

Working with and for Communities:

Building Trust and Strengthening the DHS through Community Engagement

Thank you for joining our webinar on working with and for communities. This webinar forms part of a series of online engagements hosted by the South African Learning Alliance for the District Health System (SALAD) exploring topical issues within the District Health System (DHS). The webinar focused on **building trust and strengthening the DHS through effective community engagement**, highlighting its importance as a core principle of primary healthcare, a constitutional right, and a key element of a responsive developmental state.

The webinar was facilitated by Dr Krish Vallabjee and Professor Susan Cleary, and featured four main speakers who shared real-world experiences, followed by an in-depth audience discussion and a summary of key takeaways.

PART I: Real-world experiences and strategic insights

Setting the scene, Krish Vallabjee emphasised that community engagement has been a crucial principle of primary health care since the 1970s and is enshrined in the South African constitution and National Democratic Plan for 2030. It positions communities not as passive recipients but as active participants in designing, providing, and holding health services accountable. Understanding community needs involves not just statistics but also the lived experience and reality of communities.

Trust is a vital element, defined by **character** (integrity, transparency, openness) and **competence** (ability to deliver, track record of responsiveness). A significant 'trust deficit' exists due to mismanagement, corruption, and service delivery failures. Past community engagement efforts include compliance-driven state legislation (e.g., clinic committees, hospital boards, district health councils) and civil society-led initiatives (e.g., community-led monitoring). The purpose of the webinar was to learn from real-life projects about what works and the challenges involved.

Speaker 1: Melikaya Soboyisi

Melikaya Soboyisi discussed the **community-led monitoring (CLM) program** in the Western District,



implemented across 15 health facilities and extended to NGO service providers. Launched during the COVID-19 pandemic, its initial purpose was to monitor the pandemic's impact on HIV and TB services, with a later focus on gender-based violence. The program utilised the International Treatment Preparedness Model, involving **education, evidence generation, engagement, and advocacy**. Through grassroots consultation and data collection (quantitative surveys and qualitative focus groups), the program documented community experiences. This led to engagements with District Health Management, District AIDS Councils, and clinic committees to co-create solutions and advocacy initiatives.

Key Achievements:

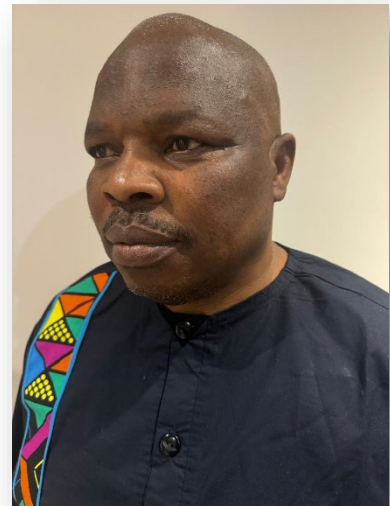
- Increased PrEP initiation: 32% more likely at monitored sites.
- Improved HIV status knowledge: From 86.8% to 88.9% among older men.
- Increased community-led HIV testing: From 20.4% to 33.6%, surpassing UN targets.
- Alleviated TB medicine stockouts: Treatment success rates at CLM sites increased from 88% to 91%, surpassing national and end-TB targets.
- Enhanced patient tracking for pregnant foreign nationals: Women at monitored sites were twice as likely to deliver in health facilities.

Melikhaya noted that initial perceptions of the initiative as ‘fault-finding’ were overcome by **co-creation of solutions and visible results**, which built significant trust with facility managers and communities.

Speaker 2: Motlatso Letshokgohla

Motlatso Letshokgohla, District Executive Manager of Capricorn District in Limpopo, highlighted the predominantly rural nature of the province, with health facilities often located within traditional areas. He emphasised **observing community engagement protocols** to build trust, including:

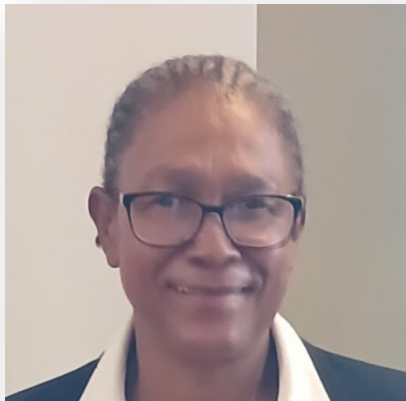
- **Proper communication:** Directing correspondence to the correct authority.
- **Punctuality:** Arriving before the agreed time.
- **Appropriate dress code and greetings:** Men wearing jackets, women covering heads and shoulders; using local languages and culturally appropriate greetings.
- **‘Lotsha’ (gifts):** Not arriving empty-handed. He stressed the importance of **balancing community demands with available resources**. Instead of over-promising, he advocated for an ‘open book’ approach, sharing data (e.g., patient headcounts, staffing, distance between facilities) to explain why certain demands, like 24-hour clinic operations, might not be feasible. This transparency, allowing communities to review data, fosters realistic expectations and amicable conclusions, thereby strengthening trust. Non-fit employees are redeployed, underscoring the serious approach to selecting suitable engagers.



Speaker 3: Christine Jansen

Christine Jansen, a committed community leader and activist, shared experiences from the Manenberg Health Committee and Klipfontein Subdistrict Health Forum. She described the transition from anti-apartheid ‘confrontation politics’ to legal engagement under the National Health Act of 2003, which provides for clinic committees. **Initial challenges** included antagonism from facility managers, a lack of trust, inadequate training from the Department of Health, and committees often being relegated to ‘box-ticking’ due to unequal knowledge. **Solutions and strategies** involved forming independent sub-

district and metro health forums to share challenges and strategize. Partnerships with progressive academics and organizations like the People's Health Movement and UCT's COMPLAS project were



crucial for **knowledge sharing and capacity building**, simplifying complex legislation (e.g., NHI regulations, roles during COVID-19). These collaborations also led to **co-creation of knowledge for training clinic committee members**. Christine advocated for a common vision where communities are involved in **planning, provision, evaluation, and monitoring** of health services at all levels, not just providing input on pre-prepared plans. She observed that trust levels are increasing but noted it's a 'work in progress,' and recommended that **facility managers and committee members train together** to foster better collaboration. She also highlighted **systemic legislative gaps**, such as the Western Cape District Health

Councils Act making no provision for clinic committees or hospital boards to participate at the district level, leading to community isolation and fragmentation.

Speaker 4: Rejane Woodroffe

Rejane Woodroffe, Director and Co-founder of the Bulungula Incubator, presented an inspiring case of integrated, place-based rural development in a remote, historically underdeveloped part of the Eastern Cape. The organization began two decades ago as a **crisis response** to an alarming child mortality rate from diarrhoea, stemming from a lack of clean water and distant healthcare facilities. Their work evolved from initially providing water tanks and health education to a holistic program encompassing education, health (maternal and child health, home-based care), sustainable livelihoods, and youth acceleration. The community built the original 'health point' (clinic) with their own resources and donated land, which now operates as a fixed outreach point in partnership with the Department of Health.



Key aspects of the Bulungula model:

- **Strengthening government partnerships:** Not replacing government, but enabling its services (e.g., Department of Health supplies medical consumables, funds some nurse/home-based care salaries, and pays for ARV delivery via the CCMD system).
- **Community-embedded Home-Based Care:** Essential for rural areas, with community health workers (CHWs) from the area building deep trust. This enabled an almost **100% COVID-19 vaccine uptake** and the **eradication of scabies** through household-level interventions that clinics alone could not manage.
- **Community Radio:** Used for health education and interactive discussions.

- **Trust Pillars:** Rejane identified **familiarity** (proximity and deep embedding), **accountability** (flexibility, listening, co-creation, fostering ownership), and **responsiveness** (acting on feedback, e.g., creating a manual for families caring for disabled members, incorporating male CHWs based on community request).
- **Person-Centered Approach:** Addressing the root cause of issues, like alcohol harm, rather than just superficial symptoms. Rejane highlighted the 'Ubuntu response' of CHWs, who often go beyond their duties due to care, suggesting this ethos could be codified into training. She also presented their '**three-legged pot**' model, **emphasizing the essential collaboration between community, government, and civil society**.

PART II: Audience Reflections & Key Takeaways

Audience Reflections

Attendees shared diverse experiences and raised crucial questions regarding community engagement. Jenny Nash, for instance, described a challenging situation where **political factions within a community used health services as a target**, leading to volatile and confrontational interactions, including the torching of vehicles. This prompted her to question whether health officials should retreat from such situations or re-engage with smaller, trust-building initiatives. In response, Christine Jansen emphasized that **clinic committee members must be recognized by their communities**, possess a history of local engagement, and work to foster community support for health facilities. She highlighted that proper leadership rooted within the community can help prevent destructive actions against health infrastructure.

Rejane Woodroffe added that **trust and time are strongly correlated**, noting that building trust is a long-term endeavour that requires persistent effort even in difficult circumstances. She outlined key elements of trust: **familiarity**, built through proximity and closeness over time; **accountability**, by being flexible, listening to communities, and fostering a sense of ownership; and **responsiveness**, which means not just listening but actively providing meaningful, long-term benefits.

Hanne Haricharan raised a critical point about **how communities are understood and how representatives gain legitimacy**. She contrasted the top-down appointment of clinic committees by the MEC in South Africa with potentially more democratic, elected structures. She echoed Christine's view that representatives should have a long history of community involvement, questioning the effectiveness of current legislative approaches that can feel disconnected from community needs.

Janine, coming from Rwanda, posed important questions about the **sustainability of externally funded community initiatives**. She asked at what point successful NGO-led projects, often initiated to fill gaps in the health system, should be integrated into mainstream government healthcare. She also highlighted the need to be cognizant of historical and contextual issues, particularly **ensuring genuine community ownership** when projects might be perceived as externally driven or racially influenced. Rejane, in a later response, emphasized working with '**trust-based philanthropy**', where funders allow organizations flexibility to address community-identified needs rather than imposing rigid spending mandates. She shared an example where budget for transport was reallocated to an alcohol harms program after a community health worker identified alcohol as the primary issue in a household,

demonstrating a person-centered approach. Regarding security threats, Rejane simply stated that **the community itself had solved the security situation**, highlighting the power of community agency.

Melikhaya Soboyisi earlier reflected on trust, noting that when the community-led monitoring program began, it was initially perceived as a **'fault-finding initiative'** by facility managers. However, by consulting with them, co-creating solutions, and demonstrating positive results, the initiative successfully built trust with both facility managers and the broader community, leading to improved service delivery. Motlatso Letshokogohla underscored the importance of **cultural sensitivity and adherence to local protocols** when engaging rural communities, including appropriate dress code, greetings, and language. He also explained how **data is used to transparently balance community demands** (e.g., 24-hour clinics) with available resources, fostering realistic and amicable conclusions with influential community members. Christine Jansen further elaborated on the **fragmentation of statutory frameworks**, noting that the Western Cape District Health Councils Act does not provide for integrated participation from hospital boards or clinic committees, leading to isolated community efforts and a lack of 'people friendly' legislation that truly embraces co-creation.

Key Takeaways

Krish Vallabhjee provided a comprehensive summary of the webinar's key messages and insights. He underscored that **community engagement is not merely a 'nice to have' or a luxury, but rather a crucial element that yields tangible benefits and real gains**. He praised the **framework of education, evidence, engagement, and advocacy** as an effective approach to community engagement, stressing the importance of **co-creating solutions** with communities.

He highlighted the emphasis on **respectful engagement**, noting the need to pay attention to basic protocols such as dress code, language, and greetings when interacting with communities. A critical takeaway was the caution against **overpromising and under-delivering**, as this practice erodes trust. Krish acknowledged that the journey of community engagement is often challenging but ultimately constructive, leading to stronger relationships between frontline state actors, facilities, and communities, and a significant shift from the apartheid era's confrontational dynamics.

The importance of the **aptitude and training of frontline staff** in effectively engaging communities was also stressed, identifying this as an area often neglected. Krish pointed out the **gaps in statutory frameworks**, specifically mentioning how legislation, such as the district health council laws, often fails to provision for integrated governance by connecting various community and facility structures, thereby fragmenting efforts. He also reminded attendees that **communities are not homogeneous entities** and that power dynamics and divisions within them must be carefully considered. The **credibility of community voices**, including how representatives are selected and how they report back to their communities, was identified as another vital aspect.

The Bulungula Incubator was recognised as a highly inspiring example of **integrated, holistic development**, embodying the original vision of primary healthcare and demonstrating tangible benefits in areas like disability support and vaccine coverage. Krish particularly appreciated the **'three-legged potjie' model**, which advocates for collaborative efforts among communities, government, and civil society. Finally, reflections from the chat were included, such as the point that **building relationships**

with communities during 'peace time' can greatly assist during crises, and Janine's crucial query regarding how to transition externally funded initiatives into sustainable mainstream programs, while also effectively managing relationships with funders.