HEALTH SECTOR TRANSFORMATION : AN INVESTIGATION OF COMMUNITY PARTICIPATION IN PUBLIC HEALTH POLICY FORMULATION AT A LOCAL LEVEL IN MPUMUZA, KWAZULU-NATAL

By

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A: ABSTRACT

The basis of my study is the belief that governance of the local delivery of health could usefully include full and wide community representation and participation by the stakeholders and the larger community. The study was initially carried out in 2003 and now the same clinic has been targeted to carry out an update to see whether the perceptions have changed; if so why and if not what the status is.

This study investigates the proposition that if communities do not participate in policy formulation processes, implementation is crippled. The case study is of free health-care policy in a small area of Pietermaritzburg, the Mpumuza area. This area is chosen because it has a local clinic that is being used by the local people to get free primary health care services, covered by the national policy.

My interest in the study is influenced by the role I played as a public servant within the district Department of Health one and a half years ago. I dealt, on a daily basis, with service delivery (with a focus on facilitation of the process of service delivery). My interest is to know how the processes of policy development unfold in practice.

The study will be examining what the different writers allude to in relation to policy formulation and implementation, the legislative framework pertaining to health policy, the actual case study and finally the conclusions drawn and recommendations, which are open for further exploration in other studies. The study looks at the impact of lack of involvement of the **community members** (who are at the receiving end) and the role of **service providers** (who for the purposes of this study will be confined to the nurses that offer the health services at the specific local clinic).

Basically the study found that the subject of involving communities in policy formulation is a crucial one if the policy is to be successfully implemented and these are detailed later in the document.

B: CHAPTER 1

HYPOTHESIS

The hypothesis made in this study is:

"Involvement and participation of communities in issues of public health policy formulation and implementation enable citizens to take control of their own health care."

INTRODUCTION

Chapter 1 will discuss the theoretical perspective that the different authors on policy formulation and implementation outline. The development of the framework applied in this study draws from the writings of, *inter alia* Kingdon, Howlett and Ramesh, Levitt, Pressman and Wildavsky, Rifkin and Grindle.

POLICY DEFINED

In defining policy in general, Pressman and Wildavsky (1973: xiii – xiv) indicate that, in every discourse, we use policy when referring to decision-making in several striking ways. Sometimes policy means a statement of intention. Policy is treated as a broad statement of goals and objectives. Nothing is said about what might be done, has been done or will be done to accomplish a purpose, if there is one. At times, policy is spoken of as if it were equivalent to actual behaviour, which then reveals the goals and their achievement.

The authors describe policy as implying theories. Whether stated explicitly or not, policies point to a chain of causation between initial conditions and future consequences.

Policies are formulated and are administered simultaneously. Parsons (1995:98) describes a circular process, in which policy formulation involves administering it and, at the same time the administering of policy involves formulating of policy. He says that during the

implementation stage problems might be encountered which will necessitate modification of the policy in question, which may result in the policy being reformulated. These issues will be discussed in detail in this study, with reference to different authors.

PUBLIC POLICY DEFINED

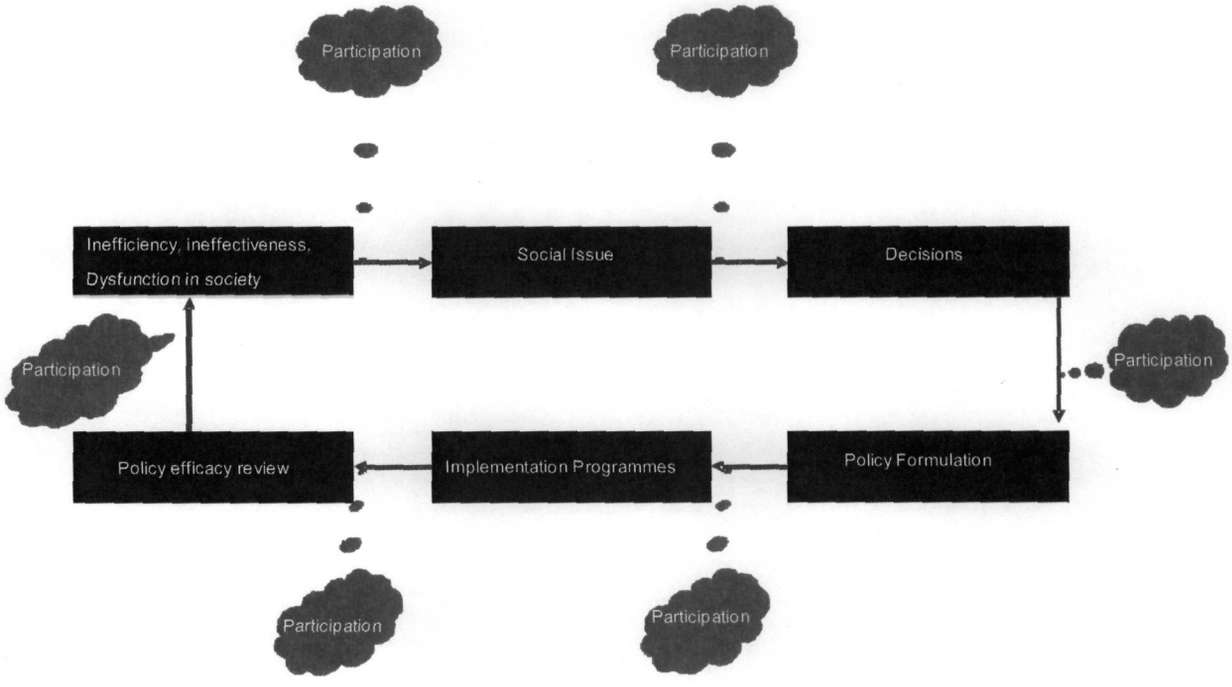
Howlett and Ramesh (1995:4 – 5) contend that public policy results from decisions made by government. Interestingly, decisions by government to do nothing are just as much policy as those that flow from decisions to do something. Thomas Dye, as quoted by Howlett and Ramesh (1995:4-5), defines public policy "as anything a government chooses to do or not to do". He specifies that the agent of public policy-making is government. This means that private business decisions, decisions by charitable organisations, interest groups, individuals or social groups do not amount to public policies. Public policies are taken to be actions of governments alone, precisely because activities of non-governmental actors may, and certainly do, influence what governments do. The decisions or activities of such groups do not, in themselves, constitute public policy.

Jenkins, as quoted by Howlett and Ramesh (1995:5), conceptualised public policy and defined it as" a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals, and the means of achieving them, within a specific situation where those decisions should, in principle, be within the powers of those actors to achieve".

Warning (2001:1) defines public policies as statements of principles underlying governmental action. They can be expressed as local, state (provincial, in the case of South Africa), or national governmental action, such as legislation, resolutions, programme regulations, appropriations, administrative practices and/or court decisions. She sees them as responses and as solutions to public issues. She indicates that public policy is a reflection of opinion and influence of those who choose to be involved in them because policies are adapted with or without the masses and it is in their best interest to adapt.

Diagrammatically, this is how policy formulation could be expressed, to indicate the different intervals at which a community participated of the process. It is a means to illustrate the importance of that participation process.

Policy Formulation Process as conceptualized by the author



Fitzgerald, McLennan and Muslow (1997:532-533), in looking broadly at community development, state that "by the 1980s the understanding of health as a holistic concept, taking into account social, psychological, physical and economic factors, became widely accepted. This logically led to the necessity of involving communities in the definition of their health and to the determination of the input of the public, private and non-governmental sectors in achieving and maintaining wellness". This line of thinking sees the user as a social being that does not compartmentalise his or her needs, but rather experiences a totality of needs, of which health services are part. As a corollary, the main focus for making services sensitive to user needs is in changing overall health policy and

planning to focus on discrete treatment programmes or interventions. This would be achieved through more participation of communities in decision-making about their health.

For participation to be effective, it has to cover the total policy process from defining needs and priorities, through implementation, to evaluation. The creation of channels for participation has to be addressed, as well as capacitating communities on decision-making processes, without divorcing them from their constituencies. It is important for distinct health authorities to encourage the education of communities and to make sure that the democratic process of user involvement goes beyond rhetoric and actually allows people to help shape policy and strategy.

Adherence to community participation does not mean that decision-makers always have to do what the community wants. Policy-makers have to engage in dialogue with communities, offering information about health trends, effective interventions and comparative needs in order to provide the full context of the complexity of policy and "allocative" decisions. At times some national and provincial priorities can override local concerns and priorities and open discussions with communities in relation to their needs.

Sustainable development requires a dialogue with communities. This dialogue offers a transparent view of opportunities that is limited to community participation. Decision-makers themselves (starting at local level) have to engage in a learning process and learn to consider community/lay knowledge as a legitimate and valued input in the decision-making process. Rikfin (1985: x), in looking at health planning and participation, states that "community participation is seen as the key to programme success. There is an indication that if people/communities get involved in the conceptualization process there will be better utilization of services".

Grenough (1975: 66), as quoted by Rikfin (1985: 46), points out that community involvement is crucial in planning, because the community knows, feels and accepts responsibility for community health, not just an individual's health. The community taps into

and develops its own resources to meet health needs in an integrated fashion and actions are taken collectively, according to community, and not individual, priorities.

POLICY FORMULATION

To get some understanding around the discussion and findings of this research on free health policy it is critical to give an overview of process. This is likely to give answers or logic to why some things happened or given more attention then others in the entire process of formulating the free health policy in South Africa.

DEFINITION

Kingdon (1995:2-3) considers public policy-making as a set of processes, including at least:

- the setting of the agenda;
- the specification of alternatives from which a choice is to be made;
- an authoritative choice amongst these specified alternatives as in a legislative vote or a presidential decision, and the implementation of the decision;
- review of the efficacy of the decision and its implementation programme and;
- adjustment or continuation of the implementation process.

Success in one process does not necessarily mean that there will be success in the others. An item may be prominent on the agenda, without subsequent passage of legislation. Passage, however, does not necessarily guarantee implementation according to legislative intent.

Howlett and Ramesh (1995:104), in looking at policy formulation, state that the most critical stage of the cycle is agenda setting. They look at how issues appear on the agenda for action and they state that, although often taken for granted, the means and mechanisms by which issues and concerns are recognised as candidates for governmental action are by no means simple. They originate in a variety of factors and must undergo complex processes

before they are considered seriously for resolution. What happens at this stage has a decisive impact on the entire policy process and the outcomes.

THE POLICY CYCLE

AGENDA SETTING

Howlett and Ramesh (1995:104), in looking at the setting of agendas, state that "pre-political or at least pre-decisional processes often play the most critical role in determining what issues and alternatives are to be considered by the policy and the probable choices that will be made. They feel that what normally happens in the decision-making councils of the formal institutions of government tends to do little more than just merely recognise, document and legalise, if not legitimise, the momentary results of a continuing struggle of forces in the larger social matrix". This, then, raises the critical question of how an issue or demand becomes, or fails to become, the focus of concern and interest within a policy.

"The manner and form, in which problems are recognised, if they are recognised at all, are important as determinants of how they will ultimately be addressed by policy-makers. The demands of government resolution of some public problems come from discontent articulated and transformed into issues by the society, whereas others are initiated by government and public policy support for policy initiatives varies across policies. This makes generalisation difficult".

Howlett and Ramesh (1995: 105), in their attempt to define what agenda setting is, state that "the agenda is the list of subjects or problems to which government officials, and people outside government closely associated with those officials, are paying some serious attention at any given time. The tendency is that out of the set of all the conceivable subjects or problems to which officials could be paying attention, they do, in fact, seriously attend to some rather than to others. So the agenda setting process narrows this set of conceivable subjects to the set that actually becomes the focus of attention".

resources to address the identified issues, it is no use putting it on the table. This circumstance is often found in government departments, where budgetary constraints might hinder affording an issue any attention and it is then sidelined.

THE POLICY STREAM

Kingdon (1995:117) describes policy communities, as "a relatively hidden cluster of participants such as academics, researchers, consultants, career bureaucrats, congressional staffers and analysts, who work for interest groups. Ideas are often seen to have a tendency to float around amongst this group of people. Depending on their call they might be softened up by a particular idea and give it some attention or else overlook it if they aren't convinced it deserves the attention". He discusses the various criteria for the survival of an idea, which is how some ideas will dominate others. He explains the availability of alternatives as another important factor that might lead to the long life of a policy agenda item.

Further to what Kingdon and Levitt describe as participants in policy-making, Lindblom (1980:44), sees policy-makers as a tiny proportion of the adult population. Given their control over policy-making, they constitute elite at all levels of government, one composed of chief executives, cabinet members, members of parliament or legislature policy-making members of the bureaucracy, upper levels of the judiciary and, in some systems, higher ranks in the military. He sees all systems as having a vast number of people who participate in some way in the power-play in policy-making.

Kingdon (1995: 118), states that the process of proposal generation, debating and redrafting for serious consideration is done by a community of specialists (to him these people merely make recommendations based on their expertise and do not have a decision-making mandate). They will merely assist with a wide range of alternatives that could be examined in addressing issues. Progression of ideas and policy proposals to him

are a selection process in which possible initiatives are narrowed to a short list of proposals that would be given serious consideration.

THE POLITICAL STREAM

In looking at how the political stream is flowing along according to its own dynamics and rules, Kingdon (1995:145 – 146) sees it as composed of sittings of national mood, election results, changes of administration, changes of ideology and interest group pressure campaigns. The discussions concern politicians and other participants who have a belief that they can sense both a national mood and changes in that mood. The national mood is perceived in the attitude of various sectors of the public and is sensed by politicians from various communications that come through, certain means of communication like mail and e-mail.

Kingdon (1995:153) states that, in government, one of the determinants of agendas is personnel turnover (which could be described as the change in staff in one given time in an organisation). Once people change in positions they bring their own agendas and the previous issue falls away. The political stream also plays a role in promoting and inhibiting high agenda power status. All the important factors in the system, not just politicians, will weigh whether or not the balance of forces in the political stream favours action. They will judge whether or not the general public would at least stand for directions pursued at the elite level.

THE POLICY WINDOW AND JOINING OF THE STREAMS

The three streams as detailed have a life of their own but there can come a time when they join which basically is a process of acceptance and giving attention to an issue seen to be of importance. Kingdon (1995:165) defines this joining of the three streams (the political, the problem and policy streams) as "an opportunity for advocates of proposals to push their

set solutions, or push attention to their special problems. This is a critical time, when the different streams (problem, policy and political) come together. A problem is recognised; a solution is developed and is available in the policy community, and political change makes policy change possible".

Policy windows, (problem and political windows) are an opportunity for action on given initiatives. They present themselves and stay open for only short periods. If the participants cannot, or do not, take advantage of these opportunities they must bide their time until the next opportunity comes along. These windows are opened either by the appearance of compelling problems or by happenings in the political stream. They exist with a distinct relation in that when a window opens due to a pressing problem, alternatives generated as solutions to the problem will only fare better if they meet the tests of political acceptance. If for any reason proposal meet administration opposition they tend to be dropped no matter the suitability to solve the problem at hand.

"When a window opens because a problem is pressing, the alternatives generated as solutions to the problem are better if they also meet the tests of political acceptability" ", (Kingdon 1995: 202-203). Although Kingdon stresses the importance of noting the window opening and seizing the opportunity because they take time to open. At times they open quite predictably, such as when legislation comes up for renewal on a schedule, or creating opportunities to change, expand or abolish certain programmes to mention a few.

Levitt (1980:205) stresses the value of consultation as one of the crucial features of public policy formulation and implementation. She says that in public policy-making, where issues tackled by the policy are less than clear-cut, consultation with interested parties is of the utmost importance. She sees this as a way to acknowledge difficulties. She emphasises the collective involvement in formulation and implementation of policy. This is a process, which can sometimes lengthen the time before action can occur, but is a price worth paying when greater degree of support and consent for the policy may be obtained.

There are a number of approaches and techniques of decision-making ranging, from the formal, quantitative models to the more informal, non-rational quantitative models. For this thesis the present author will focus on the two theories discussed by Anderson (1984:135-140), which are theories that emphasise the procedure and intellectual activities involved in making a decision. These are:-

(i) The Rational Comprehensive Theory

(ii) The Incremental Theory

RATIONAL COMPREHENSIVE THEORY

This draws from the economist's views of how a person would rationally make decisions and also from theories of rational decision-making developed by mathematicians, psychologists and social scientists. The process is that the decision-makers are confronted with a problem with known goals, values and objectives, and alternatives. These alternatives will be compared and the one that maximises goal attainment will be chosen. This stimulates the best possible decision.

INCREMENTAL THEORY

The incremental theory avoids many of the problems of the rational comprehensive theory and is more descriptive of the way in which public officials make decisions. Goal selection and actions needed are intertwined. Some alternatives will be considered and limited evaluation of consequences will be done. In the process the problem is continually redefined and there is no single solution to the problem. This is a remedial theory.

POLICY IMPLEMENTATION

DEFINITION

Once policies are formulated and adopted and decisions taken to have them gazetted as law for the country the next phase is implementation of those policies.Pressman and Wildavsky (1973: xv) define policy implementation as"a process of interaction between the setting of goals and actions geared to achieving them".

As stated by Pressman and Wildavsky (1973: xiv – xv) implementation is perceived by many to be a process that should be easy and straight-forward. When expected events do not occur, or turn out badly, people tend to be upset.

In the context of public policy what is being implemented is policy. There has to be something to be moved forward in the process of implementation. A complete programme can be conceived of as a system in which each element is dependent on the other. If a breakdown happens at any one of the stages it needs to be fixed, or else it is impossible to move to the next step. The stages to be undergone towards completion are interrelated and co-dependent. Based on this, it becomes crucial to note that programme implementation is a seamless web.

Policy implementation does borrow from the theory of programme implementation, in that, "by authoritative action, initial conditions are created. Once they are in place, the outcomes are sought. Implementation then becomes the ability to forge subsequent links in the causal chain, to obtain the desired results" (Pressman and Wildasky, 1973: xiv-xv).

Lindblom (1980:68) states that, because of the conditions in which administrators are expected to implement policy, they are compelled to join the policy-making process. He says that, most of the time, policy-making is through trial and error, in which case the preceding steps will correct the inadequacies of the next step and implementation of each

step in policy-making becomes a principal source of feedback information for the next step. He feels that, through evaluation of the previous implementation processes, new policies are pushed in a certain direction, probably new, with new information.

POSSIBLE CHALLENGES TO COMPLETE IMPLEMENTATION

COMBINATION OF CAUSES

The processes of formulating and creating an environment for policy implementation are not themselves a means to an end. It is critical to note that there could be some possibility of hindering the proper implementation of the policy and this will be mentioned very briefly in this section.

Pressman and Wildavsky (1973:99-100) discuss hindrances to the policy implementation process as anything that disrupts smooth actions to achieve the desired goals. The language they use is "reasons why participants may agree with the desired goals of a proposal and still oppose/ fail to facilitate means of making it possible".

According to Pressman and Wildavsky (1973:99-100) failure could be caused by:

- Direct incompatibility with other commitments – which means that although participants agree with merits of the proposal they might find it incompatible with other organisational goals.
- No direct incompatibility, but a preference for other programmes, in which case participants will not oppose the initial proposal, but they see it as unnecessary within a particular context.
- Simultaneous commitments to other projects. Although participants agree with the initial proposals, they will not commit to them because their focus is on projects of their own that demand their time and attention.

- Dependence on others who lack urgency in the project – for effective implementation participants get called in because of certain competencies they have, only to find that to them the project is not a priority.
- Differences of opinion on leadership and proper organisation roles – there might be agreement about which programmes need to be done, but disagreement on who should run the programmes.
- Legal and procedural differences – participants can hold up the implementation when they feel their interests are being impinged on.
- Agreement coupled with a lack of power – where participants might be willing to implement, but may lack the appropriate resources to do much to implement the process effectively.

CAPACITY BUILDING IN GOVERNMENT

Policy implementation is sometimes hindered due to lack of capacity in government. In looking at how effectively policies could be implemented and targets achieved, Grindle and Hildebrand (1995:441) state that "effective government performance is central to the creation of market-orientated economics, secure and productive populations and democratic political systems in developing countries. Capacity building to improve public sector performance is an important focus of development initiatives. Several implicit assumptions underlie most such efforts: that organisational or training activities are the focal points for capacity-building interventions, that administrative structure and monetary rewards determine organisational and individual performance, that organisations work well when structure and control mechanisms are in place and that individual performance improves as a result of skill and technology transfer, through training activities".

Grindle and Hilderbrand (1995: 441) emphasise that "effective public sector performance is more often driven by strong organisational cultures, good management practices and effective communication networks than by rules and regulations or procedures and pay scales. Grindle (1997: 4-5) points out that in the 1990s in many countries, the notion of "too

much state" was at play". This is the central role that government played in leading the process of development. In the early 1990s there were major changes that were triggered by debt and financial crises, international pressure and loss of support for centralised and authoritarian regimes.

Grindle says that this period was marked by rapid and profound changes in developing countries which ranged from government commitment to market-oriented approaches for economic growth and, at the same time, civil societies organised to press for democratic elections and greater participation in decision-making. There was a universal focus on state minimalism, that is, minimal state involvement. By the mid 1990s good government had been added to the development agenda, precisely because of greater awareness that neither market nor democracies could function well or at all, unless governments were able to design and implement appropriate public policies, administer resources equitably, transparently and efficiently and respond efficaciously to the social welfare and economic claims of citizens. Grindle then defines and discusses in detail initiatives to promote good government by looking at three dimensions and focusing on capacity-building initiatives, which are human resources development and strengthening organisations. These are:-

I. HUMAN RESOURCES DEVELOPMENT

These are the initiatives that seek to increase the capacity of individuals to carry out their professional and technical responsibilities. They are done in a bid to overcome educational and skill constraints by social and economic conditions of underdevelopment and to redress constraints set by the nature of public sector employment (Grindle, 1997: 13).

II. STRENGTHENING ORGANISATIONS

According to Grindle (1997: 15 – 16), there is a link between training (which is a personnel issue) and utilisation (which is an organisational management issue) and this directs the attention to the challenge of organisational strengthening. To the present author this means that the strengthening of organisations involve:

- strengthening organisational leadership;
- improving recruitment and utilisation of staff;
- introducing more effective incentive systems;
- restructuring work and authority relationships;
- improving information and communication flows;
- upgrading physical resources;
- introducing better management practices; and
- decentralising and opening decision making processes.

An interesting observation about African countries, made by Peterson cited (Grindle, 1997: 16) in relation to the strengthening of organisations, is that hierarchies in these countries are organised around personal structures and rules and interpersonal networks that comprise kin, clans, friends and professional entities. In view of the abovementioned set-up in African countries it is obvious that there is much fragmentation and patronage being relied on. Issues are incomplete and have many fragmentation and resource constraints. Although there is a lack of accountability and control is weak, it is suggested that these issues can be addressed through processes of process design (Grindle, 1997: 163).

III. INSTITUTIONAL REFORM

This is "the altering of rules of the game in which organisations and individuals make decisions and carry out activities. Capacity building through institutional reform involves initiatives such as the development of the legal systems, policy regimes, mechanisms of accountability, regulatory frameworks and monitoring systems that transmit information about the structures, as well as the performance of markets, governments and public officials", (Grindle ,1997: 19).

Grindle (1997: 11) feels that the problem of poorly performing officials and organisations may just be symptoms of dysfunction, rooted more deeply in political, social and economic contexts.

DECENTRALISATION AND DEVOLUTION OF POWER AS A SOLUTION FOR GOVERNMENT

It is necessary to look at some means government could utilise to share the load in trying to improve service delivery. One of these means could be the empowering and upskilling workers who are based at the levels closer to where the services get delivered.

Van Niekerk, Van der Walt and Jonker (2001:245) view decentralisation and devolution of power as one of the means of transforming government and redefining the role of government.In order to cope effectively with the challenges of change it is imperative that structures in charge of delivering services be vested with the appropriate powers. Due to high community expectation it is necessary that institutional, material and human resources are decentralised and effective communication be maintained within and between all spheres.

The best means of dealing with expectation of communities is to ensure a local people-centred approach which is based on the notion that delivery can only be achieved by local authorities, which need to be strengthened. Decentralisation can only be effective if the will

of the community has been determined though a process of public participation and involvement. It is a way of encouraging service excellence to ensure that the well-being of the communities is promoted. Decentralization can further secure justice in the application of democracy and encourages more community participation in forums, public meetings, referenda and policy-making and decision–making processes that affect the daily lives of communities (Van Niekerk, van der Walt and Jonker ,2001: 249 – 250).

STREET-LEVEL BUREAUCRACY

Street-level bureaucracy is relevant here because the policy implementers in the Department of Health are nurses and they are street-level bureaucrats. Policies are statements, in general terms, by government officials. The rest remains with the public bureaucrats to interpret, judge and execute. This might lead to different interpretations of one policy, depending on the individuals and the environment of the policy which explains the difference between policy enacted by officials and policy implemented by public workers. One public worker may change the policy in an attempt to make it more compatible with his/her environment. Lindblom (1980: 65) feels that implementation always makes or changes policy, to some degree.

The street-level bureaucrats are major recipients of public expenditure and at local level represent a significant portion of public activity. Citizens directly experience government through them and their actions are implementing the policies provided by government. Each encounter with the street-level bureaucrat translates into an instance of policy delivery.

Lipsky (1980) noted the changes in implementation by saying the policy of the street may well be different from the policy assumed by policy-makers. But the policy of the street - level bureaucrats is the policy that really matters to the people because it is the policy they can easily identify with. "What becomes necessary is that the executors of policies have to devise some means to formulate a plan of action in a way that will facilitate achieving the stated objectives". This to address what Lane (1993:75) calls an evident realisation that policy may have one appearance when enacted and quite a different one when put into practice. Policy executors may not achieve the desired outcomes because of the diversity of the environment and actors. Grindle (1980:3) is of the opinion that a variety of factors can, and do, frequently intervene between the statement of policy goals and their actual achievement in society.

THE ROLE OF STREET-LEVEL BUREAUCRATS

Street level bureaucrats currently occupy a critical role in society. They are regarded as low-level employees, but their action constitutes the services delivered by government. Their actions and decisions, added together, make up agency policy. Irrespective of what government policy is in terms of deliverables, the discretionary actions of public employees are the benefits and sanctions of government programmes and they determine access to government rights and benefits. They are a means through which the majority of the people encounter government. Each encounter with the public worker represents an instance of policy delivery (Lipsky, 1980:3-8).

According to Lipsky (1980:3), these workers are street-level bureaucrats who have a substantial discretion in the execution of their work. Examples of these workers are teachers, police officers, social workers and judges. The way in which street-level bureaucrats interact with their clients may impact negatively and/or positively on the lives of clients. Lipsky (1980:9) states that, in delivering, street-level bureaucrats make decisions about people that affect their life chances. For example teachers are supposed to implement education policies. If some teachers use corporal punishment to get their learners to co-operate in their education, negative and positive impacts may result. The positive side will be that some learners might study hard in order to avoid punishment, while the negative side may be that others may leave school to escape punishment. Those who stay at school may become professionals while those who escape may end up becoming criminals. This illustrates the power of the discretionary decisions made by street-level bureaucrats.

THE POWER AND AUTONOMY OF THE STREET-LEVEL BUREAUCRATS

Street-level bureaucrats are not neutral; they are individuals who have interests and values. By being entrusted with the implementation of policy, they are indirectly given power to make decisions about the manner in which policies are to be implemented (depending, of course, on the policy guidelines). In most cases these workers are rarely supervised and

their judgement is trusted to be appropriate in a variety of circumstances. These workers might, however, exercise their power to promote and protect their own interests and values. Limiting or maximising the power of decision-making in street-level bureaucrats is not without its problems.

Street-level bureaucrats often implement executive policies which are compatible with their values and interests with more success than those which are contrary to their own values. The recipients of policy, too, have an impact on implementation, because programmes which have their support are more likely to enjoy success. Stone (1997: iv) adds that implementation is more likely to be successful when the programme enjoys a high degree of political support.

THE EXERCISE OF DISCRETION BY THE STREET-LEVEL BUREAUCRATS

The general statement of policies allows for the exercise of discretion by street-level bureaucrats. This exercise of discretion is necessary, since these workers are faced with different individual cases that have to be dealt with differently. The diversity of individual cases in particular circumstances accounts for the modification of original policies in an attempt to adapt the policy to each situation.

Lipsky (1980:85) has much to say about the practices of these workers in their agencies. These practises often end up becoming the "policy" of the agency. For instance, police officers sometimes use illegal methods of investigation, such as beating suspects. Spies can be used to glean information that might lead to charges. Beating or threatening suspects is illegal, but sometimes it becomes acceptable practice among the police officers and their superiors because it yields positive results. The superiors may not condone illegal policies of their agencies, but they overlook them because they may be a reliable means of achieving their objectives or justice and maintaining law and order.

The conditions of work of the street-level bureaucrats may necessitate regular exercise of discretion in trying to cope with their working situations. Most public workers have to deliver the government's policy to a large number of people within a short time. In a situation where a police officer is in a public area and observes two people committing different crimes he/she has to exercise his/her discretion concerning which person to apprehend. Again, a teacher who has a class of fifty learners with different abilities is not able to offer individual attention during teaching hours. This teacher might sacrifice his/her time to cater for the under-achievers, or might just ignore these learners.

The exercise of discretion is indispensable for implementation as it may lead to dismal failure of policies. This does not necessarily mean that policies achieve success on the basis of discretionary power. Lipsky (1980:15) explains the necessity of discretion in implementation: "Street-level bureaucrats work in situations too complicated to reduce to programmatic formats. They have discretion because the accepted definitions of their tasks call for sensitive observation and judgement."

It therefore appears that if public workers were to follow rigid rules in providing government services there would be more delays (while consultation with policy makers is taking place).This could reflect on government as inefficient and unresponsive. Although discretion in implementation has its benefits, abuse and corruption also happen. Innocent suspects might be beaten by police officers who try to get them to confess their offences. Corruption on the part of public workers may be a problem of discretion. Powerful suspects who have money might bribe the police officers with substantial amounts of money to hide incriminating evidence against them. In the police station, destroying files of some cases in return for money is normal practice for some corrupt police officers. Thus the exercise of discretion in implementation has both its positive and negative side.

CONCLUSION

The theoretical perspective has entailed looking at the various definitions of public policy, pooling similarities from the various authors' definitions, authors like Pressman and Wildavsky (1973) Howlett and Ramesh (1995), Warning (2001) and others. This section highlights how policy is formulated as indicated by Kingdon (1995). The merits and demerits of the various theoretical frameworks in decision-making in public policy formulation have also been discussed.

These authors have been chosen because their principles and philosophies are in line with what this study is about, which is public policy formulation (specifically to look at whether communities are involved in this process) and what the results are. The authors lay a foundation of what public policy is, what processes are involved in policy formulation and implementation, using their different models.

Policy analysis has been examined with an eye to analysis of how important community participation contributes to development and empowerment of the people. Hindrances towards complete implementation of public policy have been summarised, with a view to later identifying hiccups in the task performance of street-level bureaucrats in the public health system.

Chapter 2 will give details of the legislature framework governing community participation and free health policy and will analyse the study of free health policy in the Mpumuza area, to ascertain the extent to which the Mpumuza community has participated in the formulation and implementation of the free health policy.

CHAPTER 2

INTRODUCTION

CONTEXT OF THE "FREE HEALTH POLICY" IN SOUTH AFRICA

THE HEALTH SECTOR PRE-1994

McIntyre (1995: 7- 8), in citing Tollman and Rispel (1995: 76) regarding her input paper on health for the poverty and inequality report, summarises the key characteristics of the South African health sector at the time of the 1994 elections. She puts these as characteristics of the South African health sector (pre-1994):

- Fragmented management of public sector health services (tricameral parliament, "self governing homelands", "TBVC homelands", provincial and local government health departments)
- Fragmentation of curative and preventative services
- Bias towards hospital-based, doctor-centred, curative care
- History of racial discrimination regarding access to health services
- Systematic under-funding of certain geographical areas (rural, particularly former "homeland areas", "township" areas and informal settlements)
- Substantial private health sector, with high levels of health care resources relative to the population served, and heavily concentrated in large urban areas
- Health service organisations that "supported the interests of those who held political power or could pay for services"

THE LEGISLATIVE FRAMEWORK GOVERNING THE FREE HEALTH POLICY IN SOUTH AFRICA

a) The White Paper for the Transformation of the Health System in South Africa, 1995

The objective of the White Paper, published in 1995 by the then minister, Dr N Dlamini Zuma, was to present to the people of South Africa a set of policy objectives and principles upon which the Unified National Health System of South Africa would be based. It is a document presenting various strategies designed to meet the basic needs of all people, given the limited resources available (White Paper for the Transformation of the Health System in South Africa, 1995:1).

One of the goals and objectives of the transformation process of the health system relating to this study was to foster community participation across the health sector which it was agreed would encompass:-

- Involving communities in various aspects of the planning and provision of health services;
- Establishing mechanisms to promote public accountability and promote dialogue and feedback between the public and health care providers; and
- Encouraging communities to take greater responsibility for their own health promotion and care (White Paper for Transformation of the Health System in South Africa, 1995 6 (F)).

This goal of community participation, as indicated in the White Paper for Transformation of the Health System in South Africa (1995:16-17), would be achieved through the following implementation strategies:

- ✓ establishment of clinics, health centres, community health centres, and hospital health committees, to permit service users to participate in the planning and provision of services in health facilities

- ✓ making every community aware of which facility is responsible for providing it with the essential primary health care package, thus clearly defining the catchment areas and making them known to all partners
- ✓ negotiating the essential primary health care package between the providers and the communities, to ensure that priorities perceived by the communities are addressed and that the communities have a clear understanding of their entitlements
- ✓ electing individuals who would represent communities with regard to health matters and clarifying of roles
- ✓ establishing community-based information systems with the support of health staff, so that information is available to communities for the identification of priorities, monitoring of progress on locally established objectives and decisions on actions to be taken
- ✓ identification of underserved communities by the community representatives and formulating strategies to teach these communities, together with the health teams

b. The Constitution of South Africa Act 108 of 1996

The Constitution of the South Africa, Act 108 (1996: 9, 13) is the supreme law of the country. This Bill is the cornerstone of democracy in South Africa. It enshrines the rights of all people in South Africa and affirms the democratic values of human dignity, equality and freedom.

Under freedom of expression the Bill states that everyone in South Africa has the freedom to receive or impart information or ideas, including academic freedom and freedom of scientific research. In terms of health rights, everyone has the right to have access to health care services, including reproductive health (section 27(1)).

It is on the basis of these fundamental rights that the involvement of communities in the formulation of health policies is looked at.

In relation to the provision of the health services by the three spheres of government, the Constitution of the Republic of South Africa clearly outlines the powers and functions of the three spheres of government that form the bedrock for the division of functions within the national health care system. The national government has the power to make national legislation, set norms and standards, relate to international organisations and the ministries of health of other countries, monitor the delivery of services and take over the function if a province is incapable of providing services which, because of economies of scale or financial constraints, cannot be provided at provincial level. Provinces are charged with planning, regulating and providing health services with the exception of municipal health services. Local government or municipalities are responsible for the rendering of municipal health services.

c. Green Paper on Transforming Public Service Delivery, June 1997

The Green Paper of June 1997:1-2, on transforming public service delivery, was produced as a document that suggested an approach for service delivery in the public service. Its major aim was to address the need for a specific policy and criteria to meet the priorities of public service delivery. It proposed a set of principles to develop service delivery strategies in all line departments. A prerequisite for these strategies would be effectiveness in delivering services that meet basic needs of all South Africans. It suggested an adoption of "customer comes first" culture by the departments, in order to improve service provision to the public.

This culture would be achieved within a framework of consultation with users, by regular contact, in order to inform the public of priority areas and also to collect information from the public that would be considered when planning for public service delivery. These consultations would be in the form of service standards that would be openly published, be

courteous to the service users, provide better and more information, consider what is available and what the customer entitlements are ensure openness and transparency through constant contact with service users, and increased responsiveness and maximal utilisation of available resources to benefit the public.

d. The National Health Bill B32B of 2003

The fundamental purpose of the Bill is to provide a framework for a structured uniform health service within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments, with regard to health services, and to provide for matters connected therewith (the National Health Bill B32B, 2003:2).

In terms of eligibility to free health services in public health establishments, the National Health Bill B32B, 2003: 9, states that the Minister of Health, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed. In setting conditions, they need to have regard for the range of free health services currently available, categories of persons already receiving free health services, impact of any conditions on access to health services and the needs of vulnerable groups such as women, children, older persons and the physically challenged.

The Bill states that, subject to any conditions prescribed by the Minister, the state clinics and community health centres funded by the state must provide:

- All pregnant and lactating women and children below six years, who are not member of beneficiaries of medical aid schemes, with free health services
- All persons except members of medical aid schemes and their dependants and persons receiving compensation for occupational diseases with free primary health care services
- Women subject to the choice of Termination of Pregnancy Act, 1996 (Act No 92 of 1996), free services for the termination of pregnancy. These are seen as the goals of government by the "free health care policy", using the primary health care approach.

These pieces of legislation are very crucial in guiding the decision on a free health policy in South Africa and will be referred to or quoted at time in this study.

Based on the pieces of legislation detailed in this chapter the next chapter will look at how they were or were not utilised in guiding the free health policy within the community of Mpumuza and the impact thereof

CHAPTER 3

CONTEXT

In his inaugural address to the joint sitting of parliament on 24 May 1994, the then President Nelson R. Mandela reiterated his government's commitment to creating a people-centred society of liberty, binding it to the pursuit of the goals of freedom from want, hunger, deprecation, ignorance, suppression and fear. It is on these grounds that the Rural Development Programme (RDP) process was born in South Africa, with the fundamental aim of directing the progress of the transformation strategy. It was seen as a phase of "the end of one process and the beginning of the other" (RDP: 1994).

One of the policy objectives of the RDP (1994) was the improvement of maternal and child health (MCH) care services, programmed under the development of an MCH programme that included free health services to needy pregnant and lactating women and children under six years.

The Free Health Care policy (FHC) was introduced with the following intentions:

- To take care of all pregnant and lactating women and children below six years of age who are not members or beneficiaries of medical aid schemes, in terms of health services' free primary health care;

- To provide free primary health services for all persons, except members of medical aid schemes, and their dependants and persons receiving compensation for occupational diseases; and

- To provide free termination of pregnancy services to women subject to the choice on termination of the Pregnancy Act (Act No 92 of 1996).

This decision was seen by McIntyre (1998:31) as a means to making the most significant impact on improving access to health services for the poor. It was introduced in two phases:

- Introduction of free care for pregnant women and children under six years of age on 1 June 1994, after the announcement by President Mandela on May 24 1994
- The introduction of free primary health care services for all patients on 1 April 1996.

In 1996, an evaluation of the Free Health Care (FHC) policy by the Health Systems Trust was probed to assess four areas of the policy:

- The effect of the FHC on the utilization of health services (private and public)
- The monetary cost of the policy in terms of additional expenditure and loss of fee revenue
- The perceptions, attitudes and opinions of health care users
- The perception, attitude and opinions of health care providers (private and public)

The present study is trying, within a very specific area (the Mpumuza area, in a semi-rural clinic), to look at two areas:

- The perceptions, attitudes and opinions of health care users
- The perceptions, attitudes and opinions of health care providers after a period of nine years of the study by The Health Systems Trust.

The methods used to conduct this evaluation include an analysis of health service utilisation patterns, as well as an assessment of the perceptions of health service providers and users. The study was done in 2003 and the results consolidated. In 2005 the study was repeated and the results will be compared to see whether or not there have been any changes, especially changes that are informed by the McCoy study that has already been documented and tabled and, partially, since the study done in 2003 by the author.

McCoy's study (1996) drew the following conclusions in terms of the attitudes of health service users to the FHC policy:

- There is general support by health users for the FHC policy
- Respondents felt that access to health care has improved, especially for people living in rural areas, informal settlements and on white-owned farms.
- There is, however, concern that the health services will not be able to cope with the extra work.

In terms of attitudes of health care providers to the FHC policy, these were the findings:

- A large proportion of public sector health workers (40%) believe that the FHC promotes the health of the general population. Seven out of every ten respondents felt that the free health care policy helped prevent serious illness or death amongst pregnant women and children under six.
- However, the dominant opinion was that the FHC policy had aggravated a number of existing problems within the health services, such as poor working conditions and low pay, a shortage of medicines, overcrowding and low staff morale.
- Health workers (and consumers) agreed that one of the main reasons for the "inappropriate" use of the referral hospitals was the inadequacy of primary care facilities.
- While a majority (54%) of private general practitioners who responded to the survey felt that the FHC policy was good in principles, more felt that the policy was unsatisfactory in practice.
- A general sentiment was that the implementation of such extensive changes should be preceded by greater consultation and planning with health personnel, McCoy D (1996)

The complaints of health providers that patients were "misusing" the FHC policy, and the complaints of patients about the unsatisfactory attitude of health workers, suggest the need for communities and health services to work more closely in resolving problems.

The implementation of the FHC policy caused much of dissatisfaction. This highlights the need for more careful planning and the involvement of health workers and health service consumers.

FREE HEALTH CARE POLICY IN MPUMUZA AREA

Context of the Mpumuza area

The Mpumuza tribal authority area falls within District Council DC22 (Umgungundlovu District). It is a Tribal Authority falling under the jurisdiction of an inkosi, inkosi's councillors (izinduna) and politically elected ward councillors (Umgungundlovu District Municipality GIS Planning, 2002).

Statistics from Umgungundlovu District Municipality GIS Planning, 2005, indicate that District Council 22 is made up of seven local municipalities (KZN's) these being:
KZ 221 – Umshwati Municipality
KZ 222 – Umngeni Municipality
KZ 223 – Mpofana Municipality
KZ 224 – Impendle Municipality
KZ 225 - Msunduzi Municipality (within which the Mpumuza area falls)
KZ 226 – Umkhambathini Municipality
KZ 227 – Richmond

According to Umgungundlovu District Municipality GIS Planning (2005) this is a district that hosts Africans, Coloureds, Indians and Whites. It has a population of 824 298 and is characterised by urban, dense settlements, villages, farmlands and scattered settlements, with no areas classified as rural. The Msunduzi Municipality, within which Mpumuza area falls, has a population of more or less 524 948 (see KZ 225 map attached as Appendix A).

The present study was carried out in the Mpumuza area to investigate what changes have taken place in the health care system, over time, and particularly to assess how a sample of

people in Mpumuza view processes of community involvement in the formulation of the free health care policy and the impact thereof on policy implementation.

The Mpumuza Tribal Authourity Area was chosen for the different experiences of the people in that area. There is a mixture of people who have a rural, semi-rural and urban experience of the area, depending on accessibility to amenities. It has a population of about 132, 660. Most of the households are located within a radious of 100 m from the clinic and 200 m radius from Edendale Hospital. This is in line with commitment by government to bring services closer to the people.

RESEARCH METHODOLOGY

❖ RESEARCH DESIGN

The researcher utilized an interpretative research design, which is both descriptive and qualitative. Terre Blanche and Durrheim (1999:123) state that "the interpretive method does not translate experiences into a language of variables and mathematical formulae, as does the explicitly positivist approach, but it tries to harness and extend the power of ordinary language and expression, developed over a number of years, to better understand the social world we live in".

It is a methodology that relies on first-hand accounts and it tries to describe what it sees in rich detail and presents its finding in engaging language. The community, it was assumed, would be able to give their own assessment of the processes and thus be able to give a critical view of the outcomes of providing free health care.

Rubin and Rubin (2005) state that questionnaires are a good means of getting depth, detail and vividness from the respondents. This means getting thoughtful answers based on considerable evidence, as well as getting full consideration of a topic from diverse points of view.

❖ DATA COLLECTION

A qualitative information gathering methodology is described in detail under "design". Fifty structured questionnaires were used in the first review, which was done in 2003. Interviews were chosen specifically because, as specified by Terre Blanche and Durkheim (1999:128), they are a more natural form of interacting with people and fit in well with the interpretive approach methodology adopted for this study. They give an opportunity to get to know people intimately so that the interviewer can really understand how they think and feel. There were schedules for: (i) people within the households (ii) nursing personnel and (iii) authority personnel (Inkosi of the area). The structured interview schedule was used, in view of the fact that direct questioning by the interviewer is necessary so that guidance and support could be provided to the respondent on site, to eliminate or reduce ambiguity that could alter the findings.

The distribution of respondents was as follows:

- ❖ One ward councillor assigned the task of monitoring and lobbying with health personnel for the improvement of health care in the Mpumuza area. This councillor carries the mandate from the Inkosi of the area.
- ❖ Five nurses (who will be referred to as service providers in the document i.e. street level bureaucrats) at the clinic, each from a specialist section of the clinic:
    - maternity
    - child health
    - surgical
    - casualty
    - mother and baby
- ❖ Forty four were ordinary people (who will be referred to as service users in this document) of Mpumuza who utilise health services in the area.

In the year 2005, when the study was revived, another sample of 50 was chosen, but not the same individuals, in the interest of gaining more responses and also to gauge whether or not there has been a change in perception after a period of not more than two years. A comparison of the two sets of findings will be made and conclusions drawn.

ANALYSIS OF THE FREE HEALTH CARE POLICY STUDY IN THE MPUMUZA AREA

CONTEXT

The study investigated the two main groups that are directly affected by the free health policy, these being the service users (the community) and the service providers (the nurses working at the clinic*).*

The following areas were examined, in an attempt to consider the hypothesis stated, namely that "involvement and participation of local communities in issues of public health policy formulation and implementation enables citizens to take control of their own health care":

- Demographic details of the area, to gain an understanding of how people perceive their area in relation to the available infrastructure
- Access to health care services, whether residents have to travel long distances to clinics or whether the accessibility is good
- Knowledge, perceptions and experiences of the health care service, to assess what residents understand a service to be
- Participation in the formulation and implementation of the free health care policy and the impact thereof, which is the purpose of the study.
- To find out what the people's views are on how the policy could be improved, which is crucial if this study is to inform the other policy formulation processes, at a later time.

Replies to the questions used are presented in summary form in Appendix B

FINDINGS: 2003

ANALYSIS OF STUDY DONE IN 2003 (A DETAILED DATA ANALYSIS IS PRESENTED FOR EASE OF REFERENCE)

In assessing **demographic details** of the 50 respondents (the service providers, the service users and the Inkosi) one person indicated that the Mpumuza area is a semi-rural area. Every other respondent said it is a semi-urban area, specifically because it has the infrastructure. It is an area with electricity, water, tarred roads and sewage removal systems. The one respondent who does not view it as semi-urban said "I don't have electricity in my house and I get water from a road tap. Yes, the road is tarred but my house's toilet is not a flush type". The present author then engaged in a talk concerning to paying for the services to get to their yard and paying for their maintenance on a monthly basis. The response was: "I am not working and couldn't afford what you are talking about. For me it is a fantasy".

Of the 50 respondents, 100% are very impressed with accessibility of the services. They indicated that the clinic is within a walkable distance of about five kilometres radius. One respondent said even pre-1994 period, "we have been very lucky, because all along there have been clinics in our area that were built by the tribal authority, through the Amakhosi, and we never had to walk long distances unless one had to go to hospital and the nearest for the area is Edendale Hospital, which is still within a walkable distance if you are not too ill".

To assess the knowledge, perceptions and experiences of the health care service respondents were asked if they are familiar with health issues in and around their areas and what service specifically. They were also asked how they rate the kind of service they are being offered. The responses were very distinct. Of the fifty, the five nurses and the Inkosi said they are familiar with health issues. Twenty - one community members said they do not know what the issues are and the other twenty - three said they are very familiar. What became clear is that what nurses understood as issues was work-related. One respondent said, "I am familiar with the kind of services I have to render at primary health care level and the different policies that guide my work, which are available in the clinic".

The Inkosi's understanding of issues concerned his involvement in health matters in his area: "I get involved in some meetings on health e.g. when the clinic was started I was involved, when the school feeding scheme was initiated in schools in my area I was involved, etc".

The 23 respondents who said they are familiar with health issues all related their responses to disease patterns happening around the area. All said they know about HIV/AIDS, breast cancer, TB, breast feeding and cholera. One said "I remember last year that there was a big tent up there at the community hall. The Inkosi, Izinduna and the health workers and the MEC and the community were there and there was talk about breast feeding and HIV/AIDS." Another said "we get advice on a daily basis at the clinic about diseases like HIV/AIDS, TB, etc" and one more said "how can I not know, we have just had a cholera outbreak in this area and we are all scared and trying to be careful".

It is interesting to note that the community's understanding of issues is either non-existent or else they think diseases are issues. The present author thinks this is due to the fact that when health is mentioned it is usually because someone is sick, even within the family, and there is less talk about a comprehensive health system or programmes which would encompass formulation of health policies, even at community and household levels.

In relation to rating the quality of the services offered there were mixed responses. The rating was done to assess the standard of services within the free-health policy. Of the five nurses that responded, all are not impressed. They are fully appreciative of the policy and why it was formulated, but they stated that it exerts huge pressures on them in terms of numbers that flock to the clinic considering the repercussions of the scourge of HIV/AIDS and TB.

The other major issue that nurses raised is the shortage of staff due to the migration of staff for better salaries. "I find myself having to work beyond the eight hours due to the long queues and the intensity of the diseases like TB and HIV/AIDS that require spending more than an hour with one patient at times". "It becomes very difficult to render a

comprehensive service due to the numbers that attend". "If I was given an opportunity to voice my views about the policy I would have suggested a sifting mechanism to ascertain that it benefits the intended group, because I have seen people who are working in queues at this clinic and I can't question and chase them away due to the fact that they have medical aid". "I am on my way out, probably in December my travel documents and work permit will be ready for me to assume a job in Saudi Arabia". "The policy is abusive of us, because it never went further to look at the impact it would have on us. Right now I am finished". "When next will this policy be reviewed, because I am sure I will demand a hearing", are some of the responses from the nursing personnel. "The only way I can cope with such big numbers is to ignore some of the policies and rules. There is no way I can spend more than 10 minutes with one person; it is the best I can offer. If that is not enough, then it's bad".

The Inkosi of the area had a very positive response to the standard of the service. "It is an excellent service; it has improved, greatly improved. These days we have community health workers that work within the community, we have directly observed therapy workers that assist in the TB programme and HIV/AIDS lay counsellors that do lay counselling within the HIV/AIDS programme. All these components, I think, are improving the service standards".

It needs to be noted that, although the Inkosi is the head of the community, he has the responsibility, together with government officials, of putting systems and processes in place. What he talked about are systems. To him, once those are in place then the service is good. As evidence of that, when he was asked whether he utilises services at the clinic, he was emphatic that he has medical aid and he prefers private hospitals.

Service users, people in the community also had mixed responses about the service standards. "I am so happy not to pay because I am not working". "If I were to have a say I would immediately scrap the free health policy because look right now we don't get good medication, you hardly get attended to by a doctor, sometimes the medication is not even there, nurses don't have what it takes, they are cheeky and rude, but I guess they are tired because we come in our numbers". "I have been coming to this clinic for the third time now

and all they are telling me I need a referral letter from the referring hospital, what is that? Maybe your presence will bring me some joy, you might ask about this on my behalf. Is this the kind of service we are to receive for free, because if it is, we are willing to pay for a better service". "The least that could have been done was to be allowed a say in relation to this service. I would have said let's pay a nominal fee to sustain the service. I think the reason for not getting the medication at times is that we don't pay and it's too many of us that need to be serviced".

In assessing participation in the formulation of the free health policy, all five service providers indicated that they did not participate. One respondent said "I only knew about it when we were informed by officials in the regional office at that time and all we were expected to do was to stop taking money from patients up to now. There hasn't been a time when I have seen even a policy document explaining it. Even if there was one, where would I get time to read through it with such a work load?"

Service users also indicated that they were never involved. It was clear, though, that ordinary people are not fully aware of their fundamental right of expression, as stated in the Bill of Rights (the Constitution of the Republic of South Africa, 1996:9). Six of the respondents said "Why are you asking this question? Am I supposed to have a say or I have to get told by the government? Who am I in relation to policies?" The rest categorically stated that they were never involved.

The Inkosi expressed anger over non-involvement. "I was never part of it, but I am expected to advocate for buy-in. I only got to know about it over the media. The least that could have been done was to involve me, because I have got viewed that I could have erred and I am positive they are appropriate and would have helped. Due to lack of participation, which would have made me understand more even when enrolling my subjects I am battling to control service ownership from the people and am suspecting some abuse of the service at large".

In conclusion, all categories of respondents' views were sought on how they think the policy could be improved. The Inkosi acknowledged the context change. He said it is not too late

for the policy to be juggled around with, and changes made, before things blow out of proportion. He strongly believes that people respect their leaders and if they get enrolled appropriately by their leaders they do not resist: "What government has to do is to call an Imbizo [big meeting] of leaders to revise this policy, so that together we can powerfully inform it. We will then go back with agreed-upon resolutions to enrol the local level and, at the end; we all have a common understanding of the free health policy and agreed-upon impacts. We can still alter it, if we have to, because we have learnt lessons that will inform the necessary changes".

Service providers are anxious to start re-planning. "We have so much to say about this policy, both good and bad. We want it to work, but in a way that will benefit all. At the moment we are suffering. Is there a possibility of it being reviewed, because we will appreciate that". We are thinking if that can happen we will get an opportunity to indicate our views at an early time when changes could still be made where necessary.

Service users would really appreciate having a say. "After all, the policy was formulated for us, but not by us. No one knows what we could have said if all was laid on the table for us. Although we enjoy the free part, we are fully aware of the negative results. We want to own this policy so that, at the end of the day, we don't blame anyone".

FINDINGS: 2005

In carrying out similar interviews two years later, in 2005, it was apparent that the findings more or less the same in terms of the defined key areas of the research, because no follow up or new features had been introduced within the period in question:

- Demographically Mpumuza area is improving and is becoming more of an urban area with tremendous improvement of the infrastructure and improvement in levels of education
- Accessibility of services to the community has greatly improved with the local clinic being upgraded into a community health centre that opens twenty four hours a day. Schools have been improved in terms of streams offered at schools that give a variety of fields to pursued by learners
- Responses about knowledge, perception and experiences on health issue indicate that although there's a basket of issues there is still a great concern and focus around issues of HIV and Aids
- On involvement of the stakeholders in the formulation process, there is still a general feeling that there was no involvement of the right people when this policy was formulated. As a result it is subjected to massive abuse. Some respondents indicated that there are people who stock up with the medication because they know they get it for free.
- Understanding of health issues, knowledge and perceptions. Health issues are still perceived by most, including the nurses, to mean diseases. This is an indication that more needs to be done to indicate that issues mean more than just diseases. It includes issues around good health and how to live a healthy lifestyle.
- Perceived standard of the free health services that are provided. The nurses who are service providers are still not happy with the heavy workload, which they perceive as being the result of free health services. They are faced with the challenges of staff shortages challenges due to the exodus for better salaries outside the country.

In conclusion the views of respondents from all categories were sought on how they think the policy could be improved. It should be noted that the the state of affairs still remains as in 2003, thus the similarities in the findings of the two studies. These similarities are detailed in the section below as: similar study findings (comparison)

SIMILAR STUDY FINDINGS (COMPARISON)

Effect on service utilisation

The Health Systems Trust (HST) (1996) discovered that the policy led to a rise in attendance of patients in most public sector facilities. This leads to the assumption that the policy *did* improve access to clinics for patients. Antenatal clinics attendance also increased. It noted that clients who formally attended as private cash-paying clients now attended as 'free' publicly funded patients. The same conclusions were drawn from the Mpumuza study.

Attitudes of health service users (The Community)

HST (1996) found that there was general support for the free health policy by the users. They felt that access to the services had improved, especially for people in rural areas, those staying in farming areas and those in informal settlements. Concerns were raised, though, by the users that due to the increase in utilisation of the service they do not think the system will cope, because the service is free. Results of the Mpumuza study similarly indicate these concerns from the Mpumuza service users.

Attitudes of health care providers

A large proportion (40%) believed that the free health care policy promotes health of the general population (HST, 1996). The majority, though, felt that it is due to the free health care policy that there are poor working conditions, pay has decreased, there is a shortage

of medication, there is overcrowding, and staff morale has declined. This then results in inadequate use of primary care facilities (which are the lowest level of care). Although the policy was found to be good in principle, it was found to be unsatisfactory in practice. It was felt that such extensive changes should be preceded by greater consultation and planning with all stakeholders.

Another study, by Ijumba (2002), on behalf of the HST, looked at concerns of primary health care facility workers. She touched on the effect of transformation on health care workers. The implementation of the free health care services in 1994 was part of the transformation process by government.

One of the respondents in Ijumba's study (2002) said the following in relation to the free health care policy, "I know that that's a government decision. They decided this in parliament, that patients don't have to pay, but if you look at patients coming every week, the same patients coming for nitty-gritty things, they should really (and you are not allowed to turn patients away) implement something where patients must pay, whether it is R5 or R10. Our pensioners want to pay – they are prepared to pay". This has come up in the Mpumuza study, where people think that maybe if they had been informed they would have opted for nominal fees. Nurses feel the policy was imposed upon the people concerned.

In conclusion the two case studies and other related work done by other researchers have revealed that there are still challenges around how policies on free health care are formed and this impact negatively on the implementation process. This study has presented an opportunity for policy makers to look at the possibilities for improving this policy and for the future to see how they can better initiate policy formulation processes in order to address the issues and problems highlighted.

The chapter, that follows (which is the last chapter of this thesis) will conclude on the findings relating them to the theoretical perspective

CHAPTER 4

CONCLUSION

In interpreting the findings I will engage within the areas covered in the theoretical framework and relate these as much as possible to the findings of the study. The said areas being:

- Public policy
- The policy cycle
- Policy implementation
- Street level bureaucracy

It is evident in the findings of this study that if communities do not participate in policy formulation they tend not to take control of their health

Public Policy in the Mpumuza Study

Howlett and Ramesh (1995:4-5) define public policy as a result of decisions made by government. Decisions made by government to do nothing are just as much policy as are decisions to do something. Thomas Dye, as quoted by Howlett and Ramesh (1995:4-5), defines public policy as "anything a government chooses to do or not to do".

This is true of the present study because it is stated that, on 24 May 1994, the then President, Mr N.R. Mandela, announced on behalf of his cabinet, that free health care would be introduced (McIntyre,1998:31). This is a decision that had been made by government and it became policy and was implemented on 1 June 1994.

Policy Formulation Processes in the Mpumuza Study

Kingdon (1995; 2-3) describe policy formulation as happening in stages. The stage of setting the agenda, they say, is influenced by pre-political or, at least, pre-decisional processes. This is the stage at which it is determined what issues and alternatives are to be considered and which choices shall be made. This stage, Kingdon (1995: 105) states, comprises the list of subjects or problems to which government officials, and people outside government closely associated with those officials, are paying serious attention. Some are then given higher priority than others.

The free health care policy was formulated to address particular crises that existed within South Africa at that time. This scenario dated to the pre- 1994 period. McIntyre (1998: 7-8) states that the health system of that time was characterised by:

- Fragmentation of curative and preventative services
- Bias towards hospital-based, doctor-centred, curative care
- History of racial discrimination in access to health services
- Systematic under-funding of certain geographical areas
- High levels of health care resources in the private sector, which was disturbing if compared to the population numbers served
- A health service organisation that favoured interests of those in political power.

It became evident that the announcement by the then State President, Mr Nelson Mandela, on 24 May 1994, of the free health care policy was influenced by pre-political processes. It was crucial that the health services transformed. Thus the free health care policy came into being.

Part of what Lindblom (1980:44) discusses under the policy making process is policy-makers. He estimates that these are a tiny proportion of the adult population. Given their control over policy-making, they constitute an elite, are composed of the chief executives and cabinet members, members of parliament or legislature policy-making members of the

bureaucracy, upper levels of the judiciary and, in some systems, higher ranks in the military. This has proven correct in the Mpumuza study, because 100% of the respondents (who are people not in high or powerful positions), did not participate in the free health care policy-making process.

Community Participation

Fitzgerald, McLennan and Muslow (1997: 532 – 533) state that, for participation to be effective, it has to cover the total policy process, from defining needs and priorities, through implementation to evaluation. The creation of community participation channels has to be addressed, as well as the skilling of communities in decision-making processes, without divorcing them from their constituencies. This adherence to community participation, they state, does not mean that decision-makers always have to do what the community wants, but policy-makers have to engage in dialogue with communities. For sustainable development in the health system there needs to be dialogue with communities for the sake of transparency.

The need for community participation was indicated by 100% of the respondents in the Mpumuza study. To mention one respondent, the Inkosi of the area, who is in charge of his subjects, he said that he did not participate in the free-health care policy formulation in order for him to gain insight and then appropriately enrol the community at large.

Lipsky (1988:3-8) sees public service workers as street-level bureaucrats. They occupy a critical role in society. They are regarded as low-level employees, but their actions constitute the services delivered by government. Their actions and decisions, added together, make up agency policy. Irrespective of what government policy is in terms of deliverables, the discretionary actions of public employees are the benefits and sanctions of programmes of government and they determine access to government rights and benefits. They are the means through which most of the people encounter government. Each encounter with them (the service providers) represents an instance of policy delivery.

In the Mpumuza study, the nurses that were interviewed confirmed the statement made by Lipsky (1980:3-8) that they deliver a service on behalf of those that formulate the policies. The policies that were formulated without their involvement, they said, were impacting greatly on them.

In their role of implementing policy, Hanekom (1987:55) sees street-level bureaucrats as having an opportunity to exercise discretion. This is necessary, because these workers are faced with different individual cases that have to be dealt with differently. This diversity of individual cases accounts for the modification of all original policies. The Mpumuza study does indicate the exercise of this discretion. One respondent is quoted in the findings of the study as saying "The only way I can cope with such big numbers is to ignore some policies and rules. There is no way I can spend more than 10 minutes with one person, it's the best I can offer. If it's not enough, then it's bad already."

It is behaviour like this that makes Lipsky (1988:xvi) say that, eventually, street-level bureaucrats find themselves having to formulate mechanisms with which to cope with the situations, which they find themselves in. They also discover that, in most cases, they have to apply their own discretion to process their workload quickly and to deal with different clients. They then become "policy makers" instead of policy-implementers.

Lipsky (1980:15) thus sees street-level bureaucrats as a group that exercises much discretion in implementing the policies. This, he says, might be necessary for them to cope with their working situations, such as the nurses in the Mpumuza study, who said that queues are long and there is a staff shortage and people are very sick, which is why then end up modifying the free-health care policy by not offering a comprehensive service. This means that they will only treat the diseases and not the sources.

The power and autonomy of service-providers in the Mpumuza study

Street-level bureaucrats are not neutral, but are individuals who have interests and values. By being entrusted with the implementation of the policy, they are indirectly given power to make decisions about the manner in which policies are to be implemented (depending on

the policy guidelines). In most cases, these workers are rarely supervised and their judgement is trusted to be appropriate in a variety of circumstances. The workers might, however, exercise their power to promote and protect their interests and values (Lane 1993:110).

Lane (1993: 110) suggests that policy implementers often execute policies which are compatible with their values and interests with more success than those which are contrary to their own values. The recipients of the policy, too, have an impact on implementation, because the programmes which have their support are more likely to succeed

The Mpumuza study has confirmed that the service-providers have power and autonomy. Their exercise of discretion in changing the free health care policy to suit their context is evidence of this, when some respond by saying:

> "It becomes very difficult to render a comprehensive service due to numbers that attend in the facility. As a result they can only spend 10 minutes of time per person".

It is not policy to do this, but because of the constraints, service-providers, service providers sometimes do exercise their power and autonomy. Due to a number of factors they cannot be constantly supervised and the education they have is taken as an appropriate tool that gives them the ability to make good judgements.

In the Mpumuza study, respondents reduce the time they spend with clients because of a need to protect their interests and values. Nowhere in their responses do they indicate categorising their clients in terms of complexity of diseases so that they are better informed on how much time to spend with whom. It is then questionable whether the interests and values evident are in line with the free health care policy.

FINAL THOUGHTS

The study done in Mpumuza directly confirms the hypothesis made that "Involvement and participation of communities in issues of public health policy formulation and implementation enable citizens to take control of their own health care." The final thoughts on the study are that:

- People from the disadvantaged groups have access to free health care services and they come to the facilities in large numbers, more than the service providers can cope with. The service is indeed free at primary health care level.

- The health system in South African is bio-medical. The primary focus is to cure the disease a patient presents with. Respondents in the study did not know nor did they have any access to, knowledge, perceptions and experiences of the health care services. To them this meant diseases. They know something about HIV/AIDS, TB, etc., but they do not know about how they ended up not paying for the health care service. During the normal routine of attending the clinic someone said that from now onwards they do not pay. They have no idea why and what this means for now and in the future.

- The role of the Amakhosi is not yet clearly defined in South Africa. The Inkosi of the area the researcher went to says he should have been consulted. People would then have been more informed and owned the free health care policy.

- The kind of service being offered under the banner "free health care" leaves much to be desired. Nurses are overwhelmed, they are tired and this impacts negatively on the implementation processes. The service users having mixed feelings. Some are happy not to pay. Some are looking deeper into the kind of service they get for free. It is seen as up to standard and they believe free services are of a low standard.

- One hundred percent of the respondents (the Inkozi, service providers and service users) feel a great need for re-planning. They have things to say, they have contributions to make and they really want a change in this policy.

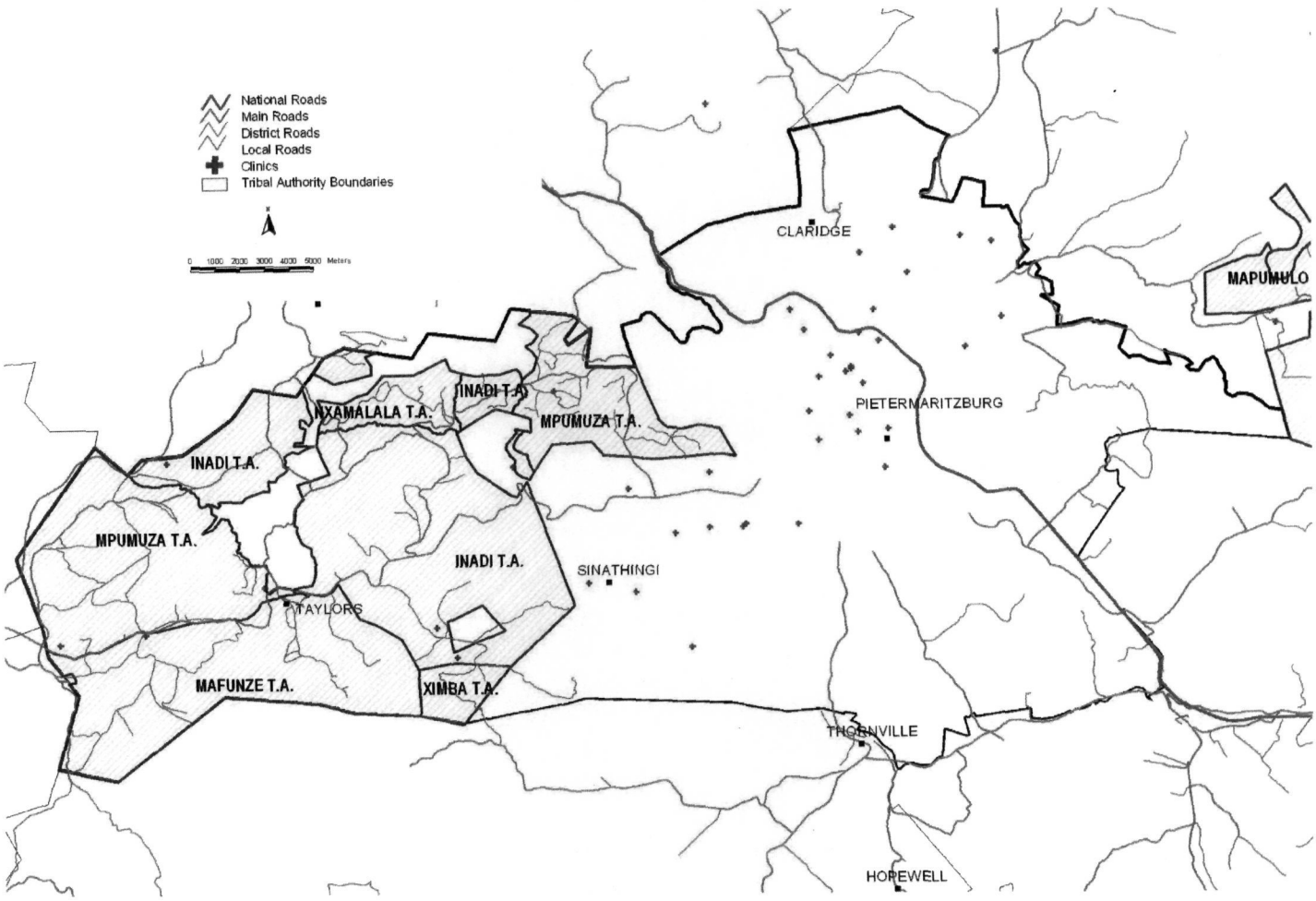
- One hundred percent of the respondents (the Inkosi, service providers and service users) indicated that they were not involved in the formulation of the free health care policy. It was imposed on everyone. Nurses were sent a directive not to collect any money from the patients. People heard through the media that they did not have to pay for services. No clarity was made and as a result, some respondents wanted to know from the researcher, why they are made to pay when they go to hospital.

- There is hope that this policy can still be improved with 100% of the respondents. They all want to go back to the negotiation table, so that they can air their views and be given an ear and an opportunity to influence the existing policy.

- One hundred percent of the respondents see themselves as major stakeholders that should have been involved when the free health care policy was formulated; they still are available to be involved.

- The system is being greatly abused. The present study has revealed this, when some respondents state that they have seen people who are working and can afford to pay for medical expenses coming to the clinic, but they are afraid to question them. This is not in line with the requirements of the Bill, which categorically states that free primary health care services are for all in South Africa, except members of medical aid schemes and their dependants and persons receiving compensation for occupational diseases.

APPENDIX A: MAP OF KZ 225



APPENDIX B: DETAILED DATA ANALYSIS: SERVICE PROVIDERS

Of the fifty participants for this study five were service providers. For purposes of subjectivity and inclusiveness more then one category each from a specialist section of the clinic these being maternity, child health, surgical, casualty and mother and baby were involved. These being:-

- Chief professional nurses (CPN)
- Professional nurses and
- An enrolled nurse

The study was administered in the year 2003 and another reassessment and comparison of findings done in 2005 and as documented.

RESPONSES (SERVICE PROVIDERS)

QUESTIONS	RESPONSES				
1. What job do you do?	1	2	3	4	5
	CPN	PN	PN	CPN	EN
2. What services are available for the community of this area?	Clinic and hospital	Clinic and hospital	Clinic and hospital	Clinic and hospital	Clinic and hospital
3. For how long have you worked in this facility?	15yrs	7yrs	11yrs	5yrs	6yrs
4. Do you think the community understands free health policy?	Not well understood, it's being abused by some.	I don't know	Some are happy and some not, an inferior quality service	Misuse of the service because it's free	It's an incentive for voting and entitlement

5. What is your understanding of this policy?	A PHC service for the poor	It's for women and children	Think it's for the poorest	It's a burden to us service providers	For those who cannot pay
6. What role was played by service providers in formulating free health care policy?	None	None, only a directive was sent for implementation purposes	Don't recall any role	None, only heard about it over the media	None
7. What impact does this policy have on your performance as service providers?	Overworked	Overworked due to the large numbers that come in.	Overworked cause the clinic is always full	Overwhelmed. People are moving to Saudi, I'm also waiting for my pin and will go	Overcrowding in the facility
8. What coping, mechanisms have you already put in place?	Ignore the comprehensive health care policy	I leave people in queues to have a meal otherwise I would never	I can't give a comprehensive service	• I've told patients to come early • I don't do a comprehensive service • I make patients move to different queues	I only treat the disease and not the whole being (no comprehensive service)
9.Do you think the policy is achieving it's purpose / is it a good policy?	No, cause I've seen working class people in queues	Not a good one because we are so overworked. I'm not sure whether the right people are benefiting	I've seen people who work standing in queues	Service providers are overworked and people who work stand in queues	I'm over worked because of this policy
10. What can be done to improve on this policy?	Use of selection criteria to ascertain that people don't work	Maybe people could be checked whether they are deserving or not	There needs to be selection criteria	• Introduction of a nominal fee • A means of identifying the indigent	Introduction of a check list to ascertain work status

11. What further suggestions can you around improvement of this policy?	Involvement of us next time cause we end up on the receiving side	No	• Put down a selection criteria • Involvement at policy formulation stage	• More nurses • Salaries decided by amount of work done • Incentive for overworked staff • Involvement in policy formulation	We have to have a say in policy formulation, maybe we need to relook at formulation of a revised version of this policy. It's not late.

INTERVIEWS SCHEDULED ON :

The views of service providers at Mpumuza clinic with regard to the formulation and implementation of the free-health policy at their health facility.

1. **Person identification**

   a) Gender male/female

   b) Age ☐

2. **Employment/pension status**

   a) 1. What job category are you employed in?

   b) What level of income/pension do you fall in (i.e. salary/pension per month)?

      i. R0-300
      ii. R300-R1000
      iii. R1000-R2000
      iv. R2000-above

3. **Type of services available in the area of Mpumuza**

   What services are available for the community of this area?

4. **Length of service of the respondent in Mpumuza clinic**

   For how long have you worked in this facility?

5. **Assessment of the understanding of the policy by the community.**

   Do you think the community understands free health policy?

6. **Assessment of personal understanding of the policy as a service provider**

   What is your understanding of this policy?

7. **Understanding of the role played by service providers in formulating this policy**

   What role was played by service providers in formulating free health care policy?

8. **Assessment of the impact the policy has on service delivery**

What impact does this policy have on your performance as service providers?

9. **Assessment of coping mechanisms**

What coping, mechanisms have you already put in place?

10. **Assessment of whether the policy is achieving the objectives it was designed for**

Do you think the policy is achieving it's purpose / is it a good policy?

11. **Suggestions around how the policy could be improved**

i. What can be done to improve on this policy?

ii. What further suggestions can you around improvement of this policy?

THANK YOU FOR YOUR CO-OPERATION

APPENDIX C: DETAILED DATA ANALYSIS: COMMUNITY MEMBERS

Of the fifty participants for this study forty five were community members. Of the forty-five one member was an inkosi (chief) of the area. The chief was brought to get his views on the subject as the leader of the community who has a responsibility to monitor the services on behalf of government at local level. Community members were randomly selected with an inclusion of both genders to get the different views and lessen possibility of biasness.

The study was administered in the year 2003 and another reassessment and comparison of findings done in 2005 and as documented.

RESPONSES FROM THE COMMUNITY MEMBERS

Question 1

Indication of the gender and employments statuses of the respondents

AGE/S	GENDER/S	EMPLOYMENT STATUS	
• 45 years	Male	Unemployed	
• 20 years	Female	Unemployed	
• 36 years	Female	Unemployed	
• 45 years	Female	Unemployed	
• 36 years	Female	Unemployed	
• 26 years	Female	Unemployed	
• 22 years	Female	Unemployed	
• 33 years	Female	Unemployed	
• 30 years	Female	Unemployed	does voluntary work for people with HIV/AIDS
• 38 years	Female	Unemployed	
• 31 years	Male	Unemployed	
• 65 years	Female	Unemployed	
• 26 years	Female	Unemployed	
• 41 years	Female	Unemployed	
• 29 years	Male	Unemployed	
• 25 years	Female	Unemployed	

• 27 years	Female	Unemployed
• 22 years	Female	Unemployed
• 45 years	Female	Unemployed
• 35 years	Female	Unemployed
• 42 years	Female	Unemployed
• 32 years	Female	Unemployed
• 24 years	Female	Unemployed
• 30 years	Female	Unemployed
• 17 years	Female	Unemployed
• 21 years	Female	Unemployed
• 25 years	Female	Unemployed
• 25 years	Female	Unemployed
• 60 years	Female	Unemployed
• 39 years	Female	Unemployed
• 19 years	Male	Unemployed
• 41 years	Female	Unemployed
• 52 years	Female	Unemployed
• 53 years	Female	Unemployed
• 60 years	Female	Unemployed
• 33 years	Female	Unemployed
• 34 years	Female	Unemployed
• 40 years	Female	Unemployed
• 30 years	Female	Unemployed
• 30 years	Female	Unemployed
• 75 years	Female	Pensioner
• 22 years	Female	Unemployed
• 23 years	Female	Unemployed
• 22 years	Female	Unemployed
• ± 45 years	Male	iNkosi of the area

Question 2

Indicate type of health facility you accessed pre 1996 and distance travelled to the said facility.

• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Never used a clinic cause I was very healthy	± 2km travel
• Clinic	± 2km travel
• I was still young at the time	(Now I travel ± 2km)
• I wasn't sickly	(Now I travel ± 2km)
• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Never used a clinic cause I was very healthy	± 2km travel
• Clinic	± 2km travel
• I was still young at the time	(Now I travel ± 2km)
• I wasn't sickly	(Now I travel ± 2km)
• Clinic	± 2km travel
• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Never used a clinic cause I was very healthy	± 2km travel
• Clinic	± 2km travel
• I was still young at the time	(Now I travel ± 2km)
• I wasn't sickly	(Now I travel ± 2km)
• Clinic	± 2km travel
• Hospital	± 3km travel
• Clinic	± 4km travel
• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Never used a clinic cause I was very healthy	± 2km travel
• Clinic	± 2km travel
• I was still young at the time	(Now I travel ± 2km)
• I wasn't sickly	(Now I travel ± 2km)
• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Never used a clinic cause I was very healthy	± 2km travel
• Clinic	± 2km travel
• I was still young at the time	(Now I travel ± 2km)
• I wasn't sickly	(Now I travel ± 2km)
• Clinic	± 2km travel

• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Never used a clinic cause I was very healthy	± 2km travel
• Clinic	± 2km travel
• I was still young at the time	(Now I travel ± 2km)
• I wasn't sickly	(Now I travel ± 2km)
• Clinic	± 2km travel
• Hospital	± 3km travel
• Clinic	± 4km travel
• I was very healthy	(Now I travel ± 2km)
• Hospital	± 8km travel
• Clinic and nearby hospital	± 1km travel
• Clinic	± 3km travel
• Never used a clinic cause I was very healthy	± 2km travel
• Clinic	± 2km travel
• I was still young at the time	(Now I travel ± 2km)
• I wasn't sickly	(Now I travel ± 2km)
• Clinic	± 2km travel
• Hospital	± 3km travel
• The chief (tribal authority)	± 2km travel

Question 3

Level of community participation in health planning and needs identification in the area.

- Involved in disease awareness events/days e.g. TB and HIV/AIDS days
- None, involvement that is known of
- None, we have never been made to identify our needs
- None that I'm aware of
- Not involved
- I know of diseases that are there e.g. HIV/AIDS
- I guess cholera, TB,HIV/AIDS are what I know about
- Not aware of any
- Not aware of any and I'm not aware of any needs
- I know about cancer, TB and HIV/AIDS
- I know about TB, cancer and HIV/AIDS

- I don't know any
- I think I do but can't mention any issues I know of right now
- I don't of any
- We are part of planning, as a result I know about TB, cancer, family planning
- I think there is participation. I know about breastfeeding, vaccines.
- I don't think there's any involvement
- I don't think there's any involvement
- I don't think there's any involvement
- I haven't heard of such an exercise
- We participate as a result I know about HIV/AIDS, blood pressure and diabetes
- I think we participate, I now know about TB, HIV/AIDS.
- I don't know any
- I don't think so as a result I cant mention any issues I know of right now
- My knowing about TB, HIV/AIDS, I think, means I'm involved
- I think so because I know about TB, Cholera and AIDS
- Yes, I know we participate because we know about diseases
- We do participate and we are aware of diseases like HIV/AIDS
- We do participate
- Yes we do participate, which is why we know about diseases
- We do participate
- I don't remember any participation
- We don't participate
- We don't participate as a community
- We sometimes participate which is why I know about breastfeeding
- We don't participate
- There's no participation
- Yes we do participate and I know about disease like cholera
- Yes we do participate e.g. in HIV/AIDS awareness
- We don't participate

- We do participate in awareness like TB, HIV/AIDS
- Yes we do participate e.g. in baby care
- Yes we do participate
- We do participate
- There is very little and unclear participation (in health events) as an Inkosi I am involved in some

Question 4

Compared to pre 1996 period, have the services improved or not?

- I would say cause we don't pay
- To me they are bad there is not enough medication but good in that we don't pay
- Good services (for free)
- We don't pay and we get medication for free,(good)
- Good, free services
- Good, free services
- Not good, not enough medication (good in that it's free)
- Good cause it's free services
- I haven't been getting a good services, I've sat here for too long, it's full and nurses are not attending to us on time
- I think they are failing to cure me since 2001, I would say the service is good then
- Good, free services
- Good, free services
- Medication of lower quality I have to come back on a monthly basis
- Good, free services. Improved or not
- Good, free services
- Medicine shortage, too long queues, long wait
- Good, free services

- Good
- Active staff with enough medication for free
- Medication shortages mostly
- Very poor shortage medication
- Very poor at times (shortage of medication)
- Good free services
- Not sure of how to categorize the services
- A bad service, not enough medication, nurses having to many tea breaks/lunches etc. Waiting too long in queues
- Good free services
- Good, free services
- Poor, long queue, not enough medication and no injections
- Good free services
- Very bad, staff shortage, long queues, lack of respect by some staff
- Good, free services
- Good, free services
- Good, free services, bad with overcrowding and very long delays, need more space and more staff
- Good, free services
- Good, free services
- Good, free services
- Not good at all, medication shortage and quality are posing a threat
- Good, free services
- Very poor services, wrong diagnosis at times because there's no doctors on site
- Good, free services
- Good, free services
- Very bad, my child's illness has worsened because I was given medication of an inferior quality
- Good, free medication

- Good, free services
- I think they have improved because as an Inkosi, I have been allocated community health workers, HIV/AIDS lay counsellors and directly observed therapists to work with the community(to me that is a huge improvement)

Question 5

Are you aware of the free health care policy?

- Not aware
- Not aware
- Not aware
- I'm aware
- I'm aware
- I'm aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware

- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- Not aware
- I am aware
- Not aware
- Not aware
- Yes I am (we don't pay for services)
- Not aware
- Not aware
- I think I don't (isn't it what we are getting here for people like myself who are unemployed)
- Not aware
- Not aware
- Not aware
- Yes I do
- Not aware
- Not aware
- Not aware
- Not aware
- As Inkosi, I would say I'm fully aware of this policy although I've heard about it being advertised in the radio and newspapers

Question 6

What comments can you make about the free health care policy?

- No comments
- No comments
- No comments
- I don't have comments
- I don't have comments
- I don't have comments
- I don't have comments
- I don't have comments
- I don't have comments
- I don't have comments
- No comments
- No comments
- No comments
- The policy is good
- No comments
- No comments
- No comments
- I think rather than Free health care we should have been given free education
- No comments
- It's good but some people are abusing it
- A good policy
- I think it's a good policy
- I don't have comments
- It's a good policy
- I don't have comments
- although it helps with the unemployed, there is a lot of system abuse
- I don't have comments

- It's good if it benefits the poor and the unemployed
- I don't have comments
- I don't have comments
- I don't have comments
- The policy is wonderful
- It's a good policy, although it's not easy to single out those who are abusing the system
- I don't have comments
- I don't have comments
- No comments
- I accept the policy, especially because I'm unemployed
- No comments
- No comments
- It benefits people like orphans, so it's good it has to be there.
- I have no comments
- I have no thought and comments
- I don't have any thoughts
- I think it is good (because people who don't work- like me, benefit
- I don't have any elaborate thoughts about it.
- It wasn't well planned, thought about and communicated. It is lending the government to abuse by some

Question 7

Do you think people at local level or in the community are aware of this policy and do they understand it?

- No. I don't know
- No. It is not familiar even to myself.
- Yes, I think they know that children need to be taken to hospitals and clinics when they are sick. And also that pregnant need to attend antenatal clinic.
- I don't know
- I don't know
- I don't know but I haven't heard anybody talking about it.
- I don't think so because I would have known about it myself.
- They understand it because people are aware that they don't have to pay for health services.
- No, maybe some do know about it but I personally don't know about it.
- No, I'm not sure I think they were not informed about it as usual.
- No, it was not well communicated to local communities.
- I don't know
- No, I've never heard of anyone talking about it.
- I think so, it addresses our problems but we should have been represented when it was formulated.
- I don't think so because we were not involved in the formulation.
- I don't know
- Yes I think so because we are benefiting from it.
- I'm not sure.
- No, I don't think so.
- I don't think so because we never get informed about anything.
- I don't know

- I think they do because they understand that its free services when they are sick.
- I don't think so because we never get involved about anything in this area.
- No, I don't think people know
- No, I don't think people know
- No, I don't think people know
- I think they do but they don't understand the implications.
- No, I would have known about it even myself.
- I don't think so.
- I don't think so.
- I don't know.
- They would be very few that would understand it.
- No, I don't think so. The Department hasn't done enough to let the people at local level understand this policy.
- No, I don't think people know
- No, I don't know.
- No, I don't think people know
- No, most people at local level are illiterate and health workers hardly find time to explain things to communities.
- I don't know.
- I think most people don't know about this policy.
- I think some people do know about it.
- I don't know.
- I don't know.
- I don't think so.
- I don't think so because I haven't heard anything like that from the community and the clinics.
- Being Inkosi of the area, I don't think they know about it as a result everyone wants to get free health care services.

Question 8

In your opinion do you think communities were involved in the formulation of the free health care policy?

- I don't think so.
- I don't think so.
- I don't think so.
- Yes, because it's a policy that helps us all.
- I don't think so.
- I don't think so because they don't know about it.
- I don't think many people know about it and I haven't heard people talking about it in my area.
- I think so.
- No, normally we are never involved.
- No, normally people at local level are never involved when policies are formulated.
- No, people at local level are never involved.
- I don't think they involve local people.
- Local people never get involved.
- Maybe.
- Usually we never get involved.
- I don't think so.
- No, many of us don't know anything about this policy.
- I think we are involved because we have a democratic government.
- I don't know.
- The Department did it all by themselves.
- I don't know.
- I think so because the poor and unemployed benefit in the policy.
- There has never been a meeting in my area to discuss this policy.

- Normally workshops are held in the community.
- I don't know.
- I don't know.
- Maybe there were involved through local structures I don't know.
- There were never involved otherwise I would have heard about it.
- I don't know.
- Policies get done at high level of Government and we never get involved.
- We never get involved in things like those.
- We never get involved in things like those.
- I don't recall community meetings to discuss this policy.
- I don't know.
- I don't know.
- I don't know.
- People at local level are too illiterate to get involved in issue of this nature.
- I don't know.
- I think the Department handles these issues on our behalf.
- These issues get handled by the Department on our behalf.
- I don't know.
- I don't recall discussion like those in our community.
- I don't know.
- I don't recall a meeting in our community to discuss issue about free health care policies.
- No, a suggestion is that an Imbizo be called whereby communities will be enrolled properly on this policy.

Question 9

What do you think needs to be done in order to improve use of this policy (so that the right target group benefits out of it)?

- Clinics should educate communities through meetings and workshops.
- Education sessions should be held for communities.
- Meetings should be held for communities.
- I don't know.
- it's the duty of the Department to educate the communities or beneficiaries about the policy.
- Intensive education sessions need to be held.
- I don't know.
- Monthly education sessions have to be held until the community understands policy.
- It's important to involve communities.
- I don't know.
- Give information and education about policy.
- Give information and education about policy.
- I don't know.
- I don't know.
- Communities need to be involved when policies need to be formulated.
- I don't know.
- Recruit volunteers whom are going to educate people about this policy.
- Counsellors should visit the clinics to find out if the right target group benefit from the clinics
- Meetings to clarify the policy to the community might help.
- Education about the policy.
- I suggest that the policy is translated in IsiZulu and then communicated to communities.

- I don't know.
- Education about the policy might help.
- People need to sign a document that will show that they don't earn any salary so that they can qualify for free health care.
- I don't know.
- Education
- More clarity should be given about implication of this policy.
- I don't know.
- Give more information.
- Educate the community more.
- Educate and train the community.
- The media should be used to educate about community.
- More education should be conducted for the communities.
- Meetings and workshops should be arranged during weekends to improve use of this policy.
- Meetings should be conducted about this policy.
- Community should be educated about this policy.
- Workshops should be conducted for the community.
- I don't know.
- Community should be educated about this policy.
- Community should be educated about this policy through meetings and workshops.
- We have to be informed and educated about this policy.
- We have to be educated about this policy.
- Department should make a point that communities are educated about this policy.
- We need to educate about this policy.
- Imbizo and enrolment of community appropriately.

Question 10

What recommendations can you make for improving knowledge and communication of the free health care policy?

- Meetings and workshops should be conducted
- Meetings and workshops should be conducted
- None
- None
- None
- None
- Meetings and workshops should be conducted
- None
- None
- None
- None
- Involvement of communities when making policies
- Meetings should be conducted to create community awareness and allow an opportunity for involvement
- None
- None
- None
- Educate communities and recruit volunteers
- Community should be encouraged to attend meetings
- None
- None
- None
- None
- None

- None
- None
- Meetings and workshops should be conducted
- None
- None
- None
- Involvement of communities when making policies
- Department of people at local level
- Meeting and workshops should be conducted
- Involvement of communities when making policies
- Involvement of communities when making policies through workshops
- Involvement of communities when making policies
- Involvement of communities when making policies
- Committee should be formed for drafting policies
- None
- Meetings and workshops should be conducted
- Community involvement
- None
- None
- Meetings and workshops should be conducted
- Meetings should be conducted to discuss policies
- Stakeholders should be told before the masses, so that by the time they (community) are called for imbizo, the stakeholders will help in supporting and encouraging them.

INTERVIEWS SCHEDULED ON :

The views of community members at Mpumuza with regard to the formulation and implementation of the free-health policy at their health facility.

1. Person identification

a) Gender male/female

b) Age

Length of residence in Mpumuza area

How long have you resided in Mpumuza area?

2. Employment/pension status

Are you (i) employed?

(ii) Self-employed?

(iii) Retired?

What level of income/pension do you fall in (i.e. salary/pension per month)?

- R0-300
- R300-R1000
- R1000-R2000
- R2000-above

3. Type of area of residence

1. Rural
2. Semi-rural
3. Urban
4. Peril-urban

4. **Knowledge of the current health services available at Mpumuza**

What public health facility is available for the community at Mpumuza?

- ❖ Community Health Centre?
- ❖ Clinic?
- ❖ Hospital?

5. **Access to public health services in Mpumuza prior to 1996?**

How did you access health services in Mpumuza prior to 1996?

6. **What was the cost of basic health services that were offered at that time?**

7. **Roughly, how many kilometers did you travel to the public health facility?**

8. **Knowledge of current health services provided in Mpumuza**

- ❖ Do you know what health services are currently offered at the Mpumuza health facility? Yes/No

- ❖ If yes, just enumerate at least four

- ❖ If no, why is it that you have no idea of health services offered in the health facility in your area?

9. **Knowledge of government policy with regard to the provision of health services**

- Do you know what the government has prescribed with regard to the provision of health services in South Africa? Yes/No

- If yes, what is that you know about it?

10. Knowledge of the government's free health policy

- ❖ Do you know anything about the rendering of free health services to communities? (free health policy) yes/no

- ❖ If yes to above, what are your views about it ie: is it a good policy

  Or is it beneficial to the target group in your area?

11. Community general understanding of the health policy and its implications on the health services in your community.

Do you think that the people in your area/community understand the free-health policy indicated in question 11 above? Yes/No

- ❖ If yes, to the above, can you say why you believe they understand it?

  _____

- ❖ If no, why do say so?

  _____

12. Involvement of communities when the policy was formulated

- At the time when the health policy was being debated in Parliament i.e: 1995, was your community offered an opportunity to make an input through community consultative meetings with ward counselors, tribal authorities and health personnel?

- Can you explain the reason for your answer to question 9 (ii) above?

13. Involvement of communities at the implementation phase of the free health policy

- Do you think that the community is involvement in implementation of the policy i.e.: are there any representatives of the community; who were democratically elected to serve on the clinic committee?

- If yes, explain how this being done

- If no, give reasons for your answer

14. If your answer to 13(a) and 14(a) above is "no", what do you think have been results of the exclusion of community members from the whole process?

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15. How, in your own opinion, can people of Mpumuza be involved in the formulation of the free-health policy?

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16. What improvements do you think need to be made with regard in the implementation of the free health policy; such that the target groups, can benefit from it?

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17. What do you think ward councillors (for the health sector) in Mpumuza could do by way of helping in the implementation of the free health policy at the Mpumuza health facilities?

THANK YOU FOR YOUR CO-OPERATION

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Service providers	Mpumuza Clinic	18 May 2003

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