THE ROLE OF COMMUNITY STRUCTURES IN MANAGING HEALTH OUTCOMES: THE CASE OF THE ZEBEDIELA SUB-DISTRICT, LIMPOPO, SOUTH AFRICA.

BY

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DECLARATION

I, Tseke Phuti Matthew Masemola declare that the mini-dissertation hereby submitted to the University of Limpopo for the degree Master of Business Administration has not been previously submitted by me for a degree at any other university; that it is my own work in design and execution and that all material contained therein has been duly acknowledged.

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ABSTRACT

The health profiles and outcomes in South Africa are unsatisfactory, not seeming to improve appreciably, amid the robust reform efforts, policies and strategies. These health challenges comprise largely of preventable conditions, as demonstrated by the quadruple burden of disease. Community participation, including the use of community governance structures in improving community health profiles and outcomes, are alluded to be beneficial in improving these communities` health profiles and outcomes.

The main aim of this study was to understand the current and the potential future role and the factors at play, of the community governance structures in managing their communities` health profiles and outcomes, in the Zebediela sub-district, Limpopo, South Africa. A qualitative study was conducted, using the Zebediela sub-district as a case study, where from six out of the potential nine governance structures were interviewed and recorded in focus groups, using a pre-determined discussion guide. The recordings were analysed in-depth for themes, using the consistency matrix and the N-vivo data analysis.

The results indicate that, the community governance structures are aware of the unsatisfactory health profiles and outcomes in their communities, but are not doing anything specific towards intervening to improve the situation. However, they are keen and willing to participate in improving the situation and are able to identify the potential role they can play, the skills and resources in themselves and in the communities, including the factors that facilitate and those that impede, their participation together with the recommendations of what can facilitate their participation and efficiency in improving their communities` health profiles and outcomes.

The community governance structures represent a good opportunity to improve community health profiles and outcomes, through a specific strategic focus that would empower, support, motivate, strengthen and reinforce their current level of skills, functioning and participation.

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CHAPTER 1
INTRODUCTION

1.1 BACKGROUND INFORMATION

The Zebediela sub- district represents the western wing of the Lepelle-Nkumpi sub district, which is on the South-East portion of the Capricorn District of the Limpopo province of the Republic of South Africa. The community of the Zebediela sub- district is estimated to be just over 125 000, comprising of 52% females and 42% males. As part of the Limpopo population, 47% are youths, with 37% being children aged fourteen years and younger. The economically active population (15-64 years) constitutes 57,6% of this population, while the unemployment rates are reported to be 30,6% for 2008 and 28,1% for 2009. An estimated 43% of the households are female headed. Education attainments are typically less than the national figures for the 20 years and above age group. Those with some primary education are 22,1%, national being 31,9%, while those with standard ten are 12,5%, national being 18,0%and 6,4% have tertiary education, while national is 8.8%. Those who had no schooling, the total is higher than national at 19,4%, national being 9,4%. The Zebediela community, which is spread over 30 different villages, represents and lives within a typical rural setting. (Limpopo Employment Growth and Development Plan, 2009-2014, 2009; Stats SA, 2008).

Health care in the Zebediela sub- district is delivered through a system of six fixed clinics, each with its own clinic committee, three mobile clinics, all managed by the Lepelle-Nkumpi Primary Health Care office. The above are supported by the Zebediela District hospital with 108 allocated beds. Weekly visits to each clinic are on the programme of the hospital. The team from the hospital that visits the clinics comprises of pharmacists, doctors, clinical support services and dental services. The hospital has a hospital board in place.

Other stakeholders in health in the sub district include the South African Police Services, on medico-legal and community safety issues, the Department of Education, Social Development and the South African Social Services Association (SASSA) division, the two Traditional Leadership Councils comprising of *Magoshi* and *Mantona, as* community representatives, leadership and support, municipal councillors and Traditional Health Practitioners who have their own local associations, sitting on the clinic committees. *Magoshi* are the traditional heads of the tribes, under whose service are the *Mantona,* who head the respective local villages and together, make up the traditional local councils.

Specific challenges in the delivery of health care in Limpopo are the following:

- The large burden of disease, especially HIV and TB, not being adequately prevented,
- the slower than intended progress with the Millennium Development Goals, especially in the child and maternal mortality rates and,
- Weaknesses which are observable in the governance and accountability within the health system. (Limpopo Employment Growth and Development Plan, 2009-2014, 2009).

1.2 RESEARCH PROBLEM

The health outcomes and the health profile in the Zebediela community comprise largely of preventable conditions, the commonest include, HIV/AIDS/TB, unsatisfactory Maternal, Neonatal and Child health outcomes, high trauma, violence and sexual assault, high teenage pregnancy rate and high chronic diseases morbidity, such as, for example, hypertension, diabetes mellitus, with the resultant high mortality and morbidity rate. This picture manifests amid the available strategies, resources and structures. (Zebediela District Health Information System (DHIS) Report, 2011-2012,2013; South African Strategic Plan for a Campaign on Accelerate Reduction of Maternal and Child

Mortality in Africa (CARMA), 2012; Reducing Maternal and Child Mortality through strengthening Primary Healthcare (RMCH), 2011) . The problem is that despite the fact that the health problems in this area are largely preventable ones, the Health system still needs to investigate how and if they can enlist the help of the community to reduce these preventable health diseases/challenges. Thus, this study intends to find out if the community members feel that they can actively contribute towards the management of health issues in their area and how they can contribute.

1.2.1 Sub Problems

The health system in the Zebediela sub district appears to be experiencing:

- A high incidence of mostly preventable diseases and health challenges
- Unsatisfactory health outcomes and profiles despite the available health strategies and facilities currently in place,
- Inefficiently available health prevention systems and structures,
- An apparent lack of common focus, synergy and linkages of the health subsystems and structures in their functioning in the sub-district, towards improved outcomes and profiles.

1.3 THE RATIONALE FOR THE STUDY

The rationale of this study is to attempt to improve the role that the community governance structures can play, in ensuring community accountability, in its health outcomes and profile, through understanding factors that are important and relevant, so as to inform the recommendations of measures towards improving the health situation, in the Zebediela sub-district.

The study will hopefully help health workers in their continuous endeavour to improve the health outcomes and the health profiles of the communities they serve.

1.4 AIM AND OBJECTIVES OF THE STUDY

1.4.1 Aim of the study

The main aim of this study was to understand the current role of the community governance structures in improving the health outcomes and profiles in the Zebediela sub-district community through accountability, as well as, understanding what these structures think their role can be, including the perceived factors at play in supporting or impeding their participation.

1.4.2 Study Objectives

The objectives of the current study were to:

- To elucidate how the community governance structures perceive and describe their communities` health profiles and outcomes.
- To understand the perceived current role played by these community governance structures in managing the community`s health outcomes and profiles,
- To elucidate the perceptions of the community's governance structures in their possible future role in the management of their communities` health outcomes and profiles,
- To find out any perceived barriers impeding these community governance structures in the management of their community health outcomes' improvement roles
- To find out any perceived factors that would facilitate these community governance structures in the management of their community health outcomes and profiles.
- To find out if they are willing to assist in health promotion and if not, why not.

- If they are willing, to find out how they think they can assist.

1.5 THE RESEARCH QUESTION

The study was guided by the following question:

What role are the community governance structures playing in the management and the improvement of health outcomes and profiles in the Zebediela sub-district community?

1.5.1 Sub-Questions

In attempting to answer the main research question, the following sub-questions were addressed:

- What do the community governance structures perceive their current community health profiles and outcomes to be like?
- What are they currently doing to improve the health profiles and outcomes of their communities?
- Are they willing to assist in improving the community's accountability on health outcomes and profiles?
- If they are willing, how can they assist?
- If they are not willing why not?
- What do they perceive as barriers to their participation in improving their communities` health profiles and outcomes?
- What do they perceive as factors to facilitate their participation in improving their communities` health profiles and outcomes?
- What recommendations do they have for the community to improve their health outcomes and health profiles?

1.6 DELIMITATIONS

- The study was confined only to the community governance structures implied in the health of the Zebediela sub-district communities, formalised and recognised as such.
- This study focused only on the health facilitation role of these governance structures and not on any other roles these structures are undertaking.

1.7 DEFINITION OF TERMS

1.7.1 **Community governance structures:** these are the recognised formal structures which represent the community in dealing with issues pertaining to the community, e.g. hospital boards, clinic committees, traditional leaders (Magoshi and *Mantona)* councils. These community governance structures comprise of a hospital board, six clinic committees and two traditional leaders councils comprising *Magoshi* and *Mantona*.

1.7.2 **Health outcomes**: the eventual health outcomes as the result of healthcare service intervention, measured by using specific indicators such as e.g. maternal mortality rates, neonatal and child mortality rates and the number of cases of deaths from specific diseases like HIV/AIDS, TB, hypertension, diabetes and others

1.7.3 **Health profile**: the picture of the health status of the community and the present health conditions, such as the burden of disease challenging that community, derived from the community`s health data , which depict the health position of that community.

1.7.4 **Community accountability**: community awareness, acknowledgement and a conscious conjoined participation and planning to improve the health outcomes and status of the particular community.

1.8 THE IMPORTANCE OF THE STUDY

As a case for study, the in-depth understanding of the factors and issues around the role of the community governance structures in improving community accountability, will be helpful in managing the community's accountability aspect for improving health outcomes and the community's health profiles in the sub-district, the district, the province and the nation as a whole. For example, community participation improving health outcomes and health profiles of the community have important benefits that can hopefully result in the reduced mortality and morbidity, the reduction in health costs (expenditure per capita), reduction in the population size and composition, (demographics), effective utilisation of the health care resources, better planning and allocation of resources and the economic growth of the South African nation. It is noted that, even internationally, health care needs always surpass the available resources and in that an innovative approach needs to be put into place to manage this situation (WHO, 2000).

Results are hopefully to inform policy in terms of the role of these governance structures.

1.9 ETHICAL CONSIDERATIONS

The following are important ethical considerations in this study:

- Obtaining permission to undertake the study from the Limpopo Department of Health through the research ethics committee,
- Obtain permission and consent from the respondents to be interviewed and recorded, allowing for informed decisions and consent to participate in the study

- Guarantees on the anonymity of the information obtained from them (interviewees), that it will not be divulged, who said what in the interviews, including the confidentiality guarantee.

1.10 RESEARCH METHODOLOGY

1.10.1 Research Design

The research design of this study is qualitative, seeking to understand, in-depth, the current role and orientation of the existing governance structures towards ensuring community accountability and participation in managing their health profiles and outcomes, in the Zebediela sub district.

The target population was the governance structures within the communities in South Africa`s health districts. The established and functional governance structures, with at least two years in function, within the given district, in this case, the Zebediela sub-district of the Lepelle Nkumpi sub district, which has nine (9) such structures. The governance structures are made up of six (6) clinic committees, one (1) hospital board, two (2) traditional leadership councils comprising of *Magoshi* and *Mantona* and two (2) Traditional Healers associations. Each traditional leadership council has ten (10) members. Each clinic committee has six (6) members while the hospital board has eight (8) members.

This method allowed all the identified groups to participate, in separate specific focus group discussions. There was a total of nine focus groups. Each focus group was engaged in a pre-determined and planned discussion session, over an estimated one to two hours of discussion time.

Focus group discussions were conducted, using a discussion guide, while, recording of the discussion was done through note taking and audio recording by the facilitator, in this case, the researcher, to allow in-depth and unlimited recording of the themes being studied. The focus group numbers were between five and fifteen, in the identified targeted sample. The focus group discussions were conducted with the use of a pre-determined discussion guide to achieve the research objectives. It will be based on the research questions. Analysis of data was done through the use of the data analysis spiral/ process

1.11 OUTLINE OF STUDY

- **Chapter 1:** The first chapter gives the overall background information, the introduction to the study, its purpose and aims and objectives, meaning and orientation.
- **Chapter 2:** The objective of this chapter is to give an overview of the literature review on current health issues and the identified strategic responses to these. The chapter will also look into what other localities have done, including their communities in the management of their health challenges.
- **Chapter 3**: Chapter three will outline the research design to collect data for the study as well as the method of data collection.
- **Chapter 4**: In this chapter, analysis and interpretation of results will be presented.
- **Chapter 5**: The final chapter of the study will give conclusions and recommendations from the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter gave a general overview and the background on the health situation and the salient health issues facing health care, health service delivery, the achieved health profiles and outcomes for the Zebediela subdistrict.

In order to give context to the health situation, the concurrent reform endeavours, together with the resultant health outcomes and profiles in South Africa and elsewhere, the review of the available literature is presented in this chapter and includes the following topics as outlined below:

- The South African health situation and challenges
- The South African burden of disease
- The health situation in Limpopo
- The health reforms in South Africa
- The Millennium Development Goals
- Community Participation
- Governance

2.2 THE SOUTH AFRICAN HEALTH SITUATION AND CHALLENGES

South Africa was ranked number 175th out of 191 member states on the league table of health systems performance, according to the World Health Organisation (WHO, 2000). The South African health situation is viewed as being in a crisis over the past decade and is facing specific challenges. (Schaay, Sanders, Kruger 2011; Seedat, Van Niekerk, Jewkes, Suffla, Ratele. 2009; Coovadia, 2009). These challenges and the system problems existing today, are said to be largely related to the unique features of the South African past history (Schaay et al., 2011).

The South African health system is also observed to manifest both sector-wide and institutional failures in its reforms and transformation processes` endeavours since 1994, (Schneider, Baron & Fonn, 2007; Van Holdt & Murphy, 2007). According to Chopra, Lawn, Sanders, Barron, Abdool-Karim, Bradshaw, Jewkes, Abdool-Karim, Flisher, Mayosi, Tallman, Churchyard and Coovadia, (2009) and Schneider et al. (2007), there is an observable gap, between the promise of the intended reforms and policies and the actual practise thereof, in the form of implementation. The policy implementation gap is alluded to be characterised by, for example, implementation factors such as the failure to establish the District Health System in most parts of the country (Coovadia, 2009).

Critical challenges with historic connotations faced by the South African Health Sector include the following, (Schaay et al. 2011):

- Equity;
- Access to healthcare services and/or resources; and
- The skewed allocation of health resources

Over and above the challenges mentioned above, the cost of health, the quality of care and the unacceptable health profiles and outcomes are notable challenges, as pointed

out in The Ten Points Plan of the Ministerial Priorities (2011). The critical challenges that the health sector in SA are facing will now be discussed.

2.2.1 Equity

Using the Gini-coefficient as a measure of income equality, South Africa is the second most unequal country in the world, with its Gini coefficient increasing from 0.56 in 1995 to 0.73 in 2005 (Coovadia, 2009). These disparities in wealth are currently, apparently still standing, with the richest 10% of the population accounting for 51% of the income, while the poorest 10%, whose source is mainly from the social grants, account for just 0.2% of the income. Similarly and consequentially, the marked differences in disease rates and mortality outcomes between races is said to also persist, observed to reflect the racial differences in the basic household living conditions, including the other social health determinants. According to the Committee on Morbidity and Mortality (CoMMIC) (2011), an example of this pattern is in the under-five (i.e. for children under five years of age) mortality rates difference between the poor provinces such as the Eastern Cape, Kwa Zulu Natal and Free State at 44.7 deaths per 1000 of live births, against the more economically rich ones like Western Cape and Gauteng at 28.8 per 1000 live births, in the year 2008.

2.2.2 Access

Access to health care is reported to have several barriers, amongst which are, the distance to health facilities and the costs of travelling. The poorest 20% of the households were observed to travel for 40 minutes on the overall average, to the nearest health facility, while the cost of a single visit is noted to be 11% of the household's monthly expenditure (CoMMIC, 2011; McIntyre, 2010).

2.2.3 Skewed Resource Allocation

The persistent skewed allocation of resources between the public and the private sector is reported to also adversely affect the access to health. Less than 15% of the population are noted to be members of the private medical schemes, yet 46% of all health-care expenditure is absorbed by these schemes, illustrating this disproportionate funding challenge. (Harrison, 2009 ; Coovadia 2009). Concurrent with the above disproportionate financial allocations, is the observed similar skew in the human resource allocation, illustrated by the significant vacancy rate of 42.5% amongst health professionals in the public sector in 2010, the decreasing nurse to patient ratio per 100 000 population from 149 in 1998 to 110 in 2007and the increasing percentage of nursing professionals working in the private sector from 40% in 1980 to 79% in 2007. (Coovadia, 2009; Lloyd, Sanders, and Lehmann, 2010).

COST

The health care in South Africa, is described as destructive, ‘hospi-centric’ and curative in nature, rendering it extremely costly and unsustainable, meriting complete re-engineering, according to the Minister of Health, Dr A. Motsoaledi, in his Health Budget Vote Policy speech of 2011 to the National Assembly, 31 May 2011.

QUALITY OF CARE

Quality of Health Care in South Africa is another recognised challenge, to such an extent that it has a specific policy programme developed, geared at improving it to specified standards, according to the National Department of Health (NDOH) (NDOH, 2010) and the National Core Standards for Health Establishments in South Africa

(2011). The quality of health care is recognised as a factor that influences all other challenges such as access to care and the overall health outcomes and profiles of any nation (Schneider et al., 2007). The significance of this quality of healthcare challenge is evidenced by the recent launch of the 'Fast Track' to Quality project at the National Consultative Conference on Quality of Health Service in October 2010. This quality drive is based on the patient-centred care approach that identifies the six most critical areas, namely:

- Improving staff attitudes
- Reducing waiting time and service delays
- Ensuring cleanliness
- Ensuring infection control
- Ensuring safety
- Ensuring medicine supplies,

These patient-centred care efforts are in line with the need to build strong rapport, confidence, improved access and high quality health care, with the eventual improved health outcomes and profiles of the nation (National Department Of Health`s Annual Performance Plan, 2011/2012). Mandating these quality patient-centred efforts are, for example, the National Health Act (2003), the Ten Points Plan encompassing the Patient Rights Charter and the Batho Pele Principles. The orientation of these mandates, over and above the quality of health care improvement drives, is noted to be towards health reforms that are said to be based upon the good international practices and the quest to improve the health outcomes and profiles (NDOH, 2010).

THE GENERAL HEALTH PERFORMANCE FACTORS

In their analysis, Schaay et al. (2011) identify three areas of concern that are enumerated as challenges to the health situation in South Africa viz.:

- A greatly increased burden of disease, primarily related to HIV and AIDS.
- Significant areas of weakness in health system management and
- Poor health outcomes, relative to the country's wealth and health expenditure.

Poor and even worsening health outcomes in South Africa are representing a paradox, measured against the apparent progress in areas of the progressive and excellent public health legislature reform policies and better unified health system intentions (Schaay et al. 2011; Chopra, 2009). According to UNCEF`s State of the World's Children (2010) and the WHO (2010), examples of poor South African health outcomes as of 2008 are cited as follows:

- Under five years mortality rate for South Africa was 67 per 1000 live births. Brazil 22, China 21 and Egypt 23.
- Infant mortality rate was 48 per 1000 live births, Brazil 18; China 18, Egypt 20
- Maternal mortality rate was 400 per 100 000 live births, Brazil 110; China 45; Egypt 130

The National Department of Health's report of the Health Data Advisory and Coordination Committee (HDACC) of November 2011 confirms the same observation of the unacceptably high under-five perinatal and maternal mortality rates in South Africa, with the under-five mortality rate of 56 per 1 000 live births and maternal mortality of 310 per 100 000 deliveries.

According to HDACC (2011), the underlying causes of under-five's deaths are identified to be related to:

- HIV and AIDS related deaths, including TB (40%)
- Diarrhoea diseases (11%)
- Pneumonia (6%)
- Severe malnutrition (5%)

- Neonatal causes (18%)

While the causes for the maternal mortality, according to them, are identified to be related to:

- Non pregnancy related infections, mainly AIDS
- Obstetric Haemorrhage (14%)
- Complications of hypertension (14%)
- Pregnancy related infections (5%)
- Complications of pre-existing medical conditions such as diabetes (9%)

The majority of maternal deaths (over 40%) and the under-five death (over 9%) are observed to be preventable, with the use of the strategic situation analysis, implementations and programme plans (CoMMIC, 2011). South African National Strategic Plan for the Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA, 2012). The question is, why the paradox and why are the desired outcomes are not achieved? Of further concern is, the noted deterioration of some indicators when matched against the well-intended reform interventions of the past 17 years as exampled by the increasing child mortality rates (Chopra, 2009).

Therefore, the South African health situation still has room for improvement, including improvement also in areas of health outcomes and profiles. It is also facing specific challenges such as cost, skewed resource allocation and availability, the quality of care, equity and access to health.

2.3 THE SOUTH AFRICAN BURDEN OF DISEASE

According to Abool et al, (2009) ,Chopra et al. (2009), Coovadia, (2009), McIntyre , (2010) and Seedat, et al. (2009), major conditions noted to overload the South African heath burden of disease basket are said to include the following:

- The morbidity and mortality burden,
- The communicable disease burden,
- The non-communicable diseases and the diseases of life-style burden,
- Violence and injuries burden,

Each of these major conditions will now be reviewed and discussed.

2.3.1 Morbidities and Mortalities Burden

Globally, the number of deaths in children of less than five years of age is reported to have decreased from 13, 6 million in 1980, to 8.8 million in 2008 (UNICEF, 2009). According to the first triennial report of the 2011 Committee on Morbidity and Mortality in children under five years, the levels of child mortality, in South Africa remain unacceptably high and are higher than those of other middle-income countries, established at between 65 to 70 deaths per 1000 live births when compared with the targeted 20 deaths per 1000 live births (CoMMIC, 2011).

Even previously, the under-five mortality rates of South Africa were already recorded as not satisfactory as indicted by the South African Demographic and Health Survey of 1998, in which the under-five mortality rates are reported to have been at 61 deaths per 1000 live births and at 57,6 deaths per 1000 live births in 2003.

The Millennium Development Goals (MDG) report published by the Statistics South Africa (Stats SA) in 2010, estimates the under-five mortality rate to be even higher at 104 per 1000 live births thereby depicting a very bleak picture of the health outcome status of South Africa. In their study of the provincial mortality in South Africa in 2000, Bradshaw, Groenwald, Joubert, Laubscher, Nannan, Nojilana, Norman, (2003) indicate the burden of disease of the under-five mortality to be at 95 per 1000 live births for South Africa (Bradshaw et al. 2003). Of concern is the noted increase of the under-five mortality rates in South Africa, moving from 57 per 1000 live births in 1990 to 67 in 2008, (Count-Down to 2015 Decade Report, 2000-2010, 2011).

At the global level, acute respiratory infections, mostly pneumonia, diarrhoeal diseases and neonatal causes, are the most important causes of death for the under five children, according to CoMMIC (2011). The South African picture is almost similar, as reported for 2010 by the Stats SA, which uses the death notification system that unfortunately undercuts death causes due to HIV/AIDS (Stats SA, 2010). The infant and the neonatal mortality rates are reported to be at 40 and 14 deaths per 1000 births respectively, according to the National Department of Health (NDOH) Report of the Health Data Advisory and Coordination Committee of 2011. These ratios are unacceptably high, when compared with the earmarked MDG targets for 2015.

The following causes are reported to be involved in the deaths of infants and new-borns in South Africa in 2008:

- Diarrhoea = 22%
- Neonatal = 31%
- Lower respiratory infections 17%
- Ill-defined 12%
- Child conditions 10%,

(National Perinatal Morbidity and Mortality Committee Report, 2008-2010, 2011). In the same report, the average perinatal mortality rate is estimated at 35 per 1000 live births; with this rate observed to be changing to the highest figure of 64.5 per 1 000 live births with maternal age of above 34 years. This report motivates for community health education, to support communities to avoid pregnancy at the extremes of the reproductive age. The Child Healthcare Problem Identification Programme (Child PIP) identifies the leading causes of death in children for South Africa to be Diarrhoea, Pneumonia, Septicaemia, TB and Pneumocystis Pneumonia, which are HIV related (Stephen, Mulaudzi, Kauchali and Patrick, 2009).

Using the District Health Information System (DHIS) as a source, the South African case fatality rates for acute respiratory infections stood at 9.7 in 2008 and 6.7 for 2009, while the case fatality rates for diarrhoea related disease were 9.2 for 2008 and 7.4 for 2009. (CoMMIC, 2011). Compounding to the causes of child mortality burden is the under-nutrition problems, which is reported to be present in one out of ten children aged 1-9 years, with the 1-3 years most severely affected and living in rural areas and on commercial farms. An estimated 37% of children are noted to have clinically severe malnutrition (Labadarios, Swart and Maude, 2007). A high proportion (49.9%) of hospital deaths between the years 2007 and 2009 are observed to be associated with HIV, of which group, 76,5% are found to be either exposed or infected, (Child PIP,2007-2009; Stephen et al., 2009).

According to Chopra et al. (2009), the majority of these conditions and deaths are from acute respiratory infections, Diarrhoea related diseases, HIV/AIDS and under-nutrition, conditions which are preventable and treatable. Similar optimism is expressed by the Committee on Morbidity and Mortality in children under five years, with the proposition that, attending to the modifiable factors, will reduce these high child deaths. (CoMMIC, 2011). Some authors, in their propositions on strategies and the eventual interventions

to deal with this high burden of the under-five mortality in the health activities, include the following:

- Promotion of breast feeding
- Immunisation
- Promotion of appropriate and early health seeking behaviour,
- Prevention and treatment of HIV
- Safe home care of children. (Chopra, 2009; CoMMIC, 2011).

These interventions clearly need community involvement and participation for them to be successful because they all have do with receiving community appreciation, buys-in and motivation for behaviour change and the orientation towards better health outcomes.

Maternal mortality remains a cause for concern to the South African health burden of the disease basket, with the estimated Maternal Mortality Rates (MMR) of 400 deaths per 100 000 live births, over the period 2006-2007, which represent an increase of 20% over the rates of the period 2002-2004, (Saving Mothers Report, 2005-2007). In the same Saving Mothers report, it is indicated that, the top five causes of maternal mortality have remained the same. These are alluded to be HIV and AIDS at 43%; hypertension at 15.7%, obstetric haemorrhage at 12.4%, pregnancy related sepsis at 9% and pre-existing maternal medical diseases at 6%. The Millennium Development Goals (MDG) Country Report of 2010 estimates the South African Maternal Morbidity rate to be at 625 per 100 000 live births, while the 2015 target stands at 38 per 100 00 live births.

According to the assessors in the fourth report on Confidential Enquiries into Maternal Deaths (NCCEMD) in South Africa, 38% of the maternal deaths that occurred within the health system are due to avoidable causes. Mentioned in this report are the factors such as:

- non-attendance to anti-natal care, which increases the risk of maternal death four times,
- the patient`s delayed anti-natal booking,
- teenage pregnancy,
- abortions and
- the non-pregnancy related infections, especially HIV/AIDS, Pneumonia and Tuberculosis.

Chopra (2009) identifies the added factors that are related to the failure of obstetric care. These identified and avoidable factors seem also to be captured by the priority intervention strategies and plans such as, the Reducing Maternal and Child Mortality through Strengthening Primary Health Care (RMCH)and the South African National Strategic Plan for the Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA), (RMCH, 2010; CARMMA, 2012). These strategies prioritise community participation, communication, information sharing, health education campaigns including the promotion of community accountability and advocacy. This is exemplified by the key components of the CARMMA's implementation plan, with a strong orientation towards community participation.

2.3.2 Communicable Diseases Burden

Major in this category for South Africa is the HIV and Aids epidemic and the Tuberculosis pandemic, together with their complications, co-morbidities and their concurrent socio-economic impact on the country (Stats SA, 2010; WHO, 2011).

2.3.2.1 HIV and AIDS burden of disease

HIV infection and its resultant sequel represent an established burden to the South African healthcare system, with untoward outcomes on the health status of the nation. Five million, out of just over 50 million South Africans were noted to live with HIV and accounting for 35% of the global burden of the HIV infection. Its prevalence amongst the total population of South Africa was observed to be at a steady 11% by 2009 and a substantial difference has been observable across the age, gender and the geographic divides, according to the National Antenatal Sentinel HIV and Syphilis Prevalence Survey of 2009, for example:

- Kwa Zulu Natal with the highest prevalence of 15, 8%
- People aged between 15 and 49 years are noted to have a prevalence of over 15%
- HIV infection rate amongst woman aged between 30 and 35 years increased from 39.6% in 2007 to 40.4% in 2008 and 41.4% in 2009,
- in 2009 alone, 314 000 South Africans died of Aids.
- More than a third of pregnant woman attending ante-natal care in the public sector clinics nationally are already infected with HIV, highlighting the enormous burden of infection in young pregnant women in South Africa.

From the same source, 410 000 new infections occurred in 2010 alone with an estimated 281 400 AIDS related deaths in the same year (Stats SA, 2010). Furthermore, together with other infections, HIV co-infection is amongst the leading causes of both maternal and the under-five mortalities in South Africa according to the National Enquiries into Maternal and Child Deaths (NECCMD, 2010).

The Higher Education Sector Study, South Africa (HEAIDS) 2008-2009 estimated the mean HIV prevalence for students to be 3.4%, ranging between 2,7% and 4,4 , with the highest prevalence in the Eastern Cape at 6,4% and the lowest in the Western Cape at 1,1%. By mid-2008, it was observed that there were a total of 568 000 adults and children receiving Anti-Retroviral Therapy (ART) in South Africa, with 79% attending the

public sector (Stats SA, 2010). UNAIDS reported this number to be at 971 556 by December 2009, representing a 56% ART coverage and 37% of the target of the World Health Organisation (WHO) guidelines to universal access by 2010 (WHO, 2010).

The predominant mode of HIV transmission in South Africa is reported to be through heterosexual sex, which accounts for 80% of all HIV infections followed by the mother to child transmission (MTCT) (Shisana et al.2002; Abdool-Karim et al. 2009; Doherty, McCoy, Donohue. 2005). Major drivers of HIV infection and spread are observed to include:

- Social in cohesion emanating from the migrant labour system,
- “No sense of future” resulting from the high unemployment rates in South Africa,
- The low perception of self-risk,
- -Multiple concurrent sexual partnership practices,
- Poor internalisation of the HIV risk,
- High burden of Sexually Transmitted Diseases,
- Peer pressure for young people, to be sexually active
- Lack of knowledge of individual’s HIV status
- Gender and power disparities to negotiate sexual contract and prevention (Coovadia, 2009; Lurie, 2003; Seedat, et al. 2009).

At the bottom of all these drivers it is observed that it has all to do with human behaviour. Community participation and the appreciation of the community involvement is indicated to be essential, if we are to be successful in any strategic plan and implementation, including the fostering of partnerships and collaboration with stakeholders to turn the tide (Abdool-Karim, et al. 2009; National HIV, AIDS and STI strategic Plan, 2007-2011, 2007).

The National HIV, AIDS and STI strategic Plan 2007-2011, 2007 strategic plan seems to have, as one of its objectives, the reduction of the new HIV infection by 50%, through

the use of the community level activities to overcome barriers to change such as fear, stigma and discrimination. These include the social mobilisation to ensure broader conscientiousness of communities and their structures in the participation drive to alter the course of the HIV epidemic in South Africa.

All efforts are put into places to increase the uptake of testing, for example, from the current 1.1 million people to the figure of 3.2 million in 2011/15 (National Strategic Development Plan (NSDP) of (2010). The Business Sector HIV Counselling, Testing and Wellness Screening Strategy targeted to reach 2 million of its people in addressing the HIV burden of disease (Business Strategy, 2010).

However, with all the intense efforts to ease the burden of HIV in South Africa that are cited above, equal challenges are noted to threaten their success, for example, the grim feasibility based on the resource availability and the capacity issues (Novario, 2014). Patient losses between HIV testing, the base-line CD4 cell count phase, the start of care phase and the ART use phase are also reported to be high, showing the need for health information systems that can link testing programmes with the care and the treatment programmes. (Stats SA, 2010; South African Health Review (SAHR), 2010). The yearned for success seems to still be very far and not anywhere on the horizon.

2.3.2.2 Tuberculosis burden of disease

South Africa is estimated to have the fifth highest burden of Tuberculosis (TB) in the world, which burden is reported to be further complicated by the high HIV co-infection rates, together with a growing epidemic of the drug resistant TB, according to the global estimate of the epidemiological burden of TB in the top five Countries in 2007 (SAHR, 2007). The incidence of TB for South Africa is 948 per 1000 population per year, Nigeria is 311, Indonesia is 228and India is 168. While the TB prevalence rate in South Africa is

at 692 per 1000 population per year (Nigeria at 521; India at 283, Indonesia at 244) while The TB Mortality rate is reported to be 193 per 1000 population per year of HIV positive cases (compared to 40 for Nigeria, 205 for India and 2.4 for Indonesia). This indicates the real grim TB burden status in South Africa (SAHR, 2010).

The TB case detection rate remains a challenge in South Africa, reaching only 78% in 2007, while the TB treatment success rate is observed to only increase minimally, for example, from 63% in 2000 to 71% in 2005 and to a mere 74% in 2009 being well below the desired target of 85%. As a result, South Africa declared a TB emergency together with the TB Crises Management Plan (NDOH TB Strategic Plan of 2007-2011, 2007; Abdool-Karim et al., 2009). By then, the TB burden of disease had almost doubled from 188 695 in 2001 to 341 165 in 2006 while the estimated HIV co-infection rates were at 55%.

According to Abdool-Karim et al. (2009) , challenges faced by South Africa in relation to TB are multiple and complex and include the following:

- The increasing case-loads in the face of an over-burdened health infrastructure,
- Extremely poor cure rates in some provinces,
- High mortality,
- High treatment interruption rates,
- High levels of multi-drug resistant TB (MDR-TB) and
- The emergence of excessively drug resistant TB (XDR-TB).

Over and above that of the high burden of TB disease South Africa is noted to have the highest estimated TB cost, (Abdool-Karim et al., 2009; SAHR, 2010). This cost burden is alluded to be due to the following two reasons:

- The enormous cost interest in maintaining approximately 8000 TB beds and

- The enormous cost of diagnosing and treating the drug resistant TB.

The above challenges and costs are said to be compounded by the following:

- High treatment interruption rates,
- Late presentation of patients to health facilities,
- Insufficient community engagement,
- The HIV epidemic and
- The socio economic determining factors, especially poverty. (Seedat, et al., 2009).

To this extent, Abdool-Karim et al. (2009) proposed world-wide recognition of these challenges as inherent in the developing countries that they merit focus and engagement beyond the Daily Observed Treatment Strategy (DOTS) recommending focus into combined prevention strategies that target multiple antecedents of TB. They further purpose decentralised management of TB and its complications, including mobile clinics together with community involvement and support. Lonnroch (2009) in the SAHR (2010:241) further propose invigorated actions in four broad areas to achieve progress towards TB control namely:

1) The continued scaling up of early diagnosis and proper treatment of all forms TB in line with the STOP TB Strategy
2) The development and enforcement of bold health systems and policies.
3) The establishment of links with a broader developmental agenda and
4) The promotion and the intensification of research towards innovation.

All these four actions are targeting to induce positive responses, compliance and participation of communities. There is, however, no upfront specifications and a void on the detail on how communities are going to be involved and mobilised, including the lack of specifics on the community involvement to appreciate the plight of TB to them,

as a community, their participation in the local anti -TB strategy design and the implementation activities , for example.

2.3.3 Non-Communicable Diseases and Diseases of Lifestyle Burden

Non-communicable disease (NCD) and chronic diseases of lifestyle represent another significant burden of diseases and one of the major public health challenges facing all countries regardless of their economic status, according to the World Health Organisation (WHO) report of the 2010 Global Survey. These NCDs were observed to have been responsible for over 60% of global deaths and to threaten the economic and social development of countries with the predication to increase if not given the necessary concerted efforts at country level (WHO, 2010).

The WHO estimates of the burden of disease in South Africa suggest that, the NCD caused 28% of the total burden in 2004 when measured using the Disability -Adjusted Life Years (DALY'S) as expounded by Mayosi et al. (2009). These authors observed the current burden of diseases estimate in South Africa to be two to three times higher than those in the developed countries and similar to those in the Sub-Sahara and the Central European countries, which are in the highest world NCD burden quartile. They further observed that the distribution of these NCD, to reflect the socio-economic disparities, with the heaviest burden on poor communities in the urban areas.

The Lancet's series of articles (Abdool-Karim, et al. 2009; Chopra et al. 2009; Coovadia, 2009; McIntyre, 2010 & Seedat, et al. 2009) on Health in South Africa also points out that these non-communicable diseases are emerging in both the rural and the urban areas, most prominently in poor people living in urban settings resulting in the increasing pressure on the acute and chronic health care services with the ensuing health service sustainability and development challenges (The Lancet series, 2010).

According to Abdool et al. (2009) in The Lancet series (2010), the raising burden of non-communicable diseases is shown by the increase in the number of deaths from diabetes, chronic kidney diseases, cancers of the prostate and the cervix and by the increasing proportion of Disabilities Adjusted Life Years (DALYs) attributed to Neuropsychiatric disorders. Further, they note in the South African study on diabetes for the years 1995 to 2010 which is showing an increase in the number of people newly diagnosed with Diabetes Mellitus. Together with the observed increase in the ageing population, the high prevalence of chronic and multiple diseases is increasing and represent the most important driver of medicine expenditure, which stood at 31.1% of the total expenditure for 2007 (Mediscor Medicine Review, 2007, in SAHR, 2010:302).

2.3.4 Chronic Diseases

According to the NHI Policy Brief 3 in their analysis of the impact of chronic diseases on the future of the NHI in South Africa, major chronic diseases with impact noted are hypertension, diabetes mellitus and asthma, singularly or in combination (SA NHI Policy Brief 3, 2010). Adding to the NCD`s burden of disease, are the effects of the factors of behaviour and awareness which include: diet, exercise, alcohol consumption, smoking and the use of other illicit drugs (National Youth Risk Behaviour Survey, 2008).

2.3.4.1 Obesity

Obesity is noted to be an additional and contributory burden factor to the non-communicable diseases strongly associated with diseases of behaviour and lifestyle representing a major risk factor for cardiovascular diseases and diabetes mellitus (Harrison, 2009refer). Further, according to the South African Demographic and Health Survey of 2003, roughly 23.3% of adult females and 8.3% of males ware observed to be obese.

2.3.4.2 Mental ill-health

Mental ill-health, as part of the NCD, is reported to have a negative impact on the health, social and economic development of nations carrying with it pervasive and far reaching untoward effects which lead to poverty, high unemployment rates and poor educational and health outcomes (Mental Health Report, 2010). The mental health burden requirements in South Africa are noted to surpass the available resources by over three quarters and thus fall short of complying with the norms and standards (Burn, 2010). Mental depression at 24% and suicide at 21% are noted to be more prevalent in the youth as indicated by the 2008 National Youth Survey, in SAHR of 2010.

2.3.4.3 Cancers

Cancers represent another burden of the NCD in South Africa and it is noted to be increasing in incidence especially in the low and middle income groups. (The Lancet, 2010). Risk factors to cancers are reported to be known and are alluded to include: smoking, low awareness and low early screening with focus on early detection according to the Lancet series. Substantial prevention is advised to obviate growth of the cancer burden which could render treatment virtually unaffordable to countries in the long term, (Farmer et al., in The Lancet, 2010).

Progressive growth of cancers is noted to have occurred in South Africa, for example, from 53 310 patients in 1994 to 74 433 patients in 2009 according to the NHI Policy Brief 5. According to this brief`s estimates, the incidence of cancers of the cervix, breast, prostate, lungs and oesophagus are the highest five of all incidences, nationally, standing at 13,6% , 12,5% , 9,9% , 8,7% and 7,8% respectively. The top three mortalities due to cancers in males are reported to be from the prostate at 58,9% (for males at 60yrs of age), lungs at 30,6% and oesophagus at 23,5% respectively, while for females these are reported to be: breast at 41%, cervix at 26,6% (for females at 30years of age) and oesophagus at 12,5% respectively.

Complicating the cancers' incidence and burden is its association in its development with other risk factors such as, HIV infection in women, for example, which is observed to increase the risk of cervical cancer four to five times with the Human Papilloma Virus (HPV) co-infection (SAHR, 2010). This represents a grim picture, which calls for focussed preventative strategies. Of note is the omission of the full grim picture of cancers' incidence in South Africa by the National Department of Health`s report on cancers, which report only refers to the cancer of the cervix screening (NDOH Annual Report, 2010).

2.3.5 Violence and Injuries Burden

South Africa is observed to face an unprecedented burden of mortality and morbidity in relation to violence and injuries for a country not at war (Schaay et al., 2011). The overall injury death rate is recorded to be 157,8 per 100 000 of the population, being higher than the African continent average of 139,5 per 100 000 of population and double the global average of 86,9 per 100 000 of the population. Seedat, Van Niekerk, Jewkes, Suffla and Ratele (2009) noted that violence and injuries were the second leading cause of death and lost Disability-Adjusted Life Years (DALYs) in South Africa.

2.3.6 Homicide

The homicide rate of women by intimate partners was estimated to be six times the global average (Seedat et al., 2009). Sexual violence experienced by women and girls in particular is reported to remain a huge and a daunting problem in South Africa (Mullick, Teffo-Menziwa, Williams and Jina, 2010). These authors indicate the untoward impact of the Sexual and Gender Based Violence (SGBV) on the health sector and the range of its outcomes, some fatal and some non-fatal bringing with them higher morbidity and mortality. Fatal outcomes are enumerated to include femicide, suicide,

AIDS related mortality and maternal mortality while the non-fatal outcomes include physical ones such as injuries, sexual-reproductive ones such as unwanted pregnancies and the psychological ones such as mental depression.

The recommendations of Seedat et al. (2009) and Mullick et al. (2010) in the bid to address this scourge of SGBV include the need to develop a coherent approach that includes co-ordination and collaboration with stakeholders, including female youth and community groups, in South Africa.

2.3.7 Road traffic accidents

Over and above the impact of SGBV, road traffic accidents are noted to also be significant in contributing to the high mortality and morbidity in South Africa. The crude road traffic accident death rates are observed to steadily increase, for example, from 9,9 to 11,8 per 100 000 population from 2001 to 2006, being the highest in the age group 35 to 49 years and 76% of these fatalities being males, according to the Road Traffic Management Report (2009). This trend is observed to be associated with unsafe behaviour as a factor that is contributing to this high burden of traffic injuries in South Africa, for example, alcohol intake in 38% of cases. The South African road traffic fatality rates are observed to be higher than the norm of 19.5 per 100 000 of the population for the middle income countries globally while the low income countries are at 21.5 and the high income ones are reported to be at 10,3 per 100 000 of population (WHO Global Road Safety Report, 2009).

2.3.8 Summary of the South African Burden of Disease

- South Africa has 17% of the global burden of HIV infection and one of the world`s worst TB epidemics. Using the Daily-Adjusted-Life Years (DALYs), a large proportion of the total burden of disease in South Africa is represented by HIV and AIDS, estimated to be associated with 40% of the country`s burden of disease. This situation is compounded by the TB pandemic together with the emergence of the multi-drug resistant TB strains proving to be very costly to treat and control.
- Using the international indicators such as the mortality rates to assess the health outcomes of countries as markers of progress in their interventions, South Africa presents unacceptably high indicators. Some indicators are observed to even be on the increase and not meeting the expected targets such as those of the Millennium Development Goals (MDGs). For example, the child mortality rates, especially the under-five mortality rates have been observed to increase from 57 to 67 per 1000 live births from 1990 to 2008. Similarly, the maternal mortality rates for South Africa have been observed to also be un-acceptably high, recorded to be at 625 per 100 000 live births according to the MDG`s Country report of 2010 and at 400 per 100 000 live births. (Stats SA, 2010). This represents the lack of desired success of the country`s endeavours to improve its health outcomes and the inferable poor progress of the health systems. Two good questions arising then are: why and, how can this situation be turned around? These represent the basis of this research.
- The chronic and the non-communicable diseases put together, associated with the diseases of life style, are adding further to the increasing burden of disease. They contribute to an estimated 28% of the South African's burden of disease. These include conditions such as Hypertension, Diabetes Mellitus, Asthma, Cancers, Obesity and Mental ill-health.
- Violence and injuries represent a further unprecedented burden of morbidity and mortality in South Africa. The South African over-all injury death rate is the highest on the African continent and is double the global average while the homicide rate of women by their intimate partners is six times the global average over and above the

noted high Sexual and Gender Based Violence(SGBV) which is reported to be at a pandemic level.

- Road accident fatalities and the untoward behaviour factors such as substance abuse, particularly alcohol and illicit drugs use contribute to these fatalities.
- The Lancet series on Health in South Africa (2009) summarises the South African health situation to constitute a quadruple burden of disease which is reported to comprise of:
  1) Communicable diseases such as HIV and AIDS,TB and STIs
  2) Non-communicable diseases and diseases of life style, for example, diabetes mellitus, hypertension, asthma and mental ill-health including untoward behaviour such as smoking and alcohol abuse,
  3) Mortality of children and maternal mortalities that are un-acceptably high and are on the rise against the expected and the set targets,
  4) Violence and injuries carrying with it high morbidity and mortality including Sexual and Gender Based violence (SBGV) and the road traffic accidents.

Of note as common to all these components of the South African quadruple burden of disease is the observation that they all are preventable and amenable to improvement, given the appropriate focus and strategies.

The question is why is the situation as it is with no appreciable progress amid the rigorous health reforms and policies that are in place?

2.4 THE LIMPOPO PROVINCE HEALTH SITUATION

The population of Limpopo was recorded to be just over 5.4 million, accounting for 11% of the population of South Africa in 2009 (Stats SA, 2010). An estimated 35.7% of the Limpopo population is youthful and comprises of children less than 15 years of age, while 52.3% of the population are females. It is noted that 80% of the Limpopo population is rural based with 33.4% of this population aged 20 years and older,

comprising of women of whom 19.4% have no formal education (NDoH and Social Development Report, 2005; Stats SA, 2009).

Close to 26.9% of the economically active members of the Limpopo community are observed to be unemployed, as compared to 24.3% nationally. Limpopo has five districts, the greater Sekhukhune district falls in the lowest socio-economic quartile even nationality and it is together with the other four districts that fall between the second and the third quartiles (District Health Barometer, 2010). This situation depicts a very rural and a disadvantaged health setting that is very strongly adversely influenced by the socio- economic determinants of health outcomes (Limpopo DoH Annual Performance Plan 2010-2013, 2010).

The average Primary Health Care Expenditure per capita was observed to be even higher than that of national by 13% prior to 2009, while the average nurse clinical workload recorded the lowest amongst all the provinces and remained virtually unchanged for several years (District Health Barometer, 2010; Stats SA, 2010). The Limpopo province`s burden of disease is noted to be similar to that of the whole of South Africa, nationally, with some areas of exception for example:

- The maternal mortality ratio was 176 per 100 000 while the neonatal mortality ratio was at 12.8 per 1 000 and the under-five mortality at 42 per 1 000 in 2012, compared to national maternal mortality ratio at 410 and the under-five mortality ratio of 62 per 1 000 live births (Limpopo Accelerated Plan, 2014).

The Capricorn District has the highest still births' rate of 26.5 per 1000 live births and perinatal mortality rate of 39 per 1000 live births (District Health Barometer, 2010).

For Limpopo, major causes of maternal mortality are identified to be: HIV and AIDS at 35.8%, Hypertension at 11%, Post-Partum Haemorrhage (PPH) at 11.6%, Ante-Partum

Haemorrhage (APH) at 6.3% and cardiovascular related conditions at 5.8%, (National Confidential Enquiries into Maternal Deaths (NNCEMD), 2008-2010, 2012).

The avoidable factors observed to be associated with these causes are enumerated in the NNCEMD 2008-2010 (2012) report to include:

- Unsafe abortions
- Delay in seeking care during labour by patients (25%),
- No antenatal care attendance and even late booking

The major causes of the under-five mortality in Limpopo are noted to include birth asphyxia, prematurity, neonatal infection, pneumonia, diarrhoeal diseases, severe malnutrition, HIV and TB (Limpopo Child PIP, PPIP, 2013; District Heath Information System (DHIS), 2013). The factors identified by the Limpopo PIPP include:

- Late and belated booking by pregnant mothers,
- Delay is seeking medical attention during labour,
- Non usage of child growth monitoring e.g. Road to health chart (RTHC),
- Poor nutrition,
- Decline to do HIV test,
- Patients delaying in getting to the next level of care upon being referred (Limpopo PPIP, 2013; Limpopo Child PIP, 2013).

Common to all these mortality causes and factors is the observation that they are all avoidable, dependent largely on the participation of the patients and the community and their level of motivation and understanding to conform to the expected ideal behaviour. This needs a dedicated strategic approach to successfully effecting change and getting the required results.

The major burden of infectious diseases in Limpopo comes from HIV and AIDS and TB (District Health Barometer, 2010; Limpopo Annual Performance Plan 2010-2013, 2010). An estimated 22.3% of the Limpopo burden of disease is recorded to be from mortalities associated with maternal and child health while 24.2% is due to communicable diseases. The largest burden is from the non-communicable diseases and the diseases of life-style, carrying an estimate of 32.1%, while the remaining 11.4% is from violence and trauma. (Stats SA, 2010).

Limpopo is noted to have the third lowest HIV and AIDS prevalence in the country, at 20.7%, compared to 29.3% of Mpumalanga and 38.7% for Kwa Zulu Natal, using the Anti-Natal Care Survey of 2008 (NNCEMD report 2008-2010, 2013). However, on reviewing the major causes of mortality and morbidity, HIV and AIDS is prominently a major factor that is associated with 35.3% of cases (NNCEMD report 2008-2010, 2013).

Limpopo represents the lowest incidence of TB in South Africa at 178.3 new smear positive cases per 100 000 people and the cure rates increasing from 60.4% in 2006 to 62.2% in 2008 (District Health Barometer, 2010; South African Health Review (SAHR), 2010). However, TB is amongst the most common infectious diseases increasing the Limpopo Mortality and Morbidity, especially the under-five mortality rates (Limpopo Accelerated Plan of 2014; Limpopo Annual Performance Plan 2010-2013, 2010). The estimated TB death rates per 100 000 for Limpopo, while lowest, increased from 69 to 96 from 2003 to 2007 (SAHR, 2010). Put together, HIV/AIDS and TB are estimated to account for 24.2% of Limpopo's burden of disease (SAHR, 2010).

The containment of these infectious conditions do merit strategies that value community participation and involvement (NDOH Monitoring and Evaluation Framework for HIV/AIDS-National Strategic Plan 2007-2011, 2012). Health spending in Limpopo increased by an average 16.7% between 2005/06 – 2008/09 and 4.8% average

increase on real per capita health expenditure bases between 2005 and 2012. The District Health Services expenditure marginally increased annually from 2.9% in 2006/07 to 5.8% in 2011/12, representing a more than doubling of the district health expenditure over the same period.

According to the observations of the Limpopo Employment Growth and Development Plan (LEGDP, 2009), despite these rising financial allocations and expenditures in health, the health system in Limpopo continues to be hamstrung by the following triad of health challenges:

1) The large burden of disease, especially from HIV/AIDS and TB,
2) The slower than the expected progress of the Millennium Development Goals, especially in the child and maternal mortality
3) Weakness in governance and accountability.

This situation was also confirmed by the Premier's State of the Province Address on 11 June 2009.

Life expectancy was observed to decline over the years 1996 to 2007, from 56 years to 50 years respectively, with the female's figures dropping from 59 years to 51.6 years over 2000 to 2007 and the males from 52 years to 48.4 years. The drop is alluded to be due to the impact of the HIV/AIDS, TB, diseases of lifestyle and the trauma and violence scourge (LEGDP 2009-2014, 2009; Stats SA, 2010; Health Statistics report, 2010). The Health Systems Trust (HST) estimates the life expectancy of Limpopo to have improved to 65.7 years for females and 60.0 years for males by 2013, while the national ones moved from 58.3 years and 51.9 years to 61.7 years and 55.4 years respectively (HST, 2013).

The burden of non-communicable disease and disease of lifestyle are estimated to be just over 32% and comprise of Hypertension, Diabetes Mellitus, Asthma, Mental health, Cancers and high risk behaviour such as alcohol abuse (SAHR, 2010). In this review, the Limpopo`s estimates are comparable with the national ones, for example:

- Hypertension prevalence per 1000 at 66 for Limpopo and 132 nationally
- Diabetes prevalence per 1000 at 66 for Limpopo and 87 nationally
- Cancer of the cervix Mortality prevalence per 1000 at 66 for Limpopo and 15 nationally

These estimates compare well with the national ones while in some instances they are higher (e.g. cervical cancers) and others lower e.g. hypertension prevalence (SAHR, 2010). Behaviours related to mental health, in particular suicide, for example, are observed to be emanating from substance abuse, tobacco, alcohol and the use of illicit drugs such as marijuana (National Youth Risk Behaviour Survey (NYRBS), 2008; SAHR, 2010). According to the South African Community Epidemiology Network on Drug use (SACENDU), alcohol remain the dominant substance of abuse across all treatment sites.

Limpopo has recorded an increase in the percentage of alcohol dependent population from 6.1% for females and 25.7% in males in 1993 to 9.4% for females and 23.1% for males in 2003, while the national figures recorded 9.9% for females and 27.6% of males in 1993 and decreased to 6.3% females and 21:4% for males in 2003.The average prevalence of smoking stood at 28.5% for females and the 29,2% for males in Limpopo, while the national figures stood at 32.5% for females and 42.3% for males between 1999 and 2009. Insufficient participation in physical activity for Limpopo stood at 40.7% for females and 28.6% for males, while the national figures were 43.0% and 30.5% respectively in 2002 (SAHR, 2010).

However, it is noted that the prevention modalities required and the reduction strategies towards all these challenges will all have to get the total buy-in and the participation of the stakeholders including the community.

Violence and injuries represent the second leading cause of death and lost disability adjusted life years in South Africa (Seedat et al., 2010). These authors link widespread poverty, unemployment, income in-equality, patriarchal notion, widespread alcohol and other drugs' misuse, exposure to abuse, poor parenting and weakness in the law enforcement mechanisms on the level of violence. The road traffic accidents' death rate is highest in the age group 35-49 years and just over twice as high in males 76.2% than in females at 33.33% (RTNC Road Traffic Report, 2009). The human factor contributed 83% of these fatal crashes out of which 38% are noted to be related to unsafe behaviour such as alcohol use. The highest road traffic accident death rate in the country was recorded in Limpopo at 27.8% and the lowest in Gauteng at 22.6%, while the highest figures were recorded in the December month and lowest around January and February for the year 2013.

Sexual and Gender Based Violence is also noted in Limpopo and carries with it varied health consequences and outcomes both in the short and the long term, carrying with it a higher relative impact on morbidity (Mullick et al., 2010).

The Limpopo Employment Growth and Development Plan includes the plan to fight against HIV and AIDS, TB and other communicable diseases, diseases of life style and other causes of ill-health and mortality in Limpopo, including the phasing in of a National Health Insurance System. This plan includes the development of cohesive and sustainable communities with the sense of being part of the common enterprise together with the promotion of shared values and social solidarity.

Therefore, the Limpopo health situation depicts presence of lots of areas for attention in order to improve the health outcomes of its citizens together with their health profiles. Major issues of concern include the deep rural component with poverty, low economic activity, incompatible literacy levels that are matched against a composite burden of disease that spans across unacceptable mortalities and morbidities, communicable and non-communicable diseases and trauma and violence. These seek innovative strategies and plans to improve.

2.5 HEALTH REFORMS IN SOUTH AFRICA

Health reforms are at the centre focus of countries worldwide including the use of frameworks for strengthening and assessing the performance of countries` health systems (WHO, 2002; WHO, 2007). The WHO conceptual frame-work specifies the five key functions that are required to improve the national health systems towards better health outcomes as: leadership and governance, health work-force, financing system, health information system and the supply management system. The three main objectives of these key functions are identified to be:

1) Health service delivery through
2) Inter-sectorial health action and collaboration and
3) To respond to the community demands

In order to achieve the expected health outcomes it is everybody`s business to strengthen health systems in order to improve health outcomes (WHO, 2007). For South Africa, health reforms are also based upon the democratic ideals and the considerations of accessibility, equity, quality of service and appropriate health outcomes, community demand responsiveness and accountability (South African National Department Of Health (SA NDoH) Strategic Plan, 2010; Negotiated Service Delivery Agreement (NSDA), 2010).

The current reforms were apparently started from a diagnostic process, with the aim to elucidate the challenges facing the health sector, which activity culminated in the eventual health sector roadmap which preceded its offspring in the form of the Ten Point Plan (2010) (Schaay et al., 2011). The Ten Points Plan is alluded to serve as the guide to government health policy and an opportunity identifying means towards a coordinated health sector effort, to improve access to affordable, quality health care in South Africa (Rispel and Moolman. 2010).

Out of the Ten Points Plan, the National Department of Health Strategic Plan 2010/11-2012/13 was developed (Schaay et al., 2011). These authors view this strategic plan to be an intent by the government to monitor the improvements in the health system, since it is using quantifiable and tangible objectives and comprises of ten identifiable priorities, which are enumerated to be:

1. Provision of strategic leadership and creation of a social compact for better health outcomes
2. Implementation of the National Health Insurance
3. Health service quality improvement.
4. Strengthen health care systems' management.
5. Improve Human Resource development, planning and management.
6. Infrastructural revitalisation,
7. Accelerated improvement of HIV, STI and TB related strategies.
8. Intensity health promotion programme and mass mobilisation.
9. Review drug policy and
10. Strengthen research and development

In support of these strategic health reforms is the observed outcome based approach to monitoring and evaluation of outcomes across the government ministries (Schaay et al., 2011; Improving Government performance, undated). The reforms activities are using

this approach of the national planning ministries in the presidency, out of which a reference guide to planning and resource allocation was generated, which is called the Medium Term Strategic Framework (MTSF), 2009-2014.

This guide is said to represent the government's intent for definitive improvement (Schaay et al., 2011) as it identifies five developmental objectives and also highlights the strategic priority of the improvement of the nation's health profiles.

For the purpose of this study, the objective of the improvement of the nation's health profile is relevant, including the strategic priority five which is leaning towards health improvement.

The following two key strategies apply to the health sector:

- key strategic outcomes 2, targeting a long and healthy life for all South Africans and
- key strategic outcome 12, aiming at an efficient and a development oriented public service and an empowered, fair and inclusive citizenship.

To ensure implementation of this outcome based approach for the health sector, the Minister of Health signed a Negotiated Service Delivery Agreement (NSDA) with the president in 2010. The Minister of Health in turn is reported to have entered into a formal performance agreement with each of the nine provincial Members of the Executive Committee (MEC) for health, in order to ensure focus towards achievement of health outcomes. The Negotiated Service Delivery Agreement identifies four Strategic outputs to be achieved by the health sector, namely:

Output 1: Increasing life expectancy

Output 2: Decreasing maternal and child mortality

Output 3: Consulting HIV and AIDS and decreasing the burden of diseases from T.B.

Output 4: Strengthen Health system effectiveness.

Oversight, support, monitoring and review of this NSDA performance is purported to be done by the Department of Performance Monitoring and Evaluation (DPME) in the presidency. Two further key legislative and policy reform initiatives are engaged by the Minister of Health in order to realise the NSDA outcomes in the form of:

1) Re – engineering Primary Health Care in South Africa and
2) The National Health Insurance Scheme, (Schaay et al., 2011).

According to Schaay et al. (2011), Re – engineering Primary Health Care Initiative aims to improve and strengthen the District Health System (DHS) management and the accountability for the health to its population. This initiative is apparently implied to:

- Place greater emphasis on the community based service delivery, reaching out to families and focusing on disease prevention, health promotion and community participation.
- Focus on the factors outside the health sector that impact on health, for example, the social determinants of health.

This Primary Health Care (PHC) re- engineering is also observed by Schaay et al. (2011) to introduce three additional functions within the current primary health care system, namely:

1) The deployment of the District Specialist Team, aimed at strengthening clinical governance to address the unacceptably high infant, child and maternal mortality,

in order to achieve the NSDA outcomes 2 and the Millennium Development Goals 4 and 5.

2) The revitalisation and strengthening of the School Health Policy of 2003 in collaboration with the Departments of Basic education and Social Development. It involves the deployment of a school health nurse to a group of schools focussing on early childhood development and full immunisation and also on sexual and reproductive health and prevention of substance abuse.
3) The PHC ward based outreach model where community health workers reach out to communities. Their roles are health promotion, prevention campaigns, early detection and intervention of health problems, follow up, treatment support and the basic health support.

This re-engineering of PHC is aligned to the community-based primary care model of Brazil, which uses the family health programme and focuses on infant mortality (Macinko, Fatima, De Souza, Guanais and Simoes, 2007). It also closely aligns to and addresses the Ten Points Plan priority 4.1 (NDPH Strategy plan 2010/11 – 2012/13, 2010).

The National Health Insurance (NHI) scheme represents a health funding mechanism to purchase service from pre-accredited providers (public and private), in order to achieve a universal health care coverage with improved access to quality health service (SAHR, 2010). NHI is said to be a response to priority 2 of the Ten Point Plan of the NDOH's Strategic Plan 2010/11 – 2012-13, (2010).

Of note about these well intended reforms is that they are outcome-based with well-articulated objectives and have the concurrent monitoring and evaluation outputs. They also advocate for the community involvement and participation through a community oriented District Health System and re- engineered PHC that includes the community care givers on an outreach based model. However, according to Schaay et al. (2011),

potential risks and gaps in relation to the sequencing of these reforms and interventions are highlighted and enumerated to include:

- The fact that coherence and sequencing is not apparent,
- The reforms are complex and ambitious raising questions as to whether this already overburdened system can implement them;
- The sense of inadequate recognition given to the health human resource capacity needed to translate policy and the implementation thereof,
- A perceived gap between policy and implementation and
- The increasing emphasis on regulation and compliance and their actual impact on performance (Schaay et al., 2011).

Further, these strategies and reforms are observable to be paternalistic and obviate the community participation and involvement in their formulation and implementation which participation is entrenched as an important success factor in the good governance cycles (Jones, 2008; Fontan, Hamel, Morin, Shragge, 2008; Schoeman & Fourie, 2008). This study seeks to identify the community governance structures' involvement and participation in the management of health profiles and outcomes to address this gap. Further of note, according to WHO, is that it is everybody's business to strengthen health systems in order to improve health outcomes (WHO, 2007).

2.6 MILLENNIUM DEVELOPMENT GOALS

For purposes of ensuring efficient and effective global strategic health reforms and improved health outcomes with monitoring and evaluation, 189 countries, including 147 heads of states and governments, signed the Millennium Development goals (MDGs) and targets. These goals and targets were further refined and agreed upon by member states and adopted by the General Assembly of the World Summit in 2005 (WHO, 2010). These MDGs are said to be representing a partnership between the developed

and the developing countries to create an environment conducive to development and the elimination of poverty (WHO, 2010; United Nations (UN), 2005). They are perceived to represent an ambitious agenda for reducing poverty and improving lives (Schaay et al., 2011). These goals and targets are purported to be interpreted as interlinked and interdependent and form a complementary whole.

Specific to health are the following MDGs:

- Goal 4: Reduction of child mortality
- Goal 5: Improvement of maternal health
- Goal 6: Combating of HIV/AIDS, Malaria and other infectious diseases.

This MDG's effort is reported to be an inter-countries peer review measure aimed at the countries' performance improvement towards the pre-established specific targets. An example is the estimated South African maternal morbidity rate of 625 per 100 000 live births for 2010 while the 2015 target is 38 per 100 000 live births (The Millennium Development Goals (MDG) Country Report, 2010). This is a measure that targets to address Goal 5 which is to improve maternal health. A further example of this MDG is the peer reviewing of a province against the national performance such as, the maternal mortality ratio for Limpopo which was reported to have 176 deaths per 100 000 compared to national with the maternal mortality ratio of 410 deaths per 100 000 in 2012 (Limpopo Accelerated Plan, 2014).

Similarly, about the MDG Goal 4, which aims at reducing the child mortality rate, according to the same Limpopo Accelerated Plan, the national under-five mortality ratio was at 42 per 1 000 in 2012 while that of Limpopo was recorded to be 62 per 1 000 live births being way above that of national and is the highest in the country. The Millennium Development Goals thus seem to be representing a practical peer performance reviewing tool to support countries and every health performance inclined service

improvement setting. However, the eventual desired health impact will come out of continued assessment, improvement planning and appropriate monitoring and evaluation in line with the strategy implementation imperatives (Slack and Lewis, 2011; David, 2013; Huysamen, 1990).

2.7 COMMUNITY PARTICIPATION

Community engagement and participation is noted as a critical process towards effective, transparent and accountable governments, generating better decision making and delivering sustainable economic, environmental, social and cultural benefits (United Nations report, 2005, 2007). Local accountability and the participatory processes are demonstrated by the United Nations report as critical elements to building developmental structures, including the benefits of promotion of social cohesion and focus within the local communities which are recommended as an essential foundation. Community engagement is alluded to be a two way process offering the opportunity to develop inclusive, targeted and effective programmes and policies with an indigenous centred approach (United Nations report, 2005). Major benefits are noted to be the resultant trust, innovation and the democratic ideals' achievement, including those of collectivism and inclusivity.

The World Health Organisation (WHO) in their motivation for the prioritisation and strengthening of Primary Health Care by countries highlight and the importance of doing this with full community participation (WHO, 2000). They cite community participation to enable efficiency in achieving best results in the health system's accessibility, costs, usage and upgrade and the so essential considerations of sustainability, development and the self-reliance of the health systems. This approach is said to hinge on the deliverance of essential health care with the necessary efficiency, universal accessibility and the social acceptability within the available resources without losing the developmental and the sustainability focus.

Their enumerated elements of PHC are:

- Education concerning prevailing health problems and their methods of preventing and controlling them.
- Promotion of food supply and proper nutrition.
- Adequate supply of safe water and basic sanitation
- Maternal and child health care, including family planning.
- Immunisation against the major infectious diseases.
- Prevention and control of locally endemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.

All eight these elements have to do with individuals and families within the community. Therefore, only acceptable methods and technologies in the health system's improvement efforts are advised to be used, necessitating full community participation.

Similar expressions of community participation are encountered in the recommendations by Schaay et al. (2011) after analysing the South African health sector reforms. For example:

- Recommendation 5: the distinction and the prioritisation of the linkages between the initiatives such as the PHC re-engineering and the NHI with full articulation and wide dissemination to key stakeholders, including members of the civil society and communities.
- Recommendation 7: the core platform for implementation to be based on a properly functioning District Health System with real decision making powers at district authorities, inclusive of the local society.
- Recommendation 10: To make use of potential governance models as a basis for reforms with relevant stakeholder involvement ensuring greater accountability and responsiveness to the served communities.

In addition, at least six out of the ten identified priorities in the National Department of Health's Strategic Plan of 2010/2011 to 2012/13 are directly implying community participation and involvement namely:

1. Provision of strategic leadership and the creation of a social compact for better health outcomes.
2. Implementation of the National Health Insurance.
3. Health Service Quarterly improvement through standardised care.
4. Acceleration improvement of HIV/STI and TB related strategies.
5. Intensification of health promotional programmes and mass mobilisation and
6. Strengthening of Research and development.

A similar orientation towards community participation is observed in the Medium Term Strategic Framework (MTSF) 2009 – 2014 with the intent of improving the health profile of the nations through an efficient and a developmental, inclusive and a fair public service.

However, the strategies and guidelines referred to above, together with many others intended for health improvement, while having and recognising the comprehensive community participation and involvement, fall short of detailing how these will be achieved and manifest gaps in the specifics required for the implementation plans (Schaay,et al. 2011). Innovative approaches are, instead, encouraged at local level advocating and motivating for viable and adaptable transformational models of change that embrace community participation. One such effort is seen in the guidelines for the establishment of hospital boards and clinic committees (Limpopo Province Regulatory Framework for the Co-ordinations and Governance of the Hospital Boards, 2008).

These guidelines for the hospital boards and the clinic committees are mandating for the comprehensive community representation, participation, accountability, interest and

sensitivity (Limpopo Province Regulatory Framework for the Co-ordinations and Governance of the Hospital Boards, 2008). The guidelines` values and principles, for example, some (2.7 to 2.9) of the values enshrine the following:

1) People's needs must be responded to and the public must be encouraged to participate in policy making.
2) Transparency must be fostered by providing the public with timely, accessible and accurate information.
3) Personal management practices to be based on ability, objectivity, fairness and the need to redress the imbalances of the past to achieve broad community representation.

However, community engagement and participation are purported to be maximised through good governance (Jones, 2008) thereby espousing the following principles of value to the successful transformation:

- Legitimacy – which is giving opportunity to participation by all members, allowing broad consensus on what is in the best interest of the stakeholders, together with the development of agreed upon goals, policies and procedures.
- Accountability – of participants to the stakeholders and their associated groups, through owning up to the performance and the outcomes.
- Transparency – which espouses openness and the free flow of information leading to decision making and the openness of the processes involved to ensure stakeholders' understanding and appreciation.
- Performance drive - being responsive to the stakeholder's needs with the necessary efficiency focus to produce the desired and expected results.
- Fairness – ensuring that all persons have the same opportunity to receive a standard and similar level of the desired care which takes care of the democratic ideals of quality, access, equity, rights to care and advocacy.

The orientation and context of these principles are very similar to the quality service delivery principles of Batho Pele (NDOH Batho Pele Principles, 2006). These also espouse quality service through transparency, information sharing, value for money, redress, accountability and a standardised care and services to the recipients, who are stakeholders, in the form of the served community. Similar advice is given by Bayat and Meyer.(1994) who asserts that encouraging community participation and involvement does ensure fairness, reasonableness, respect of the democratic rights of individuals, accountability, efficiency and effectiveness, leading to the achievement of the best outcome.

In the social change intervention projects, the Foundation for Professional Development (FPD) uses the holistic transformation approach at different levels of the system, which includes individuals, families and communities in their natural setting as a model of community participation. Using the Gestalt theory, FPD believes in community participation through the individual and the collective's capacity to change, upon the recognition that we each have the will and the ability to hope, care and stimulate change in solidarity with others, for our immediate communities by focusing on specific issues.

This approach aims at changing both the attitudes and the behaviour of the community through all levels of the individual, the families and the whole community through participation and focus on reality of existing social dynamics and concerns at local level. They motivate for the valuing of trust, listening, mutual respect, participation and interaction that opens up the inner domains of individuals as well as at the intra-community domains thereby stimulating change. They further motivate for the facilitated interactions to stimulate deeply reflective and intimate conversations, which will shift inhibitors such as power relations and strengthen ownership and responsibility for change thereby mobilise awareness of individuals and local capacity, including that of the local resources (FPD, 2009).

They also see the presenting opportunity of translating this principle of participation into a developmental practice, given appropriate facilitation, capacitating individuals and communities to understand, discuss, decide and act on issues affecting their lives. Facilitated community participation is also said to bring together men and women of different generations, allowing different perspectives to be heard and to be taken into consideration for the fundamental decisions aimed at change. In this way it is observed to bridge the gaps between the leadership and their constituents thereby also contributing to the democratic ideals and good governance (WHO, 2007; FPD, 2009).

A further benefit is observed by FPD (2009) to be the improvement of the local capacity, efficiency and development towards self-propagating and sustainable health systems by its people. Therefore, full community participation through appropriate facilitation seems to be not dispensable as a factor in order to achieve change and transformation at community level towards improved health outcomes.

2.8 GOVERNANCE

According to Jones (2008), the Governance concept deals with several normative principles which include accountability, transparency, participation, responsibilities and equity etc. It is said to be constructed as a system and a process by which a community and the organisation corporate agreed upon and established to meet the goals of the community and those of the organisations, in our case, the department of health and the government. It is alluded to enable the successful transformation of the philosophic strategy into practical programmes and plans. Jones (2008) further discusses some of the principles of good governance, to include the following:

- **Legitimacy**- which enables participation by all members allowing broad consensus on what is best in the interest of the stakeholders in line with the agreed goals, policies and procedures.

- **Transparency** – with free flowing of information regarding the decisions and decision making process, with adequate information provided to stakeholders, to facilitate proper understanding of the situation and the outcomes or the results.
- **Performance** – this relates to the responsiveness to sufficiently serve the stakeholders based on the presenting situation with due focus on effectiveness and efficiency to procedure and the results that meet the expectations.
- **Fairness** goals of the stakeholders – where all persons have the same opportunity to receive the standard level of service desired. It talks to the frameworks on issues of Equity, Access, Quality of care, Advocacy and Rights, thereby representing the democratic ideals

Similar expressions by Schoeman and Fourie (2008) are, who emphasises how critical governance is based on the elements of participation, transparency, responsibility, equity and accountability to enhance social capital and the overall improvement of linkages amongst local communities? Schoeman and Fourie (2008) cites critical success factors that are necessary to achieve the needed community engagement and the indigenous approach. He depicts governance as pivotal in translating broad values contained in the overall vision into more concrete outcomes. Furthermore, he argues that next is the responsibility factor that ensures accountability, quality and access of service, community participation and the consensus in decision making. Encouraging community involvement and participation was mentioned to ensure fairness, reasonableness, respect of the democratic rights of individuals through accountability, efficiency and effectiveness and thus the best outcomes for all stakeholders and good governance, (Bayat and Meyer, 1994).

The values and principles for the Limpopo Province Hospital Board and Clinic Committees, as the governance structures in District Health, include the requirement of being guided by the democratic values, the responsiveness to local people's needs and transparency and encourages local community participation and good governance.

Definition of governance is seen to emphasise different components (Pierre and Peters, 2001).

- The process and mechanism through which significant and resourceful actors coordinate their actions and resources in pursuit of collectively defined objectives.
- A shift from hierarchy to horizontality and rely as interdependence and collaboration amongst multiple players.
- Players' interest and responsibilities intersect in a fluid and contingent way.
- The relationship of players are in a flux and stagnant, not necessarily exclusively permanent.
- Represent implementation of a strategy that aims to improve living condition and health outcomes through resource mobilisation. These elements bring in collaboration focus on community needs to elicit response to social demands while looking at development and improvement of overall quality of life and emphasise citizen participation, mobilisation and individual empowerment into self-respect, personal autonomy and responsibility (Fontan, et al., 2008)

Schaay et al. (2011) in their review of health sector reforms in South Africa, put the following recommendations in the same line of good governance:

- Recommendation 3 – current health reform policies to have appropriate mechanism to be translated into concrete and manageable operational plans.
- Recommendations 5 – prioritisation of linkages between initiatives (e.g. PHC re-engineering and the NHI) which should be well articulated and disseminated widely to key stakeholders, including members of the civil society.
- Recommendation 7 – the core platform for implementation to be based on a properly functioning district health system with real decision making powers delegated to semi-autonomous and accountable district health authorities.
- Recommendation 10: to make use of potential governance models as the basis for reforms with relevant key stakeholders' involvement to develop a clear set of

proposals for governance, delegation training and performance management (of profiles and health outcomes) of the community, ensuring greater accountability and responsiveness to the served communities.

Therefore, from Schoeman and Fourie, (2008); Jones (2008) and Bayat at al. (1994), it is recommendable to strengthen good governance and community (stakeholders') participation and involvement to achieve both the best outcomes in the reforms endeavour and the government's vision of a long and a healthy life for all South Africans as also alluded to by the NSDA (2010).

2.9 SUMMARY

This chapter provided the theoretical framework that the research will be based on. It depicted the health situation in South Africa and elsewhere, looked at the context and the presenting challenges and the reform trends, analysis of the improvement potential which ties in the necessary community participation ideal together with the importance of the governance aspect.

The next chapter will look at the research design together with the research methodology used in obtaining answers to the research question. The target population, method used to collect data, how the study was conducted and the research process will be described in this chapter.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter a detailed outline of the research methodology used to collect data in order to achieve the research objectives is provided. The focus will be on the research design, the sampling procedure, the data collection instrument, the data collection method and eventually the data analysis method used. This research methodology chapter thus outlines the techniques used to collect and analyse data (Leedy and Ormrod, 2013:76).

3.2 RESEARCH DESIGN

Leedy and Ormrod (2013:74) describe the research design to be the general strategy for solving a research problem which provides the overall structure for:

- the procedures that the researcher follows,
- the data that the researcher collects,
- the data analysis the researcher uses .

Research design entails the identification of the resources used, the procedures followed and the form that the data will take in the planning stage while it gives opportunity for more efficiency and effectiveness, according to them. Research designs and thus studies are said to be generally categorised into two broad categories namely, the quantitative and the qualitative designs, each with distinctive characteristics (Leedy and Ormrod, 2013: 95). A quantitative research study is said to be orientated into

looking at the amounts or quantities of one or more variables in some numerical way, while a qualitative research study looks at characteristics or qualities that cannot be entirely reduced to numerical values because they stand as nuances and complexities of a particular phenomenon.

This research study uses the qualitative research design. A qualitative study was conducted in order to understand in-depth the current role and the orientation of the existing governance structures towards their community`s health profiles and outcomes. The study represents a case study, which uses a single case of the Zebediela sub-district in this instance and the governance structures, to gain the complete understanding of their role and orientation towards their community`s health profiles and outcomes. This is also called an idiographic approach wherein an analysis of subjective accounts is done by getting inside the situation and involving oneself in order to gain the complete understanding of the context and the processes around the area of interest. However, the findings from a case study may not be generalisable to other situations (Leedy and Ormrod, 2013:141-2).

3.2.1 Study Population and Geographic area

The study was conducted in the Greater Zebediela sub- district of the Lepelle-Nkumpi sub-district in the Capricorn district of the Limpopo Province.

The study population is the governance structures within communities in South Africa`s health districts. The target population consisted of the established and functional governance structures with at least two years functional experience, within the Zebediela sub--district of the Lepelle-Nkumpi sub-district which has nine (9) such structures. These governance structures are made up of six (6) clinic committees, one (1) hospital board, two (2) traditional leadership councils which each comprises of *magoshi* and *mantona* that has at least ten (10) members .Each clinic committee has at

least six (6) members, made up of community representatives in various categories and capacities for example, the clinic management, local councillors, traditional healers, traditional leadership and non-government organisations. The hospital board has eight (8) members.

3.2.2 Sampling Procedure and the Study Sample

All nine functional and established community governance structures with at least two years functioning history in the greater Zebediela sub- district of the Lepelle Nkumpi sub district, comprising of six (6) clinic committees, one hospital board, two traditional leadership councils were included in the study on a census basis. Welman, Kruger and Mitchell (2005:101) indicate that in a census, all people selected within the study population are regarded as respondents and form part of the study wherein the determination of the number of people in the various categories of the entire study population is a requirement. They further highlight the appropriateness of this census approach in cases of relatively small study populations like is the case with this study. This census method allowed all the identified groups to participate in separate specific focus group discussions (Groenewald, 1998; Saunders, Lewis and Thornhill, 1997).

The hospital board with eight members was a focus group on its own, while each of the six clinic committees, with six members each, constituted individual focus groups, resulting in six clinic committee focus groups. Each of the two *traditional councils*, comprising of ten members, constituted a separate focus group. There were a total of nine focus groups in the target population. One of the traditional councils` groups was utilised as a pilot focus group. Therefore, for the eventual study, eight focus group discussions were planned to be conducted. Each focus group was engaged in a pre-determined and planned discussion session following a pre-planned discussion guide over an estimated one to two hours of discussion time.

3.2.3 Method of Data Collection

A focus group discussion was conducted using a discussion guide while recording of the discussion was done through note taking and audio recording by the facilitator, in this case the researcher, to allow in-depth and unlimited recording of the themes being studied. The focus group numbers were between five and fifteen in the identified targeted study samples. Audio recordings of the discussions were also done as a support to the note taking during the discussions which were then analysed later for content and for themes to be used in the subsequent interpretation of the results.

Anonymity and confidentiality were guaranteed to the participants, including the establishment of the necessary rapport, to ascertain opening up and free sharing.

The advantage of focus group discussions is identified to include the opportunity for the respondents to discuss and share in detail honing into complex contextual issues in interplay allowing for the elucidation of inputs through self-expression which would add up to rich detail and the required depth. (Saunders, et al. 1997). However, there had to be caution about the potential of the respondents to digress, including being irrelevant, unsystematic and uncoordinated, which would make the analysis of the collected data to be very difficult and time consuming. The respondent focus groups would also be different in their degree of details over the issues under discussion. This was obviated by sticking to the discussion guide through moderation during the discussion process which was exposed in advance to the participants to get the feel and the orientation of the expected discussion areas (Saunders, et al.1997; Smith, 1995).

Further, the following concerns had to be noted and minimised:

- The lack of objectivity that would challenge the validity and the reliability of the observations.
- facilitator interference with the group dynamics, passively and also unwittingly for example by posture and gestures, voice tone and talking more than necessary instead of allowing more discussion to come from the members.
- the lack of deductive generalisation of the resultant findings out of this case study had to be borne in mind .

3.2.4 Pilot Study

According to Leedy and Ormrod (2013:89), the validity of a measuring instrument is the extent to which the instrument measures what it is intended to measure. To ensure validity, the research instrument was developed with the assistance of an academic experienced in the designing of research instruments. One traditional council group was utilised as a pilot focus group to test the discussion guide for any possibility of ambiguity, the respondents' understanding and their accurate interpretation of the elements of the discussion guide. Comments and suggestions obtained in the pilot study were used to refine the final discussion guide used for data collection. This separate pilot focus group discussion was also used to train the research facilitators in perfecting the data collection instrument used, their skills and techniques. Therefore, for the eventual study only eight focus group discussions were included.

3.2.5 Data Analysis

Analysis of data was done through the use of the data analysis spiral process which unfolded according to the following essential steps: (Leedy & Ormrod, 2013:141-2)

- Organising raw data; by breaking large units into smaller ones and creating a file.

- Categorisation of data, perusing the files at leisure, getting the overall sense of the data and jotting down the preliminary interpretations
- Interpretation of data in their single instances for specific meanings they might have,
- Identification of patterns through scrutinising for underlying themes and patterns that categorises the case.
- Synthesis and generalisation of the overall picture using tables, diagrams and hierarchies, which represent the inductive reasoning and analysis (Leedy and Ormrod, 2013:97).

The study also considered the use of the NVIVO-10 statistical package for further data analysis together with the university statistician`s support.

3.2.6 **Trustworthiness**

Babbie and Mouton, (2012) express the notion of trustworthiness as the key and the base of the principle of objectivity, which is the hallmark of a good qualitative research, and espouses the necessary neutrality of the research findings or decisions.

According to Babbie and Mouton,(2012) qualitative study cannot be deemed transferrable unless it is credible, and it cannot be deemed credible if it is not dependable, all of which stand as the criteria elements of the trustworthiness notion.

To ensure credibility of this study, triangulation, referential adequacy and member check were done. In triangulation, the collected data was analysed and compared to the findings in the literature sources. Referral adequacy was done through the repeated review of the audio taped materials on record, to concretise the churned themes on record.

Transferability was ensured through the collection of sufficient and detailed descriptions of the context as data for analysis, through audio taping.

Steps taken to ensure credibility, are equally addressing the dependability of this study, which ascertains that, similar findings will be obtained if the research were to be repeated with the same respondents in the same context. (Babbie & Mouton, 2012) .

CHAPTER 4

RESULTS

4.1 INTRODUCTION

In this chapter, the research results focusing on the opinions of the focus group discussions on the role of the community governance structures in managing the health profiles and outcomes in the Zebediela sub--district of Capricorn District Municipality are presented. Common themes out of the opinions of the participating focus groups responding to a pre-planned discussion guide were ordered and categorised into a consistency matrix and interpreted for meaning in addressing the research objectives.

4.2 RESULTS OF THE STUDY

Out of a total of nine (9) targeted focus groups, one (1) was used for a pilot study. This left eight (8) potential focus groups for the study out of which only six (6) participated in separate discussions representing a 75% response rate. The outstanding two potential focus groups could not meet for appointment within the period of study as they were then dysfunctional. The six groups that participated were clinic committees that comprised of community representatives in their various categories and capacities such as the clinic management, local councillors, traditional healers, traditional leaders and the non-governmental organisations where available. The two potential groups not included in the study were the hospital board that was dysfunctional at the time of the study and the Seloana Traditional Council whose appointment could not be finalised within the period of the study.

The results will be presented on the opinion responses of the focus groups as well as using cross tabulations on the role of these governance structures in managing the community health profiles and outcomes in the Zebediela sub--district. The focus groups were asked a series of open-ended questions following a pre-set discussion guide. The results are presented below.

4.2.1 The Health Profiles/Outcomes of the Community

All the six (6) groups responded by describing their community health challenges / profiles/ outcomes to be:

- Bad
- Not acceptable
- A matter of great concern
- Spelling a grim future for the community
- With lots of room to be improved

The following six (6) issues were mentioned on a consensus basis to be the major specific common health challenges in the particular group`s communities: substance abuse, violence and assault, HIV/AIDS and other infectious diseases, teenage pregnancy, chronic diseases and other conditions.

1) **Substance abuse** is explained to include the observed excessive use of alcohol by members of all the groups` communities (6) with an element of unhealthy regular use as a pastime and source of pleasure across a broad age range and the gender divide. Substance abuse has also been observed to be associated with unhealthy and unsafe behaviour including excessive violence and assaults, associated increase in theft, house breaking, robbery and fatal assaults on members of the community. Use of illicit drugs such as dagga (cannabis) and now lately, “Nyaope” (a

concoction including apparently cannabis, opiates, some medical derivatives etc.) is also reported to be on the rise.

2) **Violence and assaults** are reported by all the six (6) focus groups to be rife in their communities and associated with the excessive alcohol use, substance abuse (specifically abuse of “nyaope”) and the low law enforcement level by the state together with the inadequate regulation of access to alcohol, licensing and abuse of democracy by some community members.
3) **HIV/AIDS and other infectious diseases** are consensually observed to be on the rise, un-abating, amid all the preventative advices availed to all the six (6) groups` communities. The reported context to this state of affairs is explained to be based on substance abuse, untoward and deliberate spreading by the infected to the risky behaviour prone members of the communities such as the youth and females through the use of money powered males and the innocent sexually assaulted victims.
4) **Teenage pregnancy** is noted as an issue of a health challenge by three (3) of the focus groups and is alluded to be associated with teenage peer pressure, lack of knowledge, lack of consistent educational and motivational support for the youth in the communities. The risky youth behaviour and their increasing substance abuse is observed to render them more vulnerable.
5) **Chronic diseases** are noted by three focus groups as health challenges. Diabetes mellitus, hypertension, asthma and arthritis are expressed as the observed major chronic diseases in these communities. These are reported to be on the increase and are alleged to be associated with improper nutrition, substance abuse and other habits such as smoking, life stresses and allergies.
6) **Other conditions** such as water-borne diseases such as diarrhoea and under-nutrition were noted by one focus group as a health challenge in their community, alleged to be associated with lack of health knowledge, education and poverty

These health conditions are now presented in a simple frequency of observation by the various focus groups as specific major health challenges in their communities:

Table 4.1: The Frequency of the Reported Health-related Challenges

THEME	FREQUENCY (Number of groups who reported the challenge)
Substance abuse	6
Violence and assault	6
HIV/AIDS & infectious diseases	6
Teenage pregnancy	3
Chronic diseases	3
Other conditions	3

The frequencies are then presented in a pictorial form, as depicted in the following figure 4.1

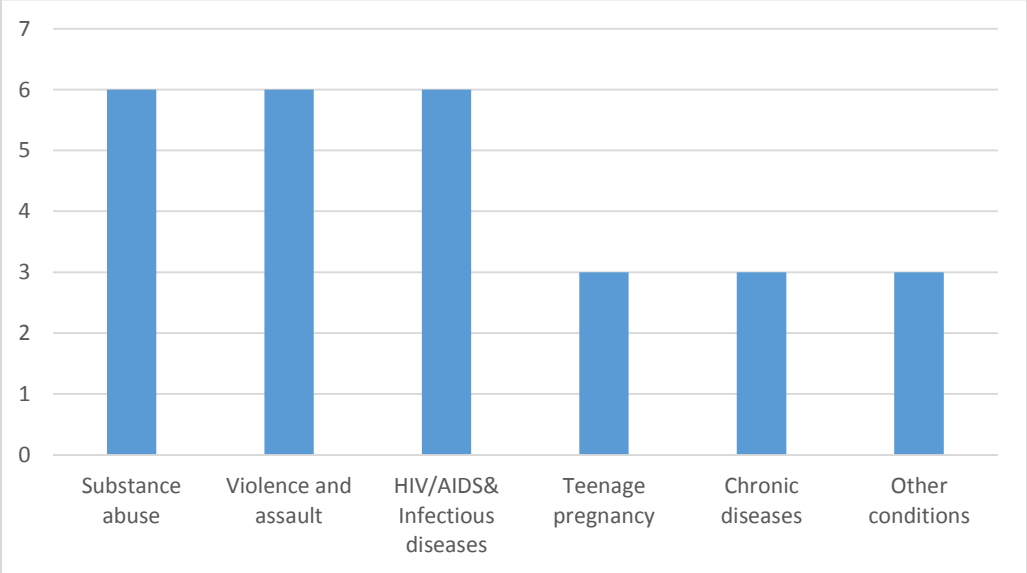

Figure 4.1: The Frequency of the Reported Health-related Challenges

4.2.2 What the identified Structures/Organisations are currently doing about the Health-related Challenges

Four (4) of the focus groups reported that they have no specific activity currently which is directly attending to this situation i.e. in helping to alleviate the health-related challenges mentioned above. Two (2) focus groups reported some activity in attending to this situation in the form of weekly morning clinic health education conducted by the organisation`s members in turn (1 group) and the other using volunteer members in some sporadic door to door activities bundled with other non-clinic activities.

Put in a simple frequency table:

Table 4.2: The frequency of the current activity to alleviate the health challenges

THEME	**FREQUENCY** **(Number of groups who reported current activity)**
Not doing anything specific	4
Doing some activity that includes health education at the clinic and at people's homes	2

The following figure 4.2 displays the frequency of the activities pictorially

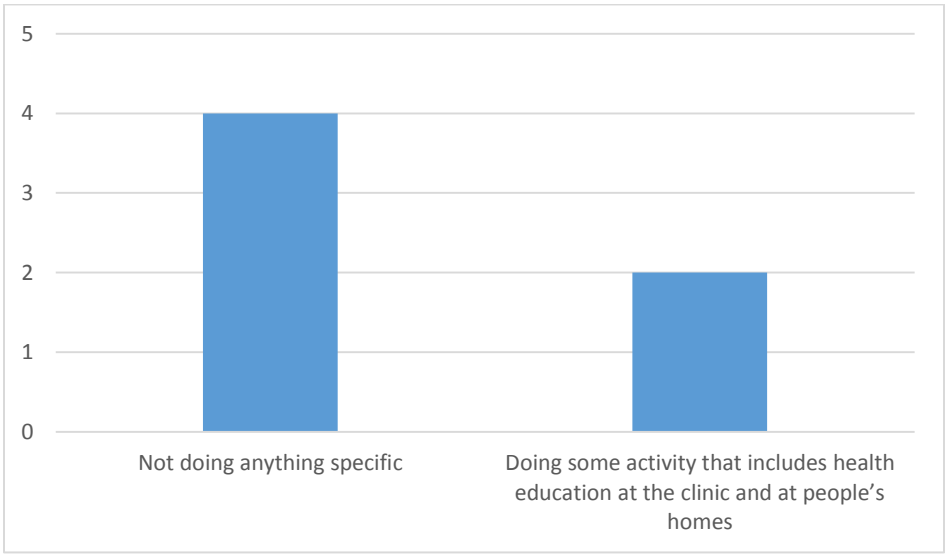

Figure 4.2: The frequency of the current activity to alleviate the health challenges

4.2.3 The Perceived Roles of the identified Community Structures/Organisations in managing the identified Challenges/Profiles/Outcomes

Three main themes were identified by the six focus groups as what they perceive to be their roles in managing the health challenges/profiles/outcomes as the community structures/organisations.

1) **Community mobilisation and health education** are identified by most focus groups (five) as the main role these structures should play. This role is seen as a need to bring about change in the understanding, awareness and the behaviour of the community members. The changed community understanding and behaviour is seen by these groups as important to improve and prevent the identified health

challenges/profiles in their communities. The participating groups see themselves to have the ability to:

- easily access and mobilise their communities, including
- the communication advantage they have with the broader communities, as entrenched by their broad and composite representation (traditional leadership, local government, traditional healers, the health sector and others).

2) **Leadership and co-ordination** is also identified as an important role by these community structures/organisations. These groups see their leadership role being in:
   - initiating activities that take information to people, motivating the community, putting up programmes and
   - participating in these and the
   - co-ordination of activities in their respective areas, including conjoined health education activities across the greater Zebediela sub--district.
   - inter-sector participation and the need for co-ordination is expressed as one of the important roles.
3) **Supporting all other stakeholders** and their existing programmes on health education and related activities to improve the health challenges/profiles/outcomes. Participation is expressed as the major support to have impact, for example, in school health education campaigns and community crime prevention forums.

These themes are presented and summarised in a simple frequency table below.

Table 4.3: The frequency of the Perceived Roles of the community structures

THEME	FREQUENCY (Number of groups perceiving the identified role)
Community mobilisation and health education role	5
Leadership and co-ordination role	4
Supporting all other stakeholders and programmes	3

Figure 4.3 below, pictorially displays these frequencies

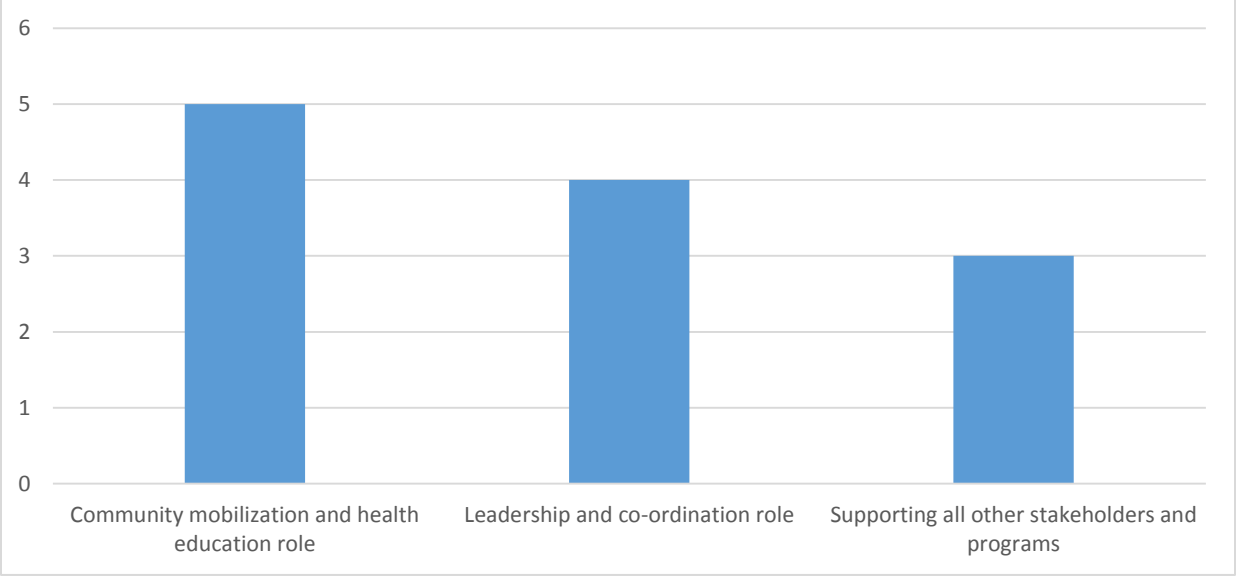

Figure 4.3: The frequency of the Perceived Roles of the community structures

4.2.4 Should the Identified Structure/Organisations Participate/Contribute towards improving these challenges/profiles/outcomes?

When the groups were asked whether they think they should participate in alleviating the identified challenges, all the six (6) participating groups responded positively with yes as an answer. Do you think it is your role as the community structure in improving these challenges/profile/ outcomes?

Table 4.4: When the groups were asked whether they think they should participate

THEME	**FREQUENCY** **(Number of groups think they should participate)**
Yes	6
No	0

Figure 4.4 below displays these frequencies pictorially

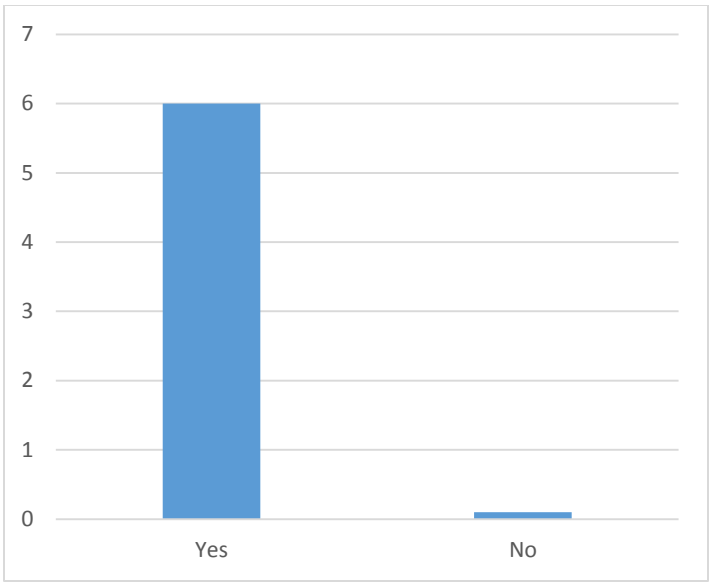

Figure 4.4: The frequency of willingness to participate in changing the situation

The main reasons expressed by all the six (6) participating groups on why they think they should participate and contribute towards improving these health challenges is put forth as:

- To bring about change in the health challenges/profiles/outcomes and prevent the impending crisis to the community, even its total extinction.
- Change context expressed to be in the form of, for example:
- improved life outcomes such as, improved life expectancy,
- a healthier life for all the community,
- an improved economy through preventing loss of lives, especially those of the economically active community members .

The groups were also asked in what way they think they can participate in alleviating the health-related challenges. Four themes were expressed by the participating groups to be the way and how they can participate and contribute to changing their communities` health challenges:

1) **Major inter-sector campaigns and events** which aim at community health education and information sharing are seen by all participating groups (six) to be one of the ways they can participate in and contribute to making the necessary changes in health challenges in their communities.
2) **Door to door campaigns** are suggested to be another way of contribution by five of these participating discussion groups
3) **Reinforcing and supporting of existing and running programmes** by other stakeholders is seen to be another way of participation/contribution by one of the discussion groups.
4) **Lobbying, support and advice to government** is also seen by one group to be a way to participate in attending to the improvement of their communities` health challenges.

The following frequency table summarises their responses:

Table 4.5: The frequency of the reported ways the groups can participate

THEME	**FREQUENCY** **(Number of groups reporting how they can participate)**
Major inter-sector campaigns and events	6
Door to door campaigns	5
Reinforcing and supporting existing programmes and	1
Lobbying, support and advice to government.	1

The following figure 4.5 depicts these frequencies for visual appreciation:

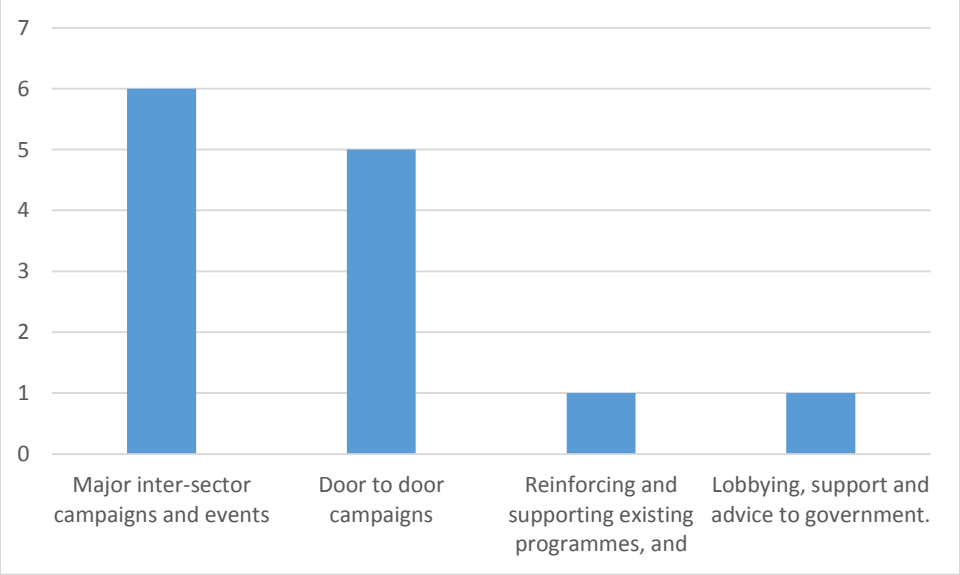

Figure 4.5: The frequency of the reported ways the groups can participate

4.2.5 Facilities/Resources and/or Skills Available to the Structures/Organisations that will facilitate their contribution/participation in improving the health challenges/profiles/outcomes in their community

Four themes were put forth by the participants to be the facilities/resources/skills which they have at their disposal to facilitate/improve their participation in improving the health challenges:

1) **Diverse representation**. This is seen by the participating groups to bring with it the following enabling context:
    - legitimacy and an acceptable composite representation to the constituencies they represent which is alleged by the groups to improve positive identification, buy-in, eventual participation and patronage by the constituencies they represent.

- composite knowledge, experience and expertise in the organisation/structure,

2) **Access to communities** at ground level: This is expressed to be available on an unlimited, broad access on a day to day basis with direct contact with communities to even benefit the feed-back loop of the monitoring and evaluation role.
3) **Communication efficiency with comprehension** are presented by the participating groups to be important in the endeavours to change community understanding and behaviour and are seen as inherent in these structures. Appropriate interpretation of the communities represented is said to be of importance in the change strategy.
4) **Willingness and motivation** by the participating group is presented as available and relevant to enable participation in the improvement of health challenges.

The following frequency table summarises the presented themes

Table 4.6: The frequency of the reported available facilities/resources/skills in the structures/organisations

THEME	**FREQUENCY** **(Number of groups reporting the available facilities/resources/skills)**
Diverse representation	6
Access to communities	6
Communication efficiency with comprehension	3
Willingness and motivation	3

Put in a figure form, the frequencies are shown in figure 4.6

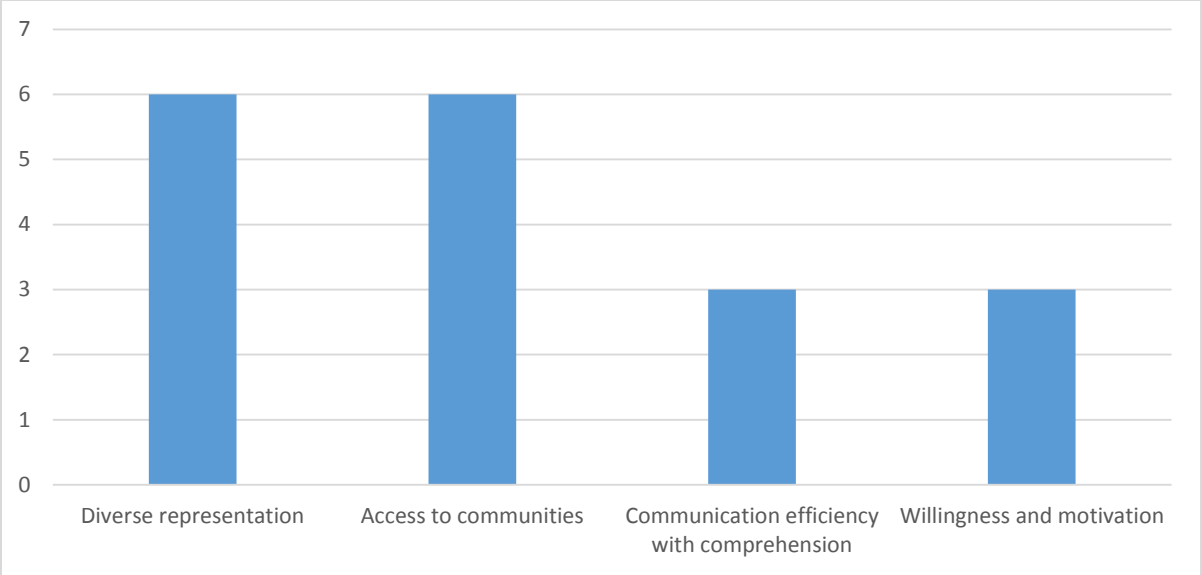

Figure 4.6: The frequency of the reported available facilities/resources/skills in the structures/organisations

4.2.6 What are the Facilities/Resources and/or Skills Available in the Community to Facilitate Contribution/Participation in improving the health challenges/profiles/outcomes

Four themes were advanced as the resources/facilities available in the communities to enable and facilitate the participating groups in improving the health challenges/profiles in their communities.

1) **Existing physical structures and functional structures** as contact points that are providing service within the communities for example, schools, clinics, churches and others,
2) Existing communication and command structures in the communities, such as
   - the traditional leadership at the *kgoshi*`s kraals,
   - the system of *mantona* and their *kgoro* channel of communication,
   - the local government system starting with the local councillors, ward based community structures up to the Lepelle-Nkumpi local municipality.

3) **Radio stations** in the form of the local community radio station such as the Zebediela community radio station and the national ones serving the local community
4) **Other stakeholders** in the form of formal and informal business, traditional healers, government structures such as the South African Police Services (SAPS), Department of Education, Department of Home affairs, Non-Government Organisations and others .

Put in a simple frequency table, the following is the picture of the identified facilities/ resources available in the communities to support the intended change in their communities` health challenges/profiles:

Table 4.7: The frequency of the reported facilities/resources/skills availability in the community

THEME	**FREQUENCY (Number of groups reporting the facility/resource/skills availability)**
Existing physical structures and functional structures	6
Existing communication and command structures	5
Radio station	3
Other stakeholders	3

The frequencies of the facilities in the community are demonstrated in figure 4.7 below.

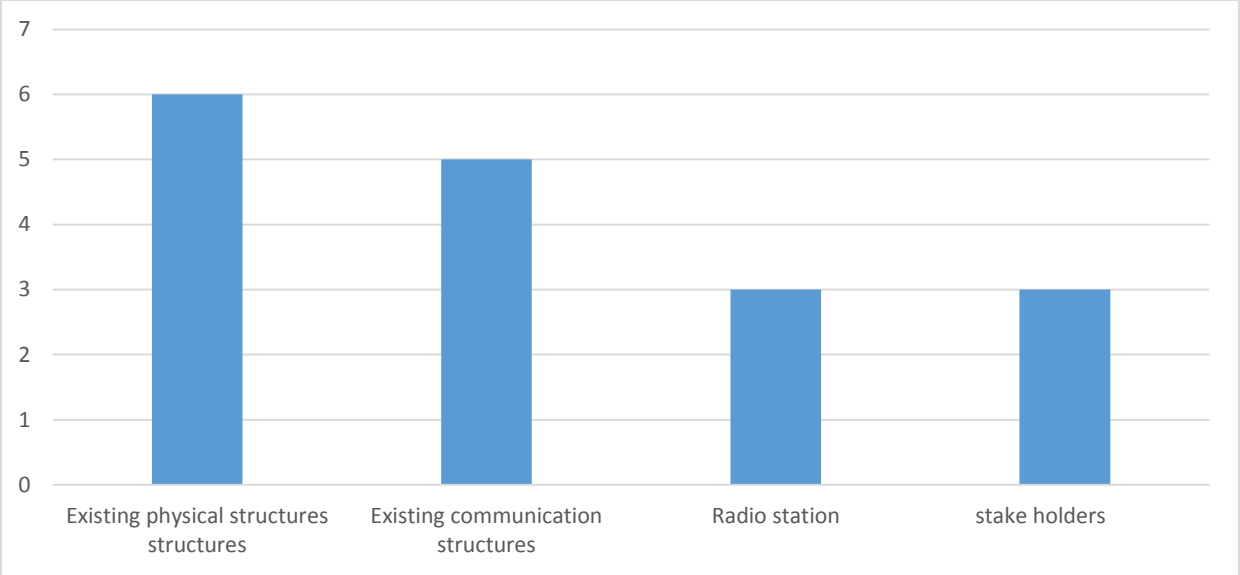

Figure 4.7: The frequency of the reported facilities/resources/skills availability in the community

4.2.7 The Facilities/Resources the identified Structures/Organisations would need to facilitate their Participation in Improving the Health Challenges/Profiles

Six (6) themes are discernible from the respondents as the facilities/resources they will need to enable them to participate in improving their communities` health challenges/profiles:

1) **Induction and training**. All participating focus groups (6) indicate the need for induction and training to enable them to participate meaningfully in the management of the health challenges/profiles in their communities. They expressed the need to be capacitated on the scope of the roles of and functions of their committees.
2) **Information on health challenges, profiles and outcomes** of the communities they serve (5 focus groups). The focus groups indicate that they would need specific information and knowledge on the particular health challenges in the communities for example, on HIV/AIDS, TB, chronic diseases and others.

3) **Finance and funding** is expressed as a need to enable the participating focus groups (4) in managing the health challenges/outcomes/profiles in their communities. Finance is seen as an enabler to run programmes, afford transportation and travel, refreshments for the attendants at the campaign sites and stipends for the group members to ensure sustainability and impact of these programmes.
4) **Support** by the government and the department of health in particular. This is expressed to necessarily include expertise, motivation, over-arching leadership, co-ordination and over-all support according to four (4) participating groups.
5) **Inter-sector collaboration and co-ordination**. Two (2) of the participating focus groups see the need for inter-sector collaboration and co-ordination as necessary to enable effective participation in managing their communities' health challenges/profiles/outcomes. Benefits of this are said to include:
    - A common and a conjoined effort that is minimising duplication and competition,
    - A potential of greater impact and an improved buy-in and support by the broader community.
6) **A programme plan** is identified by one (1) participating group to be a need for effective participation by them in contributing to the improved heath challenges.

The following simple frequency table summarises the picture:

Table 4.8: The frequency of the identified facilities/resources/skills required to facilitate the group`s participation

THEME	**FREQUENCY (Number of groups identifying the facility/resource/skills needed)**
Induction and training	6
Information on health challenges, profiles and outcomes	4
Finance and funding	4
Support	4
Inter-sector collaboration and co-ordination	2
A programme plan	1

The following figure 4.8 depicts these frequencies

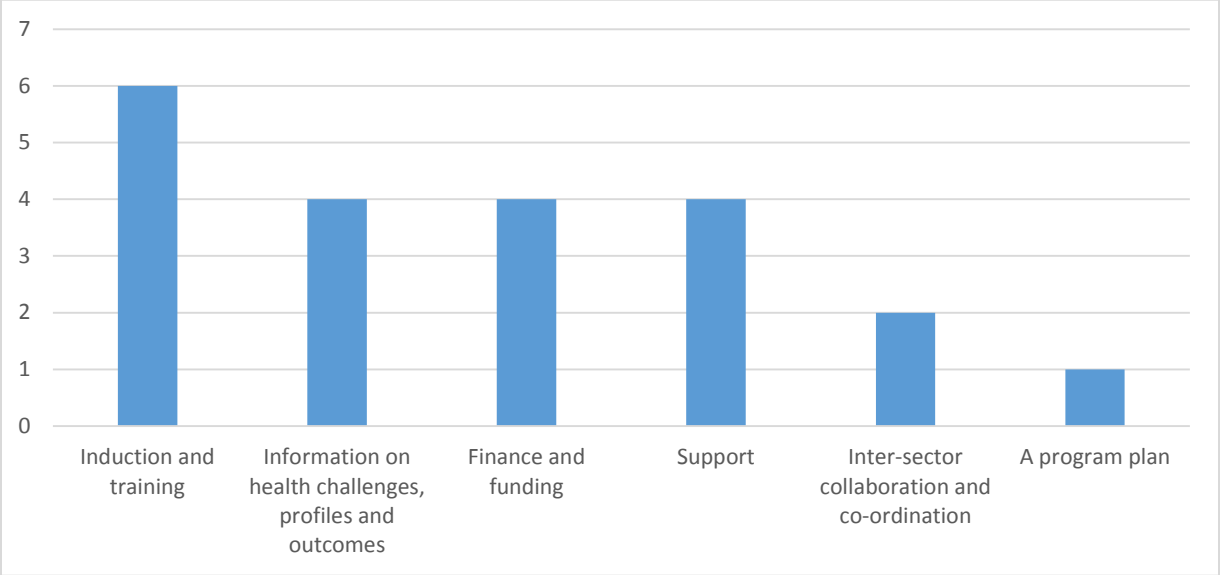

Figure 4.8: The frequency of the identified facilities/resources/skills required to facilitate the group`s participation

4.2.8 Factors that could hamper the participation of the Identified Structures/Organisations in improving health challenges/profile/outcomes

Six (6) themes are discerned as factors seen to have the potential to hamper the participating groups in their endeavour to improve health challenges/profiles/outcomes in their communities.

1) **Lack of knowledge and skills** by group members, especially on professional knowledge of each of the presenting health challenges and the skills on for example, how to organise and run various types of campaigns. This potential hampering factor is identified by all six (6) participating groups.
2) **Lack of finance/funding** as a resource to enable participation of the groups in improving the health challenges/profiles of their communities. This is seen by five (5) of the participating groups to have a potential to negatively affect their ability to run

the health education campaigns in relation to transport and travel, marketing of events, refreshments needed for campaigns, stipends, equipment such as the sound system and others.

3) **Low morale and the level of motivation** of the participating groups` members. Three (3) groups see the low morale and the low level of motivation to be a potentially hampering factor of their participation in improving the health challenges/profiles/outcomes. This theme is alleged to be already related to group members not receiving any stipends for the role they are playing in the committees, yet these activities require of them to travel for example, out of their meagre pockets. This is seen as not being sustainable and demotivating by the participating groups.
4) **Resistance to change** by the stakeholders is presented to be another potentially hampering factor by two (2) of the participating groups. This theme is seen by the participating groups to emanate from potential weaknesses such as, lack of patriotism to relevant/positive community building ethos and activities, socio-economic differences, political clans, divisions and alienation
5) **Lack of co-ordination and organisation:** Two (2) of the participating groups see the lack of common focus, approach and the co-ordination of stakeholders to be a potential hampering factor to their participation in improving the health challenges in their communities. This is viewed by these groups to potentially bring along unnecessary competition, duplication of activities and confusion to the receiving broader community.
6) **Lack of facilities and infrastructure:** Facilities such as the PA system, loud hailers, transport, office infrastructure, computers and printers, community halls and others are seen by two (2) of the participating groups to be potential hampering factors to them in their efforts to improve the health challenges in their communities**.**

The following simple frequency table depicts the respondents` views on the potentially hampering factors:

Table 4.9: The frequency of the reported factors to can potentially hamper the groups`s participation

FACTOR	FREQUENCY (Number of groups reporting the factor)
Lack of knowledge and skills	6
Lack of finance/funding	5
Low morale and the level of motivation	3
Resistance to change	2
Lack of co-ordination and organisation	2
Lack of facilities and infrastructure	2

Put in a figure, these frequencies appear as in figure 4.9 below

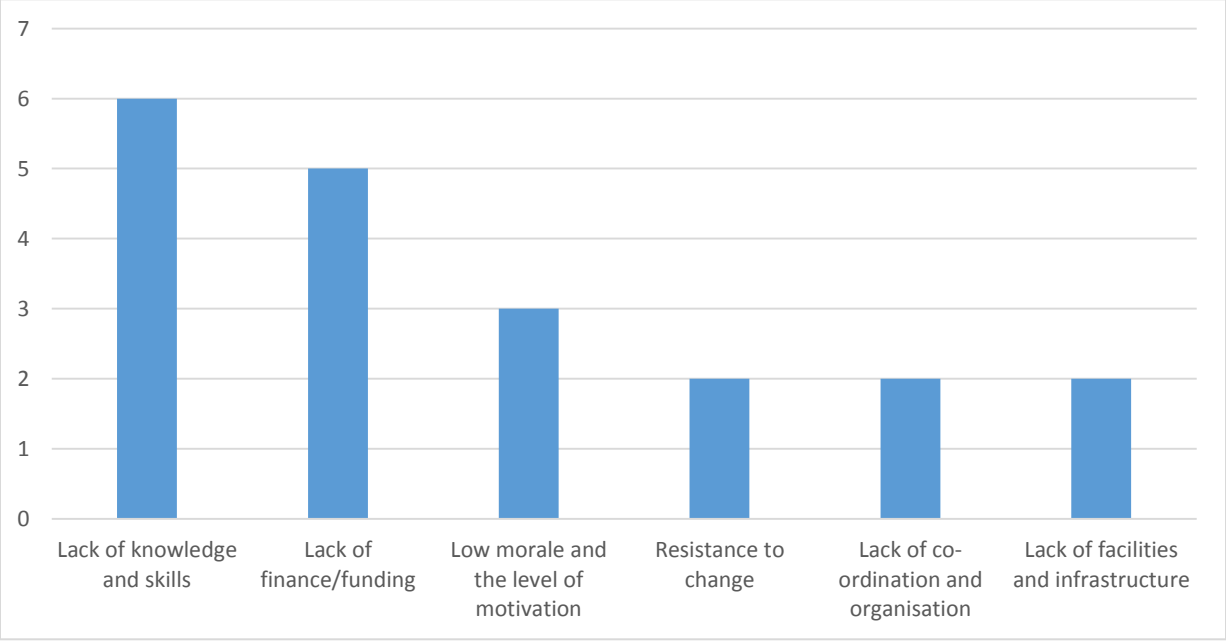

Figure 4.9: The frequency of the reported factors can potentially hamper the groups' participation

4.2.9 Additional Comments and/or Inputs regarding improvement of health challenges/profiles in the community.

All six groups had some additional comments/inputs to share regarding improvement of health challenges in their communities. Six inputs/comments were discerned as expressed themes in this category.

1) **Community focus and involvement** in all the plans and actions relating to improvement of health challenges/profiles. Aspects such as community motivation, maximal participation, common goal, breakage of silence on important matters like rape, HIV/AIDS, assaults and others are encouraged by three (3) of the participating groups .
2) **Inter-sector participation and co-ordination** are suggested by two (2) of the participating groups as important in the improvement efforts.
3) **Committee, structure membership and composition** are suggested by two (2) groups, to entail some specific important characteristics such as:
    - Appropriate representation that is comprehensive, strategic, representative and legitimate to ensure buy-in from the diverse constituency base.
    - Should consist of interested, sufficiently motivated, active and knowledgeable (not only literate) members from the communities.
    - Some members to be allowed to serve longer than the current three years term in their structures to ensure continuity of function with direction.
    - Transparent election/co-option of members from the community with emphasis on skills and abilities, not clans nor political favour based.
4) **Recognition and appreciation of other stakeholders** in the communities. Examples here are the traditional healers, informal business, foreign nationals and others, according to a further two (2) participating groups.
5) **Law and order, regulation and community values** to be strengthened according to two (2) participating groups.
6) **Expertise and professional support** are expressed by two (2) participating groups as also essential in their endeavour to ensuring improvement in the health challenges/profiles in their communities.

The following simple frequency table summarises the expressed additional factors and inputs towards the improvement of their communities` health challenges/profilers.

Table 4.10: The frequency of the additional inputs and comments to improve the health challenges/profiles in the community

FACTOR	**FREQUENCY(Number of groups identifying the additional input/comment)**
Community focus and involvement	3
Inter-sector participation and co-ordination	2
Committee, structure membership and composition	2
Recognition and appreciation of other stakeholders	2
Law and order, regulation and community values	2
Expertise and professional support	2

Figure 4.10 below, pictorially depicts these frequencies

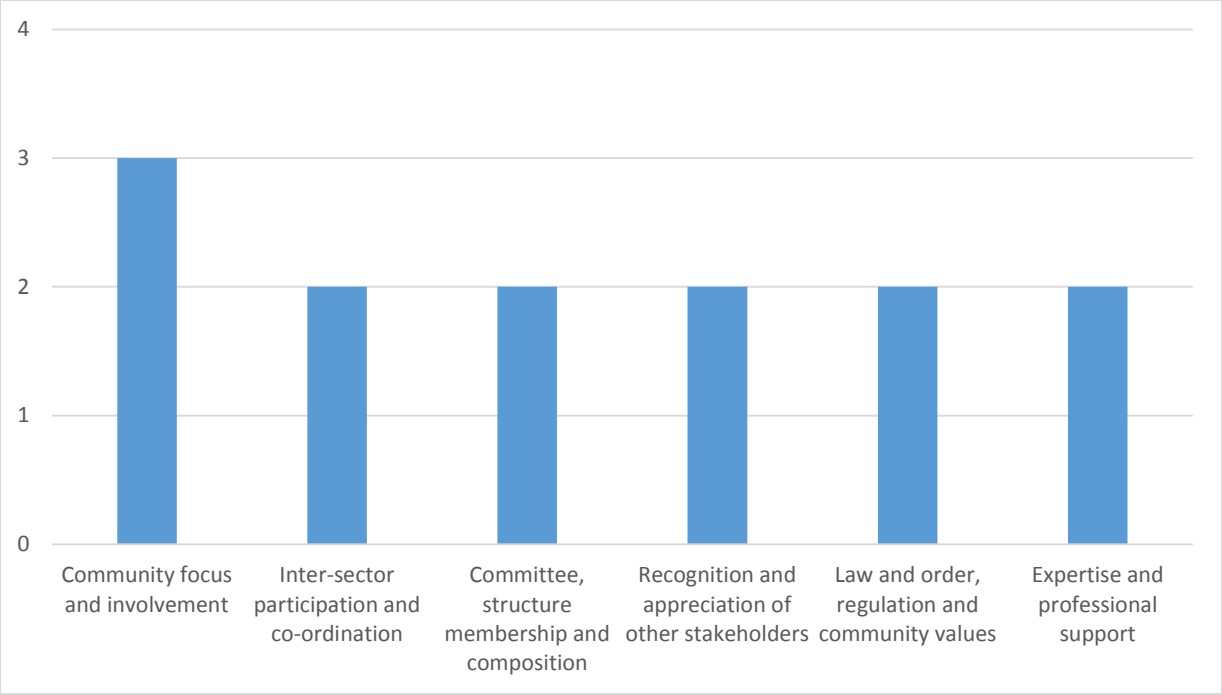

Figure 4.10: The frequency of the additional inputs and comments to improve the health challenges/profiles in the community

4.3 SUMMARY

This chapter presented the results of the study on the opinions of the focus groups obtained from the focus group discussions on their roles and their views on their communities` health challenges and profiles. The next chapter will discuss the results, draw conclusions and present the recommendations based on the presented results .

CHAPTER 5

SUMMARY OF RESULTS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This research intended to study and establish the role of the community governance structures in managing the health profiles and outcomes in the Zebediela sub--District of the Capricorn District Municipality in Limpopo. In order for the health profiles and outcomes of the community to improve, the community governance structures have to be functional, focus on and participate in the management of these health profiles and outcomes. There should be governance structures resourcing, capacitation and motivation to enable their identified strategic roles of leadership, co-ordination, comprehensive situation analysis, planning and the implementation of priority strategies so derived.

Chapter one discussed and highlighted the research problem, the rationale of the study, its aims and objectives, the research question, the importance of the study, delimitations, definition of terms and the outline of the study. Chapter two presented the literature review as the background context to the health situation, the concurrent reforms endeavours, together with the resultant health profiles and outcomes in South Africa and elsewhere, outlining the South African health situation and challenges, its Burden of Disease, the Limpopo Province health situation, the Millennium Development Goals, Community participation and the Governance Principles. Chapter three outlined the research methodology and the research design. Chapter four presented the results obtained from the study.

This chapter will discuss the summary of results of the study with cross reference to the literature review presented in chapter two, culminating in the presentation of the conclusions drawn from the study and the ensuing recommendations.

5.2 SUMMARY OF RESULTS

The results from this study indicate that:

- All the six (6) participating groups view their communities` health challenges/profiles as bad, unacceptable and having much room to be improved, especially in the following identified challenges, namely,
    - Substance abuse;
    - Violence and assaults;
    - HIV/AIDS together with other infectious diseases;
    - Teenage pregnancy;
    - Chronic diseases; and
    - Other diseases associated with water pollution.
- While only two (2) participating groups indicated that they are doing something about these unacceptable health challenges/profiles, the outstanding four (4) groups confess to be doing nothing specific about these.
- These groups see their roles in changing these health challenges to be in the form of community health education and mobilisation, leadership and co-ordination, together with lending support to existing health programmes.
- All six groups are willing to participate in improving these health challenges for the reason of ensuring the change in their communities towards a better life for all and an improved community welfare and economic sustainability which they pledge to do this through major inter-sector events and campaigns, door to door campaigns, lobbying of government and reinforcing the existing programmes.
- These groups see the following resources/facilities in themselves:
    - In the form of the diversity in their composition implying that they have a combination of various skill, experience and expertise that they can use to help in combating the identified health challenges in their communities;
    - The advantage of having access to the communities they serve;
    - A better comprehension and understanding capability of their communities

Their willingness to participate and improve these heath challenges/profiles as advantages.

- Within the communities they serve they see existing stakeholders and systems, existing community command structures, other stakeholders other than themselves and radio stations, as the available resources for them for use.
- They express their needs in order to participate in changing these health challenges to include:
    - Training, capacitation and induction,
    - Information on these health challenges on the causes of the challenges for prevention purposes as well as on the courses for treatment support and follow-up.
    - Financial and expert support together with inter-sector co-ordination and participation.

  As factors they foresee the following to have the potential to hamper them:
    - Lack of knowledge and skills;
    - Lack of finance and resources;
    - Low group member morale and low level of motivation;
    - Lack of co-ordination and organisation; and
    - The resistance to change by members of the community.

5.3 DISCUSSION OF THE RESULTS

5.3.1 The Health Profiles/Outcomes of the Community

The first research objective was to find out how the groups describe their communities` health challenges/profiles/outcomes and what they perceive to be the major specific common health challenges in their communities. The South African health situation is viewed as being in crisis over the past decade (Schaay et al., 2011; Seedat et al., 2010; Coovadia et al., 2009). In their analysis they observe the South African health outcomes to be poor and even worsening. The participating groups describe their health challenges/profiles/outcomes as "*bad, not acceptable, a matter of great concern, spelling a grim future for the community and having a lot of room for improvement*".

According to the Lancet series on Health in South Africa (2009), major conditions noted to overload the South African Burden of Disease include the following four: the mortality and morbidity burden, the communicable disease burden, the non-communicable disease burden which includes the diseases of a lifestyle burden and lastly, the Violence and injuries burden. According to the SAHR (2010), the Limpopo Province`s major burden of disease comprises of non-communicable diseases (32.1%), HIV/AIDS and other communicable diseases (24.2%), maternal and child mortalities (22.3%), violence and trauma, alcohol and substance abuse (21.4%. The participating groups describe their six major specific health challenges in their communities to be substance abuse, violence and assaults, HIV/AIDS and other infectious diseases, teenage pregnancy, chronic diseases and other groups of diseases. The participating groups` description of the health situation, profiles/outcomes and challenges in their communities are so close and in keeping with those mentioned in the literature.

5.3.2 What the identified structures/Organisations are currently doing about these Health –Related Challenges

The second objective was to establish what these identified structures/organisations are doing about these health related challenges. Only two groups report doing something, in the form of attending campaigns organised by other stakeholders and community mobilisation, while the majority (four) of the identified groups are not doing anything specific in helping to alleviate the health-related challenges mentioned above. Schaay et al. (2011) motivate for prioritisation of linkages, communication with full articulation and dissemination of information to opportune participation of the local communities as key stakeholders in the health reforms.

5.3.3 The Perceived Roles of the identified Community Structures/Organisations in managing the identified Challenges/Profiles/Outcomes

The third objective was to elucidate what the identified community structures perceive to be their role(s) in managing the identified health challenges/profiles/outcomes. The identified community structures perceive their roles to be community mobilisation and health education, leadership and co-ordination and supporting all other stakeholders and their existing programmes on health education and related activities to improve their communities` health challenges/profiles/outcomes. The NDoH Strategic Plan of 2010/2011 to 2012/2013 motivates for community participation with the intensification of health promotion programmes and mass mobilisation as one of its priorities. Schaay et al. (2011) also recommends the use of potential governance models as a basis for reforms, with the relevant stakeholder involvement ensuring greater accountability and responsiveness to the served community.

5.3.4 Should the identified Structures/Organisations Participate/Contribute towards improving these Health challenges/profiles/outcomes?

The fourth objective was to find out if the identified groups/organisations think they should participate/contribute towards improving these challenges/profiles/outcomes. All the six participating groups responded positively that they think they should participate in the improvement of these health challenges/profiles/outcomes. The main reasons expressed by the participating groups why they think they should participate and contribute towards improving of these health challenges are put forth as:

- To bring about change in the health challenges and prevent the impending crisis to the community, even total extinction,
- To improve life outcomes such as improved life expectancy, a healthier life for all the community and to improve the economy through saving the loss of lives, especially the economically active community members.

These participating groups think they can participate and contribute to change the health challenges/profiles/outcomes through major inter-sector campaigns and events, door to door campaigns, reinforcing and supporting existing programmes, together with lobbying, supporting and giving advice to government.

Community participation is recommended by the WHO (2000) and is alluded to enable efficiency in achieving best results. The Limpopo Province Guidelines for the Hospital Boards and Clinic committees establishment (2008) recommens the same community participation in lieu of maximising the response to people`s (community`s) needs. Jones (2008) further advises on good governance to achieve maximum community participation, engagement and a successful transformation. The MTSF (2009-2014) intends to improve the health outcomes of the nation through an efficient, developmental, inclusive and a fair public service. However, Schaay et al. (2011)

observe the shortfall in the strategic framework which is not detailing how the inclusive and developmental public service should be achieved, together with the manifest gaps in the specifics required for the implementation of the plans. They motivate for innovative and viable transformational models that will recognise, advocate for and encourage comprehensive community participation.

5.3.5 Facilities/Resources and/or Skills available to the Structures/Organisations that will facilitate their contribution/participation in improving the health challenges/profiles/outcomes in their community.

The fifth objective was to establish what the participating groups identify as facilities/resources/skills available to them to facilitate their contribution/participation in improving the health challenges/profiles/outcomes. These participating groups see diversity of their composition with the legitimacy and the composite knowledge, experience and expertise as the major resources/skills to their advantage to enable their participation in changing the health challenges/profiles. Access to communities, communication efficiency and their willingness to participate are mentioned as the additional skills available to them to participate in changing the health challenges/profiles/outcomes. Jones (2008) highlights legitimacy, accountability, transparency and the performance drive to be important principles to successful transformation and good governance.

5.3.6 Facilities/Resources and/or Skills Available in the Community to Facilitate Contribution/Participation in improving the health challenges/profiles/outcomes?

The sixth objective was to establish what the participating groups identify as facilities/resources/skills in the community to facilitate participation/contribution in improving health challenges/profiles. The participating groups identify the existing

physical and functional structures currently giving service within the communities, together with the existing communication and command structures in the communities, to be their major available resources to enable participation in improving the health challenges/profiles. Radio stations and other stakeholders are identified as additional enabling facilities/resources to the participation with the groups. The South African NDoH Strategic Plan (2010) indicates the considerations of improved and appropriate health outcomes and the responsiveness to community demands. The WHO`s (2007) conceptual framework specifies the inter-sectorial health action and collaboration, together with leadership and governance and health information systems as essential to improve national health systems towards better health outcomes. Their approach is hinging on deliverance of essential health care with the necessary universal accessibility and social acceptability within the available resources without losing the developmental and the sustainability focus.

5.3.7 The Facilities/Resources the identified Structures/Organisations would need to facilitate their Participation in improving the Health Challenges/Profiles/Outcomes

The seventh objective was to find out what the participating groups would need as facilities/resources to facilitate participation in improving the health challenges/profiles. The participating groups indicated that they would need induction and training, specific information and knowledge on particular health challenges/profiles, funding and financial support, inter-sectorial collaboration and co-ordination and a programme plan.

The United Nations reports of 2005 and 2007 demonstrate how local accountability and community participation opportune the critical elements of building developmental structures, promotion of social cohesion and focus, with the resultant trust, innovation, collective and inclusivity ideals, which deliver effective, sustainable and self-reliant programmes and systems, through efficient available resources management. Schaay

et al. (2011) put forth three recommendations; that full articulation and information imparting to key stakeholders be prioritised; making use of the governance structures and the local communities as the core platform for reforms with real decision making power within the functional District Health System; making use of the potential governance models as the bases for reforms, ensuring greater accountability and responsiveness to the local society.

5.3.8 Factors that could hamper participation of the identified Structures/Organisations in improving health challenges/profiles/outcomes

The eighth objective was to elucidate the factors seen by the identified groups to have the potential to hamper their participation in their endeavour to improve the health challenges/profiles. The participating groups identify the lack of the following to have the potential to hamper their participation in improving the health challenges/profiles: the lack of knowledge, skills, inadequate co-ordination and organisation, poor facilities and the necessary infrastructure. The low member morale and the motivation level, together with the resistance to change are also identified as potential hampering factors. The guiding strategic literature only go as far as mentioning the need to embrace community participation and the use of governance structures in the health reforms endeavour to improve health profiles/outcomes to be the status of the nation (The Limpopo Province Regulatory framework for the co-ordination and governance of hospital boards, 2008; Guidelines for the establishment of the clinic committees, 2008; MTSF, 2009-2014).

There is also no detail that addresses the identified needs like, knowledge imparting, skills improvement and capacitation of the governance structures and the attention to the morale and the motivational level of these structures/organisations nor the existence of specific local programme plans with community's participation from situation analysis through to strategy implementation. The FPD`s holistic transformational approach values the changing of both the attitudes and the behaviour of the community through

all levels of the individual, the families and the whole community eventually, strengthening ownership and the responsibility to change, mobilising awareness of individuals, the local capacity building and the local resources development towards self–propagating and sustainable health systems, run by its people.

5.3.9 Additional comments and inputs regarding improvement of health challenges/profiles in their communities

The last objective was to get any additional comments/input regarding the improvement of these health challenges/profiles in their communities. The participating groups identified community involvement and focus as the major additional factor of consideration together with the need for inter-sectorial participation and co-ordination, the appropriate committee structure and composition, the recognition and appreciation of other stakeholders, law and order application including improving regulation and control, uplifting community values and the availing of expertise and professional support to these structures .

5.4 LIMITATIONS OF THE STUDY

The limitation of this research study is that it uses the qualitative research design. A qualitative study was conducted in order to understand in-depth the current role and the orientation of the existing governance structures towards their community`s health profiles and outcomes. The study represents a case study, which uses a single case of the Zebediela sub-district . The findings from a case study may not be generalisable to other situations (Leedy and Ormrod, 2013:141-2).

5.5 CONCLUSIONS

The study confirms that the governance structures are aware of the health situation in their communities together with the health challenges/profiles/outcomes of these communities. These structures describe their community's health situation as bad, not acceptable, with a lot of room for improvement. In a similar way the literature views this situation as being in crisis, worsening and meriting urgent attention and intervention. The health challenges, profiles and outcomes observed by these structures as overloading the communities are similar as those expressed in the literature, comprising of the non-communicable diseases (chronic diseases an diseases of lifestyle), communicable diseases (especially HIV/AIDS and TB), substance abuse (alcohol, illicit drugs), trauma and violence and the preventable mortalities (especially maternal and child mortalities).

However, these governance structures are not doing anything specific to alleviate and improve this unacceptable health situation in their communities while the literature is motivating for their participation.

These structures perceive their roles to be those of leadership and coordination in mobilising the community through campaigns with other stakeholders to participate in health education and promotion in order to improve these health challenges/profiles and outcomes. The structures are willing and available to participate in improving the health situation and challenges in their communities because they perceive the situation as being grave and meriting definitive interventions, just as the literature is advising. Their participation is expressed to be in the form of major campaigns and events (intersector, door to door), reinforcing existing programmes, advising, lobbying and supporting the government`s strategies, which is in keeping with the NDoH Strategic Framework and the literature on health reforms strategies.

The structures see resources, skills and enabling factors in themselves and in their communities which will facilitate their contribution in improving the health situation and challenges in their own communities. These structures need the following to facilitate their participation in improving their communities` health situation and challenges:

- Induction and training
- Topic specific information and knowledge especially on the health challenges/profiles/outcomes,
- Financial support and funding,
- Inter-sector collaboration and coordination
- A programme plan

They identify the specific factors that may potentially hamper their participation in improving their community`s health challenges and profiles/outcomes as:

- Lack of adequate knowledge, skills, co-ordination and organisation, necessary infrastructure and facilities,
- Low member morale and level of motivation,
- Resistance to change by members

Additional important success factors identified by these governance structures include:

- Community involvement and focus in all plans and programmes
- Inter-sector participation and co-ordination
- Appropriate committee structure and composition (legitimacy)
- Recognition and appreciation of other stake-holders
- Stringent application of law and order, improving regulation and control
- Uplifting and promotion of community and family values
- Availing of professional support and expertise to these structures

5.6 RECOMMENDATIONS

The study recommends the following:

- Education and training to re-enforce and strengthen the existing current awareness and knowledge levels of the governance structures on the health situation and challenges in their communities.
- Reinforce and strengthen the existing sense of urgency and need for these structures to attend to and change their communities` health situation and challenges.
- Encourage and support the local situation assessment leading to the planning and the implementation of such plans, with the full participation of the local community and the governance structures from inception throughout.
- Initiate, support and motivate these governance structures to actively participate and attend to their communities` health situations in an on-going and regular basis through established local plans and programmes.
- Strengthen and support the leadership and co-ordination roles as identified by these governance structures to facilitate their participation in attending to their communities` health situation. The leadership in participating in co-ordinating campaigns, events, the reinforcing of the existing health programmes, advising, lobbying and supporting government`s health reform strategies
- Reinforce the existing governance structures` willingness to attend to and participate in their communities` health situation improvement.
- Recognise and utilise the resources, structures, facilities and skills available in these governance structures and in the communities as enabling factors to strengthen the community participation in the improvement of their communities` health situation.
- Resource and empower these governance structures to facilitate their participation in changing their communities` health situation. This will include induction and training, information, knowledge and education on the health situation factors, their

expected roles, the leadership and co-ordination and project management skills and financial support and funding.

- Note and mitigate the potentially impeding and hampering factors to the participation of the governance structures in improving the health situation of their communities. These are mentioned to include the lack of adequate knowledge, skills, facilities and resources, the low member morale and level of motivation, together with the resistance to change.
- Enhance the noted success factors such as being community focussed and involve these governance structures and the relevant stakeholders in all activities from situational analysis to implementation of programmes. This process of involvement should ensure that appropriate and legitimate governance structures are involved and there are proper control measures while uplifting community and family values.
- Avail expertise and professional support for these governance structures.

5.7 AREAS FOR FURTHER RESEARCH

- Quantification of the role of the governance structures in the management of the health challenges/profiles/outcomes of their communities.
- The underlying factors to the absence of the conscious and active attendance to the noted unacceptable and grave health situation by these governance structures
- The impact of fully resourced, supported and functional governance structures on the health profiles/outcomes of their local communities.
- The feasibility and viability of an independent, self-sustaining local health governance structure model
- The readiness of current governance structures in managing their communities health profiles/outcome

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APPENDIX 1

CONSENT FORM

Statement concerning participation in a research project

Name of project

The role of community structures in managing health outcomes: the case of the Zebediela sub district, Limpopo, South Africa

I have read the information on/heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aims and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I understand the participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular roles that I hold for my community, neither will it influence the relations that I have in my regular community roles.

I know that this study has been approved by Pietersburg- Mankweng Hospital Complex Ethics Committee. I am fully aware that the results of this study will be used for scientific purposes only and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study

..... **.....**

Name of volunteer **Signature of Volunteer**

…… …… ……

Place Date Witness

Statement by the Researcher

- I provided verbal and/or written* information regarding this study
- I agree to answer any future questions concerning the study as best as I am able.
- I will adhere to the approved protocol.

…… …… ……

Name or researcher Signature Date Place

APPENDIX 2

CONSENT FORM/FORAMO YA TUMELELANO

Tumelelano ya go tšea karolo

Leina la Morero wa Thuto

Karolo ya makgotla a setšhaba go lokišheng

ditlamorago tša maphelo a setšhaba mo

sedikong Sebetiela, Limpopo, Afrika Borwa

Ke badile ka ga Morero wa Thuto ye le go kwa maikemišetšo le morero wa yona, Ke bile ke filwe sebaka sa go butšiša dipotšišo le nako yeo e lekanego go gopodišiša taba tša yona.

Maikemišetšo le morero wa thuto y,e a kwišišhago gabotse go nna. Ga ke a gapeletšwe go tšea karolo, le ge e k aba ka kokgwa o mongwewo o rilego go tšea karolo.

Ke kwišiša le go dumela gore morero wo thuto ke o tsenela ka pelo yeo e bile e feleletšego le gore nka tlogela go tšea karolo nako efe goba efe, ntle le go hlagiša mabaka a seo. Seo se ka se be le khuetšo go maemo a ka a go šhomela šetšhaba, le tswalano ya ka le mediro yaka ya ka mehla setšhabeng.

Ke tsebišitšwe gore morero wo wa thuto o dumeleletšwe ke Pietersburg Mankweng Hospital Complex Ethics Committee. Ke bile ke lemošitšwe ka botlalo gore dipoelo tša morero wo wa thuto, di ka šhomišhwa go tša mahlale a tšwelopele, le go phatlalatšwa dingwalong tša maleba.

Ke dumelelana le seo ka tshephišho ya gore, maina le ditswaetso tša ka, di ke se phathalaetšwe go ba bangwe.

……. ……
Maina Signature

…… ……. ……
Lefelo Letšatši kgwedi Hlatse

Boikano bja Moithuthi Mogolo

- Ke fane ka hlaloso ka molomo le dingwalwa tša go hlaloša ditaba ka moka tša Morero wa Thuto
- Ke dumela go araba dipotšišo ka moka tšeo di ka latelago, Ka morago ga morero wo w a thuto, Go fihla ka mokgwa woo nka kgonago ka gona.
- Ke tla šhala morago melawana ka moka ya tšhepidišo ya merero ya thuto.

…… ……. ……. ……

Leina la Moithuti Mogolo Signature Letšatšikgwedi Lefelo

APPENDIX 3

DISCUSSION GUIDE

THE ROLE OF COMMUNITY STRUCTURES IN MANAGING HEALTH PROFILES/OUTCOMES

1- WHAT ARE THE HEALTH CHALLANGES/PROFILES/OUTCOMES OF YOUR COMMUNITY LIKE?

_____

_____

_____

_____

2- AS A STRUCTURE/ORGANISATION, WHAT ARE YOU CURRENTLY DOING ABOUT THIS SITUATION?

_____

_____

_____

_____

3- WHAT DO YOU THINK ARE YOUR ROLES IN THE COMMUNITY STRUCTURE IN MANAGING THESE CHALLANGES/PROFILES/OUTCOMES?

_____

_____

_____

_____

4- Do you think your structure/organisation should participate/contribute towards improving these challenges/ profiles/outcomes?

Yes No

4.1 If yes, <u>why</u> do you think your structure should participate?

_____

_____

_____

_____

_____

4.2 If yes, in what way (i.e. How) can they contribute/participate?

_____

_____

_____

_____

4.3 If not, why not?

_____

_____

_____

_____

5- What are the facilities/resources and/or skills that you have as a structure/organisation that will facilitate your contribution/participation in improving the health challenges/profiles in your community?

_____

_____

_____

_____

6. What are the facilities/resources and/or skills that you have in your community that will facilitate your contribution/participation in improving the health challenges/profiles in your community?

_____

_____

_____

_____

7. What kind of facilities/resources would you need to enable you to participate in improving the health challenges/profiles in your community?

   _____

   _____

   _____

   _____

8. What are the factors that could hamper your participation in improving health challenges/profiles in your community?

   _____

   _____

   _____

   _____

9. Do you have any additional comments/inputs regarding improvement of health challenges/profiles in your community?

   _____

   _____

   _____

   _____

THANK YOU SO MUCH FOR SHARING YOUR VIEWS WITH ME

APPENDIX 4

ETHICS COMMITTEE CLEARANCE CERTIFICATE

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

ETHICS COMMITTEE
CLEARANCE CERTIFICATE
UNIVERSITY OF LIMPOPO
POLOKWANE MANKWENG HOSPITAL COMPLEX

PROJECT NUMBER : PMREC – 83/2014

TITLE : The role of community structures in managing health outcomes: The case of the Zebediela sub-district, Limpopo, South Africa

RESEARCHER : Dr T Masemola

ALL PARTICIPANTS : N/A

Supervisor : Ms MF Rachidi

DATE CONSIDERED : 06 May 2014

DECISION OF COMMITTEE

- Approved

DATE : 07 October 2014

PROF A J MBOKAZI
Chairperson of Polokwane Mankweng Hospital Complex Ethics Committee

NOTE: *The budget for research has to be considered separately. Ethics committee is not providing any funds for projects.*