

Community Participation In Providing Antenatal Services In Zimbabwe

Mrs BR Chitambo
MA Cur student
Department of Advanced
Nursing Sciences
University of South Africa
Pretoria
South Africa.

Mrs JE Smith
Lecturer
Department of Advanced
Nursing Sciences
University of South Africa
Pretoria
South Africa.

Dr VJ Ehlers
Senior Lecturer
Department of Advanced
Nursing Sciences
University of South Africa
Pretoria
South Africa.

ABSTRACT

Community participation has been hailed as the panacea for enhancing the successful implementation and continuation of many community programmes. Community participation at high levels empowers communities, increases self-reliance, self-awareness and confidence in self-examination of problems and in finding solutions for them. Behavioural changes are promoted; utilisation as well as support of services is facilitated. These aspects could exert important influences in determining the effectiveness of ante natal care (ANC) services in communities. The purpose of this study was to determine the extent to which women participated in the provision of ante natal care. Pregnant women's perceptions, expectations and participation in the provision of ante natal care were examined.

Rifkin's model for evaluating community participation was used in constructing guided interview schedules. Thirty conveniently selected pregnant women, residing in the area of the Chinamhora clinic, in the Goromonzi District of Zimbabwe in Southern Africa, participated in this survey. The results indicated limited participation in Rifkin's five process indicators of community participation. However, all the women regarded community participation as being important. The majority of the women wished to be involved at high levels of participation, but did not know how to approach such involvements. The results of this study should be valu-

able to health care professionals in formulating strategies and modifying existing programmes to enhance community participation.

KEY WORDS

Community participation, primary health care, community expectations, health care providers, antenatal care, pregnant women.

BACKGROUND INFORMATION

International approaches to community participation in Primary Health Care services

Since the adoption of the concept of primary health care (PHC) by the World Health Organization (WHO) member countries in 1978, community participation has been hailed as the panacea for most community programmes (Rifkin 1990:7; WHO 1995:25). The WHO and the United Nations Children's Education Fund (UNICEF) emphasised that merely giving health information to a community is not as effective in promoting optimum health as fostering



community participation in the provision of services. Furthermore, there is a shift in viewing health narrowly in terms of diseases to a broader perspective where health is an integral part of the socio-economic development (Rifkin 1990:2), hence the promotion of multidisciplinary and multisectoral approaches to health. King (1996:220) emphasises the importance of a multidisciplinary, intersectoral team approach in enhancing the facilitation of community participation. The emphasis should therefore be on community participation that suits local conditions.

Community participation is defined as community involvement or partnership between individual groups, organisations and health professionals (WHO 1995:225). People are empowered to express their rights to be active in the development of appropriate health services and programmes (NPPHCN 1999). Community participation at high levels empowers communities, increases self-reliance, self-awareness and self-confidence in self-examination of problems and in seeking solutions for them (WHO 1991:15). Community participation promotes equity through sharing responsibility, solidarity and serving those in need. Behavioural changes are promoted and utilisation and support of services is facilitated. Culturally more appropriate services are created as communities contribute their unique knowledge and their unique needs. However, the concept of community participation is a complex one with many definitions, and the need to be acceptable to the community, the service providers and the government (WHO 1996:16).

Most studies limit their investigations to the health care providers and the different programmes of community participation, not necessarily including the actual involvement of the community itself in these programmes. Developing countries in Africa, Latin America and China are implementing different ap-

proaches of community participation, many of which suffered from nonsustainability. "Despite many successes the majority of community health programmes and activities come to an untimely end" (WHO 1996:34). Community participation poses a great challenge to many developing countries that are implementing the PHC approach. Therefore in evaluating the extent of community participation programmes, it is important to investigate the views of both parties on the issue of partnership, in order to come up with locally acceptable strategies for stimulating and maintaining community partnership.

Zimbabwe's approach to community participation in Primary Health Care services

Zimbabwe adopted the PHC approach in 1980. Four levels of health care delivery were established; primary, district, provincial and central level (Ministry of Health Zimbabwe 1986). A variety of sectors exist within this structure, namely the Ministry of Health, the Ministry of Local Government, church hospitals, industrial medical services and the private medical sector. The structure of the health system corresponds with the political structures established after independence. Zimbabwe is divided into ten provinces and each province is subdivided into seven or eight districts. The districts are further subdivided into wards and each ward comprises several villages. A ward forms a catchment area for a clinic. Wards are discernible geographical units to which the term community in this study refers. The head of this community is a councilor chosen by the people. These existing structures could be used to promote community participation in PHC issues. Zimbabwe adopted the PHC approach with community participation as one of its principles.

Antenatal care in Zimbabwe
Maternal and child health (MCH) is one of the priority programmes

in Zimbabwe. Pregnant mothers are expected to book for ante natal care (ANC) within the first 20 weeks of pregnancy. Pregnant women are expected to attend clinics regularly, initially at four weekly intervals up to 32 weeks then every two weeks until 36 weeks and then weekly until delivery.

Plausible arguments have been presented in the literature explaining why women should actively participate in all aspects of their health care delivery. Women have the traditional and natural role in providing care. In Zimbabwe, the variety of traditional activities that women carry out, especially in the rural areas, such as child rearing, preparation of food, collection of water, firewood and tilling of fields reflect the multi-sectoral approach to improving health. They also have the opportunity of disseminating information during the course of performing their domestic tasks (Rifkin 1990:7).

PROBLEM STATEMENT

Despite the fact that PHC has been used for almost 20 years in Zimbabwe, the community involvement of women in health care has not been evaluated. Although there has been great improvement in health care provision, it's not clear how much women are involved in the planning, decision-making, implementation and evaluation of their health care services. The ante natal mothers provide an ideal focus group to stimulate community participation in health care delivery.

PURPOSE OF THE STUDY

The purpose of the study was to determine the extent to which pregnant women were participating in the provision of ANC; and to identify pregnant women's perceptions and expectations regarding community participation.

RESEARCH QUESTIONS

This survey attempted to answer the

following research questions:

- What was the extent of participation of pregnant women in the provision of ANC within the existing health care system in Zimbabwe?
- What were the perceptions of the pregnant women attending ANC regarding their own involvement in ANC health care delivery?
- What were the expectations of pregnant women regarding their participation in the provision of ANC health care in Zimbabwe?

RESEARCH DESIGN

This survey utilised the quantitative nonexperimental, descriptive and exploratory research design.

The conceptual framework guiding the research

The conceptual framework guiding this study is Rifkin's model for as-

sessing community participation in health programmes. This model was chosen because it allows the examination of multiple factors in assessing the level of participation. This model is derived from the five levels of participation, namely the level where people participate in benefits of the programme; participate in programme activities; implement health programmes; participate in monitoring and evaluating health care programmes; participate in planning health care programmes (Rifkin 1990). On recognising the need to examine the process, rather than the impact of community participation, six factors which influence participation were identified, namely: needs assessment, leadership, organisation, resource mobilisation, management, and focus

on the poor.

Indicators are variables which help to measure changes (WHO 1981) for example, adult literacy is an indicator for social and economic development. Indicators are used when changes cannot be directly measured (Dreyer et al 1997). In this study, in order to determine the extent of community participation in the Murape ward, five process indicators for community participation were used. These were leadership, organisation, resource mobilisation, management and needs assessment. Data to determine the extent of participation in each process indicator was collected from pregnant mothers.

Table 1 shows Rifkin's descriptions of narrow participation and wide participation for each indicator.

Ranks	Narrow, nothing 1	Restricted, small 2	Mean, fail 3	Open, much good 4	Wide, very much excellent 5
1. Leadership (L) [Wealth minority - variety of interests]	One-sided (i.e. wealthy minority; imposing ward-chairman: health staff assumes leadership; or: inexistence of heterogeneous WHC	WHC fu;ntioning under the leadership of an independent CHL	WHC fu;ntioning under the leadership of an independent CHL	Active WHC, taking initiative	WHC fully represents variety of interests in community and controls CHL activities
2. Organisation (O) [Created by planners - community organisation]	WHC imposed by health services and inactive	WHC imposed by health services, but developed some activities	WHC imposed by health services, but became fully active	WHC actively cooperating with other community organisations	Existing community organisations have been involved in creating WHC
3. Resources Mobilisation (RM) [Small commitment + limited control - good commitment + committed control]	Small amount of resources raised by community. No fees for services. WHC does not decide on any resource allocation	Fees for services. WHC has not control over utilisation of money collected	Community fund raising periodically, but no involvement in control of expenditure	Community fund raising periodically and WHC controls utilisation of funds	Considerable amount of resources raised by fees or otherwise. WHC allocates the money collected
4. Management (M) [Professional induced - community interests]	Induced by health services. CHL onl supervised by health staff	CHL manages independently with some involvement of WHC. Supervision only by health staff	WHC self-managed without control of CHL's activities	WHC self-managed and involved in supervision of CHL	CHL responsible to WHC and actively supervised by WHC
5. Needs Assessment (NA) [Professional view - community involved]	Imposed from outside with medical, professional point of view (CHL, VHW, HP-staff); or latrine building programme imposed on community	Medical point of view dominates an 'educational' approach. Community interests are also considered	CHL is active representative of community view and assessed the needs	WHC is actively representing community views and assesses the needs	Community members in general are involved in needs assessment

Table 1: Ranking scale for five process indicators for community participation

Table 2 shows the three point scale which was designed with the contribution of some experts in community health nursing and also from the literature reviewed (Bjara et al 1991:199). To determine the extent of community participation in Murape Ward, narrow, medium and wide participation were measured on each indicator.

& Hungler 1999:279). The sample size for this study constituted 30, conveniently selected pregnant women. During the data collection period the pregnant women had stopped attending ANC clinics, protesting against increases in fees for health care (including ANC) services. Thus the pregnant women were interviewed in their homes.

tary information, One researcher conducted the interviews to ensure consistency and the questionnaire was also translated into Shona in order to communicate in the respondents' home language to maintain consistency. The questionnaire consisted of four sections:

Section 1: 12 items capturing de-

Indicator [range]	Narrow	Medium	Wide
1. Leadership	VHC and WHC. Not functioning, health staff assume leadership. VCW works under health staff.	WHC functioning under leadership of health professionals. Represent fewer groups.	WHC actively represents variety of interests in community.
2. Management	Externals and professionals make decisions.	Joint decisions by professionals and community.	Community makes decisions using professionals as resources.
3. Resources mobilisation	Official fees only. No other contributions.	Contribution from community but no control.	Considerable amount of resources and WHC involved in allocation of resources.
4. Needs assessment	Imposed from outside. Professionals decide.	Professionals and community define needs together, represents community's views.	Community asks for programmes
5. Organisation	WHC created by planners and health care workers not functioning VCW chosen by the people.	WHC created by planners and health care workers. Functioning.	WHC fully active, widely representing the community. Existing organisations involved in creating the WHC.

[VCW = Village Community Worker; WHC = Ward Health Committee; VHC = Village Health Committee]

Table 2: A three point scale used to determine the extent of community participation in this study

This design was appropriate as it facilitated collection of data about the extent of community participation in the provision of ANC as well as the perceptions and expectations of the respondents regarding such community participation.

Research population

The population is the entire group of persons or objects that is of interest to the researcher and to whom the results could be generalised (Polit & Hungler 1999:232). The population in this study were pregnant mothers from the ten villages of Murape ward, who under normal circumstances would receive ANC from Chinamhora clinic.

Research sample

Sampling is the process of selecting a portion of the population to represent the entire population (Polit

The target population was pregnant women with one or more children with histories of using the ANC services.

Each voluntary community worker (VCW) organised a meeting with each participating pregnant woman on a specific date. Each participant had to be a pregnant woman with at least one child, who used Chinamhora's ANC services, and a permanent resident of Murape ward.

Research instruments

Two data collection instruments were used for this study, a structured questionnaire and a checklist. The two data collection instruments were based on information acquired during the literature review. Closed and open-ended questions were employed. The structured interviews allowed for collection of supplement-

ary information

Section 2: 28 items evaluating the extent of women's participation in the provision of ANC; based on Rifkin's model

Section 3: 9 items concerning women's perceptions of community participation in the provision of ANC services

Section 4: 6 items that captured the respondents' expectations regarding their participation in the provision of ANC services.

Design of the checklist

A checklist was designed to validate some of the pregnant women's responses on the extent of community participation in the provision of ANC. Information to complete the checklist was obtained through per-

sonal interviews with the nurse-in-charge of the clinic and the VCWs.

Validity and reliability of the data collection instruments

Content validity refers to the extent to which various research elements measure what each one purports to measure. Content validity is concerned with the sampling of adequacy of items for the construct that is being measured (Polit & Hungler 1999:412). Content validity of items in this study was achieved through critical review of the instrument by experts in the area of study. Reliability refers to the consistency, accuracy and dependability with which the instrument measures. A pretest, utilising clients with similar characteristics to the sample, was conducted to evaluate the clarity of the items and the consistency of the responses. Anomalies were detected and necessary adjustments were made.

Data collection procedures

Permission to carry out the research was obtained from the Research Council of Zimbabwe, the District Council, District Health Committee and the Councilor of Murape ward. The district nursing officer introduced the researcher to Chinamhora clinic staff and the Councilor and the clinic staff introduced the researcher to the VCW, and the VCW introduced the researcher to each woman participating in the survey.

Ethical considerations

Informed verbal consent was obtained from the clients following disclosure of information on the study purpose, type of information sought and the procedures used to collect the information. Subjects were informed that they had the right to refuse to answer any specific question(s) or to withdraw from the research. The clients were also informed that the study findings would be reported collectively, but not individually, and no participant would be identifiable.

Analysis of Data

Following the collection of data, the discovery phase of research begins as the meaning of the data is determined through analysis (Burns & Grove 1997:407). Data was prepared and cleaned for use in the Statistical Package for Social Sciences (SPSS). The open-ended questions were grouped and categorised. Descriptive statistics; measures of central tendency (means, mode, median), measures of dispersion (standard deviation, range) and frequencies were used to summarise and describe the data.

RESEARCH RESULTS

Demographic data of the pregnant women

The ages of the 30 participating pregnant women ranged from 19 to 41 years, with the majority, 14 (46,7%) being between 25 and 29 years of age. Twenty-nine (96,7%) clients were married, only one (3,3%) was divorced. All participat-

ing women were literate and 20 (66,7%) attained some secondary school education. Despite their relatively advanced literacy levels, all the women were unskilled workers engaged in market gardening and housework. The reported household monthly incomes ranged from Z\$700 to Z\$2 000, with an average of Z\$3 707 (US\$1=Z\$300 - approximately depending on inflationary fluctuations of the Zimbabwe Dollar).

The majority of the women belonged to church organisations. Nine (60,0%) of the women belonged to farming groups, 2 (16,7%) to tree planting groups and 1 (3,3%) was a member of a burial society. The farming and tree planting groups were income generating groups, to which only 11 (36,7%) belonged.

The extent of women's participation in the provision of ante natal care

Twenty-five respondents (83,3%) mentioned that women were involved in providing ante natal care as VCWs, selected by the people to deal with health activities in the area. The VCW was also involved in health activities such as conducting deliveries, treating minor ailments and promoting income generating projects. Seventeen (56,7%) women thought the VCW identified ante natal health problems in their area, whereas 7 (23,3%) did not know who did so.

The women's major problem was the high fee for service, evidenced

Variable: Women's Perceived ANC Problems	F	%
Finance (fees for service too high)	28	93,3
Physical structures inadequate	08	26,7
Transport poor	12	40,0
Human resources shortage	16	53,3
Negative staff attitudes	26	86,7
Problem of amenities	14	46,7

Table 3: Women's perceived antenatal problems (n = 30)

by the boycott of ante natal services during the time of data collection. This was followed by the perceived negative attitudes of the health care providers at the clinic. The majority of the women (14 or 46,6%) did not know the channels to be followed in the event of identified health problems. Their inconsistent responses might indicate that there were no organisational structures present, or that these might not have been functioning.

The majority of the women namely 20 (66,7%) were not free to give suggestions, only 10 (33,3%) could do so. Six (20,0%) felt that issues were not taken seriously and 2 (6,7%) felt that issues were taken fairly seriously; 11 (36,7%) of the women felt intimidated by the health care providers, 3 (10,0%) felt that the health workers looked down upon them and 6 (20,0%) felt the health workers perceived them to be ignorant. All the respondents were involved in some health promotion activities:

- 27 (90,0%) were involved in the construction of wells/boreholes
- 6 (20,3%) participated in the construction of rubbish pits.

health problems were never discussed at these groups/clubs. The results seemed to indicate that minimal attention was given to health issues by other organisations.

The majority of the women namely 18 (60,0%) were not aware of the existence of the ward health committee (WHC) in the area, 3 (10,0%) were uncertain and 9 (30,0%) said the WHC existed. Although the WHC existed, it was not functioning effectively, because 29 (96,7%) of the respondents were uncertain about the its activities. This lack of awareness might be indicating limited community participation in health care. The majority of the women, namely 24 (80,0%) had no idea of any co-operation between the WHC and other organisations.

The VCWs were chosen by the people as a multipurpose cadre, representing a number of departments at village level. Thus the VCW was involved in health issues at village level and could also stimulate community participation in health care activities.

More than 90% of the respondents did not know who owned, managed or monitored health care programmes in their areas. As many as 93.3% indicated that they had never participated in any data gathering

from the ANC services offered at the clinic because:

- there was no night nurse
- drugs, bandages and other materials were in short supply
- patients were discharged too early
- patients had to supply their own food and take care of their own laundry
- the doctor no longer visited the clinic on stipulated days the nurses were too few
- the fees were too high
- clinic was too small, the beds were too few
- there were no waiting shelters for mothers that live very far
- very sick people just joined the queue
- nurses were not caring
- nurses were rough and did not talk to patients
- patients were not receiving much help or care from the nurses at the clinic.

All the women felt that community participation in the provision of ANC was very important. The majority of the women, namely 20 (66,7%), thought mobilisation of women for health issues should not pose any problems. Eighteen (60,0%) of the women were not satisfied with the level of

Variable: Are you satisfied with the level of participation in the provision of ANC in your area?	F	%
Satisfied	12	40,0
Not satisfied	18	60,0
TOTAL	30	100

Table 4: Women's satisfaction with level of participation in the provision of antenatal care (n = 30)

According to Rifkin's (1990) five levels of participation, these women were participating at a low level, that is the second level of participation. All the women identified community development groups, including women's clubs (13 or 43,3%), burial societies (3 or 10,0%) and youth groups (1 or 3,3%). Nine respondents (30,0%) reported that

ering and/or decision making processes about health care services in their area. These findings indicate that the participating women did not manage to reach Rifkin's fourth level of community participation, involving data gathering and decision making.

Twenty-nine (96,7%) of the women reiterated that they were not benefit-

participation, because people were not working together (13,3%); their husbands were not involved in the running of the clinic (16,7%). The Minister of Health's comment that "while there has been active enthusiasm on the part of the communities to participate in health development, there has been little involvement of communities in the

process of planning and decision-making" is supported by these results (Ministry of Health & Welfare 1999).

Almost all 29 (96,7%) participants reported that the health care workers did not seek community participation in health matters. Yet all the participants indicated that they wanted to be consulted on matters concerning their health. Views on how women wanted to be involved in the provision of ANC included that they wanted to participate in meetings (14 or 46,7%); the financial management of the clinic (14 or 46,7%); in the formation of action groups (7 or 23,3%); monitoring of programmes (2 or 6,7%); and in peer education (1 or 3,3%). Fourteen (46,7%) wanted their husbands to be involved in, but failed to specify in which ways.

The majority of the women, namely 22 (73,3%), were not aware of the ongoing decentralisation process of the health care services, and those 8 (26,7%) who were aware of the decentralisation process, did not understand its implications.

meetings should be held more regularly in order to discuss pressing problems, 6 (20,0%) thought of forming action groups for solving health problems.

Analysis of data obtained from the checklists

The checklist was completed by conducting an interview with the charge nurse of Chinamhora clinic and with VCWs. The checklist consisted of 12 items. Information provided by the clinic charge nurse indicated that a WHC – selected by the planners and a VHC with politically selected members - existed there were no records of meetings held with the VHC, WHC, groups/clubs and other organisations it was not possible to rate the attendance at the different meetings, as there were no records the only contributions made by the community were fees for services rendered there were no letters of communication or records of community health projects in the catchment area. Information provided by the VCWs

CONCLUSIONS

The extent of women's participation in the provision of antenatal care

The women's views on their involvement and evaluation and the five indicators of community participation indicated that women were not involved in the identification of needs- free to provide any suggestions attending any health related meetings involved in health programme surveys organising meetings with health care professionals. Concerning **leadership and organisation**, the WHC and the VHC were not functioning effectively because the majority of the women lacked awareness of the existence of the WHC, its co-operation with other organisations and its representation of the people. The participating women perceived the VHCs to be politically chosen by the people, but that the activities and duties of the VHCs were directed from the top, by the health workers and other ministries. Thus the VHC did not identify nor meet the health care needs of the communities con-

Variable: Suggestion to improve community participation in the provision of ANC	F	%
Meetings	19	63,3
Outreach by nurses	15	50,0
Action group formation	06	30,0
Combine meetings with the agricultural extension workers	04	13,3

Table 5: Suggestions for improved community participation in the provision of antenatal cre services (n = 30)

Fifteen respondents (50,0%) suggested that the outreach programme by nurses should be reintroduced as this would help build trusting and supportive working relationships between the health workers and the community, "we appreciated it when the nurses were coming out to meet us in our areas". Four (13,3%) advocated for combined health meetings with agricultural extension workers. Nineteen (63,3%) thought

included that there were no health-related meetings held between the VCW and the community records of cement used for construction of toilets and boreholes were the only health records kept by VCWs and registers for income generating project members all the VCWs confirmed that a VHC existed in each village.

cerned.

Findings relevant to **resource mobilisation** indicated that women contributed fees for service only. They lacked knowledge about the owners, planners and monitors of such programmes. Data indicated that women expected to be consulted about issues pertaining to their health. They viewed community participation as being very impor-

tant, but differed on the levels at which they wanted to be involved. The overall research findings indicated that there was narrow participation in the provision of ANC in all the five indicators of Rifkin's community participation model. Failure by both the planners and the health professionals to realise the community's potential contributions impeded the implementation of the process of community participation (Freyens et al 1993:253). The pregnant women did not identify themselves as being owners of the clinic in their area, they felt that they were not benefiting from the ante natal services provided and the majority, 18 (60%) felt dissatisfied with their level of participation in the provision of ANC. Failure by the women to perceive the clinic as belonging to the community might imply several problems. At the time of data collection the women were boycotting the services due to an increase in the fees for service. Dennill et al (1995:7) note that the community must be aware of its own and other's perceptions, rights and responsibilities in order to be able to handle its health issues rationally. The women's responses and reactions seemed to indicate that there was a lack of training and education to give sufficient skills to the community to be able to handle their relevant health issues. Communities would be better able to reach their own decisions with regard to their health situation if they were adequately informed (WHO 1995). The majority of pregnant women had not heard about the decentralisation process. There were no meetings and the outreach programmes had been stopped. The health workers were not consulting the women on issues pertaining to their health, contrary to the women's expectations. The women suggested having meetings with health care workers; restarting the outreach programme; combining health meetings with those of agricultural extension officers; forming an action group on health; being involved with moni-

toring and financial management.

IMPLICATIONS OF THE STUDY

Major objectives of PHC such as equity, affordability, appropriateness could not be achieved if their wide participation lacked in the provision of these services. Improvement in the people's health depends on their full participation in the provision of health care services. If people do not perceive themselves as the owners, commitment to the improvement of service is not easily generated nor maintained. The mothers were not attending antenatal services in the area during the time of the study due to the increases in the fees for service. This is a major problem as all the efforts to improve the health care of the women and children were defeated by the increased fees for services.

Lack of awareness about the structures and their functions and lack of awareness about the decentralisation process being implemented, might lead to failure to successfully implement the process. Introducing programmes without involving the community in the decision-making process might produce major problems. One such problem relates to the lack of sustainability of the programmes as there will be no community ownership nor commitment.

LIMITATIONS OF THE RESEARCH

In interpreting the findings of this research some limitations to the generalisations of these research results need to be considered:

- sample size: the small sample size of 30 women that were selected from the meetings is not representative of all the women in Zimbabwe
- sampling method: the sample was conveniently selected from those women that attended the organised meetings; it is therefore possible that some clients with different characteristics were excluded.

Despite the limitations the study

showed willingness to participate at different levels.

RECOMMENDATIONS ARISING FROM THE RESEARCH

- Programmes should be set up with different approaches to empower the communities to make their own assessments of the situations, identify problems and come up with their own solutions.
- Outreach programmes should be resumed with different approaches promoting equal partnerships and not merely the delivery of services.
- Implementation of the decentralisation process: Community service needs should be seriously considered during the early period of implementation, one of these should be ensuring full participation of the communities.
- The VHC is a subcommittee of the village development committee, which is a political structure. People might feel uncomfortable in a group that is politically affiliated, thus the ideas about forming an action group for solving health problems should be considered seriously. The results of this research showed that women were participating at low levels in the provision of ANC. Each indicator, as specified in Rifkin's model for the evaluation of community participation, namely leadership, resource mobilisation, management, needs assessment and organisation, was reviewed for knowledge, evaluation and involvement by the women. Participation by women in the provision of ANC was limited in all five of Rifkin's indicators of participation. All the women realised the importance of community participation and wanted to be involved in several ways, but lacked knowledge as to ways in which they could establish and maintain such involvements.

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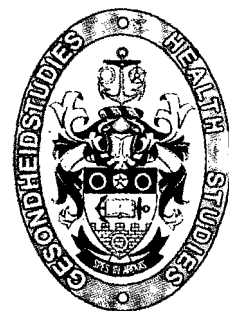
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Department of Health Studies
University of South Africa
Telephone: +27 (0)12 429-6036
Facsimile: +27 (0)12 429-6688

E-mail
artes@unisa.ac.za



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