HEALTH AND HEALTH CARE IN MHALA

Gazankulu is one of South Africa's so-called "black states". The Mhala district is an isolated island mid-way between Nelspruit and Tzaneen. It is typical bushveld with limited water and poor agricultural potential. 152 000 people live in Mhala's 57 villages which vary in size and infrastructure. Health services are underdeveloped and comprise one 260-bed hospital (Tintswalo), one health centre, eleven clinics and a mobile clinic.

This paper focuses on the day to day realities of health and health care in Mhala.

Mhala is a "homeland" area like many others. The people who live there are poverty-stricken and, therefore, peoples' state of health is poor. The health service cannot do anything to do away with this poverty; and the health service does not give good quality health care that is in reach of everyone. The homeland policy brings about more problems because it breaks up the services and forces divisions between people. This article looks at the problems of health care in this area. Similar problems can be found with health and health care in other "homeland" areas. The writers of this article would like to show that it is nonetheless worthwhile to try and develop health services within the limits of the policies that cause social ills in this country.

This paper was written at the beginning of 1984. The figures in this paper give a picture of the conditions at the time. Even though slight changes might have happened between then and now, the general problems and the conclusions that can be drawn from the figures, have not changed fundamentally.

Socio-Economic Conditions

A study done by the "Institute for Development Studies of the Rand Afrikaans University" has shown just how

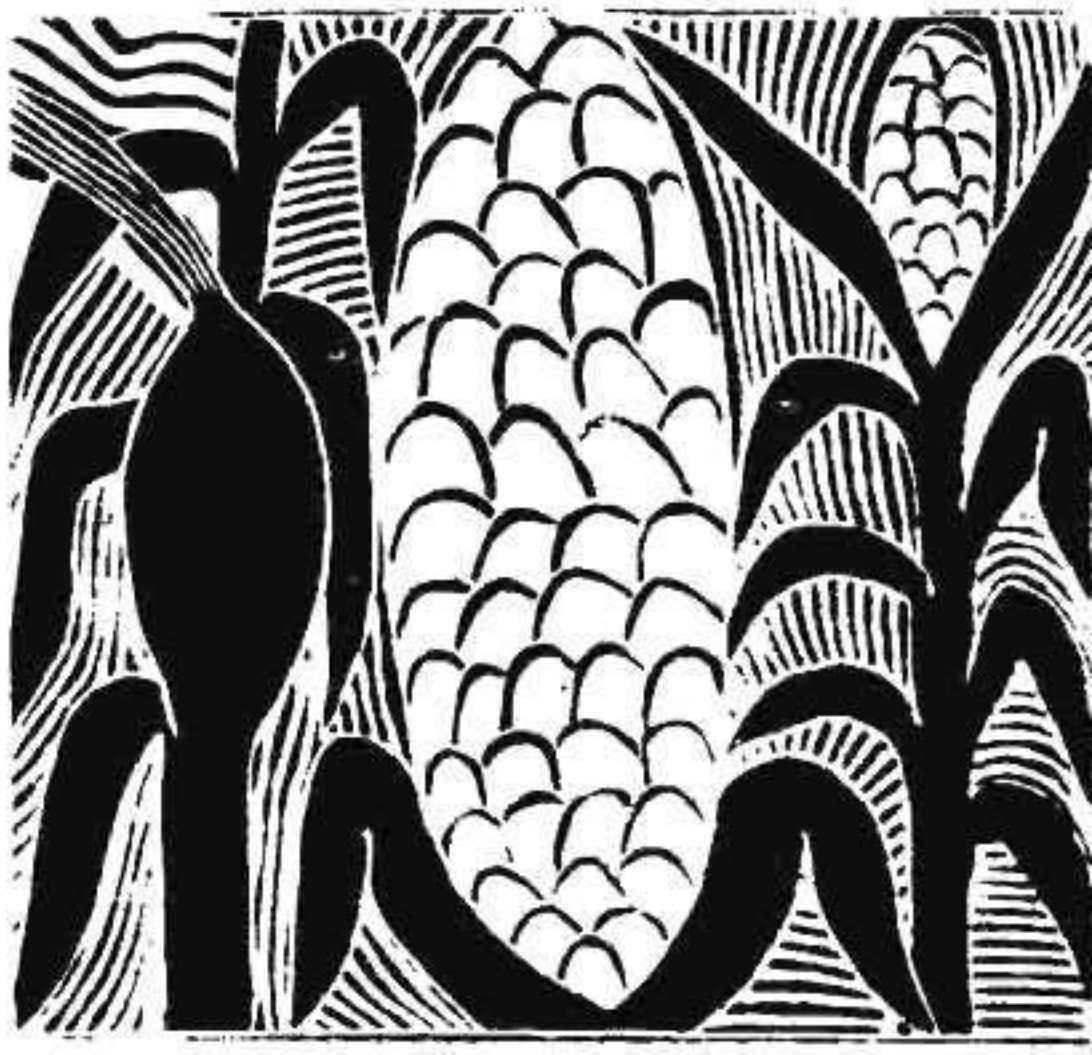
widespread and far-reaching the poverty in Gazankulu is. How do the problems of land, food, water, transport and education affect the people in their daily lives?

Land

There are 152 000 people living in the 1 204 square kilometer area of Mhala. On average, 126,2 people are living on one square kilometer of land. Most people live in closely spaced villages. They have limited access to land. The average plot is 1/4 hectare. People are given a further two hectares if this is available.

Food

People are not able to produce enough food on their land and do not have enough money to buy it. The result is malnutrition.



Even in the best years, a harvest will not provide food for more than five months. It is only in the few special development projects that fields can be watered.

The average family gets between R40 and R50 per month. This, in most cases, is what migrant workers send home. This money has to cover everything the family has to buy, including food. (The average family size is 5.) This is not enough under any circumstances, but it is made worse by the high cost of food in rural areas. (For any goods bought in the local shops, people from Mhala have to pay up to 44% more than in a supermarket in Nelspruit.)

Water

165 boreholes are the main source of water in Mhala. 31 boreholes have engines and 29 have reservoirs. Most boreholes feed into a single standpipe, but some have

more than one outlet. On average, one tap is used by 760 people.

The water situation is made worse by the distribution of boreholes and by inadequate maintenance. In April 1982, seven villages (with altogether 15 582 people) had no boreholes, and a further six villages (with altogether 16 846 people) had all their boreholes out of order.

This means that 32 428 (48,6%) of the 66 615 people in the 25 villages of Mhala South could not get clean water.

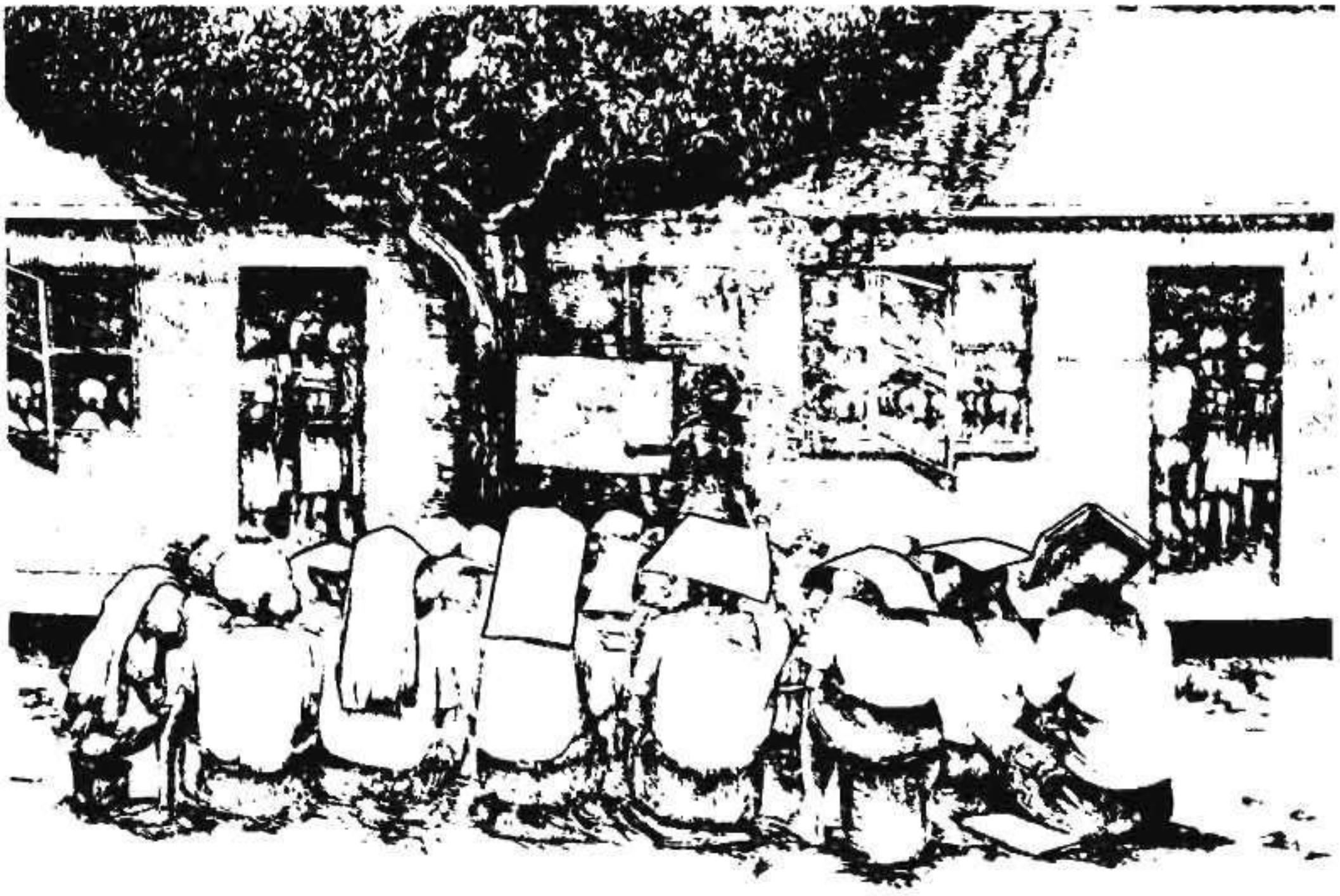
Transport

There is no bus service and only 6 kilometer of tarred road in Mhala. Transport is possible by means of taxis. But the taxi fares are so high that most people cannot afford them. People have to pay 80 cents for a return trip from the nearest village to the hospital, and R16.00 from the furthest village. At night, this increases to R10.00 for a return trip from the nearest village to the hospital, and to R80.00 for a return trip from the furthest village to the hospital.

Education

The primary schools in Mhala have one teacher for every 53 pupils. Many teachers are not qualified. There are shortages of classrooms and textbooks. Often, there are as few as five textbooks for a class of 60.

Given these poor socio-economic conditions, the disease patterns in Mhala are not surprising.



The Diseases

The diseases of poverty

Malnutrition

At least 5 021 (26,3%) of 19 021 children under five years are malnourished. 804 (4,3%) of them are seriously malnourished. The school health service found that 39,6% of 2 609 school children had not had any food before coming to school.

Communicable Diseases

Communicable diseases are diseases that spread from one person to the next. They spread particularly quickly where people are living without adequate food, and without proper sanitation facilities.

In 1983, 279 people were admitted to Tintswalo for TB. The number of people admitted to Tintswalo for Typhoid has steadily gone up from 111 in 1976 to 830 in 1982. Typhoid is endemic in the Mhala area. Cholera struck Mhala in 1981. 41 cases were confirmed.

Diseases in the children's ward

Tables 1 and 2 show that diseases that come with poverty are the main reasons for admissions to the children's ward, and for deaths. 63,9% of admissions are caused by 7 diseases. All of them are diseases of poverty. 69,7% of the deaths were due to 3 causes that have to do with poverty.

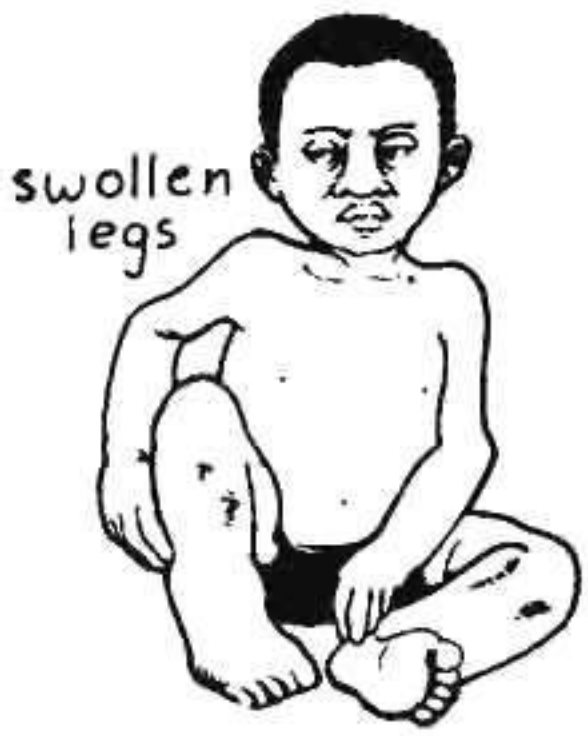
Table 1:Causes of Admissions to Tintswalo Hospital Children's Ward

Cause of Admission	Number of Admissions	% of Total
Gastroenteritis +/-dehydration	271	20,4%
Kwashiorkor and/or marasmus	175	13,2%
Pneumonia	153	11,5%
Typhoid	64	4,8%
Skin infections	64	4,8%
Paraffin ingestion	62	4,7%
Burns	59	4,4%
All other causes	479	36,1%
Total admissions	1 327	100,0%

Table 2: Causes of Death in Tintswalo Hospital Children's Ward (January - December 1983)

Cause of Death	Number of Deaths	% of Total
Gastroenteritis and dehydration	26	34,2%
Kwashiorkor and/or marasmus	17	22,4%
Tetanus	10	13,2%
All other causes	23	30,3%
Total deaths	76	100,0%

marasmus



kwashiorkor

marasmic-kwashiorkor

Harmful Health Behaviour

There are more and more things that people buy and use which may be harmful to health. Nowadays, many people eat refined foods. Also, people have come to rely on infant formula foods, alcohol, cigarettes and skin lighteners. Using these products is harmful in any society, but more so in poor communities, because they misdirect scarce resources and because people have not been warned about the harm that may befall them.

Diet

The staple diet used to be unrefined maize, with peanuts and dark green leafy vegetables as relish. Now only refined maize is available, which people eat with sugar, cabbage or tomatoes; and so proteins, roughage and vitamins are lost.

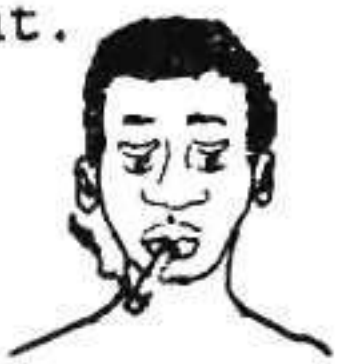
The traditional diet is not being encouraged and people do not realise that the changes they are making are for the worse. For example, only 22% of 46 mothers interviewed in an infant feeding study believed that peanuts were an important food.

The same study found that 80% of mothers had given their children fizzy drinks, 96% "chips" and 92% sweets.

Alcohol

The alcohol trade is flourishing and is supported by radio advertising. Bottle store owners do not give ex-

act sales figures, but say that business is "very good". This is probably true when one looks at the number of powerful people who get into the bottle store business. 8 of the 14 bottle stores in Mhala are owned by chiefs, headmen or ex-members of the Gazankulu parliament.



Cigarettes

Cigarette sales are going up all the time. Shop-owners say that people have changed from single cigarettes to buying packets and that the demand for new brands of cigarettes is increasing. Many people prefer status brands, such as "Benson and Hedges Gold" and "Dunhill".

Skin lighteners

The skin lightener market has grown very fast over the last few years. Sales have jumped and more and more products are becoming available on the rural market.

This is the picture of the diseases of poverty, and of the things people buy and use which may be harmful to their health. The next section looks at how adequate the health services are to deal with these problems.

The Health Services

This section shows that resources for health care are scarce. It also shows how this affects peoples' access to health care, and the quality of health care.

Accessibility

An "accessible service" would be one that is less than 5 kilometers away from where people live, and that provides care at all times, at a cost that people can afford. Health service policy and the behaviour of health workers should not alienate people.

Distance

About half the people of Mhala live more than 5 kilometers away from their nearest health facility. Tintswalo Hospital (the only hospital in Mhala) is situated in the north-west corner of the district. It has already been mentioned that transport is inadequate and expensive.

Those people who live further away are not likely to come to the health service as often and as regularly as they would need to. Although Tintswalo serves more than 50 villages, in February 1984 70,7% of outpatients came from only 8 villages. The three Gazankulu villages make up 13% of the population of Mhala. The same 8 villages mentioned earlier made up 59,9% of the deliveries at Tintswalo in 1983. The distance of the villages from the clinics also affects clinic attendance. About half the ill patients and children at child health clinics come from the village that the clinic is in; attendance goes down as the distance between the villages and the clinics or hospital increases.

Cost

Many outsiders think that health care in Mhala is "cheap". But in actual fact, it is beyond the means of the people living in Mhala. This can be shown by the results of statistical studies. In October 1982, the hospital and clinic fees were, on average, doubled. As a result, there was a drop in attendance in all but the free services.

There are more figures to show that people cannot afford health care. 65,8% more outpatients are seen at Tintswalo during the first week of every month than in each of the other three weeks. This is because people have more money at this time. December is the exception. The hospitals and clinics have equal attendance in all four weeks of the month of December, probably because migrant workers are home, bringing with them their Christmas bonus payments which allow people to go for treatment.

Time

Health workers at the hospital see far fewer patients at night than at urban hospitals. This does not mean that at night, fewer rural people need treatment. It is much more likely that people who need treatment at night cannot afford the high cost of night transport. At that time, also, patients cannot go to the clinics any more because the clinics close at 5 o' clock in the afternoon.

Alienation

If people feel unhappy with the health service, they are less likely to seek help from it. Health workers should therefore develop good relationships with their patients and give them all the information that they need. Health workers should show respect for traditional beliefs and practices. Some health workers, by their behaviour towards the patients, tend to make the patients turn away from the health service. For instance, a nurse might scold a mother who brings a dirty-looking child for treatment, not considering that the mother and the child had to walk a long distance to get to the hospital or clinic.

There are good reasons for health workers getting in touch with traditional healers. This is not allowed at Tintswalo - a policy dating from the time of mission control. Many patients choose to seek care only from traditional healers, or to get care from both traditional and modern sources. Care from traditional healers is readily available in Mhala. There are even training schools for traditional healers in the area.

How many in need of health care do actually get treated?
The problems of distance, time, cost and alienation are the reasons why only few of those people who need care, actually get it. Statistical studies have shown that the need of people for care is mostly met in the case of ante-natal care and delivery of babies. But other needs for health care like child health, family planning, home visits, and care for sick people, are far from being met.

It is important to realise that patients' needs for health care are real. It is wrong to believe that people in rural villages "don't want health care". If ways are found to give more people access to the health services, more people will come to the hospital and the clinics. This can be shown by the much higher rates of attendance when people have money and when they live near to the health services. When a mass immunisation campaign was held, more children came to be immunised than were believed to be in Mhala. This was because the service was available for free in every village; and informing the people had helped to overcome alienation.

Quality of care
The inadequate resources for health care in Mhala make for poor quality health care. Health workers have learnt to accept and work within this inadequate system. That is why standards and practices that would be queried elsewhere, are the norm in Mhala. For example:

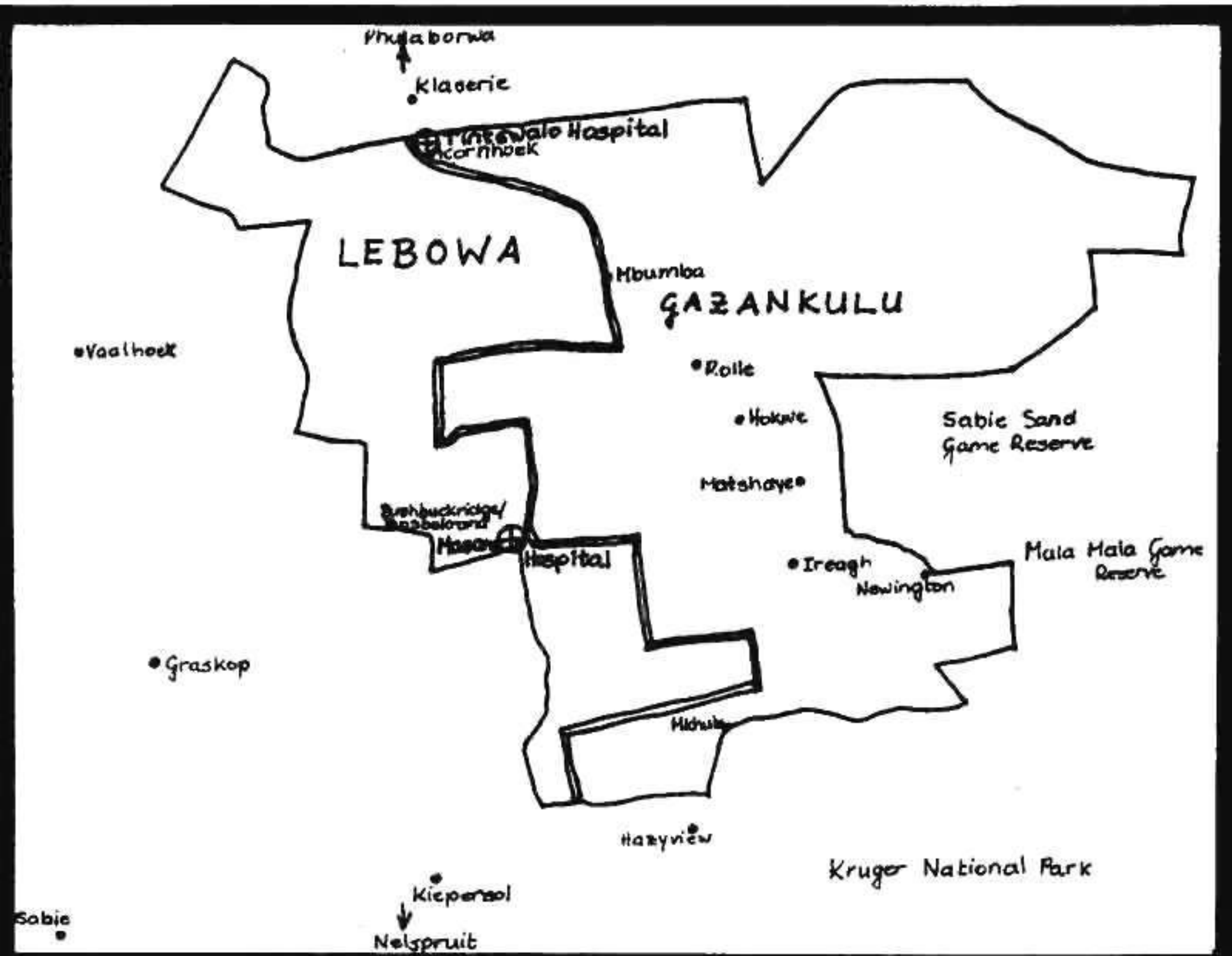
- It is acceptable that patients may be treated without having been examined.
- Workers function in areas where they have inadequate skills.
- Patients are not always explained what is happening to them.
- Patients die because there is no adequate referral system.
- It's "too bad" if things are out of stock or supply is short - patients just do without.

None of these shortcomings are planned or deliberate. They happen because of the inadequate framework in which

health care is delivered.There are not enough nurses and doctors to treat people in need of medical help; there is only a small amount of money available for hospital and community services; and health workers do not get adequate training for the work they are expected to do.

The Effects of the Homeland Policy

Tintswalo hospital and its neighbour, Masana, were previously responsible for the care of the communities around them. Tintswalo now serves the Mhala district of Gazankulu, and Masana the Mapulaneng district of Lebowa. The implementation of homeland policy has led to fragmentation of health services and divisions between people.



Fragmentation of health services

Before homelands were introduced, health services had the policy of serving nearby communities, of co-ordinating the services, and of communicating with each other. Now the Mhala district of Gazankulu is Tintswalo's responsibility, and the Mapulaneng district of Lebowa is Masana's responsibility. Each is now responsible for community health services on each other's doorstep. This wastes scarce staff-time and transport, and weakens an already inadequate support system.

The hospitals no longer co-ordinate policy. For example, when health workers at Tintswalo approached Masana for working together in the care of TB patients, they were told, "Gazankulu can do what it wants to, but Masana will follow Lebowa's policy". During the polio epidemic, health workers at Tintswalo wanted to run a joint immunisation campaign with Masana. But they were told that they should run their own immunisation campaign, and Masana, in turn, would run its own. Even in the face of an epidemic, the fragmentation of health services was carried on.

In the meantime, however, co-operation between the two hospitals has improved. The senior staff saw the bad effects of homeland divisions in health care and have co-ordinated some of their efforts. But there are limits to co-ordination and co-operation as long as the homeland policies remain.

Divisions between people

The health services do not officially distinguish between people whom they treat. Nonetheless, people are beginning to understand that Masana belongs to the "Sothos" and Tintswalo to the "Shangaans". For example,

- Some patients have been told by Masana staff to go to "that Shangaan hospital".
- Patients referred from Tintswalo's clinics to Masana have had to pay again, unnecessarily.
- Ambulance drivers from Tintswalo have refused to take patients to the "Lebowa hospital".

These are just a few of the results of the division be-

tween people. Others can be seen in the fact that Tintswalo only accepts "Shangaan speakers" for nursing training; that Sotho speakers in the Mhala district are beginning to feel that they should go to "the Sotho hospital" and not to Tintswalo; and that polio, when it broke out in Gazankulu, was regarded as a "Shangaan disease", and so many "non- Shangaan speakers" did not see the need to immunise their children.

Developing Health Services Under Apartheid

We have seen in this article what kinds of problems result from health services which function in a society based on inequality. People in most South African rural areas, especially in the "homelands" are poverty-stricken and find it hard to survive. They are in poor health, and the diseases which break out among them are the diseases of poverty.

Added to this are the problems of the health services themselves. The health care system is far away from the community, not only in kilometers, but also because of the time and money that it takes people to get to the health service. Also, many health workers cannot talk to and understand their patients well enough. All of these problems are responsible for the fact that only a small number of those people who need care, actually get it.

Many of these problems could be overcome with enough finance, staff, facilities and equipment. There is no hope that these will be forthcoming, given the unequal allocation of resources under the apartheid system. Health workers should not accept the poor quality of care as a norm. Finally, health workers should combine and co-ordinate their efforts to work against the bad effects of apartheid health services, so that health care will be better and more accessible to people.

Looking at all these problems, the question arises: Why try and develop health services if their chances for providing good care are so small? Why not wait for major changes in the structures of society that will remove

the barriers of apartheid and allocate resources in a more equal way?

We would like to argue that it is still worthwhile trying to develop health services in Mhala today. The reasons for this are:

- Health services are important in rural areas.
- It must become clear that what is seen as good enough in terms of the quality and accessibility of health care in rural areas, does not, in fact, meet standards of good health care.
- Alternative methods of delivering health care have hardly been explored in South Africa. This needs to be done.
- People need to develop an understanding of what is needed for setting up adequate health services.

In these ways, we can help the process towards and prepare for an improvement in the health services under changed social and political conditions.

This paper was presented by Cedric de Beer and Eric Buch to the Second Carnegie Inquiry Into Poverty in Southern Africa, April 1984