The NPPHCN/SAHSSO Policy Conference 1992: an overview

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In early 1992, the policy groups of SAHSSO and NPPHCN merged to form single policy groups both at regional and national levels. While the constituencies, and to some extent the policy needs, of the two organisations are different, it was clear that we could not afford to duplicate policy research and policy activities given the scarcity of resources for this work within the progressive sector.

The programme of the policy group for 1992 had three legs. The first was to undertake a participatory situation analysis and identify policy issues arising out of that. Secondly, 'pro-active' policy work was undertaken on issues where we perceived a need to develop positions for SAHSSO and NPPHCN because these policy issues would become important in the next year or two. Thirdly, 're-active' policy work was designed to respond quickly to issues as they arose in the public arena. In general we did not include much reactive work. We responded specifically to the Medical Schemes Amendment Bill and to the government's publication of policy on primary health care. This reactive aspect of the work is not discussed further here.

Common goals of these three types of activities were:

- to raise the profile of the organisations and to establish them as players in the policy arena;
- to develop policies within the organisations on key issues;
- to build capacity of members of the organisations to participate in the discussion of policy issues and the critique of health service functioning.

Situation Analysis

The policy conference was preceded by a situation analysis. This research was intended to identify the most serious backlogs in essential health services in South Africa. It was designed to strengthen the ability of members of NPPHCN and SAHSSO to evaluate health services and participate in health policy debates. The research involved discussing, with some community members and organisations, their perceptions and attitudes as regards current health services

and priorities.

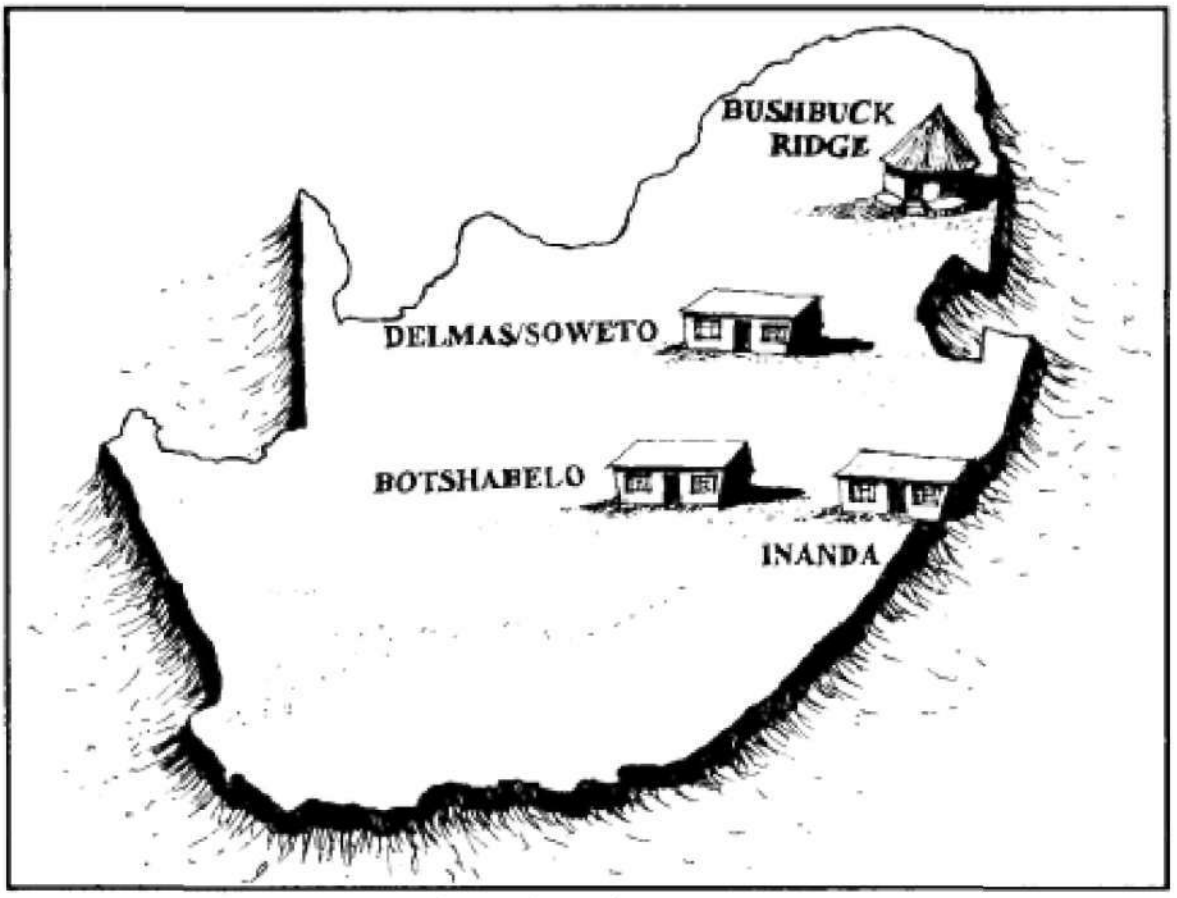
The findings of the situation analysis are reviewed in the next article. Here we will briefly describe what was done. (See also table 1)

The situation analysis consisted of three separate activities. The first was a set of questions inserted into a national survey done by the Human Sciences Research Council looking at utilisation of health services and private expenditure on health care. Preliminary results of this survey were presented at the national conference, but more detailed analysis still has to be completed.

The second component of the situation analysis consisted of a questionnaire which was sent to all members of SAHSSO and all NPPHCN projects. The questionnaire was designed to enable members or their projects to do micro analyses of the health services in their own environment. After establishing local demographic and socio-economic information, the questionnaire asked for information on health services in the area, health providers and facilities, access to ambulances, referral systems, access to mental health and rehabilitation services and support groups, and general questions about the perceived best and worst features of the health service. Of 1300 questionnaires which were distributed, about 100 were returned. The questionnaires were never intended to provide a national or representative overview of health service provision, but rather to provide us with a view of the range of problems especially the problems as perceived by health workers. Thus the analysis of these questionnaires is not a quantitative statistical analysis, but rather lists of priorities and concerns. The effort that had been put into completing these questionnaires was truly impressive and the information obtained is interesting.

The third aspect of the situation analysis was the conduct of five in-depth studies of health and health services in five local settings. The main objective of these in-depth studies was to identify the most serious backlogs in essential health services in those particular communities. Aside from collecting information on health, health services and factors affecting health (like water availability), the in-depth studies conducted community interviews to obtain qualitative information on community perceptions of the best and worst features of their health services.

This was intended to be a major capacity building exercise with the local SAHSSO/NPPHCN policy committees deeply involved in the studies. In each of the five settings, Bushbuckridge (north eastern Transvaal), Diepmeadow (Soweto), Delmas, Botshabelo (Orange Free State), and informal settlements near Durban, a fieldworker was employed for two to three months, and a supervisor was identified and paid to assist in the work. The fieldworkers and supervisors received training at national workshops.



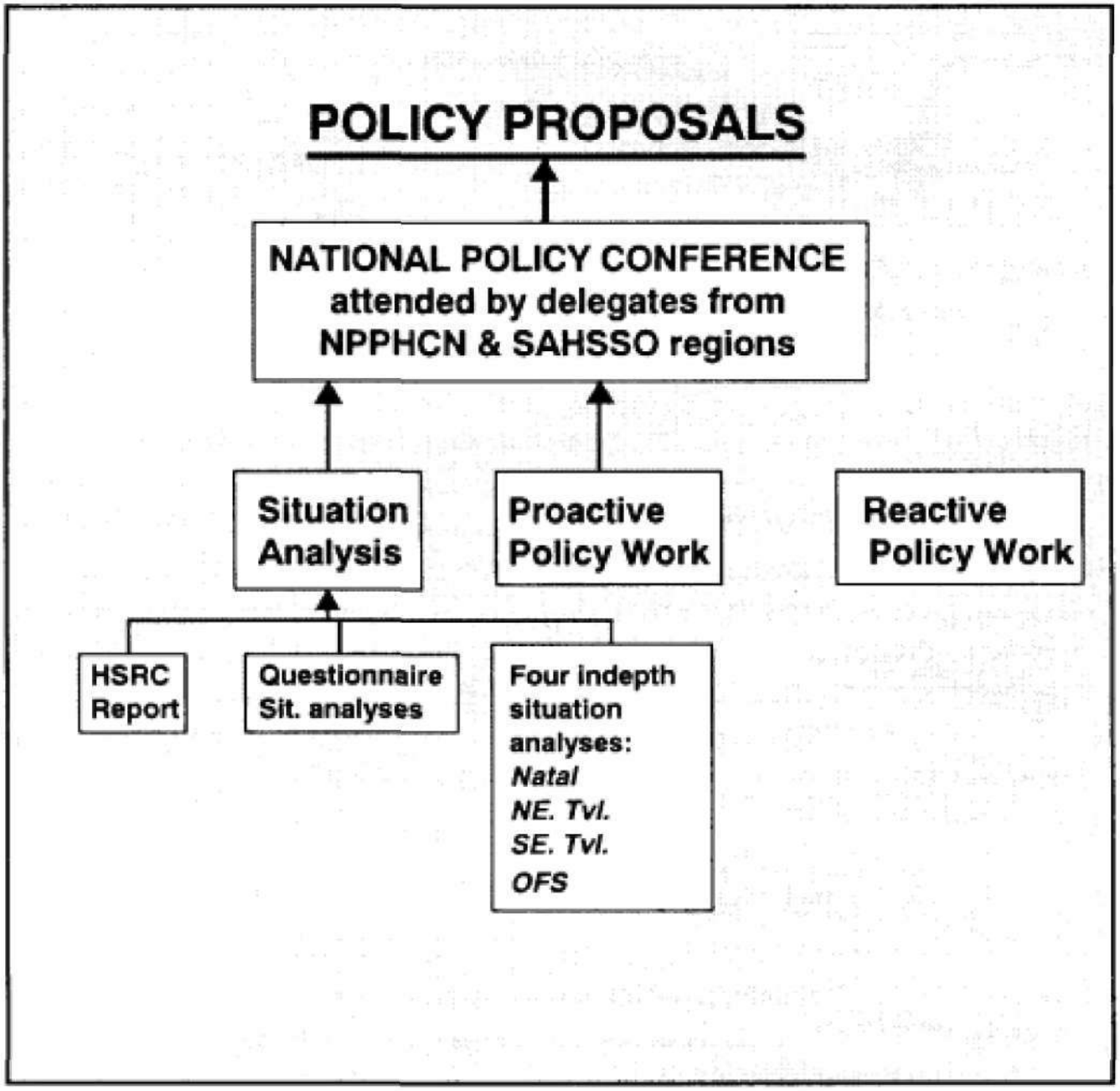
Location of areas

The in-depth situation analyses were meant to include both the communities involved and the regional policy committees in order to build capacity among both these groups. In reality most of the work was done by the fieldworker and supervisor. Community and regional committee involvement was minimal. Therefore the in-depth analyses did not really succeed in building capacity beyond the individuals directly involved. Nevertheless the content of these reports was very interesting and useful. These will be published in full as a separate publication.

Pro-Active Policy Work

Throughout the year members of the policy groups identified issues to research and on which to develop positions. Amongst others, these included questions on health financing, women's health, occupational health policy, health status and health service indicators, community health workers, and definitions and conceptualisation of primary health care. On most of these topics, the steering committee identified people in the country who had done work on these areas and either commissioned them to write a discussion document or obtain from them material that they had previously published (see table 2). This together

with all other policy related material has been placed in a database in the NPPHCN offices and a list of these publications is available on request. In addition documents on some of these issues were circulated to all the regional committees for them to discuss and offer feedback. The main purpose and value of this activity was to prepare organisation members for the national conference in December at which many of these issues would again be discussed.



National Health Policy Conference

The five day conference held at Broederstroom (outside Johannesburg) was attended by 160 delegates from SAHSSO and NPPHCN branches around the country, as well as delegates from fraternal organisations, and a few local and

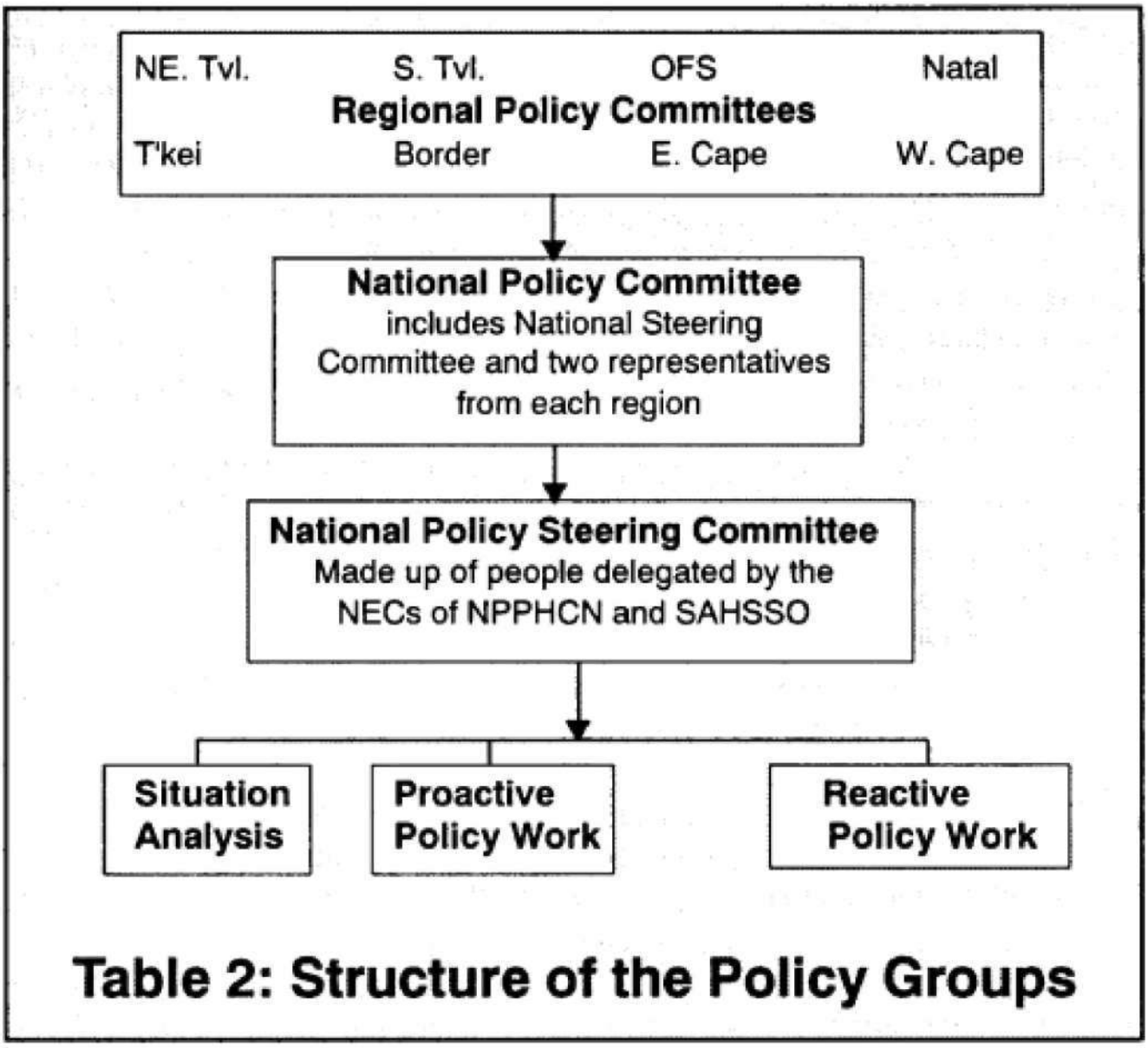


Table 2: Structure of the Policy Groups

overseas experts who would provide inputs on their specific areas of expertise.

In the process of planning the conference, the organisers were concerned that we should not simply have another broad, all inclusive policy conference which would issue policy goals and broad consensus, and not take matters any further. During the preceding 2 to 3 years, the Maputo conference held in April 1990, the Joint Conference in Cape Town in July 1991, the ANC health policy conference in January 1992, as well as numerous NAMDA, SAHWCO and OASSSA conferences, had addressed issues of privatisation, financing health services, mental health policy, PHC policy, women's health, etc. This conference needed to do something new, useful, and also take advantage of the grassroots experience of our membership and the delegates, while recognising that many would not be familiar with the more technical policy and planning issues.

The strategy adopted was to build the programme around the situation analyses with few pre-defined topics, or inputs. The first day was spent in small groups reviewing the situation analyses, and conference participants identified a large number of health care problems, usually at the micro level. During the plenary at the end of the day, delegates then selected about 16 priority areas that they wish to deal with.

These priority issues were discussed by small group commissions over the next two days. Each commission lasted 4 to 5 hours, and was expected to generate concrete recommendations to deal with each problem. The reports and recommendations of the commissions were discussed in plenary at the end of each day.

In addition to the above, in plenary session each morning, local and overseas experts gave inputs, mainly for general information, providing technical background and an international perspective on problems the commissions were likely to be addressing.

The commissions focused on the following topics:

*** General health service structure**

1. Health service financing
2. The delivery of primary care in a NHS and the relationship with independent primary care providers
3. National, regional and district and local health authorities' organisational structure of health services
4. Processes and strategies for transformation
5. Community participation in the health sector.

*** Health personnel**

6. Community health workers
7. Health personnel in transition: transforming the civil service (including policy on labour relations in the health sector)
8. Improving the quality of public health services - including redistribution of health personnel
9. Traditional healers.

*** Programmes within health services**

10. Role of NGOs
11. Women's health
12. Occupational health
13. HIV, AIDS and sexually transmitted diseases

14. Drought, nutrition and intersectoral collaboration
15. Mental health
16. Rehabilitation services.

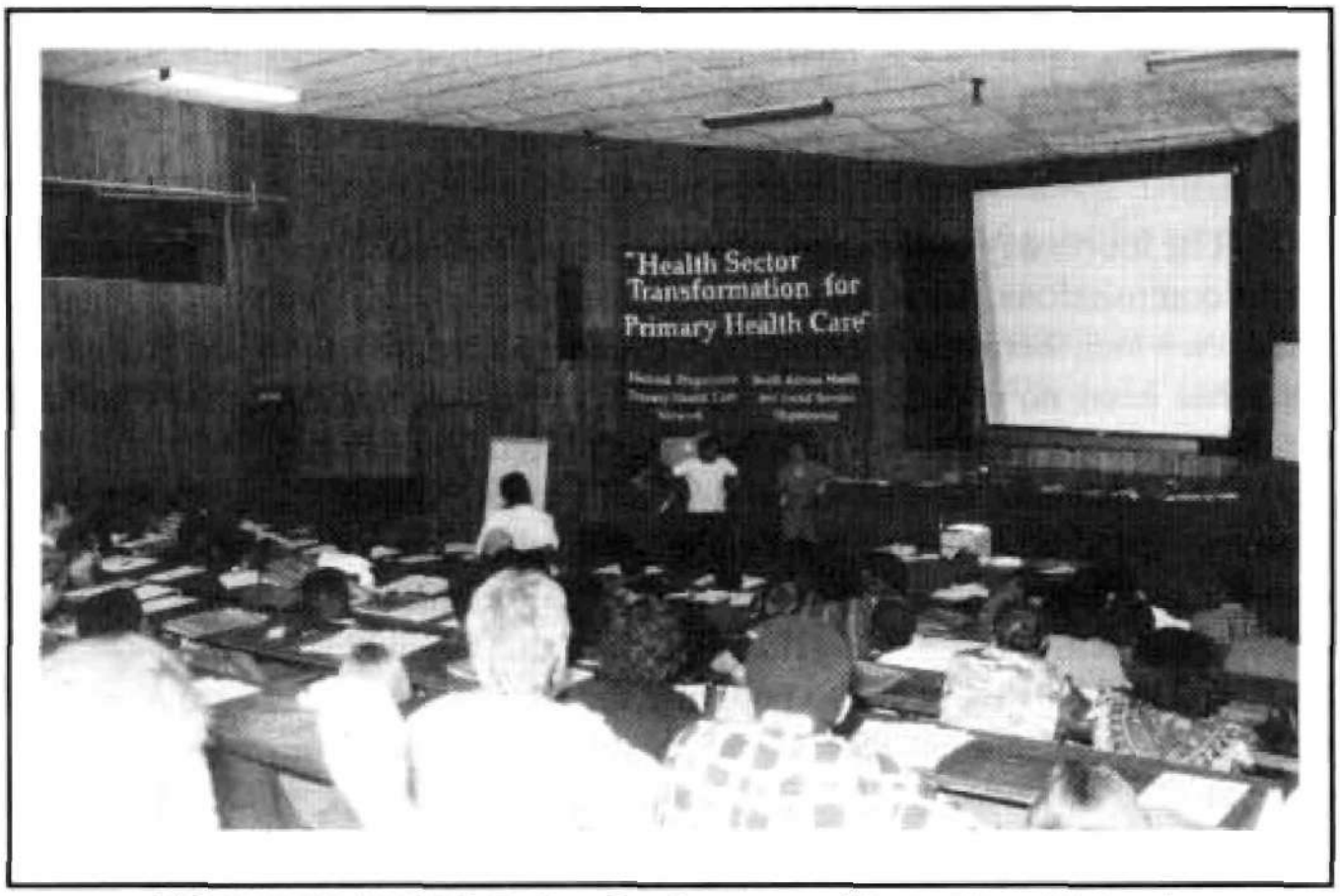
The fourth day of the conference was used to summarise the proposals of all the commissions, develop consensus statements where possible, and identify issues on which there was no consensus. In addition, a number of issues (on which there has been no commissions) were discussed, such as Essential National Health Research and the need for a National Medicines Policy.

The final day, was an open day, held at the Market Theatre in Johannesburg. Press advertisements invited public attendance and invitations were also sent to a large number of progressive and state aligned organisations, foreign diplomats, press and funders. The purpose of this day was to inform people of SAHSSO and NPPHCN and to publicise the conclusions of the conference, so that these organisations' profile was matched by clear information on their policies. The day was also intended to engage other organisations on selected policy issues.

Thus, the policy conference differed from other conferences in a number of ways. Firstly, the problems being dealt with were generally identified through the situation analysis of specific local health services. Secondly, the approach to solving the problems was based on participants' personal experience of these situations. Thirdly, the small group commission process with quite a lot of time available for discussing each issue, resulted, we believe, in building the capacity of participants. Finally, the high profile, final day, began the process of engaging other actors in the health sector by taking the initiative in presenting our views - clearly, in writing, in public, and directly to those with other views on policy in the health sector. (Of course, there was no time during the public presentation to entertain substantial debate on the numerous policy issues raised.)

The Way Forward

An enormous amount was achieved through the situation analyses, the national conference, and the general mobilisation of many members of our organisations into policy work. There were also many areas requiring ongoing development, however, particularly in terms of capacity building. A formal external evaluation of the year's activities including the conference will be completed shortly and this will inform future policy work of SAHSSO/NPPHCN. However, the feedback already received suggests that the major activities for 1993 should be



NPPHCN/SAHSSO Policy Conference. *Photo: Ismail Vawda*

to take back the 20 policy proposals generated at the conference and to discuss these thoroughly in the regions as a way of educating members about the issues, and of increasing members' confidence and skills for participating in policy debates. In addition, SAHSSO and NPPHCN as organisations have still to ratify or modify the policy proposals as supported by the conference delegates. (It should be noted that the proposals were resolutions of the conference and are not binding on the respective organisations.)

Finally, most of the policies demand government action and are directed at the future transitional and democratic governments. However, some call on the present government to make changes. We are still opposed to unilateral restructuring, and therefore these changes must be made through negotiation with credible leaders of the major political organisations, and with legitimate community representatives.

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