

DEVELOPMENT AND EVALUATION OF

PSYCHOLOGICAL SERVICES FROM

EMPANGENI HOSPITAL

BY

DUMISANI R. NZIMA

2002

(i)

**DEVELOPMENT AND EVALUATION OF
PSYCHOLOGICAL SERVICES FROM
EMPANGENI HOSPITAL**

BY

DUMISANI R. NZIMA

2002

A thesis submitted in fulfillment of the requirements for the degree of PHD Community
Psychology in the Department of Psychology University of Zululand.

PROMOTER: PROF S.D. EDWARDS

JANUARY, 2002

(ii)

TABLE OF CONTENTS:

	PAGE
CHAPTER ONE: INTRODUCTION	
1.1 INTRODUCTION	1
1.2 A SHORT OVERVIEW	2
1.3 STATEMENT OF THE PROBLEM	3
1.4 MOTIVATION	5
1.5 DEFINITION OF KEY TERMS	7
1.5.1 Community psychology	7
1.5.2 Community participation and involvement	9
1.5.3 Community development	11
1.5.4 Health promotion	12
1.6 PURPOSE OF THE STUDY	13
1.7 VALUE OF THE STUDY	14
1.8 RESUME	14
CHAPTER TWO: LITERATURE REVIEW	
2.1 INTRODUCTION	16
2.2 EMPANGENI HOSPITAL CRISIS CENTRE UNIT (CCU)	17

	(iii)	PAGE
2.3	THE CCUs HEALTH CARE TEAM: PERSONAL REFLECTION	20
2.3.1	Advantages of a team approach to health care delivery	23
2.3.2	Barriers to effective team work	24
2.4	SHIFTING THE FOCUS FROM THE CLINICAL TO COMMUNITY-BASED MODEL OF INTERVENTION	26
2.4.1	Reconstructing the attitude of a community	27
2.5	DEFINITION AND MEASUREMENT OF POVERTY	29
2.5.1	Theories on the causation of poverty	30
2.5.2	Anti-poverty action	34
2.6	COMMUNITY EMPOWERMENT	34
2.7	COMMUNITY PARTICIPATION IN THE PREVENTION OF DISEASE AND THE PROMOTION OF HEALTH	36
2.7.1	Different interpretations of the concept of community Participation in health promotion	37
2.7.2	Reasons for emphasizing community participation	39
2.8	THE SIGNIFICANCE OF COMMUNITY DEVELOPEMENT IN SOUTH AFRICA	40
2.9	GOVERNMENT INITIATIVE TO HELP ALLEVIATE POVERTY	43

2.10	CHARACTERISTICS OF A COMMUNITY DEVELOPMENT PROJECT	44
2.11	SOME GUIDELINES FOR STARTING A COMMUNITY DEVELOPMENT PROJECT	45
2.11.1	Clarity about who the community is	45
2.11.2	Working with the community, not for the community	46
2.11.3	Knowledge and skills needed for community development	47
2.11.3.1	Knowledge	48
2.11.3.2	Skills	48
2.12	RESUME	49

CHAPTER THREE: METHODOLOGY

3.1	INTRODUCTION	51
3.2	PARTICIPATORY ACTION RESEARCH	52
3.3	BEGINNING THE JOURNEY FOR A POSITIVE CHANGE	54
3.3.1	Phase I : Request for assistance	54
3.3.2	Phase II: Negotiation	56
3.3.3	Phase III: Planning	57
3.3.4	Phase IV: Implementation and monitoring of the projects	58

	(v)	PAGE
3.4	FURTHER TRAINING OF CO-RESEARCHERS ON VARIOUS PARTICIPATORY ACTION RESEARCH METHODS	59
3.5	METHODOLOGICAL ISSUES IN PARTICIPATORY ACTION RESEARCH	61
3.5.1	A preference for qualitative methods	62
3.5.2	Dialogical encounter as data collection technique	63
3.6	OBJECTIVITY AND VALIDITY IN PARTICIPATORY ACTION RESEARCH	64
3.7	RESUMÉ	67

CHAPTER FOUR: EXPERIENCES OF CO-RESEARCHERS AS AGENTS OF CHANGE (RESULTS)

4.1	INTRODUCTION	69
4.2	BACKGROUND TO THE PROJECTS	69
4.3	COMMUNITY DEVELOPMENT PROJECTS	77
4.3.1	Hlanganani Sewing Club	77
4.3.1.1	Communal spirituality with all club members	81
4.3.1.2	Recurrent themes from narratives	87
4.3.1.3	Theme verification	88
4.3.2	Zamani Community Garden	89

(vi)	PAGE
4.3.2.1 Problems encountered	90
4.3.2.2 Solutions sought for the sustainability of the project	90
4.3.2.3 Recurrent themes in the stories	95
4.3.3 School health education programme	96
4.4 RESUMÉ	97

CHAPTER FIVE : CONCLUSION

5.1 INTRODUCTION	99
5.2 THE GOALS OF EMPOWERMENT	99
5.2.1 Conscientization	100
5.2.2 Emancipation	101
5.2.3 Learning	101
5.2.4 Generating autonomy	102
5.3 HEALTH PROMOTION AND HEALTH EDUCATION	103
5.4 MAJOR CHALLENGES FACED BY CO-RESEARCHERS IN LOCAL COMMUNITIES	104
5.5 THE IMPACT OF RECONSTRUCTIONIST THEORY ON COMMUNITY DEVELOPMENT	105
5.6 CONCLUSION	107
REFERENCES	109

LIST OF TABLES

Table 2.1	:	Referral network between multidisciplinary team at Empangeni hospital crisis center unit	18
Table 2.2	:	Records of clients intake at Empangeni hospital for the period 1999, 2000 and 2001.	20
Table 2.3.1	:	Cycle of deprivation	32
Table 2.4	:	Cycle of inequality	33
Table 2.5	:	The illness/wellness continuum	41
Table 3.1	:	Action research: this repeated cycle of research and action, with neither possible without the other, produced a process of ongoing learning and empowerment for all the participants in the study.	53
Table 3.2	:	Participatory action research contract between different research project participants	57
Table 3.3	:	Qualitative and quantitative research methodologies	62
Table 3.4	:	Qualitative and quantitative notions of objectivity	65
Table 4.1	:	Dates for meetings and activities performed in each meeting	70

Table 4.2	:	Personal profile for each woman who participated in Hlanganani Sewing Club	79
Table 4.3	:	Zamani Community project evaluation by co- researchers	91

(ix)

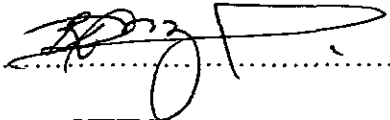
APPENDICES

- APPENDIX A** : Fund raising proposal for Zamani
Community Garden project
- APPENDIX B** : A copy of fund raising proposal for
Isibani Sempilo Traditional Healing
Centre.
- APPENDIX C** : Evaluation questionnaire

(x)

DECLARATION

I hereby declare that this thesis is my own work and does not incorporate, without acknowledgement, any material previously submitted for a degree in any university or other educational institution – nor does it contain, to the best of my knowledge and belief, any material previously published or written by another person except where proper referencing is made in the text.

A handwritten signature in black ink, appearing to read 'D.R. Nzima', is written over a horizontal dotted line.

D.R. NZIMA

JANUARY, 2002

ACKNOWLEDGEMENTS

Grateful acknowledgements are extended to:

My promoter Prof S.D. Edwards whose critical responses were always helpful and illuminating.

Mrs Avril Bishop who, with endless patience, typed the manuscript.

The National Research Foundation for a Team Research Grant for Community Psychology in Zululand.

Friends and colleagues in the Psychology Department at the University of Zululand for advice and support.

My family whose understanding, care and support enabled me to complete my studies.

ABSTRACT

From the beginning community psychology was concerned with social change, particularly in those systems of society where psychologists were active participants in the process of community empowerment. This study was an on-going attempt of community psychology to give psychology away to the people, especially those who were under-privileged.

The study emphasized community participation/involvement in the projects which were formed to assist the poor local communities of Empangeni in the fight against poverty.

The specific aims of the study were, among other things, the:

- * identification and optimization of local expertise within disadvantaged communities visited by co-researchers.
- * sharing of information and knowledge, through co-researchers, on the prevention of illness and the promotion of health.

Participatory action research was used as it allowed all participants (professionals and non-professionals) to have equal partnership in the process of knowledge and information exchange.

What emerged from the study was that community development projects could play a significant role in uplifting the standard of living of the poor people. Moreover, ensuring effective community participation was a daunting task which necessitated patience and understanding among all those who were involved. It appeared that if community participation was to contribute towards achieving community empowerment, it should be approached holistically, recognizing the complexity of the community, and at the same time respecting its culture and uniqueness. Communal spirituality and intentionality, as opposed to individualism, were significant in restoring a sense of universality and belongingness to the group. These ideals instilled in each individual member of the group a sense of power, hope and self-reliance which they all needed for the sustainability of the community development projects.

CHAPTER 1 : INTRODUCTION

‘Where shall I begin, please your Majesty?’

he asked. ‘Begin at the beginning,’ the King

said, gravely “and go on till you come to

the end : then stop.’

Lewis Carroll – Alice in Wonderland

1.1 INTRODUCTION

This chapter introduces and contextualizes the research in terms of a narrative around the main theme, community psychology and its community setting around Empangeni hospital, Zululand. It begins by looking at the background history of community psychology movement and how it has impacted on the field of community psychology as a science, and as it is practised today. The study used participatory action research in the process of empowering the poorest and disadvantaged rural communities to have control over their own local resources.

Drawing heavily from Paul Frere’s theory of reconstructionism, the study concludes by looking at the significant role played by small scale projects in encouraging the historically disadvantaged communities to identify and optimise the use of local resources in their own self development.

1.2 A SHORT OVERVIEW

The emergence of community health movement in the United States in the mid 1960's had a great impact on the future role and status of community psychology as a science. In his address to the Congress in 1963, President John F. Kennedy announced a bold, new approach to the care of the mentally ill (Levine & Perkins, 1997). He advocated reducing the number of mental hospitals and reintegrating the mentally ill into the community. He also called for the prevention of illness and the promotion of mental health. This meant, among other things, that the process of deinstitutionalization, that is; the transfer of treatment of mental disabilities from inpatient mental institutions to community-based facilities that stress outpatient care, was to be given a priority.

Large numbers of people could be released from mental institutions and treated in community-based centres (Lamb, 1998). The community psychology movement was, and still is, an attempt to take psychology to the people, especially to help historically, economically and socially disadvantaged communities help themselves through improved social welfare, education, health, networking and development of projects (Orford, 1992; Edwards, 1999). The philosophy of community-based services include training teachers, ministers of religion, family physicians, *indunas* and counsellors who directly interact with community members to offer lay counselling and various workshops such as assertiveness training or coping with stress. This approach helps to optimise local resources, resolve inequalities of the past and improve relationships between and within communities. In this way more people receive help in settings

where they are more likely to be comfortable (Orford, 1992) than in traditional mental health centres.

1.3 STATEMENT OF THE PROBLEM

The recent political changes which took place in South Africa highlighted the need to transform many factors influencing the health and well being of South Africans. As of 1994, the health sector has undergone major changes and restructuring in an attempt to address the many inadequacies in health care provision that exist as a result of apartheid policies and their consequences (Dennill, King, Lock & Swanepoel, 1995).

The importance of community involvement and partnership or intersectoral collaboration in health promotion, to meet the World Health Organization strategy of 'health for all', cannot be overemphasized especially in a developing country like South Africa. As indicated earlier, the community psychology movement evolved as a direct response to the inaccessibility of the clinical model to the great majority of underdeveloped and poverty-stricken people. The movement aimed to address this problem by developing a system whereby communities would be helped to help themselves through knowledge and information sharing, needs analyses resources identification and action that could be taken to address those needs.

The Ottawa Charter identified strengthening community action as one of the key areas of health promotion (Dennill et. al., 1995). In the Charter participation and involvement

of community members are recurrent themes. The Charter stresses the collective and active involvement of people in issues which affect their lives. It is concerned with issues of powerlessness and disadvantage and it is no accident that community development projects were not set up in affluent residential areas. The process is concerned with the empowering and enabling of those who are traditionally or historically deprived of power and control over their common affairs. Lee Adams (Cox & Findlay, 1990, p.6) has distinguished the following main features of a community development approach to health.

- A whole person, holistic approach is emphasized in contrast to depersonalised topics, diseases or parts of the body.
- It is something done with people, not to them. The members of the group or community are involved at all stages.
- The public are encouraged to identify their own needs rather than receiving a professionally prescribed list of priorities. Problems are seen to be interrelated *not* compartmentalized into 'health,' 'housing' and 'education.'
- The outcomes of such approaches are to a certain extent unpredictable and this has important implications for evaluation.
- Lay understanding is emphasized in contrast to professional mystification.
- More emphasis is placed on issues common to many members of a community rather than concentrating upon individuals and their problems in isolation.

- It seeks to achieve greater participation by communities in their own health and health care delivery.

The principles of community empowerment and participation were initially emphasized in the Alma Ata Declaration, upon which the Ottawa Charter builds (Coulson, Goldstein & Ntuli, 1998; Jones & Sidell, 1997) as basic principles in any attempt at health promotion. The present study tries to apply these fundamental community psychological principles by means of community-focused intervention programmes to the disadvantaged communities around Empangeni region.

1.4 MOTIVATION FOR THE STUDY

This thesis was founded upon a story of community psychology which was introduced, through the University of Zululand to the Empangeni Hospital. The programme started in 1993 and before this time there were absolutely no organized psychological services offered at this hospital. Today it has become a nexus for various other health centres inside and outside Region-H of KwaZulu-Natal province of South Africa. Some of the health centres that receive psychological help from this hospital include Manguzi Hospital (situated approximately 300 km north of Empangeni – that is, near the border between South Africa and Mozambique), Benedictine Hospital (some 180 km also north of Empangeni), Nkandla Hospital (some 150 km in the west of Empangeni), Mseleni, Mosvold, Bethesda, Hlabisa Hospitals, Zululand Mental Health Society and other welfare agencies in the region.

Individuals from rural and urban settings came to Empangeni Hospital Crisis Centre for psychological services such as educational and emotional assessment, family and couple, trauma, HIV/AIDS counselling, grief, stress, anxiety and depression therapy. Here it was realized that problems presented by these individuals to the centre were just a tip of the iceberg, especially in view of the fact that modern professional health services are generally inaccessible to the majority of the population in this country. Some of the reasons for this problem are that these services are costly and individually oriented in their approach, the number of trained specialists is limited, and they are mainly found in urban locality.

In 1999 the Health Professions Council of South Africa (HPCSA) had in their records only 4889 psychologists, 10 307 social workers, 30 091 medical doctors, 173 703 nurses registered and who were to serve over 40 millions people of South Africa (Edwards, 1999a).

- 250 000 traditional healers
- +\- 1 million African Independent Churches
- There are approximately 10 million AIC members in South Africa today (Oosthuizen, 1999).

In South Africa problems such as those mentioned above are further compounded by the legacy of Apartheid which has created many imbalances in the communities

resulting in sequelae such as unemployment, poverty, crime, violence, corruption and related ongoing psychological trauma. Ideally, an opportunity to present a community rather than a clinical model to health care provision was envisaged. This meant identifying and optimising existing community resources within and between various community settings around Empangeni.

1.5 DEFINITION OF KEY TERMS

1.5.1 Community psychology

Definitions of community are many and varied. Some definitions are functional in their orientation. For example Warren (1963, p.9) describes community as "...that combination of social units and systems which performs the major social functions having locality relevance" and again as "...a complex interrelated structure of interaction patterns, on the basis of which certain locality relevant functions are performed." Wigley and Cook (1975, p.4) also define community functionally as "...wherever the needs of the individual are being met." Other definitions relate to locale as the basis for community. For instance Cohn and Tingle (1974, p.2) state that "community is a defined geographical area characterized by social, cultural and environmental factors." While Spradley (1981, p.5) defines it as "...a collection of people who share some important feature of their lives."

Despite the diversity of definitions of the concept of community, analysis of the examples given reveals that there are certain elements that all of the definitions have in common. Such common elements include:

- public interest as opposed to private or special interests,
- some kind of bond between individual members, and
- some type of human interaction

In this study the concept of community is used to refer to a group of people who live in a particular area and who have shared values, cultural patterns and social problems as well as a group awareness which facilitates the residents interacting more intensely with each other than they would with outsiders.

Man has formed aggregates, or groups, called communities because it is in his interest to do so. Through the agency of the group, man can gain access to more of the skills, services, necessities, and amenities of life than he is capable of providing for himself as an individual. In order for the community to continue to provide these services, it must safeguard its survival. For this reason the concept of community must include an orientation to group rather than individual goals. Individual interests are not always in the common good. The concept of community therefore, includes the idea of collective action in regard to common concerns.

Community psychology evolved from two almost paradoxical concepts, namely; community and psychology (Rappaport, 1977, p.1). Broadly defined psychology refers to a study of human behaviour (individual or in groups) as well as mental processes.

Community psychology is therefore interested in social change (Rappaport, 1977; Mann, 1978), particularly in those systems of society where professionals (psychologists) and non-professionals are active participants. Change in society involves relationships among its component parts, encompassing those of individuals to social systems such as schools, hospitals and courts as well as to other individuals. Change toward a maximally equitable distribution of psychological as well as material resources is sought. The goal is clearly an expression of a set of values that follows from the perspective of cultural relativity, support for diversity, and an ecological view of man. The process is open-minded, however, for the goal can never be completely accomplished and social change will always be necessary (Rappaport, 1977; Woelk, 1992).

1.5.2 Community participation and involvement

Community involvement for health promotion is understood to refer to “a process to establish partnership between mental health professionals and local communities in the joint planning, implementation, evaluation and use of local resources in order to increase communities’ self-reliance and control over health care” (Dennill et. al., 1995, p.58). Community involvement means therefore that local people, who have both the

right and duty to participate in solving their own problems, have greater responsibilities in assessing health needs, mobilising local resources and suggesting new solutions, as well as creating and maintaining local organizations. In this study community involvement or participation are used interchangeably to refer to the mechanism in which the community is acknowledged as a partner in the process of achieving optimal health for all.

In one of the Empangeni workshop meetings, where all participants were involved, the idea came out that community participation was a process of empowerment of communities through enhancement of people's own capacities to improve their own lives and to take control over their own destinies. This was an important point with reference to the need to allow the community to be part of the decision-making process. Ideally, only once the community has the right and opportunity to participate in the actual decision-making processes which affect health care, will community participation be truly democratic. This approach is supported by the view of Shisana and Versfeld (1993, p.6) who describe effective community participation in terms of successful power sharing. They also express the opinion that community partnership involves a negotiated relationship in which both service and community organizations accept responsibility to perform tasks that have been agreed upon to enable the community to achieve its objectives.

The various interpretations of community participation can be summarized as follows:

- people's involvement in decision – making processes
- their involvement in implementing programmes and decisions by contributing various resources or co-operation in specific organizations or activities
- their sharing in the benefits of development programmes
- their involvement in efforts to evaluate such programmes

The present study was carried out with co-researchers bearing in mind that for community participation to be effective, it must acknowledge the importance of power sharing, allow community involvement in decision-making processes and assist each community in its development.

1.5.3 Community development

Community development involves local empowerment through “organized groups of people acting collectively to control decisions, projects, programmes and policies that affect them as a community” (Coulson et. al., 1998, p.133). The implication here is that *community participation (or involvement)* is a vital part of community development. It can be argued that community development is a natural result of community participation.

It is also true that any attempt at establishing community development must include the development of the people, which means that the community, by participating in the

efforts, plays an active part in its own development. Democratization of the management of development programmes (Shisana & Versfeld, 1993, p.5) is ensured through involvement of the community.

In this study community development was about change at a local level. It was about empowerment and therefore a process by which a community:

- identified and prioritised its needs and objectives,
- found the resources (internal and/or external) to deal with these needs and objectives,
- took action in respect to them and in so doing,
- extended and developed co-operative and collaborative attitudes and practices in the community.

1.5.4 Health promotion

When beginning to think about health promotion, we need to start by answering the question: What is health? This is because health is the most precious resource that human kind has. Healthy societies and healthy communities will foster healthy individuals and families, enabling societies and individuals to reach their full creative human potential. The World Health Organization (WHO) defines health as “a state of physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). This definition is important because firstly it encourages a

holistic understanding of health and also implies that a person's physical and emotional health is interrelated with the environment in which he or she lives or works. Secondly it regards health as something positive, an asset, rather than as an absence of ill health. The Ottawa Charter (1986) defines health promotion as:

‘... a process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a source for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well being.’

In this study health promotion strategies and programmes were adapted to the local needs and possibilities of individual communities, taking into account differing social, cultural and economic circumstances of each community.

1.6 PURPOSES OF THE STUDY

The general purpose of this research was to develop and evaluate community psychology programme initiated from Empangeni hospital. This purpose can be impacted as follows:

- Identification and optimisation of resources within communities visited by co-researchers.
- The sharing of information and skills, through co-researchers, on the prevention of illness and promotion of individual and community health.
- The evaluation of this process using various methodologies such as participant, or direct systematic observation.

1.7 VALUE OF THE STUDY

This study is an ongoing attempt of the community psychology movement to “give psychology away” to the people (Rappaport, 1977). The knowledge and skills shared among professionals and non-professionals, the latter of which are usually community leaders, help communities to help themselves through mutual-aid groups. Therefore, the study tried to reiterate the central tenet of community psychology; namely, intervention at a community rather than individual level, and emphasizing prevention and promotion rather than cure.

1.8 RESUMÉ

This chapter has provided an overview on the background and development of community psychology movement and its attempts to give psychology away to the people. It has introduced and contextualized the study which took place in the rural

community settings of Empangeni. Community participation (or involvement) in any attempts by health care workers to empower the disadvantaged poor communities optimise the use of local expertise in their own self development was emphasized. This is important because empowerment as a dynamic process involves a situation whereby community members come together to share and discuss their problems and need, prioritise them and find possible solutions which they then plan, implement and assess through continuous monitoring, dialogue and evaluation based on their objectives.

CHAPTER 2 - LITERATURE REVIEW

Health promotion works through effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities and the ownership and control of their own endeavours and destiny (WHO, 1986).

2.1 INTRODUCTION

In the previous chapter the concepts of community participation or involvement, empowerment, prevention of illness and health promotion – which are central in community psychology intervention programmes were defined. This chapter presents a theoretical framework which underpins the theory and practice of community psychology with specific reference to the intervention programmes which were started in two different local communities, namely: Macekane reserve and Kwa Mbonambi area, near Empangeni. As indicated earlier, the idea of introducing a community-oriented rather than an institution-based (or clinical) model as an option to psychological service delivery was born out of my experience working of eight hours a week sessional work at Empangeni hospital's crisis centre unit (CCU). Firstly, a bird's

eye view of how the centre operated is necessary to give the reader a feel of how team-members interacted with one another with regard to client/patient care.

2.2 EMPANGENI HOSPITAL CRISIS CENTRE UNIT

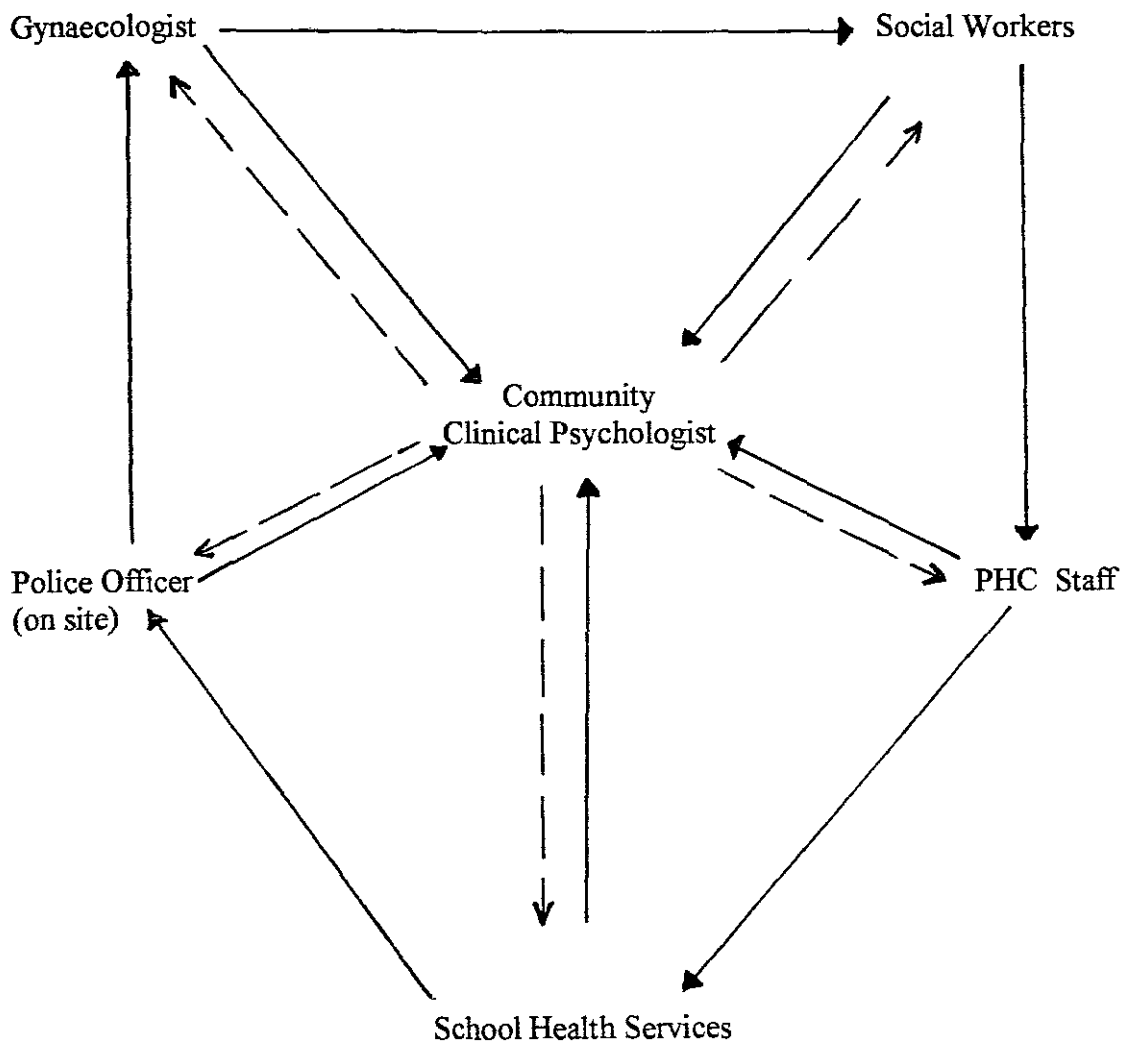
The CCU was introduced to Empangeni hospital in 1998 and was housed in the primary health care (PHC) building of the hospital. Its main objective was, among other things, to attend to all child and women abuse problems which were reported from the surrounding communities of Empangeni. The coming of a psychologist in 1999 as a supervised intern extended the scope of service delivery at the centre. It consisted of a social worker, a female police officer from the child protection unit (CPU), the primary health care staff, the school health services staff, a gynaecologist who operated mainly in the ward and a psychologist. As of 1994 Empangeni Hospital has dealt mainly with female problems such as obstetrics and gynaecology and other general medical conditions are treated at Ngwelezane Hospital. Referral network in this regard was paramount as some clients would rotate from one professional to the other, depending on the nature of the presenting problem. This can be represented diagrammatically as follows:

Table 2.1: Referral network between multidisciplinary team at Empangeni Hospital

Crisis Centre Unit.

KEY: → Main referral route

--- Feedback Route (if necessary)



In the above scenario, the community clinical psychologist played a pivotal role in the health care delivery system as part of the multidisciplinary intervention team. The clients who included children, youth and adults were referred to the psychologist by different team members. For instance a young girl reported to have been sexually molested was first interviewed by the police officer who, after taking the statement, escorted the victim to the gynaecologist for physical examination. Thereafter, the victim would be taken to a social worker for counselling and empowerment and to determine her family circumstances. The same client was referred to a psychologist to work on the cognitive and emotional aspects to help train her on assertiveness skills and so on. Similarly, school health nurses might identify a child at school who was reported by teachers to have repeated a grade several times without any signs of improvement. He would be referred to the CCU for psychological assessment to ascertain whether repeated failures were due to learning difficulties or mental retardation. Feedback would then be given to desperate parents, or to the referral source if parents were unable to return as many of them came from economically disadvantaged backgrounds. They could not afford even the bus/taxi fare. Most children who were seen at the centre presented with poverty – related conditions which in turn affected their learning capabilities at home and school. Owing to this multidisciplinary approach to health care service delivery, the following cases were seen for psychological services in the past three years:

Table 2.2 : Records of client intake at Empangeni hospital for the period 1999, 2000 and 2001.

		1999	2000	2001	TOTAL
1.	Childhood assessment for learning difficulties/mental retardation	47	51	66	164
2.	Pervasive developmental disorders; ADHD; etc.	12	20	31	63
3.	Youth counselling -- behavioural problems	18	23	34	75
4.	Child sexual assault	11	19	37	67
5.	Couple/Family therapy	13	15	20	48
6.	Other psychological disorders, e.g. depression, grief counselling, anxiety, etc.	52	248	319	619
	TOTAL	153	376	507	1036

2.3 THE CCU's HEALTH CARE TEAM: PERSONAL REFLECTIONS

Research evidence revealed that more and more frequently, health care delivery in the community was being accomplished with greater success through a team approach (Clarke, 1984; Thwala, 2001). Teams of health professionals and non-professionals functioned together in a joint effort to meet the health needs of a community. At the crisis centre regular meetings on certain Fridays of each month were held where cases

would be discussed and knowledge shared amongst professionals. In this way the members of the team utilized the knowledge and expertise of each to provide more effective health care to clients at all levels.

Brill (1976) maintain that a team is not merely a collection of people who work toward a solution to client problems. Many clients (individuals, families and communities) receive services from a variety of health care providers as shown in Table 2.1.

The providers working with the particular client do not necessarily constitute a team. His argument is based on the fact that each health professional may be dealing with the client on a one-to-one basis without any attempt at coordination of the services provided. He defines a health care team as “a group of people each of whom possesses particular expertise; each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to communicate, collaborate and consolidate knowledge, from which plans are made, actions determined and future decisions influenced” (Brill, 1976, p.22).

Teams have been classified on the basis of membership (Bloom & Parad, 1976), decision-making processes (Mailick & Jordan, 1977). Leadership styles (Brill, 1976) and focus of care (Vaun, 1975).

The most useful of these classifications for the team work at the centre were the first two. Bloom and Parad (1976) described three categories of teams based on membership.

The **unidisciplinary team** consists of members of a single discipline. An example of a unidisciplinary team was the nursing team. Members of this team would include community health nurses, school health nurses and other registered nurses. The second category of team described by Bloom and Parad (1976) is the multidisciplinary team in which members of different disciplines coexist and interact informally when a particular situation causes their individual practices to converge. The interdisciplinary team, on the other hand, consists of members of various disciplines who interact meaningfully through a formal arrangement for the purpose of maximizing the effectiveness of the health care provided.

Mailick and Jordan (1977) maintain that any of several team types or models may be appropriate in a particular setting. The models described are the **authoritative**, **consensus** and **matrix** models. In the authoritative model one member directs the team activity. This means member roles are well defined and involve a high level of expertise in specialized areas. Communication between members is limited as each performs a well-defined task. The implication here is that decisions are made by the leader and carried out by the team. This type of model was, however, not applicable to our team at the crisis centre.

The consensus model provides a team that works collaboratively with a more egalitarian framework. At a knowledge-sharing meeting with a team of nurses, they mentioned that in their case no one team member is the acknowledged leader and decisions are made conjointly by team members utilizing a problem-solving approach. In the matrix model

those team members with the expertise required by the situation and on hand interact to solve the current problem. Team composition and member participation will fluctuate from time to time based on current client needs. In this study a programme planning committee or team of researchers as discussed in Chapter 3 might be an example of a team based on the consensus model. The way in which the crisis centre team functioned was a good example of a matrix model. The police official, social worker, nurse and a psychologist dealt most effectively with problems of one client.

2.3.1 Advantages of a team approach to health care delivery

One of the major advantages to teamwork at the centre was its focus on the needs of the total client rather than on segmented aspects of the whole. Team effort also provided an opportunity for relatively more efficient use of the special expertise of team members. *Thus it resulted in more comprehensive and better integrated services than would be done - individual or parallel practice.*

Because the team approach provided for more efficient use of expertise, the individual members produced more meaningful work and relatively enjoyed greater job satisfaction. According to Brill (1976) this can lead to self-actualization and growth of the individuals as group members and of the group as a collectivity. For instance when the school health nurses could rely on the psychologist for intellectual assessment of a child identified as showing poor progress at school, they could then engage in activities more meaningful to them such as immunization and health education to school children.

Through regular meetings that we had on certain Fridays of the month, the team provided a forum for discussion of ideas from differing points of view and resulted in a learning experience for team members. In this way duplication, fragmentation and gaps were avoided. Changes were also noticed in some individual members' attitudes toward the client on the basis of insights from other team members.

Perhaps the most significant advantage to a team approach was expressed by Bloom and Parad (1976, p.670), "... the outcome of ... a well functioning interdisciplinary team effort can be significantly greater than the cumulative effects of the discrete performance of individual practitioners." In other words health care providers can accomplish more through a team effort than they can operate in isolation.

2.3.2 Barriers to effective teamwork

A group of people with a common goal and purpose does not necessarily constitute a team. There are many factors that may act as barriers to their ability to work as a team. My observation was that the main barrier to our effective service delivery had to do with the mode of communication. For instance other team members used medical codes (or jargon) in their referral letters which was difficult for others to read. Clark (1984) pointed out the need for a common language to be used by all disciplines on the team and suggested the use of the problem-oriented record as a vehicle for that commonality. In the early seventies, Pluckham (1972) described a significant barrier in her discussion of professional territoriality. She maintained that human beings, like animals, lay claim

to territory that they defend assiduously. This territory may encompass physical space, rights and privileges, or a professional role. Stanhope and Lancaster (1988m p.75) stated the issue quite aptly:

“ Every profession is to some degree surrounded by a zone of ambiguity – the trouble with this zone of ambiguity is not that it is a no man’s land, but that it seems to be everyman’s land. And sometimes this leads to undeclared war between adjacent occupations.”

Other barriers mentioned by many authors (Bloom & Parad, 1976; Mc Cally, Sorem & Silverman, 1977; Mailick & Jordon, 1977; Given & Simmons, 1977; Mazir, Beeston & Yerxa, 1979), which were not necessarily common amongst members of our team are:

- lack of knowledge on the part of team members regarding the abilities and expertise of other members
- lack of education for skills necessary for team interaction
- differences between health professionals in terms of orientation to time, styles of interpersonal interaction, methods of organization, knowledge base and value systems
- concepts of authority, power, status and autonomy
- personal characteristics of each member of a team.

2.4 SHIFTING THE FOCUS FROM THE CLINICAL TO COMMUNITY-BASED MODEL OF INTERVENTION

As indicated in the previous paragraphs, much of the intervention work which involved team members was carried out in the institution. The school health services and the community health nurses would on certain days of the week visit their service points, identify and refer those clients they could not help to the institution for further intervention. In particular many clients who were referred for psychological services were children presenting with a variety of childhood and adolescent problems. Many of them came from rural areas presenting more with learning difficulties than mental retardation, probably due to high rate of poverty.

Collateral information from the accompanying parent would reveal, among other things, that there were more than five children in the family, parents were unemployed and older siblings did not get at least up to matric. In some instances a parent would give negative details about the child, like underdeveloped speech and low intellectual capability. The idea behind would probably to present a very bad picture about the child so as to influence a psychologist to recommend a disability grant. However, assessment results would not confirm the statements by parent. When given feedback parents would not be happy because the results never promised any income for the family.

It was realized that poverty, unemployment and powerlessness were among the factors which contributed to poor conditions in the rural families. I felt that cases which came to the centre represented just a tip of the iceberg. This marked the beginning of a series of meetings with community health nurses, school health services staff and a social worker in which training in community psychological principles as outlined by Orford (1992) was conducted. The aim was to reach out to the communities and help them to help themselves through the identification and optimal utilization of the local resources. Of course, this would remain a dream without the communities participation and involvement in projects which would be set up for their own benefit.

2.4.1 Reconstructing the attitude of a community

In the 1960's Paulo Freire, a Brazilian educationalist, radically changed the thinking of adult educators. He worked as a literacy teacher during a period of revolutionary change in Brazil (Abbott & McMahon, 1987; Rooth, 1995). He wanted to develop a method of teaching that would truly liberate the "oppressed" masses from a history of colonialism. Freire believed that for individuals to be truly liberated they needed to be given the tools to critically understand and take action about their own worlds. He felt the traditional model of education by means of lecturing was domesticating and filled people's heads with information that they were not necessarily able to use in their own empowerment (Werner, 1982).

Informed by the ideas of reconstructionist theory this study proposes that firstly, community is in need of constant reconstruction or change. Secondly such social change should involve both a reconstruction of the community's sense of powerlessness and helplessness and the use of educative forums in reconstructing a community. Reconstructionism advocate an attitude toward change that encourages individuals to try to make life better than it was or is. I believe that in our own age, particularly reconstructionism could strike a responsive card because we are faced today with a bewildering number of problems regarding race, poverty, crime, ecological destruction and technological inhumanity that call for an immediate reconstruction of all our existing religious and philosophical value systems. According to Gibbs & Fuery (1994), ideas and values that once seemed workable for family life and education, for example, no longer seem as viable as they once were.

Twenty-first century South African individuals seem bewildered not only by the changes that have already taken place, but also by the prospect of future changes that must be made if we are to cope adequately with these problems. However, it is important to note that the key to Freire's liberating approach to education was firstly to change the power relationship between the educator and learner. He believed the relationship must be equal (Werner, 1982; Coulson, Goldstein & Ntuli, 1998). His methodology included the use of pictures or photographs to represent to learners (children and adults alike) key activities or events in their own lives. In this study community members were treated as collaborators, as indicated in Chapter 3, in the process of empowering them.

2.5 DEFINITION AND MEASUREMENT OF POVERTY

According to Townsend (1979), poverty is a relative concept measured in terms of people's ability to sustain a basic life style in accordance with the norms and standards of their own society. Although world indicators of poverty exist (Allen & Thomas, 2000), most debates are about the relative positions of different groups within a particular society or across a range of countries with similar economic and social characteristics. The most common way of thinking about poverty is in terms of life and death, of not having enough nourishment, warmth or shelter to survive. One of the best known and influential definition of poverty has been 'subsistence,' which is defined as the level at which an individual or household has just enough income or resources to meet a minimum number of basic needs such as food, clothing and shelter (Booth, 1981; Rowntree, 1901).

Townsend (1979) challenged the subsistence approach and put forward the concept of relative poverty as 'relative deprivation' within a society. He sought to establish as far as possible an objective measure of poverty, a threshold below which families or groups in the population were clearly excluded, materially and socially, from the society in which they lived. He argued poverty can be defined objectively and applied consistently only in terms of the concept of relative deprivation.

“... individuals, families and groups in the population can be said to be in power when they lack the resources to obtain the types of diets, participate in the activities and have the living conditions and amenities which are customary, or are at least widely encouraged and approved, in the societies to which they belong. Their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities” (Townsend 1979, p.31).

The above definition augers well with the conditions under which rural communities which were targeted for development projects live. My observation was that in these communities people who lived below the bread-line were particularly older people, unemployed people, single-parent families, women and people with disabilities. Large and extended families were more at risk of poverty. Glendinning and Millar (1987) and Halonem and Santrok (1999) commented on the increasing visibility of women among those in poverty throughout the world and that there was some evidence that the ‘feminization of poverty’ had been increasing. This has significant implications on any attempts at the health promotion initiatives aimed at benefiting those poverty-stricken communities.

2.5.1 Theories on the causation of poverty

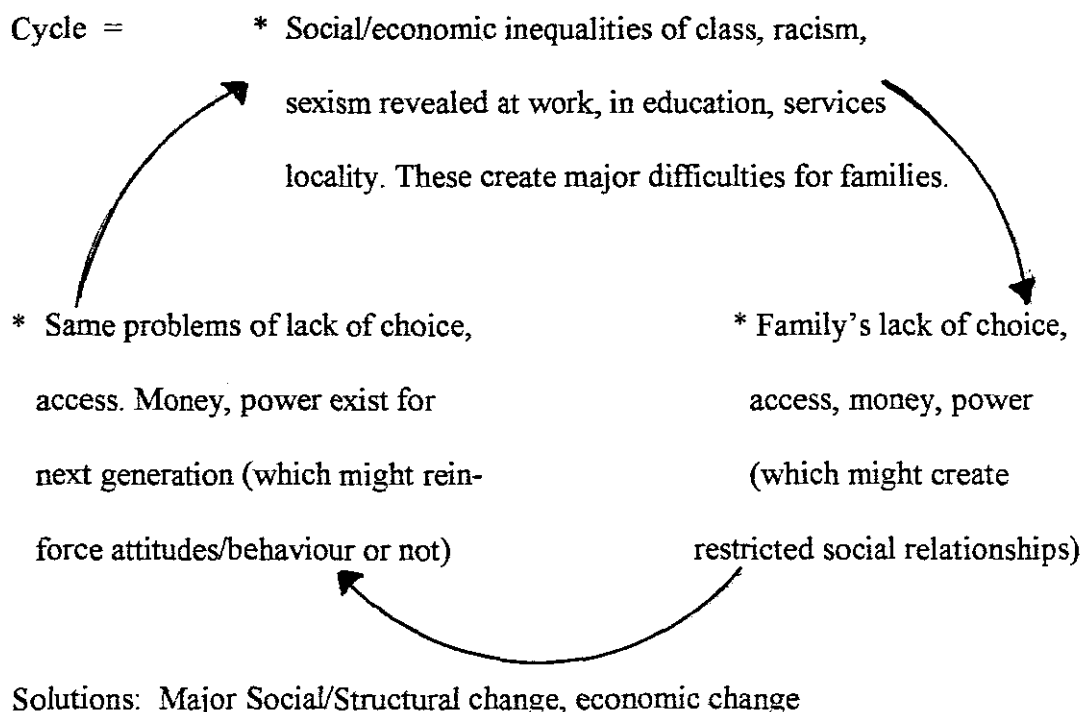
Watt and Rodmell (1988) and Watt (1996) state that special policy provides an analysis of poverty and a framework for understanding how health promotion might challenge

poverty and begin to improve health. This involves shifting from a pathogenic approach to health; that is, concentrating most efforts on care and treatment at an individual level. It also involves a shift from modifying individual or family behaviour. The pathogenic, behavioural focus can be seen as falling within an individualist theoretical framework (Jones 1994), drawing upon the cycle 'cycle of deprivation' model (Table 2.4). In other words it is the individual or family (or subculture) that is being targeted. Poverty and poverty – related ill health and lack of response to health education, is seen as largely generated within these subsystems, in dysfunctional families and communities. The practical steps taken are to modify and change behaviours by health advice and more effective education (Jones 1994).

However, if the causes of poverty are seen to lie in wider social and economic structures of inequality then the potential focus of health promotion is much broader. (Table 2.4). A cycle of inequality' explanation of poverty points to disparities of wealth and income within communities as a whole. Structural factors and a range of social divisions along the lines of class, race, gender, age and disability can be seen as playing a part in the course and continuation of poverty and ill-health.

Table 2.4: Cycle of inequality (Adapted from Jones, 1994)

Assumptions: Unequal society
Complexity of poverty
Structural problem



2.5.2 Anti-poverty action

In part, debates about poverty necessarily focus on influencing policy change at a national or international level (WHO, 1986, 1992). But at grass-roots level we realized that there was plenty of scope for action. Blackburn (1991, 1995) commented that when health services are flexible and responsive to people's needs they can help mitigate some of the effects of poverty, whereas insensitive or inappropriate services can make matters worse. She argued "putting a poverty component into health-needs assessments and information collection" can transform the priorities of a contract and the working of a *primary health care team*. *Hlanganani Sewing Club* and *Zamani Community Garden* which are two community development projects formed by communities of Kwambonambi and Macekana, respectively; as part of this study helped to encourage local people to work together to mitigate the effects of poverty for themselves. Although it was mainly women from the beginning who showed interest in participating in community development projects, unemployed men eventually became interested and joined in projects that would benefit their communities. Details of how each of these projects was formed are outlined in Chapter 3.

2.6 COMMUNITY EMPOWERMENT

Rappaport (1987, p.122) maintains that "empowerment refers to a mechanism by which people, organization and communities gain mastery over their affairs." His notion of empowerment intends to include both a psychological sense of personal control and

concern with actual social influence, political power, and legal rights. As Zimmerman (1990, p.5) summarized, "... psychological empowerment includes beliefs about one's competence and efficacy and willingness to become involved in activities to exert control in the social and political environment. Psychological empowerment is a construct that integrates perceptions of personal control with behaviours to exert control."

Although these definitions of empowerment include actual control and influence as part of the concept, in a great deal of research actual control is conflated with the sense of personal control. For example, in a study of the development of community leaders, Kieffer (1984) described the fundamental empowering transformation ... from sense of self as helpless victim to acceptance of self as assertive and efficacious citizen. Chavis and Wandersman (1990) warned that the individual's experience of power or powerlessness may be unrelated to actual ability to influence and an increase in the sense of empowerment does not always reflect on increase in actual power. Indeed, a sense of empowerment may be an illusion when so much of life is controlled by the politics and practices at a macro-level. However, this does not mean that individuals can have no influence or that individuals' perceptions are unimportant, but rather that to reduce power to individual psychology ignores the political and historical context in which people operate.

In this study the process of empowerment was carried out guided by ideas of Hollander and Offerman (1990, p.179) who distinguish **power over** (explicit or implicit

dominance) from **power to** (the opportunity to act more freely within some realms ... through power sharing) and **power from** (the ability to resist the power of others by effectively fending off their unwanted demands). The local community intervention programmes which were set up with co-researchers as participants and change agents aimed to increase the people's power act (Riger, 1993) for example, by enhancing their self-esteem and to affect their power over local resources such as land, knowledge and skills. This was done by encouraging community participation and involvement in all the programmes that were developed.

2.7 COMMUNITY PARTICIPATION IN THE PREVENTION OF DISEASE AND THE PROMOTION OF HEALTH

The concept of community participation was broadly defined in Chapter I. I feel it is important to realize that community participation in health promotion is far more than a basic requirement for the attainment of optimal health of a community. As a process of interaction between people to achieve specific goals, it not only gives them the right and opportunity to be involved in decisions that affect their future existence, but also ensures the successful development of the community as a whole. Thus local community intervention projects were developed with these intentions in mind.

2.7.1 Different interpretations of the concept of community participation in health promotion

Although community participation is generally accepted as a vital component of effective health care, the effectiveness and value of the concept have not always been viewed in the same way by all concerned. For instance Vuori (1984, p.331) maintains that not only are there different interpretations of the concept but that there is in fact “no agreement on who participates in what, and in spite of public lip service, the true attitudes may be hostile.” As was evident from the discussion (Subcommittee: primary health care: 1992), reflecting the commitment of the Departments of National Health, Social Welfare and Population Development and others towards the concept of community participation, there can be no doubt that community participation is a vital component of any attempt at achieving optimal health promotion. According to Rifkin and Cassels (1990, p.39), community participation can be interpreted in one of the following ways:

- compliance: people are motivated to accept interventions, or to act according to the advice of professionals
- contribution: the community supplements the contributions of professionals
- collaboration: the community participates in planning and introducing initiatives
- control of activities and resources by the community

The views most often expressed about the approach towards community participation can broadly be categorized as being community participation with hidden or open agendas. For instance there are those who believe that the state promotes community participation merely to co-opt to provide a service which it is unable or unwilling to provide itself (Robb, Ferrinho & Wilson, 1991). In such a view the promotion of community partnership is seen as oppressive and with various hidden agendas. Wilson, Robb, Ferrinho and Ntswanisi (1991) refer to the traditional description of community participation in primary health care as it relates to the extent to which community members give freely of their time, their labour and their money towards their health service. The authors describe poor rural people involved in building and running their own health centres and warn that not only is it the responsibility of governments to build health centre, but that the democratic rights of health workers who have their own needs and interests must not be confused with the democratic rights of the community. A more acceptable approach to community participation is one in which the community, as part of the multidisciplinary health care team, is involved in the planning, provision and control of all efforts aimed at promoting their health. Of course, community members should participate in identifying local health needs and priorities and should agree on the nature of their personal contribution towards solving their identified problems.

2.7.2 Reasons for emphasizing community participation

The advantages of community involvement in health promotion, as outlined by the WHO (1991, 1993), can be summarized as follows:

- Community involvement is a basic right of all people.
- Involvement in the decisions and actions affecting people's health builds up self-esteem and encourages a sense of responsibility.
- Through community involvement limited resources can be applied more appropriately to satisfy needs as identified by the local community and can complement and supplement formal health services.
- Community involvement in health promotion can help create political awareness, encouraging people to get involved in other areas of development of the community.

According to Sekgobela (1986, p.30), support for community participation in health activities is however not unanimous. She maintains that some people avoid involving the community on the basis of their alleged ignorance, while others are uncertain as to how or when the community should be involved. Nevertheless, she list the following advantages:

- Through community involvement the health care team can obtain first-hand information about local conditions and needs

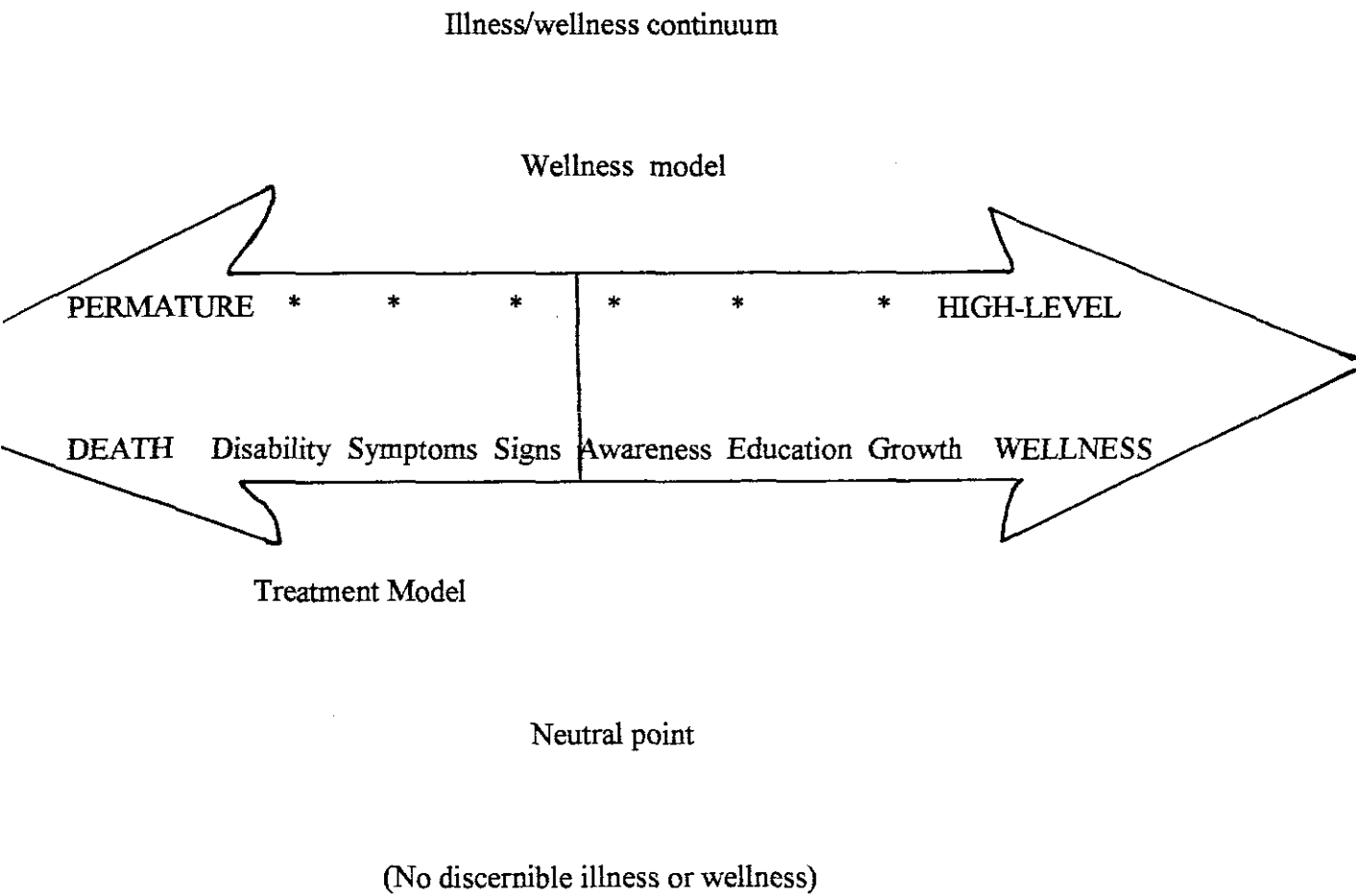
- Community members will be more committed to community projects if they are involved in the planning, preparation and maintenance of projects they consider important
- Community participation gives the community an opportunity to exercise its democratic right to be involved in its own development
- Through participation the community will become more self-reliant, self-sufficient, self-confident and independent

2.8 THE SIGNIFICANCE OF COMMUNITY DEVELOPMENT IN SOUTH AFRICA

Years of apartheid and systematic abuse of South Africa's population have left a legacy in which huge numbers of South African live and work (or are unemployed) in desolate conditions. Traditional patterns of living and working have been thoroughly undermined by unfair legislation. Enforced segregation and migrant labour have destroyed families and community networks. Happy and healthy communities need access to basic amenities (Case, 1995). They need to be in control of their lives and to feel that they can participate in decisions which affect the well-being of individuals and families in that community. Basic amenities are at least inadequate and often non-existent. As a result, the health and well being of many South Africa's communities, especially black South Africans, fell into a state of despair (Ibid).

Health is considered as an open and constantly changing process of experienced energy that ranges on a continuum. The continuum extends from an optimal wellness condition, with available energy at its maximum, to death which represents total energy depletion (Cookfair, 1991. p.169).

Table 2.5 : The Illness/wellness continuum



According to Rankin and Stallings (1990, p.129), health is energy as a result of system balance. This implies that the client (community, group, individual) as a system, constantly monitors itself by making adjustments as needed to attain and maintain stability for an optimal state of health. However it is a recent, popular notion that health and illness are viewed on a continuum (Webb, 1994). Health can still be achieved despite the existence of a chronic or life-threatening illness and illness is not inevitable even if certain factors are present within, or impinge upon, humans. Therefore concerted efforts, not only in the form of charities from the national or provincial government, but also in the form of local community development projects are necessary to restore the health and wellbeing of a community.

Statistics released by the National Household Survey of Health Inequalities in South Africa, undertaken by the Community Agency for Social Enquiry in 1995 found, among other things, that:

- Two-thirds of all rural households have incomes of less than R900 per month and nearly a quarter of them have incomes of less than R300 per month
- Twenty-three percent of rural families said they were too poor to feed their children properly
- Only 20% of these families have a tap inside their homes
- Sixteen percent of them have no toilet of any kind and nearly 60 % have no electricity (Case 1995, p.7).

2.9 GOVERNMENT INITIATIVE TO HELP ALLEVIATE POVERTY

When the Government of National Unity (GNU) was incepted in 1994, one of the first things it did was to create a national reconstruction and development programme (RDP). The government realized that if South Africa was to become a flourishing and healthy country then it needed to try to ensure that all its citizens had basic needs met. The RDP targeted large sections of the population which, for historical and political reasons, deserved special attention (Coulson et. al., 1998).

The country's poorest, most economically vulnerable communities were identified as being in need of land rights, proper housing, water and sanitation, schooling and health care. While a number of RDP projects still exist, it has become clear that the rapid improvement in living conditions among the poorest communities, which many had hoped for, will only materialize slowly. But what does exist is legislation in a number of areas relating to land, housing, water, schooling and other basic human needs which can be used for community development.

The limitations of the RDP mean that if communities are going to be developed, then it is mostly going to happen at a local level. Communities will have to work together, organise among themselves and where relevant make use of resources which the government has allocated for development. South African communities have a long and proud history of working together for change. One example is a group of farm workers in the North West Province who, instead of losing their jobs when the farm was to be

sold, got together and raised money to buy the farm. The farm is run collectively and is now starting to make a profit.

2.10 CHARACTERISTICS OF COMMUNITY DEVELOPMENT PROJECT

Ewles and Simmet (1996) list the following characteristics of a typical community development project.

- Ideally any community development project must be initiated by the community itself, rather than being a project initiated by outsiders
- The community must be in control of the planning and execution of the project. Community projects controlled by outsiders cannot really be called community development projects
- Control should be exercised by members of the community at all levels, in order that those whose voices are least often heard (women and children/youth) can be fully part of the project
- Clear structures for the running and management of the project must be identified. They must be understood and agreed upon by as many members of the community as possible
- Voices from as many stakeholders as possible must be heard and encouraged to participate actively
- The long-term goal for the project must be that the community will manage it

- The involvement of a community worker must focus upon facilitating the project and attempting to ensure that the above processes are in place.

2.11 SOME GUIDELINES FOR STARTING A COMMUNITY DEVELOPMENT PROJECT:

Rifkin (1990) and Smithies and Adams (1990) provide a framework for any health care worker who wish to start a community development project. The community projects which were developed for this study followed the recommendations made by these authors. These guidelines are that the worker should:

2.11.1 Clarity about who the community is

The fact that the worker should know very well the community for which the project is intended cannot be overemphasized. In South Africa communities seem to be defined most often on a geographical basis, for example, all the people living in an informal settlement, or everyone in one zone of a township. Communities, as was shown in Chapter 1, can also be defined according to age or gender. For instance projects may be directed toward a group of rural women, youth and disabled individuals. However, a community is defined (Sarrano-Garcia and Bond, 1994), it will be inevitable that for some individuals being part of that community is central to their definition of themselves, while for others membership of the community is more peripheral to their lives and interests.

2.11.2 Working with the community, not for the community

Smithies and Adams (1990) emphasize that there are three common ways of getting involved with community development projects, namely:

- Some members of the community may want to get a project off the ground and may seek help in doing so.
- A problem within the community may be so pressing that some sort of development project seems the only way to go about solving the problem. In this instance an outsider may take initiative together with the community to start a project like it happened with some projects we initiated to help local communities at Empangeni.
- There may already be projects under way which have been started but are not succeeding and one in need of help.

What I realized in our projects with participants was that whatever the reason for our initiative and involvement, it was necessary:

- To think inclusively so as to get as many different sections of the community to participate in the project as early as possible. This was time-consuming since in some instances there were key sections of the community which were reluctant to get involved. Therefore careful negotiation at this state to

bring these sections on board was crucial for the long-term sustainability of the project.

- To think critically and realistically. Some communities complained about lack of schools and clinics in their areas. Big projects such as these could be tempting, especially in needy communities, as it would be difficult to achieve their goals. O'Neill and Morgan (2001) suggest that it is more empowering for any community to successfully achieve a limited project than to fail in achieving a more ambitious one.
- To build team work so that the process of sharing knowledge and skills would become a reality. Working together would also facilitate future joint projects.
- To build in sustainability – of people, programme and funds. Developing the flexibility and resources so that the projects could continue to survive.

2.11.3 Knowledge and skills needed for community development

Sullivan, Campbell, Angelique, Eby and Davidson (1994) state that being an agent for community development requires good leadership skills, having the ability to be flexible, creative, sensitive and open. It also requires the knowledge and ability to help a community negotiate with bodies that hold resources that the community needs, such as local councils, NGO's and industry.

2.11.3.1 Knowledge

There are two main fields of knowledge which are needed. Firstly, a good knowledge of the community includes knowledge of:

- who the leaders are (civic and traditional)
- which organizations (churches, stokvels, community-based organizations) are working in the community
- which factions work well with one another and which factions are in conflict
- the demographic make up of the community
- what resources, especially health-related resources, exist for the community
- what health promoting activities (if any) are already in progress.

Secondly, knowledge about the project itself is important. For instance if the project is a women's empowerment project which aims to start a small business for women in the community, it will be important to have a basic understanding of how business operates to share with the community.

2.11.3.2 Skills

A wide range of skills such as negotiations was required in facilitating community projects. Sullivan et. al., (1994) maintain that central to negotiation skill will be:

- the ability to listen to everyone's point of view without being judgemental
- respecting everyone's point of view
- asking for solutions from the concerned parties rather than trying to impose outside solutions
- encouraging a climate in which all parties feel it is in their interest to both give and take.

Skills sharing empowered the disadvantaged communities and facilitated the continuity of the projects. Other skills include problem-solving, financial management, organisational skills, running meetings, and conflict resolution (Coulson et. al., 1998).

2.12 RESUMÉ

This chapter began by looking at the manner in which the Empangeni hospital's crisis centre operates. The type of professionals who work there as a team in patient health care was discussed. Details of how the paradigm shift from an institutional/clinical model to community empowerment – focused intervention were given. The discussion also centred around issues of community participation and empowerment in the process of alleviating poverty.

The urgency to develop community participation in programmes which aim to promote their own health can be summarized in the following statement made during the technical discussions at the 47th World Health Assembly in Geneva in May 1994:

“... the urgent need for community action for health promotion arises from a combination of factors. On the one hand, the community has gradually come to realize its need and responsibility to assume a greater share of the initiative for its own health care. On the other hand, there has been a growing awareness among health-care decision makers that without community action, much-needed behavioural changes will not occur and opportunities to prevent major causes of mortality and morbidity will be missed” (WHO, 1994, p.8).

The changing circumstances in South Africa and acknowledgement of the importance of affirmative action and the right of all people to be part of decision-making processes that affect their health and wellbeing, highlighted the urgency of eliminating all obstacles that could adversely affect the facilitation of community participation in health. Only when all members of the multidisciplinary intersectional health team acknowledge the community as an active, equal partner of the team, in a spirit of cooperation and acceptance, will the goal of optimal health for all become more than an unattainable dream.

CHAPTER 3 : METHODOLOGY

3.1 INTRODUCTION

'What is to be done ought not to be determined by reformers, be they poetic or legislative but by doing a long work of comings and goings, of exchanges, reflectors, trials, different analysis'

(Foucault, 1981)

The above quote from Foucault captures much of the impulse behind research concerned not just with analysis but to effect positive structural change. In his Thesis on **Feuerback**, Marx famously wrote:

*'Philosophers have interpreted the world,
(the point, however, is to change it.)*

This study was concerned not only with the identification and optimisation of local community resources. It also aimed to cascade information and skills, through co-researchers (as change agents), on the prevention of illness and promotion of individual and community health. A participatory action research methodological approach was used to exchange information between community members and co-researchers. The

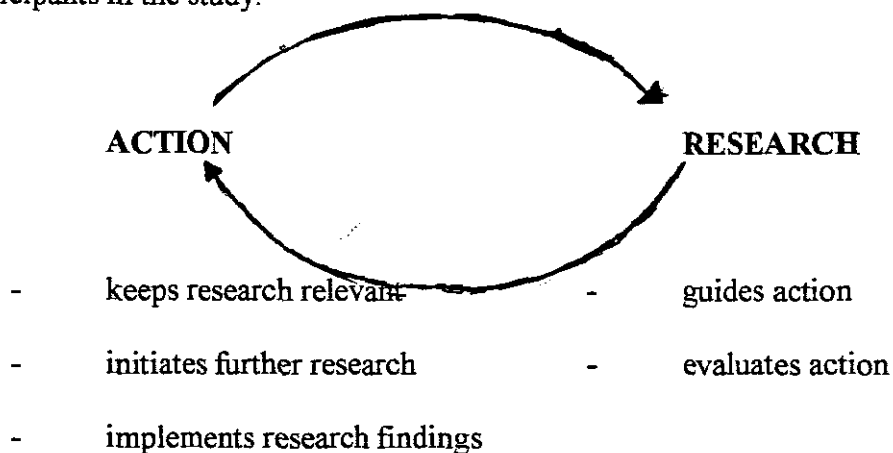
story of the participatory action research approach that used participant observation and narratives as methods of data collection and analysis is described in the following section.

3.2 PARTICIPATORY ACTION-RESEARCH APPROACH

Participatory action research is one of the most widely used research approaches that is characterized by both participation and action by the researcher. It is a commonly used approach to grassroots development interventions (Babbie & Mouton, 2001) and particularly valuable in underdeveloped rural settings where communities suffer the effects of poverty, lack of knowledge and skills, learned helplessness, and unequal sharing of resources (Bless & Higson-Smith, 1995).

In this study, co-researchers (a social worker, school health nurses and primary health care staff) worked with communities who were rural, underdeveloped, poor, socially and economically exploited and oppressed. Participatory action research emerged as part of the search to render developmental assistance which was more responsive to the needs and opinions of local people. This implied that co-researchers did not impose their own ideas on how the problems of local communities could be solved. Instead they listened, negotiated, planned and implemented programmes with the goal of every participant being able to share a sense of ownership. In this way the relationship between action and research, which is demonstrated in the following table, began to emerge.

Table 3.1: Action-research: This repeated cycle of research and action, with neither possible without the other, produced a process of ongoing learning and empowerment for all the participants in the study.



Consequently, participatory action research was applied in this study with special reference to the following basic principles:

- The role of the researcher as change agent
- The importance afforded to the role of ‘participation’ in participatory action research
- The democratic nature of the research relationship
- The incorporation of local knowledge and wisdom
- The fact that knowledge is generated for the purposes of beneficial action for all community members
- Empowerment was viewed within participatory action research
- Respect for participants’ interests and culture

3.3 BEGINNING THE JOURNEY FOR A POSITIVE STRUCTURAL CHANGE

Drawing heavily from the theory of social constructionism (White, 1977), this study began with a series of meetings between co-researchers (change agents) and community group leaders. Such meetings were important to achieve, among other things, the deconstruction of the communities relative lack of power and together reconstruct more positive structural and hopeful change through common sharing of knowledge and skills. The process can be conceptualised as having unfolded into **four** distinct sequential phases.

3.3.1 Phase I: Request for assistance

Members of the community approached health care workers at certain service delivery points requesting assistance on a number of common problems they reported were in their localities. Some of the problems mentioned include:

- Learners who were not progressing well at school
- Diseases associated with child malnutrition
- Child sexual abuse
- Women battering
- Limited knowledge about the HIV/AIDS pandemic and
- High unemployment rate

It became a challenge to us as co-researchers and interventionists as we had to explore the need for the inquiry, decide what the subject and goals of the research would be, and set the agenda for the inquiry (Collins, 1999; Babbie & Mouton, 2001). At this stage there was an ongoing training of co-researchers on the principles of community psychological intervention, namely:

- Assumptions about the causes of individual and community problems: An interaction over time between person and social settings and systems, including the structure of social support and social power
- Levels of analysis
- Location of practice
- Approach to planning services
- Practice emphasis on prevention rather than treatment
- Research methods
- Position on working with non-professionals

Thereafter collaborative programmes evolved from interactions with community representatives and co-researchers all as participants in the field which led to the next phase.

3.3.2 Phase II: Negotiation

Collins (1999) states that some negotiation often occurs between the researchers and community leaders, which may pose ethical dilemmas for the former. One such problem we faced was that community leaders were not truly representative of the wishes and needs of the local community. For such a problem, co-researchers had to check out whether the situation as presented by community representatives accurately reflected the will of the majority of people within that particular community.

Both co-researchers and community representatives ensured that every person who might have something important to contribute to the project was present to discuss the problem. Thereafter all participants established a broad ethical framework based on mutual trust, respect and democracy within which they could work together. This was considered important so that if the representatives from any group felt that they would not be able to work usefully with people from another group (for whatever reason), this would be discussed during this phase. Once a comfortable working relationship had been achieved, it was time to consider the goals of all the groups that would be involved in the project.

According to Bless and Higson-Smith (1995), the best way to resolve such difficulties is to construct a formal action-research contract. Such a contract would outline exactly what each party is expected to contribute to the project and what each party can expect to gain from the project. For the purposes of this study, the following simple participatory action research contract was brainstormed:

Table 3.2: Participatory action research contract between different research project participants

	COMMUNITY	CO-RESEARCHERS
To Provide	<ul style="list-style-type: none"> - active participation - skills - material resources - firsthand, practical knowledge of the problems on the ground 	<ul style="list-style-type: none"> - active participation - skills training - access to material resources - academic knowledge and theory - research skills
To Receive	<ul style="list-style-type: none"> - a solution to their particular problems - a solution for future similar problems - skills to solve future problems - skills training and access to resources 	<ul style="list-style-type: none"> - a general solution to similar problems applicable to a range of similar communities -increased understanding of the problems faced by some communities - development of theory - publication

3.3.3 Phase III : Planning

In the third phase, all co-researchers worked together to find a way of solving community problems and meeting goals set out in the contract. This involved three distinct tasks. Firstly, co-researchers tried to find a way of defining the problem for each project that was clear and acceptable to everyone. This was done in order to reach a point of shared understanding, as co-researchers had different world-views, which

required long and patient discussion. Secondly, it became necessary to determine exactly what information was needed in order to find solutions to problems and how that information was to be collected. It was at this point that co-researchers decided what their specific aims were and how these aims were to be achieved. Finally, each project was broken down into manageable tasks and responsibility for each of these tasks was distributed among co-researchers. It was during the negotiation and planning phases that co-researchers built up rapport or a sense of cooperation. A good relationship between everyone involved was essential for the success of the action and research involved in the final stages.

3.3.4 Phase IV : Implementation and monitoring of the projects

This phase included primarily the gathering of data or collection of information by means of periodic fact-finding trips and investigations of the participants environment. This process then informed some kind of action which the action-research partners undertook together. Thereafter, the results of the action were assessed and a further period of research (of an evaluative nature was initiated). Commenting on this exercise, Collins (1999, p.47) states that “it may be necessary, depending upon the results of the study, to develop or completely redesign the original action undertaken.” This is so because action and research, as demonstrated in Table 3.1, continue as alternate processes in the solution of the community’s problems. In this sense participatory action research is a particularly valuable tool because:

- It is concerned with solving particular problems facing communities
- It helps individuals, organizations and communities to learn skills and get resources so that they can function more effectively in future
- It provides a way of spreading the understanding gained through research to people and communities who can benefit from those findings
- It attempts to understand the person and the community (Orford, 1992) within the broader social context
- It aids communication between social researchers and communities in need of assistance
- It shakes the 'ivory tower' of scientists (Bless & Higson-Smith, 1995, p.61) and makes their work directly beneficial to society.

3.4 FURTHER TRAINING OF CO-RESEARCHERS ON VARIOUS PARTICIPATORY ACTION RESEARCH METHODS

As mentioned earlier, a team of school health services staff, primary health care nurses and a social worker from Empangeni hospital were involved in this study. This essentially meant an ongoing series of meetings with all staff members as co-researchers in order to:

- receive training on how to do community psychological research, its definition, vision, mission and goals

- evaluate implications of this definition for theory, practice and development of community psychology
- assist co-researchers develop, apply and evaluate community psychological programmes using various methodologies such as participant-observation, field studies, need analyses, action research, outcome evaluative methods and qualitative methodologies appropriate to the particular community context
- establish a structure for the ongoing maintenance, documentation, updating, improving and evaluation of such community programmes

As part of evaluation of the effectiveness of community psychology projects, co-researchers were given a questionnaire with **five** related guiding questions which they had to answer. Researchers were to report on:

- The change in your approach
- Your actual activities
- Your experience of the project
- Evaluation of its effectiveness
- Describe the theme/essence of this community psychology programme in your own language.

3.5 METHODOLOGICAL ISSUES IN PARTICIPATORY ACTION RESEARCH

Babbie and Mouton (2001) state that participatory action research is multidisciplinary and eclectic because of its applied and problem-solving nature. This implies that the methods participatory action research mobilizes should therefore be tailored to each specific situation and be adapted to what the participants jointly believe to be relevant to reach their objectives, for example, measures should be generated in response to the local situation. As a result, participatory action research was structured differently in different settings. This explained the use, in practice of a wide array of research methods and techniques. This study revealed among other things that participatory action research was “open-minded” (McTaggart, 1991, p.177) about what counted as data. It covered a whole range of expressive forms of data, including song and dance as well as “more orthodox” forms of data.

The study produced data mainly by involving all co-researchers in keeping records, as local information was considered more important in the implementation of projects. Such data included both **objective** records, which described what was happening as accurately as possible, as well and **subjective** records of each participants, reactions and impressions.

3.5.1 A preference for qualitative methods

Although participatory action research may use both quantitative and qualitative methods (Cresswell, 1998; Richardson, 1996), it is commonly accepted that it gives preference to qualitative rather than quantitative methods of data analysis. This view is supported by evidence deriving from anthropological as well as sociological traditions where participatory action research has strong roots (Hening, 1995; Huysamen, 1997; Silverman, 1993) and which are more qualitative, interpretive and inductive in nature.

Table 3.3: Quantitative and qualitative methodologies

	QUANTITATIVE STUDIES	QUALITATIVE STUDIES
Approach to the setting	<ul style="list-style-type: none">- Controlled settings- Selected samples	<ul style="list-style-type: none">- Natural settings- Whole context
Aims of research	<ul style="list-style-type: none">- Quantitative descriptions- Explanation and prediction	<ul style="list-style-type: none">- Thick descriptions- Interpretive understanding
Research strategy	<ul style="list-style-type: none">- Hypothetico-deductive- Generalizing (nomothetic)	<ul style="list-style-type: none">- Inductive- Contextualizing (idiographic)
Notion of objectivity	<ul style="list-style-type: none">- Natural scientific definition: maximum control over extraneous variables	<ul style="list-style-type: none">- Intersubjectivity: gaining trust and rapport in order to get as close as possible to subjects/credibility and trustworthiness.

In this study participant, or direct systematic, observation was chosen because this method:

- facilitated co-researchers' in-depth (or richer) understanding of the local community within which they were working,
- assisted co-researchers in seeking understanding of communities' subjective experience of their own situation, and at the same time tried to give working accounts of the contexts in which meanings were constituted,
- enabled co-researchers to rely on local knowledge, which was congruent with participatory action research's reliance on local wisdom and lay leadership.

3.5.2 Dialogical encounter as data collection technique

All participants met periodically to attend workshop meetings in which information and skills were shared. During these meetings much information was collected and systematized on a group basis, while a variety of expressive activities were engaged in which enriched the inquiry. The meetings were considered important sources of data and objective (and authentic) knowledge of facts.

In this study dialogue was a key notion, given that participation was perceived in terms of "continuous dialogue" (Fals-Borda, 1991, p.8).

Through dialogue participants were helped to develop knowledge by learning from their “own reality” (MacLure and Bassey, 1991, p.190), and specifically by learning to critically analyze their own particular situations and problems. In this way dialogue became “reflective” and “empowering” (Reason, 1994, p.335). Participants were also encouraged to discuss what they could do by uniting to overcome, for example poverty and unemployment. In this sense self-mobilization or organized action emerged from their own deliberations. Workshop meetings also served the egalitarian objective of participatory action research; that is, as a means through which regular checks were made to ensure that the agenda of community empowerment became an important focus of the participants group work. Consequently, meetings ensured that the subject-object relationship of traditional science and research gave way to a one of mutual co-research and intervention.

3.6 OBJECTIVITY AND VALIDITY IN PARTICIPATORY ACTION RESEARCH

Lincoln and Guba (1985, p.290) suggest that all research must respond to “canons that stand as criteria” against which the “trustworthiness” of the study can be evaluated. These canons can be phrased as questions such as the following:

- How truthful are the particular findings of the study? By what criteria can they be judged?
- How applicable are these findings to another setting or group of people?

- How can other researchers be reasonably sure that the findings would be replicated if the study were conducted with the same participants in the same context?
- How can researchers be sure that the findings are reflective of the subjects and inquiry itself rather than the product of the researcher's biases or prejudices?

The above questions establish the 'truth value' or authenticity of the study, its applicability, its consistency and its relative neutrality. Lincoln and Guba (1985) propose four constructs that more accurately reflect the assumptions of the qualitative paradigm; viz, credibility, transferability, dependability and confirmability. They match these constructs to the conventional positivist paradigm as follows:

Table 3.4: Quantitative and Qualitative notions of Objectivity

QUANTITATIVE	QUALITATIVE
Internal validity	Credibility
External validity	Transferability
Reliability	Dependability
Objectivity	Confirmability

Creswell (1998) regards the following procedures as crucial to verification of data collection:

- Prolonged engagement and persistent observation
- Triangulation
- *Peer review and debriefing*
- Negative case analysis
- Clarifying researcher bias
- Member checks
- Writing in rich, thick descriptions
- External audit

For purposes of this study prolonged engagement and persistent observation, triangulation, continuous member checks and rich descriptions of spontaneous recognition were used. The term 'triangulation' is derived from navigation, where it refers to the notion of "fixing an object from two independent locations in order to increase the accuracy of the siting" (Richardson, 1996, p.194). In fact the nautical analogy is perhaps unfortunate because it suggests the need for a perfect fix or an absolutely true reading. Generally, triangulation in social research is used as a way of strengthening the claims that researchers make, of getting a richer or fuller story, and not a route to an absolute truth. Triangulation was used as a viable research strategy in capturing the "multiple voices" (Fielding & Fielding, 1986, p.23) and therefore truths, that exist in relation to any phenomenon. Marshall and Rossman (1989) affirm that

designing a study in which multiple informants, or more than one data gathering technique are used, greatly strengthens the study's usefulness to other settings. Therefore using triangulation our truth becomes "the intersection of independent lies (Richardson, 1996, p.194).

Member validation varied at different phases of the study. The feedback by participants made it possible to establish whether the interpretations were correct. In particular, participatory action research enabled participants to develop their own system of verification, thereby returning to the participants the "scientific legitimacy" (Whyte, 1991) of the knowledge they were capable of producing. In other words, validation was an exercise which included all participants in the study. This point is further reflected in the terms "social validation" or "social verification" of knowledge, which imply that ordinary people validate the data being used (Whyte, 1995). Social verification was made possible through engaging activities which included dialogue, discussion, argumentation and consensus, or participant confirmation. This empowered participants and gave a different type of verification and authenticity to the study,

3.7 RESUMÉ

Throughout the discussion on the methodological character of this study it has become evident that participatory action research is fundamentally based on concerns for power and powerlessness. It does not differ from quantitative and qualitative studies primarily at the level of research methods or techniques, although it has preference for qualitative

methods. The main difference relates to a concern with power and the politics of research.

In this study participatory action research was used, among other things, with the aim to confront the way in which the established and power-holding elements of societies (world-wide) are favoured because they hold a monopoly on the definition and employment of knowledge. This was achieved by self-consciously reducing, or countering, the researcher's professional monopoly over the knowledge generation process. This made participants to realize that they were co-owners and beneficiaries of information and knowledge which were shared in the workshop meetings. In other words, the study was committed to helping participants access appropriate knowledge produced by the "dominant knowledge industry" (Reason, 1994, p.329) for their own interests and purposes. As Rahman (1988, p.128) states, participatory action research aims to return to the participants the "legitimacy of the knowledge they are capable of producing through their own collectives and verification systems, and their right to use this knowledge not excluding any other knowledge but not dictated by it – as guide in their own action."

CHAPTER 4 : EXPERIENCES OF CO-RESEARCHERS AS AGENTS OF CHANGE (RESULTS)

4.1 INTRODUCTION

The previous chapter explained how the process of participatory-action research, involving both health care workers and local community leaders, all as co-researchers, unfolded. This chapter looks at the actual projects which were developed by all participants with the ultimate aim of benefiting the poor local community. Because the social worker, community and school health services staff had different service points which they visited a week, three most needy communities were identified by each team to participate in the project set up in their locality. The result was the founding of Hlanganani Sewing Club (Kwa Mbonambi), Zamani Community Garden (Macekane reserve) and a school health education programme (implemented relatively successful at various rural primary schools around Empangeni district). The chapter closes by exploring the description of experiences (by health care workers) who participated in their respective projects.

4.2 BACKGROUND TO THE PROJECTS

The idea of emphasizing health promotion rather than the treatment of disease was born out in 1999. As an intern-psychologist in that year, I used to travel with the community health nurses in hospital vehicles to different points where they rendered their services.

Apart from marketing the psychological services to the surrounding communities, I realized that many of the ailments presented to the health care workers were a result of poverty. In particular children had symptoms of *kwashiokor* such as inconsistent weight levels on the clinic growth-chart and protruding stomachs. This was noticed in almost half of the seventeen service delivery points I visited within a six-month period when I was placed there as intern. It was only in September 2000 that the first meeting involving the multidisciplinary team working in the crisis centre was held to discuss common problems that colleagues dealt with in their weekly visits. A total of eighteen (18) people participated in these meetings; namely, one social worker, seven school health services staff and ten community health nurses. The first meeting resulted in a series of other meetings which eventually saw the implementation of projects in the targeted poor local communities during the first semester of the year 2001.

Table 4.1 : Dates for meetings and activities performed in each meeting

Dates for meetings and general issues discussed were:

SESSION	DATE	ISSUE DISCUSSED (ACTIVITY)	PERSONS INVOLVED
1	01/09/00	The role of a psychologist in the mental health care team	Social workers, School health nurses, community health nurses, psychologist
2	29/09/00	Common problems encountered with children and adults in different service points	All

SESSION	DATE	ACTIVITY	PERSONS INVOLVED
3	06/10/00	Training of co-researchers on community psychology principles	All
4	27/10/00	<ul style="list-style-type: none"> - Training continued - General discussion on community projects 	All
5	03/10/00	<ul style="list-style-type: none"> - Visit to Mbonambi church hall - Listening to the community needs - Community select their representatives 	Social worker, psychologist, local community members
6	24/11/00	<ul style="list-style-type: none"> - visit to Macekane tribal authority day clinic - Same procedure as on 3/11/00 	Community health nurses, psychologist, local community members
7	01/12/00	Visit to Manqamu Prim. School – Mkhobosa (near Esikhawini)	School health nurses, psychologist, educators

SESSION	DATE	ACTIVITY	PERSONS INVOLVED
8	15/12/00	<ul style="list-style-type: none"> - Follow up meeting on possible community projects which could be implemented beginning of the year 2001 - Co-researchers discuss priority projects according to the local communities' needs 	all; i.e. Social worker, school health nurses, community health nurses, psychologist.
9	12/01/01	<ul style="list-style-type: none"> - Mbonambi community revisited - Contract was accomplished - Planning with the community began 	Social workers, psychologist, community members
10	19/01/01	<ul style="list-style-type: none"> - Macekane community revisited - Contract was accomplished - Planning with the community began 	Community health nurses, psychologist, community members
11	26/01/01	<ul style="list-style-type: none"> - Manqamu Prim. School meeting - Discussing health education issues - 	School health nurses, psychologist, educators

SESSION	DATE	ACTIVITY	PERSONS INVOLVED
12	09/02/01	- Zamani Sewing Club was formed with two sewing machines	Social worker, local community members
13	09/03/01	- Hlanganani Community garden was formed – after land for gardening was confirmed by local induna	School health nurses, psychologist, educators
14	16/03/01	New school health education programme introduced at Manqamu Prim. School	School health nurses, psychologist, educators

Below are stories which were shared by some of the co-researchers on what they used to do in the community before training in community psychology began.

Case Study 1

Sbongile Ndlovu reflecting:

“As a social worker I work four days in the hospital and one day in the community every week. I have about eight places that I visit every two weeks. In the hospital I am

usually responsible for liaison activities with community social service agencies. I make the initial agency contacts in client referrals and contribute my knowledge of community resources. I also provide data regarding the client's background and environment and information about any emotional stress impinging on the client. I deal with client problems with interpersonal or environmental relationships and assist them and their families to engage in problem solving. I also engage in counselling clients referred to me by the ward staff, and assist to arrange shelter for those who have serious family conflicts as well as social, personal and emotional problems. Additional responsibilities sometimes involve psychosocial evaluation and help in adjusting to the limitations and problems resulting from illness.

In the community I work a lot with child and women abuse. Rural women suffer abuse ranging from emotional to physical and sexual abuse. They are so disempowered that sometimes even the in-laws are a source of distress. I empower them with their rights, assess their family backgrounds and refer them to the legal aid clinic or relevant agencies for further intervention. I refer children who are reported to have been sexually abused to the crisis centre at Empangeni hospital."

Case Study 2

Hellen Zikhali reflecting:

“School health nursing entails visiting to an age-selected group of the community, from six to sixteen years of age. Many of the problems facing the service arise from the fact that these children are drawn from a variety of homes and institutions and are in close proximity for long periods each day. The service is essentially preventive and promotive rather than curative and is a specialized service which falls under the Department of Health. Aims and objectives of the service are, among other things:

- To appraise the health status of learners and to ensure that every child may benefit from his education in an optimal state of health
- To detect and correct any physical defects as early as possible and so curtail the hardships that these might bring
- To note and be aware of signs and symptoms of child abuse
- To prevent and control infections and contagious diseases in schools (and hostels where possible).
- To provide health education for school children, guiding them towards healthy ideals appropriate to their mental age and social background
- To arrange school exemption and appropriate placement for ineducable children

Ultimately we provide, organize and maintain a comprehensive school health service to all the 33 government and government-aided school we visit in the Empangeni district. Such services include preparation for medical inspection, routine examination of learners, checking visual defects, hearing defects, personal hygiene, malnutrition and detail defects. Learners who are found to have any physical defects are referred to the doctor for further intervention.”

Two main issues seem to stand out in these stories narrated by co-researchers. Firstly, their approach to problem solving was individually focused. School health nurses dealt with individual children who presented with a variety of health problems. They never involved teachers in their intervention process. The process of teacher/educator empowerment through sharing of knowledge and skills on school health related matters were not taking place. In short there was a visible working distance between the nurses and teachers at schools. It also did appear that the social worker dealt with individual cases of child and women abuse. Secondly, health care workers were very often the service providers with no attempt at resource identification within each locality which could be utilized by a community for its own benefit. Community members were mere recipients of help with no sense of empowering them to have control over their resources.

4.3 COMMUNITY DEVELOPMENT PROJECTS

Of the many service points visited by health care workers, only three were targeted for community development projects; namely, Kwa Mbonambi, Macekane and Manqamu Primary School.

4.3.1 Hlanganani Sewing Club

Hlangamani is a Zulu word which means join together. In its plural form the word expresses a sense of communal spirituality and intentionality as it pervades in all communities. It began as one of the themes discussed with community members, the majority of whom were women, in the KwaMbonambi area, approximately fifteen km north of Richards Bay and twenty-five km north-east of Empangeni. KwaMbonambi is one of the poverty-stricken areas near a fast developing, highly technological and industrialized city of Richards Bay. The area is characterized by high rate of unemployment, illiteracy, crime, child and women abuse. The social worker had worked with this poor community, using a local church hall, since 1993. During this time she was working for the Advice Desk for Abused Women, a non-profit organization based in the Social Work department, University of Zululand – before she joined Empangeni Hospital in 1998. In one of the meetings the community mentioned, among other things, the following as some of the problems they experienced in their daily lives:

<i>Ukungabikho Kwemisebenzi</i>	-	unemployment
<i>Ububha/ubuphofu</i>	-	poverty
<i>Indlala</i>	-	famine
<i>Ukusweleka kwamanzi ahlangekile</i>	-	lack of purified water
<i>Imigwaqo emibi</i>	-	poor roads
<i>Ukungabikho kwezinkulisa</i>	-	lack of crèches

We realized that the community had, amongst its resources, *umhlaba* (the land) which was under utilized. Some of it was used to grow low quality sugar cane and *imifino* (vegetables). *Izithelo* (fruit trees) were rarely grown within the family yard here as they grew naturally in the nearby bushes. During specific seasons there were lots of bananas, guavas, paw-paws, mangoes and avocado pears. Of the fifteen (15) women who regularly attended our meetings (*imihlangano*), two of them had good second-hand sewing machines which they used in their homes. Some of the women could do *imisebenzi enhlobonhlobo ngobuhlalu* (an assortment of beadwork), *amacansi* (floor mats) and a variety of hand works. Together with the community members, we decided to start a small project with achievable goals. This led to the formation of Hlanganani Sewing Club which consisted of a group of fifteen women. The club comprised women who were desperate and wanted to see change in their lives, especially their children. The personal profile for each of them looked as follows:

Table 4.2: Personal profile for each woman who participated in Hlonganani Sewing Club

key: S - Single; M - Married; W - Widowed; D - Divorced

	Marital Status	Person working in the family, husband, wife or both	No. of children in the family	Children at school	Main means of survival
1	S	None	5	3	- Care dependency grant (cdg)
2	S	None	8	6	- Tips from neighbours - Cdg x 2
3	M	Husband	4	3	- Husband's salary - Cdg
4	S	None	1	1	- Selling hand-work
5	S	None	3	2	- Selling fruit, vegetables and hand-work. - cdg

	Marital Status	Person working in the family, husband, wife or both	No. of children in the family	Children at school	Main means of survival
6	W	None	7	6	- Cdg
7	D	None	6	4	- Cdg x 2
8	S	None	4	4	- Tips from friends and neighbours
9	M	Husband	6	5	- Cdg
10	M	None	9	5	- Cdg x 2
11	S	None	-	-	- Piece-jobs from neighbours
12	S	None	2	1	- Cdg
13	S	NONE	4	2	- cdg x 2

	Marital Status	Person working in the family, husband, wife or both	No. of children in the family	Children at school	Main means of survival
14	W	None	6	4	- Tips from neighbours - Cdg x 2
15	S	None	3	1	- Cdg

When one looks at the above table, it is interesting to note that the majority of women were unemployed, single-parents with four children on average. Only three were married but their husbands were earning a meagre income as they performed unskilled jobs for their employers. Moreover, it appeared that the majority of homes were dependent on the care dependency grant as the main source of income, which grant stopped when the child turned six-years of age. Some families had more than one child below the age of six and all of those children were getting the grant. This had significant implications on the welfare and psychological well-being of these families.

4.3.1.1 Communal spirituality within all club members

The spirit of humanity (*ubuntu*) which existed in the group was amazing. The two women volunteered to use their sewing machines to teach others how to cut patterns from the fabric. The group met almost every day for six days a week. The nearby

church hall was identified as a suitable venue for meetings, and even the wife of the church priest was a participant. The social worker assisted the two women when teaching others as she herself had a sewing machine at home. She also helped to collect some fabrics donated by the local fabric shop (the Waste Centre) in town. Two supermarkets were approached and they donated some food parcels in smaller amounts and these were carried along to the group on certain days. One day I visited the group and observed a good spirit they showed when interacting with one another. Those who had learnt how to cut certain patterns were showing other members how to do it. When engaged in their activity, they would sing a chorus in unison, dance around, each stamping her foot quietly on the floor whilst the hands were busy on the fabric. Of the many choruses they sang, the following was the most popular one:

Vuma; Vuma x 2

Vuma; Vuma ...

Vum' usindiswe

Ekhay' ezulwini

Kunezethembiso

Vum' usindiswe

Translated into English, the chorus goes as follows:

Say yes; say yes x 2

Say yes ...

To our Saviour

Heaven is our home

Full of hope

Say yes

To our Saviour

The chorus seemed to draw an important distinction between Heaven and earth. The latter seemed full of despair for these women. It was associated with poverty, famine and all sorts of human suffering. The church which existed right in the midst of human misery appeared to symbolize a positive future which was full of hope and righteousness. It symbolized Heaven wherein all men were equal in the eyes of the Lord. The chorus served as an important source of energy from which came power, a renewed sense of wholeness and spiritual fulfilment, a feeling of internal and external locus of control. This sense of regained power which permeated all their communal activities made them to not think about their own individual circumstances but to concentrate on what they were doing. Music had a therapeutic effect for the participants and they all seemed to love it, a theme well put by Shakespeare in one of his famous comedies,

Romeo and Juliet:

‘If music be the food

Of love, play on’

It has been said that anyone incapable of appreciating music is not a human being. Music has an ‘infinity of functions; to soothe, relax, arouse, evoke, pleasure, to identify and explore feelings, enhance communications and sociability, promote self-confidence, foster skill development, assist in sport and movement therapy, in individual and group therapy, occupational therapy with children, adolescents and the elderly’ (Edwards, 1995, p.16).

Therefore working in the group enabled participants to share their common experiences, support and care for one another in the process of their own self development and empowerment. After a sixth-month period the social worker, like other co-researchers, had to report on our community psychology project with regard to the five guiding questions as shown in Chapter 3 (see section 3.4). Her transcriptions were as follows:

The change in your approach:

‘Previously, I used to consult my clients and counsel them individually. But, now I work with a group of women and together we have decided to form a club. I found it more informative because individual members feel free to talk to one another as equals. We know one another and share information and skills even better.’

Your actual activities:

‘I share knowledge pertaining to sewing with my group members in a free and relaxed environment, something which was not happening before. Sometimes I bring them some food parcels that I collected from the local supermarkets which have shown interest in community activities. I also counsel and empower group members about their basic human rights as women since they seem not to know what to do when they are faced with all sorts of abuse.’

Your experience of the project:

‘It is educative and self-healing because all of us learn a lot from one another. Help reaches many people at once, and in that sense group empowerment, as opposed to individual empowerment, is time and energy saving. Learning is a two-way or reciprocal process. There is no teaching but just exchange of ideas, skills and information needed for the advancement of the project.’

Evaluation of its effectiveness:

‘People like the project very much. They gain a lot of knowledge and skills about sewing. Before joining the group, the majority did not know how to do it. We started with a group of fifteen women. Now the number has increased to twenty-four. We need more material and equipment for the sustainability of the project. More customers are

putting their orders as they see the wonderful dresses made by the group. The group has now selected five people amongst themselves to sell their products in town. They count the stock every afternoon. Discussions with the two nearby schools are still underway to ascertain if the club cannot make uniforms for the schools. In this sense I can say that the standard of life of the people is improving.’

The theme of the project in your own language:

‘Lapha sizama ukugqumemezela abantu, ikakhilukazi omame ukuba basebenze ngokubambisana ndawonye. Lokhu Kungenza ukuba izinga lezimpilo zabo, kanjalo nemindeni yabo lithuthuke. Emandulo kwakhna umfelandawonye noma ilima, yilapho abantu babehlangoma khona bakhe inhlangotho ukuze umsebenzi uzobalula. Lokho kwenza ukuthi abantu bakhohlwe usizi louso nalowo analo uma esebenza nabanye ndaoronye.’

English translation:

“Here as participants we are encouraging one another to unite and work together in the fight against poverty. In the olden days the elders used to form *umfelandawonye* or *ilima* to help one another in the fields. Hence the saying that ‘two heads are better than one.’ In this way people tend to forget, at least for a while, about their miserable home backgrounds. Instead their worries disappear into the group.”

4.3.1.2 Recurrent themes from above narratives

- Emphasis was made of **communalism** rather than individualism. Participants helped one another in a group context where the communal spirit permeated all being. In this way universality and a sense of belongingness to the new trouble-free family emerged.
- **Sharing**, rather than teaching, and **learning** pervades throughout the interactive process. The social worker not only shares her knowledge with the group members, but she also learns so much from the local expertise.
- Local women were double disadvantaged. Besides being victims of poverty, some women suffered physical, emotional and sexual abuse from their partners. Therefore the worker did a lot of **empowerment** about human rights and referred others to relevant agencies. Participants also felt empowered if they found that their ideas and knowledge were recognized by others.
- **Spiritual and personal growth** – Communalism and group membership that brought all the elements together resulted in each members spiritual and personal growth. This saw membership increasing, and is well expressed by Zulu words such as *ukucobelelana* (sharing), *ubungani* (friendship), *ukuzwana okuhle* (good and harmonious relationship).

4.3.1.3 Theme verification

As indicated earlier, participatory action-research demands that researchers and community are equal partners in the planning and implementation of a project, and that each brings valuable resources to the project. Furthermore, action and research take place alternatively in an ongoing learning process for every one involved. In this study member validation, prolonged engagement, triangulation and persistent observation were used. Member validation helped to check the degree of consensus between research participants on issues which were being discussed. For instance one of the group members once commented:

“When the social worker and our representatives encouraged us to work together as a group, it never made any sense to me. I thought there was nothing I could contribute to the group. How could I join a group of people who had nothing and expect to come out with something? I was hungry and all we wanted at home was food. But now I can see what they meant. I can see how much helpful it has been to me and my family to join *Hlanganani* Sewing Club. Our sisters show us how to cut the ‘yards’ and make dresses, something I never thought I would be able to do in my life. Sometimes I show others how to cut the pattern. On certain days we sell our products at the Bay taxi rank. Others go to Empangeni rail where I think the market is doing very well. I feel great bout this. I am happy because now I can buy food for myself and my family. I can buy school uniforms for my children and also pay school fees. People in the group are nice, understanding, caring and supportive.”

4.3.2 Zamani Community Garden

Zamani Community Garden was a project formed by a small community of Macekane reserve, some ten km west of Empangeni. The project was started after the local community sought assistance from health care workers to revive the site of what used to be a community garden in the area. *Zamani*, a Zulu word which means ‘try again,’ was the name given to the project because the garden was initially started in the early 1990’s by the local community members. According to the community nursing staff, Macekane is one of their service points with the highest rate of malnutrition among children. The rate of unemployment is also high; and many children who attend antenatal clinic are underweight. The garden used to be a source of life, for the surrounding community. The area is known to some quarters as a host to notorious gangsters in town. Of course, not all its young people are troublesome.

From 1996 the garden lost its popularity as there were some thieves who stole vegetables during the nights. Then the garden was poorly fenced, and certain community members were not really committed to it. Generally, the community did not have the resources to keep the garden sustainable. *Zamani* was very fortunate because four of the community members were retrenched former employees of a local agricultural college, situated approximately thirty km away from the garden site. So they had knowledge about gardening. After a series of meetings with the community representatives, the agricultural college donated good second-hand treated poles and a fence. The local *inkosi* also donated with the remaining portion so that the garden was

completely fenced. The local *induna*, who was also one of the representatives had a tractor which assisted by tilling the soil. Other offices which were approached for assistance were the local district office of the Department of Agriculture (which donated a variety of vegetable seedlings) and Department of Health. Both men and women approximately twenty-seven in all participated in this project. Today it is up an running. Advisors from the Department of Agriculture (on request by the representatives) visit this community and offer advice on such issues as crop rotation. The community is again proud of this project as it rekindled their lives and helped them fight against poverty.

4.3.2.1 Problems encountered

- Shortage of water to irrigate the plants
- Laziness amongst certain group members
- Fear that their vegetables may be stolen again as it happened in the past.
- Certain elements in the community, which are ot part of the system, may vandalize their efforts.

4.3.2.2 Solutions sought for the sustainability of the project

- Local leaders including *induna* (headman), a counsellor and project leaders from the local community were very influential in emphasizing a sense of ownership of the project to the community. Every community member was

given the responsibility to look after their property as no one else would do so except themselves. So far no theft or vandalism were reported.

- Certain departments (Department of health, Water Affairs and Forestry) were approached to assist in whatever way they could for the sustainability of the community garden project. Fund raising proposals (see Appendix A) were sent out in this regard.
- When evaluating the progress made with regard to the effectiveness of the project, ten co-researchers wrote as follows:

Table 4.3: Zamani community project evaluation by co-researchers.

	Change in your approach	Your actual activities	Your experience of the project	Evaluation of its effectiveness	Common themes
1.	I used to do counselling to the mothers regarding genetics, chronic disease, immunization, etc., now I'm involved group work	Networking with people in other departments who can assist the community with whatever way they can.	It's more educative. I've learnt a lot from group members on how to do gardening.	The garden started in about 8 months ago. It has opened job opportunities for others. People eat and sell fresh vegetables.	Prevention is better than cure.

2.	I no longer teach all the time, but I listen to group members sharing with us some information they have.	I organize health education awareness campaigns. I still do counselling, immunization, family planning.	I find it more empowering and bringing back to people that confidence which they seem to have lost.	Now people have at least vegetables to eat and we hope in future the number of babies with <i>kwashiokor</i> drop in this area.	<i>Inkunzi isematholeni</i> (today's children are tomorrow's leaders)
3.	I share information with community members rather than telling them what is right and wrong.	I assist the community with health related knowledge.	There are no barriers between ourselves and community members. We are all equal partners in the project.	Much of trust and communication has been built amongst all participants.	Importance of vegetables in our body.
4.	There's been less of dealing with clients individually. Instead there is	I supply all participants with health education charts. At	We learnt a lot from one another. There is more hope among group	More people are reached out in each visit. Personal growth and self-	<i>Masihlangane ukuthuthukisa izimpilo zethu</i> (let's work together to

	more of group work.	times I do family panning to men and women.	members.	awareness have improved.	improve quality of our lives).
5.	More emphasis is now on encouraging group work and support of the other.	I help to organize dates for such events as HIV/AIDS awareness campaigns.	It is more healing because it keeps people busy of which I think they need a lot.	Local people support the project, as it is a means of survival to them.	Knowledge is power.
6.	Focus is now on group activities rather than individual problems only.	I advise members how to water the plants, especially when they are still small.	Friendship and understanding of each other grows stronger and stronger.	It's a source of food for more families	Prevention is better than cure.
7.	I share information with group most of the time	I educate on issues such as immunization, family planning and also treat	The project seems to offer spiritual and physical healing to all participants	The number of children with malnutrition problems is gradually decreasing.	<i>Yazi umzimba wakho nexidingo zawo</i> (know your body and what it needs)

		minor ailments.			
8.	Previously I used to do a lot of teaching, but now there is a lot of sharing and listening	I organize posters for the community on health related matters.	In the group many people learn a lot from others and that they are not alone in their situation.	Local people lives are improving.	<i>Ukubahuleka kokudla okunomsoco emzimbeni</i>
9.	I spend more time helping individuals in groups.	I do a lot of advocacy for the group, though we share information sometimes.	The group is more informative and everybody gains a lot.	People know the importance of nutritious food in the body.	Knowledge is power.
10.	I exchange information with others rather than just teaching them	I share with the group knowledge on how to cook vegetables.	People feel free and better when they do something with others.	People get fresh vegetables from their own garden. Diseases associated with malnutrition are prevented.	Together we can achieve more.

4.3.2.3 Recurrent themes in the stories

One of the dominant themes in these narratives is that of **prevention** of disease and **promotion** of health. Community health nurses usually intervene at primary and secondary levels. They gave talks on various topics, as well as treat minor ailments such as scabbies. Here the culture of teaching and information sharing was a one-way process; that is, from nurses to the community. *Zamani* Community Garden has been an eye-opener not only to the local community members, but also to the nursing staff. There was high rate of malnutrition amongst children in this area. Nurses used to refer numbers of them for psychological assessment at the crisis centre. Therefore starting a community garden under such conditions was considered ideal by the community in the fight against poverty. Below are some of the themes which were already highlighted by the social worker, but were also common in the above stories:

- Networking
- Equal partnership amongst group members
- Sharing, rather than teaching of knowledge and skills
- Hope and positive self-esteem
- Health education (this theme is explored further in Chapter 5).

4.3.3 School health education programme

One of the schools which school health services visited in the surrounding areas of Empangeni was Manqamu Primary School, the most needy school with regard to health education facilities. Nurses reported that children in this school presented with various problems such as physical, emotional and sexual abuse, worm infestation, visual and hearing deficits, which resulted in learning difficulties in class. As a result the principal and staff requested the school health nurses to assist in this regard and the programme on health education which would include teachers, children and their parents was conceptualized.

The school is situated in just a few kilometers from Esikhawini township. It is surrounded by many shacks and the area is over populated. Many residents there are foreigners, particularly from Mozambique. The standard of living and the rate of literacy are very low. Besides the many meetings we had with teachers, this project had been very slow to take off. Attempts to get parental involvement are still in progress. At one stage the principal called a parents meeting and one of the items in the agenda was to explain to everybody (teachers and parents) what the community stood to benefit from the programme. Only less than a quarter of parents who were expected turned up for the meeting and as a result it was postponed.

Some of the observations made by co-researchers which were also confirmed by the principal and teachers were:

- Lack of parental involvement in school matters including supervision of their children's homework.
- Illiteracy rate in the majority of parents was very high.
- When nurses had identified children who had problems and made referrals to relevant interventionist, very few parents ever took their children to those specialists. One of the co-researchers commented: "Every school we visit has a number of traumatized , disabled as well as slow learners. Even though we refer these children to the crisis centre at Empangeni hospital, we realized that only five percent of parents do take their children for assessment. The education department does not cater for the needs of these children. If it is possible that you people can train school health nurses on handling family conflicts (as they affect children at school) and counselling skills, you will not only empower us, but we can teach those skills to the educators."

Again this emphasized the importance of multidisciplinary approach in dealing with community health related matters. Lightfoot (1991, p.1) summarized it as follows:

“Coming together is a beginning,
Keeping together is progress, and
Working together as a team is success.”

So little progress has been made in this programme. It will continue again in the beginning of the year 2002, whereby the support of all people concerned, including the department of education, will be enlisted.

4.4 RESUMÉ

This chapter began by looking at the background history of the three community development projects which were formed in different local communities. Transcripts of co-researchers where they evaluated the effectiveness of the two projects, which are up and running, were also explored. What seemed common among the evaluations was that there was equal sharing of knowledge and information between all co-researchers as participants in the project. Community members became more empowered when they felt that there was something they could share with others in the group context. The following chapter concludes the study by looking at the significance of community development projects at the local level, with special reference to rural communities. The concept of health education will also be given further attention.

CHAPTER 5 - CONCLUSION

5.1 INTRODUCTION

Previous chapters have charted out how participatory action research was chosen and applied to local communities with the aim of empowering them with knowledge and skills to have full control over their own resources. Since then there has been a growing interest, particularly among other health care workers, in how to enable and encourage people to participate in and take action to improve the health status of their communities.

This interest in community participation, collective action and the possibility of growth of our community health promotion projects has embraced the notion of community development as an effective means of achieving this. Central to the principle and philosophy which underpin community development is the way in which inequalities in health are acknowledged and addressed through the empowerment of local communities, so that they can have more power and control over their everyday lives and the factors which influence these.

5.2 THE GOALS OF EMPOWERMENT

The concept of community empowerment has been broadly explored in the previous sections (see section 2.6). However, it is important to realize that participation in knowledge creation and the actions generated and promoted by participatory action-

research set the ground work for empowerment, which is a central focus, goal, or key element of participatory action–research.

The question which may therefore be asked is: how is this empowerment achieved in participatory action-research? Our local community development projects revealed that this can be done through conscientization, emancipation, learning and generating autonomy.

5.2.1 Conscientization

One of the less concrete action objectives participatory action research strives to attain is that of conscientization, also termed ‘consciousness raising’ (Chesler, 1991, p.765), ‘sensitization’ (Karani, 1991, p.22) or ‘awareness raising’ (Rahman, 1991, p.16) of participants. In this study conscientization was achieved through the incorporation of participants’ own local knowledge in the projects.

Collective self-inquiry and reflection conscientized the participants with regard to the value of local knowledge in their own self-development. For conscientization to be realized, it was again of central importance during the participatory research process that any form of teaching or indoctrination was avoided, only exchange of information and knowledge was permitted. This was directly linked to what Fals-Borda (1984, p.18) regarded as one of the final aim of the methodology of participatory action research; that is, “to produce and elaborate the people’s own sociopolitical thought.”The aim of

conscientization was then to empower participants so that they “see through the ways in which the establishment monopolizes the production and use of knowledge for the benefit of its members”(Reason, 1999, p.8).

5.2.2. Emancipation

Participatory action-research scholars (Elden & Chisholm, 1993; Chitere & Mutiso, 1991) agree that participatory action research should first and foremost ‘liberate’ the participants’ minds for critical reflection, question and the continuous pursuit of inquiry. In this way participatory action-research establishes self-critical communities of people who develop a new knowledge system which is considered to be a key element to their empowerment and liberation. Projects which were described in Chapter 4 were really aimed at achieving these goals of empowerment, freedom and democracy whereby people take initiative in the development of, by and for themselves.

5.2.3 Learning

The learning process does not necessarily form an integral part of participatory action-research, but is considered to be ongoing or continual and therefore, inseparable from participatory action-research function. This explains why some researchers refer to participatory action-research as an “approach to education” (Sarri & Sarri, 1992, p.100) or a “research-cum-learning process” (Maclure & Bassey, 1991, p.199). More

specifically, in this study participatory action-research processes empowered the participants in the following ways:

- Basic learning, that is; learning new skills and acquiring new knowledge
- Learning to be self-reflexive and critical
- Learning to articulate and systematize knowledge
- Learning to be assertive regarding their knowledge and power

5.2.4 Generating autonomy

Generating autonomy means that participatory action-research plays an important role in “clearing space for the people for their own action and for at least partial increase in control of their own affairs’ (Swantz & Vainio-Mattila, 1988, p.140). It aims to generate an enhanced sense of community self-determination, which increases the possibility that the change or development facilitated by participatory action research will be more sustainable over time. With our local community development projects, we (as change agents) were very careful not to play a dominating role. Instead, we were facilitative and supportive. This view extends to external resources, which in participatory action research are not considered to be primary in solving participants’ problems and are only offered as supplements to the mobilization of the people’s own resources skills, when needed and available.

5.3 HEALTH PROMOTION AND HEALTH EDUCATION

Part of the comments on the evaluation of the effectiveness of each project made mention of health education as having been very instrumental in facilitating the learning process among all participants. During their study on health promotion, Gott and O'Brien (1990) encountered the frequent practice of referring to and interpreting health promotion and health education as one and the same. In this regard Webb (1994) warns that the terms health promotion and health education are not interchangeable. Health promotion was explained in detail in Chapter I (see section 1.5.4). Health education can be viewed as the process of influencing behaviour and producing changes in knowledge, attitudes and skills required to maintain and improve health, by the use of education process. Sharing of knowledge and information on matters pertaining to family planning, genetic inheritance of certain ailments was all meant to assist people to facilitate change to more helpful behaviours. This change resulted in communities own self-development and control over the local resources. Moreover, community development for health has a well established tradition within health promotion of supporting and enabling local communities to work together to improve their collective health and well-being. Health education programmes like those meant to help families cope with marital disruption (Lewis & Lewis, 1989), stress and poverty (Sarafino, 1998), have the potential to create knowledge, critical consciousness and the pressure to change to healthier lifestyles amongst the people for whom they are intended. Therefore the goal of health education is to make the community part of the education process in order that the information provided can be used to enhance the health status.

5.4 MAJOR CHALLENGES FACED BY CO-RESEARCHERS IN LCOAL COMMUNITIES

One of the major challenges faced by co-researchers was the reluctance of some local community members to participate in the projects. There were many reasons for this and some of which were the following:

- Poor people had become victims of party political fightings in the region because of the apartheid policies of the past. So they tended to distance themselves from any grouping even if the motive was to empower them with information.
- When community leaders approached health care workers for help, certain individual members thought they would be given some money rather than be part of a project which would take sometime before they could support their families.

Whatever the reasons, working with a community needs patience and understanding of its diversity (Tricket, 1996) of norms and values, beliefs and convictions and its general concrete outlook on life. It is on these grounds that any community participation will only be successful if professionals accept the community as active members of the team and not as a threat to their positions.

Vuori (1984, p.12) is of the opinion that at the heart of this issue is the right balance between “vesting enough power in the governors to govern, while still enabling the governed to exercise final control and engage in effective involvement in the process of governing.”

For the sustainability of our projects it was important to encourage balanced communication between health care workers and community representatives as well as the latter and their respective local communities.

Of utmost importance is that obstacles to community participation are not only associated with professional health care workers and party politics. At times local communities might lack the necessary leadership to promote participations. We were fortunate with Hlanganani Sewing Club and Zamani Community Garden because community leaders were active and visionary, which added value to the projects’ strength and sustainability.

5.5 THE IMPACT OF DECONSTRUCTIONIST THEORY ON COMMUNITY DEVELOPMENT

Community development has been much influenced by the work of Paulo Freire (1972). Although working within a different cultural environment, his thinking has been applied in this study as it dealt with the disadvantaged and powerless groups. Friere (1972) argued that human fulfilment can only be achieved when people are liberated from

oppression. This can only happen if they acquire a critical awareness of the world in which they live. Conscientization as a process of change in consciousness enabled participants in the projects to gain the knowledge to make a relatively accurate and realistic awareness of their place in the world in relation to others and thus exercised full control over their own local resources as well as problem posing. The notion of having control over the problem posing is very much in line with Foucault's (1980) analysis of the relationship between knowledge and power. For Foucault it is not so much the acquisition of knowledge which bestows power but the designation of a body of knowledge or 'discourse' as the dominant discourse which then has the power to set the agenda.

In relation to health, medical knowledge has become the most powerful. Lay knowledge about what constitutes health has been relegated to "realms of folk tales" (Labonte, 1993). The effect of this has been to create an unequal power relationship between medical and lay personnel with medical personnel and institutions having control over both the problem posing and the problem solving (Ibid).

Our community development projects were about creating healthy and equitable power relations between health care workers and local communities, all as participants in the process of psychological and economic empowerment through sharing of information and skills.

5.6 CONCLUSION

Dr. Hiroshi Nakajima, then director-general of the World Health Assembly, once argued that "... the concept of community action is receiving greater interest and support than ever before. Governments, communities and non-governmental organizations NGO's are exploring the possibility of creating innovative types of partnerships for health which could contribute to making the goal of health for all a reality" (WHO, 1994, p.2).

In this study the importance and inherent value of community participation in health promotion and illness prevention were evident. It emerged, among other things, that ensuring effective facilitation and sustainability of community participation was more complex. It was crucial that not only the health workers, but the community representatives as well, be trained and retrained so that they could become competent in the participatory processes, and continue to feel confident as members of the team.

The ideals of self-reliance and empowerment were foreign both to members of the communities, who had become used to being passive recipients of services, and health workers (co-researchers) had to learn to participate with the community, and in this way allowing the values of trust, understanding and true partnership to flourish. There is no doubt that community psychology interventions are dynamic processes which can provide the framework and foundations for innovative and creative approaches to health promotion. However, whilst local community action can be a force to influence change

and, as such, presents a challenge to professional autonomy it may be extremely difficult for communities to achieve fundamental change. Therefore, in order to maximize this potential, it needs to be harnessed with partnership ways of working and organizational development. These processes are fundamental to achieving improvements in the community's health status.

Community participatory ways of working are a challenge to all; community, lay and professional alike. Implicit in community participation is the notion of equity which by definition implies that not only does each member have both rights and responsibilities but also their skills, knowledge and experience are acknowledged and valued equally. It requires the development of openness, trust and a willingness to take action and change existing ways of working. The commitment to and pursuit of a common vision maximises the resources available by effectively harnessing the skills and talents of those who live and work in the community.

REFERENCES

- Abbott, F. & McMahon, R. (1987). *Teaching health-care worker: a practical guide*. Basingstoke: Macmillan Education.
- Allen, T. & Thomas, A. (Eds.). (2000). *Poverty and development into the 21st century*. Oxford: Oxford University Press.
- Babbie, E. & Mouton, J. (2001). *The practice of social research*. Oxford: Oxford University Press.
- Blackburn, C. (1991). *Poverty and health, working with families*. Oxford: Open University Press.
- Blackburn, C. (1995). *Poverty and health: tools for change*. London: Public Health Alliance.
- Bless, C. & Higson-Smith, C. (1995). *Fundamentals of social research methods: an African perspective*. (2nd Edition). Cape Town: Juta and Co, Ltd.
- Bloom, B.L. & Parad, H.J. (1976). Interdisciplinary training and interdisciplinary functioning: a survey of attitudes and practices in community mental health. *American Journal of Orthopsychiatry*, 46, 660-677.

- Booth, C. (1891). *Life and labour of the London poor*. London: Macmillan Publ.
- Brill, N.I. (1976). *Teamwork: working together in the human services*. New York: J.B. Lippincott Company.
- Case for the Henry J. Kaiser Family Foundation. (1995). *A national household survey of health inequalities in South Africa*.
- Chavis, D. & Wandersman, A. (1990). Sense of community in the urban environment: a catalyst for participation and community development. *American Journal of Community Psychology*, 18, 159-162.
- Chesler, M.A. (1991). Participatory action research with self-help groups: an alternative paradigm for inquiry and action. *American Journal of Community Psychology*, 19 (5), 757-768.
- Chitere, O. & Mutiso, R. (Eds.) (1991). *Working with rural communities: a participatory action research in Kenya*. Nairobi: Nairobi University Press.
- Clark, M.J.D. (1984). *Community nursing health care for today and tomorrow*. Reston, USA: Prentice-Hall Company.

- Cohn, H. & Tingle, J. (1974). *Manual for nurses in family and community health*. (2nd Edition). Boston: Little, Brown and Company.
- Collins, K. (1999). *Participatory research: a primer*. South Africa: Prentice-Hall South Africa (Pty) Ltd.
- Cookfair, J.M. (1991). *Nursing process and the practice in the community*. St. Louis: Mosby.
- Coulson, N.; Goldstein, S. & Ntuli, A. (1998). Promoting health in South Africa: an *action manual*. Sandton: Heinemann.
- Cox, R. & Findlay, G. (1990). *Community development health project: a review of achievements so far*. Cambridge: Health Promotion Service.
- Cresswell, J.W. (1998). *Qualitative inquiry and research design: choosing among five traditions*. London: Sage Publications.
- Dennil, K.; Ling, I.; Lock, M. & Swanepoel, T. (1995). *Primary health care in South Africa*. Cape Town: International Thomson Publishing Inc.
- Edwards, S.D. (1995). *Everyday helping psychology*. KwaDlangezwa: University of Zululand.

Edwards, S.D. (1999a). *Community psychology: a Zululand perspective*.

KwaDlangezwa: University of Zululand

Edwards, S.D. (1999b). Promoting mental health in Zululand, South Africa.

International Journal of Mental Health Promotion, 2, 16-18.

Elden, M. & Chisholm, R.F. (1993). Emerging varieties of action research:

introduction to the special issue. *Human Relations*, 46 (2), 121-142.

Ewles, L. & Simnett, I. (1996). *Promoting health: a practical guide* (2nd

Edition). London: Scutari Press.

Fals-Borda, O. (1984). Participatory action research. *Development: Seeds of*

Change, 2, 18-20).

Fielding, J.E. & Fielding, P.N. (1986). Frequency of worksite health promotion

activities. *American Journal of Public Health*, 79, 16-20.

Foucault, M. (1980). *Power/knowledge: selected interviews and other writings*.

1972-1977, Gordon, C. (Ed.). Harvester Press.

Foucault, M. (1981). *The archeology of knowledge*. London: Tavistock.

Frere, P. (1972). *Pedagogy of the oppressed*. Harmondsworth: Penguin.

Gibbs, J.T. & Fuery, D. (1994). Mental health and well-being of black women: towards strategies of empowerment. *American Journal of Community Psychology*, 22(4), 559-582.

Given, B. & Simmons, S. (1977). The interdisciplinary health team: fact or fiction? *Nursing Forum*, 16 (2), 165-184.

Glendinning, C. & Millar, J. (Eds.). (1987). *Women and poverty in Britain*. Harvester.

Gott, M. & O'Brien, M. (1990). The role of the nurse in health promotion. *Health Promotion International*, 5 (2), 137-143.

Halonen, J.S. & Santrock, J.W. (1999). *Psychology: contexts and applications*. (3rd Edition). Boston: McGraw-Hill Companies Inc.

Hening, E. (1995). Qualitative educational research: soft or solid option? *South African Journal of Education*, 15 (1), 29-34.

Holander, E.P. & Offermann, L.R. (1990). Power and leadership in organizations: relationships in transition. *American Psychologist*, 45, 179-189.

- Huysamen, G.K. (1997). Parallels between qualitative research and sequentially performed quantitative research. *South African Journal of Psychology*, 27 (1), 1-8.
- Jones, L.J. (1994). *The social context of health and health work*. UK: Macmillan Publishers
- Jones, L.J. & Sidell, M. (1997). *The challenge of promoting health: exploration and action*. London: Macmillan Publishers.
- Kieffer, C. (1984). Citizen empowerment: a developmental perspective. *Prevention in Human services*, 3 (2/3), 9-35.
- Karani, F.A. (1991). The role of the university in rural development in Kenya. In: Chitere, O.S. Mutiso, R. (Eds.) *Working with Rural Communities: A Participatory Action Research in Kenya*, 19-25, Nairobi: Nairobi University Press.
- Labonte, R. (1993). Community developments and partnerships. *Canadian Journal of Public Health*, 84 (4), 237-240.
- Lamb, H.R. (1998). *The homeless mentally ill*. Washing, DC: American Psychiatric Association.

- Levine, M. & Perkins, D.V. (1997). *Principles of community psychology: perspectives and applications*. (2nd Edition). Oxford: Oxford University Press.
- Lewis, J.A. & Lewis, M.D. (1989). *Community counselling*. Pacific Grove: Brooks/Cole.
- Lightfoot, G.V. (1991). Working together as a team. *ITC Communicator*, Jan-Feb: 1.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.
- Mann, P.A. (1978). *Community psychology: concepts and applications*. New York: The Free Press.
- Maclure, R. & Bassey, M. (1991). Participatory action research in Tozo: an inquiry into maize storage systems. In: Whyte, W.F. (Ed.). *Participatory Action Research*, 190-209, Newbury Park: Sage Publications.
- Mailick, M.D. & Jordan, P. (1977). A multimodel approach to collaborative practice in health settings. *Social Work in Health Care*, 2, 445-453.
- Marshall, C. & Rossman, G.B. (1989). *Designing Qualitative Research*. London: Sage Publication.

- Mazir, H. ; Beeston, J.J. & Yerxa, E.J. (1979). Clinical interdisciplinary health team care: an educational experiment. *Journal of Medical Education*, 54, 703-713.
- McCally, M.; Sorem, K. & Silverman, M. (1977). Interprofessional education of the new health practitioner. *Journal of Medical Education*, 52, 177-182.
- Mc Taggart, R. (1991). Principles for participatory action research. *Adult Education Quarterly*, 41(3), 168-187.
- O'Neill, D. & Morgan, M. (2001). Pragmatic post-structuralism (I): Participant observation and discourse in evaluating violence intervention. *Journal of Community and Applied Social Psychology*, 11, 263-275.
- Oosthuizen, G.C. (1989). Indigenous healing within the context of the African Independent Churches. In: Oosthuizen, G.C.; Edwards, S.D.; Wessels, W.H. & Hexam, I. (Eds.). *Afro-Christian Religion and Healing in Southern Africa*. Edwin Mellen: Lampeter.
- Orford, J. (1992). *Community psychology: theory and practice*. Chichester: Wiley & Sons.
- Pluckhan, M.L. (1972). Professional territoriality: a problem affecting the delivery of health care. *Nursing Forum*, 11, 301-310.

Rahman, M.A. (1988). The theory and practice of participatory action research.

In: Fals-Borda, O. (Ed.). *The Challenge of Social Change*, 107-132, London:
Sage Publication.

Rahman, M. (1991). The theoretical standpoint of participatory action research. In:

Fals-Borda, O. & Rahman, M.A. (Eds.). *Action and Knowledge: Breaking the
Monopoly with Participatory Action Research*, 13-23, New York, Intermediate
Technology Publications.

Rankin, S.H. & Stallings, K.D. (1990). *Patient education: issues, principles, practices*
(2nd Edition). Philadelphia: Lippencott.

Rappaport, J. (1977). *Community psychology: values research and action*. New York:
Holt, Rhinehart and Winston.

Rappaport, J. (1987). Terms of empowerment/examples of prevention: toward a theory
for community psychology. *American Journal of Community Psychology*, 15,
121-148.

Reason, P. (1994). Three approaches to participatory inquiry. In: Denzin, N.K. &
Lincoln, Y. S. (Eds.) *Handbook of Qualitative Research*, 324-339, Thousand
Oaks: Sage Publication.

- Richardson, J.T.E. (Ed.). (1996). *Handbook of qualitative research methods for psychology and the social sciences*. Leister: BPS.
- Rifkin, S.B. (1990). *Community participation in maternal and child health/family planning programmes*. Geneva: WHO
- Rifkin, S.B. & Cassels, A. (1990). Training managers for primary health care: teaching about community involvement. *Medical Teacher*, 12 (1), 39-45.
- Riger, S. (1993). What's wrong with empowerment. *American Journal of Community Psychology*, 21 (3), 279-292.
- Robb, D.; Ferrinho, P. de L.G.M. & Wilson, T.D. (1991). Democracy in health services management. *South African Medical Journal*, 80, 372.
- Rooth, R. (1995). *Life skills: a resource book for workshops*. Johannesburg: Macmillan Boleswa.
- Rowntree, B.S. (1901). *Poverty: a study of town life*. London: Heinemann.
- Sarafino, E.P. (1998). *Health psychology: biopsychosocial interactions*. (3rd Edition). New York: John Wiley & Sons, Inc.

- Sarri, R.C. & Sarri, C.M. (1992). Organizational and community change through participatory action research. *Administration in Social Work*, 16 (3-4), 99-122.
- Sekgobela, M.J. (1986). Community participation: the heart of community health. *Nursing RSA Verpleging*, 1 (9), 30-31.
- Serrano-Garcia, I. & Bond, M.A. (1994). Empowering the silent ranks: introduction. *American Journal of Community Psychology*, 22 (4), 433-445.
- Shisana, O. & Versfeld, P. (1993). Community participation in health service institutions (issues in medicine). *South African Medical Journal*, 83, 5-8.
- Silverman, D. (1993). *Interpreting qualitative data: methods for analyzing talk, text and interaction*. London: Sage Publication.
- Smithies, J. & Adams, L. (1990). *Community participation in health promotion*. London: HEA.
- Spradley, B. (1981). *Community health nursing concepts and practice*. Boston: Little, Brown and Company.
- Stanhope, M. & Lancaster, J. (1988). *Community health nursing: process and practice for health promotion*. (2nd Edition). St. Louis: Mosby Co.

Subcommittee: Primary Health Care. (1992). *Strategy for primary health care in South Africa*. Pretoria: Government Printer.

Sullivan, C.; Campbell, R.; Angelique, H.; Eby, K.K. & Davidson, W.S. (1994). An advocacy intervention programme for women with abusive partners: Six-month follow-up. *American Journal of Community Psychology*, 22 (1), 101-122.

Swantz, M-L. & Vainio-Mattila, A. (1988). Participatory inquiry as an instrument of grass-roots development. In: Reason, P. (Ed.). *Human Inquiry in Action: Developments in New Paradigm Research*, 127-143, London: Sage Publications.

Thwala, J.D. (2001). *Team Building in a psychiatric context*. Unpublished PhD.in Community Psychology. KwaDlangezwa: Zululand University.

Townsend, P. (1979). *Poverty in the United Kindom*. Harmondsworth Pengiun.

Tricket, E.J. (1996). A future for community psychology: the context of diversity and the diversity of contexts. *American Journal of Psychology*, 24, 209-234.

Vaun, W.S. (1975). Team health care – cliché or reality, the impatient setting. *Providing a Climate for Utilization of Nursing Personnel*. New York: National League for Nursing.

- Vuori, H. (1984). Overview-community participation in primary health care: a means or an end? *Public Health Review – IV International Congress of the World Federation of Public Health Associations*, 12, 331-339
- Warren, R.L. (1963). *The community in America*. Chicago: Rand McNally & Company.
- Watt, G,C,M, (1996). All together now: why social deprivation matters to everyone. *British Medical Journal*, 312, 1026-1029.
- Watt, A. & Rodmell, S. (1988). Community involvement in health promotion: progress or panacea? *Health Promotion*, 2 (4), Oxford University Press, 359-367.
- Webb, P. (1994). *Health promotion and patient education*. London: Chapman and Hall.
- Werner, D. & Bower, B,. (1982). *Helping health workers learn*. Cape Town. The Hesperian Foundation.
- White, E.H. (1977). Giving health care to minority patients. *Nursing Clinics of North America*, 12, 27-40.
- Whyte, W.F. (Ed.). (1991), *Participatory action research*. Newbury Park: Sage Publications.

- Whyte, W.F. (1995). Encounters with participatory action research. *Qualitative Sociology*, 18 (3), 289-299.
- Wigley, R. & Cook, J.R. (1975). *Community health: concepts and issues*. New York: D. Van Nostrand Company.
- Wilson, T.D.; Robb, D.; Ferrinho, P. de L.G.M. & Ntswanisi, D. (1991). Insights into community participation. *South African Medical Journal*, 80, 372-373.
- Woelk, G.B. (1992). Cultural and structural influences in the creation of and participation in community health programmes *Social Science Medicine*, 35 (4), 419-424.
- World Health Organization. (1946) *World health organization constitution: basic documents*, WHO.
- World Health Organisation. (1986). *Ottawa charter for health promotion*, WHO.
- World Health Organisation. (1991). *Community involvement in health development*. Technical Report Series No. 809. Geneva: WHO.
- World Health Organisation. (1992). *We can do it, Sundsvall handbook* from the 3rd international conference on health promotion. Sweden: WHO.

World Health Organisation. (1993). *Community action for health*. Report of the 46th Session of the WHO Regional Committee for South-East Asia. New Delli: WHO.

World Health Organisation. (1994). *Statements of Dr Hiroshi Nakajima, director-general, to the executive board and the world health assembly*. Geneva: WHO.

Zimmerman, M. (1990). Taking aim on empowerment research: on the distinction between individual and psychological conceptions. *American Journal of Community Psychology*, 18, 169-177.

APPENDIX A

ZAMANI COMMUNITY GARDEN PROJECT

FUNDING PROPOSAL

1. Introduction

Zamani Community Garden is situated at Macekane Reserve, some 10km west of Empangeni. The garden was a local community own initiative and it started in the early 1990's. During that time it did not have a name but was just the property of the community in the true sense. From 1996 vandalism to the garden was very common as thieves stole some vegetables, and this happened during the night. With the assistance of the health care workers, the community decided to revive the garden something which took place in March 2001. According to the community health nursing staff, there was a great need to revive and sustain such efforts because Macekane area was one of their service points with the highest rates of unemployment and malnutrition among children.

2. Goals of the Project

The goals of the project are, among other things:

- To help poor local community get fresh food from their own garden
- To assist local community in the process of their own self-development
- To facilitate exchange of information and skills about farming amongst all participants
- To protect children against diseases of malnutrition such as kwashiorkor, scabies and so on
- To optimize the use of local resources by community member for their own benefit
- To promote the spirit of ubuntu in the local community

3. Identified Needs of Zamani Community Garden

The local community representatives including the local induma, councillor and project leaders have identified the following as needed for the sustainability of the community development project:

- Water tank(s)/container(s) to assist with water to irrigate plants
- Proper fencing to keep stock (and thieves) away from the garden
- Vegetable seedlings
- Garden tools, e.g. spades, forks, etc.

4. Budget for the Project

The project leaders have estimated the costs as follows:

(a) Fencing	R15 000
(b) Water tanks (5000L x 2)	R25 000
© Vegetable seedlings	R 3 000
(d) Garden tools	R 5 000
Total	R48 000

5. Option for Funders

Funders have two options open to them:

- Sponsorship in the form of money which may be credited to Somopho Tribal Authority Trust Fund
- Donation of any material or garden tools as mentioned above

6. Contact Details

For further information, contact:

Mr F T Methembu (Project Co-ordinator)
Zamani Community Garden Project
P O Box 1801
EMPANGENI
3880
Cell: 082 4155634

Mr D Nzima
University of Zululand
Private Bag X1001
KWADLANGEZWA
3886
Tel: 035 9026609
Fax: 035 9026603
Cell: 083 234 7847

* * * *

APPENDIX B

ISIBANI SEMPILO TRADITIONAL HEALING CENTRE

FUNDING PROPOSAL

INTRODUCTION

Research evidence reveals that indigenous healing has been practised since earliest times in all areas of the world. In Africa it was in practice as far back as 2500 BC (Gumede, 1990), whilst the western medical system was recorded to have begun around 500 BC. Even though it may not enjoy the same scientific professional status of modern medicine, indigenous healing (in Africa) is much more popular and widely practised by the people. In South Africa for instance more than 80% of the people (Freeman, 1992) visit indigenous healers for preventive and curative services in both rural and urban areas of the country.

The abovementioned statistics indicate that most people clearly recognize indigenous healing as resource. Many people in our African communities consult indigenous healers before, during and/or after they receive the services of the modern doctors.

KWAZULU-NATAL PROVINCIAL GOVT INITIATIVE ON HEALTH PROMOTION

In 1997 the KwaZulu-Natal Health Legislature held public hearings (throughout this province) to weigh the public opinion regarding the future role and position of indigenous healers in the primary health care. The results were doubtless positive. Since then the *Izinyanga* National Association (INA) started organizing training workshops for its members. The workshops were then (and are still) followed by intensive examinations in which candidates would have to convince their examiners that they had thorough knowledge of uses and properties of certain medicinal plants.

The *aims* of examinations and workshops are:

- ♦ To protect consumers from charlatanism (or quacks who operate in the name of the association).
- ♦ To share experiences and knowledge of indigenous healing.
- ♦ To explain the code of ethics of the association to its members.

One of the many developments which INA has undertaken for her members is to locate two indigenous healing sites (one at Esikhawini, some 10km east of the Zululand University, and another one at Mandini) which will be used as Primary Health Care centres. At Mandini the centre has been named Isibani Sempilo Traditional Healing Centre, for which this proposal serves to raise funds.

GOALS OF THE ISIBANI SEMPILO TRADITIONAL HEALING CENTRE

In line with the constitution of the Centre, some of the major goals are:

- ♦ To share knowledge and experience of the healing art amongst traditional/indigenous healers themselves.
- ♦ To use the centre as a knowledge - exchange base between traditional/indigenous healers and Primary Care Workers from Sundumbili Clinic, Catherine Booth hospital, Stanger Provincial hospital, and other interested government and non-governmental institutions.
- ♦ To establish a registered centre, with a recognized referral system between traditional and modern healing systems.
- ♦ To teach INA members the correct ways of preserving fauna and flora, and this will be done in conjunction with the Natal Parks Board.

- ◆ To establish a laboratory where research on traditional/indigenous medicinal plants will be undertaken, and thus encourage information exchange to take place.

4. SERVICES

Among other things, services to be offered in the centre will include:

- ◆ Treating (in indigenous ways) individuals and families experiencing culture-bound syndromes.
- ◆ Crisis counselling for victims of violence, sexual abuse, AIDS, and neglect.
- ◆ Workshops for healers and other health professionals on a wide range of topics.
- ◆ Conflict resolution.
- ◆ Counselling for young and adult individuals experiencing marital, work related or other interpersonal problems.
- ◆ Training of traditional/indigenous healers-to-be.

5. IDENTIFIED NEEDS TO SET UP THE CENTRE

The Board of Directors of the Isibani Sempilo Traditional Healing Centre (chaired by Mr S M Mhlaba, also national chairperson of INA) has identified the following as needed to start the construction process:

- ◆ Assistance with levelling the site where different healing houses will be erected.
- ◆ Servicing of the site fully.
- ◆ Fencing the entire site for safety of the material/property to be used during/after the construction process as well as the safety of the patients.
- ◆ Building material and furniture to be used by staff and patients.

6. BUDGET FOR THE CENTRE

The Board of Directors has estimated the costs as follows:

	R
1. Levelling the site	8 000
2. Construction of visitors, divining and ancestral huts	24 000
3. Fencing	30 000
4. Construction of a building with wards for in-patients	<u>140 000</u>
	<u>R202 000</u>

7. OPTION FOR FUNDERS

Funders have two options open to them.

- ♦ Sponsorship in the form of money which may be credited to the University of Zululand Foundation. The UZ Foundation has been appointed to manage the funds of the Centre.
- ♦ Building any of the huts/rooms mentioned in 6 above.

For further information, contact:

Mr S M Mhlaba
 Isibani Sempilo Traditional Healing Centre
 P O Box 3066
 SUNDUMBILI
 4491
 Tel: 032 - 454 1678
 Fax: 032 - 454 2855
 Cell: 083 981 7308

Mr D Nzima
 University of Zululand
 P/Bag x 1001
 KWADLANGEZWA
 3880
 Tel: 035 - 7933911 x 2541
 Fax: 035 - 7933265
 Cell: 082 471 4531

TO WHOM IT MAY CONCERN

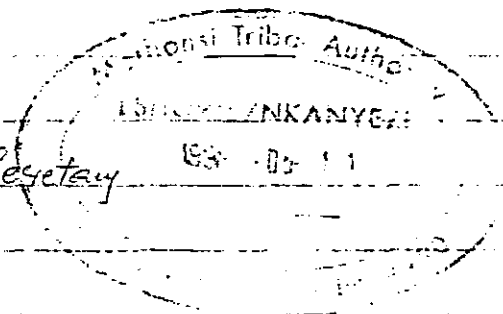
49

THIS IS TO CERTIFY THAT INYANGA'S
NATIONAL ASSOCIATION IS A WELL-
KNOWN ASSOCIATION IN OUR TRIBAL
AUTHORITY UNDER INKOSI L.S. MATHONSI
IN THE DISTRICT OF INKANYEZI.

THE ASSOCIATION WAS GIVEN A PLOT
TO BUILD A TRADITIONAL HOSPITAL
AT AMANDA-FARM AREA. INKOSI
AND HIS COUNCILLOR HAS NO OBJECTION
TO ANY FORM OF ASSISTANCE BEING
GRANTED TO THEM (ASSOCIATION) TO
BUILD THE SAID HOSPITAL IN A SAID
PLOT.

Yours FAITHFULLY

Shumungu ayo (T/Secretary)



IMINITH/MINUTE/MINUUT

10/3/2/2/3/0511

25 / 02 / 19 99

N. M. NYUNGAMA

0354 - 75329 / 75512

MAGISTRATE-INKANYEZI

PRIVATE BAG 502

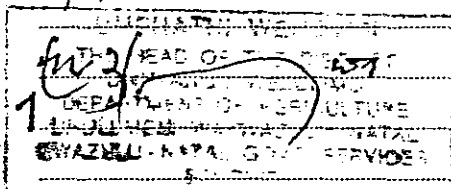
ESHOWE

1. The site was demarcated on the 23rd February 1999 and four mounds.

2. The Extent of the Site $79m \times 55m = 5445m^2$

3. These Sites will not disturb future development.

I therefore recommend the proposed sites application.



PROVINCE OF KWAZULU NATAL

ANNEXURE A

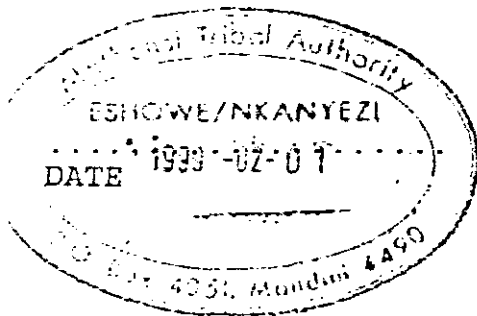
(REGULATION 2)

KWAZULU LAND AFFAIRS (PERMISSION TO REGULATIONS, 1994
RECOMMENDATION FOR ISSUE OF PERMISSION TO OCCUPY
...*MATHONSI*!...TRIBAL AUTHORITY

TO:.....(delete of Minister)

It has been resolved to recommend the allocation
to *ISIBANNISEMPILO..INJANGA..ASSOCIATION* (allottee's name)
identity registration* no.....
of a portion of land allotment* in *AMANDA-FARM* (tribal ward)

Your are invited to arrange a site inspection with our
representative and the allottee.



K.S. MATHONSI.....
CHAIRMAND OF TRIBAL AUTHORITY

[Signature].....
SECRETARY OF TRIBAL AUTHORITY

PROVINCE OF KWAZULU NATAL

ANNEXURE B

(REGULATION 4(C) (i))

KWAZULU LAND AFFAIRS (PERMISSION TO OCCUPY) REGULATIONS, 1994
SITE INSPECTION CERTIFICATE

.....
SERIAL NO.

This is to certify that:

1. An inspection was carried out on 23rd FEBRUARY 1999..
of allotment TRAINING SITE.....
in ward AMANA - FARM / MATHONSI TRIBAL AUTHORITY..
in extent 99M X 55M = 5445M².....
2. The allotment has been allocated to
ISIBANISEMPIKO INYANGA ASSOCIATION (allottee's full name)
identity/registration No. * N/A.....
#for TRAINING PURPOSES..... purposes.

UMPHATHI WENGO
HEAD OF DISTRICT
OFFICE
DATE 99/02/25
DATE
ESHOYE
KWAZULU NATAL

UMPHATHI WENGO
THE HEAD OF THE DISTRICT
OFFICE
UMHANGO WELDON
DEPARTMENT OF AGRICULTURE
AND RURAL DEVELOPMENT
FOR SECRETARY

.....
For:..... Tribal Authority

.....
*delete that which is not applicable

#delete if the allotment is in the area of a town planning scheme

PROVINCE OF KWAZULU NATAL

ANNEXURE C

(REGULATION 4(C) (ii))

KWAZULU LAND AFFAIRS (PERMISSION TO OCCUPY REGULATIONS, 1994)

SKEETCH

SERIAL NO.

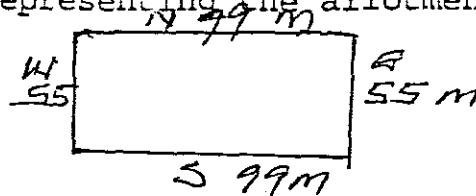
Corner point description

Sides in metres

A: NORTH
B: SOUTH
C: EAST

AB= 99 M
BC= 55 M
5445 M²

(draw figure representing the allotment here (below))

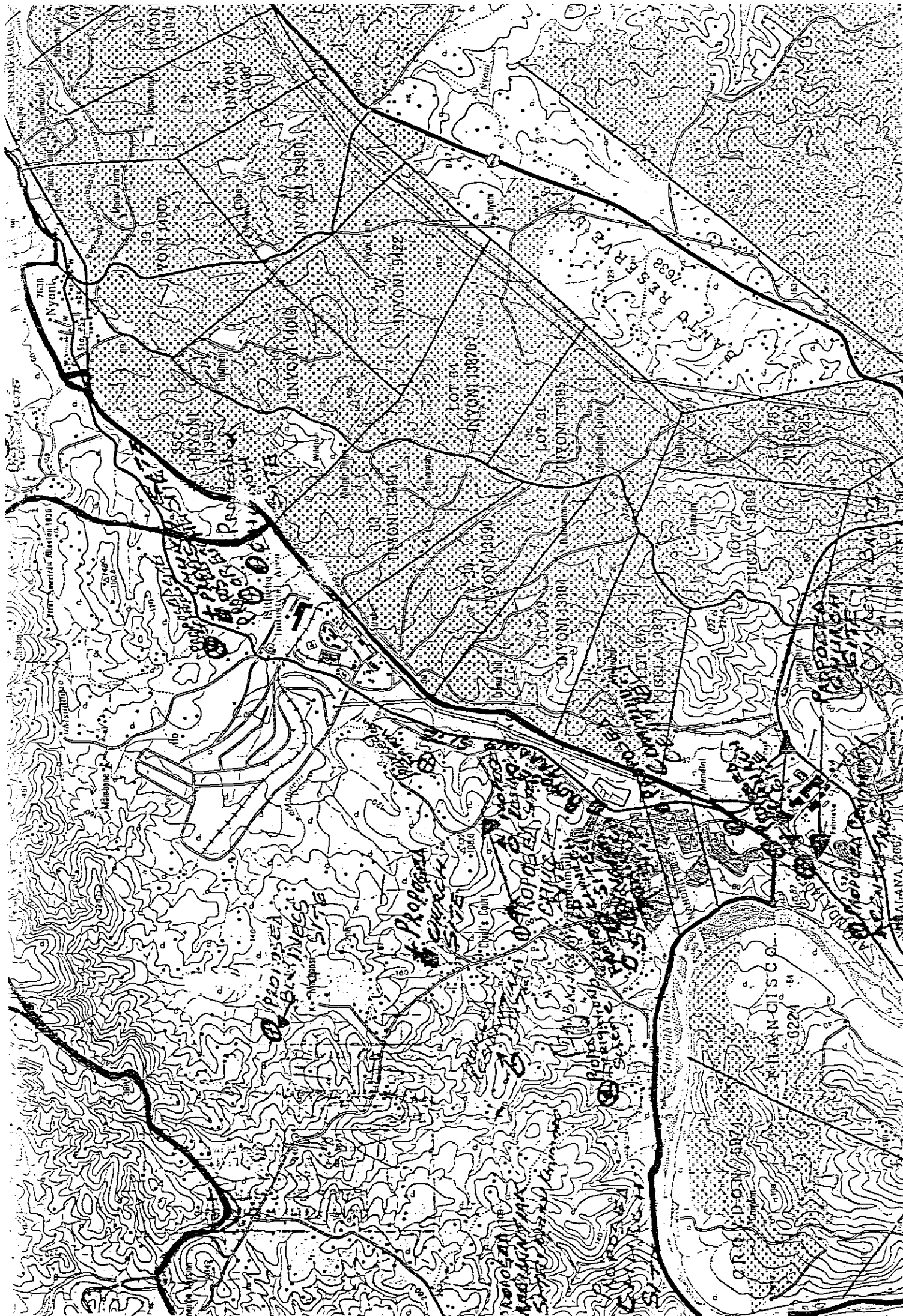


The figure..... 5445 M²
represents allotment ISIBANI SEMPILO INYANGA ASSOCIATION
in ward AMANAA FARM / MATHONSI TRIBAL AUTHORITY
area/district of ESHOWE DISTRICT
in extent... 5445 M²..... square metres

UPHLETHI WENDANI
DATE 99/02/25
DATE
ISIBANI SEMPILO INYANGA ASSOCIATION
ESHOWE DISTRICT
MATHONSI TRIBAL AUTHORITY

FOR SECRETARY
FOR TRIBAL AUTHORITY

Copy received by me on..... (date) (signature of holder)



THE CONSTITUTION

ISIBANI SEMPILO TRADITIONAL HEALING CENTRE

2000

Translation from Zulu to English and editing by: Mrs VJG Baloyi-Sikhakhane

Lecturer-Faculty of Law

University of Zululand

Private Bag x1001

Kwa-dlangezwa

3886

Tel: (035) 933911 ext 2490 (W)

(035) 933990 (H)

e-mail: Vsikhakh@pan.uzulu.ac.za

S.20-210300

THE CONSTITUTION OF THE TRADITIONAL HEALERS OF ISIBANI SEMPILO TRADITIONAL HEALING CENTRE

PREAMBLE - contains information on the history of the constitution and the purposes for enacting it.

We, traditional healers of **SUNDUMBILI -Amanda Farm** witnessed the high death rate in our nation due to lack of co-operation between the traditional healers and modern doctors and, therefore adopt this Constitution to:

- Meet the needs of those patients who could only be cured by the use/by means of traditional methods of healing or by the use/means of traditional medicines.
- Satisfy/make sure that all patients receive/get proper treatment and; proper care
- Improve the standards of healing by herbs /traditional medicines and; to meet the needs of our changing/contemporary society.
- Arrange that patients who cannot be assisted at the centre, the patient maybe transferred to a hospital, to satisfy/make sure that he/she shall be able to receive proper care and treatment.
- Create a relationship /bond with other healing Centres so as to save our nation from the high death rates due to lack of co-operation between the African traditional healers and western/modern doctors.

Section 3 is now the Preamble.

SECTION 1. NAME OF THE CENTRE

The name of the Centre shall be: **Isibani Sempilo Traditional Healing Centre**, hereafter referred to as the Centre.

SECTION 2. PLACE OF BUSINESS

The place of business shall be: **Sundumbili-Amanda Farm**.

SECTION 3. MODE OF OPERATION OF THE CENTRE/HOW IS THE CENTRE GOING TO FUNCTION/OPERATE

- (1) The Centre shall manufacture its own medicines/herbs which shall be administered to the patients by an *inyanga* employed by the Centre depending on the needs of the patient and the nature of his/her illness/disease.
- (2) The Centre shall treat and also admit those patients that require day and night care.
- (3) The Centre shall operate for 24 hours a day depending on the conditions/business at that point in time.
- (4) There shall be traditional healers as follows: Izangoma; Izinyanga. They shall be responsible for looking after the health of the patients who are sick and also treated at this traditional healing centre.
- (5) There shall be ordinary workers as follows: receptionists/switchboard operators; clerks; catering staff; car mechanics; cleaners; laundry workers; and other general workers as the management may deem fit at a point in time/depending on the needs of a particular time.

SECTION 4. WHO ARE TO TREAT THE SICK AT THIS CENTRE/QUALIFICATION FOR APPOINTMENT IN THE HEALING STAFF

- (1) Any person who is a South African citizen by birth and who can produce proof that he/she is licensed to heal by means of traditional medicines/is a licensed *inyanga*.
- (2) Any person who is an alien/foreigner from any of the African states/countries and who can produce proof that he/she is licensed to heal by means of traditional medicines/is a licensed *inyanga* and he/she must also supply information as to how he/she qualified/trained to be such.

- (3) Any person who is an *isangoma* or *umthandazi* and who can produce proof to that effect.

SECTION 5. THE MAIN OBJECTIVES/AIMS OF THE CENTRE SHALL BE:

- (1) To teach izinyanga modern/contemporary methods of the healing art used by healing Centres of a similar nature, so as to enable them to meet the needs/demands of our changing society and to acquaint them with modern diseases/illnesses.
- (2) To establish pharmaceutical companies which shall be responsible for manufacturing medicines necessary to be distributed to traditional healing centres.
- (3) To establish a laboratory for researching cures for various diseases and also for researching on traditional medicines.
- (4) To establish firm environmental protection measures(centres) /nature conservation measures(centres) and also to preserve trees needed for manufacturing medicines; other medicines shall be bought whenever there is a need.
- (5) To increase the number of centres that heal by means/by the use of traditional medicines./To increase the number of traditional healing centres.

SECTION 6: BOARD OF DIRECTORS AND BOARD OF TRUSTEES

- (1) There shall be a board of trustees consisting of five members all of whom shall be izinyanga.
- (2) There shall be eight directors who shall be appointed as follows: four, two whose appointment shall be based on their expert knowledge of traditional medicines; and two whose appointment shall be based on their valuable contributions to the Centre.
- (3) and four, whose appointment shall be based on their financial contributions to the Centre; the amount payable/financial contribution made/payable by these directors shall be determined by the trustees/management of the Centre.

SECTION 7: THE CENTRE SHALL HAVE ITS OWN PROJECTS OR FUNCTIONS AS FOLLOWS:/PROJECT COMMITTEES AND FUNCTIONS/DUTIES OF THE CENTRE

The Centre shall have its own projects and functions as follows:

- (1) **Committee responsible for the Pharmaceutical Company** as follows; five members responsible for the manufacturing of medicines and also their assistants who shall be appointed whenever a need arises/there is a need.
- (2) A committee of five members, responsible for the researching of various diseases and the cures for such diseases (**research laboratory**).
- (3) **Committee for Nature Conservation/Environmental Protection** consisting of eight members as follows; Chairman, Vice-chairman, Secretary, Treasurer and four additional members; functions of these committee shall be/is of paramount importance in that it shall be responsible for preserving trees needed for manufacturing medicines for healing patients from its plantation to its manufacturing.

SECTION 8. FUNCTIONING OF TRADITIONAL HEALERS

- (1) No *inyanga* may/shall bring his/her bag of medicines to the Centre; all medicines shall be provided for by/ available at the Centre as provided for by sections 5(2) and 7(3) above; an *inyanga* shall use his/her own expertise to decide how patients shall be treated; the Centre shall then give medicines as prescribed by the *inyanga* concerned.
- (2) No *inyanga* shall treat/cure a patient by himself, an *inyanga* shall treat a patient in the presence of his/her assistant at all times until the procedure for treatment or cure is complete.
- (3) An *inyanga* shall be guilty of misconduct if he/she discharges a patient in view of treating the patient at his own home/residential premises for his own benefit/ personal gain/in order to secure his/her own private income.

SECTION 9. MEETING OF BOARD OF TRUSTEES AND BOARD OF DIRECTORS

- (1) The Board of trustees and the Board of directors shall meet twice a month to consider all matters/issues relating to the functioning of the Centre; or problems and progress of the Centre and other issues/matters.
- (2) It is this board that shall take decisions on all matters/issues relating to the functioning of the Centre; including salaries/wages of the staff members/employees of the Centre.
- (3) No agreement shall be made by any person in the name of the Centre/on behalf of the Centre without the approval of this board; all agreements made in the name of this board shall be approved/voted for by all board members.

SECTION 10: FEES PAYABLE BY OUT-PATIENTS, OVERNIGHT AND ADMITTED PATIENTS

- (1) Fees payable by patients of this Centre shall be determined by the management of the Centre; taking into consideration the rate of inflation and the nature of the illness/disease.
- (2) Fees for admitted patients shall differ from fees for out-patients; overnight patients shall be charged separately.

SECTION 11: OFFICIAL WORKING HOURS FOR STAFF MEMBERS OF THE CENTRE

- (1) All general/ordinary staff members shall start at 7h30 and knock-off at 16h30.
- (2) Traditional healers shall start at 8h00 and knock-off at 11h00; after the healers had knocked off, assistants shall carry on with the duties as prescribed/stipulated by an *inyanga*.
- (3) The Izinyanga shall work on a week shift-relief basis.
- (4) There shall be one standby *inyanga* per week who shall be responsible for emergencies; the standby shall also be relieved on a weekly basis.

SECTION 12: VISITING HOURS OF THE CENTRE AND PROCEDURE

- (1) Visiting hours shall be as follows: 11h30 to 12h30; 14h30 to 15h30 and 18h30 to 19h30.
- (2) No visitors shall be allowed in to see their relatives after the visiting hours have elapsed.
- (3) All persons entering the Centre shall be thoroughly searched by a guard in order to make sure that dangerous objects that may endanger both the patients and Centre are not brought/do not enter the Centre; therefore the safety of our patients shall be our priority.

SECTION 13: FUNDS FOR RUNNING THE CENTRE

- (1) Funds for running the Centre shall be funds donated by companies and charities in and outside South Africa.
- (2) Other funds shall be funds from the board of trustees appointed in terms of section 6(3).

- (3) And also funds generated from the operationing/functioning of the Centre.

SECTION 14: UNIFORM FOR THE HEALING STAFF OF THE CENTRE

- (1) *Izinyanga* shall dress in grass green coats.
- (2) *Izangoma* shall dress in their day to day attire.
- (3) *Abathandazi* shall also dress depending on the type of patients that they shall be treating at a particular time; they shall dress/put on the grass green coats whenever they desire.

SECTION 15: UNIFORM FOR ORDINARY STAFF

Ordinary/general workers shall dress as follows:

- (1) Cleaners shall dress in grass green overalls.
- (2) The dress uniform for caterers shall be determined/or decided by the board.
- (3) Waiters shall dress in khakis.

SECTION 16. GROUNDS FOR DISMISSAL OF AN ORDINARY EMPLOYEE OR HEALER

- (1) Death of a patient due to the negligence/gross negligence of an *inyanga* or healer.
- (2) Sexual abuse of a patient by any person employed at/by the Centre.
- (3) Drinking alcohol during working hours/drunkenness during working hours.
- (4) Theft of property used by the Centre or any property belonging to the Centre.
- (5) Use of language which may cause a patient to loose hope/ be demoralised.

SECTION 17: QUALIFICATIONS FOR APPOINTMENT IN THE OFFICES OF THE CENTRE

- (1) To be appointed as a clerk an applicant must at least be in possession of a matriculation certificate.

- (2) If a person shall be using a type writer in carrying out his/her duties, one must be in possession of a typing course certificate.
- (3) If a person shall be using a computer in carrying out his/her duties, one must be in possession of a computer course certificate.
- (4) Izinyanga, Izangoma shall also be required to be lawfully licenced in terms of section 4 (1);(2);(3) and (4) above.

SECTION 18: POLITICAL RIGHTS/RIGHTS OF WORKERS/EMPLOYEES OF THE CENTRE

- (1) Workers/employees shall have a right to be represented whenever matters concerning them are discussed.
- (2) Workers/employees shall have a right to be members of a lawful workers union.
- (3) The right to be a member of a lawful union does not cover izinyanga, izangoma because of the nature of their calling/prohibitions that their calling carries with.

SECTION 19: REMUNERATION OF EMPLOYEES OF THE CENTRE

- (1) All employees of the Centre shall be remunerated on a monthly basis.
- (2) All workers/employees shall enjoy the benefit of/ shall be entitled to a week-end leave pay and leave pay.
- (3) The month-end date of the Centre shall be the 25th of each month.

SECTION 20: MANAGEMENT OF THE HEALING CENTRE/GOVERNORS OF THE HEALING CENTRE

- (1) There shall be five Trustees and seven Directors.
- (2) The first trustees of the healing Centre shall be constituted by inyangas who are the original founders of the Centre; the Centre shall be registered in the name of these trustees in all matters; they shall also have the power to sue and be sued on behalf of the Centre/in the name of this healing Centre..

- (3) The board of directors shall be constituted into two as follows: four directors, two whose appointment shall be based on their expert knowledge of traditional medicines which they have contributed to the Centre and two whose appointment shall be based on the knowledge that they have contributed to the Centre, it may be knowledge required by the trustees or knowledge of any other nature.
- (4) Four directors, whose appointment shall be based on their financial contributions to the Centre; at the end of the financial year directors, trustees and the financial committee shall meet so ?????????
- (5) Trustees and directors shall meet and appoint the **executive committee of the Centre** which shall be constituted as follows; chairman; vice-chairman; secretary; vice-secretary, treasurer and eight additional members.
- (6) Of the additional members four members shall be appointed and they shall be responsible for finance related matters; together with the trustees, they shall be responsible for raising donations/funds, buying of equipments, taking care of the funds for running the Centre, remuneration/salaries/wages for the employees of the Centre, buying of medicines that shall be used at the Centre; but all matters relating/concerning the use of funds shall be decided upon by the executive committee of the Centre as provided for by section 20(5) above.
- (7) There shall be two accounts of the Centre as follows; the main account shall be the trust account which shall be under the supervision of the trustees as provided for by section 20(2) above; the account shall be held at Standard Bank; three persons viz chairman of the trust, Secretary and treasurer, all from the board of trustees shall sign for the account; all proceeds/ funds generated from the operation of the Centre shall be kept in this account and also funds from donations and charities shall be kept in this account; if the financial committee needs/requires the/to use any funds they shall put their/make a request to the trustees who shall upon being satisfied of such a need determine such funds.
- (8) The second account of the Centre shall be a savings account; It shall be responsible for functions whose costs have already been determined and for emergencies; the account shall be held at any bank of the choice of the chairman of the executive committee appointed in terms of section 20(5) and his committee; the chairman, secretary and the treasurer shall sign for this account.
- (9) The name of the account shall be **Isibani Sempilo Traditional Healers Trust Fund** and it shall be registered as such.
- (10) The treasurer shall prepare/make financial statements of monies/funds used/utilised and of monies/funds received by the Centre; the treasurer shall also be required to prepare a balance sheet(balance sheet, income statement and cash flow statement) as prepared by

the auditors fairly stating or presenting the state of affairs of the financial situation/position of the Centre as of the/ 30th of June of each year(the annual financial statements of the Centre shall fairly present the state of affairs of the Centre at the end of the financial year concerned and the profit and loss for that financial year); the financial statements shall be lay/laid before the annual general meeting of the management/governors of the Centre as stipulated in section 9(1) above.

SECTION 21: APPOINTED MANAGEMENT OF THE CENTRE

- (1) The centre shall establish an administration department which shall be headed by an **administration manager** who shall be responsible for employing both senior and junior staff members; he shall be responsible for all employees who shall be performing all the duties under his supervision.
- (2) There shall be a labour control manager/labour relations officer who shall be responsible/supervise the work performance of the employees as follows: cleaners, caterers, waiters, those who work at the laundry, drivers and mechanics employed by the Centre; If an employee/ worker has been found guilty of misconduct, it shall be the duty of the labour relations manger/officer to charge the employee following the rules of the policy of the Centre applicable to both senior and junior staff members; both senior and ordinary employees shall be treated in terms of this policy.

SECTION 22: SUPERINTENDENT OF THE CENTRE

- (1) The superintendent of the Centre shall be responsible for all matters concerning izinyanga; medicines; assistants to the healers; dispensary; pharmacists; cashiers; patient file/records cabinets; consulting rooms and the healing section; prayer room for the inyangas; If an employee/ worker under the supervision of the superintendent commits a misconduct/s, he/she shall be charged following the rules of the policy of the Centre as stipulated by section 21(2) above.
- (2) All employees shall complete application forms as stipulated in section 21(b) and section 22(a) above; employees stated in section 22(a) shall in addition to the ordinary application forms, also complete a declaration to the effect that they shall never abandon patients in order that their needs may be met.
- (3) Some of the appointed management staff/employees shall sit in some of the meetings of governors as stipulated in section 20(a) above; the appointed are as follows; administration manager; labour control manager and the superintendent; they shall be expected to give reports/feedbacks on the functioning of their respective departments and also to raise suggestions that may contribute to the progress of their respective departments.

- (4) An employee charged and found guilty of misconduct in terms of section 21(2) above shall be dismissed; but the power of dismissing an employee and the final decision regarding the dismissal of such an employee shall vest in the administration manager/officer.
- (5) If an employee and his/her representative are not satisfied with the outcome of a departmental inquiry, he/she shall have a right to/of appeal to the administration manager; if after the matter has been brought before the administration manager they are still not satisfied and the employee is dismissed, he/she shall have a right of/to appeal to the Constitutional Court of South Africa in terms of the Labour Relations Act; in this regard the administration officer shall sue and be sued on behalf of the Centre.
- (6) All employees of the Centre shall be treated in terms of the Labour Relations Act of South Africa and also following the rules of the policy of the Centre as stipulated by/in section 21(2) above.
- (7) All employees shall be entitled to leave and week-end leave with pay and leave with pay in terms of section 19(1) above; they shall also be entitled to information about/concerning the running of the Centre, this means that internal bulletins/newsletters shall be issued/released by the management of the Centre.

SECTION 23: PATIENT CONSULTANCY/TREATMENT OF PATIENTS

- (1) All patients treated or cured at this Centre shall be consulted in private in the healing section, where a healer shall treat or cure a patient in the presence of his assistant as it is stipulated in sections 8(1) and 8(2) above.
- (2) All medicines prescribed for patients/used to heal the patients shall be medicines kept at the dispensary of the Centre; and also from inyangas mentioned in sections 5(2) and 6(2) above; a person responsible for dispensing medicines shall be one who is well trained to deal with traditional medicines and he must be clean at all times; other medicines shall be ordered from *izinyanga* with expert knowledge of certain illnesses/diseases; his willingness to assist the Centre in this regard shall be regarded as his agreement to sell medicines that may help patients of the Centre; purchase of medicines from the inyanga concerned shall depend on an individual patient/purchase of medicines bought in terms of this section shall depend on the patient concerned.

SECTION 24: MATERNITY AND MIDWIVES OF THE CENTRE

- (1) There shall be a midwife of/for the Centre for the purpose of assisting babies born with ancestral gifts in relation to the loss of such ancestral gifts due to western methods; the loss of such gifts may hamper the life of the child concerned for the rest of his or her life; the Centre shall try by all means to make sure that a baby born with an ancestral gift takes

the gift home with him/her; and also to advise the parents of the baby as to the meaning of the gift to the baby and what to do with the gift when they get/reach home; if a gift is lost at the Centre the midwife concerned shall be held liable/responsible and this may result in the dismissal or charge of the midwife concerned.

SECTION 25: TRADITIONAL ILLNESSES

The Centre shall try everything in its power to treat/assist those patients that are suffering from tradition related illnesses caused by the non-observance of customs and traditions; these patients shall be treated by means of traditional methods/procedures by taking him/her to the healing section where incense shall be burnt for him to inhale; from the healing section the patient shall then be taken to the fig tree where the healers say their prayers; from the fig tree the patient shall be taken to the kraal of the Centre where he/she shall be bathed/cleansed and finally/lastly the patient shall be taken to the healing section/consulting wards to be treated.

SECTION 26: ASSISTANTS TO THE HEALERS OF/AT THE CENTRE

Assistants of the healers shall be required to receive six to twelve months training/be trained for six to twelve months; they shall be trained by an expert who is qualified to train *izinyanga*; the reason being that when the *izinyanga* knock off, the assistants shall be responsible for assisting the patients with administering of medicines/herbs that shall be prescribed by the *izinyanga* concerned; administering enema; steaming; nipping (*ukunandla*);sniffing; inhaling; and other treatments that shall have been prescribed by the *inyanga* concerned; *inyangas* shall prescribe medicines and the assistant shall collect medicines/herbs at the dispensary and administer them to the patients; only in special circumstances shall medicines be administered to patients by an *inyanga* personally themselves.

SECTION 27: EXCESS/SURPLUS FUNDS AFTER EXPENDITURE

All excess funds remaining after funds for various functions have been allocated, (such as ???for directors, government taxes, debts of the Centre, employee salaries and budget for the following year) shall be deposited into the development project fund of the Centre; if after funds have been deposited into the development project fund, the funds are still in excess, such excess funds shall be deposited into funds for establishing new Centres of a similar nature since the main objective is to establish more Centres of a similar nature throughout South Africa.

SECTION 28: DISSOLUTION OF THE CENTRE

The request for the dissolution of the Centre shall be made by 13-14 members in writing within 14 days; After dissolution all equipments received as donations or from charities shall be passed/transferred to needy organisations/institutions or to other Centres of a similar nature; funds/monies shall be added to employees bonuses; interests of monies contributed by directors and trustees; government taxes; and discharging/settling all debts of the Centre.

APPENDIX C

BIOGRAPHICAL DATA OF CO-RESEARCHER

Occupation :
Gender :
Home language :
Age in years :
Work experience :

Please report on our community psychology project with regard to:

1. The change in your approach

2. Your actual activities

3. Your experience of the project

4. Evaluation of its effectiveness

5. Describe the theme/essence of this community psychology programme in your own language.