- How should the available resources be equally shared among all health stakeholders?

The objectives of this study were achieved hence the study undertaken by the researcher was aimed at finding possible answers to these questions and the findings are presented in the later sections of this chapter.

5.3 RESEARCH METHODOLOGY

Exploratory research of both qualitative and quantitative nature was used to collect the relevant information. The study was conducted over a period of 30 months. A study of available literature on non-governmental organisations that were providing health services was conducted. Two questionnaires (A1 and A2) were administered to the communities and NGOs, respectively. Visits to Health Systems Trust, Valley Trust, local hospitals, libraries and KwaZulu-Natal Health Department were made to collect information. The fieldwork was undertaken between July 1997 and August 1998 and informal interviews were conducted with the relevant officials and community members. The media (T.V., newspapers and radio) also provided with the relevant and updated information.

5.4 STUDY SAMPLE

This study was undertaken after a 'pilot study' was completed and the results indicated that the study was feasible. Questionnaire A1 was administered to an initial sample of 260 would-be respondents. Of that sample, 220 responses were obtained and the researcher selected 190 completed questionnaires. An additional of 15 questionnaires were administered to those respondents who were illiterate. These questionnaires were marked **'i'**-indicating illiterate. These questionnaires were translated from English to Zulu and during the interviews notes were taken. For checking of possible inconsistences due to language differences a language expert was consulted and responses were translated back to English. In all 10 questionnaires that yielded maximum responses were selected. The total number of the completed questionnaires was 200.

Two non-governmental organisations were chosen for this study as discussed in the previous chapter (chapter 4) and these NGOs are; Health Systems Trust and the Valley Trust. A separate questionnaire (A2) was administered to these NGOs. There were other NGOs like the RED

and the National Progressive Primary Health Care Network which the researcher visited, however, the researcher felt that by studying the sample it might be possible to generalise the findings to the NGOs that are providing health services in KwaZulu-Natal.

5.5 RESEARCH INSTRUMENTS

Two pre-coded questionnaires, A1 and A2 were administered to respondents from the study sample of community members and NGOs, respectively. Questionnaire A1 was a standardised structured questionnaire designed in English. The questionnaire was translated from English to Zulu for those 15 would-be respondents who were Zulu-speaking. Questionnaire A2 was administered to the officials of the respective NGOs. Questionnaire A1 consisted of 21 items divided into three sections.

SECTION A - contained questions from 1-7 pertaining to the role of NGOs in the past, present and future.

SECTION B - contained questions from 8-15 pertaining to the nature of non-governmental organisations and their functions. A Likert scale was used where respondents were required to respond from strongly disagree to strongly agree.

SECTION C - contained questions from 16-20 and these were questions on the funding of the non-governmental organisations.

Closed questions which yielded responses such as YES or NO were asked and also open-ended questions which allowed respondents to respond freely and substantiate on their responses. An additional question number 21 was included for respondents to provide the researcher with as much information as possible which might not have been covered by the other questions. This also helped the researcher to acquire more information which might not have been known. Interviews outside the study sample were conducted with officials and workers from hospitals, schools, libraries, other NGOs not providing health services and other members of the community. Probing questions were asked to those people who were interviewed but did not provide satisfactory responses.

Questionnaire A2 was also a standardised structured questionnaire designed in English. The questionnaire was administered to different officials of non-governmental organisations in KwaZulu-Natal. The researcher selected two NGOs which were involved in the provision of health care services. These NGOs have very strong organisational structures and they also disseminate health information to different health stakeholders. They are the Health Systems Trust and the Valley Trust. Questionnaire A2 consisted of 8 questions. The findings of qustionnaire A2 have been presented in chapter 4 of this study.

5.6 INTERPRETATION OF RESEARCH FINDINGS

In this section the information that was collected by the researcher through questionnaires, interviews, observations, study of the relevant literature was interpreted and presented, using bar diagrams and tables.

SECTION A: PAST, PRESENT AND FUTURE ROLE OF NGOs

It is important to note that the non-governmental organisations that were chosen for this study were those involved in the provision of health care in KwaZulu-Natal. The questions asked in Section A were aimed at understanding the role played by non-governmental organisations in the past, present and in future.

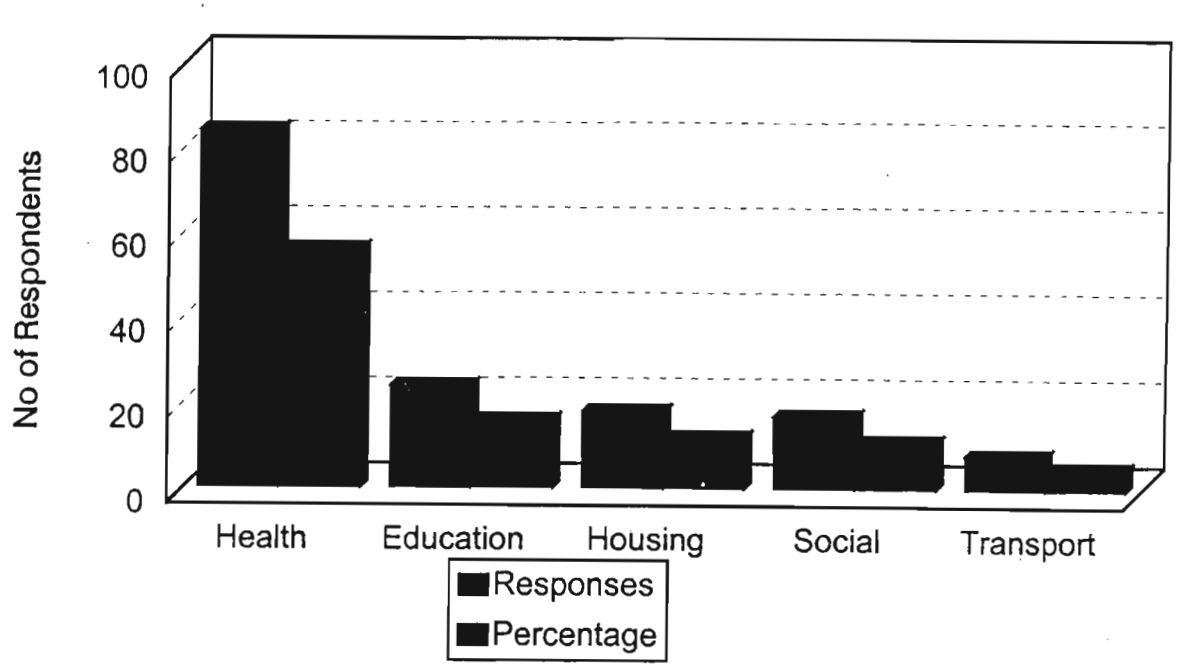
QUESTION A1: 3 Priorities of NGOs

Respondents were asked to mention three (3) priorities of NGOs in their respective communities. The question was asked in order to understand the most important areas in which non-governmental organisations provided assistance.

TABLE 1: PRIORITIES OF NGOs

	Health	Education	Housing	Social	Transport
No. of respondents	84	24	18	17	8
Percentage of responses	56%	16%	12%	11%	5%

FIGURE 7: PRIORITIES OF NGOs



From the responses, most respondents (84) which is fifty six percent, indicated health as a priority. Education was second with sixteen percent which is 24 responses. Housing had 18 responses which is twelve percent (this however surprised the researcher as some households were overcrowded and did not have proper housing). Social programme (11%) and had 17 responses and transport had 8 responses (5%).

QUESTION A2: NGOs have been providing affordable health care to the poorest sectors of the population

This was a closed question which yielded a YES or NO answer. It was asked in order to understand whether or not NGOs provided affordable health care to the most vulnerable (rural, poor, old, women and children) communities. The majority of the respondents (198) agreed that NGOs were providing affordable health care to the poorest segments of the population. Only two respondents disagreed.

QUESTION A3: Is it a major problem to raise funds from the poor?

The question was asked following the ongoing debate of non-payment for services by the majority of the community. All respondents (200) indicated that raising funds from the poor was problematic. Respondents also indicated that the reasons for not attending hospitals and clinics was lack of funds to pay for health services. Some respondents indicated that they were prepared to pay for these services, provided they had some sort of

income. The researcher also observed that most respondents were unemployed.

QUESTION A4: Were NGOs accountable to the community?

Accountability of an organisations indicates its responsibility. Resources (financial, physical and human) should be utilised efficiently and effectively. From the responses of this study 186 (93%) indicated that NGOs were accountable whilst 14 (7%) stated that they were not. Previously, non-governmental organisations were only accountable to the donors or funders of their projects.

QUESTION A5: Do NGOs have the resources to handle development?

Development is a process which needs a comprehensive approach and resources namely; human, physical and financial. The question was asked so as to identify the resources that were available to non-governmental organisations. The majority of respondents (188) stated that NGOs did not have the necessary resources to handle development. Respondents also

stated the following problems:

- lack of transport like ambulances
- lack of hospitals and clinics; and
- unavailability of funds

Twelve of the respondents agreed that non-governmental organisations have resources to handle development. The researcher noting the geographical area of KwaZulu-Natal and development that needs to be taken concluded that the resources that were available were inadequate. Generally, speaking NGOs have limited resources.

QUESTION A6: Should NGOs maintain their independence from the government?

The Government of national unity is committed to a better health for all. This has been supported through the policy of free health care for pregnant women and children under 6 years. The question was asked to access the present and future relationship between government and non-governmental

organisations. One hundred and eighty (90%) respondents agreed that NGOs should maintain their independence from government and they provided the following reasons:

- government is not delivering on its promises
- communities need to be protected from the bureaucracy of the government; and
- government is remote from the communities.

Twenty (10%) respondents stated that NGOs should not maintain their independence because they will need the support of the government, particularly funding.

QUESTION A7: Should the role of non-governmental organisations change in the new dispensation?

In the past (apartheid era) non-governmental organisations confronted the government and there was always an element of antagonism. The role of NGOs was to provide health services where the government did not

provide. The political changes that haveoccurredd in South Africa especially after 1994 have challenged the NGO sector to review its position. One hundred and sixty eighty (84%) respondents stated that the role of NGOs should not change and provided the following reasons:

- government is slow in its delivery process
- corruption and maladministration of government; and
- NGOs are able to respond to the changing needs and circumstances.

Thirty two (16%) of the respondents agreed that the role of non-governmental organisations should change because of the following reasons:

- the government was committed to better health for all
- government was democratic and elected by the majority: and
- the role should change from opposition to partnership.

SECTION B: NATURE AND FUNCTIONS OF NGOs

This section was aimed at understanding the nature and functions of NGOs. A Likert scale was used in which respondents were asked to respond from strongly disagree to strongly agree on the questions.

QUESTION B8: NGOs have been carrying out functions which were considered to be government responsibilities.

In the past the apartheid government discriminated against the majority of South Africans which were particularly Blacks. Basic services were not provided to them and these communities were neglected. This question was asked to access whether NGOs were providing services that were beyond their jurisdiction. The findings indicated that although the majority of respondents - 156 (78%) agreed with the statement they did not strongly agree. Twenty four (12%) disagreed and twenty (10%) were not sure.

SECTION B9: Community must be involved in shaping health care services.

The proposed District health care by the ANC-led government is based on Primary health care which depends largely on community participation and involvement. The question was asked in order to ascertain the need to involve communities in decision-making. The results indicated that the majority of the respondents one hundred and ninety two(96%) indicated that there was a need for community involvement. From those (190), more than ninety eight percent (98%) strongly agreed with the statement. Only eight (4%) of the respondents disagreed with the statement. The researcher, however strongly believes that before communities could be involved in shaping health care services they need to undergo a vigorous training in which they could have specialized knowledge on health care.

QUESTION B10: NGOs are one of the sets of organisations which limit the power of the state in relation to lives of the citizens.

The question was asked in order to access the power and influence of

NGOs to the government. The apartheid government was powerful and authoritarian. It did not allow opposition particular the liberation movement. Non-governmental organisations had a very difficult task of challenging such government with its limited resources. Although NGOs challenged the apartheid government the resources to be effective were limited therefore NGOs were not able to limit the power of the state. The results of this study indicated that half of the respondents one hundred (50%) agreed with the statement whilst eighty (40%) disagreed in which seventy five percent (60) strongly disagreed. Twenty (10%) of the respondents were not sure. In a democratic state NGOs might have more powers in limiting the powers of the government hence there is freedom of speech, freedom of movement and association. Unlike in the past NGOs are now protected.

QUESTION B11: NGOs have taken up the challenge of promoting collaboration to help the poor cope with their needs.

Non-governmental organisations were created to help the most vulnerable sectors of the population. The question was asked in conjunction with

question 2 from section A. Respondents were consistent and one hundred and ninety eight (99%) agreed in which (180) strongly agreed and only two (1%) of the respondents were not sure. The results indicate the commitment of NGOs to the upliftment of the lives of the poorest segments of the population.

QUESTION B12: A redistribution of health workers to under serviced areas has to take place.

The government is committed to the provision of equitable health care for all South African citizens. The question arose out of the inequity of health care. Health workers and resources are unevenly distributed favoring the white communities and urban citizens. The blacks and rural communities do not receive these resources. The results indicated that all two hundred of the respondents strongly felt that redistribution was necessary. The researcher however, feels that it is important that redistribution be done in a consultative manner in which all stakeholders that are involved are taken into consideration and decision should not be imposed without proper communication as it is the case with a 'top-down' approach.

QUESTION B13: NGOs act as a pressure group to government structures.

Question ten and thirteen were aimed at understanding the views of the respondents in relation to the role of NGOs. The question was poorly answered, only twenty agreed whereas 180 indicated that they were not sure. None of the respondents disagreed with the statement.

QUESTION B14: NGOs can utilise resources more effectively than government.

The question was raised to understand the cost-efficiency of NGOs compared to the government. Non-governmental organisations have been operating with limited resources, however, they were able to deliver services to the majority of the population without even receiving any income from the beneficiaries of their services. Most of the respondents one hundred and sixty (80%) agreed with the statement (75% of the respondents - 120) strongly agreed. Only twenty percent (40) disagreed.

QUESTION B15: The services of NGOs should not be integrated with the rest of health services.

Integration of services would mean one single health sector in which all other sectors would be integrated and the costs would be minimised. The question that arises when there is integration is who is co-opted. Although, the government is in favor of the process of integration, other sectors are not because of fear of uncertainty that their project would be phased out and their role be undermined. Responses indicated that one hundred and seventy two (86%) of the respondents disagreed with the statement indicating that they were in favor of the integration process. Eighteen were against integration and ten were not sure.

From the above responses the researcher concluded that non-governmental organisations provided services which were sometimes government responsibilities. These services were provided with the limited available resources. In the new dispensation the government should redistribute resources in an equitable manner and fragmented services should be

amalgamated in a broad consultative way in which each an every stakeholder could have an input.

SECTION C: FUNDING OF NGOs

Non-governmental organisations enjoyed the financial assistance from foreign donors and governments which were opposed to apartheid policies. This section focus on the funding of NGOs in the past and future. The questions asked in this section were based from the third objective of this study - to investigate mechanisms for reallocation of health resources to the NGO sector.

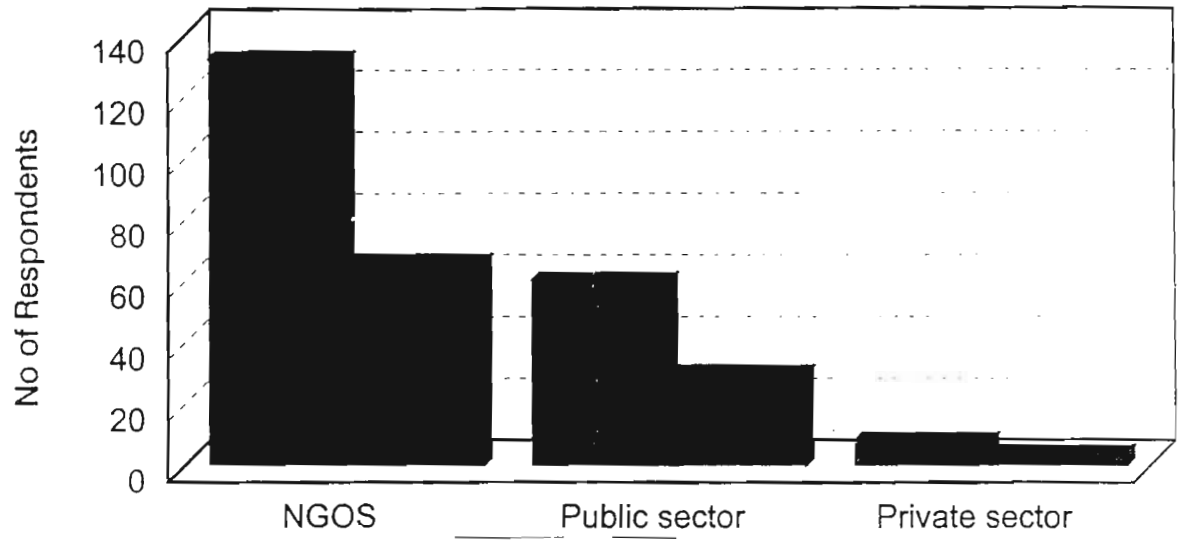
QUESTION C16: Which one of the following (private, public or NGOs) has been the major lifeline for addressing health problems?

Respondents were asked to identify the major lifeline for addressing health problems. The question was raised in order to evaluate the contribution of each of the three sectors in the provision and promotion of better and quality health care to the disadvantaged communities.

TABLE: 2 LIFELINE FOR HEALTH PROBLEMS

	NGO sector	Public sector	Private sector
No. of respondents	132	60	8
Percentage of responses	66%	30%	4%

FIGURE 8: LIFELINE FOR HEALTH PROBLEMS



One hundred and thirty two respondents indicated non-governmental organisations with (66%) responses. Sixty (30%) respondents indicated the public sector and only eight (4%) indicated the private sector. The reseacher cited the following reasons:

- NGOs were operating within these communities; and
- NGOs also provided free or affordable services.

QUESTION C17: Who should finance NGOs in the future?

The question arose because of the financial crisis, the NGOs are faced with. Foreign governments are now directly funding the government of national unity which is committed to better health for all. Non-governmental organisations are battling to raise funds.

TABLE 3: FUNDING OF NGOs

	National government	Provincial government	Local government
No. of respondents	188	60	4
Percentage of responses	94%	30%	2%

FIGURE 9: FUNDING OF NGOs

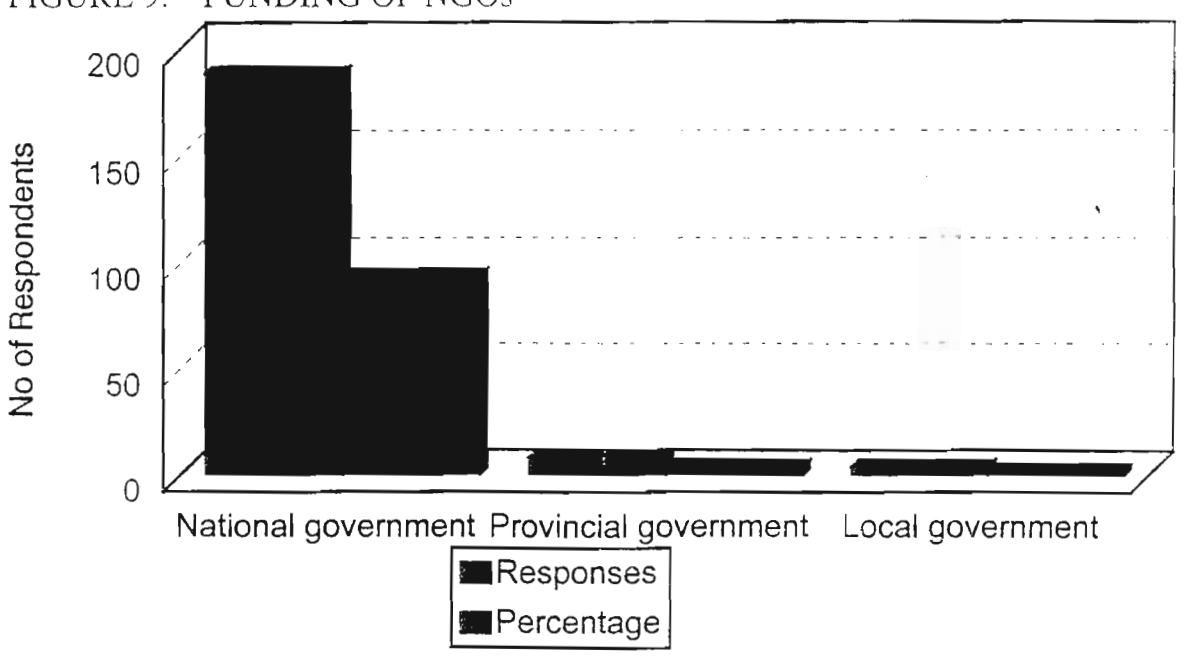
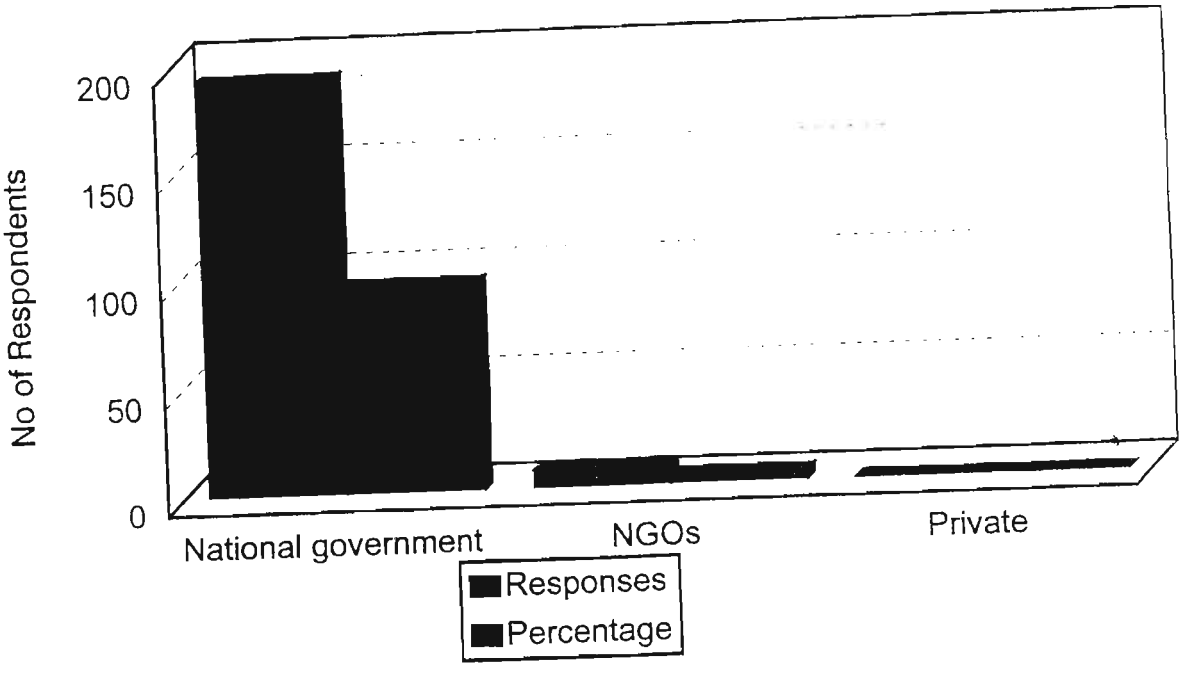


TABLE 4: FOREIGN FUNDING

	Government + NGOs	Provincial government	Private sector
No. of respondents	192	8	0
Percentage of responses	96%	4%	0%

FIGURE 10: FOREIGN FUNDING



Four of the respondents indicated provincial government and only two indicated the local government.

QUESTION C18: Where should local NGOs help most?

The question was aimed at determining the most important needs of the communities. From the responses health was ranged as a priority with sixthy two responses and respondents indicated the following challenges:

- HIV/AIDS
- T.B; and
- alcohol and drug abuse.

Twenty four respondents indicated housing. Education yielded twelve responses and only two respondents indicated that NGOs should help in all three spheres (education, health and housing)

QUESTION C19: With the new government in power who would get more funding from foreign donor agencies?

The question arose because of the recent political changes which took place in South Africa. The government of national unity came into power in 1994

One hundred and ninety two (96%) respondents indicated that government (government of national unity) are the likely to receive more funding from foreign donors. These figures were valid as foreign government indicated that they were prepared to fund the government rather than the NGO sector. Only eight (4%) of the respondents indicated that non-governmental organisations would receive more funding. None of the respondents indicated the private sector. The researcher however concluded that although funding was aimed at the eradication of ill-health, the private sector was in a better position to receive more funding as they have the resources and expertise of fundraising and attraction of foreign donors.

QUESTION C20: Where should funding for NGOs be obtained from?

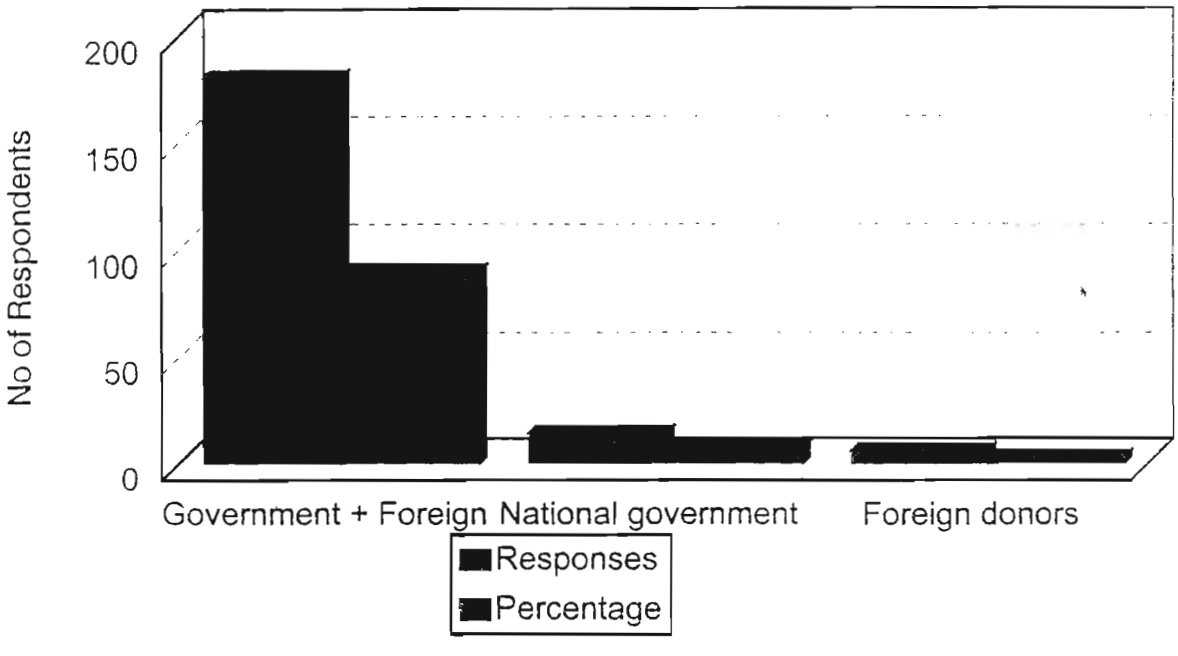
Question 17 and 20 were aimed at identifying the possible funders of NGOs in the future. The researcher identified the possible funders and they included; national government (GNU), foreign agencies or the combination the combination of the two.

One hundred and eighty (90%) of the respondents indicated that both national government (GNU) and foreign donor agencies should fund the non-governmental organisations. Fourteen (7%) indicated that the foreign donor agencies should finance the non-governmental sector.

TABLE 5: FUNDERS OF NGOs

	National government and foreign donors	National government	Foreign donors
No. of respondents	180	14	6
Percentage of responses	90%	7%	3%

FIGURE 11: FUNDERS OF NGOs



From the above results the researcher concluded that non-governmental organisation were faced with the funding crisis and because funders have rechannelled their resources directly to government, both government and foreign funders should assist NGOs financial and educational in order for them (NGOs) to survive.

QUESTION 21: Additional comments

Question twenty one was an additional question which the researcher was aiming at receiving more information from the respondents. The other questions might not have catered for. Generally the comments by respondents indicated that they supported the role played by non-governmental organisations and the comments varied as follows:

- non-governmental organisations have been assisting the poor communities for a long period and without them the communities would not survive.
- government (especially the Nationalist Party) was oppressive and discriminatory to the majority of South Africans thereby denied

them their rights, non-governmental organisations were prepared to work voluntarily to help the disadvantaged.

- non-governmental organisations have a future role in these communities as they were delivering health care services to the communities.
- non-governmental organisations provide efficient and effective health care services than other sectors.
- non-governmental organisations provide comprehensive services which include: education and training, social, cultural and health care services.
- non-governmental organisations's personnel are more responsive to the community needs and they are not remote from them.

5.7 HYPOTHESES

This section was aimed at analysing the hypotheses that were generated by this study at the beginning of chapter one. Three hypotheses were identified by the researcher and throughout this study these hypotheses have been tested.

5.7.1 HYPOTHESIS ONE: Non-governmental organisations will continue their role of providing health care services to the disadvantaged communities.

From figure seven of this study eighty four (56%) of the respondents indicated health as the priority of non-governmental organisations. This indicates that there is a future role for non-governmental organisations and the recipients and beneficiaries of these services are still in support of the NGOs. Chapter four of the study also indicated that non-governmental organisations like the Health Systems Trust and the Valley Trust are continuing with their role of providing health care services to the disadvantaged communities. This hypothesis is substantiated and tested to be correct.

5.7.2 HYPOTHESIS TWO: Many non-governmental organisations would be incapable of sustaining themselves without resources from international donors.

This hypothesis is substantiated and has been tested to be correct. It was

evident immediately after the general elections of April 1994 when the government of national unity came into power when funding by foreign donors became bilateral whereby they were directly funding the government. Many non-governmental organisations were incapable of continuing with their services without the assistance of foreign donors. Many of them decided to shut down and close.

5.7.3 HYPOTHESIS 3: Non-governmental organisations will emerge as developmental activists in the democratic South Africa.

The findings of this study indicates that most of the non-governmental organisations that were operating in South Africa were developmental organisations because they were ensuring that the lives of the poor communities were improved. They provided education and training, social services, transportation, housing and health (figure 7). The results indicate therefore that the researcher was not correct in assuming and hypothesizing that non-governmental organisations will emerge as developmental activists in the democratic South Africa hence the task began long before the elections.

5.8 SUMMARY

The chapter has analyzed and interpreted the results of this study. Tabulation of data and the creation of tables and diagrams was done in order to give a clear understanding to the reader of this dissertation. Although two questionnaires (A1 and A2) were used to collect data for this study, only questionnaire A1 has been analysed in this chapter. The results of questionnaire A have been analyzed in chapter four of this study. The findings of the study can be generalised to the non-governmental organisations that are providing health care services in KwaZulu-Natal, and with a more comprehensive study the results could be generalized to the whole of South Africa. The final chapter provides the reader with the conclusions and recommendations drawn from this study which could be relevant and useful to other provinces in South Africa.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

The challenge is not only to find and understand the root causes of the problem, but equally to find workable solutions (Schuftan 1998:104).

6.1 INTRODUCTION

This study has focused on the role of non-governmental organisations in the provision of health services in KwaZulu-Natal. The researcher set out a number of objectives and hypotheses for this study. In order to achieve the objectives of this study the researcher raised a number of questions (chapter 1 and 5). A theoretical perspective on non-governmental organisations was critically reviewed. In chapter 2 a comparative study of international and South African NGOs was undertaken through the study of available literature. Chapter 3 focused on South African Health policy and how NGOs are affected by these policies. In chapter 4 the study focused on the two NGOs (Health Systems Trust and Valley Trust) that were used as a case study. In chapter 5 the findings of this study on the role of non-

governmental organisations was presented and analyzed. This chapter concludes the whole study and also provides the reader with the recommendations drawn from the study.

6.2 CONCLUSIONS

A number of conclusions have been drawn from this study and from these conclusions recommendations were made which would contribute to the improvement of health in KwaZulu-Natal and to the South African Health.

6.2.1 South African health care services have been fragmented for a long time. There has been a huge gap between the health of South Africans. Health care was not accessible and affordable to the disadvantaged who were mainly blacks, poor, children, rural and women. The apartheid regime systematically denied the majority of its citizens access to quality, comprehensive, preventive and affordable health care. There was a huge health gap between the former four provinces. In the past there was inequity in the provision of health services.

6.2.2 Non-governmental organisations and community-based organisations emerged in the apartheid era to fill the void that was created by the apartheid regime. Many NGOs in the past were anti-apartheid and challenge the government. This confrontation often led to assassinations, detentions and tortures. Non-governmental organisations that were providing health care services operated under restrictive and oppressive conditions, (such as the Fundraising Act and Affected Organisation Act) however they were able to provide the disempowered communities with health care services that the government failed to provide.

6.2.3 The apartheid laws placed the majority of its citizens which were blacks in the most remote areas of South Africa and KwaZulu-Natal was in the former KwaZulu homeland. Health facilities were minimal and sometimes not available. Health infrastructure like hospitals, clinics and ambulances were not available. Health workers from the Department were not prepared to work in these remote areas and the health status deteroiated. Curative facilities provided by hospitals and clinics were situated long distances and the poor could not afford to access them. However, NGOs with the assistance of foreign donors and funders provided free health care

to the most vulnerable groups of the community. These non-governmental organisations gained the trust of the communities.

6.2.4 During the political instability in KwaZulu-Natal, NGOs were able to operate freely because the communities respected them and protected them. NGOs were able to provide health care services in different areas ***viz***; rural, townships and urban. They were able to communicate to different community leaders like the traditional leaders and councillors. The trust of these NGOs by the communities could be attributed to the way they operated which was; non-political, non-partisan and nonprofit. The past role of NGOs in the provision of health care was of significant importance not only to the communities of KwaZulu-Natal but to the South African population at large. Health status can affect other sectors like the economy, education, social and sports and recreation. The NGO sector played a "watchdog" role in bringing to the attention of the whole world the undemocratic and inefficiency of the apartheid regime in the provision of health care services.

6.2.5 The political transition in South Africa in 1994 challenge the NGO

sector to review its role in the provision of health care services. The ANC-led Government of National Unity is committed to the provision of health care for all South Africans, particularly those who were previously under served by the apartheid government. The GNU is targeting the previously disadvantaged communities through the RDP, free health care for pregnant women and children under six, provision of infrastructure (hospitals, clinics and other health facilities). The government is now taking responsibility and providing health care to all South Africans. The health sector is moving towards a district-based health care which is based on primary health care. Local communities should therefore be involved in decision-making as they are able to provide with working solutions to their health problems.

6.2.6 The major challenge of non-governmental organisations is funding. Donors have rechanelled their funds directly to the government. There were a number of NGOs who did not survive and were forced to shut down. However, the closure of these organisations were the weak organisational structures in which the traditional approach or top-bottom paradigm was emphasise (decisions were taken from above and then imposed to the

people at the bottom). The other challenge was the movement of personnel from the NGO sector to the government sector as government was seen as a partner and the long-standing animosities of the past have been eradicated.

6.2.7 Most people were extremely optimistic when the new government (GNU) came into power. Although the GNU is committed to better health for all there is still a role for NGOs in the provision of health care services, particularly in KwaZulu-Natal. The implementation of the RDP in the province has been very slow and in some parts this has started. The political conflict between the national government (ANC-led) and provincial government (IFP-led) has led to non-development in the province. Government officials are not prepared to work in rural areas especially those which are under the traditional leaders. The recruitment of foreign doctors (the Cuban doctors) does not solve the problem of ill-health as they are not well vested with the culture, language and traditions of local communities. In spite of the "election promises" most people are still unemployed, poor and their health status is still below that of international standard. The closure of some NGOs which provided invaluable health

care services will be a backlock both to the government and the people who benefitted from these services. The failure of the GNU through the RDP to deliver services proves that the government will not be able to effectively and efficiently provide health care services. The GNU needs the private sector as well as the NGO sector who are well experienced in working with the disadvantaged communities. The only development agencies who have enjoyed the privileged and access to disadvantaged communities have been the NGOs and CBOs because they know the problems of the local communities and were able to give working solutions to their needs. The GNU and the private sector should provide grants to the NGOs who are providing health care services so as to survive the transition.

6.2.8 South Africa should also learn from international experience that transition from authoritarian regimes to democratic ones does not automatically deliver services to the communities. The GNU has not delivered on its promises. Although there are health policies that have been formulated and agreed upon, the implementation is very slow and in other areas it is impossible because the experienced NGOs and CBOs are being replaced by government officials who do not understand the problems of

the local communities and their needs. The skills and expertise of local NGOs and CBOs should be utilised effectively. Health care services that need to be rendered in rural areas in KwaZulu-Natal should be contracted out by government to the local NGOs who have the skills of working in these areas.

6.2.9 Most non-governmental organisations are incapable of sustaining themselves (e.g. Urban Foundation) particularly in neglected areas and are forced to close down. These NGOs operating in neglected areas need assistance. Although NGOs need assistance from the government, it need to be independent of government. Non-governmental organisations must be able to take their own decisions, however they must be responsible and accountable to their funders. It is also important for NGOs to function as "watchdogs" of the communities and when the government is inefficient they should be there to protect the community.

6.3 RECOMMENDATIONS

This study has provided the reader of this dissertation with a number of recommendations that are based on the foregoing conclusions of this study.

6.3.1 EXPERTISE OF NON-GOVERNMENTAL ORGANISATIONS

Non-governmental organisations personnel have accumulated a lot of experience which need to be preserved and utilised effectively in order to eradicate ill-health from the community. The Government of National Unity should allow the non-governmental organisations that are providing health care services to continue their role. Although the GNU is committed to better health for all, most of the health workers in the public health sector are not prepared to work in disadvantaged communities. The experience and skills of NGOs in working in these areas will be an advantage to the government as there would be co-operation between the providers (NGOs) and the users (community) of health care services.

6.3.2 PROVISION OF INFRASTRUCTURE

The Government of National Unity should provide the basic infrastructure to the previously disadvantaged areas. Most rural areas do not have access to basic infrastructure *viz*; roads, recreational facilities, water, electricity, housing and hospitals or clinics. The lack or unavailability of these basic facilities will mean that the communities living in these areas would not have access to health care services. Communities who are living under poor social and economic conditions can lead to ill-health.

6.3.3 FINANCIAL ASSISTANCE

Non-government organisations that are still operating in KwaZulu-Natal are faced with the funding crisis. The political transition from apartheid to democracy has seen traditional donors and funders of non-governmental organisations redirecting their finances to the government. The government to government funding would mean that the GNU would accumulate more funds and NGOs would not be able to compete with the government for external funding, the state should therefore provide grants to progressive

NGOs so as to achieve the common goal of better health for all. Lack of funding to most of the NGOs would mean that they should shut down. The experience and skills would be lost. It is also recommended that the government provides the NGO sector with other available resources that will assist in the provision of health services, for example, provision of mobile rooms for consultation and also with transport which NGOs could use in order to reach these disadvantaged communities.

6.3.4 DEVELOPMENT OF NGOs CAPACITY

The capacity of non-governmental organisations should be developed. All the major health stakeholders (government, private sector, donors/funders and NGOs) should be involved in developing the capacity of non-governmental organisations and community groups through training and providing skills. They (NGOs) would not be expected to acquire external expertise which are sometimes unavailable or unaffordable. They would be able to deal effectively with national issues *viz*; HIV/AIDS epidemic, TB, cancer and alcohol and drug abuse. Non-governmental organisations would then be able to take informed decisions and help to prevent and control the

spread of these disease and misuse of these substances.

6.3.5 STRATEGIC PLANNING

The top management of non-governmental organisations should be empowered with management skills and NGOs that are involved in health should engage in a strategic planning process. Non-governmental organisations should plan pro-actively to move towards a district-based health care in South Africa. The Health Systems Trust and the Valley Trust are involved in strategic planning. Other NGOs should reposition themselves so that they could continue to play a crucial role of acting as the link between the government and civil society. They should develop skills such as communication, management, financial, research, education and training, organisational, administration and leadership skills in order to be able to have meaningful contributions.

6.3.6 PARTNERSHIP

There must be increased co-operation between non-governmental

organisations, government and the private sector in the provision of health care services. The available resources should be shared and utilised towards the attainment of the common goal - provision of health care services. The business sector should assist the NGO sector in training and education of personnel and financial resources. The government should also assist with grants and contracting some of its services to progressive non-governmental organisations like the Health Systems Trust and the Valley Trust. Non-governmental organisations should also be a reservoir of talent and skill for the public and private sectors.

6.4 SUMMARY

The study of the role of non-governmental organisations in provision of health services in KwaZulu-Natal was aimed at understanding the role of NGOs in health and was also investigating mechanisms in which health care in South Africa, particularly, KwaZulu-Natal could be improved and provided to all the inhabitants of the province without discrimination of any kind. In order to achieve quality and affordable health care for all it is important for all the stakeholders involved in health to work in partnership.

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ANNEXURE A1

QUESTIONNAIRE A1

Role of Non-Governmental Organisations in the provision of Health Services in KwaZulu-Natal.

Guidelines to completion of Questionnaire:

- Please read the entire form before making any entries
- Answer each question as accurately and carefully as possible
- This questionnaire consists of 3 sections:

SECTION A : Past, Present and Future of NGOs.

SECTION B : Nature and functions of NGOs

SECTION C : Funding of NGOs

NB: NGOs refer to non-governmental organisations that are specifically rendering health care services.

SECTION A : THE PAST, PRESENT AND FUTURE OF NGOs (Make a CIRCLE on ONE answer).

1. Please list 3 priorities of NGOs in your community.

   A. .....

   B. .....

   C. .....

2. NGOs have been providing affordable health care for the poorest segments of the population.

   A. NO

   B. YES

3. It is a major problem to raise funds from the poor.

   A. YES

   B. NO

4. In your opinion, do you thing NGOs were accountable to the community?

   A. NO

   B. YES

5. Do NGOs have the resources to handle development?

   A. YES

   B. NO

6. Should NGOs maintain their independence from the government?

   A. NO

   B. YES

   Please explain your answer

   .....

   .....

   .....

   .....

7. Should the role of the NGOs change in the new dispensation?

   A. YES

   B. No

   If the answer is YES, please indicate how?

   .....

SECTION B : NATURE AND FUNCTIONS OF NGOs (CHOOSE ONE ANSWER BY MAKING A CROSS ON AN APPROPRIATE BLOCK)

8. NGOs have been carrying out functions which were considered to be state responsibilities.

9. Community must be involved in shaping health care services.

10. NGOs are one of the sets of organisations which limit the power of the state in relation to the lives of the citizens.

11. NGOs have taken up the challenge of promoting collaboration to help the poor cope with their needs.

12. A redistribution of health workers to under services areas has to take place.

13. NGOs act as a pressure group to government structures.

14. NGOs can utilize resources more effectively then government.

15. The services of NGOs should not be integrated with the rest of health services.

QUESTION	STRONGLY DISAGREE	DISAGREE	NOT SURE	AGREE	STRONGLY AGREE
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

SECTION C : FUNDING OF NGOs (CIRCLE ONE ANSWER)

16. Which one of the following has been the major lifeline for addressing health problems in your community?

A. Private sector

B. Public sector

C. NGOs

17. Who should finance the NGOs in future?

a. National Government

b. Provincial Government

c. Local Government

18. Where should local NGOs help most?

a. Education

b. Health

c. Housing

19. With the new government in power who in your opinion would get more funding from foreign Donor agencies?

a. Government

b. Private sector

c. NGOs

20. In your opinion where should funding for NGOs be obtained from?

a. National Government

b. Foreign agencies

c. A and B

21. Additional comments:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Thank you for your time and assistance in completing this questionnaire.

Yours sincerely

Basil Siphiwe Ndlovu

Reg No: 8934021

(Phone No : 031 2629127 - 192).

ANNEXURE A 2

QUESTIONNAIRE A2

SWOT analysis for non-governmental organisations (NGOs) providing health care services in KwaZulu-Natal.

Guidelines to completion of questionnaire:

- Please read the entire form before making any entries.
- Answer each question accurately and carefully as possible.

NB: NGOs refer to non-governmental organisations that are specifically rendering health care services.

1. Name of your Non-Governmental Organisation (NGO).

.....

.....

2. Describe in brief the role of your NGO with respect to health-care delivery.

.....

.....

.....

.....

.....

.....

3. What is your mission statement? (Please attach)

4. Mention the four most dominant strengths of your NGOs.

a. .....

b. .....

c. .....

d. .....

5. What would you consider your four major weaknesses?

a. .....

b. .....

c. .....

d. .....

6. Mention four of your opportunities.

a. .....

b. .....

c. .....

d. .....

7. What are your four main threats?

a. .....

b. .....

c. .....

d. .....

8. Additional comments

.....

.....

.....

.....

.....

Thank you for your time and assistance in completing this questionnaire.

Yours sincerely

Basil Siphiwe Ndlovu

Reg No: 8934021

(Phone No : 031 - 2629127 - 192).

ANNEXURE B1 : MISSION STATEMENT - THE VALLEY TRUST

MISSION STATEMENT

The Mission of THE VALLEY TRUST is to offer quality education and training associated resources in fields relating to comprehensive primary health care and sustainable development, to strengthen the capacity of individuals and communities to improve their own quality of life .

ANNEXURE B2:

MISSION OF THE HEALTH SYSTEMS TRUST

"The Health Systems Trust is committed to a health care system which meets the needs of all South Africans. It seeks to help realise this vision through independent support for research and skills development aimed at improving policy and planning at all levels, as well as other strategic initiatives which move us toward this goal".

ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH SERVICES IN KWAZULU-NATAL

BY

NDLOVU BASIL SIPHIWE

DISSERTATION

Submitted in fulfilment of the requirements for the degree Magister Administrationis (M.Admin) in the Department of Public Administration at the University of Durban-Westville.

(Funded by the CSD, HSRC, South Africa)

Supervisor : Professor D Sing

Date Submitted : January 1999

DECLARATION

I hereby declare that the ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH SERVICES IN KWAZULU-NATAL is entire my own work and that all sources used or quoted have been acknowledged.

NDLOVU BASIL SIPHIWE

....

Signature Date

ACKNOWLEDGEMENT

Firstly, I am thankful to the Almighty GOD for granting me strength to complete this study.

I express my gratitude to my Supervisor, Professor D Sing for his invaluable guidance and encouragement during this study.

I also wish to extend my appreciation to all the interviewees (respondents) who willingly participated in this study.

The financial assistance of the Centre for Science Development, (HSRC, South Africa) and a research grant from the University of Durban-Westville towards this research is hereby acknowledged.

Several individuals and organisations have assisted in this study and I am grateful to the following people for their resources and information:

The Health Systems Trust

The Valley Trust

The Don Africana Library

I express my appreciation to my mother for her support and motivation during my studies.

Finally, my thanks and appreciation goes to all other individuals who assisted me during this study.

A BIG THANK YOU TO YOU ALL!

ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH SERVICES IN KWAZULU-NATAL

By

Basil Siphiwe Ndlovu

SYNOPSIS

Supervisor	:	Prof. D. Sing
Degree	:	M. Admin
Faculty	:	Commerce and Administration
Department	:	Public Administration
University	:	University of Durban-Westville

This dissertation focuses on the role of non-governmental organisations in provision of health care services in KwaZulu-Natal. The study had three objectives which were:

- identify the role of non-governmental organisations in the provision of health in KwaZulu-Natal.
- describe mechanisms for enhancing collaboration between the government and non-government organisations.
- investigate mechanisms for redistribution of resources from the public and private sectors to the non-government organisations.

The Nationalist Party government, supported by its apartheid policies created imbalances in the provision of services in South Africa. Generally speaking, inequity in all spheres of life was visible between the white population which was the minority and their counterparts, the blacks which were the majority. Health care services were fragmented and divided in racial lines. The whites who were predominantly located in urban areas had access to curative health care which was affordable to them. The blacks were located in rural areas which were referred to as homelands. The health services were minimal and in most places they were unavailable. Curative facilities provided by hospitals and clinics were situated long distances from where the majority of the population could find them. Transport facilities like roads were not well developed, ambulances and health care workers were not available. Health care facilities was inadequate in these areas.

The health care provided by the apartheid government was inadequate and structures which were outside the government known as non-government organisations were formed. These NGOs acted as the first line of health defence to the marginalised sectors of the South African communities. Non-governmental organisations were also functioning in the province of KwaZulu-Natal and some were comprehensive in approach and did not provide only health services but also training and education, housing, social services and other development activities. The role of these non-governmental organisations involved the following:

- improving health in the most remote and disadvantaged communities, for example, informal settlements, rural and the ultra poor areas.
- providing integrated and comprehensive services, for example, employment generating projects, education and training and housing.
- unifying the different racial groups and breaking down prejudices and assumptions with regard to race and gender.

Although non-governmental organisations operated in South Africa, there was always confrontation between the government structures and NGOs, particularly those which were actively involved in the upliftment of the lives of the previously disadvantaged communities, namely the blacks. These non-governmental organisations provided these services under a variety of unpleasant conditions, characterised by assassinations, tortures

and imprisonment. These NGOs were banned by the government and others operated under restrictive and authoritarian government policies.

The recent political changes which took place in South Africa - the unbanning of political organisations like the African National Congress and the Pan Africanist Congress highlighted the need for transformation in all aspects of life. In 1994 a democratic government which was ANC-led was legitimately elected. The government of national unity was committed to the upliftment of the lives of all South Africans, particularly the provision of health care for all. People were extremely optimistic when the new government (GNU) came into power.

The role of non-government organisations was theoretically non-existence and minimal as the government was aiming at providing health care services to the previously disadvantaged communities. Foreign donors and funders redirected their financial assistance to the government and the funding was between government to government. The personnel from non-governmental organisations was recruited to business and government sectors which also challenged NGOs to replace these dedicated and committed people. The funding problem has become a major challenge to non-governmental organisations and most of them have been forced to shut down. The political transformation has challenged non-government organisations to reposition

themselves and work with government in the upliftment of the lives of all South Africans. The government of national unity is committed to the provision of equitable, preventive, promotive, curative and rehabilitative services at all community levels, particularly the previously disadvantaged.

The researcher has identified two non-governmental organisations as a case study and these NGOs are providing health care services in KwaZulu-Natal. The NGOs are the Health Systems Trust and the Valley Trust. In addition to these two NGOs literature which was relevant to this study was also reviewed.

The researcher reached the following conclusions after the findings of the study were analysed:

- Non-governmental organisations have played an important role in the past in the upliftment of the lives of South Africans.
- Resources have been inequitable been distributed and there is a need to redistribute these resources equally.
- South Africa is faced with health problems which needs all stakeholders to be involve in order to eradicate ill-health.

The study offers a number of recommendations based from the conclusions which can be generalised to non-governmental organisations providing health services.

ABBREVIATIONS

ANC	-	African National Congress
AIDS	-	Acquired Immunodeficiency Syndrome
CBO	-	Community Based Organisation
CHW	-	Community Health Worker
CHESS	-	Centre for Health Education and Social Studies
DHS	-	District Health Systems
EU	-	European Union
GNU	-	Government of National Unity
HIV	-	Human Immunodeficiency Virus
HSRC	-	Human Sciences Research Council
HST	-	Health Systems Trust
IFP	-	Inkatha Freedom Party
IMR	-	Infant Mortality Rate
KZN	-	KwaZulu-Natal
NGO	-	Non-Governmental Organisation
NHIS/SA	-	National Health Information System of South Africa
NHS	-	National Health System
NNP	-	New National Party
NPA	-	Natal Provincial Administration
NPPHCN	-	National Progressive Primary Health Care Network

PHC	-	Primary Health Care
PHID	-	Project for Health Information Dissemination
PSC	-	Public Service Commission
PSNP	-	Primary School Nutrition Programme
RDP	-	Reconstruction and Development Programme
STD	-	Sexually Transmitted Diseases
SWOT	-	Strengths, Weaknesses, Opportunities, Threats
TB	-	Tuberculosis
UNICEF	-	United Nations Children Fund
VHW	-	Village Health Worker
VO	-	Voluntary Organisation
WHO	-	World Health Organisation

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CHAPTER 1

GENERAL INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Access to basic rights such as education, housing, water, electricity, refuse removal, sanitation facilities, nutrition and health, is still beyond the reach of a large proportion of the population. Disadvantaged people do not perceive that health rights are for them. The circumstances of their lives such as travelling distances, long waiting times, lack of money the disrespectful attitudes of health care providers, their lack of knowledge about when, where and how to seek appropriate health services are experienced by many people as very disempowering and dehumanising (NPPHCN Annual Report 1996:20).

The apartheid government was inefficient in the provision of services, particularly in the provision of health care services to the majority of its population and this led to the emergence of the non-governmental organisations which were formed to challenge these injustices. Non-governmental organisations mainly targeted those sectors of South African population which were the most vulnerable, ***viz*;** blacks, rural, poor, women, children and the neglected communities.

NGOs have historically provided local health services under a variety of conditions in South Africa. In most cases NGO services have filled a void created by neglect of health care needs for under served populations. In many instances NGOs have paved the way for development of sustainable health care services at the community level. In other instances NGOs have the capacity to create innovative services which do not fit into conventional health service provision (ANC 1994:72).

It is important to note that the apartheid government through its discriminatory policies created two classes of citizens in South Africa and the population was divided in racial lines. Non-governmental organisations then came into existence to bridge the gap between the wealthy and poor. However, this was a challenging task because NGOs had to operate under restrictive measures which ensured that the ***status quo*** (apartheid) prevailed.

Political changes in South Africa, especially after 1994, when the democratically elected government (ANC-led Government of National Unity-GNU) came into power challenged the role of non-governmental organisations, as Pavlicevic (unnumbered) noted that much has changed in South Africa since the advent of a new democratic government, not least of which is the role of NGOs. Under the old regime (apartheid),

NGOs have a firmly established place in resistance to the government. Because of the involvement of the anti-apartheid movement, they had access to funding as well as both national and international expertise and support.

In this chapter the researcher provides an overview of the whole study which includes objectives, hypotheses, study area, research methodology, terminology, limitations of the study, layout and overview of chapters and finally the conclusion of the first chapter.

1.2 OBJECTIVES OF THE STUDY

The study had three objectives which were to:

- Identify the role of non-governmental organisations in the provision of health services;
- Describe practical mechanisms for enhancing collaboration between the government and non-governmental organisations; and
- Identify mechanisms for the reallocation of resources from the government and private sectors to the NGO sector.

In order to achieve the objectives of this study a number of questions were raised by the

researcher and included among others the following:

- What was the past, present and future role of non-governmental organisations in the provision of health services?
- What was the nature and functions of non-governmental organisations?
- Is there any relationship between government, business and the NGO sector in the provision of health services?
- Where should funding for NGOs be obtained from?
- How should the available resources be equally shared among all health stakeholders?

It was the objective of this study to find possible answers to these questions and the findings of this study are presented in the later sections (chapter five and six) of this study and are not only limited to KwaZulu-Natal but are also important for South African Health.

1.3 HYPOTHESES OF THE STUDY

The study generated three hypotheses which the research was based on and are:

HYPOTHESIS: 1

Non-governmental organisations will continue their role of providing health care services to the disadvantaged communities.

HYPOTHESIS: 2

Many non-governmental organisations will be incapable of sustaining themselves without resources from international donors.

HYPOTHESIS: 3

Non-governmental organisations in South Africa will emerge as developmental activists in the democratic era (after the 1994 general elections).

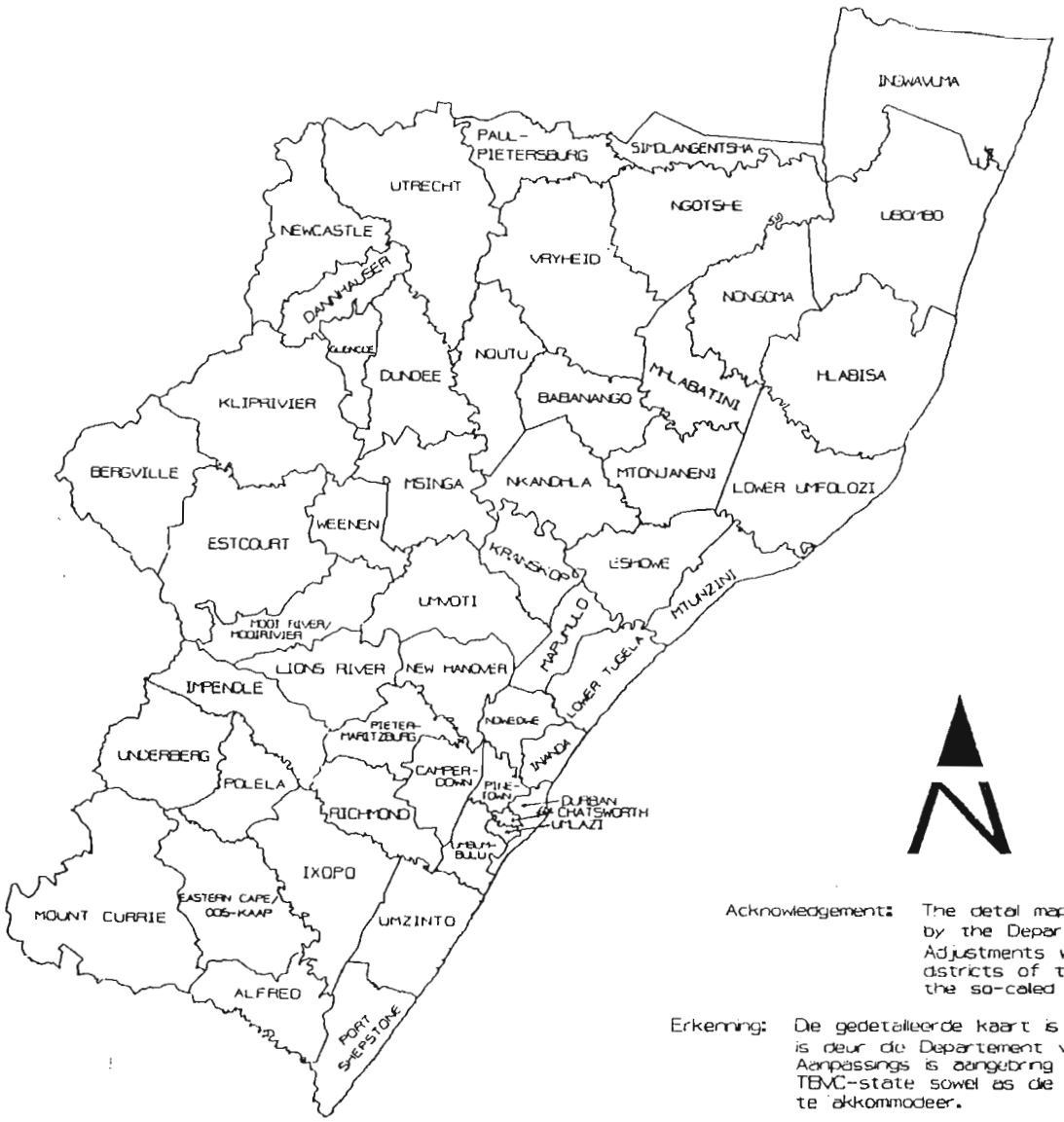
The three hypotheses that were generated by this study were tested through a research that was conducted in the KwaZulu-Natal province and the findings are also presented in chapter five of this study. The study was aimed at investigating whether these three hypotheses could be substantiated or not.

1.4 STUDY AREA

The study was conducted in South Africa, with particular emphasis in the province of

KWAZULU/NATAL BY DISTRICT

KWAZULU/NATAL PER DISTRIK



Acknowledgement: The detail map is based on co-ordinates provided by the Department of Regional and Land Affairs. Adjustments were made to accommodate the districts of the former TBVC states as well as the so-called self-governing territories.

Erkenning: Die gedetailleerde kaart is gegrond op koordinate wat verskaf is deur die Departement van Streek- en Grondsake. Aanpassings is aangebring om die distrikte van die voormalige TBVC-state sowel as die sogenaamde selfregerende gebiede te akkommodeer.

FIGURE 1: KWAZULU-NATAL MAP

KwaZulu-Natal (Figure 1). There are a number of non-governmental organisations that are operating in this province and they include the RED CROSS and the National Progressive Primary Health Care which are also involved in the provision of health care services. Two non-governmental organisations were chosen for this study and are the Health Systems Trust and the Valley Trust. These two NGOs operate around the province and were chosen because of their relevance and accessibility in terms of resources and scope for this study. The Premier of KwaZulu-Natal (by March 1999) was Mr. Lionel Mtshali from the Inkatha Freedom Party and the Provincial Health Minister was Dr. Zweli Mkhize of the African National Congress.

According to the Health Care (1996:9) the total population of KwaZulu-Natal is 8.5 million with 39% of the total population under 15 years of age. The average population density is 93 people per kilometre ranging across regions from 40 - 1064. Over three fifths of the population (63%) live in areas classified as rural. The health service formerly under the Administration of KwaZulu, the Natal Provincial Administration, the Department of National Health and Local Authorities, need to be brought with the private sector to create one coherent health service. Formerly, the Natal Provincial Administration was responsible for hospitals, curative care and limited preventative care in the area, whereas the KwaZulu Administration rendered all services in all areas under

its jurisdictions.

The KwaZulu-Natal MEC Dr Zweli Mkhize has a daunting task of integrating these fragmented Departments of health into one coherent, efficient and effective health department. The other challenges are to integrate other sectors like the NGO sector as well as traditional healers into the main stream which are arguable the most accessible and affordable sectors to the majority of rural communities in KwaZulu-Natal. Fragmentation of this department created inequity in the provision of health care services and resulted in one group of the society being under served and the other which was over served. As highlighted earlier in this study, one of its objectives was to find mechanisms of reallocation of resources from previously advantaged communities to those who were disempowered.

1.5 RESEARCH METHODOLOGY

As no similar research was previously conducted in KwaZulu-Natal, an exploratory research of both qualitative and quantitative nature was used to collect the relevant information for this study. This study was conducted and completed over a period of thirty (30) months. A study of available literature on non-governmental organisations

that were providing health services was undertaken. Two questionnaires (A1 and A2) were piloted before they were administered to the communities and NGOs, respectively. Visits to the Health Systems Trust, The Valley Trust, local hospitals, libraries and KwaZulu-Natal Health Department were made, to collect more relevant information. The fieldwork was conducted between July 1997 and August 1998 and interviews were scheduled and conducted with the relevant officials and community members. The media (T.V., newspapers and the radio) also provided with the latest developments and relevant information.

1.6 TERMINOLOGY

For the purpose of this study the terminology used will be defined within the Public Administration context and the terms will include: apartheid, district health system, non-governmental organisation, primary health care and reconstruction and development programme which are all important and relevant to this study.

1.6.1 APARTHEID

Fox and Meyer (1995:7) define apartheid as "... the value system which, from 1948 to

1990, was the basis of the official policy of the Union, and later Republic, of South Africa. The most important point of departure of this value system is that race, or acceptance by a racial group, is the basis on which a person's role within the state is defined. The clear ideological component of apartheid is reflected in its philosophical basis and its practical application. Various statutory measures were taken to separate whites and blacks by, ***inter alia***, establishing separate residential areas, transport facilities, educational institutions, public amenities, churches and political representation. During the 1960s the emphasis was placed on **"development"**, and the Nationalist Party's policy was renamed **"separate development"**. This resulted, ***inter alia***, in the creation of political institutions, economic structures and the selective development of human potential.

1.6.2 DISTRICT HEALTH SYSTEM

A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost a well defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private [or]

traditional. A district health system therefore consist of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services (ANC 1994:62).

1.6.3 NON-GOVERNMENTAL ORGANISATION (NGO)

Not belonging to or associated with government (Tullock 1993:1032).

Bonbright and Honey in (Kleinenberg 1994) define non-government organisation as "... civil society refers to all society outside the government sphere of life. It includes the non-government for profit sector which we call business, and the non-government, non-profit sector sometimes called the voluntary or NGO sector".

1.6.4 PRIMARY HEALTH CARE (PHC)

Primary health care is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should

be involved in it (The Valley Trust 1987-1988:78). The National Health Plan For South Africa (1994:20) also states that "... PHC will form an integral part of the country's National Health System, of which it will be the central focus, while the PHC approach will guide the overall social and economic development of the community".

1.6.5 RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)

According to the African National Congress (1994:1) RDP is an integrated, coherent socio-economic policy framework. It seeks to mobilise all our people and our country's resources toward the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future.

For the purpose of this study non-governmental organisations and voluntary organisations will be used interchangeably and will mean the NGO sector as defined above.

1.7 LIMITATIONS OF THE STUDY

Among the problems the researcher confronted, was the refusal from the 'would -be'

respondents to participate in the study. This was experienced mostly in the rural areas, especially from heads of households (usually males) who refused to participate in the study and sometimes did not allow any member of his family to participate. These people thought the study was political and were not interested in political issues, however the researcher explained that the objective of the study was mainly on health-related issues.

The study was limited to the KwaZulu-Natal province. Conducting the study in areas that were under the jurisdiction of traditional leaders (**Amakhosi**) was very unpleasant and frustrating due to restrictions imposed. This is because in rural areas traditional leaders still play an important role in organising and deciding on events and action within the community.

The other problem for this study was that of 'no-go areas' whereby areas were controlled by a particular dominant political group and there was animosity and even violence between the opposing groups and sometimes the views of opposing group/s were unacceptable to the other group and therefore suppressed.

Documents that were important for this study were not disseminated freely and

sometimes the respondents especially those from the non-governmental organisations were not available for the scheduled interviews and this increased the cost burden on the researcher. Lack of transport in some areas was also a problem.

1.8 LAYOUT AND OVERVIEW OF CHAPTERS

This study is divided into six chapters in which the reader is introduced to the study and conclusions and recommendations are presented in the final chapters.

CHAPTER 1

GENERAL INTRODUCTION AND BACKGROUND

Chapter 1 is the general introduction in which the researcher provides the background for this study. This chapter included the objectives of the study, hypotheses, study area, methodology, terminology, limitations of the study, layout and overview of chapters and finally the conclusion of the chapter. This chapter provides the reader of this dissertation with a brief overview of this study.

CHAPTER 2

NON-GOVERNMENTAL ORGANISATIONS:

A THEORETICAL PERSPECTIVE

Chapter 2 reviews literature associated with the NGO sector. The international perspective on NGOs is significant for this study as most local NGOs were financial viable through the support of foreign governments and donors. This chapter discusses the following topics which falls under the non-governmental organisations and are the:

- terminology
- history
- characteristics (both international and local)
- strengths, weaknesses, opportunities and threats
- relationship with government (past and present); and
- summary.

This chapter provides the theoretical background of non-governmental organisations which the study was based on and also provides with a global perspectives on how NGOs emerged and the role they played in their respective communities.

CHAPTER 3

SOUTH AFRICAN HEALTH POLICY

AND NON-GOVERNMENTAL ORGANISATIONS

Chapter 3 discusses the history of the South African health and how it was structured and the fragmentation in the provision of health care services which resulted in the majority of the population neglected by the government. Non-governmental organisations came in to fill the void created by the government. Like any other organisation Pavlicevic states that "... NGOs usually operate within the framework of a constitution, or founding document which outlines the structure of the organisation ...". The chapter discusses how these organisations operated under the oppressive health laws of the past government.

In the past, apartheid laws were oppressive and discriminatory to the majority of the population which marginalised them to an inefficient and ineffective curative health system. Preventative health measures were provided to a minority group and health care services did not reach all the sectors of the South African population. The political reforms that occurred in 1994 whereby the apartheid regime of the Nationalist Party was replaced by a democratic Government of National Unity which is ANC-led, saw a

transformation in all aspects of South Africa. Although there are health policies that have been implemented, the overall process is very slow. This chapter discusses the health plan for South Africa and includes:

- national health plan
- national health bill
- national health act
- provincial health legislation
- reconstruction and development programme and GEAR
- taxation of non-governmental organisations; and
- summary.

CHAPTER 4

ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH CARE: a Health Systems Trust and the Valley Trust case study

Chapter 4 presents the findings of questionnaire A1 in which two non-governmental organisations that are providing health care services in KwaZulu-Natal were selected for the study. Most of the fieldwork for this study was conducted in the Health Systems

Trust and Valley Trust. Research through interviews and observations was conducted in the respective communities of these two case studies. The chapter provides the reader of this text with the role of non-governmental organisations in the provision of health services in KwaZulu-Natal.

CHAPTER 5

RESEARCH FINDINGS: ANALYSIS AND INTERPRETATION OF DATA

Chapter 5 analyses and interprets the findings of questionnaire A1 and A2. The bar diagrams and tables are used to illustrate the findings. The findings in this chapter can be generalised to KwaZulu-Natal because the non-governmental organisations that were studied have been providing health care services (Valley Trust) and disseminating and providing health information and services (Health System Trust) to the population of KwaZulu-Natal.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

Chapter 6 is the final chapter of this study and draws conclusions on the role of non-

governmental organisations in the provision of health services in KwaZulu-Natal. It was the conclusion of this study that non-governmental organisations have contributed significantly to the promotion of better health in the province and as the country is faced with health problems like chronic disease such as HIV/AIDS, cancer, TB and others, the NGO sector has a future role to play for South African health. The study also provided with a number of recommendations which were based from this study.

The bibliography and appendices that were relevant to the study were also included.

1.9 SUMMARY

This chapter has provided the reader of this dissertation with the background and the overview of the non-governmental organisations that are providing health services in KwaZulu-Natal. The chapter included the objectives of the study, hypotheses, study area, research methodology, terminology, limitations of the study, layout and overview of chapters and the summary of the study. The following chapter will discuss the theoretical perspective of non-governmental organisations.

CHAPTER 2

NON-GOVERNMENTAL ORGANISATIONS:

A THEORETICAL PERSPECTIVE

2.1 INTRODUCTION

Organisations are groups of people who come together for a common purpose. There are profit making organisations or business in which people come together to make and sell products or to provide a service in order to make a profit. In a non-profit making organisation the main purpose is to serve people in some way, and not to make money (Pavlicevic 1996:1).

This chapter reviews literature on both international and local non-governmental organisations and organisations that are associated with the NGO sector in order for the reader of this text to theoretical understand the non-governmental organisations. This chapter discusses the following topics of non-governmental organisations:

- terminology
- history

- characteristics (both international and local)

- strengths, weaknesses, opportunities and threats

- relationship with government (past and present); and

- summary of the chapter.

2.2 TERMINOLOGY

It is important for this study to provide the reader of the text with definition of terms that are used in this chapter and they include; non-governmental organisations, voluntary organisations and community-based organisations.

2.2.1 NON-GOVERNMENTAL ORGANISATIONS (NGOs)

Pavlicevic (1992:2) states that there is usually a fairly large group of non-government, non-profit organisations which are funded by members, or donors. In South Africa these are usually called NGOs (Non-Governmental Organisations).

Non-governmental organisations (NGOs) embraces a variety of organisations. A working definition that perhaps proximate all the features ascribed to NGOs is offered

by Bernstein in Reddy (1996:254) "... NGOs are non-profit groups outside of government, organised by communities or individuals to respond to basic needs that are not being met by either the government or the market. Some produce goods; others deliver services; and some of the largest do a combination of both. The groups are either formed at the neighbourhood level, by and for the community, or at a regional level where they have intermediary functions".

These NGOs are non-profit and have the common objective of restoring dignity to the lives of its communities. Sometimes the term civil society is used as in the following definition: Civil society refers to all society outside the government sphere of life. It influences the non-government for profit sector which we call business, and the non-government, non-profit sector sometimes called the voluntary or NGO sector (Kleinenberg 1994:1).

de Beer & Swanepoel (1994:17) also define NGOs as organisations not in any way dependent on or responsible to either the public or private sectors. Usually NGOs come into existence to address specific problems e.g. health (Valley Trust)... they address a number of problems in the field of development.

2.2.2 VOLUNTARY ORGANISATIONS (VOs)

Voluntary-organisations (VOs) are also non-profit organisations. They are defined by Kjaerum (1993:13) as nonprofit and nongovernmental (***sic***) organisations, organised by groups of people in the sphere of civil society, working for a cause for the benefit of society, which very often contribute as well to the development of democracy.

Voluntary organisations usually employ voluntary workers who are not paid or sometimes who are not full-time employees and do not posses the highest expertise of the job. However, this has been changing over the years in such that the voluntary workers are now become highly skilled and can match their counterparts from the private as well as the public sector.

2.2.3 COMMUNITY-BASED ORGANISATIONS (CBOs)

Community- based organisations (CBOs) are non-profit organisation working within specific localities in which they provide services for the local communities. CBOs may include churches, schools and local institutions which are not government structures. These local structures are elected by the people to represent them and provide them with

the goods and services they need (Kleinenberg 1994:3).

The community-based organisation is also known as the popular sector and de Beer & Swanepoel (1994:17) argue that popular sector, ... consists of organisations founded in and run by individuals or groups within communities.

2.3 HISTORY OF NON-GOVERNMENTAL ORGANISATIONS

NGOs vary in size, activity, organisational form, goals and objectives. They range from informal to formal, small or large, rural to urban, conservative to liberal and they differ from place to place. However, they aim at improving the lives of individuals or groups which are being neglected by the government. NGOs range from politically aligned to women, social and those who are providing health care services like those discussed in Chapter four. According to Kjareum(1993:15) NGOs exist for different reasons which may include:

- tension between state and civil society
- ineffectiveness and inefficiency of the government
- competition with the government

2.3.1 OLD NON- GOVERNMENTAL ORGANISATIONS

Carrol (1992:19-20) revealed that the old NGOs were:

- Ranging from baking clubs to women lawyers associations.
- They perform welfare work and are also involved in income generating activities for women which are dominated by white liberal women.
- They support only those activities which could support (or at least not challenge) colonial power and its economic structures.
- The traditional NGOs are generally characterised by weak management and organisational structures.
- Although the NGOs had been implementing income generating projects for women on a large scale.
- These traditional NGOs usually have reinforced women's marginal position by focusing on women's traditional roles as mothers and home-makers only.
- The accountability of many NGOs is no longer to the constituency they represent but rather to the donor agencies who fund them.
- Some NGOs claim that they have evolved from welfare organisations to development. But with the same structures and staff in place, this is questionable.

- These old fashioned income generating projects had not befitted women at all and that it is time to re-address their approaches.

2.3.2 NEW NON-GOVERNMENTAL ORGANISATIONS

Carrol (1992:21) distinguishes between old and new NGOs as follows:

- This type is mainly urban based and tends to take a more activist stand.
- These organisations usually emerged from a group of (women) who came together on a professional basis and who had realised that neither government nor the old NGOs could be expected to work effectively towards women's emancipation.
- They have an advantage over the more traditional organisations as they start off on a more professional basis, often being in a position to learn from the mistakes of traditional NGOs.
- The organisational and management structure is generally more professional.

Carrol (1992:9) uses the terms grassroots support organisations (GSOs) and membership support organisations (MSOs) when referring to non-government organisations (NGOs). He argues that GSOs and MSOs are the two sets of the broad spectrum of NGO and he

also states that NGO term encapsulates hundreds types of organisations which many vary from political organisation to church and sports clubs. However, he maintains that MSOs and GSOs are only those NGOs with specific developmental purposes and also function at a certain level. He also makes a distinction between GSOs and MSOs on the basis of ownership and he states that in the former the members are not the beneficiaries whilst in the latter the stakeholders and the beneficiaries is the members.

(i) GRASSROOTS SUPPORT ORGANISATION (GSO)

A GSO is a developmental body that offers services and support to disadvantaged groups and individuals. It acts as in intermediary between these beneficiaries and often remote levels of government, donor and financial institutions. It may also perform a networking function by providing services to other organisations that support the poor (Carrol 1992:11).

The Valley Trust has been supporting remote areas and communities though projects that were aimed at eradication of poverty, illiteracy and ill-health. These projects have been comprehensive in approach and through the networking of different stakeholders the disadvantaged communities have been reached.

(ii) MEMBERSHIP SUPPORT ORGANISATION (MSO)

MSO also provide support to local groups. An example is local cooperative or trade union. A second-level group will be an association of these base groups. A third-level can also be formed resulting in a national federation. The second and third-level membership organisations are referred to as MSOs (Carrol 1992:1).

In South Africa the membership support organisation can be associated to trade unions like the Congress of South African Trade Union (COSATU) which has be operating in the country and helping communities in different aspects of their lives, particularly in work-related issues like retrenchments and unfair labour practice by employers.

(iii) PRIMARY GRASSROOTS ORGANISATION

These organisations are distinguished from GSOs and MSOs by scope, level, complexity and function. They are the smallest group of individuals or households that engage in developmental activities which are of common interest. GSOs and MSOs operate on a

level above the grassroots organisation providing them with the necessary support (Carrol 1992:11).

These primary grassroots organisations work like the community-based organisations where they organise small projects like bricklaying, adult education and educare. These projects have been successful, especially in remote rural areas whereby infrastructure such as roads, schools and hospitals is unavailable. These facilities have been welcomed by the beneficiaries and have been instrumental in the upliftment of the lives of these communities. The community utilises the available skills and resources to achieve a common goal and the services provided are affordable and every member of the community contributes to the success of that particular project.

FIGURE 2 : GSOs and MSOs within the spectrum of NGOs
GSOs and MSOs are within the boxes (Carrol 1992:10).

PURPOSE

Political action
Advocacy of special interests

Advocacy combined with service or assistance to the base

Charity
Relief
Development

Economic development Social development Social business combined with equity objectives

MAIN ACTIVITY

Fraternal, social, recreational
Education

Education combined with development services or direct assistance Organisational assistance

Research
Research combined with development services
Lobbying

Lobbying combined with development services

Networking

Coordination, brokerage, representation

LEVEL

Local (single primary groups and communities)

Regional Locality (Grouping of communities) National

2.4 CHARACTERISTICS OF INTERNATIONAL NGOs

Non-governmental organisations or voluntary-organisations at an international level will differ from local NGOs. Kjaerum (1993:14) is of the view that voluntary organisations have common features which he lists them as follows:

Firstly, voluntary organisations do not belong to the apparatus of the state. They may seek to exert influence on the formation of public policy and they may be financially supported by the state, but they are legally and organisationally independent from the apparatus of the state (Kjaerum 1993:14).

Secondly, voluntary organisations are to be distinguished from commercial and profit-oriented organisations operating in the market place. Special features of voluntary nonprofit organisations are their idealistic mandate and commitment to a cause. Voluntary organisations may provide services for their members on a commercial basis (for example, by charging fees for services), but they do not act as companies or other business entities, striving for profit on the market (Kjaerum 1993:14).

Thirdly, voluntary organisations are conceived by groups of individuals pursuing common interests. Their organisational forms are nonformal in the sense that they are self-imposed (even though the organisational form is often highly hierarchical) and represent non elected groups of people. In this sense they often represent a "minority" in the society as opposed to the majority elected by the people to the national parliament (Kjaerum 1993:14).

Finally it should be stressed that the defining feature is the activity more than their common interest. The very activity of members of sympathisers of voluntary organisations acting in the grey zone between state and market is quite simply their prime resource. This is opposed to the state's legitimate monopoly of power and the capital accumulated in private companies (Kjaerum 1993:14).

Pavlicevic (1996:3) also identifies five characteristics of international non-governmental organisations as follows:

- They meet a non-commercial need by providing services and occasionally material products (like food or clothing) to their members, or to members of the greater community.

- They rely to a large extent on being able to raise money from members, donors or the general public.
- They are accountable to those who benefit from their service, and to the wider community which provides financial support.
- They measure success by how well they meet the need they were set up to deal with.
- They have some form of governing or controlling body which is finally responsible for seeing that the money raised is used for its intended purpose (Pavlicevic 1996:3).

2.5 CHARACTERISTICS OF SOUTH AFRICAN NGOs

Although South African NGOs share many characteristics of international NGOs, they have their unique features which are identified by Cross in Reddy (1996:262-264). The oppressive and discriminatory policies of the previous Nationalist Party regime marginalised the majority of South African in all spheres of lives. There was inequity in the provision of services. The emergence of NGOs in South Africa took its own direction which was sometimes is in contrast with the other parts of the world.

Cross in Reddy (1996:262) argues that many South African non-governmental organisations originated from an anti-apartheid constituency, and therefore viewed the state as an enemy or hostile entity. Therefore, there was great deal of opposition between NGOs and the state.

He continues the argument that many of them (NGOs) developed around charismatic individuals who emerged during the era of mass struggle, who assumed leadership positions, and who now find themselves engaged in development work. In the process an element of possessiveness about their NGOs has taken root. An innate prosperity towards rivalries and "turf wars" between NGOs had also developed. This has become more problematic and intensified as some NGOs constitute a vehicle for the ambitions of particular individuals.

Some NGOs could more appropriately be described as "tribunate" (`claiming to speak in the name of the people') organisations rather than as purely voluntary. They are structures that have a particular political intent with an implicit agenda to capture and manage the process of community mobilisation at an intermediate level. This is the aftermath of decades of political struggle. Such organisations tend to impede the goal of promoting social and economic advancement, as their dominant purpose is to control

the development process in order to benefit from the patronage, status and prestige derived from the delivery of basic social services. Arguably, in the South African NGO context, `populism, development and democracy' have often been viewed as `strange bedfellows' (Reddy 1996:263).

It is important to note that there are a number of different perspectives about NGOs and besides that they differ in activities and sizes. Nevertheless they also have some commonalty in which most of the NGO sector is associated with and that is working towards the upliftment of communities and societies especially those who are perceived as disadvantaged. However, these communities differ from place to place for example, European countries look at the disadvantaged communities as the minority groups whilst African and Asian countries define the disadvantaged groups as the majority who are disempowered. Basically the characteristics of NGOs that are common outweighs the differences of these NGOs. The characteristics of these NGOs are also determined by the role they play and this will be discussed in Chapter four of this study. The characteristics of NGOs providing identical services will also differ from country to country, for example, those NGOs from United States of America that are providing with health care services will differ from those NGOs functioning in Ethiopia because of the difference in needs, resources (human, natural and otherwise) and also because

of the development levels between the two countries. As mentioned earlier the objective will be the same and that is rendering of health care services to the disadvantaged groups.

2.6 ROLE OF NON-GOVERNMENTAL ORGANISATIONS

The role of NGOs is numerous and is ever escalating. Governments are loosing the battle against NGOs, the people are loosing trust of their governments. Even in democratic governments most of the disadvantaged communities are being catered for by the NGO sector especially those who are in remote areas like rural, informal settlements and unproductive areas. The roles of NGOs will also differ from organisation to organisation. Kjareum (1993:15-16) highlighted the following common functions:

- Articulating the demands of citizens;
- Encouraging diversity and growth of opinions;
- Being agents of political mobilisation;
- Being agents of political socialisation;
- Providing early warning mechanisms, on a national as well as international level;

- Being a buffer against the state and against the market.

2.6.1 ARTICULATING THE DEMANDS OF CITIZENS

According to Kjareum (1993:15) a key function of voluntary organisations is their role in the articulation of the demands of citizens and thereby transformed into political process. This process is often fueled by in-depth analysis and monitoring of government policy by NGOs. The so-called "watchdog" function.

2.6.2 ENCOURAGING DIVERSITY AND GROWTH

Voluntary organisations play an important role in encouraging diversity and the growth of different opinions. This is supported by Kjareum (1993:15) when he argues that freedom to join or form an organisation is one of the fundamental democratic rights on a par with the right to vote and the freedom of expression. It is often assumed in democratic theory that this right is utilised so as to facilitate the formation of organisations that compete against each other.

2.6.3 AGENTS OF POLITICAL MOBILISATION

One effect is the facilitation of integration of groups in civil society and into the country's political process. An obvious example is organisations supporting migrant workers and refugees, not to mention their own organisations. These organisations are crucial for migrants and refugees when they want to be heard as a minority and when policies are counter-productive to their integration into the society of the new country. Another effect is that government, in responding to the pressure from all these diverse and mutually competing organisations, can obtain a higher political quality (Kjareum 1993:15).

2.6.4 AGENTS OF POLITICAL SOCIALISATION

According to Kjareum (1993:15) voluntary organisations also function as agents of political socialisation. Through activities in voluntary organisations individuals are trained in the role of ***homo politics***. Organisations working under repressive regimes often reflect undemocratic tendencies in their own structure.

2.6.5 EARLY WARNING MECHANISM

Voluntary organisations also assume the role of being an early warning mechanism. The international network of voluntary organisations is an important factor in disseminating information about undemocratic tendencies or repression in a given state, information that is normally not accessible to government institutions like embassies. An international network also affords protection against repression from the state, since an international reaction can be expected if an organisation does not get the opportunity to work freely within the framework of the state (Kjareum 1993:15).

2.6.6 BUFFER AGAINST STATE AND THE MARKET ECONOMY

Voluntary organisations ***defacto*** perform a protective function, partly because public policies often are implemented through networks of voluntary organisations, and partly because the social acceptance or legitimacy of state policies to a certain extent depends on voluntary individuals. Voluntary organisations also function as a buffer against the market economy (Kjaerum 1993:15-16).

Non-governmental organisations all over the world have been playing a developmental

role. Without the NGO sector the disadvantaged communities will suffer. The governments with their limited resources are unable to fulfil all the needs of its people. The bureaucracy that is involved in government institutions makes the delivery to be ineffective and inefficient. The centralisation of power makes decision-making to be slow.

2.7 STRENGTHS OF NON-GOVERNMENTAL ORGANISATIONS

The strengths of NGOs represent the weaknesses of the public sector. This section will focus on the strengths and opportunities of the NGO sector especially in the health care delivery. According to Brown & Korten (1989:16) NGOs have the following capacity:

- fend for the poor and other groups not served by public or private sectors. This commitment is related to their dedication to helping the poor and other disadvantaged groups;
- ease the mobilisation of local resources and the establishment of private organisations to promote participatory development. NGOs are very versatile and can easily identify and adapt to local needs and circumstances;

- provide basic services at low cost. This is related to the NGOs capacity to galvanise local resources and voluntary labor; and
- find creative solutions to unique problems and to promote successful innovation in the public sector. This capacity is related to 'their small size, administrative flexibility, and relative freedom from political constraints.

The strengths of NGOs in the delivery of health care are identified in the Health Systems Trust (1994:6-8) as follows:

- Filling the gaps
- Involving communities
- Nurturing democracy and equality
- Holistic approach
- Committed leadership and workers
- Responsiveness and flexibility; and
- Optimal use of resources
- Building bridges
- Attraction of funding

2.7.1 FILLING THE GAPS

NGOs usually targeted people and areas which were relatively neglected by the public sector. The unfair provision of services under apartheid had meant that many disadvantaged groups did not even have their most basic needs addressed by the State. NGOs had played an important role in addressing these needs. CBOs had often also provided an affordable service where public services were unaffordable (Health Systems Trust 1994:6).

The apartheid government was providing health care service to a minority group which were whites and the majority of blacks were neglected. Those from the remote areas like rural, informal settlements and the former 'Bantustans' suffered the most.

2.7.2 COMMUNITY INVOLVEMENT

The close relationship that many of the NGOs had with the people they served is demonstrated by the fact that, in many communities, the health committees served as the ***defacto*** public representatives. Often, health was used as the development issue through which communities were organized. Communities often had considerable say in the

management of NGOs (Health Systems Trust 1994:7).

Community involvement is very important for the people to feel ownership of the projects and thereby respecting and being responsible for the property which they are in control of. Involving the community also has its advantage and that of developing the talents and skills the people have.

2.7.3 NURTURING DEMOCRACY AND EQUALITY

Within many organisation, a culture of democracy was engendered. Although clearly not unanimously recognized. NGOs had often played an important role in breaking down prejudices and assumptions, particularly with regard to race and gender. Democracy was important for the NGO sector whereby there is transparency within the organisation and accountability by all within the organization (Health Systems Trust 1994:7).

2.7.4 HOLISTIC APPROACH

As NGOs were confronted by the reality of the entire spectrum of people's needs, they

were often compelled to respond to all of these needs. Consequently, their approach tended to be more integrated and comprehensive than health facility-based intervention. Often, CBOs involved in health care delivery were also involved in other sectoral activities such as educare and employment generation (Health Systems Trust 1994:7).

The ANC (1994:22) supports the comprehensive approach and the view that most NGOs were not only concentrating on the health care delivery only but on other sectors that affected health.

2.7.5 COMMITTED LEADERSHIP AND WORKERS

People working in community-based organizations tended to be visionary and committed. The financial reward of working for NGOs was minimal. These voluntary workers were involved in health care delivery primarily to provide health care services to the disadvantaged and did not expected financial reward for the services because they knew that the people did not have the financial resources to compensate them (Health Systems Trust 1994:8).

2.7.6 RESPONSIVENESS AND FLEXIBILITY

The small size and close proximity to communities often meant that NGOs were able to adjust rapidly to people's changing needs (Health Systems Trust 1994:8).

Unlike their counterparts (government -which was remote and ineffective) and (private sector -which was expensive and unaffordable), NGOs were always with the people and they understood the people's needs and were able to respond immediately with no charge for their services.

2.7.7 OPTIMAL USE OF RESOURCES

NGOs were often able to achieve much with limited resources. Maximum use of people's skills was encouraged, even if people did not have formal qualifications for the work (Health Systems Trust 1994:8).

The active involvement of community members in the health sector is very important as sometimes one finds out that the local community understand the health problem and able to find cure for it. Sometimes these workers like traditional healers have been

serving the local communities for a long time and a culture of thrust had been developed between the users and providers.

Derman & Makanjee (1996:137) state that consistent training has been provided in primary health care for community members to become Village Health Workers (VHWs), and for traditional healers. There is a long established system of referrals between VHWs and traditional healers and ***vice versa***.

2.7.8 ATTRACTION OF FUNDING

At a time when the government was being isolated, CBOs provided an accountable vehicle through which international support for community development could occur. Significant donor funding were ***inter alia;*** European Union, Henry J. Kaiser Family Foundation and the Kellogg Foundation (Health Systems Trust 1994:8).

Successful NGOs focus on one rather than many tasks; prudently choose staff who sympathies and identify with the poor; develop an administrative structure that is modest, more user-friendly, and has more flexibility than the public or private sectors; adopt an `increment alist' and creative approach to development; notice, and respond

sensitively to the needs of clients who also participate in the design and execution of projects; establish linkages to influential forces in the political, public and private sectors; and sensitively merge social issues with technical expertise Cross cited in Reddy (1996:259).

2.8 WEAKNESSES OF NGOs

Non-governmental organisations' weaknesses and threats represent the strengths of public health sector. Brown & Korten (1989:16-17) identifies several reasons for criticism of some NGOs and are summarised as follows:

- they are not able to undertake complex projects. This is related to their limited budgets and small size, especially in terms of staff, pay scales and capacity to attract qualified professionals;
- they are unable to implement successful projects on a regional or national basis. This is because of their limited size and resources, restricted 'administrative systems, intensive focus on a few communities, and in attention to developing real efficiency and expertise in a well defined technology';
- they are unable to establish community organisations that can function

independently. This is linked to the small scale and short-term operations of NGOs, as well as their limited funding. Also, NGOs do not give sufficient attention to sustainability in project planning;

- they often work in isolation, focusing on the micro level, and ignoring the wider context in which they function, as well as the strategic linkages that could be forged with other major actors. Such deficiencies may arise from a combination of 'commitment to locality-specific interventions and a sense of moral superiority that leads to undervaluing the ability and intentions of other organisations'; and
- they have weak administrative, managerial and organisational skills. There are several interrelated reasons for these weaknesses: limited skills, scarce resources and the inflexibility associated with administrative bureaucracies.

The Health Systems Trust (1994:9-10) revealed the following weaknesses of NGOs:

- Dependency on leadership
- Lack of marketing .strategy
- Tardiness
- Tendency to retain unproductive staff

- Slow decision-making processes
- Tendency to empire-build
- NGO culture resistant to change
- Lack of financial accountability
- Erratic feedback to communities; and
- Lack of evaluation.

2.8.1 DEPENDENCY ON LEADERSHIP

NGOs were often managed by dynamic leaders, whose departure from organisations left a large leadership vacuum. Strong individual leadership often created dependency with inadequate managerial skills development in subordinates (Health Systems Trust 1994:9).

2.8.2 LACK OF MARKETING STRATEGY

It is important for any organisation to engage in a strategic planning and to plan in advance so that it could avoid crisis situations. Lack of this (strategic) planning would lead to a collapse of that organisation.

NGOs often lacked the drive to market themselves and their product. They were often resigned to a fate dictated by availability of funding, rather than forward thinking and promotion of their ideas (Health Systems Trust 1994:9).

2.8.3 TARDINESS

The same article states that NGOs had developed a poor reputation regarding punctuality. A lack of commitment to deadlines had undermined their productivity.

2.8.4 UNPRODUCTIVE STAFF

The close-knit working environment of NGOs meant that many found it difficult to retrench unproductive staff membesr ***(sic)***. NGOs ended up carrying a lot of 'dead wood' (Health Systems Trust 1994:9).

2.8.5 SLOW DECISION-MAKING PROCESS

The downside of the commitment to accountable decision-making was that decision-making was often a lengthy and protracted procedure (Health Systems Trust

1994:9). This has been associated with the bureaucratic procedures which are lengthy and unfamiliar to the ordinary citizens. For example, a decision to attend to a seriously ill patient could take over ten hours because of procedures the patient should follow before being attended by a health worker, particularly a doctor. Many cases in which patients have died through these lengthy procedures have been reported to the Department of Health.

2.8.6 TENDENCY TO EMPIRE-BUILD

Personal aspirations, coupled with rivalry for funding, often resulted organizations expanding and developing without regard or consideration for other organizations. Information was often hoarded and there was often a reluctance to share resources. This tendency to empire-build often resulted in fragmentation of services (Health Systems Trust 1994:10).

2.8.7 NGO CULTURE OF RESISTANCE TO CHANGE

Change especially transformation is usually met with resistance and likewise "... NGOs had developed a character and 'culture' of their own which was, at times, as rigid

and resistant to change as any public service bureaucracy (Health Systems Trust 1994:10).

2.8.8 LACK OF FINANCIAL ACCOUNTABILITY

In some organizations, financial management had been poor and had even resulted in embezzlement of funds. This problem was compounded by a reluctance to confront each other for fear of disrupting the organizational dynamics (Health Systems Trust 1994:10).

Donors are only interested to those organisations that have sound financial policies in which their money would be spend on those goods or services for which they were initially budgeted for. Without a responsible management, financial accountability would be impossible and therefore for organisations to receive more financial assistance non-government organisations should engage in vigorous financial management and be accountable.

2.8.9 ERRATIC FEEDBACK TO COMMUNITIES

Although NGOs often claimed to be the voice of communities, they sometimes became remote from the people they served by being too immersed in their own activities (Health Systems Trust 1994:10).

2.8.10 LACK OF EVALUATION

The same article argues that due to time constraints and inadequate skills, there was often little evaluation of either the operations of the organization or its impact. Non-governmental organisations as well as community -based organisations have been working under stressful conditions in which they were directly involved in improving the health of disadvantaged communities like rural and informal settlements. Although the NGOs and CBOs that were involved in providing health care were seen as ineffective by the government, the communities that they were serving saw them as efficient and effective because the government that was responsible was remote to these black communities and was only serving the white communities in urban areas. Therefore one would argue that these 'weaknesses' were actually a success on the part of the NGO sector hence they had a very minimal and limited resources as compared

to their counterpart - the government which was ineffective and inefficient (Health Systems Trust 1994:10).

2.9 RELATIONSHIP BETWEEN GOVERNMENT AND NGOs

The relationship between government and the NGO sector should not be looked at in isolation, hence there are other important influential factors which affect the relationship of government and NGOs. In the South African context these factors are ***inter alia;*** political, social, cultural and otherwise. This section discusses the relationship from:

- Past (pre-elections)
- Present (post-elections)

2.9.1 PAST RELATIONSHIP (BEFORE ELECTIONS)

The relationship of government and NGOs in South Africa was not healthy. The Nationalist Party government with its apartheid policies was seen as an authoritarian regime and thereby an element of antagonism and opposition prevailed. Under very

repressive authoritarian regimes, the nature of that relationship is " ... one largely of opposition and protest" (Carmichael 1993: 1 9). This was the relationship between the past apartheid government and the non-governmental sector. International NGOs were able to communicate directly with local NGOs in all spheres for example; social, political, educational or in health.

NGOs were seen as a threat by the apartheid government and this led to the contrast of interest in which NGOs were assisting in delivery of health care services whereas the apartheid regime was not interested in improving the lives of all its citizens but for the minority group which was white. Carmichael (1993: 1 8) states that NGOs were working under difficult environment which were ***inter alia;*** Many such groups have been closed down by the state, their leaders have been banned, jailed, tortured, even assassinated, and fundraising has been made difficult.

Although the NP government was oppressive, it did allow the NGO sector to function and the NGO sector was able to utilise that opportunity effectively. The apartheid policies encouraged the NGO sector to develop complex networks in which they could operate and deliver health care services to the disadvantaged groups.

During the years of apartheid, public participation and development dialogue were principally conducted through international support to a vibrant and vocal non-governmental organisational sector. This sector in turn supported community-based organisations. Many of these organisations built strong networks that supported family survival through a broad based, multi-sectoral approach which attempted to address all aspects of poverty. Non-government organisations in South Africa have a wealth of experience which should be exploited during the current phase of transition. Their holistic approach recognises that many of the causes of ill- health fall outside of the health sector. For example overcrowding, poor sanitation, lack of water, poor transport and telecommunications all impact on an individual's health status. In contrast government is often constrained in its delivery system and often cannot easily adopt a very community-based approach. The size and delivery scope of some community-based organisations is not adequately recognised in South Africa (South African Health Review 1996:136).

The tension between the past government and NGO sector is also articulated by Williams in Reddy (1996:260) and he argues that the reason for NGOs and government conflict is that they are sometimes forced to compete with each other economically and politically. Many NGOs have displayed an amazing capacity to collect large sums of

money independently of the government. This generates suspicion that some governments would like to tax these resources and/or control the NGOs. Some governments feel threatened by the capacity of NGOs to organise and mobilise the poor around important social issues neglected by the state. However, there are strong grounds to support collaboration between NGOs and governments. For example, 'getting experienced NGOs into national and local policy making, programme design and project formulation may contribute to development that is more sensitive and responsive to the needs of the poor'.

After the unbanning of political organisations the NGO sector increased in number as political exiles returned to the country and seeking alternative jobs, more professionals and academics were drawn into this field and one could say that most opponents of the apartheid regime worked in the NGO sector. As the government was interested in separate development, the NGO sector was for development. Although there was inequity in the provision of health care services the NGO sector with its limited resources was able to offer help to the most disadvantaged communities of South Africa. The tension between the government and NGOs was inevitable.

2.9.2 PRESENT RELATIONSHIP (AFTER ELECTIONS)

The post-election phase is the period after the April 1994 elections in South Africa. This was a change in government - transition from the apartheid regime to a democratic government. The legitimate Government of National Unity (GNU) had to replace the old political order which was an illegitimate apartheid National Party (NP) government. There was change of interest from the government. The ANC-led GNU was committed to a new order in which the lives of all its citizens will be improved particularly those of the disadvantaged majority which were blacks. The GNU would prefer to work together with the NGOs i.e. from antagonism to partnership. As the GNU represented the majority of South African and committed at building a healthy nation it was necessary for the government and the NGO sector to change. However, there are very important factors which need to be considered and partnership would be possible if the following factors articulated by Matlhasedi (1994:18-19) are considered:

- Coalitions
- Partnership
- Co-ordination
- Co-option
- Funding

2.9.2.1 COALITIONS

The aim with this theme is to promote collaboration between NGOs and CBOs, particularly those in the health sector, organised at district, regional, provincial and national levels (NPPHCN 1996:7).

National as well as provincial NGO coalitions is very important. The Western Cape, Eastern Province and KwaZulu-Natal had made a significant progress on NGO coalitions.

NGO coalitions indicate that the organising of an NGO coalition that will effectively and authoritatively represent the NGO sector and thereby be a viable partner for government in development does not take place within such a short space of time (Matlhasedi 1994:18).

This would be welcomed by the Government of National Unity hence coalition of NGOs would reduce the number of NGOs to a single sector which is not as fragmented as that of the past. This would also place these non-governmental organisations in a better position to access state funds or grants.

2.9.2.2 PARTNERSHIP

The GNU would prefer to work in partnership with the NGO sector. The GNU would have to recognise the NGOs and CBOs as partners.

Matlhasedi (1994:18) however, warns that this partnership must not result in a situation wherein government relegates its duties to NGOs, but where a dynamic partnership between government and NGOs are established. The willingness and readiness of both the government and the NGOs to assume responsibility when the other is less capable of performing a certain task or in service delivery must be nurtured within this partnership.

2.9.2.3 CO-ORDINATION

Matlhasedi (1994:18) strongly believes that the NGO/Government partnership should be formed around the co-ordination of works and programmes that are part of a common development agenda, where communities are consulted and part of the process. Organisations should be able to criticise the government's approach in areas of development where they do not agree while working collaboratively in other areas.

Rensburg ***et al*** (1997: 27) argue that the post-apartheid era has seen a wide range of health and development activities in the NGO field. Because of scarce resources, co-ordination among NGOs has become important for strengthening their achievements in development. In order to address the immediate funding crisis, a South African NGO Coalition was instrumental in establishing the Transitional National Development Trust. This Trust is an interim development funder and formal link between government and non-governmental organisations.

It is therefore important for NGOs, donor agencies and the Government to coordinate their activities so as to achieve the common goal of improving the health of its citizens.

2.9.2.4 CO-OPTION

The non-governmental personnel and leadership has been co-opted into government with attractive financial packages which they did not earn in the NGO sector. This has drained the skills, resources, leadership from NGO to the government sector.

Matlhalsedi (1994:19) agrees that although NGOs and CBOs must vigorously attempt to target partnerships with certain units of a new government, especially those

government departments involved in projects that would be of benefit to the communities in which they work, this should not result in the wholesale co-option of NGOs by government.

NGOs should not be forced to operate with the government. NGOs should be allowed to work as watch dogs and not be threaten if they do not co-operate. Many NGOs are prepared to work together with the ANC-led Government of National Unity (GNU) however, they are not prepared to be subordinate but have equally role in the provision of health care service. Even if NGOs are co-opted into government they should continue their role of serving the disadvantaged communities.

2.9.2.5 FUNDING

Matlhasedi (1994:19) maintains that NGOs and CBOs must remain independent of government. Maintaining and strengthening alternative centers of power and democracy outside the formal government structure (even though it is democratic and legitimate) remains an important imperative for NGOs and CBOs.

NGOs, government and the donor agencies should agree on the funding channels and

also adhere to those agreements. These may include ***inter alia;*** taxation, donors/funders, projects and amount of funding.

NGOs are now faced with the problem of funding. With the new democratic and legitimate government in power NGOs would have to compete with the GNU in that donor agencies would now channel their funds to the government.

The European Union (EU) continued to be the single biggest donor within the health sector. However, this funding has been jeopardised by events around the ***Sarafina 2*** AIDS play. The extent of further support by the EU to the health sector remains to be seen (South African Health Review 1996:xvii).

Funding is also directed to health research. The Finance Week (June 1994:14) in an article by Molobi revealed the following about NGOs. Most NGOs are in financial crisis and many have closed down like the Urban Foundation which was also functioning in poorest and remote areas of KwaZulu-Natal. About half of the estimated 54 000 NGOs operating in South Africa could be out of business by 1995. This was

correct as many NGOs decided to close down as they were unable to compete with the GNU and with other powerful NGOs like the Health Systems Trust, The Valley Trust and Kagiso Trust.

Most of the funding comes from the Corporate donors & local foundations which is estimated at R100-R200 million and is channeled mainly to Universities. The other sum is received from the Department of Health (R50 million). The Department of science & technology also contributes up to R50 million. The other contributors are the Department of Education, Foreign donors and Pharmaceutical companies. Both local NGOs and international NGOs also fund some health research (Edwards & Mametja 1996:121).

Competition for foreign funding is not only between the GNU and the NGOs\or CBOs but between the NGOs themselves. It is possible for foreign donors to directly fund the GNU instead of an individual NGO hence the present Government is democratic and legitimate. This is however questionable as the GNU is also not delivering and the RDP is seen as a failure in most communities especially those from KwaZulu-Natal particularly the rural and informal settlements.

2.10 SUMMARY

This chapter has discussed the theoretical perspective of both international and local non-governmental organisations. Organisations that are associated with the NGO sector have been identified. The characteristics of non-governmental organisations differ from country to country as this was the case with South African NGOs, however it was evident in the discussions that the common purpose of all the non-governmental organisations was the upliftment of the lives (health for the purpose of this study) of the disadvantaged communities. It is therefore important to note that the relationship between government and non-governmental sector was different during the apartheid whereby the government policies were based on apartheid. The Government of National Unity is committed to a better health for all which means a positive relationship with government.

CHAPTER 3

SOUTH AFRICAN HEALTH POLICY AND NON-GOVERNMENTAL ORGANISATIONS

3.1 INTRODUCTION

The Department of Health, as a national authority, has the responsibility to determine the country's health priorities and policies. The Department is also ultimately responsible for the delivery of services to South Africa's people (Government Gazette 17910 of 1997:188). However, according to Hindson & McCarthy (1994:147-148) few countries in the world show such racial disparity in health status indicators as South Africa. Health and welfare services are fragmented by racial and spatial divisions. Priorities favor individual care for the privileged rather than adequate care for all, and a strong urban bias exists. Voluminous literature has demonstrated that those who need health care in South Africa have least access to it ... studies show that people most at health risk are:

- the rural poor, especially those far from health and social services
- squatter communities, especially recent arrivals

- people with high migrancy rates; and

- people not reached by primary health care services.

This chapter focuses on the health policy in South Africa and includes:

- history of health care in South Africa from 1910 to 1990's

- national health plan

- national health act

- provincial health legislation

- reconstruction and development programme

- growth, employment and redistribution

- taxation of non-governmental organisations; and

- summary.

3.2 HISTORY OF HEALTH CARE

This section of the study will provide the reader with an overview of the South African health care from 1910 up to the 1990's.

3.2.1 UNIFICATION IN 1910

Naidoo in the South African Health Review (1997:53) explained that "... in the South Africa Act (1910), there was neither special mention of health services, nor did it repeal the previously fragmented colonial health legislation...". Although there was unification, fragmentation of authority for health was visible as Naidoo (1997:53) noted that responsibility for health care was transferred from the four colonies to the four provincial administrators. The four provincial administrations continued to provide public curative services independently, environmental and preventive health services were still provided by local authorities under the jurisdiction of the Department of Internal Affairs.

3.2.2 PUBLIC HEALTH ACT OF 1919

According to Naidoo there were serious health problems in South Africa in 1918 and argues that the disastrous influenza epidemic of 1918 which claimed 142 000 lives was directly responsible for a fundamental reorganisation of South Africa's health care. This epidemic revealed the shortcomings in the organisation and co-ordination of the health services at that time, but also stressed the fact that the State had to assume

responsibility for public health, especially where disease threatened society as a whole. A new dispensation with a definite health policy and clearer authority structures came about shortly after this epidemic ... the original purpose of the 1919 legislation, namely the co-ordinated supply of health care, was lost as provincial administrators continued to have autonomy, exacerbating the polarisation between preventive and curative services. A further critical shortcoming of the Act was that it made no reference to the place and role of the rapidly emerging private health sector (South African Health Review 1997:54).

In 1938 in accordance with Government policy, the Department of Health decided to establish a completely segregated health service for Africans which would be administered jointly by itself and the Department of Native Affairs (van Rensburg ***et al*** 1992:44).

3.2.3 GLUCKMAN REPORT OF 1944

The National Health Services (Gluckman) Commission's report was the culmination of the reformist thinking in health care. Its brief was to make recommendations regarding the provision of an organised national health service, and the necessary

administrative, legislation and financial measures required for this purpose (Naidoo 1997:54).

The Gluckman Commission recommended the following:

- establishment of a national health service for South Africa (a detailed programme to implement such a service was formulated).
- establishment of a single national health authority responsible for all personal health services and for co-ordinating all non-personal health services (this was never implemented).

3.2.4 HEALTH REFORM IN THE 1970's

For nearly sixty years, the 1919 Public Health Act determined the organisational framework of South African health care. It was repealed and replaced by the Health Act of 1977. In essence, the Act reinforced the administrative and functional fragmentation of health care, delegating responsibility for preventive services principally to local government, while retaining provincial control over hospitals. Consequently, local authorities provided a limited range of health services, varying in nature and extent (Naidoo 1997:54).

3.2.5 FRAGMENTATION IN THE 1980's

The shortcomings of the Health Act of 1977 rapidly became apparent as Naidoo (1997:54) noted that a number of plans aimed at streamlining the services were devised (Commission of Inquiry into Health Services 1980, the National Health Services Facilities Plan 1980, and the National Health Plan 1986). However, any efforts at creating a more logical service were stymied by the grand apartheid plan, with further fragmentation due to the homelands policy and the constitutional changes of 1983. The consequence of these policies, evolved over eighty years, was a conglomeration of health providers, each responsible for a limited range of services and with little interaction between them.

3.3 NATIONAL HEALTH PLAN

The plan is based on the belief that every individual has the right to achieve optimal health. Aspects of the plan were clarified in the Reconstruction and Development Programme (which is discussed in the later section of this chapter). According to Dennill (1995:77) the government is responsible for ensuring that health services are

available to all South Africans and the ANC is committed to using primary health care approach as the underlying philosophy to attain this restructuring of the health system.

3.3.1 PRIMARY HEALTH CARE

The World Health Organization has set a target of "Health for all by the year 2000. The means whereby this target is to be reached is Primary Health Care (PHC) which is defined in the Declaration of Alma At. For the developing countries community participation is seen as essential in making PHC available to every person and family. In addition, lay community health workers (CHWs) are seen to be an essential part of such community involvement. This realization led to the introduction of a CHP in several wards in KwaZulu from 1977, an informal basis, and mostly by non-government organizations (Steyn ***et al*** 1991:3).

In order to achieve the goals of the Primary Health care it is important for government to involve and to have confidence in people who are involved in the provision of health care services, for example, the non-government organisations. Health Minister Dr. Nkosazana Zuma said the basic building block for Primary Health Care was the nurse working at the clinic. Community Health Workers (CHWs) could supplement the nurse

but under **no** circumstances could they replace her. "... no health service can be built on CHWs" (Health Systems Trust March 1995:3). The Minister argues that they (CHWs) are selected by, and work in a community, they must be seen as part of the community. They will therefore have to be employed by the community or NGOs or voluntary organisations.

However, one could argue that CHWs are from the community and they understand the problems of the community far better than the nurses from the public sector and the community is free to discuss any kind of problems with the CHWs. Unlike the nurses the CHWs visit the patients in their homes without them (patients) paying for the services.

3.3.2 EQUITY

Dennill (1995:76) argues that health for all cannot be acquired through the supply of equitable health services but through the achievement of equitable social and economic development. The need for employment, education, adequate housing, water, sanitation and electricity are all vital if "health for all" is to be attained.

3.3.3 RIGHT TO HEALTH

This principle is based on the premise that each individual has the right to attain optimal health and the government must provide the environment in which this can be achieved. This is stated in the ANC (1994:14) as follows: every person has the right to achieve optimal health and it is the responsibility of the state to provide the conditions to achieve this. Health and health care, like other social services, and particularly where they serve women and children, must not be allowed to suffer as a result of foreign debt or structural adjustment programmes.

A policy on free health care for children under 6 and pregnant women has been implemented and has shown positive results for the previously disadvantaged communities. This policy was publicised as follows in the Government Gazette Notice 657 (1994:111):

> As from 1 June 1994, free health services must be provided to:
>
> (a) pregnant women for the period commencing from the time the pregnancy is diagnosed to 42 days after the pregnancy has terminated, or if a complication has developed as a result of pregnancy is diagnosed to 42 days after the pregnancy has terminated, or if a complication has developed as a result of the pregnancy,

until the patient has been cured or the conditions as a result of the complication has stabilised;

(b) children under the age of 6 years; non-citizens of South Africa who are in the groups mentioned in par (a) and (b), and who incidentally develop a health problem whilst in South Africa.

Free health services is aimed at disadvantaged communities who are generally in the areas which are predominantly controlled by the NGO sector. The services will be provided at state health care facilities ***viz***; hospitals, community health centers, clinics and state-aided hospitals.

3.4 NATIONAL HEALTH ACT

The Government of National Unity has to pass a National Health Act that would transform the South African health care system. At present (January 1999) the Health Act of 1977 is still legally enforceable and does not give the legal authority for the setting of a district health system which is the cornerstone of Ministry of Health in South Africa. The nine provinces continue to be governed by the previous laws of the

apartheid regime. On the 16 April 1997, the Minister of Health, Dr Nkosazana Zuma published the White Paper on the Transformation of the Health System in South Africa in the Government Gazette No.17910 of April 1997. This document presents the policy objectives and principles of the Ministry of Health in South Africa. The Department of Health ***inter alia*** intends to:

- transform the health care delivery system
- decentralise management of health services
- increase access to services by making primary health care available all South Africans
- rationalise health financing through budget reprioritisation; and
- develop a National Health Information System.

To realise these objectives and principles the Department of Health will have to incorporate all stakeholders ***viz***; government, private sector, NGO sector and the communities. Active participation and involvement of all sectors of South African society in health and health-related activities is essential.

The Government should engage non-governmental organisations in the provision of

health care services so that the most vulnerable section of South African community could benefit. Until new legislation is passed South Africa will remain subject to the Health Act of 1977.

3.4.1 NATIONAL HEALTH BILL

The most important of the proposed legislation for 1997 was the National Health Bill. It is very important to understand the procedures that are to be followed when passing a Bill to an Act of Parliament. Wigton (1997:12) describes the process as follows:

Parliament is the legislative branch of the national government lists primary function is to pass governmental laws. Parliament is comprised of two Houses: the National Assembly and the Senate.

Either Houses can introduce a Bill: however, the majority of Bills are introduced in the National Assembly. Most Bills are introduced by Ministers. If a Minister wants to introduce a Bill he or she first requests the State Law Advisors to prepare the Bill in appropriate legislative language. The sponsoring Minister then submits the Bill and its intentions to the Speaker who puts it on the Order Paper, which is a list of business to

be discussed.

The Bill is made available to the public for review (via the Government Gazette), and concurrently, the Minister sponsoring the Bill presents it for a First Reading to the full Assembly. During the First Reading, the sponsoring Minister may give a short overview of the background to, reasons for, and objectives, of the provision of the Bill. One member of each party of the House then may make a three minute response to the Bill.

Next, the Speaker of the National Assembly refers the Bill to the appropriate Portfolio Committee, which conducts hearings or requests information about, and offers amendments to the Bill. The Committee submits a report back to the House which outlines consensus reached, any disputed aspects of Bill, and amendments.

The Bill is put on the Order Paper for a Second Reading. During the Second Reading the Committee presents the Bill with its amendments, the Bill is debated, and a vote is taken on whether or not to "carry" (approve) the Bill. If the Bill is rejected at this point, it cannot be reintroduced into parliament during the same year.

The Bill is then sent to the Senate for review, goes through a similar process, and is

returned to the National Assembly. If the Senate adds amendments to the Bill, these must be approved or rejected by the National Assembly. A Bill passed by one House and rejected by the other is referred to a Joint Committee consisting of members of both Houses. If approved by both Parliamentary Houses, the Bill is sent to the President for signature. The Bill then becomes an Act of Parliament.

The South African government, through its apartheid policies, developed a health care system which was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care (ANC 1994:7).

3.4.1.1 ADVANTAGES OF THE HEALTH BILL

The following positive aspects of the Health Bill have been cited by Toms in the Health Systems Trust (March 1997:9):

- It has a comprehensive framework for transformation of the health services,

particularly the development of a district health system.

- The Bill is a progressive move that will decentralise authority to the local level, thereby making real community involvement far more possible.
- The Bill will definitely improve health because of its progressive nature
- Its major thrust is in the direction of the district health system, and by allowing for intersectoral collaboration it broadens the view of health to cover all the socio-economic factors leading to ill- health.

Another positive aspect of the Bill is that non-governmental organisations that are involved in health care delivery were also invited to contribute on this Bill.

3.4.1.2 DISADVANTAGES OF THE HEALTH BILL

Ntsalumba argues in the Health Systems Trust (March 1997:10) that the major disadvantage of the Bill was the omission of the controversial area of dispensing doctors, however, there was a conscious decision to omit this area as it falls under the Medicines Control Act. This Act covers dispensing doctors, generic substitution, parallel importation and the review of the Medicines Control Council.

The Department of Health has decided to hold public meetings around the country in addition to having written submission as meetings are simpler, particularly for rural and illiterate communities. This will ensure consultation and all stakeholders outside of the government department *viz*; NGO sector and the private sector will be invited. While the New Constitution pressurises the government to begin to improve the health care and social services provided to all South Africans, the Department of Health has passed no national health legislation to give legal substance to these promises for people on the ground. The Department of Health has drafted numerous policy documents and begun implementation on a series of health issues, but none of the proposals has the force of law. These documents serve as guides for public servants within the Ministry of Health for implementation of reforms, but they do not hold force for people outside the Ministry (South African Health Review 1996:197).

3.5 PROVINCIAL HEALTH LEGISLATION

The mission of a provincial health department, as mandated by the Constitution of South Africa within the national policies, strategies and guidelines, is to promote and monitor the health of the people in the province (Government Gazette 17910 of 1997:26).

The provinces are faced with similar problems which the South African Health Review (1996:199) argue that no health related bills have been passed at the provincial level. Without clarity from the national level, provinces have been reluctant to amend and rewrite provincial health legislation. Thus, the health services of each nine provinces continue to be governed by the previous laws of the four pre-1994 provinces, the former independent states, and self-governing territories that existed within provincial boundaries. In some provinces many conflicting statutes exist, making the situation unworkable in the long-term. Even where there are no conflicts, provinces like the national government are operating under apartheid era health laws. With national enabling legislation due in 1997 at the earliest, it could be December 1997 or early 1998 (this did not happen) before provincial health legislation is passed to harmonise previous health laws. It could take even longer to draft and enact new provincial legislation that fleshes out the national framework.

Progress has been made in the Free State Province and The North West in which two pieces of provincial health legislation were passed, the Hospital Act of 1996 and the Health, Developmental Social Welfare and Hospital Governance Institutions Act of 1997, respectively.

3.5.1 KWAZULU-NATAL HEALTH LEGISLATION

The KwaZulu-Natal Srategic Team for Health has made significant progress in drafting a new Health Legislation for the province. The Minister of Health in KwaZulu-Natal, Dr Zweli Mkhize has divided policy issues not two categories, namely;

- matters that should be regulated by the province (KwaZulu-Natal); and
- matters that should be competencies of the National Department of Health.

The KwaZulu-Natal Health Department has prepared new legislation on non-controversial issues and senior provincial officials have expressed a commitment to enact enabling legislation on provincial health matters with or without clear direction from the national level. The KwaZulu-Natal province has been engulfed with controversies, this is because of the different of opinions and interest between the leaders of the province (Inkatha Freedom Party) and the National Government which the IFP refused to participate in.

The most relevant and important aspect (for this dissertation) of this legislation is Chapter three of the discussion document for KwaZulu-Natal legislation which is the

Community participation and contains several aspects of health which are discussed in the following section.

3.5.1.1 COMMUNITY PARTICIPATION

Chapter three of the discussion document for KwaZulu-Natal legislation deals with the following aspects of health:

- organisation of health services
- promotion of non-governmental bodies
- community health forums
- reporting procedures
- voluntary workers; and
- contracting out of services.

(i) ORGANISATION OF HEALTH SERVICES

Public sector health services must be so organised as to enable the community to participate, through appropriate structures at community and health district levels, in the formulation of health policy and the control of its application (KZN 1995:10).

(ii) PROMOTION OF NON-GOVERNMENTAL BODIES

The KwaZulu-Natal Health taskforce has taken a positive direction by recognising the important role of non-governmental organisations (NGOs), community-based organisations (CBOs), churches, schools and clubs in assisting the formal health sector in the delivery of health care services.

Health authorities and agencies in KwaZulu-Natal must promote and support the establishment of non-governmental bodies which have as their objective organised participation in programmes for the promotion and improvement of the public health, and in programmes for disease and accident prevention, disability prevention and the rehabilitation of the disabled (KZN Strategic Team for Health 1995:11).

Government intervention will only be successful if every component of civil society as mentioned above, is involved and given a significant role to play in the provision of health care services at the provincial level. KwaZulu-Natal is faced with the HIV/AIDS epidemic and the involvement of non-governmental organisations is of paramount importance as they act as the first line of health defense to the marginalised communities.

(iii) COMMUNITY HEALTH FORUMS

The discussion document for KwaZulu-Natal states that the political head of the Department may, from time to time by notice in the official gazette, establish one or more community health forums with any health district. The objective of a community health forum is to provide a forum for various community groups working in the field and interested members of the public to discuss health issues relevant to their health district and region and the political head of the Department may issue guidelines in respect of the membership, objectives and terms of reference of community health forums (KZN 1995:13).

(iv) REPORTING PROCEDURES

The political head of the Department may, by notice in the official gazette, establish procedures whereby the public may report to the relevant authorities for example:

- events, acts or omissions that represent a risk or that cause injury to the health of the population
- irregularities or shortcomings detected in health services delivery, and

suggestions for the improvement of health services; and

- the existence of persons requiring health services, when those persons are unable to request assistance themselves (KZN 1995:14).

It is therefore important for the Department to ensure that the above mentioned procedures are widely publicised in all areas of KwaZulu-Natal. This is also supported by the South African Health Review (1995:196) that a summary of the framework was made available for comment to a wide range of interested structures and organisations, as well as the general public via accessible centers such as public hospitals. Notice of the availability of the document was published in 23 local newspapers, as well as on radio services. Both the notice and the framework itself were made obtainable in both English and Zulu (South African Health Review 1995:196).

As the Department of Health reports to the public it would receive tremendous response and the comments would help to improve the Health Bill of the province.

(v) VOLUNTARY WORKERS

Health facilities may utilise the services of voluntary workers. These workers may

collaborate, without remuneration, in assisting persons suffering from chronic diseases, persons suffering from disabilities, and the elderly, in particular by providing company and recreation, by performing simple health care, domestic or social welfare tasks, and by participating actively in programmes of health education and their activities must be co-ordinated by the superintendent of the health facility concerned. However, the activities of voluntary workers must be restricted to what has been ethical principles that guide the activities of the health facility (KZN 1995:15).

Nigel (1992:1) perceived voluntary work as one of the greatest endeavors to which people commit themselves. It harbors an enormous variety of activity, and much of it is altruistic. It is thus, important for voluntary workers to be committed to their work and continue their main objective of improving the quality of life, of individuals or of communities and this is discussed in Chapter four.

(vi) CONTRACTING OUT OF SERVICES

The Department may establish commissions and technical committees, enter into agreements, and formulate joint programmes that are required for the greater effectiveness and efficiency of its duties and functions under this Act, with trade

unions, non-governmental organisations, private health services providers, statutory bodies, academic and research institutions and professional and civic organisations (KZN 1995:16).

The activities of the public, private and non-governmental organisations should be integrated in a manner that makes optimal use of all available health care resources and it should also promote equity. This is also highlighted in the Government Gazette no.17910 (1997:32) as follows: costs of health services and on the efficiency of resource utilisation is a crucial requirement for the cost effective and cost efficient health service delivery.

3.6 RECONSTRUCTION AND DEVELOPMENT PROGRAMME

The Reconstruction and Development Programme (RDP) was the development initiative of the post-apartheid government. The RDP was of the view that NGOs in South Africa have an important role to play particularly in health care, however, the RDP emphasised transparency and accountability for the NGOs to survive.

The Reconstruction and Development Programme (RDP) is an integrated, coherent,

socio-economic policy framework drawn up by the ANC-led alliance in association with other key mass organisations such as NGOs and other research organisations (ANC 1994:1).

Five broad programmes were identified to promote the objectives of combating poverty and were:

1. the meeting of basic needs
2. upgrading human resources
3.. strengthening the economy
4.. democratising the state and society
5. making the state and the public sector more efficient.

Health and development policies of the post-apartheid era have been cast in the RDP mold.

3.6.1 RDP AND NGOs

Apart from the strategic role of government in the RDP, mass participation in its elaboration and implementation is essential. NGOs, as part of civil society are, therefore, expected to contribute to the attainment of national priorities and programmes (Government Gazette 17910 of 1997:189).

However, the Government of National Unity through the RDP has occupied the space that NGOs occupied in previously disadvantaged communities by an illegitimate government. Although there is a new democratically elected Government in South Africa, there is still a need for NGOs to continue providing health services. Poorest provinces like KwaZulu-Natal which is drawn into a political battle between the ANC and IFP still need the NGOs for the upliftment of their standards of living.

The reality of the new political order is that the ANC-led government of national unity must "deliver" development to an expectant constituency (Business Day October 27, 1994).

3.6.2 FUNDING OF NGOs

The Government and its departments are not responsible for the funding of NGOs. Such funding is a matter between donors and the NGOs concerned. Where the Department of Health commissions as NGO(s) to execute some of its programmes, the Department will be responsible for mobilising the financial resources for such a programme (Government Gazette 17910 of 1997:189).

A high percentage of aid monies targeted in the past for anti - apartheid work is now being redirected to government reconstruction and development projects (Finance Week, June 23-29,1994).

The funding battle between government and NGOs has been going on since the election of a legitimate government. There has been drastic changes whereby donors channeled their monies directly to the Government of National Unity complicated by donor attentions shifting away from social concerns towards larger issues of economic growth and trade. In addition, the Reconstruction and Development Programme concentrates overwhelmingly on the delivery of 'hard' products such as water, housing and sanitation. However, it is also vital to fund information services, processes and products

to encourage public participation and allow fundamental needs to be expressed (South African Health Review, 1996:38).

Although there has been shift by donors to fund NGOs, the Henry J. Kaiser Family Foundation (USA) and the Kellogg Foundation remain significant funders of non-government organisations like the Health Systems Trust. It is important for NGOs and CBOs to remain independent of government so as to allow the former to act as a "watchdog".

3.6.3 CLOSURE OF THE RDP OFFICE

On the 28 March 1996 the South African State President Dr. Mandela announced the closure of the RDP office as a result of a cabinet reshuffling. Without the RDP office it was unclear what will happen to all the RDP structures and projects. During its tenure the RDP office expressed difficulties engaging line departments in intersectoral processes.

There was a large scale attempt to improve the physical access to primary level care through a clinic building and upgrading programme. By June 1996, R190 million of the

Reconstruction and Development Plan (RDP) funds had been used to build 60 new clinics, to upgrade 47 more and to equip a further 73. In addition, 142 mobile units have been purchased and general improvements made to a large number of clinics around the country (South African Health Review. 1996:xvi).

The failure of the RDP could be attributed to the following;

- lack of integrated planning
- inefficient delivery
- lack of capacity
- underspending on projects bureaucratic bottlenecks; and
- protracted and inefficient consultation processes (South African Health Review 1997:24).

3.7 GROWTH, EMPLOYMENT AND REDISTRIBUTION

The failure of the RDP saw the government presenting its new Growth, Employment and Redistribution Programme(GEAR) in mid-1996. GEAR was introduced as an integrated, macro-economic strategy for rebuilding and restructuring the economy.

Though GEAR reaffirms commitment to the RDP, the GEAR strategy conveys quite a different message which boils down to economic growth and employment creation.

GEAR is also criticised for not being in the interest of the poor, and that it will not solve the problem of crime because the "trickle down" effects of both foreign investment and free market policies could take a long time to materialise. The general argument then is that GEAR will impose additional hardships on the country's poor rather than alleviating the inequities inherited from apartheid (South African Health Review, 1997:25).

By November 1998 the government agreed that the GEAR policies did not achieve its goals in schedule and there was a need to re-assess the budget allocation of funds (SABC 3: Parliament). The government however, reaffirmed its position of redistribution and the creation of more jobs and health services to the most vulnerable, poor, rural and unemployed South Africans by the year 2000.

3.8 TAXATION OF NGOs

Tax avoidance is not the same as tax evasion. Tax avoidance is the legitimate arrangement of one's affairs in such a way as to pay the minimum amount of tax required by law. Tax evasion on the other hand, has the same motive but implies illegal and dishonest behavior for which the Act prescribes harsh penalties

(Emslie ***et al***.1985:3).

This is reiterated by Deloitte & Touche (1996:9) that no one should pay more tax than the law requires of them. The best way of not paying more than your fair share of taxes is through tax planning. Tax planning is **not** tax evasion. Tax evasion is any manoeuvre of which the purpose is to hide income otherwise subject to tax (for example, failing to declare all your interest income). The tax planning involves reviewing your financial goals, and then arranging your activities to achieve these goals at the least tax cost by using tax rules that permit you to reduce or defer taxation, increase deductions, or avoid tax traps. In the apartheid era NGOs were operating under numerous ineffectual Acts, like the Fund-raising Act which was passed in the mid-70s and was seen as an attempt by government to control NGOs. This Act was seen as restrictive and bureaucratic by many NGOs. The past government viewed the NGO sector as a threat and thereby

imposed these restrictive laws to counteract the anti-apartheid organisations. With the new democratic government in place the laws governing NGOs have also changed.

According to Meyerowitz (1997-98:A18) donations tax is payable at a flat rate of 25% on donations made by a person ordinary resident in the Republic or by a domestic company. It is immaterial whether the property donated is situated in or out of South Africa.

It is very difficult for an NGO to qualify for tax exemption, however with the new South African constitution there are NGOs which are entitled for tax exemption.

Strydom (1997:Chapter 10 of the Income Tax) states that non-profit companies or bodies for the promotion of research, health services, social or recreational amenities, or group commercial or professional interest are exempted from tax.

3.8.1 CATEGORIES OF DONATIONS

The Government Gazette (No.17910, 16 April 1997:187-188) states that there are three

categories of donations to NGOs and they are *viz*; financial, technical expertise and other donations.

(a) FINANCIAL DONATIONS

(i) The acceptance of funds donated by external agencies must be in keeping with South Africa's fiscal policy and financial legislation.

(ii) Subject to the general guidelines, the donation of funds should be focused initially on bridging finance for the reconstruction and rationalisation of the health services.

(iii) Funding of recurrent expenditure for predetermined periods should focus initially on priority areas, as identified in the Government document titled "The Health of the Reconstruction and Development Programme" -and other government policies (Government Gazette 17910, 1997:187).

(b) DONATIONS OF TECHNICAL EXPERTISE

The Department will solicit and accept contributions of a technical nature from the donor community. This will only occur if there is a local shortage of such skills, or if

such contributions are geared to enhancing local skills.

Costs related to the provision of international expertise will be supported by the donor agency(ies), upon review and agreement with the Department (Government Gazette 17910, 1997:188).

(c) OTHER DONATIONS

Donations of equipment will be subject to the following principles:

- appropriateness of and need for the particular equipment in South Africa; and
- Adequate and readily available support structures, including:
- expertise, potential for training and availability of suitable health personnel;
- an adequate maintenance service, including the availability of service personnel and parts at a reasonable price; and
- the necessary infrastructure, such as electrical power supply, adequate roads and telecommunications.

Donations of equipment which would replace existing equipment generally should

take preference over the provision of new equipment, as the later would result in an increase of recurrent costs.

Donations involving capital projects should facilitate job creation, capacity building and community development, with particular emphasis on disadvantaged communities. In assessing such projects, one of the fundamental factors is their sustainability in the medium to long- term (Government Gazette 17910, 1997:188).

3.8.2 GUIDELINES FOR DONORS

The conditions attached to donations are as follows:

(i) acceptable to both the donor agency and Government;

(ii) in accordance with broad Government policies;

(iii) assist and support the sound planning and management of health services:

(iv) aimed at making an impact on the health services;

(v) promote Intersectoral collaboration and co-ordination; and

(vi) develop South Africa's capacity (at the national, provincial and/or local levels) (Government Gazette 17910, 1997:184).

3.8.3 PRINCIPLES FOR DONORS

According to the Government Gazette (16 April 1997:185-186) there are principles that must be advanced by all donor projects or programmes and these are ***inter alia***:

(i) SUSTAINABILITY

Donations which have recurrent cost implications for Government must evaluated, to ensure that the required financial resources are available to sustain such programmes or projects (Government Gazette 17910, 1997:185).

(ii) EQUITY

Donations must address - the shift to primary health care:

- inequalities between provinces, as well as unequal development within provinces;
- under-served areas, especially rural areas; and
- the needs of specific groups in society, such as women and children (Government Gazette 17910, 1997:186).

(iii) ACCESSIBILITY

Donations should be directed at making health services accessible to all South Africans, irrespective of race, gender, income status or geographic location (Government Gazette 17910, 1997:186).

(iv) EFFICIENCY

Donations should promote the efficiency of health services through different mechanisms, e.g. training programmes for health workers, establishment of sound information systems, technical support initiatives and strengthening community involvement and participation in health services delivery (Government Gazette 17910, 1997:186).

(v) ACCEPTABILITY

Donations should not only be acceptable to Government structures, but also to the community for whom such donations are intended (Gov. Gazette 17910, 1997:186).

3.9 SUMMARY

The aim of the South African health policy should be the rendering of quality health that is accessible and affordable to all South African and the improvement of the health of the community. The transition from apartheid to democracy will have no impact if legislation has not changed. Political transformation should be followed by a change in all other sectors namely; social, economic, educational, health and in other sectors. South African health needs a comprehensive health policy in which all health stakeholders should be involved in matters pertaining to health issues. The new legislation should ensure cooperation between government and non-governmental organisations and should address the fundamental health issues that South Africa is faced with. Although the Government of National Unity introduced the Reconstruction and Development Programme to address the imbalances of the past, the non-governmental sector should also play its role and not hope that government would deliver all goods and services, particularly on health . This chapter has discussed the available health legislation in South Africa with an emphasis on its impacts on the non-governmental sector.

CHAPTER 4

ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN PROVISION OF HEALTH CARE: a Health Systems Trust and the Valley Trust case study

4.1 INTRODUCTION

Non-governmental organisations have played an important role in the provision of health care services in the KwaZulu-Natal. Health care services that were provided by the former Health Department were inadequate and unaffordable to the majority of South Africans. Historically disadvantaged communities in particularly the blacks, rural, poor, women and children were the most vulnerable to ill-health. Many non-governmental organisations emerged in the past as anti-apartheid movements and most of them were committed to the upliftment of the lives of the most vulnerable communities. This chapter will discuss two of these non-governmental organisations which have been chosen for this study and they are: Health Systems Trust and the Valley Trust. Most of the information was gathered through the two questionnaires (Annexure A1 and A2), reports, interviews and observations.

It is important to note that these two successful organisations also provide other health stakeholders around South Africa with health-related information.

4.2 THE HEALTH SYSTEMS TRUST (HST)

The Health Systems Trust (HST) is an independent non-governmental organisation established in 1992. The HST was officially launched on the 1st of April 1993. It is funded by the Henry J. Kaiser Family Foundation, Commission of the European Union, Rockefeller Foundation, the Kagiso Trust and the National Department of Health, whose funds are channeled through the Medical Research Council (MRC). The HST was initially located on the 5th floor of corner of Smith and Field Street, however due to business demands it has been relocated to Maritime House on the 4th Floor in KwaZulu-Natal, Durban.

The HST has a very explicit agenda with regard to research, namely; to understand and support health systems research which will help clarify health policy options and lead to improvements in health care delivery. The HST was established to support the restructuring of health care in South Africa, primarily through health systems research.

The HST invites funding proposals for projects which will further its mission (Harrison 1998: interview).

4.2.1 HST MISSION STATEMENT

The Health Systems Trust is committed to a health care system which meets the needs of all South Africans. It seeks to help realise this vision through independent support for research and skills development aimed at improving policy and planning at all levels, as well as other strategic initiatives which move us toward this goal (HST Annual Report 1996:1). (Refer also to Annexure B 2).

4.2.2 HST - ORGANISATIONAL STRUCTURE

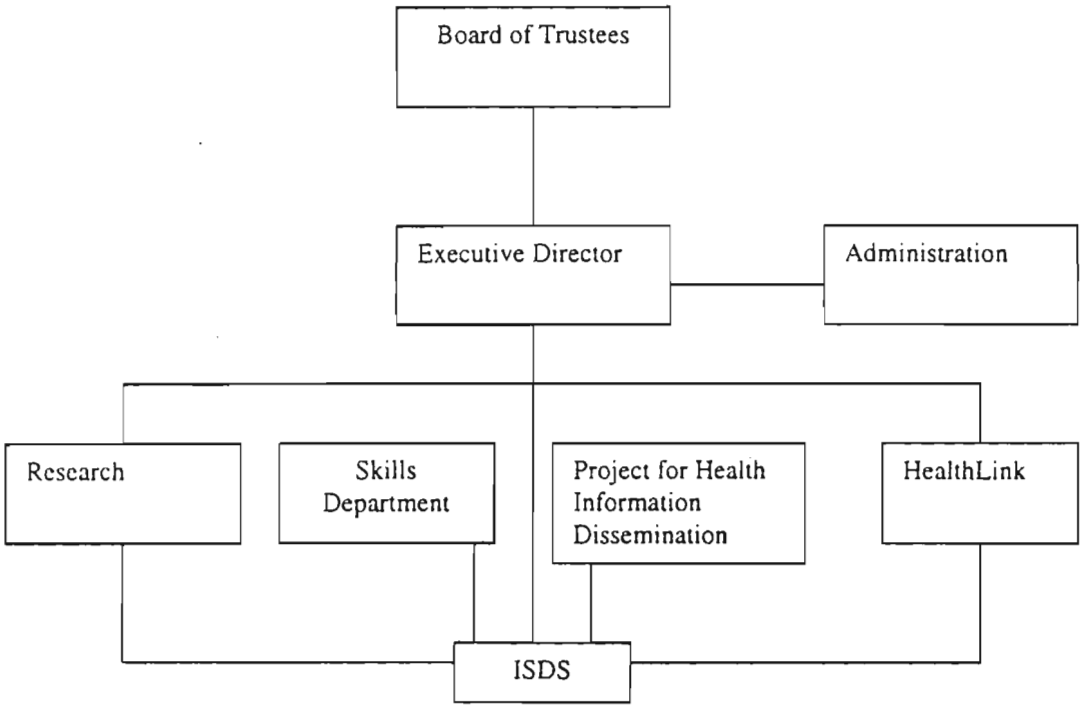
The HST is governed by a Board of Trustees which is responsible for policy setting, and the overall management and disbursement of funds. The secretariat under the leadership of an executive director is responsible for the implementation of the programmes of the Trust. (Figure 3) is an illustration of the HST's organisational structure.

The Board of Trustees consists of eleven members. The Board is committed at maintaining and developing the Health Systems Trust as a successful independent non-governmental organisation supporting health systems reform in South Africa. Reddy (1996:5) in the HST Annual Report maintains that this would be achieved by focusing on the following:

- bringing our programmes closer to implementation, particularly at the lower levels of the health system as the current transition phase plays itself out;

FIGURE 3: HST - ORGANISATIONAL STRUCTURE

(Adopted from the HST Annual Report 1996:97)



- providing independent and critical review and assessment of health policy developments;

- in partnership with other NGOs, strengthening smaller and more localised NGOs to ensure effective community participation in health care;
- nurturing individual and institutional capacity development already started within health services, historically black institutions and other non-governmental organisations.

The HST is under the leadership of David Mametja who has taken over from David Harrison who stepped down as Executive Director. The Administrative staff is dedicated to the success of the HST.

The Health Systems Trust has five programmes which are:

- Research
- Skills Development
- Project for Health Information Dissemination
- HealthLink; and
- Initiative for sub-district support

4.2.2.1 RESEARCH

HST has two mechanisms for funding research. Namely in response to submitted proposals, and commissioning research around key issues. The main criteria for selection of any research project are: its relevance and potential impact on health systems reform; envisaged skills transfer and development; and involvement and endorsement by the relevant health authorities (HST information brochure: undated).

HST has funded over 120 research projects, large and small dealing with both national and local issues. A special fund, the Reproductive health Research Fund was established to focus on research related to adolescent sexuality, sexually transmitted diseases, family planning and termination of pregnancy. An estimated R6 million budget over two years with equal contributions from the national Department of Health, the Department of International Development and the Kaiser Family Foundation has been allocated for this fund (Radebe, 1998 : interview).

Presently, priority areas for research support are:

- Human resource development

- District systems development and decentralisation
- Informatics support to health care
- Drug policy
- Health financing and economics
- Nutrition
- User fee policies.

HST funds and promotes high quality research that addresses priority issues and policy relevant health systems research. The trust is proactive in developing research agendas and at helping to produce targeted research outputs. Institutions like UNITRA (which has not been active in health research) is encouraged to get involved and relatively stronger institutions like University of Natal are encourage to work with the relatively weaker ones like the University of Zululand on research into school health services. Skilled researchers are also encouraged to take their skills outside the metropolitan areas to rural areas of the previously disadvantaged communities of KwaZulu-Natal like Vryheid, Ndwedwe, KwaNyuswa and Maqadini (Radebe 1998: interview).

4.2.2.2 SKILLS DEVELOPMENT

The Skills Development Programme aims to equip a core of South Africans, particularly those previously disadvantaged, with skills in health systems research, planning and management, programme monitoring and evaluation, documentation and presentation. These skills are developed through participation in problems-based training and development programmes, research internship projects and exchange placements with other developing countries. Short courses and workshops are considered as part of these projects and programmes. Special emphasis is placed on developing skills of teams rather than individuals. The programme is targeted at prospective trainees operating the public health sector within districts, in historically black institutions, NGOs and CBOs, particularly in rural areas (HST information brochure: undated).

According to Radebe (1998: interview) a Skills Development Programme was essential to:

(i) strengthen health systems research as a discipline

(ii) build institutional capacity, focusing particularly on historically black

universities, the health services and non-government organisations

(iii) build individual capacity, with particular emphasis on black South Africans

(iv) redirect funding towards geographical areas previously neglected.

4.2.2.3 PROJECT FOR HEALTH INFORMATION DISSEMINATION

The Project for Health Information Dissemination (PHID) aims to provide a reliable source of information about health and health policy developments in South Africa and to serve as a channel through which health systems research results and recommendations can be shared.

The main outputs of this project are:

- South African Health Review;
- Monthly newsletter of policy developments and HST activities (HST Update);
- Directory of Health Systems Research in South Africa and a resource centre that collects, collates and disseminates reports, journal articles, monographs and grey literature (Radebe 1998: interview).

(i) SOUTH AFRICAN HEALTH REVIEW

It is co-published by the Health Systems Trust and the Henry J. Kaiser Family Foundation. It remains the most comprehensive review of health and health care in South Africa. The South African Health Review is a culmination of hard work by many individuals, a task that has significantly grown in complexity over the years. The Review covers ***inter alia***; Health Status, Health and Development, Legislation, Financing and Expenditure, Research, Health and Media, HIV/AIDS and TB (Radebe 1998: interview).

(ii) HST UPDATE

The HST is the main vehicle for reporting research results and recommendations of HST funded and commissioned research. It is increasingly being used as a channel for communication with policy makers, particularly in spelling out the efforts at health sector restructuring. It provides up to date information on debates that have dominated the health sector during each month. Update is now distributed to approximately 3 600 readers, including health workers in clinics and hospitals nationally. The full text of Update is disseminated electronically on the Internet through Healthlink. There was a

tremendous increase in the number of people interested in receiving the newsletter. Commercial advertisers were encouraged to advertise for a minimal fee (HST Annual Report 1996:25).

HST Update is a monthly gazette which documents policy developments and serves as a platform for policy debate.

(iii) HST RESOURCE CENTRE

The resource centre maintains a rich collection of up to date research reports that emanate from HST funded and commissioned research. There is also a wide range of publications and periodicals, annual and newspaper clippings (HST Annual Report 1996:26).

The centre is managed by Cynthia Mfayela and it collects and disseminates information to students, researchers, hospitals and to NGOs.

4.2.2.4 HEALTHLINK

HealthLink is funded by the Henry J. Kaiser Foundation with commitment of resources (human, technical, physical) by the Department of Health. Its mission is:

"to address the communication and information needs of managers, providers and consumers of health care using appropriate technology" (HST Annual Report, 1996:28).

There are three areas of HealthLink activities that feed into the support for the Initiative for Subdistrict Support (ISDS) and are:

- Information resources
- Technical infrastructure; and
- User support.

Information resources is under the leadership of Candy Day (July 1998). In 1997 the World Web server became operational and started to provide services for clients. HealthLink is a project of the Health Systems Trust established to help meet the

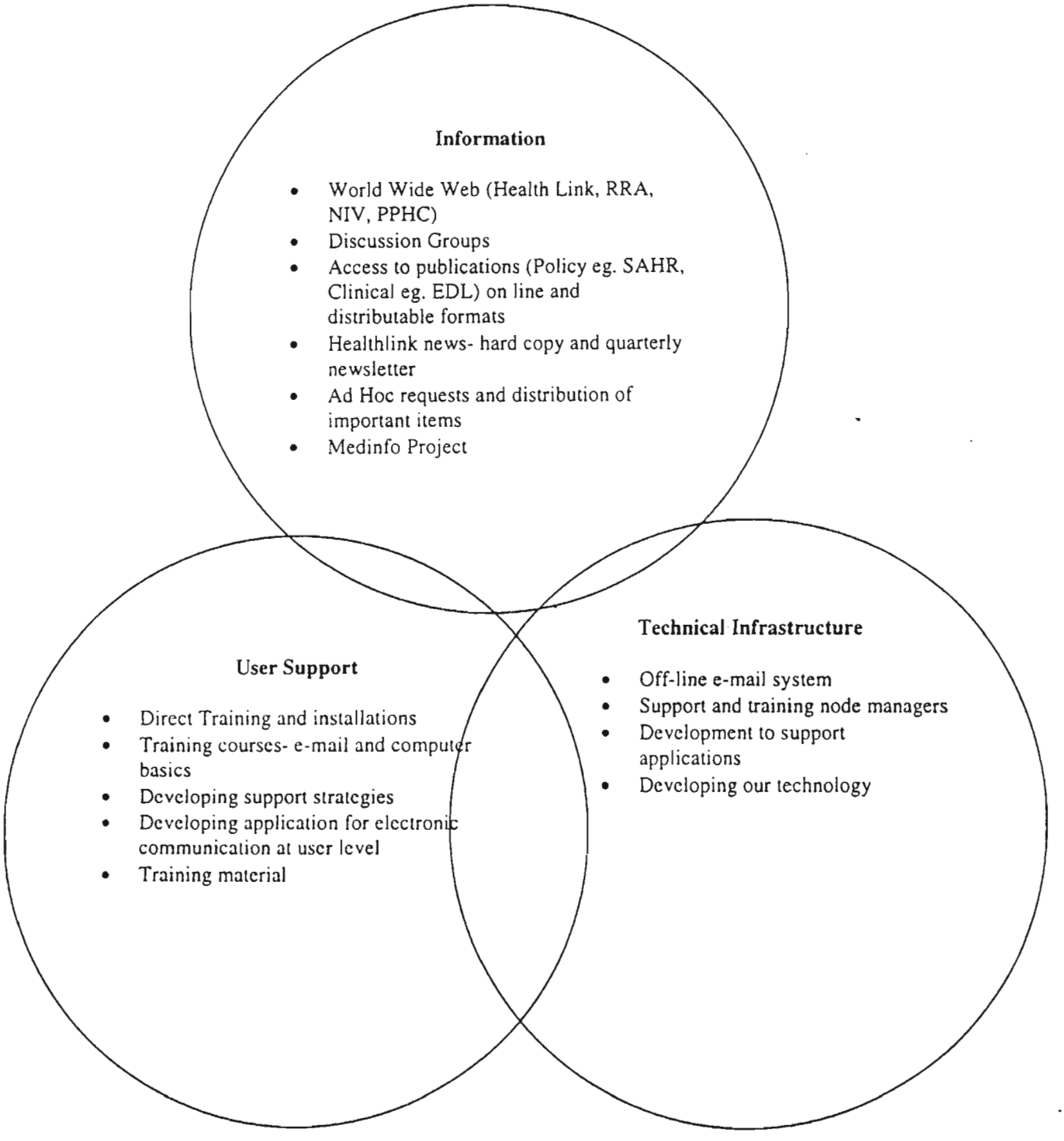
communication and information needs of health workers in South Africa (Day 1998: interview).

The Technical infrastructure is now established and supports users in every province, many of whom would have no other access to this medium without HealthLink.

The User support is a vital component of HealthLink functioning and this initiative is focusing on health facilities where HealthLink would particularly like to make a contribution (Radebe 1998: interview).

FIGURE 4: HEALTHLINK OF THE HST

(Adopted from the HST Annual Report 1996:29)



4.2.2.5 INITIATIVE FOR SUB - DISTRICT SUPPORT

The District Health Systems (DHS) is recognised as the fundamental building block of South Africa's unified health system. The Initiative for Sub-District Support (ISDS) aims to demonstrate improved standards of primary health care by providing sustained, systematic and comprehensive support to selected sub-districts. In other words, ISDS hopes to improve service delivery by identifying those factors which affect health care at local level, and developing practical ways of changing these factors for the better (Radebe 1998: interview).

The purpose of this initiative is to demonstrate the impact of a process which:

- deliberately and systematically addresses factors affecting the quality of care at local level;
- supports and strengthens the capacity of both public sector and non-government health providers;
- strengthens the capacity of communities to participate in governing and managing health services; and
- harnesses technical resources, both local and distant, to support health systems

reform at local level (Radebe 1998: interview).

4.2.3 HST - SWOT ANALYSIS

Strengths, weaknesses, opportunities and threats that were faced by the HST in the previous years are highlighted in this section, however detailed analysis is in chapter five of this study.

4.2.3.1 STRENGTHS AND OPPORTUNITIES

The strengths and opportunities of an organisation are very critical to its overall success, however if they are not realised and taken the organisation would not develop and prosper. Radebe (1998: interview) highlighted a number of factors that have been critical to the development and success of HST and are summarised as follows:

(i) FINANCING

Although there has been funding problem for the NGO sector for the past four years,

the HST has been receiving funds from both the national Department of Health and the Henry J. Kaiser Foundation.

This partnership has an active interest in the activities of HST by the Department of Health, and has an active interest in the funding from a number of other agencies which are ***inter alia***; Rockefeller Foundation, Commission of the European Union and Independent Development Trust. HST has solid support from key funders (Radebe 1998: interview).

(ii) FLEXIBILITY

Bureaucratic organisations like those in government are heavily criticised for their "top-down" approach in decision making and the process is a lengthy one. As an NGO the HST is flexible and respond quickly to needs and requests of users and providers of health care services both national and local. Radebe (1998:interview) emphasised that the organisation is "... not bogged down by bureaucratic structures...".

(iii) HEALTHLINK

According to Radebe (1998: interview) it (HealthLink) "... is a project of the Health Systems Trust established to help meet the communication and information needs of health workers in South Africa...". The evolution of HealthLink has provided a means of linking these information sources to rural and otherwise isolated health workers in the public and non-government sectors. The HST as an independent organisation is a resource for other NGOs. HealthLink also helps in introducing health workers to information technology.

(iv) RESEARCH

According to Edwards - Miller (1997:115) "... Health Systems Research focuses on issues related to the delivery of health care and it therefore cuts across the various health problems...". Radebe (1998: interview) states that HST has two mechanisms for funding research. Namely in response to submitted proposals, and commissioning research around key issues. The main criteria for selection of any research project are: its relevance and potential impact on health systems reform; envisaged skills transfer and development; and involvement and endorsement by the relevant health authorities.

The HST funds and promotes high quality, policy relevant health systems research. HST assists researchers in; proposal development, through protect support and implementation, through support for skills development, to dissemination and application of results and recommendations (Radebe 1998: interview).

(v) CAPACITY BUILDING

The HST has an explicit commitment to capacity building and skills development. This includes an internship programme, and support for short courses. The HST also provides methodological support for individual researchers. Around 10 interns per year are fully funded and are placed at institutions where they will be adequately supervised. Other research organisations, such as the Centre for Health Policy, also fund and train interns (South African Health Review 1997:115).

Funding for capacity-building which has enriched HST's research programme and enabled support for health services to move beyond planning toward support for implantation (Radebe 1998: interview).

4.2.3.2 WEAKNESSES AND THREATS

The weaknesses and threats an organisation has to faced has to be understood as challenges for that particular organisation and should be overcome in order to meet the goals and objectives of the organisation. Radebe (1998: interview) explained that there were challenges that were facing the HST and she cited the following:

(i) FUNDING

Although this has been cited earlier as one of the strengths of the HST Radebe (1998: interview) highlighted the fact that foreign government aid has become bilateral after the political transition in 1994 whereby government directly funds another government and that was the main difficulty. The support of NGOs by donors and funders have been detoriating and most NGOs have been forced to 'shut down'. The HST is no exception to this and is also faced with funding problem. The trust is faced with numerous task but has limited resources in term of finance, human and equipment to provide services to the under served communities. The task of disseminating information to users and providers of health is expensive and the trust needs more resources in attaining the set goals and objective of the organisation. The trust has

survive these difficult times through forged partnerships with the Department of Health and with important stakeholders like the J. Kaiser Family Foundation. The HST "...works alongside Government - not in competition but complementary..."(Radebe 1998: interview).

(ii) DISTRICT HEALTH SYSTEMS

The implementation of the district health system is a threat to the HST. KwaZulu-Natal has not made any progress towards the creation of districts. The implementation of district health system is impossible without district boundaries. Although there is a strong political will and commitment to the creation of a decentralised health system based on districts there has not been the same commitment in the KwaZulu-Natal province (Radebe 1998: interview).

(iii) RESEARCH

The HST is faced with conducting research that will be of national interest. The shift by donors and funders from directly funding the HST to funding the government limits the resources (human and financial) available for conducting research. Research is

expensive and without proper research conducted, the limited resources that are available would not be appropriately utilised (Radebe 1998: interview).

It is clear that South Africa is still in a phase of transition, and support for planning and policy development needs to translate into support for implementation if that transition is to be complete. There is a need for continuing independent review and assessment of health policy development. Many non-government organisations have failed to survive the transition. HST has demonstrated that non-government organisations can continue to play a critical and constructive role. Together with other NGOs within the health sector, HST has a particular responsibility to strengthen smaller and more localised NGOs to ensure effective community participation in health care. HST recognises that individual and institutional capacity building is a medium to long - term strategy, and the seeds which have been sown within health services, historically black institutions and non-government organisations need to be nurtured (South African Health Review 1996:123).

In the past research has focused almost exclusively on basic and bioclinical research. Research into the delivery of health care has been neglected and funding for this type of research remains negligible. A well-structured health systems research programme

is essential to future health policy and to adequate monitoring of the national investment in health services (South African Health Review 1997:115).

In the view of the Health Minister, Dr Nkosazana Zuma (HST Update February 1997:21) HST has an important role to play for "at least another ten to fifteen years" and the Health Systems Trust must continue to demonstrate that "things can be done differently". The flexibility and responsiveness of a non-governmental organisation like the HST should be fully used by the Department to make thinsg (*sic*) happen as quickly as possible.

4.3 THE VALLEY TRUST

The Valley Trust is a non-government organisation (NGO) founded in 1953 as an initiative of visionary medical doctor Halley Stott and was probably the first primary health care programme in South Africa then. The Valley Trust is located on the edge of the Valley of a Thousand Hills at Bothas Hill, KwaZulu-Natal. The Trust is within easy reach of both Durban and Pietermaritzburg. It is set in attractive grounds and offers accommodation for up to 44 trainees, and a variety of well-equipped venues for meetings, workshops and seminars.

The Valley Trust is an independent socio-medical protect that takes a holistic approach to development. It encourages self-help projects driven by basic needs. The Valley Trust like many similar non-governmental organisations throughout the world is not aligned to any political, religious or sectarian interest group. The trust has been providing health care services to the Nyuswa tribe. Although it works primarily in the Valley of a Thousand Hills outside Durban, an area of 250 square kilometers and some 100 000 people, it applies principles that can be used in other underdeveloped areas and share its experience by encouraging and publishing research and by a visitor and trainee programme. Health care is at the core of the trust, as it sponsors the training of community health workers, first aid stations, mobile clinics, home deliveries and HIV/AIDS programme. The trust also provides consultancy services to business, other non-government organisations, government departments and community organisations. The Valley Trust with more than 40 years of experience is respected both nationally and internationally for highly innovative work in health promotion and sustainable development. However, its efforts are not immune to an illogical state bureaucracy, as this is the case with other non-governmental organisations (Mthembu 1998:interview).

4.3.1 THE VALLEY TRUST MISSION STATEMENT

The mission of the Valley Trust is to promote the complete physical, mental and spiritual well-being of the individual and communities emphasising their dependence upon and responsibility towards the environment. It strives to uphold universally-accepted humanitarian values. The Valley Trust's philosophy is to encourage self-reliance and participation applying principles that are innovative, non-sectarian, ecologically sound and scientific (The Valley Trust Annual Report 1996:1). (Refer also to Annexure B 1).

4.3.2 AIMS OF THE VALLEY TRUST

The Valley Trust has set its aims and objectives and are summarised as follows:

(i) innovate, evaluate and replicate

(ii) strengthen local impact

(iii) become a national reference centre

(iv) promote self-reliance and sustainability at the organisational and community level

(v) improve educational and community levels

(vi) influence national policy-making

(vii) encourage the application of ecological principles within the organisation direct programmes towards those vulnerable groups with the least resources (i.e. the poor)

(viii) improve communication

(ix) improve impact on key groups (i.e. youth, women and decision makers); and

(x) integrate as far as possible the work of sections as a component of holistic work of The Valley Trust (Valley Trust Information Brochure 1997:1).

These strategic aims of The Valley Trust can be achieved through the holistic approach whereby all the factors contributing to health are taken into consideration and these factors are ***inter alia***; socio-economic, cultural, recreational and educational factors.

4.3.3 THE VALLEY TRUST ORGANISATIONAL STRUCTURE

The organisational structure of The Valley Trust consists of a board of trustees, a management committee, an executive director and a board of management controlling

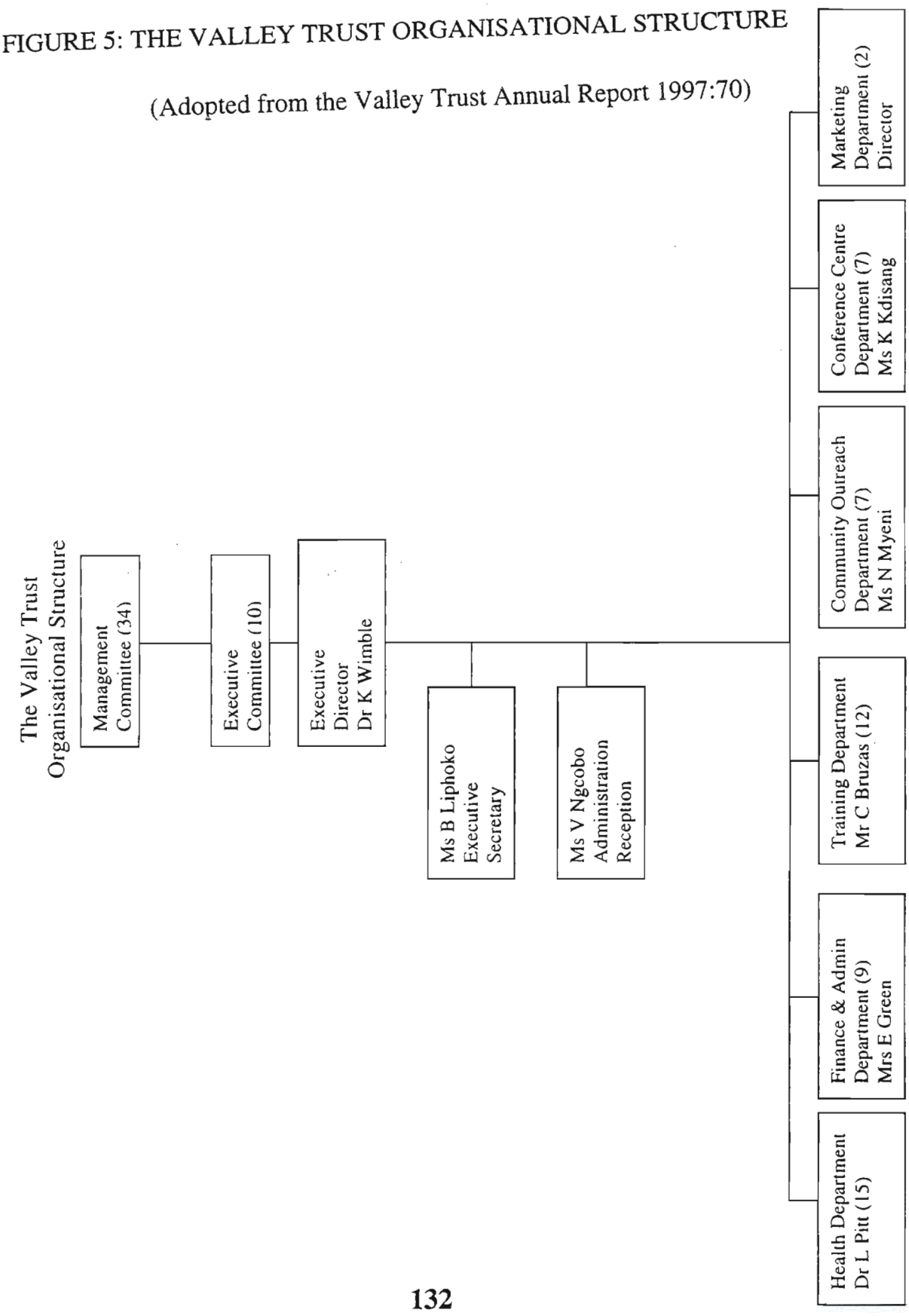
various sections. The restructuring of The Valley Trust had been taken into its third and final phase by the end of 1997. There were three additional departments which were created, bringing the total number to nine. These departments are graphically illustrated in Figure 5 and are:

1. Administration
2. Community Development and Outreach
3. Conference Centre
4. District Health and Finance
5. Education
6. Engineering
7. Marketing
8. Social Plant Use; and
9. Training

Each of the nine departments has clear objectives against which achievement is measurable in terms of verifiable indicators.

FIGURE 5: THE VALLEY TRUST ORGANISATIONAL STRUCTURE

(Adopted from the Valley Trust Annual Report 1997:70)



4.3.3.1 ADMINISTRATION AND FINANCE

The overall goal of the Finance and Administration Department is to provide effective support to The Valley Trust as a whole, to assist in enabling the attainment of the mission of offering quality education, training and associated resources in the fields relating to comprehensive primary health care and sustainable development to strengthen the capacity of individuals and communities to improve their quality of life. Planning and evaluation for the department resulted in further rationalisation and restructuring which resulted in the Conference Centre having autonomy (Mnyeni 1998: interview).

4.3.3.2 COMMUNITY DEVELOPMENT AND OUTREACH

Working with representative committees is central to the empowerment of communities (The Valley Trust Annual Report 1994/95:9).

Meetings were held between the Development Committees, **Amakhosi** (traditional leaders) and The Valley Trust Board of Managers to improve and strengthen good relationship and prioritise a way forward. Community representatives from Kwa-

Dedangendlale emphasised a desire to engage projects themselves and highlighted the crucial role required by The Valley Trust (Mnyeni 1998: interview).

The community capacity building has led to various key areas of progress which are ***inter alia***:

(i) Simunye Farmers Association

(ii) Hlanganani pre-school Association

(iii) Khanyakhwezi Adult Basic Education Association

(iv) Community Health Committees; and

(v) Community Development Committees (Mnyeni 1998: interview).

4.3.3.3 CONFERENCE CENTRE

The department has accommodation, venues, and the canteen. There has been improved security, catering, grounds maintenance, housekeeping and accommodation. A reservation and arrival procedure has been developed to ensure customer satisfaction. The KwaZulu-Natal government is faced with a challenge to use NGOs' skills and experience in project delivery (Mnyeni 1998: interview).

4.3.3.4 DISTRICT HEALTH AND FINANCE

Health care in The Valley Trust has been re-defined and the approach to health has been that of community-orientated Primary Health Care (PHC) in which district health would be achieved. In the past the Government's approach to health was more curative as opposed to the comprehensive approach in which all the stakeholders (doctors, community health workers, health promotion staff, community, nurses and leaders) are recognised and work together towards the eradication of factors that contribute to ill-health (Mnyeni 1998: interview).

A fresh commitment to a patient-orientated service, highly practical in-service training, and a new reciprocal working relationship between The Valley Trust and Don McKenzie Centre have contributed to a good standard of Primary Health Care at the Halley Stott Health Centre (The Valley Trust Annual Report 1994/95:3).

There are some areas of progress which can be identified in this section and are highlighted as follows:

(i) Health promotion

(ii) Improvement in community health indicators

(iii) Elimination of malnutrition in its acute form; and

(iv) Increased AIDS awareness.

Health promotion through district health system is now well established and there is a co-ordinating committee which provides useful forum for exchange of ideas around identified health issues. A system of governance for the District Health System which conforms with the proposed National Health Plan is moving ahead. An innovative protocol was drawn up and funding secured for research to develop a Health Information System. There are challenges which need to be addressed immediately and are ***inter alia***: bureaucracy which prevents independent decision-making and implementation of goals. Funding is not yet available to staff and manage proposed health services full time. The uncertainty surrounding the role of Traditional Authorities in local government development (Mnyeni 1998: interview).

Improvement in community health indicators continued to show progress in that five Community Health Facilitators (CHFs) were chosen to undergo training in facilitation skills and health issues. Although Community Health Workers (CHWs) are currently not recognised as formal public sector employees, there are still about 1 500 CHWs

who continue to be employed by the State (South African Health Review 1996:88).

Elimination of malnutrition in its acute form has been one of the pillars on which The Valley Trust's reputation was built and is a priority of the District Health Service. In KwaZulu-Natal, the Department of Health has approved the expenditure of R40 million for the implementation of The Valley Trust Nutrition Education Programme in 3 500 schools (South African Health Review 1997:208).

Increased AIDS awareness has been a national priority for the past three years. Educative AIDS/HIV programmes have included peer training, youth workshops, condom distribution, AIDS awareness days and workshops with traditional healers and community health workers. An AIDS awareness club for taxi drivers has been introduced and meets weekly (Myeni 1998: interview).

4.3.3.5 EDUCATION

The establishment of The Valley Trust as a centre of learning excellence in the field of integrated rural development requires a competitive and commercial ethos whereby income generated requires a training and consultation could lead to self-sustainability

in the future. The staff are to be complimented on their adjustment to this new ethos. The organisation was restructured to give effect to this new focus. A training department was established with four teams, each specialising in specific training needs. The health section worked progressively closer with the Department of Health and the Halley Stott Health Centre. A support services department was created to ensure that the environment, both administrative and infra structural, enables effective delivery of training and health promotion (Myeni 1998: interview).

A culture of learning in the Valley was emerging whereby teachers and learners were prepared to work together. Assistance to both teachers and youth to upgrade their skills was provided through centres like:

(i) IKHWEZI EDUCATION RESOURCE CENTRE

Secured four (4) computers and educational software for both school and community development, with the assistance of Kearnsney College (Mnyeni 1998: interview).

(ii) BUILDING AND EQUIPPING OF SCHOOLS

Four new pre-schools were built to address accommodation backlogs and these are Inhlakanipho and Thuthukani in Nyuswa. Phaphamani in Ngcolosi and Mbuyazi in Lower Nyuswa. Fifteen new classrooms were added to six primary schools in the Qadi-Nyuswa area (Mnyeni 1998: interview).

(iii) NUTRITION EDUCATION IN SCHOOLS

National policy states that nutrition programmes should be integrated, sustainable, environmentally sound, people and community-driven, and should target the most vulnerable groups, especially children and women (McCoy ***et al*** 1997:207). The Valley Trust's School Nutrition programme has enjoyed a lot of support from government personnel and has been funded by the IDT. The underlying sustainable theme of the project is that the final responsibility for feeding children properly belongs to the parents. Through the programme, pupils are motivated to bring food to school to supplement the snack provided by the Primary School Nutrition Programme (Mnyeni 1998: interview).

4.3.3.6 ENGINEERING

Key activities of Engineering Services were geared to contribute to the unfolding the Reconstruction and Development Program. Practical projects enable The Valley Trust to interact with relevant community committees, providing current information, training, equipment and encouragement at a very hands-on level. Road construction of 15 network roads, 24km of bus/taxi routes and major access roads, has been successfully completed. These projects maximise local labour opportunities and involve the community committee as 'client' to the contractor (Mnyeni 1998: interview).

The organisation contributed to a national water and rural sanitation document commissioned by Mvula Trust, as well as two national workshops and a special committee of the Department of Water Affairs and Forestry (The Valley Trust Annual Report 1994/95:17).

4.3.3.7 MARKETING

Marketing has been difficult for the Trust since local and foreign donors have withdrew

their funding for non-governmental organisations. Funders have been cautious not to commit themselves and the Government of National Unity has published in the Government Gazette No. 17910 (1997:186) that it will only fund those NGOs which have been assigned by the government to work on a specific health project (Mnyeni 1998: interview).

4.3.3.8 SOCIAL PLANT USE

The work of the Eco-Agriculture Section has been redefined as the Social Plant Use Programme (SPUP). This arose out of a concern that concepts such as "food production" and "social forestry" are too narrow to capture the way in which plants contributed to the livelihoods of people, their health and development. One aspect of the SPUP which gained particular relevance during the year was food security (Mnyeni 1998: interview).

The SPUP is gaining considerable attention and interest both provincially and nationally, given that it is action orientated and people centered. The Simunye Farmers Association executive committee received assistance with strategic planning. The committee restructured, and tribal garden committees have received training. Practical

work with community gardeners (mainly in Ngcolosi) has resulted in garden innovation and increased production practices through terrace stabilisation with vetiver grass, compost making and mixed planting of vegetables (Mnyeni 1998: interview).

Training of community health facilitators, community health workers and traditional health practitioner around three health posts, focusing on both food production and medical plants has taken place. Traditional health practitioners have also visited Silverglen nursery to access plant material and learn more about plant propagation (The Valley Trust, Annual Report 1996/97:13).

4.3.3.9 TRAINING

According to the Valley Trust Annual Report (1997:15) training at the Valley Trust has been approached within the context of four major challenges to improvement of health care in South Africa and these are:

- Shared understanding
- Necessary skills
- Personal and organisational change; and

- Intersectoral collaboration.

(i) SHARED UNDERSTANDING

Although Primary Health Care and its implementation through the District Health System (DHS) is accepted policy, there is not necessary shared understanding of the concepts among the major stakeholders. It is therefore important for the Valley Trust to understand that PHC is most appropriate when it takes into account local needs and people are involved in the decision-making process that affect their health (The Valley Trust 1997:15).

(ii) NECESSARY SKILLS

The necessary skills for the implementation of PHC and DSH are often lacking. The health stakeholders especially, the government should make it a priority to gradually introduce these skills (Mnyeni 1998: interview).

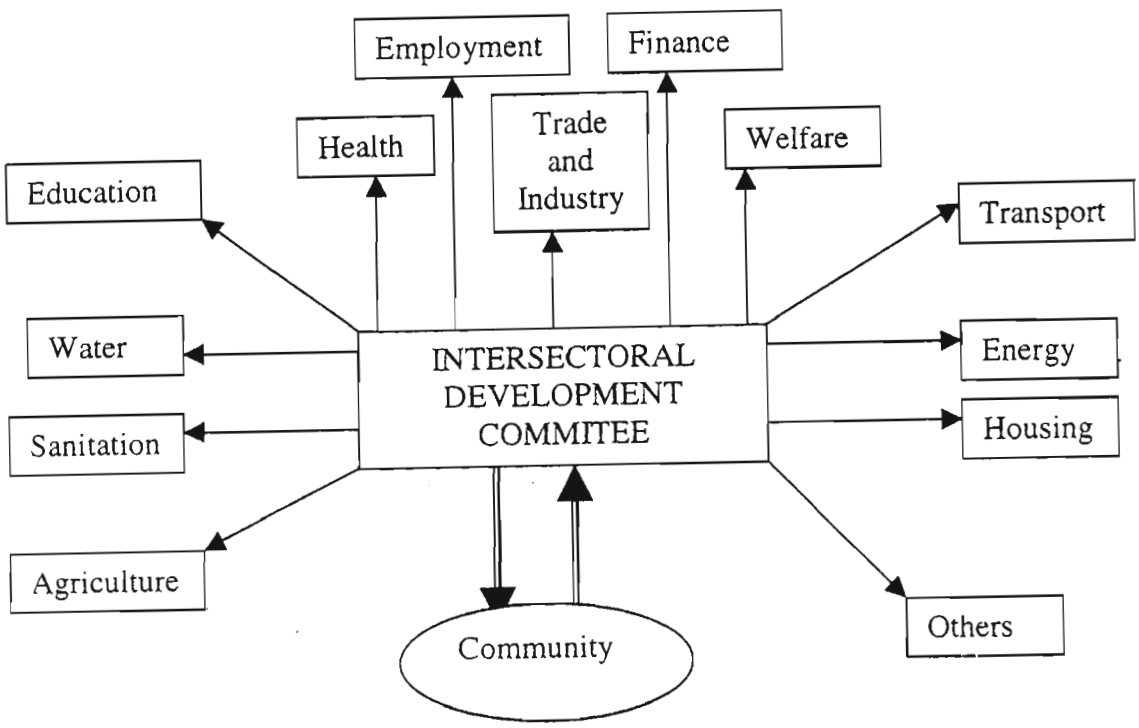
(iii) PERSONAL AND ORGANISATIONAL CHANGE

Mnyeni (1998: interview) argues that the necessary changes in understanding and implementation will not come about without all role players recognising the need for both personal and organisational change.

(iv) INTERSECTORAL COLLABORATION

Different sectors have the different resources, skills and technology necessary for the attainment of a healthy community (Dennill ***et al*** 1995:8). There is a need for a more holistic approach to PHC, recognising the importance of aspects such as food security, water and sanitation, poverty, and environmental degradation as depicted in Figure 6.

FIGURE 6: INTERSECTORAL COLLABORATION (ANC 1994:23)



The Valley Trust with the 44 years of experience is an ideal position to inform the many processes of change currently under way within the country, through training, consultancy, information and skill sharing.

4.4 ROLE OF NON-GOVERNMENTAL ORGANISATIONS

The hypothesis of this study was that non-governmental organisations played an important role in the provision of health services in KwaZulu-Natal. This study through the research instruments (questionnaire A1 and A2) that was administered to the non-governmental organisations and the beneficiaries of these services concluded that NGOs had a role to play in the past, present and in the future of health care in KwaZulu-Natal.

4.4.1 PAST ROLE OF NGOs

Progressive non-government organisations played a vital role in communication with marginalised and disenfranchised communities. In many instances, these organisations were the only support available to many disadvantaged communities. Health organisations have often been pivotal in articulating people's needs - and health, in particular has served as a rallying point for political mobilisation" (Derman and Makanjee 1996:13).

The findings of this study (which are analysed in chapter five) indicates that the main role in the past was to challenge the apartheid regime and to protect the rights of disadvantaged South Africans. Non-governmental organisations like the RED CROSS, Health Systems Trust, Valley Trust and others outside the health sector voluntarily provided basic comprehensive services to communities who were marginalised by the past government of the National Party. KwaZulu-Natal was the most neglected province by the previous regime. Curative facilities (hospitals and clinics) provided by the government were situated long distances (urban areas) from where the poor were. Transport facilities (ambulances and public) were not available and were not well developed. There was no equity in the provision of health in the province, whereby one group (minority) was receiving efficient, quality and affordable health care whilst the other group (majority) was receiving the most inferior, inefficient, inadequate and unaffordable health care services and often not receiving any service at all.

The NGO sector was required to provide health services to the disadvantaged communities which were the responsibilities of the government. The former Natal Provincial Administration (NPA) was inefficient and ineffective, it could not provide health care services to most rural communities because of lack of planning. Available resources were misused, there was corruption and maladministration. The health

officials were not responsible because they were not accountable. Non-governmental organisations then provided basic services to most disadvantaged communities at very minimal price or at no charge. Many NGOs in the province were able to provide services which the government could not provide. NGOs were able to fill the void created by the inefficiency of the government. These NGOs were able to operate in areas where there was political instabilities, and places where there was no infrastructure (clinics, electricity, roads and schools) and remote places where the government did not bother to provide health services.

The non-governmental organisations that operated in KwaZulu-Natal gained a lot of respect and thrust from local communities. This was because of community involvement. The people were consulted and were given the opportunity of taking decisions on matters affecting their health. The local communities felt that the services were provided for them, controlled by them and evaluated by them. There was a good relationship between NGOs and the local people. The donors and funders of NGOs were supportive of the course persuaded by the NGO community. Funding of these structures was not problematic and well-established and recognised NGOs like The Valley Trust were largely funded by foreign donors. Although they were able to fundraise, the government imposed restrictive and oppressive policies to these

organisations that were improving health in disadvantaged communities especially in rural and informal settlements. This often involved confrontation with the apartheid regime nevertheless NGOs were able to survive and continue their role of improving health in disadvantaged communities.

The past role of non-governmental organisations was very challenging and there was always confrontation between government and NGOs.

4.4.2 PRESENT ROLE OF NGOs

The transition from apartheid to democracy in South Africa challenged the NGO sector to review its role. The confrontation of the past between government and NGOs has to change to partnership and co-operation. The Government of National Unity now occupies the space that NGOs occupied in communities denied resources by an illegitimate government. Through government initiatives ***viz***: Reconstruction and Development Programme (RDP) the government is providing health services to the previously disadvantaged communities. The projects which are ***inter alia***; building of new clinics and free health care are aimed at eliminating health problems amongst South Africans. These health care services were normally provided in the past by the

NGO sector.

4.4.2.1 HIV/AIDS.

Care of people with HIV/AIDS is imposing an increasingly large burden on health service resources in South Africa. One estimate suggests that there will be between 3.7 and 4.1 million HIV infected people and 200 000 adults with AIDS by the year 2000 (SAJPH November 1996:1484).

Despite efforts to raise awareness, the HIV infection trend generally continued along the trajectory of the "worst case scenario". The 1995 survey of women attending antenatal clinics showed that 10.4% were HIV positive, with the figure rising to 18% in KwaZulu-Natal. The survey also showed an average of 10% of teenage girls visiting antenatal clinics across the country were infected with the HIV (South African Health Review 1996:xviii).

The NGO sector has a significant role to play especially in KwaZulu-Natal. The Health Department alone will not solve the problem, however, with the NGO sector and other stakeholders being involved in finding a solution, there are better chances to fight this

epidemic. The experience of NGOs in working with communities especially the disadvantaged will help in informing the communities about the disease. However, funds that are allocated to HIV/AIDS awareness campaign should be properly accounted for, unlike the controversy over the funding of *Sarafina 2* on the AIDS awareness play. The report alleged "... Zuma 'negligently and recklessly' omitted to stipulate a limit on the cost of the controversial musical and that her actions led to the loss of R10.5 million (Sowetan November 16 1998:2).

The government expressed its willingness to defend Health Minister Nkosazana Zuma who faces civil claim by Judge Willem Heath's anti-corruption unit over the funding of the AIDS - awareness musical *Sarafina 2*.

It is therefore important for the government to consult with all stakeholders who are involve in health care delivery like the traditional healers who know the community and their experiences, NGOs who have been working well with the communities in the past and also the community health workers who are trusted by the community. However, KwaZulu-Natal MEC Dr. Zweli Mkhize warned the traditional healers "... not to raise the hopes of residents with HIV as it is harmful to the community to claim that there is a cure that is not based on scientific evidence..."(City Press September 20 1998:1).

4.4.2.2 TUBERCULOSIS

As in other countries, Tuberculosis is being affected by HIV. It has been estimated that there were 160 000 TB cases in 1996, of which 42 000 cases could be attributed to HIV. The prevalence of HIV in adult TB patients in the Hlabisa health district of KwaZulu-Natal has risen from 36% in 1993 to 58% in 1995. The disease case load in the service has risen 3 fold and the clinical features of the disease are different. Furthermore, the HIV infected patients were 3 times more likely to fail to complete their treatment (South African Health Review 1997:10).

It is evident from the studies conducted that TB accounts to more deaths in the province and most victims are those communities with poor housing, lack of clean water, sanitation and those who cannot afford to pay for hospitals and the clinics. These communities are mostly from the rural areas. The slow delivery of the government through the RDP is seen as inefficiency on the side of the communities. Many communities in KwaZulu-Natal have lost trust in government structures because of the "election promises" that are not fulfilled. NGOs and CBOs that were

providing health care services to the disadvantaged communities have been struggling to compete with the government because of lack of funding by foreign donors.

Community Health Workers have an important role to play in the provinces. They have developed a sense of trust in their communities. They speak the local language and are acquainted with cultural norms. These groupings should be more pro-active in taking the process forward on community level (South African Health Review 1997:135).

Non-governmental organisations have a very critical role to play in the provision of health services in KwaZulu-Natal in order to supplement the provincial government in improving the health of the people of this province.

4.4.2.3 MALNUTRITION AND POVERTY

Poverty in South Africa is extensive and is predominantly associated with Blacks, especially those in rural areas, informal settlements and townships.

Poverty usually breeds ill-health because of poor nutrition. The eradication of poverty is one of the priorities of the government. However other stakeholders should also be involve in solving this problem.

The Department of Health has developed a comprehensive set of policies and objectives in order to address the problems of poor nutrition. There is now a clear policy framework for provincial Departments of Health and other relevant role players in the country (McCoy & Saasa-Modise 1997:212).

School nutrition programmes have been implemented all over the country, however there are problems that are encounter such maladministration, inefficiency of project managers and in other places the food does not reach the intended recipients (children). It is therefore important that these projects be administered and implemented by people with the necessary expertise and skills. Non-governmental organisations through the community-based organisations have a vast experience in nutrition programmes and in the eradication of poverty. The government should ensure that these nutrition programmes are sustainable and should target the

most vulnerable groups of society especially those in the previously disadvantaged communities. In KwaZulu-Natal, the Department of Health has approved the expenditure of R40 million for the implementation of the Valley Trust Nutrition Education Programme in 3500 schools (McCoy & Saasa-Modise 1997:208).

4.4.2.4 ALCOHOL AND DRUGS ABUSE

A study of all traffic-related trauma patients (drivers, passengers and pedestrians) presenting to Addington Hospital, Durban, assessed 530 patients for alcohol intoxication and marijuana use at the time of presentation to the hospital. The results indicated that 52% of all the patients were over the legal limit for alcohol, 35% had traces of marijuana in their urine and 19% were positive for both substances. A study on fatally injured pedestrians indicated that of the 60 cases examined, 78% were BAC (blood alcohol contents) positive and of these latter 47 cases, 30 (64%) tested positive for cannabis and/or Mandrax as well (Butchart & Peden 1997:218).

From the above findings it is evident that people misuse alcohol and drugs. The government alone would not solve the problem. However with the involvement of non-governmental organisations who can reach the communities through educational and awareness programmes on the harmfulness of these substances could eradicate the problems. As unemployment level is high these people tend to resolve to crime and this increase the burden of the government who spends a lot of money on rehabilitation.

The funding problem of non-governmental organisations, limits their role in the provision of health care services. NGOs have experienced difficulty in securing funding as traditional donors have chosen to redirect their funds to the government. Foreign doctors recruitment has also posed another dilemma for the NGO sector. These doctors are operating in areas that were traditional the NGOs territories. In cities there is one doctor to every 700 people, while in rural areas there is one doctor to every 10 000 to 30 000 people. This emphasise the need for more health providers (Ntsalumba 1997:7).

This should be viewed as a short-term measure to address the problems of inefficiency and unavailability of doctors in the rural areas. Therefore foreign doctors and other health providers must not be seen as a threat to local NGOs especially in KwaZulu-Natal as there is a need for health care providers. Free health care services for pregnant women and children under the age of 6 that came into effect as from the 1st of June 1994 should not be seen as a threat by non-governmental organisations although these people (women and children) are the major recipients of the services they are rendering.

Although in theory it should be possible to have a user fee system that exempts the poor and disadvantaged, this does not generally happen in practice. This is mainly due to lack of administrative capacity which is aggravated in high volume facilities where there may be even less time, space and privacy to identify those people who are exempted from fees. Other problems include a reluctance amongst staff to grant exemptions and a reluctance amongst patients to request exemptions despite being eligible (South African Health Review 1996:158).

4.4.3 FUTURE ROLE OF NGOs

Although NGOs are faced with the funding problem and the commitment of the government to the provision of equitable health care for all, NGOs have an important future role to play in the provision of health care services.

However the government will not afford to ignore the crucial role of the NGO sector as it is aiming at providing health care for all by the year 2 000.

4.4.3.1 RESEARCH AND EDUCATION

Non-governmental organisations need to conduct research and education in health related issues and illnesses like STDs, HIV/AIDS, TB, cancer, drugs and alcohol abuse and other infectious diseases. Edwards-Miller (1997:113) argues that "... skills need to be developed to ensure that rigorous and appropriate research methods are applied to these priorities. Health services, historically disadvantaged institutions and black researchers who were largely excluded from the research process in the

past, need to be financially and technically supported to build their research skills and capacity within priority health research areas ...".

4.4.3.2 DISTRICT HEALTH SYSTEM

A district health system is the vehicle for providing quality primary health care to everyone in a defined geographical area. It is a system of health care in which individuals, communities and all health care providers of the area participate together in improving their own health (Harrison1997:3).

Health care needs to take into account local needs and should be managed by the local people in order to be successful. Community-based organisations which have been successful in implementing changes in health care should continue their role with the financial assistance from the government. Harrison (1997:5) has identified 5 important reasons for district health care and are:

(i) HEALTH CARE NEEDS

In the past health services were only provided only to those who came to clinics, hospitals and those who could not afford were denied. The district health care try to meet the health care needs of all South Africans (Harrison 1997:5).

(ii) SIMPLE LOGICAL SERVICE

The health services need to be integrated and different health providers in the departments need to work together. Fragmentation of health care services also contributes to unnecessary delays (Harrison 1997:5).

(iii) DECISION-MAKING

Local people who know local needs best must have control over budget and decision-making and not by remote national or sometimes provincial governments (Harrison 1997:5).

(iv) COMMUNITY INVOLVEMENT

Harrison (1997:5) argues that local people who receive health care should be involve in improving the services they use. This has been achieved as community-based organisations participated vigorously in the formulation of health forums which are a forerunner of the District Health System. Workshops were also held on various policy issues e.g. strategies to involve males in HIV/AIDS.

(v) IMPROVING HEALTH

District health care is meant to shift the focus from administering health services to really improving the quality of care (Harrison 1997:5).

The involvement of non-governmental organisations is an advantage because they do not limit their services to particular individuals but they provide health care services to all those who need it. The communities would then support the role played by non-governmental organisations. It is important that the donor funds that are available should be used to

eradicate poverty and solve the health problems. However some non-governmental organisation officials have enriched themselves. Poor people should be supported to improve their standards of living and thereby improving their health status. Health care services provided to these communities should be improved.

4.5 SUMMARY

This chapter has indicated the role played by non-governmental organisations in the provision of health services with particular emphasis to the case study of the Valley Trust and the Health Systems Trust. These NGOs have played a significant role in the past in improving health in disadvantaged communities. KwaZulu-Natal has benefitted from these health care services. Although this involved confrontation with the apartheid health structures these NGOs managed to survive.

The future role of NGOs is ernomous as South Africa is faced with problems such as HIV/AIDS epidemic, cancer, TB, alcohol and drugs abuse however the NGO sector is faced with the problem of lack of funding.

CHAPTER 5

PRESENTATION AND ANALYSIS OF DATA: ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN HEALTH PROVISION

5.1 INTRODUCTION

The focus of this study was on the role of non-governmental organisations in the provision of health services in KwaZulu-Natal. This chapter introduces the reader of this text to the most important aspects of this study- the findings. The chapter includes: objectives of the study, research methodology, study sample, research instruments, interpretation of research findings, hypotheses and conclusion of the chapter.

5.2 OBJECTIVES OF THE STUDY

The three objectives of this study as set out in chapter 1 are to:

- Identify the role of non-governmental organisations in the provision

of health services;

- Describe practical mechanisms for enhancing collaboration between the government and non-governmental organisations; and
- Identify mechanisms for the reallocation of resources from the government and private sectors to the NGO sector.

In order to achieve the objectives of this study a number of questions were raised and included:

- What was the past, present and future role of non-governmental organisations in the provision of health services?
- What was the nature and functions of non-governmental organisations?
- Is there any relationship between government, business and NGO sector in the provision of health services?
- Where should funding for non-governmental organisations be obtained from?
- How should the available resources be equally shared among all health stakeholders?

The objectives of this study were achieved hence the study undertaken by the researcher was aimed at finding possible answers to these questions and the findings are presented in the later sections of this chapter.

5.3 RESEARCH METHODOLOGY

Exploratory research of both qualitative and quantitative nature was used to collect the relevant information. The study was conducted over a period of 30 months. A study of available literature on non-governmental organisations that were providing health services was conducted. Two questionnaires (A1 and A2) were administered to the communities and NGOs, respectively. Visits to Health Systems Trust, Valley Trust, local hospitals, libraries and KwaZulu-Natal Health Department were made to collect information. The fieldwork was undertaken between July 1997 and August 1998 and informal interviews were conducted with the relevant officials and community members. The media (T.V., newspapers and radio) also provided with the relevant and updated information.

5.4 STUDY SAMPLE

This study was undertaken after a 'pilot study' was completed and the results indicated that the study was feasible. Questionnaire A1 was administered to an initial sample of 260 would-be respondents. Of that sample, 220 responses were obtained and the researcher selected 190 completed questionnaires. An additional of 15 questionnaires were administered to those respondents who were illiterate. These questionnaires were marked **'i'**-indicating illiterate. These questionnaires were translated from English to Zulu and during the interviews notes were taken. For checking of possible inconsistences due to language differences a language expert was consulted and responses were translated back to English. In all 10 questionnaires that yielded maximum responses were selected. The total number of the completed questionnaires was 200.

Two non-governmental organisations were chosen for this study as discussed in the previous chapter (chapter 4) and these NGOs are; Health Systems Trust and the Valley Trust. A separate questionnaire (A2) was administered to these NGOs. There were other NGOs like the RED

and the National Progressive Primary Health Care Network which the researcher visited, however, the researcher felt that by studying the sample it might be possible to generalise the findings to the NGOs that are providing health services in KwaZulu-Natal.

5.5 RESEARCH INSTRUMENTS

Two pre-coded questionnaires, A1 and A2 were administered to respondents from the study sample of community members and NGOs, respectively. Questionnaire A1 was a standardised structured questionnaire designed in English. The questionnaire was translated from English to Zulu for those 15 would-be respondents who were Zulu-speaking. Questionnaire A2 was administered to the officials of the respective NGOs. Questionnaire A1 consisted of 21 items divided into three sections.

SECTION A - contained questions from 1-7 pertaining to the role of NGOs in the past, present and future.

SECTION B - contained questions from 8-15 pertaining to the nature of non-governmental organisations and their functions. A Likert scale was used where respondents were required to respond from strongly disagree to strongly agree.

SECTION C - contained questions from 16-20 and these were questions on the funding of the non-governmental organisations.

Closed questions which yielded responses such as YES or NO were asked and also open-ended questions which allowed respondents to respond freely and substantiate on their responses. An additional question number 21 was included for respondents to provide the researcher with as much information as possible which might not have been covered by the other questions. This also helped the researcher to acquire more information which might not have been known. Interviews outside the study sample were conducted with officials and workers from hospitals, schools, libraries, other NGOs not providing health services and other members of the community. Probing questions were asked to those people who were interviewed but did not provide satisfactory responses.

Questionnaire A2 was also a standardised structured questionnaire designed in English. The questionnaire was administered to different officials of non-governmental organisations in KwaZulu-Natal. The researcher selected two NGOs which were involved in the provision of health care services. These NGOs have very strong organisational structures and they also disseminate health information to different health stakeholders. They are the Health Systems Trust and the Valley Trust. Questionnaire A2 consisted of 8 questions. The findings of qustionnaire A2 have been presented in chapter 4 of this study.

5.6 INTERPRETATION OF RESEARCH FINDINGS

In this section the information that was collected by the researcher through questionnaires, interviews, observations, study of the relevant literature was interpreted and presented, using bar diagrams and tables.

SECTION A: PAST, PRESENT AND FUTURE ROLE OF NGOs

It is important to note that the non-governmental organisations that were chosen for this study were those involved in the provision of health care in KwaZulu-Natal. The questions asked in Section A were aimed at understanding the role played by non-governmental organisations in the past, present and in future.

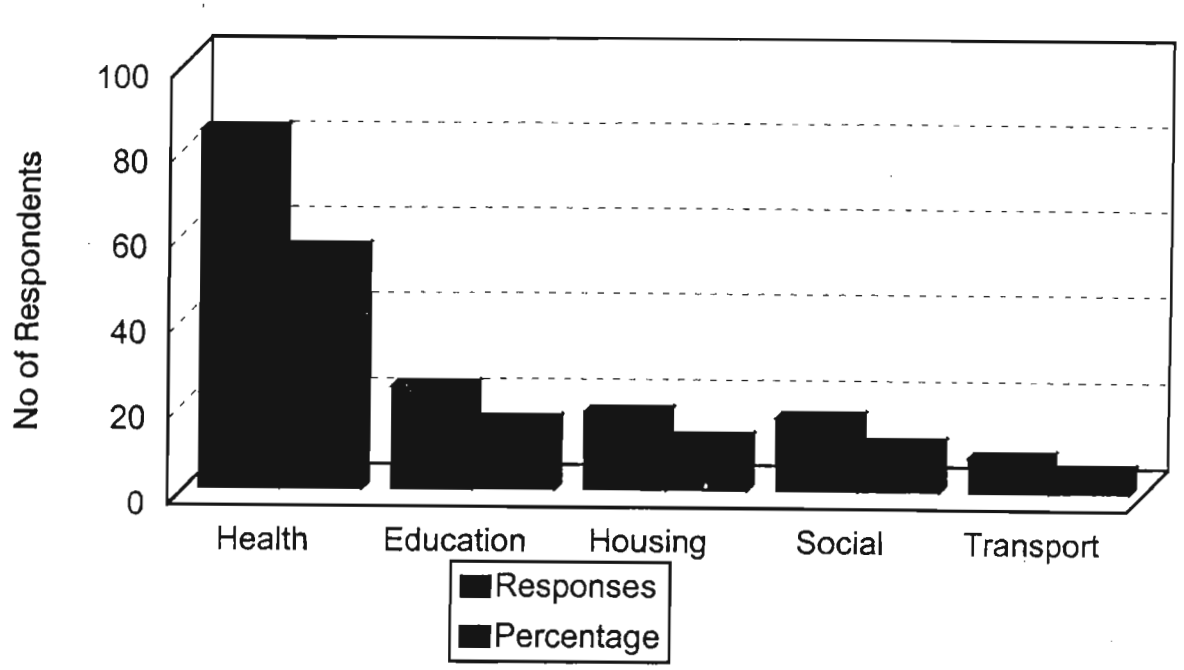
QUESTION A1: 3 Priorities of NGOs

Respondents were asked to mention three (3) priorities of NGOs in their respective communities. The question was asked in order to understand the most important areas in which non-governmental organisations provided assistance.

TABLE 1: PRIORITIES OF NGOs

	Health	Education	Housing	Social	Transport
No. of respondents	84	24	18	17	8
Percentage of responses	56%	16%	12%	11%	5%

FIGURE 7: PRIORITIES OF NGOs



From the responses, most respondents (84) which is fifty six percent, indicated health as a priority. Education was second with sixteen percent which is 24 responses. Housing had 18 responses which is twelve percent (this however surprised the researcher as some households were overcrowded and did not have proper housing). Social programme (11%) and had 17 responses and transport had 8 responses (5%).

QUESTION A2: NGOs have been providing affordable health care to the poorest sectors of the population

This was a closed question which yielded a YES or NO answer. It was asked in order to understand whether or not NGOs provided affordable health care to the most vulnerable (rural, poor, old, women and children) communities. The majority of the respondents (198) agreed that NGOs were providing affordable health care to the poorest segments of the population. Only two respondents disagreed.

QUESTION A3: Is it a major problem to raise funds from the poor?

The question was asked following the ongoing debate of non-payment for services by the majority of the community. All respondents (200) indicated that raising funds from the poor was problematic. Respondents also indicated that the reasons for not attending hospitals and clinics was lack of funds to pay for health services. Some respondents indicated that they were prepared to pay for these services, provided they had some sort of

income. The researcher also observed that most respondents were unemployed.

QUESTION A4: Were NGOs accountable to the community?

Accountability of an organisations indicates its responsibility. Resources (financial, physical and human) should be utilised efficiently and effectively. From the responses of this study 186 (93%) indicated that NGOs were accountable whilst 14 (7%) stated that they were not. Previously, non-governmental organisations were only accountable to the donors or funders of their projects.

QUESTION A5: Do NGOs have the resources to handle development?

Development is a process which needs a comprehensive approach and resources namely; human, physical and financial. The question was asked so as to identify the resources that were available to non-governmental organisations. The majority of respondents (188) stated that NGOs did not have the necessary resources to handle development. Respondents also

stated the following problems:

- lack of transport like ambulances
- lack of hospitals and clinics; and
- unavailability of funds

Twelve of the respondents agreed that non-governmental organisations have resources to handle development. The researcher noting the geographical area of KwaZulu-Natal and development that needs to be taken concluded that the resources that were available were inadequate. Generally, speaking NGOs have limited resources.

QUESTION A6: Should NGOs maintain their independence from the government?

The Government of national unity is committed to a better health for all. This has been supported through the policy of free health care for pregnant women and children under 6 years. The question was asked to access the present and future relationship between government and non-governmental

organisations. One hundred and eighty (90%) respondents agreed that NGOs should maintain their independence from government and they provided the following reasons:

- government is not delivering on its promises
- communities need to be protected from the bureaucracy of the government; and
- government is remote from the communities.

Twenty (10%) respondents stated that NGOs should not maintain their independence because they will need the support of the government, particularly funding.

QUESTION A7: Should the role of non-governmental organisations change in the new dispensation?

In the past (apartheid era) non-governmental organisations confronted the government and there was always an element of antagonism. The role of NGOs was to provide health services where the government did not

provide. The political changes that haveoccurredd in South Africa especially after 1994 have challenged the NGO sector to review its position. One hundred and sixty eighty (84%) respondents stated that the role of NGOs should not change and provided the following reasons:

- government is slow in its delivery process
- corruption and maladministration of government; and
- NGOs are able to respond to the changing needs and circumstances.

Thirty two (16%) of the respondents agreed that the role of non-governmental organisations should change because of the following reasons:

- the government was committed to better health for all
- government was democratic and elected by the majority: and
- the role should change from opposition to partnership.

SECTION B: NATURE AND FUNCTIONS OF NGOs

This section was aimed at understanding the nature and functions of NGOs. A Likert scale was used in which respondents were asked to respond from strongly disagree to strongly agree on the questions.

QUESTION B8: NGOs have been carrying out functions which were considered to be government responsibilities.

In the past the apartheid government discriminated against the majority of South Africans which were particularly Blacks. Basic services were not provided to them and these communities were neglected. This question was asked to access whether NGOs were providing services that were beyond their jurisdiction. The findings indicated that although the majority of respondents - 156 (78%) agreed with the statement they did not strongly agree. Twenty four (12%) disagreed and twenty (10%) were not sure.

SECTION B9: Community must be involved in shaping health care services.

The proposed District health care by the ANC-led government is based on Primary health care which depends largely on community participation and involvement. The question was asked in order to ascertain the need to involve communities in decision-making. The results indicated that the majority of the respondents one hundred and ninety two(96%) indicated that there was a need for community involvement. From those (190), more than ninety eight percent (98%) strongly agreed with the statement. Only eight (4%) of the respondents disagreed with the statement. The researcher, however strongly believes that before communities could be involved in shaping health care services they need to undergo a vigorous training in which they could have specialized knowledge on health care.

QUESTION B10: NGOs are one of the sets of organisations which limit the power of the state in relation to lives of the citizens.

The question was asked in order to access the power and influence of

NGOs to the government. The apartheid government was powerful and authoritarian. It did not allow opposition particular the liberation movement. Non-governmental organisations had a very difficult task of challenging such government with its limited resources. Although NGOs challenged the apartheid government the resources to be effective were limited therefore NGOs were not able to limit the power of the state. The results of this study indicated that half of the respondents one hundred (50%) agreed with the statement whilst eighty (40%) disagreed in which seventy five percent (60) strongly disagreed. Twenty (10%) of the respondents were not sure. In a democratic state NGOs might have more powers in limiting the powers of the government hence there is freedom of speech, freedom of movement and association. Unlike in the past NGOs are now protected.

QUESTION B11: NGOs have taken up the challenge of promoting collaboration to help the poor cope with their needs.

Non-governmental organisations were created to help the most vulnerable sectors of the population. The question was asked in conjunction with

question 2 from section A. Respondents were consistent and one hundred and ninety eight (99%) agreed in which (180) strongly agreed and only two (1%) of the respondents were not sure. The results indicate the commitment of NGOs to the upliftment of the lives of the poorest segments of the population.

QUESTION B12: A redistribution of health workers to under serviced areas has to take place.

The government is committed to the provision of equitable health care for all South African citizens. The question arose out of the inequity of health care. Health workers and resources are unevenly distributed favoring the white communities and urban citizens. The blacks and rural communities do not receive these resources. The results indicated that all two hundred of the respondents strongly felt that redistribution was necessary. The researcher however, feels that it is important that redistribution be done in a consultative manner in which all stakeholders that are involved are taken into consideration and decision should not be imposed without proper communication as it is the case with a 'top-down' approach.

QUESTION B13: NGOs act as a pressure group to government structures.

Question ten and thirteen were aimed at understanding the views of the respondents in relation to the role of NGOs. The question was poorly answered, only twenty agreed whereas 180 indicated that they were not sure. None of the respondents disagreed with the statement.

QUESTION B14: NGOs can utilise resources more effectively than government.

The question was raised to understand the cost-efficiency of NGOs compared to the government. Non-governmental organisations have been operating with limited resources, however, they were able to deliver services to the majority of the population without even receiving any income from the beneficiaries of their services. Most of the respondents one hundred and sixty (80%) agreed with the statement (75% of the respondents - 120) strongly agreed. Only twenty percent (40) disagreed.

QUESTION B15: The services of NGOs should not be integrated with the rest of health services.

Integration of services would mean one single health sector in which all other sectors would be integrated and the costs would be minimised. The question that arises when there is integration is who is co-opted. Although, the government is in favor of the process of integration, other sectors are not because of fear of uncertainty that their project would be phased out and their role be undermined. Responses indicated that one hundred and seventy two (86%) of the respondents disagreed with the statement indicating that they were in favor of the integration process. Eighteen were against integration and ten were not sure.

From the above responses the researcher concluded that non-governmental organisations provided services which were sometimes government responsibilities. These services were provided with the limited available resources. In the new dispensation the government should redistribute resources in an equitable manner and fragmented services should be

amalgamated in a broad consultative way in which each an every stakeholder could have an input.

SECTION C: FUNDING OF NGOs

Non-governmental organisations enjoyed the financial assistance from foreign donors and governments which were opposed to apartheid policies. This section focus on the funding of NGOs in the past and future. The questions asked in this section were based from the third objective of this study - to investigate mechanisms for reallocation of health resources to the NGO sector.

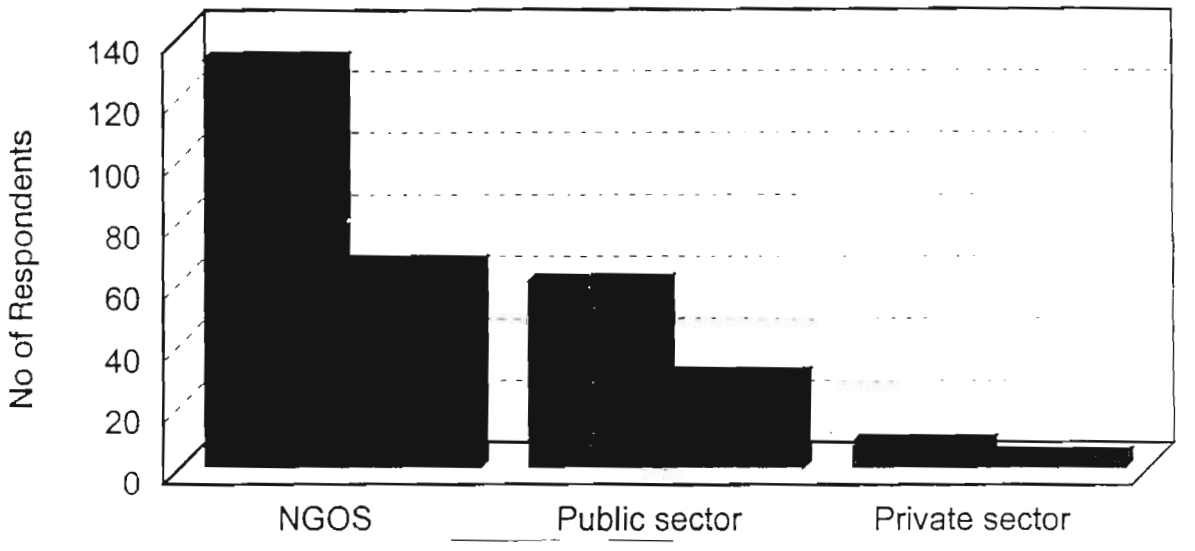
QUESTION C16: Which one of the following (private, public or NGOs) has been the major lifeline for addressing health problems?

Respondents were asked to identify the major lifeline for addressing health problems. The question was raised in order to evaluate the contribution of each of the three sectors in the provision and promotion of better and quality health care to the disadvantaged communities.

TABLE: 2 LIFELINE FOR HEALTH PROBLEMS

	NGO sector	Public sector	Private sector
No. of respondents	132	60	8
Percentage of responses	66%	30%	4%

FIGURE 8: LIFELINE FOR HEALTH PROBLEMS



One hundred and thirty two respondents indicated non-governmental organisations with (66%) responses. Sixty (30%) respondents indicated the public sector and only eight (4%) indicated the private sector. The reseacher cited the following reasons:

- NGOs were operating within these communities; and
- NGOs also provided free or affordable services.

QUESTION C17: Who should finance NGOs in the future?

The question arose because of the financial crisis, the NGOs are faced with. Foreign governments are now directly funding the government of national unity which is committed to better health for all. Non-governmental organisations are battling to raise funds.

TABLE 3: FUNDING OF NGOs

	National government	Provincial government	Local government
No. of respondents	188	60	4
Percentage of responses	94%	30%	2%

FIGURE 9: FUNDING OF NGOs

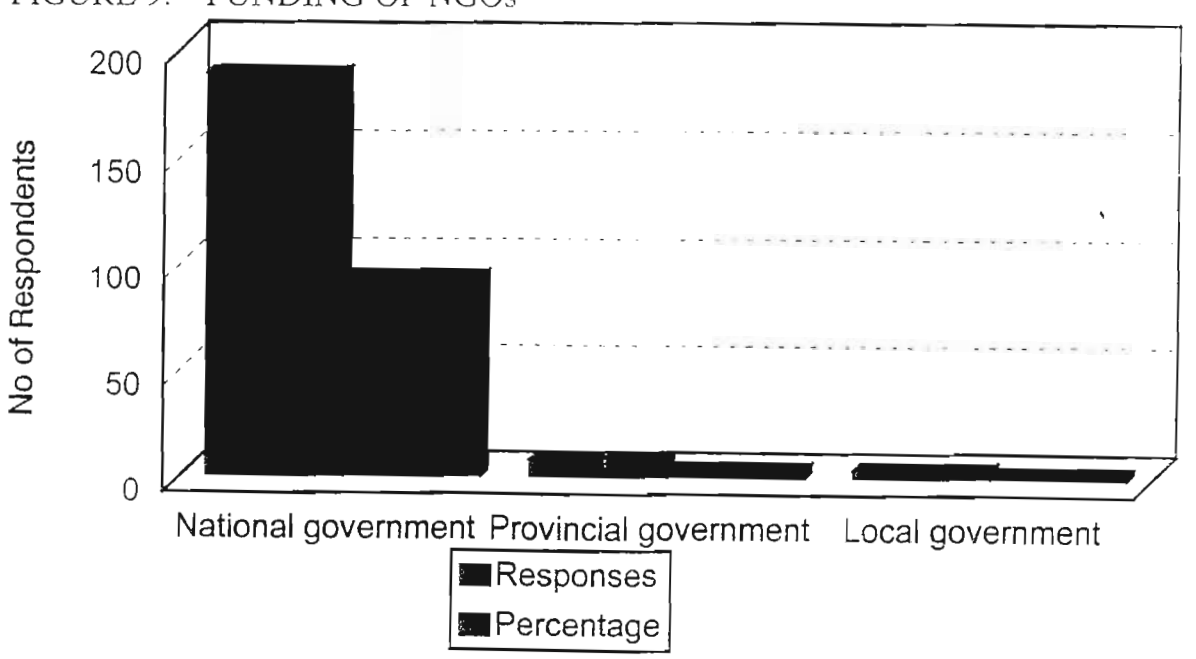
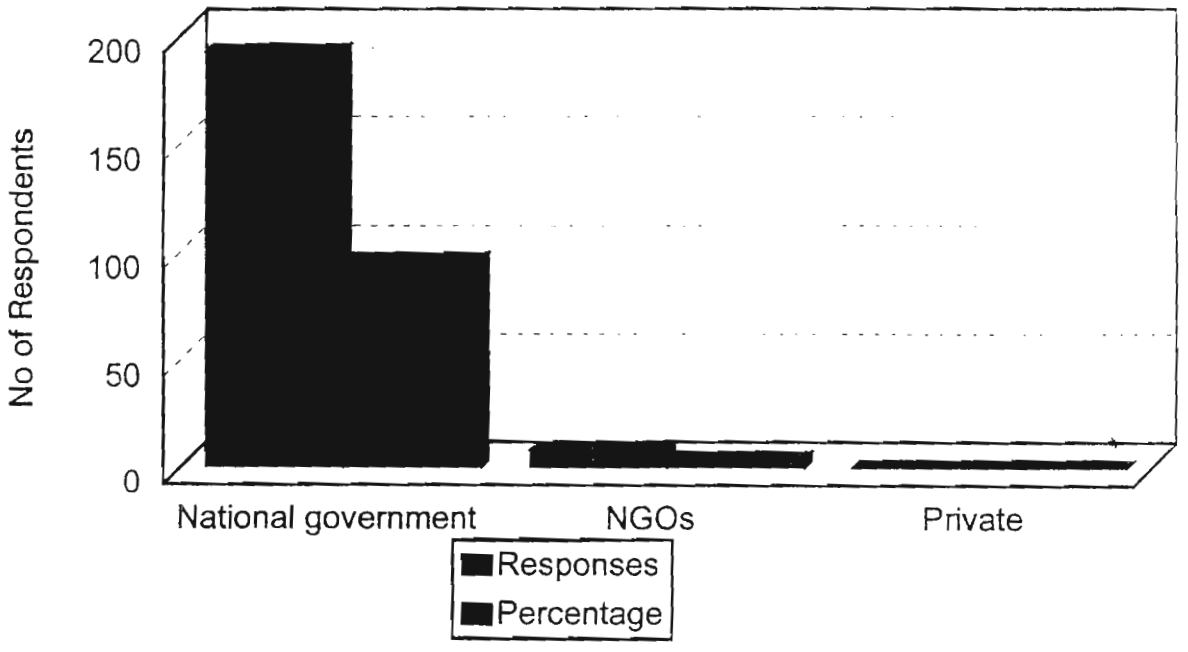


TABLE 4: FOREIGN FUNDING

	Government + NGOs	Provincial government	Private sector
No. of respondents	192	8	0
Percentage of responses	96%	4%	0%

FIGURE 10: FOREIGN FUNDING



Four of the respondents indicated provincial government and only two indicated the local government.

QUESTION C18: Where should local NGOs help most?

The question was aimed at determining the most important needs of the communities. From the responses health was ranged as a priority with sixthy two responses and respondents indicated the following challenges:

- HIV/AIDS
- T.B; and
- alcohol and drug abuse.

Twenty four respondents indicated housing. Education yielded twelve responses and only two respondents indicated that NGOs should help in all three spheres (education, health and housing)

QUESTION C19: With the new government in power who would get more funding from foreign donor agencies?

The question arose because of the recent political changes which took place in South Africa. The government of national unity came into power in 1994

One hundred and ninety two (96%) respondents indicated that government (government of national unity) are the likely to receive more funding from foreign donors. These figures were valid as foreign government indicated that they were prepared to fund the government rather than the NGO sector. Only eight (4%) of the respondents indicated that non-governmental organisations would receive more funding. None of the respondents indicated the private sector. The researcher however concluded that although funding was aimed at the eradication of ill-health, the private sector was in a better position to receive more funding as they have the resources and expertise of fundraising and attraction of foreign donors.

QUESTION C20: Where should funding for NGOs be obtained from?

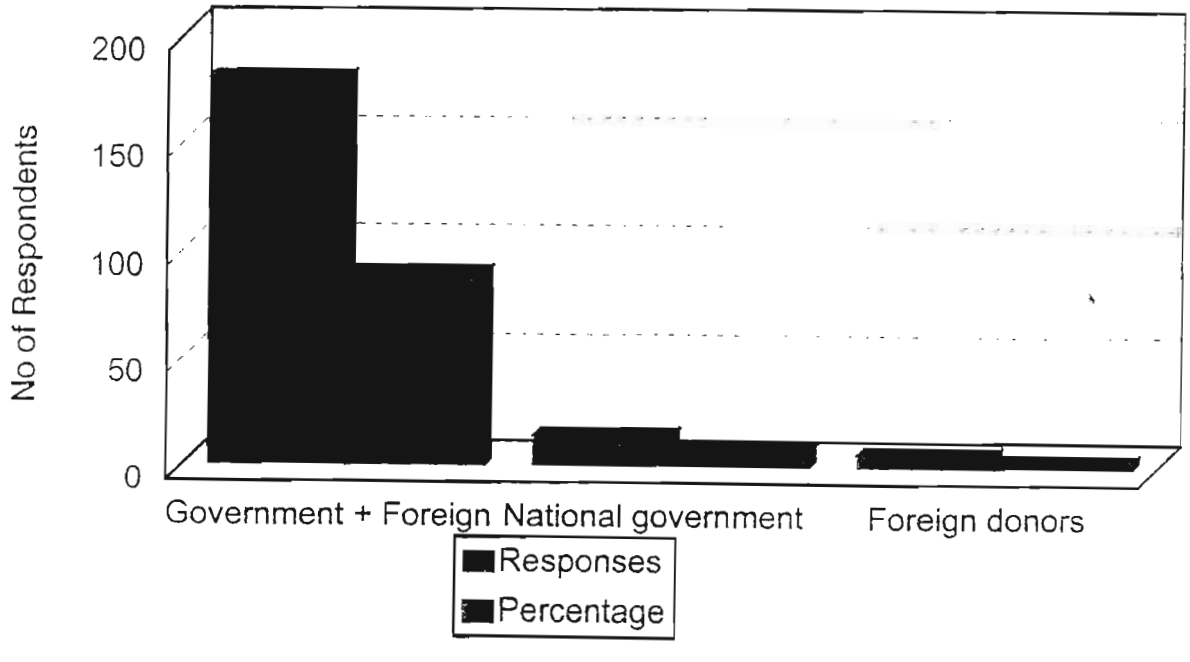
Question 17 and 20 were aimed at identifying the possible funders of NGOs in the future. The researcher identified the possible funders and they included; national government (GNU), foreign agencies or the combination the combination of the two.

One hundred and eighty (90%) of the respondents indicated that both national government (GNU) and foreign donor agencies should fund the non-governmental organisations. Fourteen (7%) indicated that the foreign donor agencies should finance the non-governmental sector.

TABLE 5: FUNDERS OF NGOs

	National government and foreign donors	National government	Foreign donors
No. of respondents	180	14	6
Percentage of responses	90%	7%	3%

FIGURE 11: FUNDERS OF NGOs



From the above results the researcher concluded that non-governmental organisation were faced with the funding crisis and because funders have rechannelled their resources directly to government, both government and foreign funders should assist NGOs financial and educational in order for them (NGOs) to survive.

QUESTION 21: Additional comments

Question twenty one was an additional question which the researcher was aiming at receiving more information from the respondents. The other questions might not have catered for. Generally the comments by respondents indicated that they supported the role played by non-governmental organisations and the comments varied as follows:

- non-governmental organisations have been assisting the poor communities for a long period and without them the communities would not survive.
- government (especially the Nationalist Party) was oppressive and discriminatory to the majority of South Africans thereby denied

them their rights, non-governmental organisations were prepared to work voluntarily to help the disadvantaged.

- non-governmental organisations have a future role in these communities as they were delivering health care services to the communities.
- non-governmental organisations provide efficient and effective health care services than other sectors.
- non-governmental organisations provide comprehensive services which include: education and training, social, cultural and health care services.
- non-governmental organisations's personnel are more responsive to the community needs and they are not remote from them.

5.7 HYPOTHESES

This section was aimed at analysing the hypotheses that were generated by this study at the beginning of chapter one. Three hypotheses were identified by the researcher and throughout this study these hypotheses have been tested.

5.7.1 HYPOTHESIS ONE: Non-governmental organisations will continue their role of providing health care services to the disadvantaged communities.

From figure seven of this study eighty four (56%) of the respondents indicated health as the priority of non-governmental organisations. This indicates that there is a future role for non-governmental organisations and the recipients and beneficiaries of these services are still in support of the NGOs. Chapter four of the study also indicated that non-governmental organisations like the Health Systems Trust and the Valley Trust are continuing with their role of providing health care services to the disadvantaged communities. This hypothesis is substantiated and tested to be correct.

5.7.2 HYPOTHESIS TWO: Many non-governmental organisations would be incapable of sustaining themselves without resources from international donors.

This hypothesis is substantiated and has been tested to be correct. It was

evident immediately after the general elections of April 1994 when the government of national unity came into power when funding by foreign donors became bilateral whereby they were directly funding the government. Many non-governmental organisations were incapable of continuing with their services without the assistance of foreign donors. Many of them decided to shut down and close.

5.7.3 HYPOTHESIS 3: Non-governmental organisations will emerge as developmental activists in the democratic South Africa.

The findings of this study indicates that most of the non-governmental organisations that were operating in South Africa were developmental organisations because they were ensuring that the lives of the poor communities were improved. They provided education and training, social services, transportation, housing and health (figure 7). The results indicate therefore that the researcher was not correct in assuming and hypothesizing that non-governmental organisations will emerge as developmental activists in the democratic South Africa hence the task began long before the elections.

5.8 SUMMARY

The chapter has analyzed and interpreted the results of this study. Tabulation of data and the creation of tables and diagrams was done in order to give a clear understanding to the reader of this dissertation. Although two questionnaires (A1 and A2) were used to collect data for this study, only questionnaire A1 has been analysed in this chapter. The results of questionnaire A have been analyzed in chapter four of this study. The findings of the study can be generalised to the non-governmental organisations that are providing health care services in KwaZulu-Natal, and with a more comprehensive study the results could be generalized to the whole of South Africa. The final chapter provides the reader with the conclusions and recommendations drawn from this study which could be relevant and useful to other provinces in South Africa.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

The challenge is not only to find and understand the root causes of the problem, but equally to find workable solutions (Schuftan 1998:104).

6.1 INTRODUCTION

This study has focused on the role of non-governmental organisations in the provision of health services in KwaZulu-Natal. The researcher set out a number of objectives and hypotheses for this study. In order to achieve the objectives of this study the researcher raised a number of questions (chapter 1 and 5). A theoretical perspective on non-governmental organisations was critically reviewed. In chapter 2 a comparative study of international and South African NGOs was undertaken through the study of available literature. Chapter 3 focused on South African Health policy and how NGOs are affected by these policies. In chapter 4 the study focused on the two NGOs (Health Systems Trust and Valley Trust) that were used as a case study. In chapter 5 the findings of this study on the role of non-

governmental organisations was presented and analyzed. This chapter concludes the whole study and also provides the reader with the recommendations drawn from the study.

6.2 CONCLUSIONS

A number of conclusions have been drawn from this study and from these conclusions recommendations were made which would contribute to the improvement of health in KwaZulu-Natal and to the South African Health.

6.2.1 South African health care services have been fragmented for a long time. There has been a huge gap between the health of South Africans. Health care was not accessible and affordable to the disadvantaged who were mainly blacks, poor, children, rural and women. The apartheid regime systematically denied the majority of its citizens access to quality, comprehensive, preventive and affordable health care. There was a huge health gap between the former four provinces. In the past there was inequity in the provision of health services.

6.2.2 Non-governmental organisations and community-based organisations emerged in the apartheid era to fill the void that was created by the apartheid regime. Many NGOs in the past were anti-apartheid and challenge the government. This confrontation often led to assassinations, detentions and tortures. Non-governmental organisations that were providing health care services operated under restrictive and oppressive conditions, (such as the Fundraising Act and Affected Organisation Act) however they were able to provide the disempowered communities with health care services that the government failed to provide.

6.2.3 The apartheid laws placed the majority of its citizens which were blacks in the most remote areas of South Africa and KwaZulu-Natal was in the former KwaZulu homeland. Health facilities were minimal and sometimes not available. Health infrastructure like hospitals, clinics and ambulances were not available. Health workers from the Department were not prepared to work in these remote areas and the health status deteroiated. Curative facilities provided by hospitals and clinics were situated long distances and the poor could not afford to access them. However, NGOs with the assistance of foreign donors and funders provided free health care

to the most vulnerable groups of the community. These non-governmental organisations gained the trust of the communities.

6.2.4 During the political instability in KwaZulu-Natal, NGOs were able to operate freely because the communities respected them and protected them. NGOs were able to provide health care services in different areas ***viz***; rural, townships and urban. They were able to communicate to different community leaders like the traditional leaders and councillors. The trust of these NGOs by the communities could be attributed to the way they operated which was; non-political, non-partisan and nonprofit. The past role of NGOs in the provision of health care was of significant importance not only to the communities of KwaZulu-Natal but to the South African population at large. Health status can affect other sectors like the economy, education, social and sports and recreation. The NGO sector played a "watchdog" role in bringing to the attention of the whole world the undemocratic and inefficiency of the apartheid regime in the provision of health care services.

6.2.5 The political transition in South Africa in 1994 challenge the NGO

sector to review its role in the provision of health care services. The ANC-led Government of National Unity is committed to the provision of health care for all South Africans, particularly those who were previously under served by the apartheid government. The GNU is targeting the previously disadvantaged communities through the RDP, free health care for pregnant women and children under six, provision of infrastructure (hospitals, clinics and other health facilities). The government is now taking responsibility and providing health care to all South Africans. The health sector is moving towards a district-based health care which is based on primary health care. Local communities should therefore be involved in decision-making as they are able to provide with working solutions to their health problems.

6.2.6 The major challenge of non-governmental organisations is funding. Donors have rechanelled their funds directly to the government. There were a number of NGOs who did not survive and were forced to shut down. However, the closure of these organisations were the weak organisational structures in which the traditional approach or top-bottom paradigm was emphasise (decisions were taken from above and then imposed to the

people at the bottom). The other challenge was the movement of personnel from the NGO sector to the government sector as government was seen as a partner and the long-standing animosities of the past have been eradicated.

6.2.7 Most people were extremely optimistic when the new government (GNU) came into power. Although the GNU is committed to better health for all there is still a role for NGOs in the provision of health care services, particularly in KwaZulu-Natal. The implementation of the RDP in the province has been very slow and in some parts this has started. The political conflict between the national government (ANC-led) and provincial government (IFP-led) has led to non-development in the province. Government officials are not prepared to work in rural areas especially those which are under the traditional leaders. The recruitment of foreign doctors (the Cuban doctors) does not solve the problem of ill-health as they are not well vested with the culture, language and traditions of local communities. In spite of the "election promises" most people are still unemployed, poor and their health status is still below that of international standard. The closure of some NGOs which provided invaluable health

care services will be a backlock both to the government and the people who benefitted from these services. The failure of the GNU through the RDP to deliver services proves that the government will not be able to effectively and efficiently provide health care services. The GNU needs the private sector as well as the NGO sector who are well experienced in working with the disadvantaged communities. The only development agencies who have enjoyed the privileged and access to disadvantaged communities have been the NGOs and CBOs because they know the problems of the local communities and were able to give working solutions to their needs. The GNU and the private sector should provide grants to the NGOs who are providing health care services so as to survive the transition.

6.2.8 South Africa should also learn from international experience that transition from authoritarian regimes to democratic ones does not automatically deliver services to the communities. The GNU has not delivered on its promises. Although there are health policies that have been formulated and agreed upon, the implementation is very slow and in other areas it is impossible because the experienced NGOs and CBOs are being replaced by government officials who do not understand the problems of

the local communities and their needs. The skills and expertise of local NGOs and CBOs should be utilised effectively. Health care services that need to be rendered in rural areas in KwaZulu-Natal should be contracted out by government to the local NGOs who have the skills of working in these areas.

6.2.9 Most non-governmental organisations are incapable of sustaining themselves (e.g. Urban Foundation) particularly in neglected areas and are forced to close down. These NGOs operating in neglected areas need assistance. Although NGOs need assistance from the government, it need to be independent of government. Non-governmental organisations must be able to take their own decisions, however they must be responsible and accountable to their funders. It is also important for NGOs to function as "watchdogs" of the communities and when the government is inefficient they should be there to protect the community.

6.3 RECOMMENDATIONS

This study has provided the reader of this dissertation with a number of recommendations that are based on the foregoing conclusions of this study.

6.3.1 EXPERTISE OF NON-GOVERNMENTAL ORGANISATIONS

Non-governmental organisations personnel have accumulated a lot of experience which need to be preserved and utilised effectively in order to eradicate ill-health from the community. The Government of National Unity should allow the non-governmental organisations that are providing health care services to continue their role. Although the GNU is committed to better health for all, most of the health workers in the public health sector are not prepared to work in disadvantaged communities. The experience and skills of NGOs in working in these areas will be an advantage to the government as there would be co-operation between the providers (NGOs) and the users (community) of health care services.

6.3.2 PROVISION OF INFRASTRUCTURE

The Government of National Unity should provide the basic infrastructure to the previously disadvantaged areas. Most rural areas do not have access to basic infrastructure *viz*; roads, recreational facilities, water, electricity, housing and hospitals or clinics. The lack or unavailability of these basic facilities will mean that the communities living in these areas would not have access to health care services. Communities who are living under poor social and economic conditions can lead to ill-health.

6.3.3 FINANCIAL ASSISTANCE

Non-government organisations that are still operating in KwaZulu-Natal are faced with the funding crisis. The political transition from apartheid to democracy has seen traditional donors and funders of non-governmental organisations redirecting their finances to the government. The government to government funding would mean that the GNU would accumulate more funds and NGOs would not be able to compete with the government for external funding, the state should therefore provide grants to progressive

NGOs so as to achieve the common goal of better health for all. Lack of funding to most of the NGOs would mean that they should shut down. The experience and skills would be lost. It is also recommended that the government provides the NGO sector with other available resources that will assist in the provision of health services, for example, provision of mobile rooms for consultation and also with transport which NGOs could use in order to reach these disadvantaged communities.

6.3.4 DEVELOPMENT OF NGOs CAPACITY

The capacity of non-governmental organisations should be developed. All the major health stakeholders (government, private sector, donors/funders and NGOs) should be involved in developing the capacity of non-governmental organisations and community groups through training and providing skills. They (NGOs) would not be expected to acquire external expertise which are sometimes unavailable or unaffordable. They would be able to deal effectively with national issues *viz*; HIV/AIDS epidemic, TB, cancer and alcohol and drug abuse. Non-governmental organisations would then be able to take informed decisions and help to prevent and control the

spread of these disease and misuse of these substances.

6.3.5 STRATEGIC PLANNING

The top management of non-governmental organisations should be empowered with management skills and NGOs that are involved in health should engage in a strategic planning process. Non-governmental organisations should plan pro-actively to move towards a district-based health care in South Africa. The Health Systems Trust and the Valley Trust are involved in strategic planning. Other NGOs should reposition themselves so that they could continue to play a crucial role of acting as the link between the government and civil society. They should develop skills such as communication, management, financial, research, education and training, organisational, administration and leadership skills in order to be able to have meaningful contributions.

6.3.6 PARTNERSHIP

There must be increased co-operation between non-governmental

organisations, government and the private sector in the provision of health care services. The available resources should be shared and utilised towards the attainment of the common goal - provision of health care services. The business sector should assist the NGO sector in training and education of personnel and financial resources. The government should also assist with grants and contracting some of its services to progressive non-governmental organisations like the Health Systems Trust and the Valley Trust. Non-governmental organisations should also be a reservoir of talent and skill for the public and private sectors.

6.4 SUMMARY

The study of the role of non-governmental organisations in provision of health services in KwaZulu-Natal was aimed at understanding the role of NGOs in health and was also investigating mechanisms in which health care in South Africa, particularly, KwaZulu-Natal could be improved and provided to all the inhabitants of the province without discrimination of any kind. In order to achieve quality and affordable health care for all it is important for all the stakeholders involved in health to work in partnership.

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ANNEXURE A1

QUESTIONNAIRE A1

Role of Non-Governmental Organisations in the provision of Health Services in KwaZulu-Natal.

Guidelines to completion of Questionnaire:

- Please read the entire form before making any entries
- Answer each question as accurately and carefully as possible
- This questionnaire consists of 3 sections:

SECTION A : Past, Present and Future of NGOs.

SECTION B : Nature and functions of NGOs

SECTION C : Funding of NGOs

NB: NGOs refer to non-governmental organisations that are specifically rendering health care services.

SECTION A : THE PAST, PRESENT AND FUTURE OF NGOs (Make a CIRCLE on ONE answer).

1. Please list 3 priorities of NGOs in your community.

   A. .....

   B. .....

   C. .....

2. NGOs have been providing affordable health care for the poorest segments of the population.

   A. NO

   B. YES

3. It is a major problem to raise funds from the poor.

   A. YES

   B. NO

4. In your opinion, do you thing NGOs were accountable to the community?

   A. NO

   B. YES

5. Do NGOs have the resources to handle development?

   A. YES

   B. NO

6. Should NGOs maintain their independence from the government?

   A. NO

   B. YES

   Please explain your answer

   .....

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   .....

   .....

7. Should the role of the NGOs change in the new dispensation?

   A. YES

   B. No

   If the answer is YES, please indicate how?

   .....

SECTION B : NATURE AND FUNCTIONS OF NGOs (CHOOSE ONE ANSWER BY MAKING A CROSS ON AN APPROPRIATE BLOCK)

8. NGOs have been carrying out functions which were considered to be state responsibilities.

9. Community must be involved in shaping health care services.

10. NGOs are one of the sets of organisations which limit the power of the state in relation to the lives of the citizens.

11. NGOs have taken up the challenge of promoting collaboration to help the poor cope with their needs.

12. A redistribution of health workers to under services areas has to take place.

13. NGOs act as a pressure group to government structures.

14. NGOs can utilize resources more effectively then government.

15. The services of NGOs should not be integrated with the rest of health services.

QUESTION	STRONGLY DISAGREE	DISAGREE	NOT SURE	AGREE	STRONGLY AGREE
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

SECTION C : FUNDING OF NGOs (CIRCLE ONE ANSWER)

16. Which one of the following has been the major lifeline for addressing health problems in your community?

    A. Private sector

    B. Public sector

    C. NGOs

17. Who should finance the NGOs in future?

    a. National Government

    b. Provincial Government

    c. Local Government

18. Where should local NGOs help most?

    a. Education

    b. Health

    c. Housing

19. With the new government in power who in your opinion would get more funding from foreign Donor agencies?

    a. Government

    b. Private sector

    c. NGOs

20. In your opinion where should funding for NGOs be obtained from?

    a. National Government

    b. Foreign agencies

    c. A and B

21. Additional comments:

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Thank you for your time and assistance in completing this questionnaire.

Yours sincerely

Basil Siphiwe Ndlovu

Reg No: 8934021

(Phone No : 031 2629127 - 192).

ANNEXURE A 2

QUESTIONNAIRE A2

SWOT analysis for non-governmental organisations (NGOs) providing health care services in KwaZulu-Natal.

Guidelines to completion of questionnaire:

- Please read the entire form before making any entries.
- Answer each question accurately and carefully as possible.

NB: NGOs refer to non-governmental organisations that are specifically rendering health care services.

1. Name of your Non-Governmental Organisation (NGO).

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2. Describe in brief the role of your NGO with respect to health-care delivery.

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3. What is your mission statement? (Please attach)

4. Mention the four most dominant strengths of your NGOs.

a. .....

b. .....

c. .....

d. .....

5. What would you consider your four major weaknesses?

a. .....

b. .....

c. .....

d. .....

6. Mention four of your opportunities.

a. .....

b. .....

c. .....

d. .....

7. What are your four main threats?

a. .....

b. .....

c. .....

d. .....

8. Additional comments

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Thank you for your time and assistance in completing this questionnaire.

Yours sincerely

Basil Siphiwe Ndlovu

Reg No: 8934021

(Phone No : 031 - 2629127 - 192).

ANNEXURE B1 : MISSION STATEMENT - THE VALLEY TRUST

MISSION STATEMENT

The Mission of THE VALLEY TRUST is to offer quality education and training associated resources in fields relating to comprehensive primary health care and sustainable development, to strengthen the capacity of individuals and communities to improve their own quality of life .

ANNEXURE B2:

MISSION OF THE HEALTH SYSTEMS TRUST

"The Health Systems Trust is committed to a health care system which meets the needs of all South Africans. It seeks to help realise this vision through independent support for research and skills development aimed at improving policy and planning at all levels, as well as other strategic initiatives which move us toward this goal".