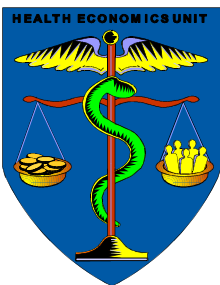


Equity Briefing



Khumalo, B. N. (2006) Strengthening household-health system accountability mechanisms at primary health care level to support improved provision of chronic disease: An investigative study. Centre for Health Policy, Johannesburg

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Embrace the change: how local accountability mechanisms can improve primary health care services

Greater community participation in health care is a key principle of South Africa's health policy. To facilitate such participation and improve service delivery, there are mechanisms that help to make service providers accountable to the communities they serve. Yet such mechanisms are not working effectively. This investigative study calls for a shake up of the old form of state–society relations that undermine accountability mechanisms.

The study suggests that training and capacity building is needed to prepare both health professionals and community members to fulfill their new roles within a more decentralised health system. Interestingly, it highlights the potential for home-based care groups to facilitate community participation in service delivery.

Developing a health system that is accountable to the people

As a legacy of the past, inequities based on race, class, gender and geographical location pervade South Africa's health system. To redress these and realise the spirit of the right to health care reflected in the South African constitution, the Department of Health initiated policies that promote community participation in health service delivery. The implementation of such policies require the establishment of accountability mechanisms at local level.

Accountability refers to the obligation to provide information about, and justify, one's actions. It is supported by penalties (ranging from legal action to negative publicity) if the obligation is not fulfilled.

Approach taken by the study

This study focused on a rural health district in South Africa. Its main objective was to determine how accountability mechanisms at a local level could be strengthened in order to improve health care services, particularly care for people with chronic disease.

The study gathered information through a variety of methods. It included a case study approach which gave a deeper insight into people's perceptions of the accountability mechanisms and the factors that enhanced, or constrained, their use. The findings draw on interviews with health facility managers, nurses, community leaders and chronic disease patients.

Key findings

The study identified three main types of accountability mechanisms:

- **bureaucratic accountability mechanisms** (initiated by the National Department of Health), for example the clinic committee and the suggestion box linked to the *Batho Pele* (People First) initiative;
- **organic structures** (which may be structures that help to maintain order in the community or focus on community development), for example the tribal authority, community leaders (indunas) and community development forum;
- **hybrid structures** (a combination of both bureaucratic and organic structures), such as home-based care groups (patient peer-support groups) linked to public clinics.

“... I am afraid that when I write something down those nurses will know it was me and they will be so angry at me that they will turn me away or refuse to give treatment”

A patient, referring to the *Batho Pele* suggestions box

In the district studied, a variety of factors were found to influence the effectiveness of accountability mechanisms. Some key points are highlighted below.

Unequal power relationships often undermine the effectiveness of the accountability mechanisms. Health workers are often perceived to have more power to influence decisions than community members. Health workers derive such power from their knowledge and training and the perception that they are only accountable to the district health office. The effects of these power relationships include:

- patients not voicing their complaints and concerns directly to health workers because they **fear** retribution from nurses
- community members feeling **powerless** to influence decisions. Even indunas (community leaders) felt inhibited from reporting people’s concerns to the clinic committee or facility manager
- a **defensiveness** on the part of nurses when faced with complaints or criticism.

“...we often fear that nurses will think that since we did not go to school we are talking rubbish ... Nurses might even say we went to the clinic to rule them...”

An induna

Strengthening accountability mechanisms

The study shows that it is vital to improve **communication** between community members and health workers in order to build a common **understanding and appreciation** of how accountability mechanisms can improve service delivery. This involves a reorientation of people’s attitudes to the health service and the meaning of ‘accountability’. Some key points to guide such a process are given below.

- **Working together:** No longer can health workers be seen as isolated from the rest of the community, accountable only to district officials. Community members need to recognise the importance of their own role in providing feedback and the value of their contribution to the decision-making processes that affect their health services.

“... the community cannot tell us what to do because they do not know how the nurses are trained. ... They must know our needs.”

A health worker

- **Inclusivity:** Community participation is not a right to be exercised only by the ‘educated’ or employed. To be truly representative, clinic committees, and other accountability structures need a diversity of members, including those with professional qualifications and those without.
- **Partnerships:** There is a need for more collaboration and co-operation, both within structures and between different structures. For example, the clinic committees could be seen as part of the networking and referral system that community leaders use when resolving community problems. It also requires that members of accountability structures are recognised as **equal partners** in the decision making process. This calls for stronger powers of decision-making at local level.
- **Guidance and training:** Posters promoting patient’s rights are not enough. There is a need for government to provide guidance and training for health workers on how to effectively support community participation. This would involve helping them to overcome their fears related to this side of their work. For example, nurses are used to operating in a closed, bureaucratic system and so may perceive community participation as a threat to their authority. Such fears need to be addressed because they pose a barrier to the effective operation of accountability mechanisms.
- **Home-based care groups** have the potential to act as an important mechanism for constructive, two-way communication between chronic disease patients and health workers. The study found that home-based caregivers often had a trusting relationship with both their patients and health workers. Whilst listening to their patients’ concerns they often informed the patients of the constraints and pressures under which health workers operate.

Copies of the paper are available from
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