A district health service in Khayelitsha — panacea or pipedream?

P. M. BARRON, S. A. FISHER

Abstract **Khayelitsha is an underserviced, largely informal urban settlement on the edge of Cape Town. It is home to some 350 000 people. This paper maintains that a district health service would be beneficial in Khayelitsha. Advantages include (*i*) the integration and co-ordination of services with coherent management of health care; (*ii*) the ability to prioritise and act on problems with the full range of preventive and curative measures as well as intersectoral support; and (*iii*) the accountability of health providers. Some of the steps taken towards the initiation of a district health service are illustrated in a discussion of the recent changes in health service structures in Khayelitsha. There are many obstacles to the implementation of a formal district health service and these are discussed briefly.**

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It is becoming widely accepted, internationally and nationally, that the 'district' is the key element in the implementation of primary health care (PHC).[1,2] The following definition of the district health system was adopted by the World Health Organisation in 1986:

'A district health system based on PHC is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic and logistic support services. Its component elements need to be well co-ordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities.'[3]

Given the imminent change in national and local government there is a strong possibility that there will be a restructuring of the public sector health services. There are a number of very important problems which the district-based health system approach could help solve for South Africa, especially in underserviced and fast-growing areas such as Khayelitsha. The present system is fatally flawed by fragmentation, over-centralisation, an emphasis on curative medicine and lack of attention to community participation. The district is the level where there can be a meeting of national policy and local needs. It is the best level for co-ordinating the public sector and private health care, for getting the community involved in planning and implementation, for managing most health services and for facilitating intersectoral co-operation.

For the health services of Khayelitsha to function effectively as a health district there are a number of prerequisites: (*i*) commitment and support from the national, provincial and local authorities; (*ii*) control over financial and personnel resources which are adequately allocated; (*iii*) authority over decision-making. In other words a health team based in Khayelitsha should be given the wherewithal to plan and implement health care delivery in Khayelitsha and should have the back-up and full support of all other levels of health service. Obviously, at present, with the above conditions not yet fulfilled, and the extra-parliamentary groupings calling for a moratorium on unilateral restructuring of the health sector, there is not a fully formed district health service in Khayelitsha. However, a number of carefully directed, important changes have occurred in Khayelitsha's health services in the past 2 years. The way in which these changes take Khayelitsha towards a district health service are described below.

Khayelitsha — background

Khayelitsha is situated about 25 km from the centre of Cape Town (Fig. 1). It is a creation of the apartheid system and was intended as a solution to the housing needs of the blacks of the Cape Peninsula. Things did not turn out as planned and instead of formal housing for all, it is now the home of some 350 000 people and is an unusual mixture of middle-class formal housing as well as economic and sub-economic housing. However, approximately 80% of its inhabitants live in informal housing with services and unplanned informal housing without services. The first residents of Khayelitsha arrived in 1984 and 1985.[4] The infrastructure has not kept pace with the extremely rapid growth, and the provision of health care is no exception. The formal health services consist of 1 maternity obstetric unit (MOU) where 3 000 - 4 000 deliveries take place annually; 2 day hospitals at Site C and Site B, the latter a 24-hour service; local authority clinics at Site C, Site B, Zakhele and 3 mobile clinics (Fig. 2). Each of these services falls under a different health authority, viz. day hospital services fall under the Cape Provincial Administration (CPA); the MOU is funded by the CPA and falls jointly under Groote Schuur Hospital and the Department of Obstetrics, University of Cape Town. Local authority services are rendered by the Western Cape Regional Services Council (WCRSC) on an agency basis for the local city council of Lingelethu West. There is also a number of other services such as school services and community psychiatric services which fall under different branches of the CPA.

In addition to the formal health authorities there are also a large number of non-governmental organisations (NGOs) active in Khayelitsha. These include the South African Christian Leadership Association (SACLA), which runs community health worker (CHW) programmes, Philani, which runs a number of nutrition clinics, and SHAWCO, a UCT medical faculty student organisation, which runs a well woman's project linked to a community worker project.

Western Cape Regional Services Council, Cape Town
P. M. BARRON, B.COM., M.B. CH.B., F.F.C.H. (S.A.)
S. A. FISHER, M.B. CH.B., D.C.H., F.F.C.H. (S.A.), M.MED. (C.H.)

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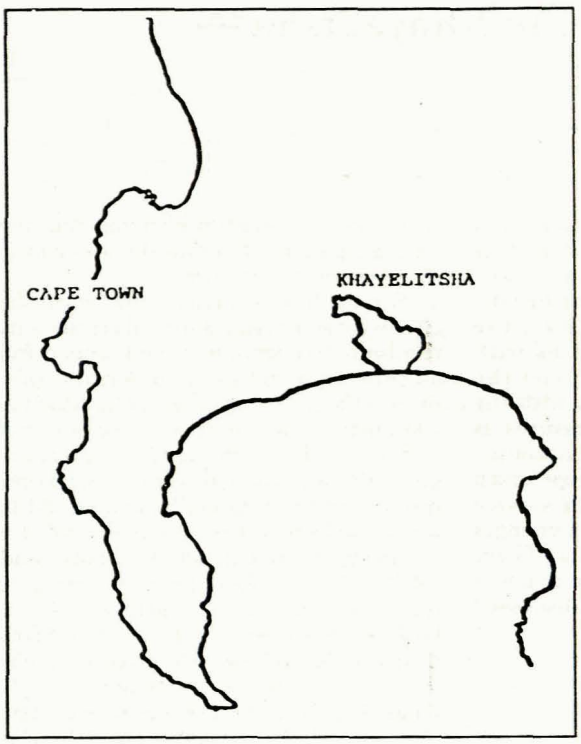

FIG. 1.
Location of Khayelitsha in the Cape Peninsula.

Toward a district health service

Until 1990 all governmental health authorities and NGOs functioned independently of each other with little co-ordination, co-operation or communication. Since then, a few steps forward on the road to a district health service have been taken.

Nolungile Clinic

This is the clinic at Site C, an area of informal housing with an estimated 75 000 people living in serviced and unserviced shacks. It is socio-economically very deprived. Towards the end of 1990, over and above the usual local authority subsidy, the Department of National Health and Population Development made additional funds available for a 'primary health care project' in the Site C area. In the ensuing 2 years a number of positive steps have been taken.

1. There was a physical integration of the day hospital and the preventive/promotive clinic as a result of the building of a connecting passage between these previously separate structures.

2. The 'curative' functions of the adjacent CPA day hospital staff and the 'preventive' functions of the WCRSC local authority staff have been integrated for child care. This has provided a more accessible, comprehensive, efficient, holistic service for young children and their mothers. It also provides a greater quality of care with far less waiting time.[5]

3. A CHW project has been set up. A portion of the funds for this PHC project have been allocated to SACLA, which has in turn employed 20 CHWs and 2 co-ordinators throughout Site C. These home-based CHWs work very closely with the professional nurses at the clinic and there is a two-way referral system. SACLA has an office in the clinic.

4. A health committee has been formed. This committee comprises nursing professionals from the two formal services, the health inspector of the area, a CHW co-ordinator, the co-ordinator of the project (a person specifically employed to facilitate community involvement) and elected members of the community. It is hoped that this committee will be the forerunner of a clinic board that will have authority over the clinic. Because of the inexperience of the community representatives in health matters, a large amount of time and energy has gone into training them for this role.

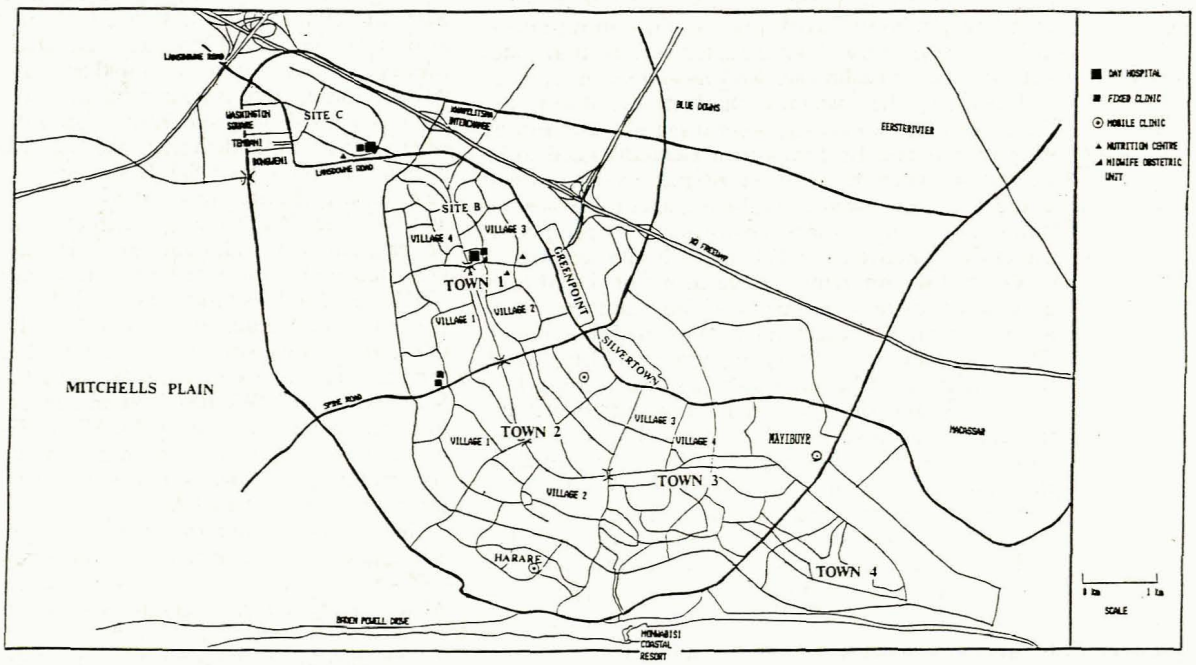

FIG. 2.
Distribution of health facilities in Khayelitsha.

Site B

In the wake of the success of the integration in the Site C facility there has been a conscious effort to extend the integration to Site B. The managerial heads of the three formal authorities at the Site B complex, viz. day hospital, local authority clinic and MOU, have agreed in principle that the services be managed by a single managerial team. These three services, although they operate from the same building, function totally independently of each other. A senior registrar in community health has been given the task of describing the way in which things operate at present as well as that of making recommendations on how to convert the fragmented services into one integrated service. At the time of writing a target date for the implementation of an integrated child health service had been set for July 1993.

At the same time a series of meetings was held with people representing different interest groups in the community, such as civic organisations. The aim of forming a health committee at Site B is to give the community an active role in changing the services to meet their needs. This has been particularly difficult because the population that this health centre serves is not well defined. But after numerous attempts, local civic and political organisations, as well as other groups, have now become involved. One of the first areas on which they are keen to focus is that of health personnel attitudes towards the community and the patients attending the health centre. This committee will have two roles, firstly to ensure that the services hear the community perspective on health problems and health facility management and secondly, to ensure that the resulting solutions are accepted and implemented by all parties, community and health services.

In addition to these initiatives the Medical Faculty of the University of Cape Town has been developing plans to use the Site B complex as a site for an academic PHC centre that can be used for the appropriate training of a wide range of health professionals.

Community involvement in health

Besides the abovementioned attempts to involve the community, there have been a number of initiatives in other parts of Khayelitsha, and health committees representating the local community have been elected in at least 4 other areas. The initial impetus for the creation of these health committees came from the health providers but once elected the committees created an identity of their own. Generally these committees have been extremely enthusiastic about their role and have increasingly made their presence felt. They have, for example, made decisions as to the siting of small local clinics as well as the appointment of non-professional staff.

Through their desire to learn, a special course for the training of health committees has been created by the Progressive Primary Health Care Network (PPHCN — a major national network of NGO organisations).

Because the health committees have a very local flavour the aim is to create an umbrella body, with representatives from all the local committees, that make decisions about health and health services for the people of Khayelitsha. An initial meeting, where the representatives of five of the six health committees met, agreed on the need for an umbrella body and a further meeting to decide on structure and function has been arranged.

In addition to the health committees a health forum has been created. This is a network of organisations, governmental and non-governmental, working in the health field. This forum was started at Nolungile with the 'PHC project' and was made viable by the creation of space within the clinic and the presence of a co-ordinator who had time to talk to people and organisations in the area. This network which was originally only for Site C now represents organisations working throughout Khayelitsha. It is taking health out of a narrow service mould and is taking on issues to do with the environment (e.g. clean-up campaigns), the well-being of children (e.g. child abuse cases, children with learning disabilities, children who are hungry at school) and is involving teachers, psychologists, police and foremen of rubbish removal teams. It is the beginning of local intersectoral networking and co-operation.

Decentralisation

A number of developments are nudging health services in Khayelitsha towards a district set-up. Partly as a result of requests by health professionals working in the Khayelitsha area, a 24-hour oral hydration unit has been set up at the day hospital at Site B. This enables a large number of children, who would previously have been referred (or who would have gone directly) to the tertiary hospitals (especially Red Cross Children's Hospital), to be seen and treated in Khayelitsha.[4] A modest laboratory service — part of the South African Institute for Medical Research — has also opened at Site B. This saves time, gives the professionals more job satisfaction and improves the quality of care given to patients. These changes make Khayelitsha's health services more independent and strengthen PHC.

The health department of the WCRSC, which renders local authority health services on an agency basis on behalf of many local municipalities and local bodies, has decided in principle that its organisational structure should centre on a district management team. This team will take responsibility for the day-to-day running of the district; policy issues will be decided in conjunction with head office management. This policy has been partially implemented.

The CPA, as part of their strategic planning for the western Cape, has closed down some of the inpatient services at Woodstock Hospital in the city centre. As a result of this a number of posts are available and many of these posts will be used to take services to those areas which did not have them before. In Khayelitsha the CPA intends there to be two teams of six, including a doctor, available to work in the underserviced areas of Harare and Mayibuye (Fig. 2). These teams will provide curative services in close co-operation with and integrated with the WCRSCs preventive and promotive services. All these services will be provided from the same facility.

Intersectoral co-operation

In addition to the health forum discussed above, other health-related organisations are working together to improve their effectiveness. In the field of nutrition the numerous governmental organisations and NGOs meet regularly to discuss strategies and operational issues with regard to how best to get food to those who need it in Khayelitsha. Another example of working together is in the field of environmental health where health inspectors and members of the engineer's department of the local authority in Khayelitsha have decided, after taking advice from the residents, on where to place rubbish disposal skips.

Problems to be overcome

There are many obstacles, some fundamental, others small, which have to be overcome before a district health service can function effectively in Khayelitsha. Many of these obstacles are not unique to Khayelitsha.

Disjointed structure of health services

There is no single coherent national health authority and therefore no political or administrative support for a Khayelitsha health district.

The many different governmental health organisations operating in Khayelitsha have to be consciously co-ordinated, since each of these operates services with their own goals, structures, managements and, most difficult to overcome, their own substantially different conditions of employment, salaries and work culture.

The relationship between the Khayelitsha health district and the local authority in the area needs to be clarified as the present local authority is not acceptable to the majority of the community.

Interprofessional communication is difficult

Within each of the different organisations the management structures are split along professional lines so that, for example, doctors, nurses and pharmacists will each have their own chain of command. This contradicts the principle of a district management team in Khayelitsha and can make tasks extremely cumbersome.

Attitudes of personnel

Health services staff have a tendency to be elitist and 'professionalised' in their attitude toward non-professionals (e.g. community health workers) and the community at large. Most health professionals have not been trained for a district health service where the health of the people of the district is their *raison d'être*. For the most part they have been trained in a hierarchical way where professional activity rather than health outcome is the goal. Health workers do not have 'the customer is always right' as their credo and do not view the patient as the customer. Retraining and in-service training in the PHC approach is required.

Lack of planning and evaluation skills

For the Khayelitsha health district to function effectively certain skills are required that have not been focused upon previously. These include research and evaluation skills. It is important that all levels of management receive training so that a culture of critical thinking, planning and evaluation is developed. In this regard there is scope for the technikons, universities and research institutions to play an important role.

Poor referral systems

Health services in the Cape Town metropolitan area are still very centralised; the referral system is inadequate with no community hospital in or close to Khayelitsha. Specialist outpatient services are also not generally available outside the Cape Town tertiary hospitals.

Conclusion

A number of small but important steps towards a district health service have been taken in Khayelitsha. A lot of hard work has gone into overcoming communication barriers between different components of the health services as well as between the health services, NGOs and the community. It has often been a case of two steps forward, one step sideways and one step backwards, but despite shortcomings, a semblance of a comprehensive PHC approach has been initiated in Khayelitsha. This is exemplified in the work at the Nolungile Clinic. The value of this pioneer work has been twofold. The success of the integrated service to children[6] has encouraged others, in and outside of Khayelitsha, to move towards this approach. More importantly its success has contributed to a subtle but distinct change in the mindset of health personnel throughout Khayelitsha. Many grassroot professionals have heard about Nolungile and are keen to have similar services in other areas. This 'new idea' has helped reduce the rigidity of health services and has opened the eyes of health managers to other options and a more flexible approach. The community has started to play a role in decision-making even though its members are not yet well versed in what they can achieve.

All of the above bode well for the future. However, one huge obstacle remains: until such time as the major players in the health field are prepared to relinquish some of their power, authority and resources to the district of Khayelitsha, it will remain a health services outpost with some areas of health service innovation rather than a model district service where innovative, specifically local solutions to local health needs are developed and improved regularly.

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REFERENCES

1. Mills A, Vaughan JP, Smith DL, Tabibzadeh I, eds. *Health System Decentralization. Concepts, Issues and Country Experience*. Geneva: World Health Organisation, 1990.
2. Zwarenstein M, Barron P. *Managing Primary Health Care in South Africa at the District Level*. Parowvallei: Health Systems Division of the Centre for Epidemiological Research in Southern Africa, Medical Research Council, Oct 1992.
3. World Health Organisation. *The Challenge of Implementation. District Health Systems for Primary Health Care*. Geneva: World Health Organisation, 1988.
4. Harrison D, McQueen A. *An Overview of Khayelitsha: Implications for Health Policy and Planning*. Parowvallei: Health Systems Division of the Centre for Epidemiological Research in Southern Africa, Medical Research Council, Nov 1992.
5. Harrison D, Barron PM, Glass B, Sonday S, vd Heyde Y. Far fewer missed opportunities for immunisation in an integrated child health service. *S Afr Med J* 1993; **83:** 575-576 (this issue).
6. Smith DL, Bryant JH. Building the infrastructure for primary health care: an overview of vertical and integrated approaches. *Soc Sci Med* 1988; **26:** 909-917.