THE DRIEFONTEIN COMMUNITY HEALTH CLINIC

The Driefontein residents' opposition to forced removals has a long history. The attempt to maintain and establish community facilities and services has formed a large part of this struggle. This article, by the Driefontein Health Advisory Committee, deals with the establishment of one such service, the Driefontein Clinic, and its role in the community before and after the reprieve.

Driefontein - area and history

Driefontein is the settlement area of a black community of some 10 000 - 15 000 persons. The settlement is situated in a rural and isolated area in the south-eastern Transvaal, approximately 350 km from Johannesburg. The town closest to Driefontein is Piet Retief which is about 50 km away from the area.

Driefontein came into being in 1912 when a farm was bought and divided into plots which were then sold to individual black farmers. Since the early 1960's this "black spot" has been under threat of removal by the South African government.

The community has strongly opposed the removal plans. Over the years it has had numerous meetings with the relevant authorities, outlining its opposition to the proposed removal. Driefontein gained international attention in 1983, when the chairperson of the Council Board of Directors of the community, Saul Mkhize, was shot by a policeman during a meeting to discuss the removal threat.

The reprieve

International and national pressure, together with a change in government attitude, led to a reprieve by the South African government at the end of 1985. This reprieve now allows the community to get on with its development and plan for its future. Over the years, the community has become democratically organized and committees have been established to represent the community on various issues including health.

Infrastructure and services - before the reprieve

Health care has long been perceived as a problem by the community. Until recently, no curative health services were available and only occasionally did immunization teams visit the area. Antenatal care and delivery services were non-existent, with mothers having to travel 50 km to Piet Retief for delivery or to

attend an antenatal clinic some kilometers outside Driefontein. There are no ambulance services, and badly maintained roads have made transportation difficult.

A major arena of the battle against removals has always centered on "development" issues, such as water, roads, health and schooling. In areas where the people are resisting removal, the government has always allowed essential services to degenerate, and in many cases it has stopped the services completely.

In Magopa for example, the buses to town were stopped, the water pumps were removed and the schools were smashed down. In Driefontein the government's actions were less destructive but they also had devastating effects. Old people could not get pensions and young people were not issued with reference books. The community's plans to extend their schools (with money which had been collected) were vetoed. The local commissioner refused to use thousands of rands which he held in trust for the community, to fix the appalling roads.

The roads could not be used in the wet season and people were unable to get out of Driefontein, even for medical emergencies.

Initiatives to build a clinic

Despite these difficulties, the community established a health committee in 1978 and started raising funds to build a clinic and a house for a primary health care sister. These were completed in the late 1970's. However, several attempts to obtain a sister through the State Health service failed.

It was therefore decided to raise funds through non-government organizations to provide a health service for the community. A Driefontein Health Advisory Committee was established in Johannesburg to help raise funds for the project and to act as an advisory body to the Driefontein Clinic Committee.

In September 1985, the clinic opened with a fully trained primary health care sister who had moved to Driefontein, and with the clinic being fully equipped. Doctors are at present voluntarily visiting the clinic every two weeks. At the beginning of 1986, a second nursing sister started working at the clinic.

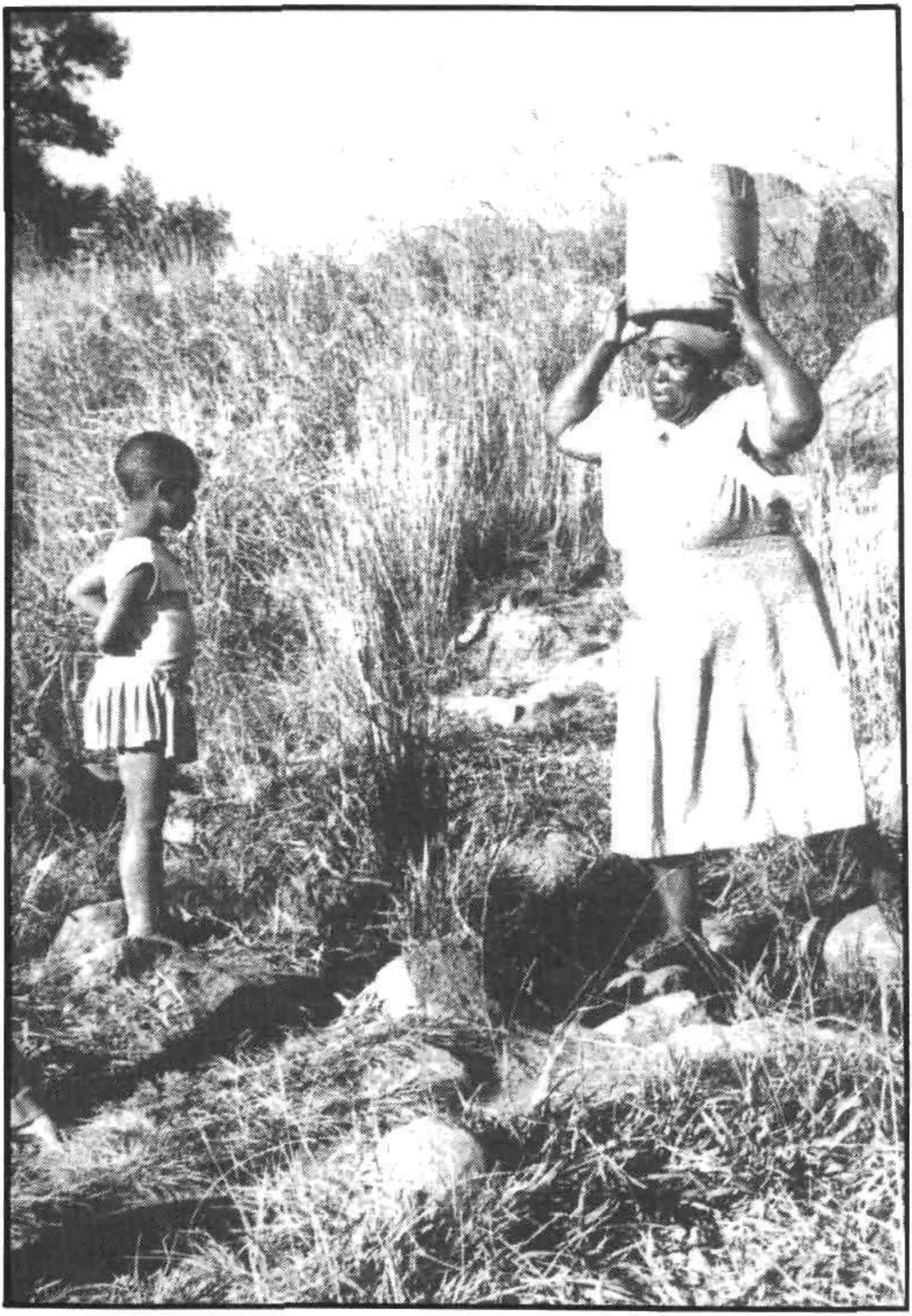
Although the clinic is still in its infancy, some 20 to 40 people are seen daily. With the arrival of the second sister, baby clinics, immunization, family planning and antenatal care are being developed. There are plans to train village health workers, and so develop and infrastructure in the community to promote health and strengthen community organisation and development.

The Driefontein Community Health Clinic has now been functioning for nearly a year.

So what is unusual about the health care project?

The Driefontein Health Care Project has a number of important features. These will be discussed under the following headings:

1) Health care services and resistance to removal
2) Community participation
3) Funding the health service with non-government funds
4) Problems relating to the geographical isolation of the Health Centre
5) The reponsibilities of the State Health Service and the DCHC



Collecting water from a spring at Driefontein

Health care services and resistance to removal

The government is using various methods to "persuade" communities to uproot themselves and settle elsewhere. In such tormented communities, as was Driefontein, the establishment of a community health service was an important issue.

Health services are a vital and felt need in any community and can therefore become an important issue around which organization and unity can be developed. This calls for democratic ways of working together. If a health service can finally be set up, it will mean a victory for the people concerned. Such an achievement would promote self-confidence and bolster the community's resolve to continue the stuggle.

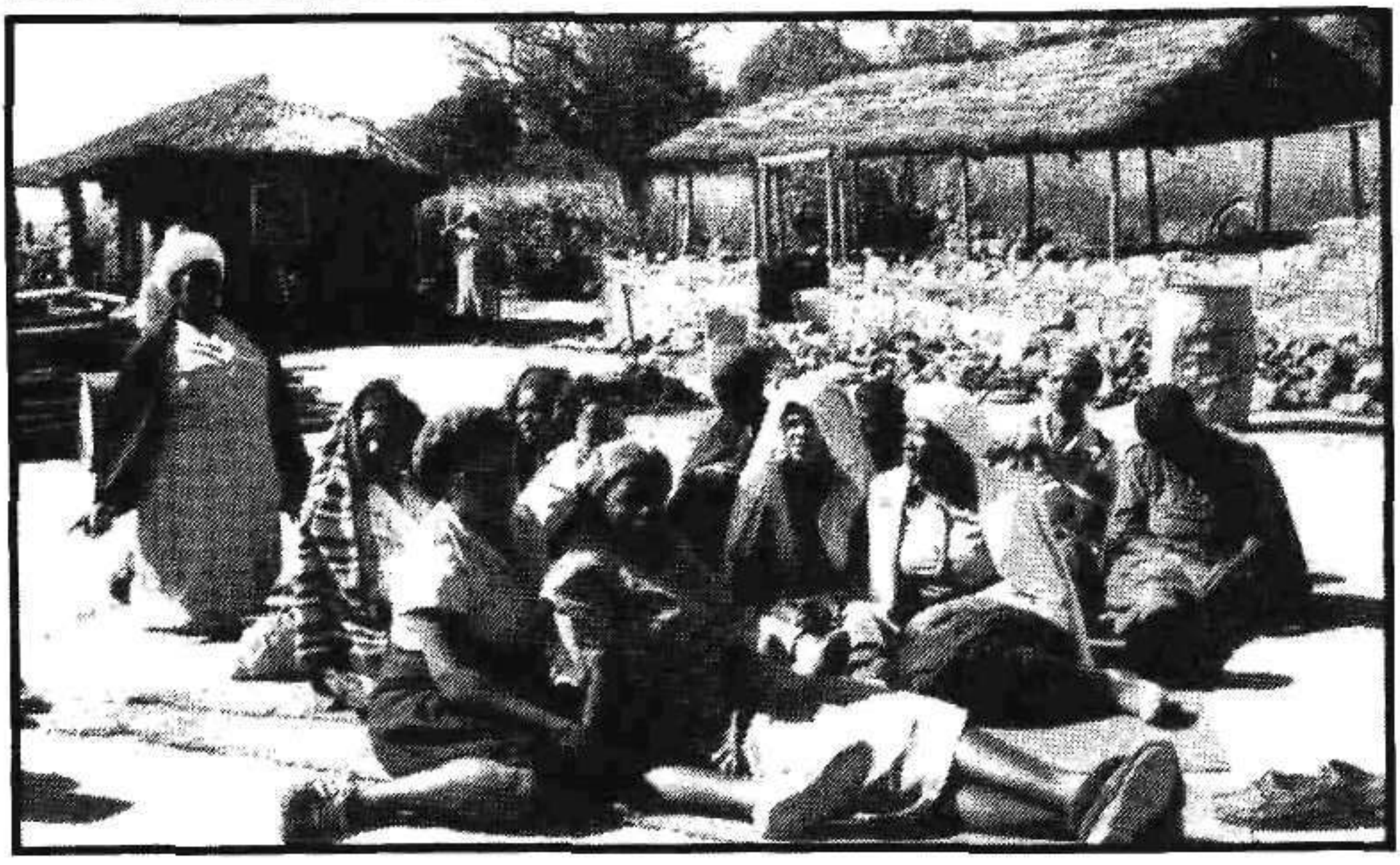
At Driefontein, there were many issues which contributed to the resistance to removal. The Health Service was but one, albeit an important one. On 21 September 1985, the Health Centre in Driefontein was officially opened. At the same time and occasion, thousands of community members and supporters celebrated the reprieve on the removal.

Community participation

Primary Health Care workers often refer to the Alma Ata Declaration which very significantly emphasises the concept of community participation in establishing and maintaining their health care service.

In 1978 the community democratically elected a Driefontein Community Clinic Committee to co-ordinate the struggle for a health service.

The committee collected funds and co-ordinated the building of the clinic and a house the clinic health worker.



Driefontein women discussing the new clinic

An advisory committee was later established, consisting of three doctors, a social worker and community worker, all from Johannesburg. This committee meets regularly and liaises with and advises the local Driefontein committee on health and other related issues.

Since the clinic has been functioning, the local committee has tended to lose some of its enthusiasm in co-ordinating various issues concerning the health care sevice. This could possibly be expected after a long hard struggle. However both the advisory committee and the primary health care nurse at the clinic made mistakes in their relationships with the community committee. The project concept is a new experience to most people involved in this sevice, and much is being learned and has been learned in the minefield of communications.

Funding the health service with non-government funds.

Various international sponsoring agencies have provided funding to equip the clinic, pay staff salaries and maintain the service.

Major organising costs are for primary health care drugs and salaries. The lack of any ambulance service also makes it necessary to find funding for a transportation service for critically ill patients. With continually rising inflation, the estimated yearly budget is in the region of R90 000.

This may seem a large amount; however it represents a per capita expenditure of approximately R6-00 for the primary health care service.

Even though R6-00 per capita expenditure is low, (KwaZulu R19-00, TPA R57-00) the possibility of raising R90 000 plus per year on a long term basis becomes problematic.

This problem raises the important question of establishing and maintaining services which should be the responsibility of the state.

Problems relating to the Health Centre's isolation

There are also some specific problems relating to the isolation of the clinic.

Surrounding hospitals (50 km) are not very sympathetic to referrals from the clinic sisters. Patients are occasionally turned away. The clinic never receives any feedback or communication on the treatment or progress of referred patients.

The absence of an ambulance service makes it extremely difficult to transport critically ill patients to the hospital.

The primary health care nurse who lives at the clinic is on constant 24-hour call to the community. It has proved very difficult to recruit adequately trained health workers to assist and to share the duties of the staff in the clinic.

Doctors from Johannesburg visit the clinic on a fortnightly basis. This means approximately 7-8 hours of travelling every time. It is almost impossible to enlist the co-operation of sympathetic and committed doctors from the local towns. These visits cannot provide an adequate back up and support system for the clinic staff.

The Responsibilities of the State Health Service and the Driefontein Community Health Centre

Clearly the long term future of the Driefontein community clinic is dependent on state health assistance. Most of the sponsors made it clear that the state should ultimately sponsor the Driefontein Health Sevice.

The track record of State Health Services to the Driefontein community is dismal. The long history of the removal issue and the negative actions of state authorities have led the community to distrust any state intervention by the community.

The State Health authorities have shown an unusual enthusiasm and interest in the clinic. They have supplied immunization; family planning drugs, devices etc and and medication for tuberculosis. They are assisting the clinic committee in building a better ventilated pit latrine. They have also expressed a keen interest to pay the nursing salaries, provide a range of primary health care drugs and even to build a new modern clinic with adequate obstetric facilities.

Indeed the State Health's response has been surprising and interesting.

The Driefontein Community Clinic Committee has reservations concerning the response of State Health.

Ultimately the most important question concerning the involvement of State Health is the extent to which it will control the clinic and prevent the community from doing so.

Traditionally, in South Africa, health services in the black communities are extremely authoritarian and oppressive. Could the Driefontein model be any different?

There are no quick answers or solutions to these questions. The relationships with the state authorities will need careful consideration and negotiation.

In conclusion, the Driefontein Health Care Project experience is determined by the interrelation of community participation and involvement, NGO sponsorship and a changing political climate and State Health reponsibilities. The future is unclear, the potential exciting and challenging.

Driefontein women dancing to celebrate the new clinic