ANC experiences in health personnel development

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Major issues in the development of health human resources revolve around questions of production and utilisation to ensure availability and accessibility of health care.

ANC policy

Consideration in the production and utilisation of health workers includes:

- ☆ acceptance of health as a basic human right;
- ☆ political commitment to health for all;
- ☆ the need to redress existing inequalities in health status and the inequitable distribution of human resources;
- ☆ co-ordination amongst all sectors in the movement (ANC) to support the health development programmes;
- ☆ community participation as an essential component in planning and implementation of health development programmes.

Because development of health personnel is located within the accepted context of primary health care, it focuses on the principle of equity, which has a moral value. After all, the future democratic government will be guided by the direction and the pace it adopts to redress the centuries of oppression and exploitation and also in the area of the provision of health care.

The development of health human resources in the ANC has, therefore, had to:

- clearly conceptualise an integrated development of health human resources;
- satisfy the requirements of the human resources both in terms of quantity and quality;
- ensure relevance and professional competence;
- guarantee proper development and efficient utilisation.

Communities

The ANC Department of Health was called upon to deliver health care to:-

- the members of Umkhonto we Sizwe who require special attention because of the type of special tasks they perform in the drive to liberate our motherland.
- the school children, who have been brutalised by the repressive and the oppressive system of apartheid;
- young, and in most cases, single mothers and their children;
- after almost 30 years of exile life, elderly people with chronic diseases such as diabetes and hypertension;
- difficulties of aclimatising to new exile living conditions have manifested themselves in mental health problems, including, amongst others, severe depression, alcoholism and drug abuse;
- diseases that are a product of racial discrimination, oppression, depression, poverty and underdevelopment are often prevalent amongst refugees from South Africa, for instance, a high incidence of tuberculosis;
- tropical diseases that are not prevalent in South Africa - malaria being the most devastating;
- recently, incidents of HIV infection and AIDS.

The ANC Health Department

In the early 1960s, members of the ANC were treated mainly by medical auxillaries, who had been trained on the job. They were referred to as "Medical Officers". Their training met the criterion of competence as it was problem-oriented. The main problem was malaria. There has been no registered death of malaria during a period of over 15 years, despite malaria being unknown to both patients and providers of health care.

Because health is a basic human right for all the ANC cadres, it is free. It is, as far as possible, made easily available and accessible. As a matter of principle, health care is also free for the local population in the neighbourhood of the refugee settlements. This therefore puts a great demand on the numbers of the health care workers.

Initially, health care was curative and institution-based. Elements of prevention and community-orientation were introduced with time. Rehabilitation, especially counselling, remains a problem in a situation of an acute shortage of trained personnel with appropriate skills. At times this becomes inadequate where communication and proper understanding of the aetiology is problematic.

With the exodus of thousands of the youth, particularly following the 1976 Soweto uprisings, it became imperative

to set up a health structure that was to provide comprehensive health care; disseminate information on the effects of apartheid on health to isolate the apartheid regime in line with the economic, cultural and academic sanctions; formulate health policies for our communities; organise material and moral support for the Movement and also identify areas for training health personnel.

A Medical Committee set up on 5 August 1977 soon expanded to a Department of Health to which all health workers belong and can be elected to any position irrespective of their field of training. This has had its problems in terms of intraprofessional working relationships and representation on international bodies. The Department of Health has a Secretariat, whose members are the Secretary for Health, the Deputy, Officers in charge of Community Health Programmes, Logistics and Supplies, Information and Publicity, Personnel Development and Deployment.

Each region has a health team that is represented and works in close collaboration with other sectors of the Movement including the regional political structures. Because the head of the Department is not a member of the National Executive Committee, some health recommendations take a while before they are actually adopted as policy.

To date the ANC has trained an army of health workers including doctors, nurses, dentists, laboratory technicians, medical assistants and more recently - social workers, whose work used to be performed by political commissars and health workers.

There has been a deliberate move to encourage people to specialise in areas of public health and administration including health planning. Lately some doctors have been encouraged to specialise in conventional areas such as gynaecology, paediatrics, psychiatry and internal medicine. Nurses have tended to specialise in health education.

In order to get a sense of managerial processes, the Department of Health has held a number of workshops on management, essential drugs, mental health, maternal child health, primary health care and many other topics. These workshops have been organised on an intersectoral approach, with members of other departments and sectors invited to participate, in order to acquaint them with health development approaches.

Joint initiatives were undertaken with SWAPO of Namibia in training health workers and also in running courses that prepared students for entry into health institutions.

Constraints and obstacles

Generally, the ANC relies on the international community for material and financial support in order to implement its programmes. Sometimes neither finances nor facilities are available. In a situation where one does not always have an indicative planning figure, serious difficulties have been encountered in trying to synchronise development with the overall plans.

Conflicts and differences of opinion between the health planners, other interested groups, professionals and even the communities who are consumers of health care, have arisen in determining the category of health worker to be trained, especially with regard to medical assistants. This is a new category of health worker, within the health profession in South Africa.

Medical assistants, together with the medical auxillaries and those trained on the job, have been the backbone of health care delivery in the settlements. It is necessary to study and understand clearly their curriculum in order to avoid time consuming, sometimes painful processes of negotiations and compromises in personnel choices. The guiding principles often have to be equity and competence.

The management of these resources can be extremely complex. The complexity is compounded by the fact that this sector is composed of people with various levels and categories of training, various attitudes, motivations and work patterns. Noticeable are the strong preferences for deployment in the settlements which are not far from the nearest town. This has often led to a maldistribution of personnel. Those in the settlements that can be referred to as "hardship working areas" remain there for extended periods of time. Motivation of course is bound to drop and this raises the question of incentives. Financial incentives are not always easy to provide. The improvement of working conditions requires both political commitment and financial resources. Sometimes the demands and expectations of communities in the settlements far outstrip the capacity of the health workers and this can make the working environment very difficult. The basic necessities are, of course, provided by the Movement. These include creches and day care centres for all, including the health workers.

Career mobility, including further training becomes the only meaningful outlet where political persuasion on commitment and improvement of attitudes fails. This is understandable. After all the Soweto uprisings were, amongst other things, around issues and struggles for education. The impatience of some health workers against the delays in obtaining placement in institutions in order to improve their level of education and also improve their skills, is therefore tolerable.

Not all the trained personnel make themselves available on a fulltime basis for service in the settlements. Even the policy of a minimum of two years deployment in the settlements has not been readily accepted by some workers. Most of them have taken up employment with the Ministries of Health, mainly in the Frontline States. Indeed, the Movement has had to make arrangements for them to be employed on local terms. And so they continue to improve their skills in preparation for returning home. While they do not work directly with the Movement, they contribute from time to time by seeing patients referred by the ANC to the hospitals. They are also part of regional structures and units.

For fulltime functionaries, this means an incredible load of work, at times with great sacrifices. There is hardly an opportunity for holidays and such workers are often unable to take upgrading courses and specialisation. In most cases, this burden falls on those who are highly politically motivated.

Some nurses have preferred to do medical training rather than develop in the nursing field. This has meant six-

seven years of training. The fact that opportunities for medical training were not easily available in South Africa, could be one of the reasons for their choices.

The question of who leads and heads the health team has often arisen as most of the nurses have long years of experience in comparison with the young qualifying doctors and medical assistants. Gender issues have been manifested in the intraprofessional health struggles, even within the Movement.

A difficult component of planning involves the implementation of supervision. Senior and experienced health workers are overstretched. Sometimes, travelling in order to supervise health workers on the ground is misinterpreted as legitimised truancy and yet these visits are usually appreciated by the health workers. Where the health workers do not have adequate skills, supervision is the key to success and continuing education.

Planning has tended to focus on numbers rather than quality issues. The evaluation of the performance of health workers, which has not always been comprehensive, clearly demonstrates the need to properly manage all the levels of primary health care to ensure quality of care and comprehensive care.

Managing volunteers has not been an easy task. They have dual accountability. Procedures of integrating their expertise to the local experience is not easily accomplished.

The role of traditional healing has been highly debated amongst health workers. Some are ready to work with traditional healers, while others believe the tragedies arising from this service are too horrifying to even begin to isolate the positive aspects involved.

By and large, the experiences of managing health personnel within the liberation movement does not differ much from management by Ministries of Health. What has been gratifying is the commitment of those health workers who left for upgrading and have come back to their communities and settlements more dedicated than ever before to continue their work. It surely should not create problems to integrate the health workers trained by the Movement into the people's health care system of a future democratic South Africa. We hope this conference can lay the basis for mechanisms and guidelines of integrating them. ❑

PERSONNEL CHOICES - AN OVERVIEW

The objective of this section of the conference was to look at the kind of personnel development necessary to achieve an equitable, accessible health service in South Africa. The first two papers outlined the current health personnel available and, given the limited financial resources available, initiated debate around the most appropriate category of health worker to be trained as a priority. One of the crucial issues to be addressed in the implementation of a national health service is which categories of health worker should deliver primary health care. Internationally, experiences have ranged between minimally trained Community Health Workers (CHW), mid-level health workers such as nurses and medical assistants and medical practitioners. Arguments for and against the various options were presented.

The lack of a coherent national policy on personnel development was partly to blame for the current irrational training and distribution of personnel and the obstacles to achieving change in this area were examined. Debate around these two articles resulted in the following proposals:

■ There was a general feeling that the most appropriate first tier of PHC worker would be the Community Health Worker (CHW) but the delegates acknowledged that the debate was still in its very formative stages.

CHWs should be elected by and be responsible to the community in which they live and their training should, as far as possible, take place in this community. They would deal with minor illnesses and play a key role in prevention and health education. They would refer difficult patients or patients needing more specialised care to the Community Health Centre which would be staffed by both mid-level health workers and doctors. Lessons can be learnt from the experiences of other countries, particularly with regard to problems with large national CHW programmes.

CHWs would have peer group supervision with the possibility of career mobility within this category (e.g. to supervisor of other CHWs and on to regional supervisors). They should be well trained to avoid "dual" standards (see previous papers), and their work should be paid for.

■ The Community Health Centre will be responsible to the community it serves. The community will in some way be able to influence services and policies of the centre. Above these centres would be regional and teaching hospitals, but the emphasis would be on primary health care.

■ Mid-level workers - it is important to work out one category of mid-level worker. Whether a decision in taken in favour of PHCNs or medical assistants, it is important that their training be relevant from the beginning of their courses.

■ Training of all health workers should be community-based, problem-oriented and should inculcate a primary health care vision.

Mamlo Tshabalala of the ANC delivered a paper outlining health personnel development within the organisation as well as the problems the Movement has faced in this regard.

Over 100 ANC doctors have been trained while in exile and an emphasis has been placed on the training of medical assistants. She stressed the need to incorporate such personnel into the health sector when they return from exile. The need for career mobility for these health workers was also stressed.

Dr Boal from the World Health Organisation (WHO) presented a paper suggesting principles and problems involved in the planning of human resources in the health sector. The following steps were recommended as an approach:-

* Analyse current trends in the health sector;
* Analyse human resources available;
* Estimate future supply of staff and compare with estimations of the future demand;
* Identify imbalances between supply and demand and generate solutions;
* Select strategies for the development of health personnel and elaborate a plan of action for their implementation to include the meeting of short, medium and long-term objectives;