

Social audit of provincial health services: Building the community voice into planning in South Africa

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Summary *Social audits of health services in three South African provinces (Limpopo 2001, Gauteng 2003 and Eastern Cape 2001) demonstrated a fusion of participatory research, qualitative data collection, epidemiological surveys and analysis, and socialising of evidence for action. The social audit in each province involved the community in covering eight principles of service delivery. In the particular case of Gauteng province, householders answered a questionnaire on public perceptions of government health services. In each sentinel community, the results were returned for discussion in focus groups, made up of a sample that had answered the household questionnaire. Institutional reviews of health facilities and interviews with health workers in those facilities gave the government side of the story. Five actions came from the community-based focus groups, all accepted by the provincial government. Firstly, redesigned communication strategies will aim to reach those with lower levels of education. The second set of actions involves rebuilding the culture of care. Thirdly, the public knowledge of ways to complain was closely related to levels of public satisfaction. Leadership in the health services turned out to be a fourth area for development. And finally, related to this, is the longer-term challenge of establishing and reinforcing community consultation mechanisms.*

Key words: *Community participation; public health; service delivery; multidisciplinary research; South Africa; CIET.*

Introduction

Health and human rights are interconnected and complementary approaches to sustainable development. On a social and economic level, good health creates and sustains the capabilities that poor people need to escape from poverty. The health of a population is not just an *outcome* of development; it is a *way of achieving* development. The public's level of engagement with health services is crucial to the benefit they will draw from those services¹.

In South Africa's Limpopo, Gauteng and Eastern Cape provinces, at the level of policy, the health services aim to promote the participation of civil society and the local community in the provision of services and to empower the local communities. Citizens' rights to health care in

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South Africa are safeguarded by the national service delivery standards. The *Batho Pele* (People First) principles—consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money—form the framework of these public-service standards.

The significance of evaluating public service lies in crossing political, social and economic divisions in order to give all citizens a voice. The economically disadvantaged are often also socially isolated, and perceive public institutions as distant, unaccountable and corrupt. Poor people's dissatisfaction with public-service institutions relates largely to issues of voice and accountability (Narayan *et al.*, 2000). Thus, emphasising the importance of community-based research and planning. This approach means that economically powerless citizens can still benefit from certain public services by virtue of their social right (Goetz & Gaventa, 2001).

From a multidisciplinary perspective, social audits can address the economic, political and social aspects of community involvement. Economically, social audits can give those without access to market-based resources access to better service. The audits' final objective of improving service delivery implies that the public should receive better value for money, while improving health-service delivery means that people's health should improve, thus increasing potential productivity.

Politically, social inclusion and public participation are fundamental to democracy. South Africa, a relatively young democratic state, has gone some way to addressing these important principles.

Socially, a community-based social audit allows for marginalized people—economically, politically and socially—to participate, influencing the development process they are supposed to benefit from (Goetz & Gaventa, 2001).

CIET is an international non-governmental organisation that conducts social audits to monitor the impact, coverage and costs of public services from the community perspective. CIET conducted social audits of the health sector in three South African provinces—Limpopo, Gauteng and Eastern Cape. The same methods were applied in each province. Since the results in each province are of local interest, only one set of results is presented—those of Gauteng.

Methods

In March 2003, a project steering committee, comprising the Gauteng Office of the Premier and the Gauteng Province Health Department, determined the framework of the survey. The social audit followed the standard social-audit cycle methodology to assemble and analyse the data (Andersson *et al.*, 1989). This hybrid of participatory and epidemiological research methodology allows for understanding and action planning, taking into account the views of community, service workers and the policy level. This dialogue between service providers and their clients becomes the basis for greater accountability and improved effectiveness and efficiency of the public services, allowing for the progressive realisation of people's basic human rights.

The four broad objectives of the audit, as identified by the Health Department steering committee were:

- (1) To establish the levels of delivery and performance of health services from the community and service perspectives, and to identify bottlenecks in delivery of health services;
- (2) To provide evidence for better planning and delivery of the health programmes related to HIV/AIDS prevention and health communication programmes;
- (3) To inform communication strategies directed at civil society, health workers and decision-makers at provincial level, based on outputs of the social audit; and

- (4) To contribute to a rights-based environment at provincial level, identifying best-practice facilities and building capacities of emerging researchers, managers and communication officers.

Sample

The sample represented the geographic and economic diversity of the province. It was selected from the South African National Census 1996, with adjustments for 'informal settlements' (squatter camps). CIETafrica stratified the sample frame by urban/rural, population density and health region, with last-stage random selection proportional to population. The final sample consisted of 60 sentinel sites. The research team selected and trained interviewers, piloted and adjusted the instruments to local conditions, supervised the household surveys and double-data entry, facilitated the institutional reviews and focus groups, analysed the data, and produced the report in May 2003.

Data-collection instruments

Four instruments collected data: household questionnaires, institutional reviews with the health-worker questionnaire, community-based focus group and, emerging from these, a best-practice group.

The household questionnaire was the starting point and covered citizens' experience of and attitudes to the government health service. Following a standards-based approach, pre-validated questions were used whenever possible in the household instrument. Institutional reviews of health-care facilities provided data on leadership, supervision and conditions in the health facilities. A short questionnaire for health workers covered reasons for satisfaction and dissatisfaction, and what they saw as obstacles to good service delivery. Focus groups with community members in the 60 sentinel sites discussed the preliminary results. This allowed the social audit to draw community-based conclusions about the performance of the public sector based on the *Batho Pele* principles and to identify best-practice sites.

Analysis

Data entry took place immediately following data collection. Using public-domain software (EpiInfo²), two data processors independently entered data from each site. Validation eliminated keystroke errors and further cleaning eliminated logical errors. Formal epidemiological analysis probed behind the indicators to deepen understanding of vulnerability in relation to exposure, attitudes and practices, using standard risk-analysis procedures. Promising associations indicating possible vulnerability or social exclusion were analysed using the standard epidemiological techniques to identify potentially confounding effects of age, sex of respondent, education, residential area and other factors. Risk analysis used the Mantel-Haenszel (Mantel & Haenszel, 1959), (Mantel, 1963) procedure. Contrasts reported as odds ratios (OR) and exact confidence intervals (CI) are those of Cornfield (1956). Gains were calculated by multiplying risk differences by the proportion requiring intervention. CIETafrica tested heterogeneity between strata using the Woolf (1955) procedure. Differences between averages (for example, cost of services and waiting time) were tested using standard procedures: where the variances of the two groups were homogeneous (95% confidence), we used the *t*-test. Where the variances were heterogeneous, the Kruskal Wallis test for two samples was used, (Kruskal *et al.*, 1952). Only those associations that are significant at the 5% level are reported. One can assume that CIETafrica tested most other associations and found them to be easily explainable by chance alone.

Policy dialogue

In addition to the interviews of health-facility managers in the sentinel sites, a series of meetings circulated the results at policy level. First, the steering committee reviewed the report. Then a province-wide retreat of health managers received the report, including senior political and civil service figures. Nurses and managers from the six health facilities with the highest community rating participated in a best-practice group. In a series of weekly meetings, these civil servants sought to identify what they were doing differently from the rest of the facilities. The best-practice conclusions formed the basis for five workshops that fed into the Annual Health Summit, a meeting of more than 300 health managers and community leaders, in October 2003.

Results*The participants*

Some 5,490 households took part in the social audit, of which two-thirds (3,590/5,436) were female. Two poverty indicators identified vulnerable groups: direct questions regarding household income and classification of type of housing. No less than 51% (2,228/4,357) of respondents fell below the national poverty line of R800 per month³, and 27% (1,442/5,399) lived in non-permanent dwellings. These two factors identified the group most likely to be socially and economically marginalized from service delivery.

Some 65% (3,516/5,446) of households were male headed and, of those, 16% (526/3,303) had no education or had not completed primary education. A female head of the household was 98% more likely to be unemployed than was a male head of the household⁴, thus demonstrating a gender-based marginalized group.

Consultation

Citizens should be consulted about the quality of the public services they receive and, wherever possible, they should be given a choice of service offered.

Consultation requires adequate facilitative mechanisms to be effective. The health-facility managers identified which mechanisms *should* be available, and the users provided information on access and use of these mechanisms. In printed documents, Gauteng's strategic priority is to 'implement, monitor and evaluate communication strategy across the organisation and with the public'⁵. Possibly the most important aspect of public participation involves the social, political and economic integration of marginalized groups. In the design of the social audit in Gauteng, however, consultation received no priority. This is a result in itself.

Many managers of health facilities said their main mechanism for health consultation was the clinic committee, although this does not by definition have community representation. One half (43/81) mentioned a community health committee, but this apparently wide availability of mechanisms for consultation could not be confirmed in the focus groups. In only four places (two focus groups were held in each of the 60 sentinel sites) had focus groups heard of health committees. Still fewer said that the committees were interacting with the communities, and most didn't know how the committees worked. There was inconsistency in the roles that the committees played.

Consultation in Gauteng could be said to happen at two levels. Firstly, it is a pro-forma requirement complied with by about one half of the facilities. Secondly, in a few places, it

formed part of local health governance. A longer-term strategy, likely to produce considerable gains, is the evolution of real mechanisms to hear the community voice.

Service standards

Citizens should be told what level and quality of public services they will receive, so they are aware of what to expect.

The public's level of satisfaction with the services was the main indicator used for consultation. In order to include the views of those who did not or could not attend government facilities, all respondents were asked about their satisfaction with government services overall, their satisfaction with prenatal services, and with services for children under the age of six years, HIV/Aids, domestic violence and ambulances. The public was most satisfied with services for children under the age of six years (77%, 3,048/3,944), while only 41% (1,699/4,159) said they were satisfied with the services for abused women and children.

Overall, slightly more than one half (56% 2,929/5,246) of the respondents (users and non-users) said they were satisfied with health services, while 82% (3,351/4,076) of users said they were satisfied with the care provided. The gap between overall and user satisfaction represents the weight of opinion of those who were not users—possibly some of them because of bad experiences with the government services.

In a multivariate model of service-user satisfaction, three factors emerged after the testing of scores of individual (for example, income, residence and education), health worker (for example, satisfaction, experience and training) and institutional factors (for example, sufficient supplies, absenteeism and visible redress mechanisms). These remaining user satisfaction factors were (1) institutions that do not charge a fee, (2) high rating of nurses' attitudes and (3) high rating of doctors' attitudes. The implication is that changing these three factors would improve the acceptability of health services to users. Table 1 shows that a combined action would have a multiplicative effect on satisfaction of users.

Another multivariate model examined *general* satisfaction (Table 2). Again, three factors emerged after consideration of scores of individual respondent, health worker and institutional factors. These were (1) institutions that do not charge a fee, (2) receiving free condoms and (3) having enough information on free services. The implication is that changing these factors would improve the general perception of health services.

Access

All citizens should have equal access to the services they are entitled to.

The health services reviewed deliver a complex series of services, and access to these services has several dimensions—geographic, cultural, temporal and economic. As an initial approximation to estimate access, CIET looked at access to health care, free condoms and disability grants. One out of every 20 households (255/5,367) reported at least one family member sick but unable to get to health services in the preceding 12 months—but only two sites reported no health-care facility. This means 95% (5,112/5,367) of respondents believed they had access to health facilities.

Two factors were associated with the inability to access health services: unemployment and female-headed households. Of those who did receive attention from government facilities, four out of every five government health-facility users (3,205/3,983) said that the care received met

Table 1. Final model of actions that can increase USER satisfaction with health services

Model 1: three independent effects	Crude OR	Unbiased OR	95%CI unbiased OR	Unbiased gain/1000	95%CI unbiased gain
Facility charges for no services	1.57	1.53	1.2–1.96	46.4	19.7–73.2
Rate attitude of nurses okay/good/v good	8.83	4.13	3.0–5.69	35.1	27.2–43
Rate attitude of doctors okay/good/v good	5.86	3.87	3.03–4.95	44.1	36.1–52.2
Model 2: combined nursing and charging reforms, independent of doctor reform					
No charges in facility AND improve nurses	3.57	2.74	2.06–3.66	186.3	133.1–239.5
Rate attitude of doctors okay/good/v good	8.83	7.13	5.35–9.51	40.3	34.4–46.2

Table 2. Final model of actions that can increase OVERALL satisfaction with health services

Three independent effects	Crude OR	Unbiased OR	95%CI unbiased OR	Unbiased gain/1000	95%CI unbiased gain
Facility charges for no services	1.20	1.19	1.02–1.39	23.9	2.9–44.9
Received free condoms in the last year	1.31	1.30	1.11–1.51	28.9	11.8–45.9
Have enough information on free services	1.28	1.25	1.06–1.48	36.3	9.1–63.5

all their needs. The same proportion (3,351/4,076) said they were satisfied with the care provided. The main reason patients' felt their needs were not met was lack of medicines.

The Health Department policy identified the condom-distribution programme as an area of concern due to its considerable expense. In the case study of condom distribution, 44% (2,538/5,755) of respondents said they had received government condoms in the year prior to the study. Free condoms had a significant impact on satisfaction with health services. However, it emerged during focus groups that many of those not using condoms were being deterred by public misconceptions about the quality of government-issued condoms. Many common myths were articulated, an area that needs to be addressed through an effective Health Department communication strategy.

Courtesy

Clients should be treated with courtesy and consideration.

The courtesy people perceive in health services is reflected in their view of corruption in the services, particularly in their conception of the nature of corruption. There is a common view that misbehaviour, for example bad service, represents corruption. In one sense this is true: corrupt service provision implies disrespect towards the public being served and therefore a lack of courtesy and consideration. The equation of corruption with disrespect does, however, detract from the solutions to 'true' corruption (the use of public goods for private gain) and also from simple lack of courtesy. The solutions are different.

One in every five households (789/4,065) perceived the Health Department as the most corrupt government department. Most attributed corruption to reselling of medicines.

Several findings pointed to severe problems with the attitude of the health personnel. Of the one in five who rated the Health Department as the most corrupt in the province, over 80%

(643/776) said this because of 'bad service'. Facility managers reported that the nurses' attitude was the main complaint of the patients. However, more than half, around 55% (295/538), of health workers felt that users would rate their facility as good.

Focus groups complained energetically about nurses' attitudes, their rudeness and discrimination in health services. The bad attitude of health workers and discrimination on an economic and language basis was a complaint brought up mainly by female focus groups.

Information

Citizens should be given full information about the public services they are entitled to receive.

One in four household respondents (1,544/5,438) said they had all the information they needed about free health services, and one in three households (2,008/5,422) had enough information about patients' rights. Where people most needed information (informal settlements), they were least likely to have it. Poor access to information was associated with low education levels, indicating the need to rethink communication strategies. Many, if not most, facilities (39/71) had no formal means of informing people about which services they had to pay for. Pamphlets and posters were the most common method of informing people about new policies and programmes, and the most common theme was HIV/Aids. The problem with this, as identified in focus group discussions, was that very often the pamphlets and/or posters were written in a language not understood by the health-service users.

The most common sources of information regarding free health services and patients' rights were clinics or health centres, followed by television and radio, with the latter being the most preferred means. Having sufficient information about free services was one of three independent effects in a multivariate model of scores of factors that can influence general public satisfaction (users and non-users) with government health services (see Tables 1 and 2).

Openness and transparency

Citizens should know how national and provincial departments are run, how much they cost and who is in charge.

The public's knowledge of the identity of the senior political officers, equivalent to the provincial minister of health, in South Africa called the Members of Executive Council (MEC), served as a key indicator of this principle. Service providers also answered questions about the MECs as well as their perception of users' knowledge of the Health Department functioning. Almost one half (2,333/5,396) of the respondents knew the name of the Gauteng Premier, yet only 4% (205/5,365) knew the name of the MEC for Health in Gauteng. This interest and engagement with government was not evenly spread throughout the province. Non-permanent dwellers were twice as likely to know who the MEC for Health was as permanent dwellers⁶. Eighty-five per cent (69/81) of health-facility managers knew who the MEC for Health was. The main reason that people thought it was important to know the MEC was so they would know to whom to address complaints and problems about the health facilities.

Most of the facility managers reported that users were not knowledgeable about health-service matters, although most of them also claimed to know the *Batho Pele* principles. Asked to name these principles, few managers could name more than three of the eight. Around 81%

(435/537) of health workers said they knew the *Batho Pele* principles. Among managers, 69/75 said they had heard of or knew of *Batho Pele*, yet only one was able to name all eight principles. The most common principles named were ‘courtesy’ and ‘consultation’, which were both poorly rated indices of performance by householders. Households attending facilities where most personnel knew the *Batho Pele* principles were significantly more likely to have information regarding free services than those attending facilities where most personnel did not know of the principles.

Redress

If the appropriate standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy. When complaints are made, citizens should receive a sympathetic, positive response.

Household respondents and service providers were questioned about making complaints about health facilities and the mechanisms available. The most commonly available procedure across the facilities reviewed was the suggestion box. This is biased against people who are unable to write. One out of 10 households (666/5,414) reported ever to have complained to the health services, and roughly one third (1,639/5,399) actually knew how to complain; among those who knew how to complain, 31% (502/1,637) had ever complained. For most people (43% 1,680/3,907), their preferred means of complaining about health services was personally, to either a matron or a doctor, and just less than a quarter (899/3,907) of respondents preferred the existing dominant practice of a complaints/suggestion box.

With restricted access to real complaint mechanisms, it would be precipitate to analyse the characteristics of those who complained and what they complained about. The first objective should be to open redress channels to everyone. When most, if not all, residents know how to complain, more detailed analysis of their complaints would be appropriate.

Value for money

Public services should be provided economically and efficiently, in order to give citizens the best possible value for money.

Household respondents were asked which department they considered the best run. As many as one in five (807/4,249) considered the Health Department to be the best run in the provinces—the same proportion that considered the department the most corrupt (though evidently different people and in different places). This shows a solid base of support and credibility upon which to build public opinion about government health services.

Three out of four (3,077/4,003) government health-service users did not pay for services. Among those who paid, the average amount was R26.20. One half (2,340/5,089) of the respondents felt it would be acceptable to pay something for health care, although the average of the figures they mentioned (R17.20) was substantially lower than that actually paid. This raises the possible strategy of charging more people less per service. However, this should be offset against the negative effect of charging on both general and user satisfaction levels (Tables 1 and 2). Until all citizens have full access to the information about what services are free, and it is possible to assess the impact on their expectations, it makes little sense to change charging policies.

Conclusion

Community-led solutions

At the initial reading of the results, after feedback discussions with the Provincial Health Department, three sets of actions were recommended—one short term, one medium term and one longer term.

The first recommendation—relatively easy to implement and with a fast turnaround—was to *re-gear the communication strategies* that underpin the relationship between the Health Department and the public. A revised communication strategy would pay special attention to those currently left out by the print-dependent existing strategies (the health illiterate). It would address the identity and contact address of the MEC, issues of free services and patients' rights, the matter of confidential redress and the issues of community consultation. A special challenge, perhaps to be met in purpose-built partnerships with Non Government Organisations (NGOs) with experience in this area, should address some of the myths associated with the distribution of free condoms. To inform refashioning of the communication strategy, it may be worth bearing in mind that more than one half of the respondents said they got their information from health workers and health facilities. This was the preference of only 16% (769/4,884) of respondents, but it did signal a huge government-public interface in need of attention.

The second set of actions, slightly longer term and more difficult to implement, involved *rebuilding the culture of care*. The explicit objective was to reduce, and hopefully to eliminate, the very damaging 'attitudes' that caused so much public dissatisfaction with health services. Much of what the public identified as 'corruption' has to do with the attitudes—perceived or real—of nurses as they interfaced with the public. The best-practice group identified at least three components to improving the culture of care. Firstly, they said, leadership is crucial—nurses tend to treat others as they themselves are treated. Secondly, the spirit of teamwork is very variable across health facilities. And thirdly, effective redress mechanisms are central to generating appropriate professional attitudes and interpersonal styles.

Related to this is the longer-term challenge of establishing and reinforcing community-consultation mechanisms. The positive aspect of the research method used is that it can realign consultation through its very nature of consulting the community being researched.

A combination of the first two sets of activities—improving communication and redeveloping the culture of care among primary health-care nurses—can result in measurable advances in more and more real mechanisms of community consultation. As expectations are managed and the insulting behaviour of health personnel removed, the perception of service standards should improve dramatically. Clearer information about entitlements and patients' rights, along with improved behaviour of nurses, might result in a reduction of the 5% (255/5,367) of households that had at least one member sick but without access to health care. Perceptions of courtesy and right to information would improve. The outcome would be an improvement across the full range of *Batho Pele* criteria.

Notes

- 1 The relationship between health and sustainable development is spelled out in the Johannesburg Declaration on Health and Sustainable Development, adapted at a meeting of Senior Officials and Ministers of Health on 22 January 2002.
- 2 EpiInfo is available for free download at <http://www.cdc.gov>.
- 3 Available online: [www.sarpn.org.29/Country poverty papers/South Africa/July 2002/woolard/pag3.php](http://www.sarpn.org.29/Country%20poverty%20papers/South%20Africa/July%202002/woolard/pag3.php), Accessed May 2003.
- 4 OR 1.98, 95% CI 1.75–2.23; 837/1,811 compared with 1,040/3,434.
- 5 Declared in the Gauteng Health Department Strategic Plan 2003–2006: Health for a Better Life, p7–10 distributed at the Gauteng Health Department Bosberaad 14 August 2003.
- 6 OR 2.0 95%CI 2.34–2.99; 171/3,871 compared with 32/1,417.

References

- ANDERSSON, N., MARTINEZ, E., CERRATO, F., MORALES, E. & LEDOGAR, R. (1989). The use of community based data in health planning in Mexico and Central America. *Health Policy and Planning*, 4(3), 197–206.
- Cornfield, J. (1956). A statistical problem arising from retrospective studies. In: J NEYMAN. (Ed), *Proceedings of the Third Berkeley Symposium*, IV (pp. 133–148). Berkeley: University of California Press.
- GOETZ, A. & GAVENTA, J. (2001). Bringing citizen voice and client focus into service delivery. *IDS Working Paper 138*. England. Institute of Development Studies, Brighton.
- KRUSKAL, W.H. & WALLIS, W.A. (1952). Use of ranks in one-criterion variance analysis. *Journal of American Statistical Association*, 47, 583–634.
- MANTEL, N. (1963). Chi-square tests with one degree of freedom: extensions of the Mantel Haenszel procedure. *Journal of the American Statistical Association*, 58, 690–700.
- MANTEL, N. & HAENSZEL, W. (1959). Statistical aspects of the analysis of data from retrospective studies of disease. *Journal of the National Cancer Institute*, 22, 719–748.
- NARAYAN, D., CHAMBERS, R., SHAH, M.K. & PETESCH, P. (2000). *Voices of the Poor: crying out for change*, Washington DC, World Bank.
- WOOLF, B. (1955). On estimating the relation between blood group and disease. *Ann. Hum. Genet.*, 19, 251–253.

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