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POLICY IN TRANSITION

Contents

Critical Health would like to thank the following people for their help with this edition: Jane Mathieson, and Ant & Monique.

Editorial

South Africa is experiencing a rapid, although turbulent, process of transformation. This process, together with the ongoing deterioration of health services, presents a new challenge to progressive health organisations. They now need to prepare their members to participate in debating and formulating health policies in the interest of the majority. NPPHCN and SAHSSO have initiated a process of building their members' capacity to participate fully in such policy formation. Members of these organisations were involved in researching and analysing the state of health services across the country. Findings of these situation analyses provided the framework for discussions at the NPPHCN/SAHSSO Policy Conference, held in December last year.

We start off the edition with a conference overview, which highlights the unusually participatory nature of the situation analyses and the conference which followed. The situation analyses were reviewed by the conference delegates from the different regions of NPPHCN and SAHSSO to identify priority issues. These were discussed in commissions and plenaries. This process led to the formulation of about twenty policy proposals. These proposals have been taken back to the regions, for discussion and debate.

This article is followed by an overview of the situation analyses, which shows that they were based on grassroots evaluation by field workers, trained and drawn from communities. The situation analyses researched the present condition of health and health related development facilities. They also looked at people's perception of the role of health workers, and their understanding of community participation.

The situation analyses also dealt with factors hindering the accountability of health services to the community. We include an article, based on a local situation analysis in the Eastern Transvaal, which shows that a lack of community participation in health projects is not only due to problems internal to these projects. The various divisions within communities and the lack of democratic structures of authority providing health services play a major role. To overcome these problems, it is suggested that non-government organisations be proactive and identify common goals around which to unite.

The articles in the second section cover some of the discussion and debate in the commissions. Prior to the conference, progressive organisations criticised the government for the poor service provided by the public sector. They opposed fragmentation and demanded a unitary health service. Many of the commissions

at the conference went beyond merely criticising and making general demands. They focussed more concretely on the things that need to be done to transform the public health sector and, more generally, the public sector as a whole. Participants debated a structure for a new public health service as well as issues that need to be addressed in order to improve the quality of service in both the health sector and other sectors of the state. They started to develop specific suggestions on ways in which the health sector can and should collaborate with health related sectors.

The next article is on the commission on health sector financing, which looked at financing from a fresh perspective. Previously, debate focussed on the pros and cons of a national insurance system for both public and private sectors, versus financing the public sector separately from the private sector. The commission, in contrast, started by discussing the objectives that need to be met by a new health sector. Participants then moved on to discuss a range of possible sources of finance to meet these objectives.

There were a number of commissions that looked at issues relating to health personnel. They debated the types of changes that are required to ensure that personnel provide appropriate health care for the majority and that health workers are provided with adequate working conditions. The article on personnel looks specifically at the debates and discussions which took place in the commission on new categories and redistribution.

The commissions reported at plenaries and all conference delegates participated in the drawing up of policy proposals. We publish an appendix at the end of this edition of all the policy proposals arising out of the conference.

The first article in the third section draws together the common themes from the different policy proposals. There was total opposition to the government's unilateral restructuring of health services. There was agreement on the need for progressive, participatory primary health care (PHC), as opposed to the government's top down approach. Various proposals dealt with human rights, including a proposal for the drafting of a Patients' Charter of Rights and a call on the government to endorse the AIDS Charter. Accountability was seen as central to improving health services. The need to redistribute resources to ensure equity was stressed. There was also emphasis on the need for proactive research, training of new categories of personnel, further training and reorientation of existing personnel, health education and health promotion.

In summing up the outcome of the conference, Malcolm Segall, argued for informed planning as a way of setting priorities. The membership of the two organisations, with other community based organisations, can do further local situation analyses and formulate policy at this level. The policies so conceived

can be applied nationally, once resource needs are determined. Policies can be modified in terms of costs and economic viability.

We also include an article by two Cuban doctors, Felipe Delagado Bustillo and Carlos Mas Zabala, in which they outline their perspective on the way forward to establish an NHS in South Africa. They stress the need to concentrate on a few priorities. These include prevention, an epidemiological surveillance system, primary health care and four specific programmes, namely to provide mother and child care and to combat tuberculosis, gastro-enteritis and sexually transmitted diseases.

The articles in our general section complement some of the themes and proposals of the conference. Francie Lund raises issues of tension in conventional perspectives on community health workers (CHWs). Training CHWs in preventive medicine should reduce the workload of nurses. Yet, the proactive work of CHWs often produces more patients for nurses to see. CHWs should also reduce the need for health professionals, yet, the act of training CHWs influences communities to perceive CHWs as professional. This has the effect of limiting community participation. Lund suggests these tensions can be overcome by networking - sharing information and skills.

One of the conference proposals calls for freedom of association for all health workers. We include an article on the issue of nurses' freedom of association. Nurses are legally compelled to be members of SANA, but there is growing opposition to SANA's statutory status. *Critical Health* examines the various issues involved, including debates over the ethics of nurses becoming members of trade unions and exercising the right to strike, as well as the various alternatives to SANA.

The conference opposed unilateral restructuring of health services by the government and, since then, SAHSSO has launched a campaign against unilateral restructuring. The campaign is a joint campaign of various organisations in the health sector and the mass democratic movement. The last article in this edition, forwarded by SAHSSO, discusses the campaign.

The cost of medicines is soaring and people are increasingly unable to afford the medicines they need. What lies behind these escalating costs? Are large drug companies and pharmacists making excessive profits? There is a shortage of personnel, especially in the public sector, and patients are not adequately informed on how to take their prescribed medication. How do we ensure medicines are accessible and appropriate in a new public sector based on primary health care? Get the next edition of Critical Health on the Pharmaceutical Industry and Drug Policy.

Acknowledgements of Organisations and Persons

The joint Policy Steering Committee of the National Progressive Primary Health Care Network and the South African Health and Social Services Organisation wishes to thank the following organisations and persons for their contribution to the implementation of the policy programme during 1992.

- The Henry J Kaiser Family Foundation for providing the funds for the situation analysis, the salary of the policy co-ordinator and the administrative activities of the National Policy Sub-Committee of the NPPHCN and SAHSSO.
- Medicins du Monde for their contributions in the development of the policy programme and for giving technical support during the situation analysis and logistical support to the National Policy Conference
- The Commission of the European Community and the Kagiso Trust for funding the December 1992 NPPHCN/SAHSSO conference
- The international speakers for their crucial input into the health policy debate in South Africa. They include:
  - Dr Gerald H Bloom (Britain)
  - Dr Joseph Carrabeo (Phillipines)
  - Prof Julie Cliff (Mozambique)
  - Dr Lilian Kimani (Kenya)
  - Dr Leonardo Antonio Cuesta Mejias (Cuba)
  - Prof Malcolm Segall (Britain)
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  - Olivetti for laptops
  - Gestetner for photocopies
  - All the regional co-ordinators and committees of the NPPHCN and SAHSSO who gave their time and other resources in support of the policy formulation programme during 1992. We also pay tribute to the individual members and other volunteers who, through various contributions, ensured the success of the policy programme.
- Finally, we also wish to thank *Critical Health* for the painstaking task of producing a publication on the policy conference.

Partiàpatory Policy Formulation:

NPPHCN and SAHSSO have embarked on a joint process of policy formulation, involving rank anf file partiàpation. Communities and health workers are highlighting the need for more accountable health services, induding community partiàpation.

The NPPHCN/SAHSSO Policy Conference 1992: an overview

Max Price

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.

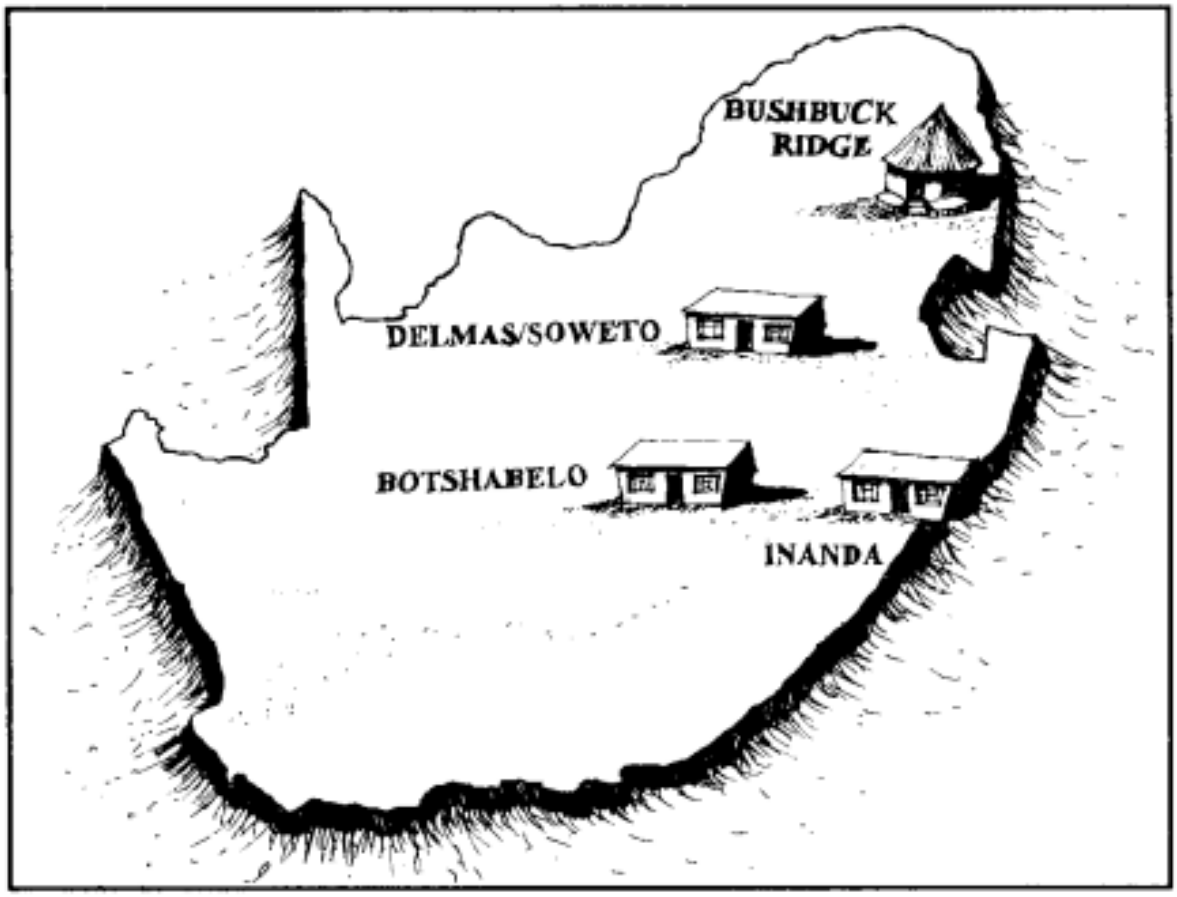
The findings of the situation analysis are reviewed in the next article. Here we will briefly describe what was done. (See also table 1)

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.



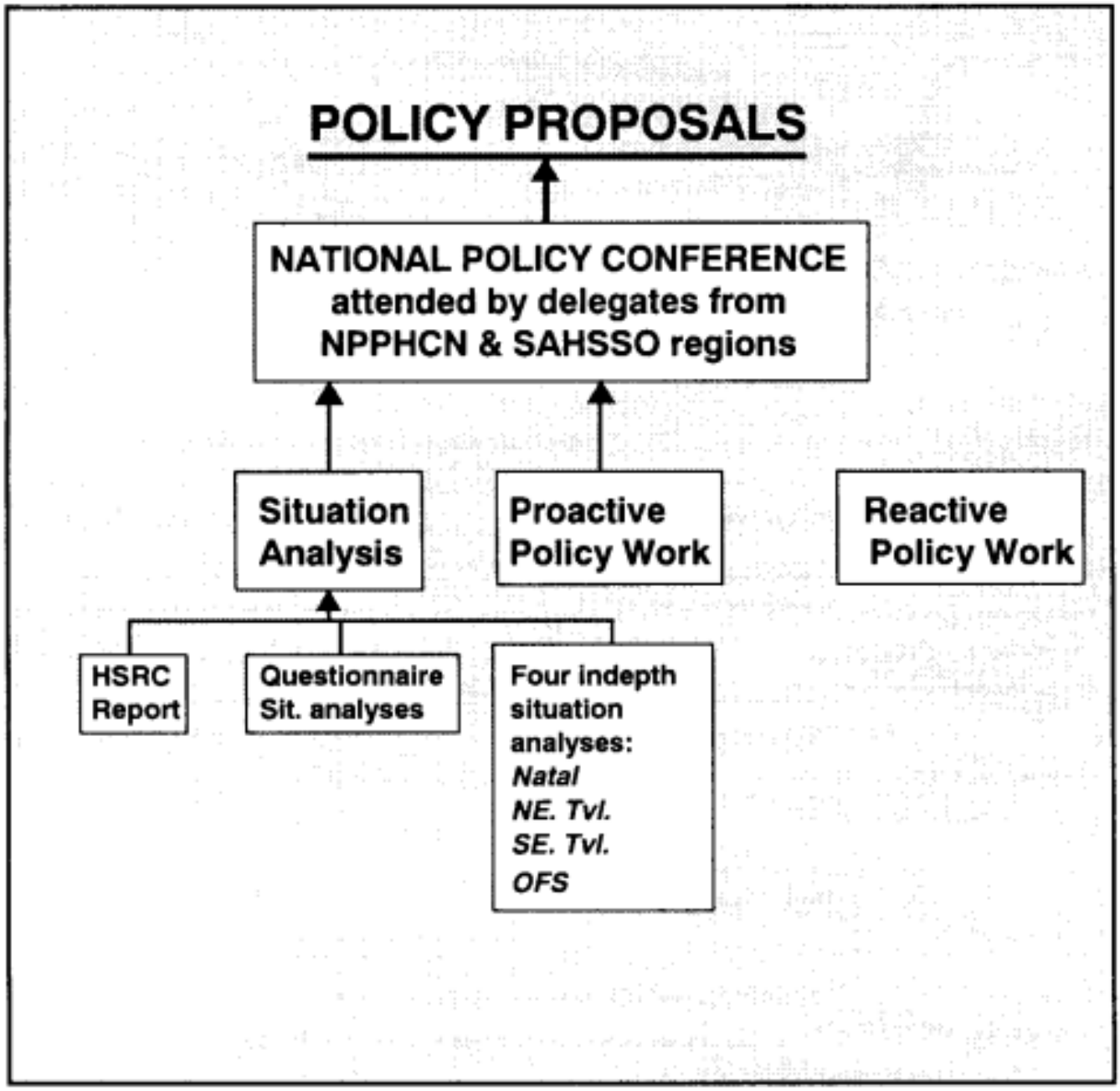
Location of areas

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

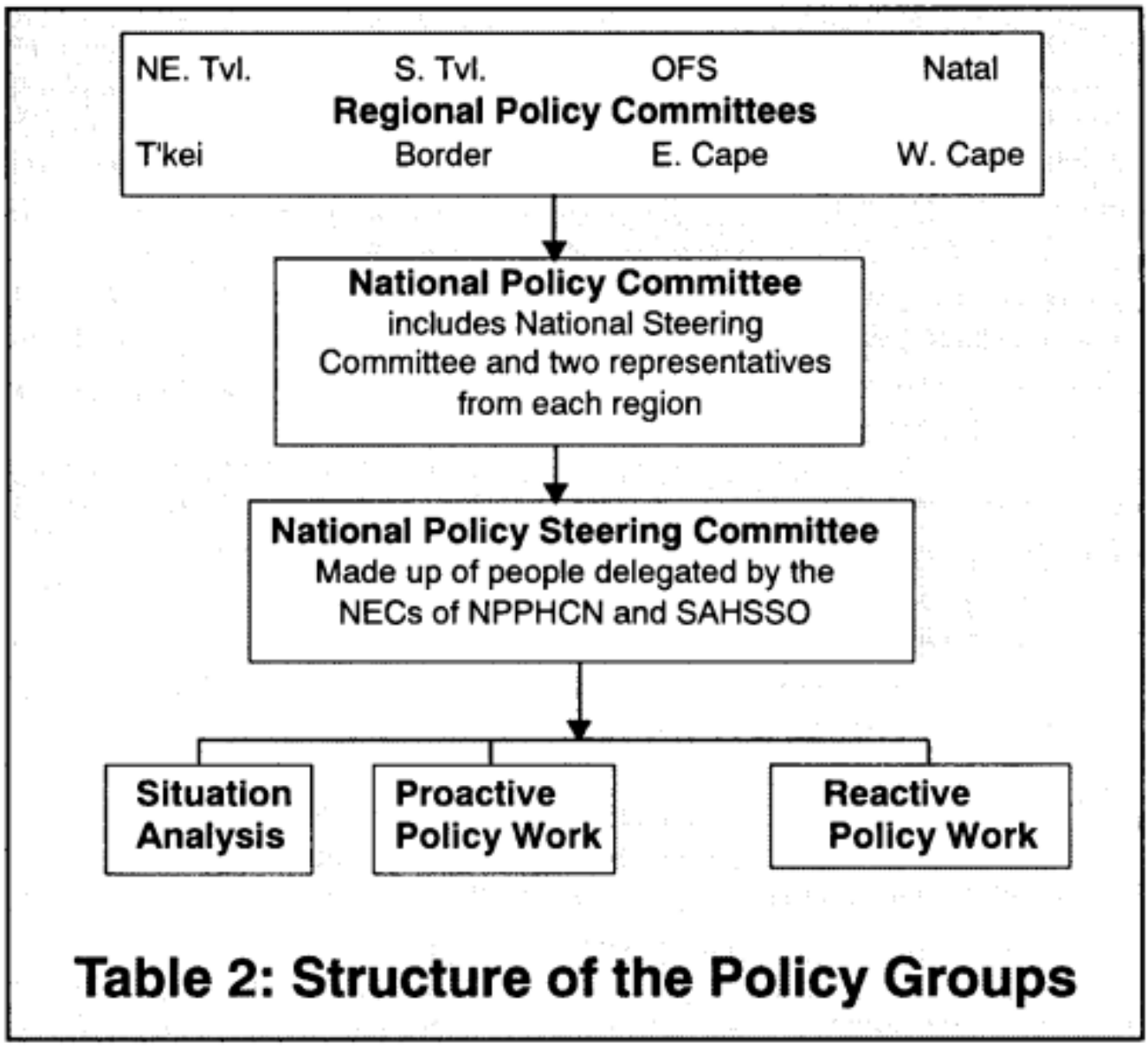


Table 2: Structure of the Policy Groups

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.

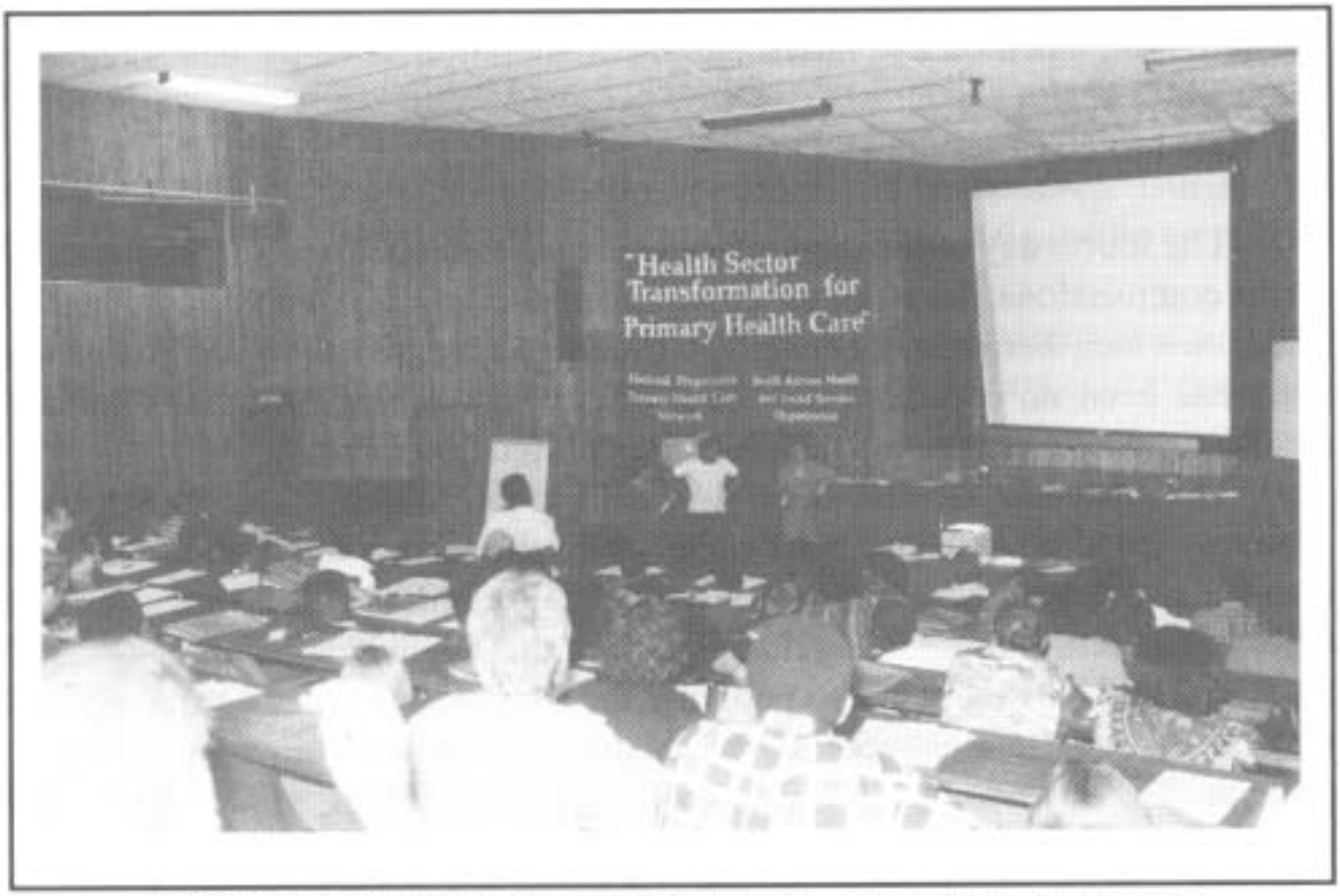
The fourth day of the conference was used to summarise the proposals of all the commissions, develop consensus statements where possible, and identify issues on which there was no consensus. In addition, a number of issues (on which there has been no commissions) were discussed, such as Essential National 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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National Situation Analysis of the Health Sector:
Perceptions of Communities and Health Workers

David Mametja

This article focuses on the indepth participatory situation analysis, including the methods used, common themes, perceptions of and attitudes towards the conditions of the health services held by some health workers, community members and organisations.

Constraints and Limitations

The main constraints that hampered the complete achievement of the objectives set for the situation analysis in some of the areas were :

1. The time allocated for the fieldwork was inadequate. There was limited time for thorough consultation with community leadership in some of the communities, and there was reluctance by some community members to participate.
2. Some of the communities identified to participate in the situation analysis were experiencing turmoil at the time. Instability is a common feature of informal settlements.
3. The lack of tangible and immediate benefits (intervention) that members of the community could associate with their participation, resulted in reluctance and disinterest in some instances.
4. The situation analyses did not enjoy maximum participation of the members of the organisations (NPPHCN and SAHSSO).
5. The limited resources from the national office to the regions, especially financial, hampered the fieldwork considerably.

Methodology
A) Study population

Four areas were identified by the National Policy Sub-committee for the analysis. They were :

- an informal peri-urban area within the Durban functional region, Natal;
- a rural area in the Mhala-Mapulaneng district in the north eastern Transvaal (N/E Tvl);
- the informal settlement of Botshabelo in the Orange Free State which emerged from forced removals in the past; and
- a dense township dwelling in Soweto, southern Transvaal (S/Tvl).

B) Research Teams

In each of these areas, fieldworkers were employed for periods ranging from 3 to 4 months to conduct 'focus group' discussions and interviews. The fieldworkers received training in interview techniques, methods and analysis, prior and during the period of the situation analysis. Each fieldworker was attached to a research centre/unit which served a supervisory role.

C) Focus Groups (FGs), Interviews and Workshops

These were the main methods used. Most of the focus groups were drawn from communities and a few from health workers. They served the purpose of directly eliciting the perceptions and attitudes of some community members and health workers on needs and problems with health services. The interviews were held with key informants, mainly, health workers. Table 1 summarises details about the focus groups, workshops and the interviews.

Summary of Themes
A) Community participation

There was lack of common understanding of what community participation means. However, the following explanations of what community participation could involve, were given :

- Many health workers believed it is the basis of making people do things for themselves.

Table 1.

AREA	NUMBER	SIZE	TYPE & COMPOSITION
NATAL	2 FGs	12 - 26	Mixed (16-38 yrs.,civics, youth) Health Committee (Females, 21-43 yrs.)
	3 Workshops	15 - 32	Members of the policy committee
	9 interviews	9	Health inspectors Community nurses Member of family
NE Tvl.	4 FGs	7 - 10	Mixed (drawn from forum of 45 people representing 17 organisations
	3 FGs*	5 - 10	Matrons (local hospital) Professional nurses (local hospital) Community Rehabilitation Worker Trainers
	4 interviews	4	Professional Nurse Former Matron Director Wits Rural Facility Director: Human Services Development Unit
OFS	10 FGs	6 - 12	Mixed and female (17-48 yrs drawn from political organisations, mothers, civics, a self-help project, church youth groups)
	3 FGs*	3 - 14	Community Health Workers, Community nurses, Chief professional nurses, social workers
	13 interviews	13	Superintendent, Family planning nurse, PHC nurse, 2 Pharmacists, Occupational therapist, Health education advisor, Director for Housing (PAO), Social workers (PAO)[1], Community based project coordinator, Unionist manager -SADTC[2]
S. Tvl.	7 FGs	6 - 10	Separate (old aged women, young mothers, youth below 25 years)
	6 interviews	6	Nurse, 3 Teachers, Shopkeeper, Youth leader

- Some of the health workers saw it as including compromise by communities, and the lowering and subsequent matching of their expectations with what is possible and available. They also saw participation as a form of health education, for instance, whereby mothers would be taught about matters such as sexual education and hygiene. They, in turn, would teach their own families.

Problems such as poor leadership, high mobility of some communities caused by seasonal migration, the lack of a common history and tradition especially in informal settlements, were mentioned as major hindrances in the attainment of successful community participation.

B) Problems in Health Services

The situation analysis identified a number of common problems communities faced, in terms of their access to health facilities. A summary list of these problems is as follows:

- There was a perpetual deficiency in emergency (ambulance) services, caused mainly by historic imbalances and inequalities. Where these services are available, they are poorly equipped and staffed, particularly in rural areas. The need for these kinds of services has been heightened by problems associated with violence, especially in informal settlements.
- Most health services (clinics) in communities are not adequately accessible. Most of them function only during working hours. They are closed after hours and during week-ends. The services are also inadequate, especially maternity services, which are non-existent at some of the clinics. This causes many pregnant women to travel long distances. They are often compelled by these circumstances to give birth unattended.
- The quality of clinical care was often seen to be unsatisfactory, by community members. A review of the qualifications of health workers providing primary health care, indicated a widespread inadequacy and inappropriateness of the training of health workers. This explains the constant demand from communities for professional categories of health workers, such as doctors. This point is further illustrated by the high referral rates from clinics located in communities, whenever such referrals are possible. However, most of the community health workers felt they were adequately trained, and were positive about services rendered.
- There are persistently long queues and waiting times before patients are attended to. This is often contrasted to the prompt, though expensive services rendered by private doctors (GPs).

- The attitude of health workers was perceived as negative, 'victim-blaming, rude and insensitive' in most cases.
- Malnutrition was seen as a major health problem. There is, therefore, a need to develop short and long term strategies to deal with this problem and other drought related crises. Clear guidelines on what structures should be responsible for implementation of programmes that emanate from these must be carefully worked out.
- There was a general appreciation of Community Health Worker (CHW) programmes, from communities in which they existed. In those communities from which they were absent, a desire was expressed for their introduction.

C) Socio-economic conditions

The most overwhelming problems in all the areas studied were - poverty, unemployment, poor levels of education and adverse environmental conditions. This includes lack of water supply and sanitation, refuse removal, over-crowded and congested housing. Some of these problems were seen as requiring national and long-term solutions. Some could be addressed through constitutional and legislative changes, for example, giving people ownership rights to land, credit facilities for housing development and access to natural water resources.

Inanda, Durban: one of the fastest growing informal settlements.
Photo: Omar Badsha

However, there are those requiring urgent and vigilant health service interventions from other sectors. These include water supplies, sanitation and refuse removal. The reasons for failure by the present ministry of health to assure the necessary input from other sectors must be analysed, and new policies and interventions be developed. Other social problems identified were alcohol and drug abuse, teenage pregnancies and child abuse.

D) Non-government Organisations (NGOs)

The role of non-government organisations in rendering health and welfare services was considered to be positive and substantial. These organisations were seen as serving communities, because of the government having neglected its responsibilities to those communities.

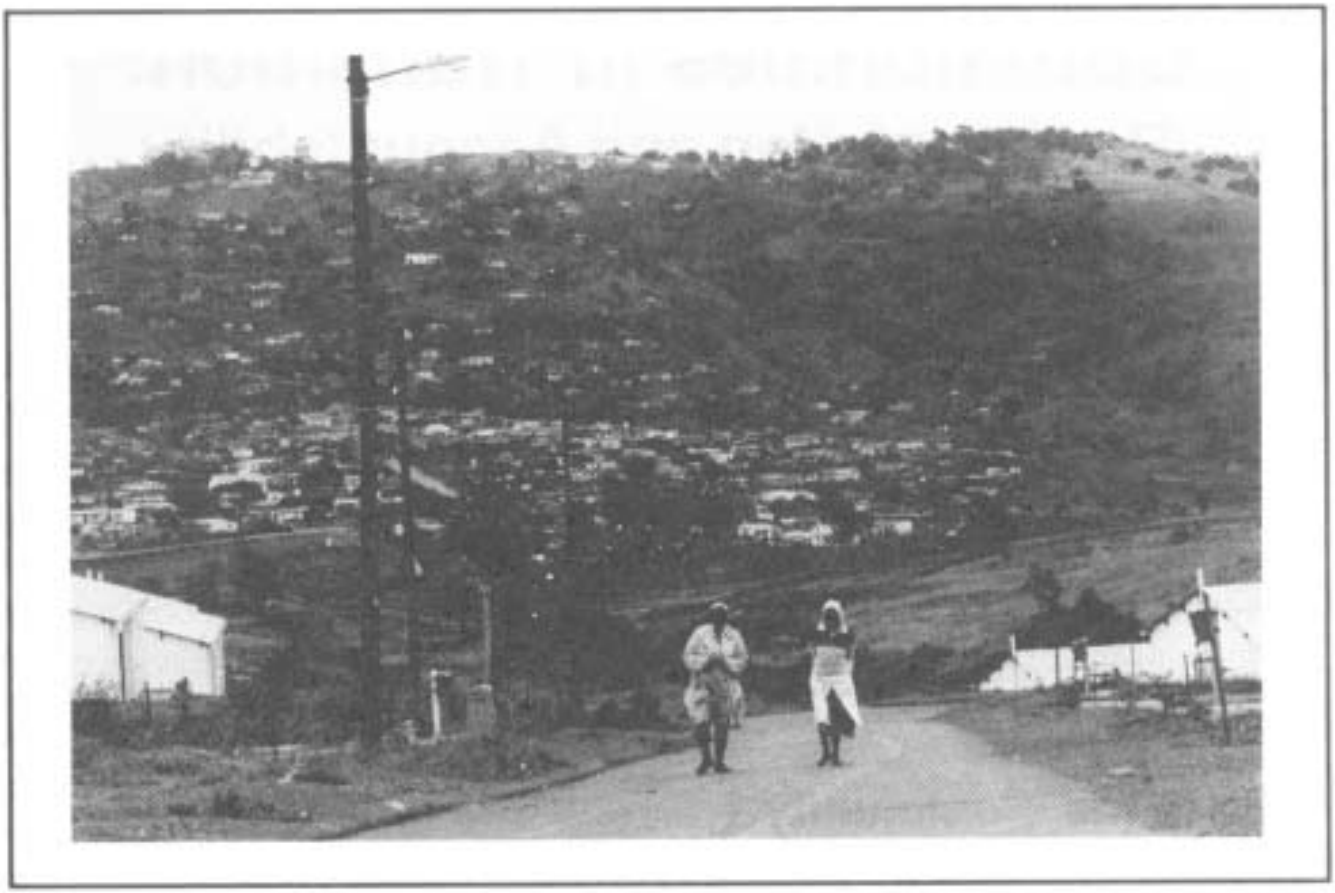
An Assessment of the Situation Analysis

In general, the quality of the in-depth analyses was high. The information gathered will be of value to communities and health planners. However, there are areas that may need further consideration.

Perceptions of communities and health workers of health services continue to vary. Could this be the result of a wide gap between health workers and the communities they serve, and a lack of contact and communication between these interest groups? The notion of community participation (widely accepted as crucial for the attainment of equitable health services) is far from being understood. Not only are health workers confused by this, but also communities are unable to articulate what role they want to play in the rendering of health services.

Does the imminent change, from an uncaring to a possibly more responsible and democratic government, require a review of the roles of NGOs? One of the objectives of the situation analysis was to build capacity within NPPHCN and SAHSSO and their memberships. This has, however, not been as successful as expected. The situation analysis has raised expectations within communities. What can the NPPHCN and SAHSSO do about such expectations in the short-term and long-term?

Moreover, although the situation analysis gives a sense of the range of problems likely to be found in the country, it cannot be used to view very clearly the problems of any particular community. The problems arising from the fragmentation of services, and the issue of incorporating community participants in decision making need to be addressed urgently. As a consequence of the



How will prioritisation of resource allocation in a country of such widespread poverty be decided? *Photo: Ismail Vawda*

scarcity of resources, even after a democratic government has taken over, prioritising resource allocation to deal with specific health problems (such as sanitation, water supply or health education) is essential. Some communities, especially in rural or informal settlements, will require more attention than others. There should be re-training and re-orientation of health workers in order to improve the quality of health services in communities.

Footnotes

* These focus groups consist of health workers only
1. POA - Provincial Authority of the Orange Free State
2. SADTC - South African Development Trust Corporation

David Mametja is a senior researcher at the Centre for Health and Social Studies at the University of Natal and is the convener of the situation analysis task force and a member of the National Executive of the NPPHCN

Communities in Transition:
Representation and Accountability

Chris Dolan

The in-depth health situation analysis conducted in the Bushbuckridge region of the eastern Transvaal lowveld reveals that community representation in health policy, and accountability of the health services to 'the community' are not easily arrived at. The complex social composition of the area, the large number of organisations and structures, the duplication of health services as a result of the homeland system, and the current political uncertainties, all present obstacles to the formation of representative structures to which a future health service could be accountable.

Who is the 'Community'?

People often talk about the 'community' as if it were a homogeneous entity which speaks with one voice. Instead there are a variety of social situations, each of which generates its own needs and wants.

A major cause of this division is the homeland system. In the Bushbuckridge area many people have been resettled, pushed together with people from different areas and backgrounds, in the interests of reinforcing ethnic identities and the homeland system. Tsonga speaking Shangaans were pushed into the Mhala district of Gazankulu, and Pedi speaking Sothos were pushed into the Mapulaneng district of Lebowa. Although the border between the two districts is arbitrary and is often marked by a road or railway line, people have only had real access to the health services in their 'homeland', even if those in the other 'homelands' were geographically more accessible. Those within the homeland system have also mobilised around their ethnic identities in disputes over resource allocation.

Other sources of social division and stratification include the gap between literate and illiterate, employed and unemployed, migrant and permanent resident. In some villages, 70% of the men are migrant workers.

Mozambican Refugees

This is further complicated by the presence of Mozambican refugees living in Mhala, who speak a version of Tsonga. Those officially registered with the

Difficulty of access to limited resources between groups causes tension.
Photo: Tsheko Kabasia

Gazankulu authorities number around 30 000, but relief organisations estimate at least double that number in Mhala alone (out of a total population of 211 000). Having arrived, the refugees are confined to Mhala, under threat of immediate deportation back to Mozambique if found elsewhere.

When refugees first arrived in large numbers in 1984-5 they were welcomed by the residents of Mhala because they share a common culture and language. However, many now live in physically distinct villages, and qualify for relief aid which is not available to the local population. At the same time, the refugees place further strain on already overstretched health and education facilities and the key resources of land, water and employment opportunities. In times of widespread scarcity, such as the drought of 1993, these issues of resource allocation cause tensions.

The deepening of divisions between three major groupings (Shangaan, Sotho, refugees), each of which is in turn stratified, makes it more difficult for people to organise themselves, and for the health services to provide equal access to all. This is compounded by the lack of clear authority structures and channels of accountability, both in public life and in the home.

Structures of Authority

The result has been the development of similar parallel structures, each designed to serve the needs of each of the major groupings described, none able to address the needs of 'the community' as a whole. The four major groupings claiming authority in public life are the tribal authorities, the civics, the homeland authorities and political parties.

Each tribal authority has a chief who is represented by indunas at the village level. Broadly speaking, the function of the chief and his indunas is to attend to the welfare of their people, particularly by resolving minor local level disputes and by representing the people to higher authorities. They are paid by their homeland government. In Mhala they tend to chair the village development committees, initiated by the Gazankulu government, which have met with varying degrees of success. Whether due to a lack of resources and/ or lack of control over resources, chiefs and indunas are sometimes reluctant or unable to tackle health issues, for instance, by assisting their communities to fund-raise.

Alternative Structures of Accountability

A major challenge to the tribal structures has been the emergence of the civic associations in the course of the last ten years. While in some areas they are trying to work in co-operation with the chiefs and indunas, their very nature as local level structures inevitably questions the authority of traditional and government structures. This is further complicated by the fact that civics seek to be broadly representative of the people but in practice tend to be ANC aligned, or are perceived as such, thus excluding some sectors of the population, particularly the older generations.

At a district and regional level, there are no well established civic structures. Support for both the two political parties active in the area (the ANC and Ximoko Xa Rexaka, an explicitly Tsonga party closely tied to bantustan structures) is patchy across the whole area, with a relatively low level of regional cohesion.

Health Related Structures

The Mhala Health Action Group and the Mapulaneng Development Committee aim to ensure that the health needs of the people of Mhala and Mapulaneng reach the attention of local health services, government and independent donors. Neither structure has a well organised constituency or can claim to be broadly

The stratification of 'community' - a complex mixture of power, ideology, and culture, all working together. *Photo: unknown*

representative. It is clear, there are no broad structures which can truly claim to represent the interests of the Bushbuckridge community. This situation is symptomatic of a general lack of democratic structures and organisations and a lack of accountability at local, regional and national level.

However, in this vacuum of public authority, churches and non-government organisations can play an important role.

Religious Groups

There are a large number of churches in the area, with both small and large followings. They include the Nazarene Revival Crusade and the Zion Christian Church (ZCC).

The welfare function of the churches needs to be documented, but many examples exist, including the use of the church buildings for non-church activities such as creches, and the involvement of the Catholic Church in relief operations to the refugees.

The University of Witwatersrand Rural Intervention

The Bushbuckridge area is unusual in having three University of Witwatersrand related rural projects based there. These include the Health Services Development Unit, the Wits Rural Facility, and the Community Rehabilitation Worker Training Programme.

The Community Rehabilitation Worker Training Programme draws students primarily from the area. A large component of the training occurs in the students' own villages, where they are expected to return on completion of training.

Wits Rural Facility is an interdisciplinary unit involved in teaching, research and outreach. It aims to influence the content of university curricula, and to engage in research of benefit to the immediate and wider communities.

The Health Services Development Unit is the oldest Wits University rural project, established in the early 1980s. It currently engages in education and training, including primary health care nurses, a village development programme, a sexual health programme and health systems development.

The most important of these, in terms of developing community representation and health service accountability is the District Health Initiative, arising out of the health systems development programme. At a local level this has involved the initiation of a number of village level health committees. More broadly, this initiative is working on 'breaking out' of the present homeland framework, and has sought support from sub-regional and national health and technical authorities. It is worth noting that even such forward looking initiatives are hampered by the fact that the government's proposed development regions differ from those of the ANC. The lack of clarity on future government structures will obviously obstruct the formation of accountable health services for some time to come.

A recent development which seeks to address this issue has been the North Eastern Transvaal Health Worker and Community Education Project (NETHWORC). Set up in late 1991, NETHWORC is working towards constructive partnership between the Bushbuchridge community, the local health services based at Tintswalo and Mapulaneng and the local University of the Witwatersrand projects mentioned above. The project has brought together traditional and non-traditional structures, governmental and non-governmental organisations, and people both with and without formal education. This process of increasing dialogue is slow but effective, and is being extended to other health related sectors, in particular water and education.

In addition a variety of small scale initiatives exist in response to the needs of specific interest groups such as women, the unemployed, and the disabled.

A path to more effective accountability

To conclude, broad community representation and meaningful health service accountability are difficult to attain when major groupings are played off against one another for political purposes, a process which has been institutionalised in the tangled web of South Africa's bureaucratic structures. It is also difficult when nobody can say exactly who has authority and power at local level, or where authority resides with different structures within a relatively small geographical area.

Although there are numerous non-formal organisations, such as the churches, many do not have health as a prime concern, nor are representation and accountability seen as important issues. Non-government organisations working in health, faced with ensuring the survival of their own projects, the obstinacy of existing bureaucratic structures and the pressure to respond to people's needs, may be pushed into providing alternative although unsustainable delivery programmes which only have a very localised impact, and which do little to engender representative and accountable health services.

The situation as described in the Bushbuckridge area is no doubt reflected in many other parts of South Africa as well. However, those difficulties are also opportunities, particularly if the non-government sector is in a position to stimulate activity. Both the district health initiative and NETHWORC have taken the above problems as their starting point and key motivation rather than as an unplanned-for hindrance. At a time when political structures are in question it is possible to bring together people around issues of common concern, people who in more settled times might not have reason to speak to one another. In these times, the message that "health knows no boundaries" has a chance of being heard.

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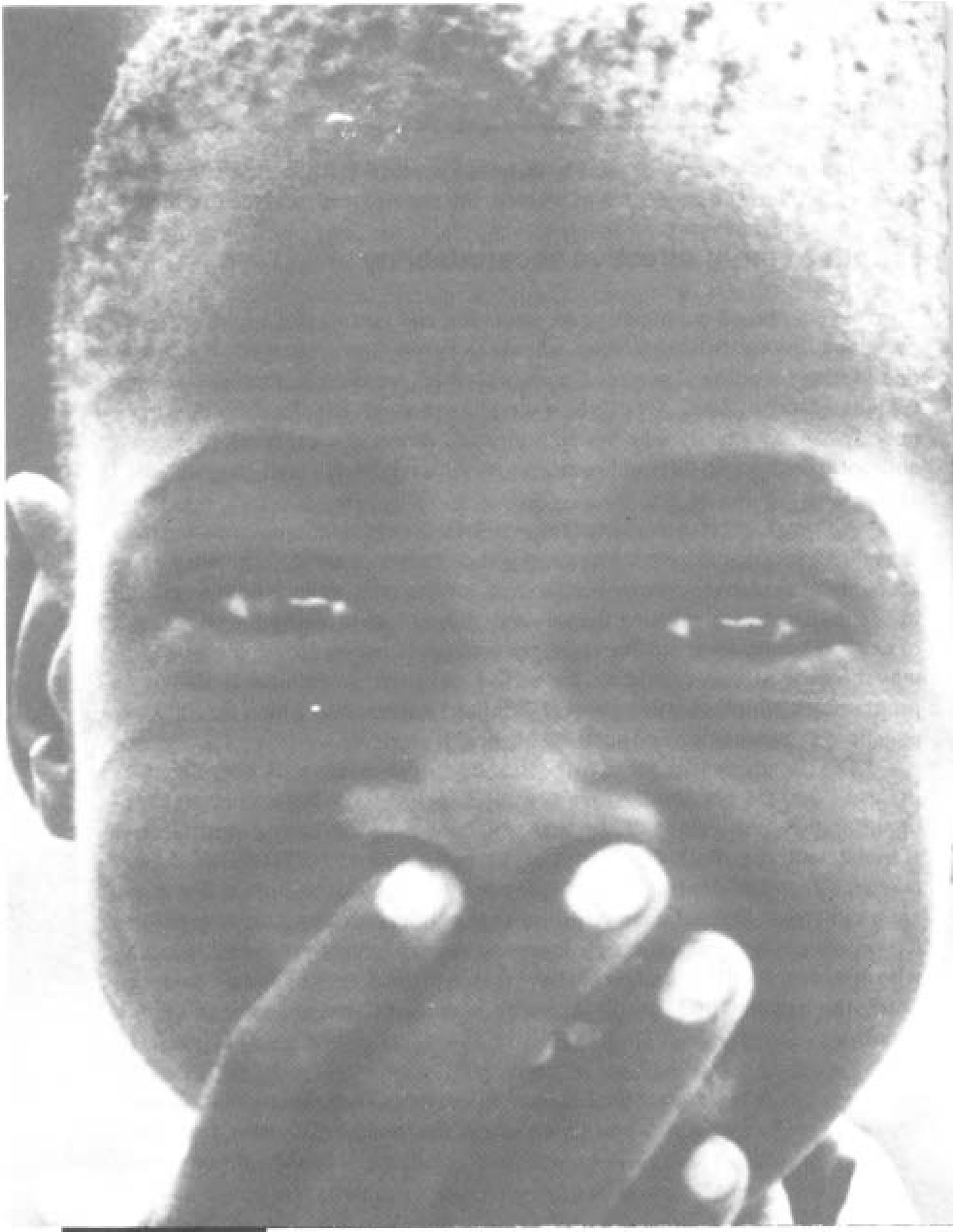

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PHC, the Public Sector and Health Personnel:

Many of the commissions focussed on the need for progressive primary health care, provided by a restructured public sector with appropriate health personnel.

Transforming the State
Health and Health Related Sectors

Critical Health & Glenda Wildschut

South Africa's public health services are plagued by fragmentation and poor administration, with serious consequences for coverage, comprehensive care, efficiency and costs. The administration is centralised and bureaucratic. There are serious disparities in health status and service provision, especially along racial and geographic lines.

This undemocratic system ignores community opinion and there is no consultation with consumers. Also, within South Africa's health care system, there is no consensus on a definition of primary health care (PHC). This leads to unco-ordinated service delivery, inappropriate training, poorly equipped facilities and a lack of the necessary managerial skills amongst staff. The health sector does not collaborate with health related sectors and this has a negative impact on diseases which are influenced by health related factors.

Previously, progressive health organisations have criticised the poor administration and fragmentation of services. They have called for a unitary health structure. They have also demanded political change. However, these organisations did not really go much beyond criticising the apartheid state or making health and political demands of a general nature.

New Challenges

Because of recent significant political changes, we can reasonably expect a new government with greater political commitment to health care in the near future. Progressive health organisations thus face a range of new challenges.

It is against this background that the commissions on organisational structures for the public sector health services, improving the quality of service in the public health sector, transforming the civil service and intersectoral collaboration were held.

It became clear from the discussions in the commissions that merely recognising the problems caused by apartheid will not help us to improve South Africa's health care system. As health workers committed to change, we have to rise to the new challenges. These include using the primary health care approach to achieve a decent level of health for all (HFA). This approach entails

a comprehensive national strategy, based on the principles of equity, affordability, efficiency, effectiveness, acceptability and participation.

The discussions went beyond general criticism. Concrete policy proposals which respond to South Africa's health needs were produced. The policy proposals identified areas of priority within the context of socio-political and economic reality.

Transforming the Public Health Sector

The commissions on organisational structures and improving the quality of service focussed on changes that need to be made to the public health sector. The first of these commissions used an input to the conference by Nicky Padayachee, titled 'Restructuring of Public Health Services: National, Regional and Local Health Authorities', as a basis for discussion.

The commission identified the various lines of fragmentation in the existing health service. It is divided along racial, tri-cameral, curative/preventive, academic/non-academic, rural/urban and homeland/South Africa lines. Participants restated the call for a unitary health system. This system should provide essential services to all and this entails a redistribution of resources. The structures should be under democratic control and allow for grassroots participation in decision making and policy formulation.

Discussion then focussed on generating detailed proposals as to how such a system should be structured. The group identified four levels in a new health service, namely district, sub-regional, regional and national. Participants agreed that the district should be the basic unit of the health service and should plan, manage and provide essential health services. These services include health education, curative care, women and child health services and nutritional services. Sub-regions and regions should be responsible for specialised services and provide support and resources to the districts. The national level should allocate finance and personnel, co-ordinate policy making (in which all the levels participate), co-ordinate health information and monitor equity and redistribution of resources.

Improving Quality

The commission on the quality of the public health sector started by identifying various problems in the public sector. Patients have to wait in long queues and facilities are closed after normal working hours. Patients, especially those in

rural areas, have to travel long distances from home to clinic. Health centres provide a narrow range of services and poor quality care. Staff often display an uncaring attitude towards patients.

The participants recognised these problems as having deep rooted origins and characterised the public sector as being in crisis. It has inadequate resources and facilities are understaffed. The fee for service system makes services inaccessible to many. There is poor planning and administration and there is no PHC vision. Staff do not recognise that the public health sector belongs to the community. Community involvement in the shaping of public health services is non-existent.

There was group consensus that the solution lies in a restructured, reorganised and transformed public health system, not in the private sector. There must be an immediate stop to cuts in public sector services and retrenchments. Facilities must be adequately staffed. The public sector must develop a PHC philosophy and share this with all health workers and the community. It must be accountable to the community, which must be involved in shaping health services. However, the public health sector must also be well managed.

The Public Sector as a Whole

Progressive organisations have long understood that the health status of communities is largely determined by factors outside the health care system. In order to improve health status, a wide range of health related problems have to be addressed by other sectors of the state.

The government has pretended to agree with this understanding of health, but this has been no more than a smokescreen for continuing to ignore the factors responsible for ill health in South Africa.

This conference made large strides in moving beyond the uncomfortable status quo. The commissions on transforming the civil service relevant to the health sector and intersectoral collaboration looked beyond the public health service to the public sector more generally. They discussed ways of ensuring that the health sector becomes an integral part of a service oriented public sector.

Towards an Accountable, Well Managed Civil Service

The civil service commission was informed by a paper written by Patrick Fitzgerald, titled 'South African Public Administration in Transition', as well as an input given by Fitzgerald at the conference. He argues that the civil service functions as a bureaucracy in which decision and policy making are dominated

The civil service maintains the pretence of neutrality by working within the framework of existing laws. *Photo: unknown*

by white, male, Afrikaans speaking Calvinists who support the National Party. They see public administration as a range of neutral administrative processes. The relationship between public administration and the socio-political, ideological and ethical environment is suppressed. The lower civil service does the 'dirty work' and the senior civil service maintains the pretence of neutrality by working within the framework of existing laws.

Until recently, progressive forces rejected the civil service as part of the apartheid system. They did not engage in debates concerning the role that should be played by the civil service. In the past year, however, debate on the transformation of the civil service has been growing. Issues being debated include the ethos and values of the civil service, the need for a development oriented public service and the need for a managerial and delivery oriented service.

For Fitzgerald, we need to create a civil service that is, on the one hand, non-racial and accountable and, on the other, well managed, cost efficient and client oriented. The civil service will obviously not automatically adapt itself to a new government. A lot of work will be needed to change ingrained attitudes and habits within the civil service. An affirmative action policy will be needed

to ensure that people with more appropriate values take up important positions in the civil service.

Affirmative Action and Filling Key Posts

The commission agreed with Fitzgerald's characterisation of the civil service. Participants identified a number of problems in the structure, functioning and management practices of the civil service. They include fragmentation and duplication of structures. The civil service is unrepresentative with regard to gender and race, and it is not accountable. Training of personnel is inappropriate and the civil service is managed in an uncaring, undemocratic and top-down manner. Corruption is rife and the civil service is not open to public scrutiny.

These problems clearly impact negatively on health. They impede the eradication of poverty and illiteracy, the promotion of PHC, the construction of social stability and, as such, the achievement of health for all.

The group paid particular attention to affirmative action and to those occupational positions which are important in transforming existing structures. Participants proposed an immediate freeze on all promotions. There was agreement on an affirmative action programme, to ensure that people from within the democratic movement who share the vision of a national health service and progressive PHC fill the key posts in the public health service.

Participants also agreed on the need for the civil service to be open to public scrutiny. The group suggested that this requires legislation to ensure that it becomes routine practice to make information accessible to the public.

Collaboration Between Different Sectors

The commission on intersectoral collaboration started from the premise that the successful development of the PHC approach requires effective collaboration between the health sector and other sectors. Participants recognised that effective collaboration can only take place if, firstly, the fragmentation of state structures and the liberation movement's suspicion of state structures is overcome and, second, a culture of consultation and collaboration is developed between the state and civil society.

The participants had not tackled this issue before and there was no clear base from which to project discussion. Participants eventually decided to focus on local areas because most participants are involved at this level. It was hoped that the collective experience of everyone present would help formulate proposals that could have a national impact.

The lack of collaboration between sectors responsible for drought relief resulted in a hit or miss approach to the effects of the drought.
Photo: Tsheko Kabasia

Two case studies were looked at. Firstly, the lack of collaboration between sectors responsible for drought relief resulted in a hit or miss approach to the effects of the drought. Secondly, interaction between the Benoni City Council and the well organised Wattville Resident's Association highlights the fact that local authorities have access to necessary resources, but that they tend to provide technocratic solutions to problems. As such, black communities and their civics have an important role in shaping public services.

Development Forums

Participants suggested the need for local/district development forums, consisting of a range of NGOs (including civics) and relevant government departments, such as health, welfare, education and finance. These forums should have the power to make and implement decisions and be represented on regional bodies. The regional structures should ensure an equitable distribution of resources as

well as adequate representation of local needs at national level.

The commission identified a number of issues which require intersectoral collaboration, including nutrition, social welfare, AIDS/HIV, environmental health (particularly water and sanitation), family planning, housing and literacy.

The participants recognised that they had only managed to scratch the surface, but they did not see this as a shortcoming of the commission. In contrast, the commission covered important ground and recognised the necessity of continuing debate and discussion on intersectoral collaboration beyond this conference.

Discussion on the need for intersectoral collaboration also took place in a number of other commissions. In the commission on proposed organisational structures for the public sector health services, it was stressed that there was a strong need for intersectoral collaboration at the district level, with regard to the provision of water, sanitation, housing, job creation, waste removal and nutritional support.

The commission on nutrition agreed that there should be a nutrition department within the national health service. This department should function intersectorally and be linked to district nutritional development committees, which should include people from the community and health workers.

Only the Beginning

It is clear that the commissions at this conference made a significant advance in that they opened up debate on the detailed actions that need to be taken to transform the public health sector and health related sectors. In many instances, this resulted in relatively comprehensive proposals, but, as indicated in the discussion in the intersectoral collaboration commission, we are entering relatively unfamiliar terrain. We are only at the beginning of the process of making meaningful change to the public sector.

This article was written by George Dor, Ismail Vawda, who participated in the commission on intersectoral collaboration, and Glenda Wildschut, a member of SAHSSO (Western Cape), who participated in the commission on the civil service

Financing Health Services

Critical Health

There has been a lot of debate within the progressive health sector over the best options for financing the health service. The details of the debate are well outlined in previous editions of *Critical Health* (see 31/32 pp26-32, 35 pp34-49 and 36/37 pp57-64). The extent of the debate is summarised by the Centre for Health Policy (*Critical Health* 35 pp45-47). Essentially, three possible options have been debated.

Nationalise the Private Sector

This implies that all private doctors would become state employees and private hospitals would have to be state administered. A criticism is that half of all money spent on private health care currently comes out of private pockets, and would disappear. The state would also face pressure from both private providers and consumers of health care if it made such a move. Mass emigration of private professionals is also a possibility.

Keep Public and Private Sectors Separate

This option is clearly outlined by Zwarenstein (*Critical Health* 31/32 pp30-32). It essentially involves building up the public sector for the provision of accessible primary health care (PHC) and leaving the private sector to provide luxury services to those who desire it. The private sector should, however, be providing care in relation to its true cost. Tax rebates for employers contributing to medical aid should be stopped. The money freed from this should be channelled into the public sector to finance PHC. Also, the private sector should pay the cost of training of public personnel who choose to work in the private sector. Revenue from this could also be channelled into the public sector.

This option may not adequately address the wastage of scarce resources presently occurring in the private sector, for example, inappropriately expensive technology and overservicing. However, some intervention such as audit and quality control, licensing capital investment and moving public sector employees off medical aid (*Critical Health* 30, p32) may go some way toward limiting wastage.

Centralise Financing for Public and Private Sectors

This involves the introduction of a compulsory national health insurance scheme (NHI) to which all employed people would contribute. The contribution of the unemployed, ill, aged and disabled would be paid out of state taxes *(Critical Health 36/37* p60). The scheme would provide a package of essential services to all, provided either by the public or private sector. Such a scheme would, in itself, not equalise access to health care, but could be the first step on the path to health care for all. *(Centre for Health Policy, Monograph 21, 1990).*

However, a "package of essential services" has not been clearly defined and, even if it is, may not be universally accepted. Furthermore, this option could lead to an expansion of the current private sector. It would not necessarily prevent overservicing by private providers, but could, ironically, lead to underservicing in the long run. The details of administering a large state run insurance bureaucracy also needs to be researched.

NHI Not Appropriate Now

At an ANC health policy conference, held in February 1992, the issue of financing the health services resulted in vigorous debate among the health activists present. Many felt that the NHI option was inappropriate at this stage for the following reasons.

Firstly, it would be difficult to regulate the private sector. It was argued that, even in countries with fairly sophisticated health insurance systems such as Canada, this remains a problem. Hence, the introduction of a health insurance system in South Africa would be unlikely to achieve one of its main aims, namely a decrease in overservicing within the private sector. This sector is, furthermore, currently facing a major financial crisis. Attempts to regulate this sector now would be strategically inappropriate, as blame for its seemingly inevitable collapse would be directed at the public sector.

Second, a large bureaucracy would be needed to administer such an insurance system. It was felt that, given the lack of management skills in the country at present, it was unlikely that sufficient expertise could be mobilised in a fairly short space of time to administer such an enterprise effectively.

Third, neither the details of what would be included in nor the costs of a package of essential services that would be covered by an NHI have been defined.

Many health activists, it seems, entered the SAHSSO/NPPHCN conference with support particularly for the second option outlined above, which

Paying for services and waiting. Always waiting. *Photo: Ismail Vawda*

suggests leaving the private sector to continue as it presently exists, on condition that subsidies (tax rebates and training costs of personnel) are removed.

First Decide What You Want

Gerald Bloom, from the Institute for Development Studies at Sussex University, gave an input to the conference on options for financing the health service. He suggested a useful approach that we could follow in order to make appropriate decisions on financing.

Bloom argued that the first thing we have to do is to clarify what we want to achieve in the next few years. We need to define what we mean by 'essential

services' and we need to state plans and objectives clearly. The next step is to calculate what it would cost to meet these objectives.

He said that, since there are many different health care providers, we need to understand the system - understand the sources of finance and the administration structures governing these resources, for example, the Ministry of Finance. We also need an understanding of the major interest groups and their demands, so as to be able to deal with them.

According to Bloom, it is only after we have defined our objectives and gained an adequate understanding of how the system works that we can deal adequately with the issue of financing.

Sources of Finance

He outlined a number of potential sources of finance. Central government has large resources collected from taxes, but, in practice, it does not make enough money available for health care. Money can be raised for primary health care from a number of other sources, including local government. However, some local government structures are rich and others poor. The latter will need some form of subsidy.

Patients can be charged for the services they receive, but there is a major problem in that the poor cannot afford to pay. Even the World Bank has come to realise that it is difficult to raise money from the poor and it is now advocating tax revenue as an important source of finance.

Money can be raised through a variety of pre-payment schemes, which entail that people put aside a little money when they are well, to be used when ill. These schemes include employer provision for formal sector employees and voluntary or compulsory insurance. Pre-payment schemes provide the opportunity to take from those who can afford, to subsidise those who cannot.

In some countries, foreign funding has become an increasingly important source.

An Appropriate Combination of Finance Options

Bloom suggested that we need to look at each option for finance and at how that option is going to contribute to meeting our key objectives. We then have to select a combination of finance options to generate the necessary revenue.

He pointed to the political nature of health finance. The health sector is structured in terms of the existing balance of political forces. In South Africa, we have a segmented health sector which is, furthermore, dominated by sophisti-

cated hospitals and specialists. This structure needs to be transformed, but this will entail a struggle over resources between competing interest groups. Moreover, it takes time to establish new institutions. In the short term, we have to think through our priorities in terms of changing the health sector and also continue allocating some resources to existing institutions.

In summary, Bloom said that he did not have a simple solution for financing health services. We need to look for the most appropriate solution for our situation.

In the commission on financing, there was very little debate on whether to opt for nationalisation, separate public and private sectors or an NHI. As outlined earlier in this article, debate on these national financing mechanisms

characterised many previous health policy seminars. This change in the focus of debate was partly because the commission took Bloom's suggestion to clarify long term as well as immediate objectives for the health sector before attempting to define the best mechanisms of financing.

The Priority - PHC For All

It was agreed that the most important priority is the provision of affordable comprehensive primary health care for all. Given the exclusively curative focus of the private sector (which is not expected to change in the near future), it was felt that the public sector should be primarily responsible for ensuring that this priority is addressed. This sector should provide an efficient, people oriented service of high quality and there should be local autonomy and community control. Finances will be needed to build and run community health centres and to establish appropriate training institutions and programmes.

There was debate on whether services should be free for everybody or whether there needs to be a graded fee structure. However, there was agreement that no one should be denied access to essential services because of an inability to pay. Family planning, maternity services, health care for children of 5 years and under, immunisation and treatment of communicable diseases such as TB and AIDS should be free.

Some resources will be freed by getting rid of the duplication and fragmentation characteristic of the current health sector. A number of other possible sources of finance were raised. Some of the proposals made were that alcohol and tobacco sales should be more heavily taxed and that the advertisement of these products should also be taxed until such advertisements are banned. A state lottery and revenue from gambling were also suggested.

The Private Sector, Regulation and Research

It was agreed that the private sector should be made to bear the full cost of its services and that tax rebates for employers contributing to medical aid should be stopped. Also, the private sector, particularly the medical aids, should be subject to monitoring, auditing and public exposure to prevent maladministration. A phased amalgamation of medical aid societies should be introduced with the view to establishing a single body.

It was, however, accepted that large scale regulation of the private sector is difficult and, moreover, not a health priority. Such regulation was considered strategically inappropriate at present, in that the private sector would attempt to blame the government and regulation for the escalating cost crisis of this sector.

Research into the cost of comprehensive PHC service provision and other areas of financing (for example, details of a possible NHI scheme) was urgently called for. It was recognised that the NHI option may well be one that could extend affordable, essential health services to all and also address overservicing and other causes of wastage of scarce resources, but more research into the details of such an option still has to take place.

The commission reported back at a plenary and this formed the basis for the policy proposals on financing.

This article was written by Ahmed Valli, who participated in the commission on financing, and George Dor.

Health Personnel
New Categories, Training and Redistribution

William Pick

A number of commissions at the conference focussed on health personnel. Some commissions, such as Redistribution and New Categories of Health Personnel, Support and Reorientation of Health Personnel and Labour Relations in the Public Health Sector, debated issues relevant to a wide range of health workers. Others, such as Community Health Workers and Traditional Healers, concentrated on specific categories of health providers.

In general, the commissions addressed two central concerns. Firstly, health personnel must provide a relevant service, appropriate to South Africa's needs. Currently, personnel are concentrated in urban, middle class, predominantly white areas and provide mainly curative services. There is a shortage of personnel who are able to provide primary health care (PHC). A significant proportion of personnel have an unprofessional manner and a lack of respect for patients. There is a need to reorientate and train existing personnel, to inculcate a philosophy of public service and provide a good understanding of the primary health care approach. A redistribution of health workers to underserviced areas has to take place and new categories of health personnel have to be established, in order to provide comprehensive PHC.

The second concern addressed by the commissions is that the health sector must provide acceptable working conditions for health workers. At present, large numbers of health workers are unhappy and demoralised. Health workers need support and appropriate training. There should be greater career mobility and there is a need for democratic and representative professional bodies. Furthermore, health workers in the public sector are still denied their basic labour rights. The Labour Relations Act must be extended to all public servants. Health workers must have the right to freedom of association and to bargain over salaries, benefits and conditions of service. They must have access to dispute resolution mechanisms and have the right to strike.

In the following article, William Pick outlines the discussion and debate that took place in one of the commissions on personnel, namely Redistribution and New Categories of Personnel.

The participants in this commission were from a wide range of backgrounds, including community development workers, community health worker trainees and a wide a range of health worker professionals. The commission was set the task of looking at two topics, namely new categories of health personnel and redistribution of health personnel.

Limitations of Existing Personnel

Discussion on the first topic started with an examination of existing categories of health personnel. The group of participants generated a list of categories. This includes nurses, physiotherapists, physiotherapy assistants, community health workers (CHWs), occupational therapists, dental therapists, dentists, rehabilitation assistants, health inspectors and doctors. The deficiencies of this conventional range of health personnel was discussed.

The main problems which were identified include a lack of appropriate training for health personnel; insensitivity and 'unfriendliness' of health personnel towards patients; inaccessibility of health personnel, especially due to inability to afford private sector care; and a lack of transport to health facilities.

Doctors and PHC Teams

There was a lot of debate about the role and power of doctors in health care. A question was raised as to whether doctors are an essential part of health care teams and, more specifically, whether they are needed to play management roles. Consensus was reached that this should not necessarily be the case. Moreover, at the level of primary health care, adequate intervention in terms of health care delivery can occur without necessarily involving doctors.

Going Beyond Conventional Categories

The plight of rural communities with no access to potable water and sanitation was discussed at great length. In view of the lack of environmental health, particularly in rural communities, participants identified the need for environmental health workers.

The need for health promotion and its neglect in the current South African health care system led to a high priority being accorded to a new category of health worker - the health promoter or advocate. The group was, however, mindful of the danger of providing new categories of health personnel that may not be sufficiently trained to meet the needs of communities. The need for

adequate training was emphasised.

The inappropriate training of existing categories of health personnel led to a discussion on the need to provide additional skills to health workers who are in the frontline of patient care. The group highlighted the need for training in management and primary clinical skills. Management skills, such as planning, financing, administrative and evaluation skills, need to be developed to manage the health system, especially at district level. Skills in primary clinical care need to be developed amongst existing personnel such as nurses. It was also suggested that a new category of personnel - the medical assistant - should be introduced to provide clinical care at the primary level.

The need for health workers trained in occupational health and the improvement of the skills of existing categories of health workers in occupational health was brought to the commission's attention by one speaker. After much discussion, the group agreed that this need could not be overlooked.

The constant breakdown of essential equipment in hospitals with no local expertise for repairing this equipment was also discussed. This led to the proposal that a special category of technicians be trained.

The discussions were permeated by the need to see health as much broader than illness and disease. This is reflected, for example, in the types of new categories which were discussed, as well as the aspects of training which were stressed by the group.

Compulsory Service

The second topic, redistribution of health personnel, was discussed in terms of the glaring inequalities in health personnel provision that exist between urban and rural; rich and poor; and private and public sectors.

The discussion on the need to redistribute existing health personnel, especially the so-called professional categories, ranged from the provision of incentives to more coercive measures. Coercive measures suggested by this commission include a form of compulsory service for health workers in underserved areas. It was argued, however, that such compulsory service should not be restricted to medical professionals, who might view this as a form of punishment. Compulsory service should also include other categories of health workers, such as health inspectors and environmental health workers. It was felt that the concept of compulsory service should not affect long established practices, but should concern newly qualified people. Compulsory service in underdeveloped areas should be linked to training and state provision of bursaries. Students should, for example, have to repay their state subsidies if they refuse to do such compulsory service.

Personnel: change the curricula, compulsory service, or both?
Photo: Ismail Vawda

Zimbabwe and the Importance of Incentives

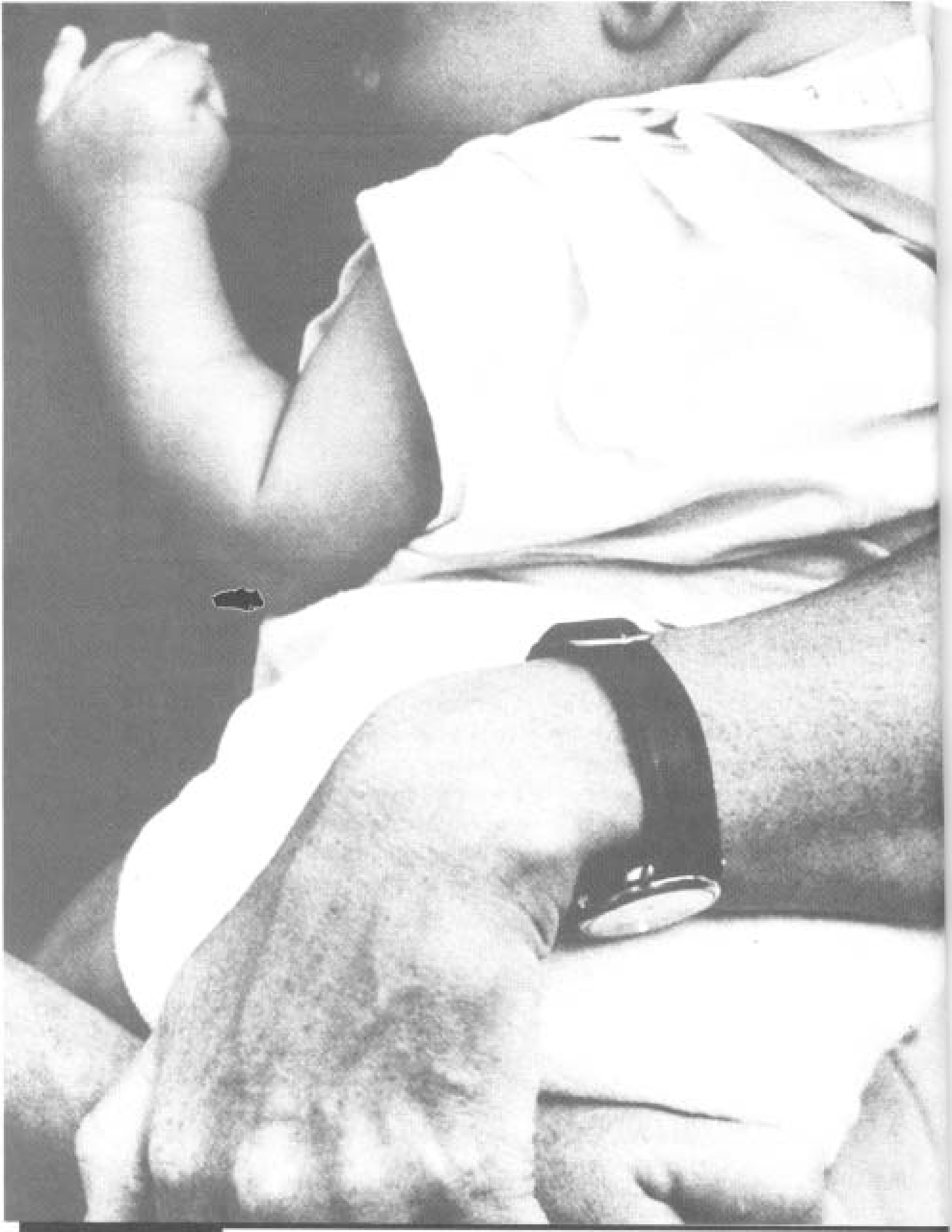
It was clear that attempts to move health personnel from urban to rural areas and other under-served communities has been largely unsuccessful worldwide. The participants suggested a close look at the reasons for this failure and the Zimbabwean experience was cited as a compelling lesson for South Africa.

This experience shows that, even where there is an attempt to reorientate the curricula of medical education in a way which satisfies the need for personnel in less developed areas, medical personnel will remain reluctant to go to these areas if salaries and other incentives in urban areas are far better than in these areas. The extent of hostility amongst medical personnel towards serving in rural areas was seen in 1988 in a strike by junior doctors refusing to serve in poorer areas. With the background of this experience, the need to provide favourable working conditions for health personnel in under-served areas was identified as central to correcting the existing imbalances.

A Few Words on Process

Initially, discussion was dominated by certain participants, but more and more participants articulated their views as time went by. It was quite a large group and this accounted for the initial unevenness of discussion. Taking this into account, the commission completed its tasks admirably.

William Pick is a professor at the Dept of Community Health, Wits Medical School



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Charting a Way Forward:

A number of common themes emerged, but the situational analyses also highlighted the need to do further local analyses to inform plan Cuban visitors stressed the need to focus on a few crucial priorities.

Common Themes of the Policy Proposals

Paul Sefularo

The policy resolutions adopted at the end of the conference are characterised by recurrent themes which could be said to emphasise the major concerns of the conference delegates about the present health service. These themes also reflect the aims of the National Progressive Primary Health Care Network (NPPHCN) and the South African Health and Social Services Organisation (SAHSSO) in their struggle towards a national health system in a democratic South Africa.

1. Unilateral restructuring

One major concern is the unilateral restructuring of the health sector by the National Party government. Examples of such unilateral restructuring are given as follows:

- In 1991 the minister of health, Dr Rina Venter, in her budget speech announced the devolution of power to local authorities. Local authorities would, from then on, be responsible for all primary health care activities. In the same speech, the minister announced the government's intention to allow autonomy to academic teaching hospitals. She also announced the possibility of allowing doctors working in state teaching hospitals to do some private practice. This was announced as a potential cost containment strategy, as doctors would be allowed to supplement their incomes with some private practice.
- The Health Matters Advisory Committee recommended the rationalisation of services within the tricameral system. At a regional level, particularly in the Cape province, Natal and the Transvaal, the provincial administrations embarked on a rationalisation programme which effectively forces senior and experienced health workers into early retirement, thereby prematurely depriving the health services of their skills.

While all the commissions at the NPPHCN/SAHSSO policy conference call for the cessation of the unilateral restructuring, the commission on the transformation of the civil service in the health sector, specifically calls on the government to freeze retrenchments and promotions until a new constitution is in place.

2. PHC: The 'real' Alma Alta Way

Primary health care as defined by the Alma Ata conference of the World Health Organisation formed the basis of all discussions and recommendations in all the commissions. True primary health care is repeatedly characterised as the responsibility of the health care delivery sector as well as other sectors, which are seen as crucial to the attainment of complete physical, mental and social well being of the people.

3. Human Rights

Many of the commissions concluded that, for both the health workers and the users of the health services, effective provision of primary health has to be based on the acceptance of the fundamental principles of human rights. There is, for example, a proposal for the drafting and strict implementation of a Patients' Charter of Rights. A more specific recommendation in this issue is from the HIV/AIDS commission which calls on the government to endorse the AIDS Charter. Mental health and access to health care services are also included as human rights that will have to be guaranteed in a comprehensive primary health care system. For workers, various commissions emphasise the need for freedom of association, freedom from exploitation and the right to occupational health and safety. Racism and gender discrimination are also condemned.

4. Accountability

The call for greater accountability on the part of health workers and authorities feature prominently in many of the commissions. The commissions that dealt with the organisational structure, the reorientation of the public sector and the improvement of the quality of services see greater accountability being very central to the achievement of these goals. Accountability is seen as crucial for both community participation, good management and greater accessibility of the health service facilities.

5. Equity

The situation analyses repeatedly point to health problems attributable to deliberate neglect by the apartheid health authorities. Consequently, equity features in almost all the recommendations that deal with the structure and organisation of health services as well as the quality and range of services.

Equity is emphasised in the context of programmes that specifically target certain areas, populations, communities or sectors for an allocation of greater resources so that they can be brought on par with the rest of society in access to health care resources if not in health status.

6. Training

Many of the problems and deficiencies of the present health sector are blamed on poor training of health workers, managers and other public servants. No less than five commissions recommend the training of new categories of health personnel and the retraining of existing managers and other categories of staff. Retraining of health personnel is recommended as a way of changing management, health practice and labour relations attitudes. New training programmes are proposed for the creation of new categories of health personnel.

7. Research

The commissions that looked at traditional healers, mental health and nutrition make a strong call for well structured research that will inform health care administration anew about these areas or at least enable them to detect problems when they arise. Other commissions variously recommend some surveillance mechanisms to monitor the trends of some health problems. These and other recommendations are backed up by a resolution that calls for the establishment of an essential national health research programme. This resolution also calls for the use of research in pursuit of equity and social justice.

8. Health Education

Health education and health promotion are seen as very important by the various commissions. The government and health workers are called upon to implement effective programmes aimed at increasing the awareness of the various target population groups as this is seen as important for improving the situation regarding nutritional, mental health, sexually transmitted disease and HIV/AIDS problems.

Another important theme, although less frequently mentioned, was the subject of affirmative action.

Paul Sefularo is on the NPPHCN/SAHSSO Policy Steering Committee

Health Policy for a post-Apartheid South Africa: a way forward

Malcolm Segall

May I start by greeting the achievement of the two organisations, the NPPHCN and SAHSSO, in pulling off a considerable feat; organising - on a participatory basis - a situation analysis of the health and social services sector in four regions of South Africa, then organising a dynamic and vibrant four-day conference with delegates from all over the country coming together to debate the findings and then, pulling it all together into policy statements on some key areas of health care, and finally, arranging a public presentation and debate.

Informed Planning

We no longer have to rely on anecdotes, personal experiences and accounts of what is happening at the grassroots. We now have recorded information. We have a direct study - a snapshot of health problems in urban, peri-urban, squatter and rural areas around the country. All this provides a good basis for health policy and the planning of what needs to be done. The conference delegates will take home with them the fruits of the work they did over the last week. Through regional workshops with colleagues and comrades, they will multiply several-fold the benefits of the situation analysis and the policy conference.

The policy formulation process was exceptional for its participatory character. South Africa can be assured that in the NPPHCN and SAHSSO, it has a core of active and committed health and social services professionals and activists of which it can justly be proud.

Radical Restructuring - a need

In South Africa, the infant mortality rate of the most disadvantaged social group is more than four times that of the most privileged group and yet the disadvantaged receive less than a quarter of the health care resources per head of the privileged. On average, a black baby born can expect to live fourteen years less than a white baby. In the light of this, who can doubt the South African health sector needs urgent and radical restructuring?

The most obvious need must be the unification of the fourteen ministries and departments of health. This fragmentation has led to the wasteful use of health care resources and made rational planning and policy formulation an impossibility. But also, there are other changes needed for an effective and efficient planning and management system in the health sector.

We have seen similar restructuring in other countries on the African continent. Zimbabwe is perhaps a similar case in terms of the challenges they faced at independence. Mozambique is also a good case in point. In both countries, restructuring in the early years was quite successful and yielded considerable health care benefits to the people. Then the economic crisis of the eighties, and the war of destabilisation in Mozambique, robbed the two countries of many of the gains they had made.

But South Africa has, despite its present difficulties, a strong economic base. We can look forward to a successful outcome of the restructuring process.

Two Approaches

There are two ways to restructure the health sector - an easy and a hard way. In the easier way, all would accept that South Africa is opening a new chapter, starting a new life and all should work together in a spirit of co-operation. In this case, restructuring will not necessarily be painless but it can proceed relatively smoothly. In the harder way, some will want to hold up events and try to hold

Power is never given up willingly. *Photo: Ismail Vawda*

back history by putting up obstacles and difficulties in the way of attempts to make constructive changes. There will still be restructuring in the end, but it will be more painful and will take longer.

Rehabilitating Services

The situation analysis pointed to serious problems with the public health services - problems in health care coverage, drug availability, health worker attitudes, and so on. These problems are not surprising under the circumstances, but the facts remain. They are not uncommon problems, but they can and must be improved upon. The public health services in South Africa are clearly under-resourced and poorly managed. There is thus a need for a vigorous programme of rehabilitation of services, which will need to include the development of the following:

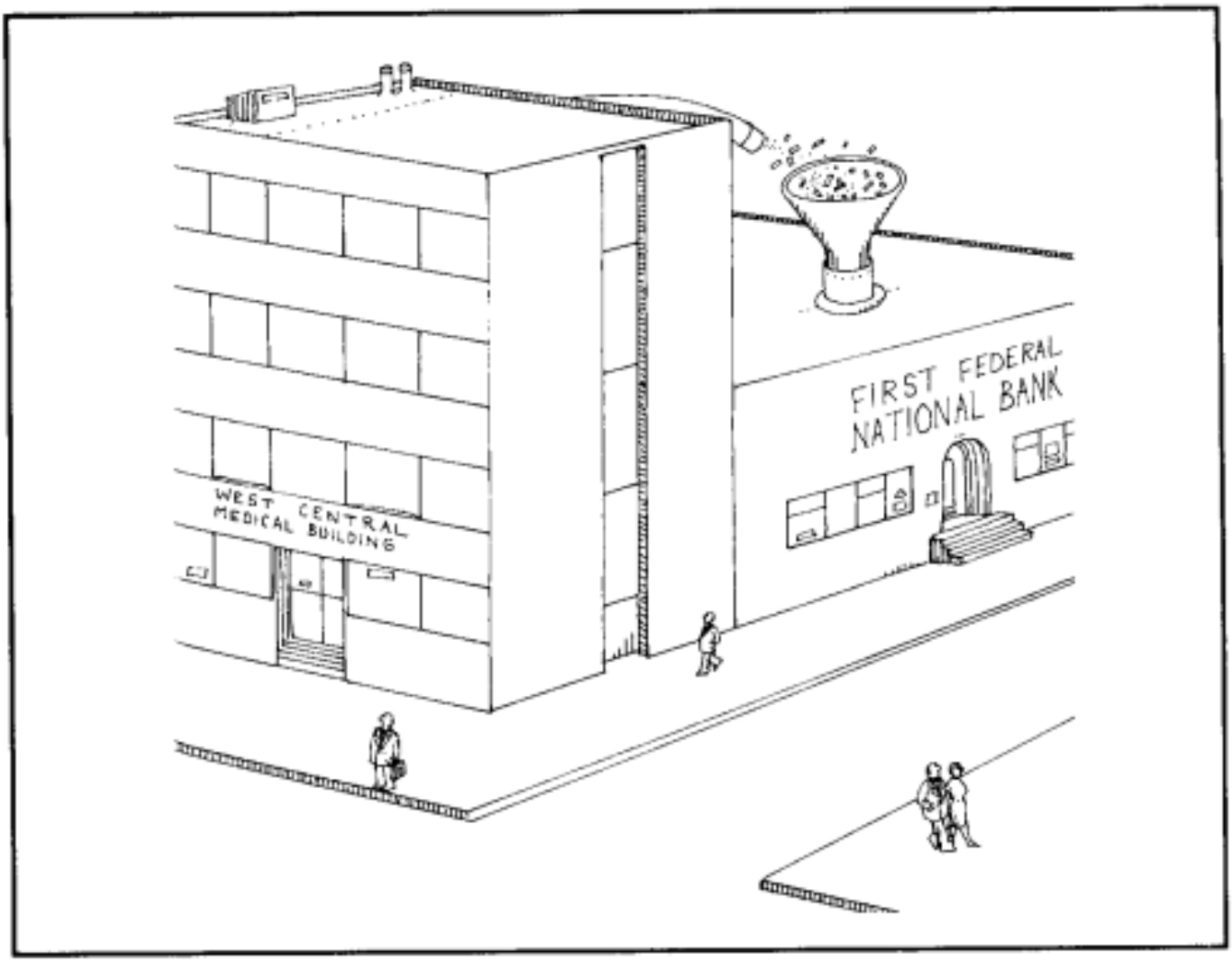
- support and supervision services for grassroots structures;
- training and retraining programmes;
- refurbishing of facilities;
- establishing community influence; and
- improving conditions of services for health workers.

Financing a Way Forward

I wish to urge the two organisations to take the process forward. You should move from the situation analysis/policy mode to a planning/costing mode. You could take some selected areas, mainly districts, and apply the policies you have formulated nationally, then see what concrete changes need to be made. You will thus make area development plans and these will give you a deeper understanding of your health policies, which may need revising.

You should cost your plans. If you gross up these costs to the whole country, you will then have a rough idea of what resources will be needed to rehabilitate the entire public health service applying the defined health policies. In this way, you will know broadly the present resource gap. You will finally have to come up with a financing strategy to bridge this gap, and if this is not possible you will have to reduce your sights on the policies. And so you can arrive at policies and plans that are economically feasible.

Friends, this may sound like a tall order for the organisations involved, but I now have faith in you. I know you can do it, the work which would be a wonderful preparation for the taking of a new democratic government.



Part of the problem? *courtesy Simon Bond*

This further work will need resources. I, therefore, appeal to the funding agencies, embassies and other organisations that are present here to support these organisations in this work. It would certainly be a cost effective investment for you.

Malcolm Segall is based at the Institute of Development Studies at the University of Sussex, England. He was invited to address the NPPHCN/SAHSSO Policy Conference

Setting Priorities for an NHS in South Africa

Felipe Delagado Bustillo & Carlos Mas Zabala

The authors of this article were invited to South Africa by the ANC Health Department. Their stay coincided with the build up to the NPPHCN/SAHSSO conference and the conference itself. They wrote this article on the basis of their experience in this country. Many of the points they raise were discussed during the course of the conference, but the article is of particular interest because the authors argue that we should put all of our energy into addressing a few key priorities, some of which were not covered in the conference. We have included it to stimulate further debate on the way forward arising out of the conference.

In human health, everything is important and no aspect of health care should be neglected. Nevertheless, it is clear that some aspects are more important than others. The importance or significance at a social scale of any health problem is determined by its social magnitude, the degree of community disturbance, its possible propagation and the economic effects that could result.

When accumulated and widespread health problems have to be addressed with insufficient funds, material resources and personnel, it is necessary to establish some priorities. These priorities have to be decided on as the first step in the establishment of a new National Health Service (NHS), so as to ensure significant short term improvements and a generally favourable impact on the health of the community.

In our opinion, there are two kinds of priorities. There are general priorities which should be built into the framework of the health system and, as such, influence a wide range of health actions. These include prevention, an epidemiological surveillance system and primary health care (PHC). There are also particular priorities to address specific health problems, including programmes focussing on mother and child care and diseases such as tuberculosis and gastroenteritis.

We will point out, according to our experience, the priorities we feel should be taken into consideration for a National Health Service in South Africa.

Prevention

The prevention of ill health should occupy the most prominent place in a health service that is beginning to provide the basis for extensive health care to a broader population that has not benefited from such care before.

Prevention includes specific actions such as immunisation and focus control. It also entails addressing general issues such as housing, work, nutrition, education, sport, water, sanitation and electricity. Without water supply, adequate sanitation and a basic knowledge of domestic hygiene, gastroenteritis will remain widespread. Without suitable housing and nutrition, tuberculosis will continue to be a social problem.

It is clear that the government authorities have the most important role to play in preventing ill health and they must modify the socioeconomic structure accordingly. Health providers can only provide part of the solution, but they can play a significant role with regard to specific health actions.

It is essential to have an adequate immunisation programme. It not only ensures an improved standard of health in the community but also saves resources that would be spent on patients suffering from immuno-preventable diseases. There is a need for vaccination programmes established permanently within an NHS, as well as short-term campaigns to limit the spread of particular diseases.

Epidemiological Surveillance

An understanding of health and illness in the community is essential in order to provide appropriate health care. For this reason, many countries have established epidemiological surveillance systems. Such a system can ensure the early detection of any diseases that appear in the community and assist in the development of an understanding of the relationship between these diseases and the social, physical, chemical and biological environment. It is an implement that provides an NHS with a scientific basis with which to plan and organise its services and resources.

An epidemiological surveillance system has two components. The first is a statistical information system, to monitor the appearance and behaviour of diseases in the community, the level of risk to humans and the environmental sanitary conditions. The second component is focus control. This involves a group of technicians and professionals (health inspectors), who are responsible for controlling the spread of diseases in the community.

Cuba, after the triumph of the revolution, began to develop a rudimentary epidemiological surveillance system together with the implementation of a new National Health Service. The system was consolidated over the years and, today, every day, it is possible to know what is happening in terms of ill health in each village, town, city and rural area. We previously focussed on the most important communicable diseases in our country and have since virtually insured Cuba's child population against the scourge of immuno-preventable diseases, acute diarrhoeal diseases and respiratory infections. We have now moved on to address first world problems, paying attention mainly to the risk factors of chronic diseases.

Surveillance and an NHS in South Africa

We make the following suggestions for establishing an epidemiological surveillance system in South Africa. The establishment of a national statistical information system must take place together with the creation of a new NHS. The information system should involve collecting information from all health units, both public and private, and should include a register or data source in all these units. Information should also be collected from ports, airports and border points.

Diagnose the community, not just the individual. *Photo: Ismail Vawda*

The surveillance system must be inserted into the national health service. The primary health care structures have an important role to play in focus control of communicable diseases and sanitary control of the environment. There should be a group of specialists in the intermediate and national levels to co-ordinate control actions.

Initially, surveillance could start in a selected area and, thereafter, it could be extended to all regions. However, once surveillance has started, it should continue forever. The surveillance system should begin monitoring communicable diseases and sanitary problems which are immediate priorities. At a later date, it can be extended to embrace all diseases, including chronic diseases.

Comprehensive Primary Health Care

Primary health care is an essential feature of the health service. A comprehensive PHC network can solve 90% of all community health problems. We suggest that the PHC service in South Africa needs to be extended into every region, rural area, township and informal settlement. It is important that the necessary facilities are built, at low cost, to ensure that the longest distance between communities and health units is less than 32 kms, and the time it takes to reach them is no more than 45 to 60 minutes. Nurses and health workers must be provided with a community oriented training to enable them to carry out the necessary preventive, curative, promotive and rehabilitative actions.

Communities should have access to medical doctors at the primary health level. Initially, it may only be possible for doctors to play a part time role, but the target should be to provide all communities with access to doctors on a full time basis. PHC relies on team work and the team should include medical doctors, nurses and other social and health workers.

Family Centred Care and Community Participation

Dr Leonardo Cuesta Mejias gave an input to the policy conference in which he referred to the family centred PHC system in Cuba. The family is seen as a unit. Care is provided to the whole family rather than just the patient. This allows for a more intimate relationship between health workers and the population, and greater participation by the community in decision making.

Family doctors have become specialists in comprehensive general medicine and, in turn, specialists in primary health care. The polyclinics have developed into co-ordinating centres of health services, teaching and research. They also include diagnostic facilities, namely laboratories and x-ray and

electrocardiogram equipment. In this way, the family doctor's office has become the basic unit of our national health system.

One of the most important functions of the family doctor in Cuba is the diagnosis of the community. This is developed in consultation with community leaders, who are elected and recognised by the people. Other health workers are selected by the family doctor in consultation with the community. The most important health problems and their possible solutions are analysed. Projects are identified and plans are developed by the family doctor and presented to the community for discussion. The community approves or modifies these projects.

Another important aspect of the health system is the link between primary and secondary levels. In South Africa a clear referral system from the clinics to the hospitals needs to be developed. Hospitals must give feedback to the clinics on the health status of all referred patients.

Specific Priorities

Our experience in visiting South Africa suggests the need for four specific programmes, addressing tuberculosis, mother and child care, gastroenteritis and sexually transmitted diseases, including HIV/AIDs.

A control programme against tuberculosis, for instance, must embrace both health workers and the general population. A register must be developed. The programme should include vaccination and measures to interrupt the chain of transmission, notably a standard diagnostic system, case searching in the community, short term treatment and focus control amongst contacts.

Mother and child care is one of the most important priorities in public health. Infant and maternal mortality are key indicators of a country's development and the quality of its social services. All pregnant women in the community should be identified and they should receive antenatal care. Midwives should be trained to work in the community. Mothers and children should receive postnatal care. Nutritional support should be provided, breast feeding should be promoted and child development and growth should be monitored. In disadvantaged communities, 'maternity homes' for pregnant women and 'nutritional homes' for newborns should be established.

Felipe Delagado Bustillo and Carlos Mas Zabala are doctors who work in the Cuban health system.

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General Section:

At times, community health workers do work which paradoxically contradicts their intended effect. nurses are starting to struggle for the right to freedom of association. SAHSSO is spearheading a campaign against unilateral restructuring.

Paradox and Policy:
Some Lessons from CHW Projects

Francie Lund

People argue for the merits of community health workers (CHWs) on different grounds. Some would say that the most important reasons for their work are cost and appropriateness. The majority of health problems in rural areas are either readily preventable, or can be dealt with by people with far less costly training than doctors or nurses.

There is a different way in which the term 'appropriateness' is used. Some argue that CHWs, coming from the community, understanding local health practices and causes of ill-health, and 'speaking the language' (in more than just a literal sense), are best placed to understand the barriers between the people and the formal health system, and to do health education.

Then there are those who see the organisation of CHWs as a platform for working towards other, non-health related goals. They see community health as an entry point for integrated rural development, and especially for the organisation of women.

In 1982, I undertook a comparative study of three projects using community health workers. I became familiar with the work of a number of others as well. They were carefully chosen to reflect different ways of working. No matter where they were located geographically (KwaZulu, Transkei, Gazankulu), or where they placed themselves in terms of the health system (inside or outside), or whether the CHWs were paid or not, or did curative or preventive care, all the projects faced important paradoxes. These were of prevention, of professionalisation, and of participation - which hindered their ability to do what they set out to do.

Community health care was a popular idea in South Africa for a brief time in the 1930s and 1940s. When I started the study, the CHW concept was being revisisted, following the Alma Ata Conference. People in the projects were therefore trying out 'new' ideas in hostile surroundings. These were exceptional people, who were learning how to go about the business of introducing more democratic, more participatory, less authoritarian forms of health care delivery. There was very little funding available for rural health. They were struggling with very few resources.

Health and development: who elects, who teaches, and how?
Photo: unkown

Much has been learned, since then, about the implementation of primary health care programmes. Some of the lessons have been learned from these particular schemes. Now, ten years later, when there is an attempt to look at how to integrate community health workers into a national policy for primary health care, it may be useful to look again at some of the chief lessons learned from the schemes. I would argue that the three paradoxes remain. They have not been resolved, because the context of unequal development still exists. We still do not have democratic structures at local government level. And now a fourth paradox has been added - the paradox of policy.

How the three paradoxes operate

The paradox of prevention: When the idea of CHWs is being introduced to other professional health personnel, the rationale is often given that the CHWs will be able to assist the nursing sister, and lighten her load. But CHWs are introduced into a context of scarce health resources and a poor health system. To

the extent that the CHWs does her work well, she creates more work for the health personnel. Her efforts at early detection of health problems means that she brings more patients to the clinic for the nursing sister to deal with.

The paradox of professionalisation: It is a popular idea that the CHWs are ideal as they are from the community, accountable to the community, and therefore they can get people to take more responsibility for their own health. In the very act of choosing some people to go for training as health workers, however, the CHWs are professionalised in the eyes of local people - who therefore are likely to say that health care is something that other people - CHWs - do. In this way a broad band of local people may become less likely to participate in health education, or health campaigns.

The paradox of participation: Another popular idea is that 'the community' should participate in the election of the CHWs, as they themselves know who the most appropriate people would be for the task. However, in a society such as ours, with little tradition of democracy, local elections get rigged and controlled by those in positions of power, and there is little real participation in a free and fair way.

How are the trainers trained?

The three projects were all trying to implement a model of experience-based, participatory learning. In this process, people are encouraged to be responsible for their own learning - to become active learners rather than passive recipients of information, building on what they already know.

All project staff acknowledged how far they were from reaching the ideal. A problem shared by directors and trainers was that they had had to learn about the experience-based approach as they went along. As health professionals, they had gone through a training that was hierarchical and authoritarian. They spoke frankly of how they had not been equipped to deal with, let alone teach others, the process of becoming an active learner, learning how to guide rather than instruct, to nurture group discussion rather than lecture, and to handle the sense of loss of control that comes when the conventional one way teaching method is overturned.

So in all projects, the trainers were learning while they were training other health workers, who were in turn being trained to educate others. If the trainers are themselves inappropriate role models, this gets transferred to the health workers. In one project, a staff member said that most CHWs considered themselves 'instructors' or 'teachers'. They felt that the early training might have contributed to this:

How are health professionals, trained in hierarchical, urban-based curative care to train others in a totally different context? *Photo: Laura Santamaria*

"I think they were trained very much in the way that health people were trained, which is a way of telling people what to do. You have the advice, and people must take your advice, rather than getting involved with people, and getting people to work together."

An important lesson for two of the projects was that, if they were to start a project again, they would introduce a more systematic and thorough course for trainers before recruiting grassroots health workers. However, given the scale on which people are being trained and will need to be trained, we should perhaps consider a far greater contribution from people with the skills and approach of adult education, lodged inside formal training institutions and in projects themselves.

An important question is thus: is it perhaps easier for well-trained adult educators to learn health content, than it is for health professionals to learn progressive educational process?

Professional attitudes towards chws: 'pathological professionalism' in progressive phc?

> "...there are some nurses who are aware of the dignity of their profession to a pathological degree."

> "Many of the sisters don't support the health workers at all. On the contrary, they think it is an intrusion into the realm of their closed profession of sisters."

The project staff who were trying to get other health professionals to accept the new role of CHW had a difficult job to do. They found themselves isolated from other health professionals in their environments.

In rural hospitals, which typically have a shortage of medical staff, the project doctors found the slow business of training and organising health workers was in direct competition with the urgency of their curative role in the hospital or at clinics. Where doctors and nurses were employed full-time on the projects, and did not have to do the 'normal' clinical work, they often faced hostility: the hospital-based staff believed that all this community work was a waste of time, a soft job, compared to their own 'real' work in the wards and theatres.

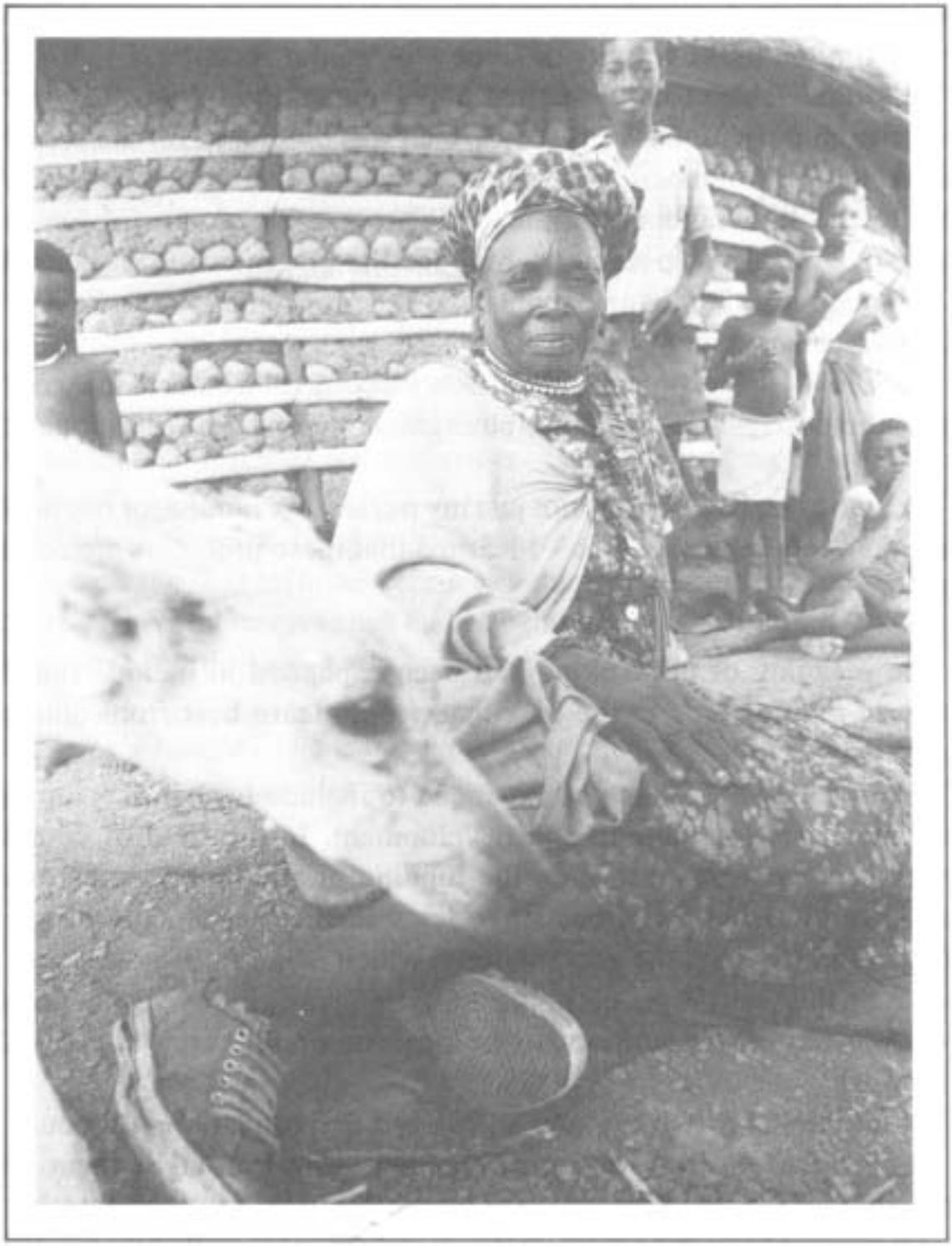
The CHWs themselves expressed a great deal of anger at the attitudes of professionals towards them - not their own project staff, but others in their environment. They singled this out - along with obstructive tribal authorities and alcoholism in the community - as one of the most serious problems in their work.

A typical story from one CHW told how, in line with her duties, she took a person to a clinic with a letter of referral. The clinic sister, overworked, isolated, and with few resources, had run out of the medication required, and took her frustration out on the CHW in full view of everyone else in the clinic. This is abusive and undermining, rather than empowering.

In this sort of situation, it was perhaps not surprising to observe a clinic sister scolding the health workers for not taking notes fast enough, expressing irritation with their slowness in understanding a point, and finishing the session with an instruction to the CHWs to go out and work with love. When she had left, a health worker said:

> "She says we must love the community, but she has no love for us in her heart, and we are the community."

Would a different training for health personnel make much of a difference under present circumstances? How effective is it to devote time to planning details of a core curriculum for community health workers independently of radical curriculum changes for the other health personnel as well? And then the material circumstances under which the professionals work in rural areas will have to be improved if the paradox of prevention is to be resolved.



New policies for South Africa are about making things equitable, empowering and democratic. *Photo: Market Theatre Photo Workshop*

Is networking something only professionals do?

Networking is the process in which people working for social change reach out to each other, share ideas, inform each other about problems, available resources, changing trends in the environment, new information about their field. Networking is very important. It is very much in vogue, not least within progressive primary health care in South Africa. However, networking has been, and still largely is, limited to the activity of some few 'senior' people.

Important lessons were learned about networking from this study, in particular from the national workshop which was organised for the community health workers. A number of key factors guided the workshop design and process: the health workers determined the programme; no professionals were allowed (save for two who acted as group facilitators, and were chosen for their skills in listening and drawing people out); and proceedings were held in Zulu, Xhosa and Shangaan, not English.

The CHWs spoke potently about how meeting each other at the workshop, with they themselves in control, was strengthening. In the words of one person:

"I came to realise that it is not just my nurses, my induna, or our husbands who are the problem in my area - I learned that these problems are across the country."

The meaning of networking had been expanded to include the CHWs themselves, giving force to the idea that people learn best from others with similar experiences.

Networking should also be expanded to include further development of existing materials for training and development. In the field of community health, there should be a brake on the funding of any more resource centres (unless in rural areas). The challenge is to share what already exists more broadly, and to translate the good material which is in English only, into more languages. In this way the people doing the training can give over what they know to the people they are training, and to the local communities in which the CHWs live and work.

An additional role for a networking and dissemination unit could be to write the stories of projects, documenting the lessons learned by them. People in the field in rural development are overwhelmed by day-to-day tasks. They know they should be writing their work up, and many know that they never will. They sit on a wealth of experience and knowledge, which is not widely shared. We cannot afford to let the lessons of our recent history slip by.

The fourth paradox: policy

The national initiative to forge a policy surrounding community health workers, in order to ensure that they have a place in the health system of the future, is surely a good thing, and very necessary in order to get the role of CHWs firmly on the agenda. But even though it comes from the progressive health sector, it will turn out to be top-down, disempowering, and regressive unless the paradox of policy is taken into account.

New policies for South Africa are about trying to make things more equitable, empowering, and democratic. But policies can tend to be prescriptive. They can make universal prescriptions - such as all CHWs must be paid, must have accredited training courses, must be chosen by communities. The intention is honourable - to stop CHWs from being exploited, and giving this category of worker a proper place.

However, the need on the ground may be for a recognition of diversity, of different needs, various conditions. And the need may be not for a forced choice - either government provision or provision through non-governmental organisations - but for an informed choice of either or both, depending on what the reality is in a particular area.

The best policies may be those which create the enabling environment within which the best informed choices between alternatives can be made. By and large, CHWs themselves can make an important contribution to defining the choices they would like to have.

Francie Lund is a senior researcher at the Centre for Social and Development Studies at the University of Natal, Durban.

Note: The full report of the study on which this article is based is Lund, F J, *The community based approach to development: a description and analysis of three rural community health projects.* Durban: Centre for Social and Development Studies, University of Natal, 1987.

Organising Nurses -
SANA Under Threat

Critical Health

Nurses entering the profession for the altruistic motive of patient care prefer the model of the professional association rather than trade unionism and, in contrast, nurses interested in their own economic gain prefer trade unionism. This assertion is made by the South African Nursing Association (SANA), quoting the findings of an American researcher, in its pamphlet entitled 'Trade Unionism or Professional Association?'.

The altruistic selfless nurse is also not in the least concerned about politics. Before engaging in an interview with *Critical Health* recently, Mrs S J du Preez, executive director of SANA, cautioned that she could not answer questions about politics because she was simply a 'caring nurse'.

According to SANA, when nurses strike over pay and conditions the issue is immediately an ethical one. This assumes nurses necessarily stop performing all their tasks of patient care during a strike. SANA was vocal in opposing nurses' participation in the 1992 hospital strike led by the National Education and Health Workers' Union (NEHAWU). At the time, the government had removed a clause in the Nursing Act whereby nurses could be severely disciplined for engaging in work stoppages. SANA reacted, assuring nurses the legislative change did not automatically grant them the right to strike. In a pamphlet 'Nurses and Strikes: Fallacies and Facts', SANA stated, "apart from the removal of the strike clause, nothing has changed: The nurse still has a legal, moral and ethical duty to her patient and her employer".

Whose Ethics?

SANA's perspective on the ethics of nursing are, however, not the last word on the issue. Worldwide, nurses are increasingly involved in strikes and other industrial action over their pay and working conditions. For many of these nurses, the ethical question is not in conflict with their fight to improve their own well being - improved pay and working conditions for nurses has a positive effect on their morale and, thereby, their day to day competence and willingness to provide patient care.

A nurse participating in the British nurses' strike of 1988, explained her

participation thus: "We can't give the nursing that's required and that's the stress nurses are feeling - it's the stress of not doing the job properly". In the 1988 strike, British nurses demanded better wages and working conditions and also expresssed strong opposition to government cutbacks in staffing and facilities for patient care.

In the past, most South African nurses accepted SANA's nursing ethics without criticism. Many, however, endured harsh conditions of service by exercising their frustration on patients. A nurse told *Critical Health*, "I'm always reprimanded ... because the matron is not sensitive to my problems and only sees me as another 'pair of hands'. This leaves me feeling depressed, frustrated and angry. I will often displace this anger by picking on those over whom I have authority - my patients and student nurses".

Do Nurses Want The Right to Strike?

It is evident that more nurses are beginning to support the right to strike. Siphiwe Mabaso, branch secretary of NEHAWU (Johannesburg) has commented, for instance, that the 1992 strike had started at Baragwanath Hospital among nurses and radiographers - a point that did not receive much publicity. Throughout the strike, various nurses, doctors and radiographers formed committees supportive of the strikers, even while they continued to work.

In turn, there was extensive victimisation against nurses who participated in the strike. In Natal, 150 nurses have appeared before the South African Nursing Council (SANC) and have been found guilty of misconduct. The council, however, found no evidence linking the participation of these nurses in the strike to deterioration in patient care. Furthermore, according to SANA's Mrs du Preez, there are many nurses throughout the country facing disciplinary charges against them.

Arising from a resolution adopted at a consultative conference of nurses at Durban in February this year, the South African Health and Social Services Organisation (SAHSSO) led protests outside the offices of both SANA and the SANC in Pretoria, demanding the dropping of charges against the 150 nurses and calling for the right of nurses to freely associate. SANA says the protests against it were misplaced, because SANA does not share the disciplinary powers of the SANC. SANA does not testify against nurses because this is not its constitutional function, although it does counsel nurses on approaching disciplinary proceedings.

SANA does, however, support the disciplinary powers of SANC, which it refers to as 'peer review'.

Tackling SANA's Statutory Status

By the 1980s, black workers in South Africa had won a long battle for official recognition as employees, the right to strike and independent trade unionism. This has encouraged some nurses to begin challenging SANA's ethics and SANA's statutory claim to represent their interests. The first major challenge to SANA came from student nurses at Baragwanath Hospital in 1985. Represented by the Health Workers Association, these nurses withheld their labour over various grievances. As a clear challenge to SANA, this included a demand for a democratically elected students' representative body.

Subsequently, NEHAWU and the Health Workers Union were launched. They initially attracted mainly general hospital workers, making only small inroads amongst nurses. By 1988, however, SANA was clearly concerned about the growing interest black nurses were showing towards these trade unions and saw this as a clear threat to its continued monopoly over the organisation of nurses. It reacted by publishing a pamphlet opposing unions in the health sector, referring to these as 'opportunistic' organisations. The pamphlet dismissed nurses' right to strike. In view of the obvious interest being shown towards trade unions, the pamphlet left the option of trade unionism open, despite a SANA central board decision "not to register as a trade union".

SANA's Referendum

Progressive organisations exerted pressure on the minister of health, Dr Rina Venter, to review legislation granting SANA statutory status alongside SANC, the disciplinary body. Dr Venter approached SANA to hold a referendum on the issue amongst its membership. A referendum was held in 1992 and the following questions were asked:

- Should membership of the association be compulsory or voluntary?
- Should the association retain its statutory status or not?
- Should the association register a section as a trade union or not?

Eightyfive percent of SANA branches voted in favour of compulsory membership, 100% in favour of retaining statutory status and 68,3% for registering a section of SANA as a trade union. Notably, the referendum was conducted on a branch basis rather than on the basis of individual membership. SANA claims a membership of about 150 000 nurses, 70 000 of whom are in the public sector. It is not clear how many nurses among SANA's claimed membership actually participated in the elections. SANA did not survey the number of these participating at branch level.

After the referendum, SANA's central board decided on registering that section of the organisation functioning at the local authority level as a trade union. According to Mrs du Preez, most local authority nurses are not defined as public sector workers. SANA cannot represent them in the public sector negotiating forum established by the Commission for Administration. SANA has to register as a trade union at local authority level in order to use industrial councils as a bargaining forum.

Criticisms of the Referendum

Progressive organisations have questioned the relevance of the referendum as a reflection of nurses' opinion generally. Some have referred to the referendum as a mockery. The conference in Durban earlier this year was convened by a group of nurses, calling themselves Concerned Nurses of South Africa, to express their dismay at the undemocratic manner in which SANA's referendum was conducted. A resolution was passed at the conference declaring SANA's referendum "invalid". It was proposed the referendum "should be declared null and void as we believe it was based on a majority of branches which are not democratically constituted and as such does not represent a decision by the majority of

SANA: the equivalent case of "you can have any colour car you want, so long as its black?"

nurses of South Africa".

According to NEHAWU's Mabaso, the union did a survey of nurses' views, outside its membership, on the referendum. The survey included a number of hospitals such as Baragwanath, Hillbrow, Natalspruit and Tembisa. The survey showed 56% of the nurses who responded had no knowledge of the referendum and had no idea of how SANA represented their interests. Many of these nurses also considered SANA to be on the side of management.

There is additional evidence casting doubt on SANA's claim to fairly represent nursing interests in South Africa. SANA has 104 branches which elect 74 regional boards. The regional boards elect the central board. On the regional boards, there are 74 members of whom 53 are white nurses. From these regional boards, 13 white nurses were elected to the central board. According to Du Preez, the association has had a non-racial constitution since 1989. The reason for the lack of black representation in SANA's leadership, she stated, seems to be a tendency among black nurses to boycott elections.

SANA: An Uncompromising Stance

SANA, according to Du Preez, cannot submit to the demand to declare its referendum null and void because the referendum was conducted in terms of its constitution. The referendum, therefore, reflects the opinion of the association's membership. Having gained in confidence from the referendum results, the association has signed an agreement with the Transvaal Provincial Administration. The provisions of the agreement include:

- furthering of healthy employer/employee relationships;
- the creation of clear rules and procedures in order to prevent the possibility of conflict between management and employees; and
- procedures for the settlement of disputes.

The agreement effectively excludes the right of nurses to strike.

Organisational Alternatives

SANA's claim to sole representation of nurses in the public sector is likely to be increasingly challenged by NEHAWU and other organisations. A growing number of nurses are seeking a more assertive approach to their representation, which organisations such as NEHAWU offer to fulfill. Since the 1992 strike, NEHAWU has continued to make inroads into nursing. According to Mabaso, this advance has not necessarily been in the form of increasing membership.

Rather, the union has consolidated nurses' involvement in its organisational structures. Until recently, there were no nurses in leading positions in the union - now, says Mabaso, many nurses are holding leading positions in the union's shop floor committees. At Tembisa Hospital, in fact, the whole shop floor committee consists of nurses. There are also a number of small nursing groups emerging countrywide, some of which intend to establish either alternative associations or trade unions. These groups include the Nursing Forum located in Johannesburg, the Democratic Association of South African Nurses (DSAN) in the eastern Cape and Concerned Nurses of South Africa.

The emergence of small nursing associations and forums independent of NEHAWU suggests that many nurses, although disenchanted in SANA, are still influenced by the ideology of professionalism and the conservative nursing ethics which SANA represents. For instance, a spokesperson for DSAN says that, as an alternative to SANA, DSAN wants to allow voluntary membership. Its constitution declares, "there shall be no restriction on the political freedom of nurses". It, however, specifically prefers the association model over trade unionism in order to protect the professional status of nurses.

It is clear that, despite many nurses still holding to the ideology of professionalism, SANA, as an organisation, is in crisis. SANA has felt sufficiently pressured by the challenge of nurses seeking organisational alternatives, to have accepted an invitation to the Durban conference, convened by one of these alternative nursing groups. The mood of the conference was often conciliatory, as many nurses were swayed by SANA's defence of its organisational practices and its reform from above. However, resolutions were passed in which both SANA and the SANC are charged with being undemocratic and in which nurses are called on to assist in the building of progressive organisations such as SAHSSO and NEHAWU. This is an indication of the persuasive presence of these organisations and other progressive political groupings at the conference.

In short, there is obvious and growing discontent with SANA, but this does not automatically entail a shift in allegiance and membership to NEHAWU and other unions. The ideology of professionalism is still strong and new organisations are attracting nurses who are dissatisfied with SANA, but unsure about joining a union. NEHAWU will need to be creative in the way in which it approaches the questions of professionalism and ethics if it wishes to significantly increase its membership amongst nurses.

This article was written by Joe Kelly.

The Campaign for People's Health and Social Services

SAHSSO

This campaign was conceived at a SAHSSO National Council in February 1993. It was motivated by the understanding that in the run-up to the transfer of power to a democratically elected authority, the present government is deliberately shifting the political economy of health towards private control, and therefore beyond the reach of a future government.

It was felt, given our long standing position of placing health and social services under the control of communities and democratic health workers, we needed to counter this manoeuvre on the part of the government and to place health firmly on the agenda of other structures in the liberation movement. It was also envisaged that the campaign would mobilise health activists, who have been inactive since the launch of SAHSSO.

Unilateral Restructuring

The theme of the campaign also derives from the government's parading as a major change, the farcical cancellation of 'own affairs' departments, resulting in the reduction of departments from fourteen to eleven. This was to occur on 1 April 1993, a date not inconsistent with falsehood and foolishness.

The areas of unilateral restructuring that raised the most concerns were:

- Rationalisation - the elimination of 'own affairs' departments has come with the simultaneous threat, from the cash strapped provincial administrations, of closure of public hospitals or sale of public hospitals to the private sector and massive retrenchments
- The Medical Schemes Amendment Act - This Act was passed in parliament recently, giving medical schemes autonomy to set their own membership rates, thereby allowing them, for profit motives, to exclude certain indigent groups, such as pensioners, from membership of medical schemes. The Act also removes guaranteed payments to doctors, which means patients will have to pay cash up front for medical attention. This would also have the effect of reducing poorer patients access to medical services.
- Autonomy of Academic Health Complexes - the government intends setting major state teaching hospitals on the route of privatisation, by allowing these

to secure and compete for their income from the private sector as autonomous academic complexes.

- **The Department of National Health's flawed PHC model**
  The internationally accepted concept of PHC seeks to empower communities and individuals to achieve improved health status. The government subverts this concept by insisting that communities pay for the cost of health services. Government expenditure on PHC is scanty, and restricted clinics and day hospitals which have a top down approach to PHC.
- **Drought relief and nutrition programmes**
  The government has created an infrastructure for the purpose of poverty relief, but funds are available for this work are grossly inadequate. Moreover, eighty percent of funds of the limited funds available go, not towards poverty relief, but towards servicing the unilaterally established infrastructure. In some outlying areas, these funds have disappeared through bureaucratic corruption - a consequence of the government's lack of wider consultation in the allocation of funds.
- **Increase in VAT on health services**
  The government has failed to zero-rate VAT on health services, showing its lack of concern about millions of people's inability to pay for health services at present costs

Organisations Involved

The campaign was successfully placed on the agenda of SAHSSO, SANCO, NEHAWU, SASCO, NPPHCN, ANC, SACP, PAC, AZAPO, SAMDP, COSATU, Diakonia, Black Sash, DHAC, NPSA, NACTU and OMHLE. This resulted in an unprecedented unity of purpose among the major components of the liberation movement and was a milestone in itself, apart from giving the campaign widespread legitimacy. The prosecution of the campaign initiated by SAHSSO has been the task of all these organisations through a joint forum.

In terms of mobilising health workers, the campaign has succeeded in focussing health workers' energies into political demands for health and has ensured an increasing participation of health workers in a progressive and democratic way.

The assassination of comrade Chris Hani, who personally endorsed the campaign, and the subsequent programme of mass action by the tripartite alliance has strengthened both the need and the desire for the successful continuance of the campaign. Numerous actions at the regional and national level have already occurred and the alliance of forces in the campaign will be

Batshabelo, March 1993. *Photo: courtesy Medecins du Monde*

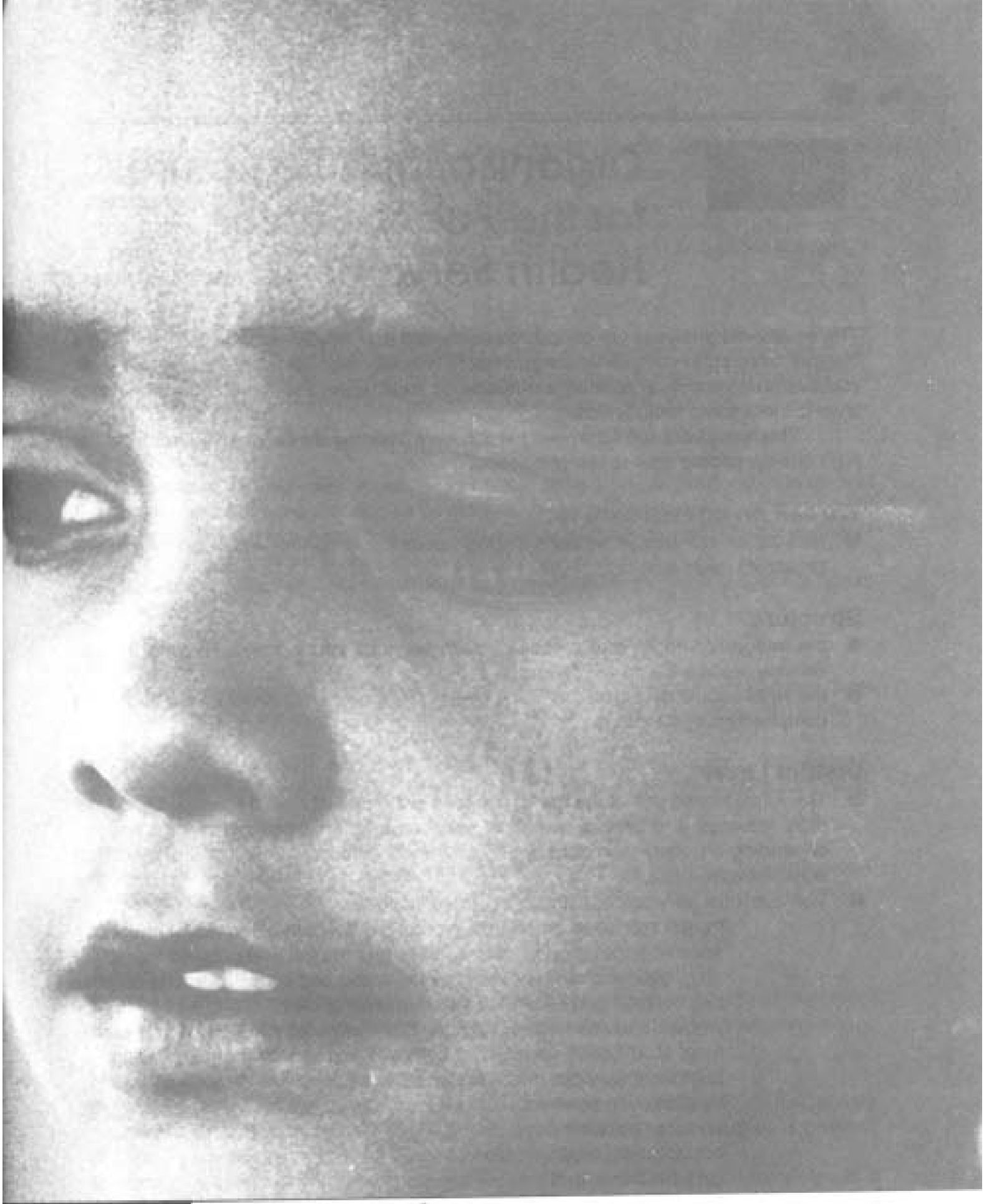
meeting shortly to determine how the campaign can be pursued within the framework of its objective and the mass action campaign.

Regions are being encouraged to continue the campaign at the local level. For example, a proposal is to be made to embark on a programme to rename the Baragwanath Hospital, the Chris Hani Memorial Hospital. A number of initiatives in other regions are being considered presently and there is confidence that the campaign will make it uncomfortable for the government to pursue a unilateral agenda in health.

In Natal, the decision to restructure King Edward Hospital and the establishment of a new academic hospital has been unanimously rejected by health workers in the Health Crisis Forum (a joint formation of progressive organisations in Natal including SAHSSO). It was felt that this would have detrimental consequences for patient care in Natal, as the new academic hospital is to be an academic complex in which only patients who suffer ailments of value to research would be catered for.

In many ways, the campaign needs to be regarded as a sustainable programme which must culminate in democratising the restructuring of health services from an apartheid anomaly to a democratic entity.

Aslam Dasoo is the Publicity Secretary of SAHSSO



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Policy Proposals

POLICY PROPOSAL

Organisational Structures for the Public Sector Health Services

The situational analyses we conducted confirmed that South Africa is plagued by the fragmentation of its health service organisation. This fragmentation along racial, tricameral, curative/preventative, academic/non-academic, rural/urban and homeland/South Africa lines is inequitable and inefficient.

This is wasteful and it prevents the coherent planning of a service which can deliver high quality, priority care to our population.

We call on government to:

- restructure our health services through democratic control which encompasses grassroot decisions.

Structure

- the integration of all public sector health services into a single National Health Service, accessible to all citizens.
- the NHS should be organised along central, regional, and district levels each with complementary functions.

District Level

- The fundamental unit of the health services is the district health service. These will plan, manage and provide essential services to a specified number of people, depending on population density and on the constitutional definitions of electoral/ administrative units.
- The essential services will, amongst others, include:
    - health education and health promotion, directed at individual patients, specific target groups, communities and the general population;
    - diagnostic and curative services for illness and injury, including community hospital and referral to the next level of care;
    - women and child health services including obstetric care, family planning, child health services for both well and sick children, including nutritional services and school health services and immunisation;
    - rehabilitation services;
    - social welfare services;
    - occupational health services;
    - geriatric services;
    - mental health services;
    - oral health services;
    - medico-legal and prison health services; and
    - pharmaceutical services.

These service delivery components will be supported by an appropriate health information system, transport (including referral and transport of supplies and pharmaceuticals) and communication facilities.
Intersectoral collaboration with other sectors and political organisations in the provision of water, sanitation, housing, job creation, waste removal and nutritional support is essential for health care.

Regional Level

- Groups of districts will be supported by the regional level health structures which will provide larger scale and specialised services. There may be a need for a sub-regional level, based on administrative, constitutional and logistical grounds.

National Level

- The national level health structure will be responsible for overall policy, the issuing of key technical and managerial guidelines, the coordination of the national health information system (including monitoring of performance), and for allocation of financial and personnel resources.
- Academic institutions will be planned and managed as part of the national health structure.

Equity

- to provide essential health services to all. Resource allocation must become more equitable and the public sector service will require more resources than it has at present.
- Resource generation and use should be monitored at all levels of the service. Redistribution of resources should occur at all levels on the basis of relative need.

District Decision Making

- With national guidelines, the district health authority will have the power for local planning, management and delivery of health services adapted to local circumstances.

Accountability

- The health service will be politically accountable at all levels. In addition, local health care services will be directly accountable to the communities they serve.

Health System Management

- Management of the health system at each level will be by multi-disciplinary management teams rather than by separate professional hierarchies as at present.
- Management training will be carried out as a priority.
- Health is determined by many aspects beyond health care and a structure ensuring intersectoral collaboration linked with a poverty alleviation programme should be instituted at each level of the service.

National Health Development Plan

- This will establish national, regional and district health objectives, the establishment of appropriate structures and specifications of service and development programmes.

Action Plan

- Local area situation analyses should be carried out on a participatory basis to identify health priorities and health service problems, formulate the objectives and draw up an action plan for their area. These should be done immediately and completed within a year of a new constitution.
- The range of essential services should be implemented with immediate effect.
- The current moves towards autonomy of academic complexes should be immediately halted and must be planned and managed as part of the national health system.

POLICY PROPOSAL

Improving the Quality of Service in the Public Sector

People who use Public Health Services experience many problems. Facilities are far from their homes and they have to travel long distances. They have to queue for long periods. Facilities are often closed when they are needed. The services offered are of poor quality and limited range. Most people cannot afford the fees and many are turned away if they cannot pay. Health workers, especially doctors and nurses, look down on them and are often uncaring and rude, blaming them for being sick and for other problems beyond their control. In some areas people have been unable to utilise facilities because of violence.

Causes:

The conference found that the above problems have deep rooted origins in the public sector and include a lack of:

- a common philosophy and PHC vision;
- an intersectoral approach;
- effective and efficient financing mechanisms;
- resources for PHC;
- genuine community involvement;
- respect for people;
- a comprehensive range of available resources;
- clear conditions of service;
- improved planning;
- effective human resource programmes; and
- effective management styles and approaches.

Recommendations

The basic solution to these problems was seen in a reorganised restructured, transformed public health service oriented towards PHC and not in privatisation or procurement by the state. The PHC service should be accountable to a democratically elected local government and the community. Imperative during the transition would be the implementation of an affirmative action programme.

We hereby call on government to:

- stop unilateral restructuring;
- stop cutting the public sector including the retrenchment of staff;
- create incentives to encourage staff to stay in the public sector;
- make all health sector information open to the community while maintaining confidentiality;
- involve staff and communities in planning;
- abandon top-down, authoritarian management styles and retrain managers for a more participatory approach;

- finally abandon racism and penalise staff who remain racist;
- urgently provide primary care facilities and services near where all South Africans live on the basis of equity;
- provide a standard and range of facilities suitable for a lower middle income country, including emergency, maternity and rehabilitation services.
- ensure a supply of essential drugs and equipment;
- implement a Patient's Charter of Rights;
- stop refusing care to people who cannot pay;
- develop a family centred patient kept record system;
- ensure safety and rights of health workers in health care institutions;
- actively root out corruption;
- institute credible public monitoring of the implementation of these measures and make it available on request; and
- democratise and institute legitimate community control of local public health services

POLICY PROPOSAL

Health Sector Financing and Expenditure

The situation analyses identified major national health care problems. Quality and access to health care are inadequate and declining. Additional funding will be required to put these problems right. The amount and source of this money needs to be investigated.

Problems Identified:

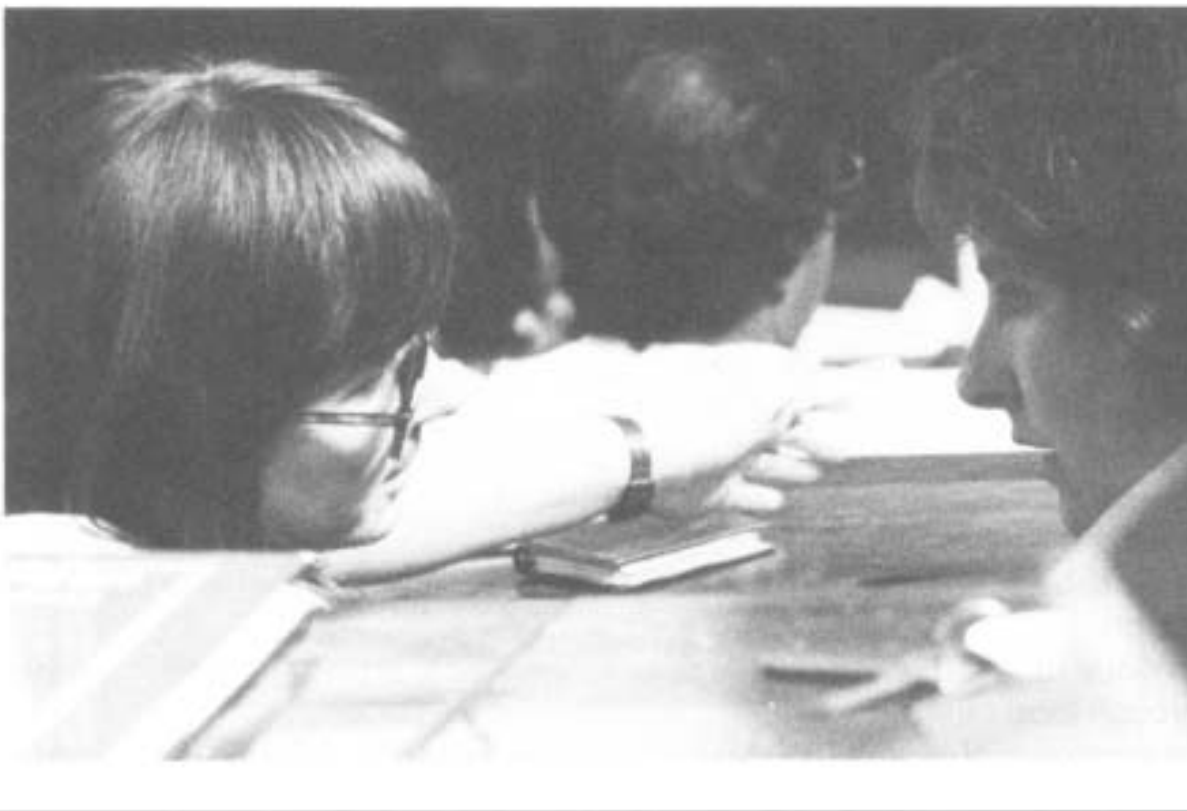
- Health care access and quality are grossly inequitable, discriminating against black, poor and non-urban South Africans;
- People are being denied access to care because they do not have the money to pay.
- Half of the total health expenditure is spent on the care of the twenty percent of the population on medical aid.
- This care is subsidised through substantial tax rebates on medical aid contributions, and through poaching of health workers trained at the expense of the taxpayer.
- Medical care in the private sector, especially drugs, is expensive.
- There is serious over-servicing and resulting doubts about quality of care in the private sector.

We call on government to:

- ensure that no one is denied access to essential health services because of an inability to pay;
- provide free care to vulnerable groups such as children under six, women receiving care related to child birth, pensioners and those with certain communicable diseases, for example, TB, STDs, AIDS;
- provide preventive and selective ambulatory curative care free at the point of service;
- charge for hospital care according to means, with a more appropriate scale of fees;
- commit additional tax revenue to health;
- substantially increase tax on alcohol and tobacco, and earmark the money raised for health care. Alcohol and tobacco related diseases consume a large proportion of health care costs;
- ban the advertising of these products; until then such advertising should be subject to heavy taxation;
- introduce a state lottery to help pay for health and social services;
- emphasize the development of the public sector, diminish the role of the private sector and stop privatisation;
- regulate the private sector to prevent adverse affects on the public sector and to control increasing private sector costs;
- remove tax rebates on medical aid and other subsidies for the private sector, such as the subsidy given to the training of health personnel who then move into the private sector;
- continue raising money for the district comprehensive primary health care systems through local rates and revenue;
- the promotion of regional equity shall be a criterion in the allocation of this money with richer areas subsidising neighbouring poorer areas; and

- to allocate central resources to ensure access according to need.

We call on government to implement the above principles and actions immediately. We further urge that research be immediately conducted to identify the amount of additional revenue required to fund a comprehensive primary health care system, and sources from which these funds can be obtained.



POLICY PROPOSAL

Intersectoral Collaboration

The successful development of the Primary Health Care approach requires effective intersectoral collaboration. Presently, the health sector collaborates poorly with other development sectors.

The problem is caused by:

- the lack of policy and motivation to collaborate intersectorally. Health is not seen to be an integral part of development; the health sector lacks a development perspective;
- the absence of mechanisms or skills for intersectoral collaboration;
- incompatible government structures;
- fragmentation within the health sector itself; and
- centralised, top-down planning and decision-making.

The health related areas in most need of intersectoral collaboration are:

- Nutrition
- AIDS/HIV
- Environmental health, particularly water and sanitation
- Social welfare
- Family planning
- Housing
- Literacy

All health personnel should be reoriented and retrained to develop a common vision and understanding of Primary Health Care, its processes and the place of health in development.

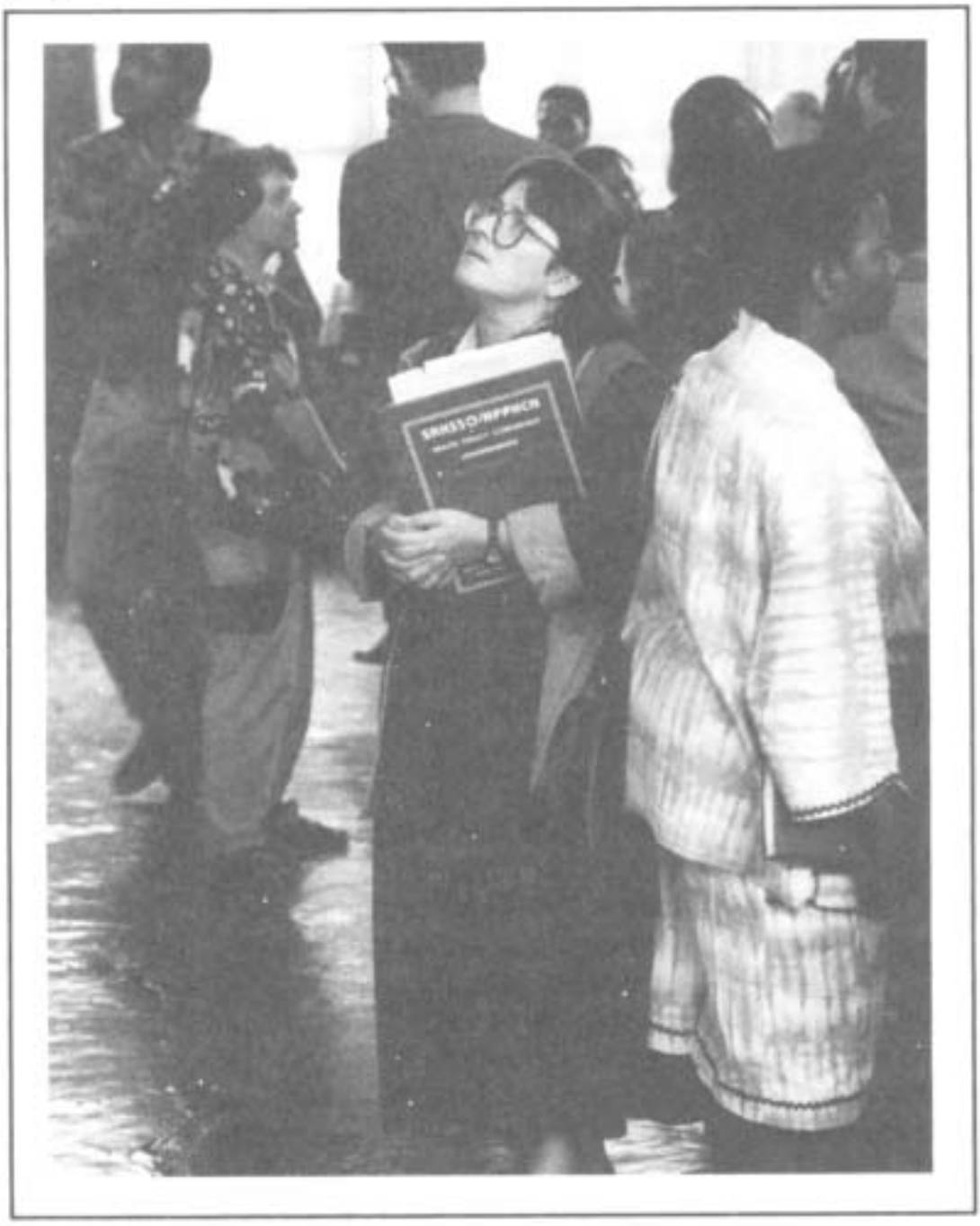
We call on government to:

- recognise health as an integral part of general development; health promotes development and development promotes health.
- restructure relevant government departments to promote intersectoral collaboration on health. This restructuring should parallel the democratically elected bodies of a new government. Implied here is that all present unilateral restructuring be halted.
- ensure and fund mechanisms and processes for intersectoral collaboration at all levels, be they district, subregional, regional or national. This will entail the establishment of development forums at these levels.
- devolve as much decision making as possible to the lowest government level to allow the line authorities maximum room to cooperate at the local level.
- establish a unified National Health Service that will facilitate dialogue with other sectors.
- undertake the needed skills training within each health related sector. The cadres from each sector should be trained together in joint courses.

- ensure that health goals are built into the plans of relevant development sectors.
- we recognise that institutionalising intersectoral collaboration is dependent upon the outcome of the present constitutional process. We do, however, believe that some health concerns require urgent intersectoral action.

We call on the interim government of national unity to promote intersectoral collaboration in at least the following priority areas:

- Nutrition
- HIV/AIDS
- Environmental health, particularly water and sanitation
- Social welfare
- Family planning
- Housing
- Literacy



POLICY PROPOSAL

Community Participation in the Health Sector

The Apartheid system has militated against community participation in health and development. This has alienated communities from their own health and from the health workers who are supposed to serve them. This has led to a number of problems which were identified through the situation analysis and during commissions. Among these problems are:

- services that are not geared to the needs of the people;
- many health professionals have negative attitudes;
- services are not available when the community needs them;
- services are imposed without consultation, representation and accountability; and
- government support for discredited local authorities at the expense of popular community representative structures.

These problems have made the community apathetic and has led them to regard health services as an extension of the Apartheid system. Civic associations and other organs of civil society should be strengthened to promote people's participation in the delivery of health, and their capacity to deal effectively with health and development issues. We call for a democratically elected constituent assembly to constitutionally guarantee the right of people to establish democratic organisations in civil society.

We call upon government to:

- promote an enabling environment for community participation in the development of a vibrant civil society; and
- stop repression and assasination of civic leaders and others.

Action plan

We resolve to:

- actively promote community participation in health and development by strengthening the role of the civic associations and other organs of civil society and by establishing health committees to participate in policy making, planning, implementation, evaluation and research. This will ensure that health services deliver quality care and that patient's rights are propagated and respected; and
- delegate a committee to work with civics to formulate and implement a charter on health and development that will be initiated within a period of two years. The charter will empower the community on how to deal with NGO's and the government;

POLICY PROPOSAL

Transforming the Civil Service Relevant to the Health Sector

The commission identified some serious problems with the structure, functioning, and management practices of the present civil service as it relates to the health sector. Many of the issues highlighted the cumbersome, bureaucratic and undemocratic practices of the civil service which impedes effective health service delivery in this country.

Causes

Structural:

- Gross fragmentation and duplication of the civil service with the numerous different authorities responsible for health delivery.
- Unrepresentativeness in civil service with regard to gender, race, ethnicity, geographic basis, and religion.
- Non-accountability and the lack of any requirement that the civil service serve the needs of social and distributive justice, and of development needs.

The current process of unilateral restructuring was seen as intended to perpetuate these imbalances as well as to limit the options of a future democratic government.

Managerial:

- Training of personnel was inappropriate to the demands of management of an accountable health system.
- The system is not transparent, not allowing scrutiny and use by the users.
- A management style that is uncaring, undemocratic, top-down, and impervious to external influences.
- A system that is bedeviled by growing and system-wide corruption.
- Chronic inefficiency

This has led to a cycle of demoralisation and uncertainty in the civil service.
These problems militate against the eradication of poverty, illiteracy, and the promotion of the PHC vision and approach, the construction of democracy and social stability in our country, and against the formation and carrying out of relevant policies.

We call on government to:

- immediately stop unilateral restructuring of the public sector health service.
- immediately freeze promotions in senior posts in all government structures, related parastatals and statutory professional boards and councils, until a new constitution is in place.
- where replacements are needed, prior to democratic government, to make these on short term contracts with guarantees for continuation.
- ensure the passage of legislation providing for a Freedom of Information Act, to

ensure that accessibility of public information is made a routine part of all functions and levels of government.
- ensure that the right of access by all individuals to all information relevant to them is included in a Bill of Rights.

We call on all political leaders to:

- ensure that the transformation of the civil service, including the health sector, to be given priority in the current debates on the transition in South Africa.

We call on the NEC's of SAHSSO and NPPHCN to:

set up a planned and coordinated affirmative action programme to develop a pool of people from within the democratic movement who share the vision of a national health service and of progressive primary health care, who could eventually occupy key posts within the public health service. Such key posts should be identified by their power to implement or to block policies.
The NEC's of SAHSSO and NPPHCN should investigate the feasibility of establishing a career structure in health service administration and training and other implications of this.

Action plan:

The government should:

- immediately stop all unilateral restructuring of health services and of the relevant civil service structures;
- immediately freeze all promotions in senior posts in all government structures, related parastatals and professional boards and councils; and
- where replacements are needed, make them only on short term contracts with no guarantee of continuation.

All political leaders are urged to:

- ensure that the transformation of the civil service, including the health sector, be given higher priority in the current debates on the transition in South Africa.

The Interim Government of National Unity should:

- prepare a Freedom of Information Act with full consultation of all relevant groups and parties.
- ensure that individual's right of access to all information relevant to them is included in the Bill of Rights.

The SAHSSO and NPPHCN NEC's should:

- initiate the affirmative action programme described above within six months.
- investigate the feasibility of establishing a proper career structure in health service administration and the training/retraining/capacity building and other implications of this within six months.

POLICY PROPOSAL

Role of NGOs

Historically, indigenous NGOs have been involved in the struggle against oppression and underdevelopment. Their continued existence is based on the history and culture of our struggle against apartheid, generally, and specifically our development towards self reliance.

The existence of many indigenous NGOs is as a result of:

- The struggle against repression and apartheid capitalist exploitation;
- Exacerbation of social and economic conditions;
- Vulnerability of deprived communities, and
- Needs and services that have been accommodated by formal structures.

Foreign aid to NGOs can be manipulative and many donors may have their own agendas which are not demand driven.

Proposals

- We believe that local communities should have the final say about international NGOs which function within them.
- We believe that NGOs are well placed to facilitate the links between tertiary education institutions and communities in which they may work. We call on both tertiary institutions and NGOs to strengthen their relationship with one another.
- We call on the government to enact legislation promoting the funding of NGOs engaged in the process of authentic people centred development which enhances the sustainability of communities without exercising control over the content of the programmes.
- We strongly recommend that NPPHCN and SAHSSO should collectively guide all proposed foreign funding to any of their projects.

POLICY PROPOSAL

Redistribution and new categories of health personnel

Various reviews of the health sector and the situation analyses have identified the related problems of inappropriately trained health personnel and their gross maldistribution in relation to health and health care needs.
The transformation of the health care system towards a unitary, comprehensive and democratised service, based on PHC principles will require substantial training and reorientation of existing personnel as well as development of new categories of health personnel.

The current problems and deficiencies include:

- concentration of health personnel in urban, middle class, white areas and corresponding underprovision in the rural areas, peri-urban, informal and black areas;
- concentration of health personnel in sophisticated, curative settings and in the private sector, with corresponding understaffing of public health sector facilities, particularly at lower levels of care;
- serious underprovision, especially in areas of greatest need of personnel able to provide basic comprehensive care at primary level as well as professionals to support such work at (especially) secondary and tertiary levels; and
- serious underprovision, or complete lack of personnel with training and skills to implement specific programmes or components of a reformed system based on PHC, for example, environmental health, health promotion, advocacy, management.

The above problems will require energetic and extensive reorientation/retraining of existing personnel as well as the urgent development of new categories. To effect redistribution of present and future personnel, both initiatives as well as new regulations will need to be introduced.

This conference therefore calls on government, and where applicable, training institutions to:

- review selection procedures to involve communities and to include as criteria candidates' social commitment with affirmative action in respect of previously excluded groups;
- develop new, often short, training programmes for existing personnel to reorient their practice towards comprehensive PHC - such programmes should be significantly problem-oriented and based at lower levels of health care system, including at community level;
- train new categories of health personnel in the following areas:
  - environmental health workers to tackle the urgent need for small water supplies and household sanitation in poor communities,
  - health promotion and advocacy - to equip communities with the skills, confidence

and self organisation to campaign for healthy public policies and appropriate services,

- management - to develop skills, especially at district level to manage the health system. This should include planning, financing, administrative and evaluation skills,
- primary clinical care - to develop skills amongst already existing personnel, for example, nurses and new categories, for example, medical assistants to provide high quality clinical care at the primary level,
- occupational health - to provide comprehensive services in workplaces - this work might be done by reorientation of already existing personnel, for example occupational health nurses, industrial hygienists, or training of a new category of occupational health officers, and
- technical support to maintain and repair equipment, including orthopaedic, rehabilitative and other health facility equipment.

This conference also calls on the government to implement measures to facilitate redistribution of health personnel to underserved areas. These measures should also include:

- Incentives such as:
  - improved conditions of service, higher pay for work in underserved areas;
  - improved amenities and infrastructure (housing, schools, childcare facilities, etc);
  - improved technical support and continuing education from higher levels of the health sector, and
  - recognition, in terms of career advancement, for service in underserved areas
- Regulations/Actions such as:
  - a moratorium on the building of new training facilities in already well served areas;
  - pressure on training institutions to render their courses more problem oriented and community based;
  - compulsory rotation through underserved areas and lower level facilities as part of preregistration and post-graduate training - this might be for several periods of six months over the post graduate training period, and
  - quotas on the number of independent primary care providers per unit population in each district.

POLICY PROPOSAL

Support and Reorientation of Health Personnel

The situation analyses uncovered a great deal of dissatisfaction about the relationship between health workers and the public. There were complaints that health workers do not treat people with respect and, at times, act in an unprofessional manner. The health workers were also unhappy and many were too demoralised to envisage a better style of work.

Causes

- Health workers feel inadequately prepared for PHC work as a result of serious weaknesses in training curricula and poor treatment of trainees.
- Racism and gender discrimination have led to alienation of health workers, and progressive health workers have been marginalised.
- Health workers are overworked because of staff shortages which have become worse due to early retirement and the drain on the private sector.
- Expectations of improvement have been disappointed by managements which are increasingly autocratic and resistant to change.
- The kind of professionalism which the statutory professional bodies instill does not encourage respect for clients.
- Promotion procedures are unfair, poorly understood, encourage nepotism, and do not encourage or reward responsiveness to clients.

We call on government to:

- stop the drain of health workers from the public health service by:
  - ending unilateral restructuring, and
  - improving conditions of service;
- improve human resource management and planning systems and to ensure an adequate supply of appropriately trained health workers;
- permit greater career mobility, with fair and open promotion criteria;
- develop a charter of rights for clients, and a code of conduct for health workers, in consultation with communities and health worker organisations;
- establish democratic and representative statutory professional bodies that accept the primary health care philosophy;
- establish mechanisms to facilitate dialogue between communities and health workers;
- adopt procedures for selection and recruitment of health workers which include consultation with communities;
- ensure the safety of health workers in the workplace, and address the root causes of violence;
- change health worker training so as to inculcate a philosophy of public service, and good understanding of the primary health care approach; and
- end exploitation of health worker trainees by recognising their rights and ensuring that menial labour does not substitute for training.

POLICY PROPOSAL

Labour Relations in the Public Health Sector

Problem

Poor labour relations damage and disrupt health care and undermine the morale of health workers. This affects their quality of care and their relationships with their patients. They feel alienated and insecure.

Causes of the Problem

Causes of the problem lie in the following areas:

1. Legislative
2. Management
3. Lack of freedom of association
4. Government promoted workers associations
5. Unequal access to benefits by all health workers

1. Legislative

- The exclusion of civil servants from the Labour Relations Amendment Act of 1991 is the root cause of poor labour relations between the state as an employer and health workers. The Public Service Act (Act III, 1984), which applies to public sector health workers sets standards and ethical codes which undermines fundamental rights of workers such as collective bargaining rights. The Act also perpetuates racial discrimination. Through its implementation of the Act, the government nurtures sweetheart worker associations like MASA, SANA, HOSPERSA, etc.

  The shortcomings of the Act include the absence of:

  - collective bargaining mechanisms
  - proper and acceptable grievance and dispute resolution mechanisms
  - freedom of association and/or freedom not to associate
  - it provides poor salary scales and entrenches inadequate managerial and administrative personnel, maladministration and nepotism.

2. Management

- Managers in the health sector are drawn from a narrow political base within South African society and do not function in accordance with principles of public service but according to political dictates. They are poorly trained for their work and do not recognise employees as partners in management.

3. (Lack of) Freedom of Association

- Through the Nursing Act, No. 50 of 1978, nurses are forced to join the South African Nurses Association (SANA) and are not allowed to form their own representative bodies.

We call upon the government to:

- extend the Labour Relations Act to all public servants;
- legislate for compulsory dispute resolution mechanisms such as arbitration and mediation through negotiation and consultation;
- legislate a duty to bargain between the state as an employer and democratically elected worker representatives over salaries, conditions of service and other relevant issues;
- guarantee freedom of association;
- retrain the managers at all levels on modern industrial relations with particular emphasis on dispute resolution techniques in order to minimise the likelihood of strike action, alternatively replace them with people who have the necessary skills;
- establish health and safety policies and occupational health service programmes to health sector employees;
- guarantee the right to strike to all health workers; and
- equalise access to benefits for all health workers.

POLICY PROPOSAL

Community Health Workers

Over the last fifteen years a number of projects in rural areas and so-called informal settlements have been developing a more appropriate community based health worker. Community Health Workers (CHWs) are non-professional, elected by the community, live in the neighbourhood that they serve and respond to the health needs of their community. Up to this point there has been an uncoordinated approach and different levels of training.

CHWs are necessary because:

- poor socioeconomic conditions cause ill health - most health professionals have not addressed these. CHWs are part of the community and experience the same problems and are thus well equipped to promote community organisation to confront the basic causes of ill-health;
- health services available to the rural areas and informal settlements are totally inadequate; and
- CHWs take skills and health knowledge previously held only by doctors and nurses and place them in the hands of the people. Home visiting makes them available and accessible to the community at all times.

This conference made the following proposals:

- CHWs should have a place in a future comprehensive primary health care system;
- CHW projects should be extended to a larger number of communities, with priority given to rural areas and informal settlements. This should preferably be done through non-government structures and not by government;
- CHWs should be accountable to representative local community structures;
- CHWs should be paid;
- There needs to be adequate support and supervision;
- There should be a core curriculum for CHWs with ongoing training appropriate to the needs of their community; and
- CHWs should have career mobility.

We commit ourselves to:

- work with local communities in the extension of CHW projects; and
- assist in training, coordination and support for CHW projects.

We call on government to:

- subsidise CHW projects through representative community based or non-government organisations who will control the funds and be accountable to the community;
- recognise CHWs and develop a supportive referral system;
- reorient health professionals to recognise, support and work with CHWs; and
- recognise the considerable experience of the non-government organisations and communities in this field, and that they should be centrally involved in any future initiatives regarding CHWs.

POLICY PROPOSAL

Traditional Healers and how the Formal Health Sector should relate to them

The situational analyses identified that the traditional healers are offering necessary healing services in their communities. The problem is that there are no stipulated guidelines or body controlling their practice leading to the non-recognition of their services by the formal health services.

Problems

- There is a lack of cooperation between traditional healers and formal health workers. In particular;
  - there is no referral system between traditional healers and formal health services; and
  - many formal sector health workers have negative attitudes towards traditional healers and their services.
- Traditional healers are not involved in preventive health methods in spite of the fact that they are community based, for example, AIDS/TB and STD education.
- Sick certificates from traditional healers are not recognised by employers.

The policy proposals generated by the conference to deal with the above are:

- Traditional healers should be encouraged to form a controlling body that will regulate their practice;
- Legislation should be amended in order to recognise traditional healers and to allow referral to them;
- Training of nurses, doctors, psychologists and social workers should include education about the role of traditional healers;
- Training in preventive health should be made available to traditional healers;
- Where appropriate, the resources of both traditional and formal health sectors should be used in the treatment of patients;
- Formulation of combined research particularly with respect to traditional medicinal remedies;
- Once there is a controlling body for traditional healers, sick certificates from such healers should be recognised by employers; and
- Payment of traditional healers should continue as it has in the past, that is, patients should pay their healers directly.

The NEC of SAHSSO/NPPHCN should consider convening a conference with all the traditional healers.

POLICY PROPOSAL

Rehabilitation

The World Health Organisation says that 1 out of 10 people in any community are disabled. In South Africa informal studies in poor communities in rural and peri-urban areas suggest a rate closer to 4 out of 10 people being disabled. The large number of disabilities is caused mainly by poverty and inadequate provision of health services, especially preventive ones.

The situation analyses identified a lack of rehabilitation services and awareness on disability issues generally, especially, in rural areas. Rehabilitation is given a very low priority. At present, all state rehabilitative services are hospital based with almost no community based provision. There is a regulation which states that hospital therapists are not allowed to do home visits, and at the same time, making no community posts available.

Disability impacts strongly on women as they are often the care-givers for children with disabilities and adults and are often unable to have paid employment because of this. This document reflects policy suggestions which require further consultation with people with disabilities and the disability rights movement.

We call on government to implement the following:

a) To be implemented immediately:

- All future planning and implementation of services for people with disabilities should be done in consultation with people with disabilities and their organisations;
- Research is urgently needed to determine how many people with diabilities there are, the nature of their disability, as well as the attitudes towards disability in various communities;
- Community posts for rehabilitation therapists to be created immediately at community health centres;
- Community Based Rehabilitation Workers should immediately be recognised as an integral part of the primary health care team and be covered by the policy for CHWs;
- An immediate stop to freezing of posts for rehabilitation personnel;
- All rehabilitation personnel should be trained in the principles of primary health care and with a strong emphasis in their training on community based rehabilitation;
- Create a service for the upkeep of equipment, for example, wheelchairs, hearing aids, crutches, etc., to be available at the local and district levels;
- To provide or subsidise transport for people with disabilities to health services, either through the health services or in consultation with taxi organisations;
- Immediately establish parity in grants regardless of race or sex. Furthermore within the next year, a review should be made of who is eligible for a grant and the amounts paid, to ensure that those in need are assisted. The review process for continued payment of grants should be critically assessed; and
- Any new public buildings should be made accessible to all people with disabilities no matter what their disability;

- Legislation should be passed concerning employment of aspecific quota of people with disabilities at all places of employment.

Initiate urgently and complete within the next five years:

- Create efficient and accessible facilities for children with disabilities and adults starting where the need is greatest, for example, rural and peri-urban areas.
- Create facilities in the community for psychiatric clients and people with speech and hearing problems.

POLICY PROPOSAL

Occupational Health

The situation analysis identified the low priority given to occupational health and the inadequate structure and delivery of occupational health services in South Africa. This is due to the following problems:

- inadequate and fragmented legislation on occupational health and safety;
- fragmentation of functions between different departments involved in occupational and environmental health;
- lack of organisation and co-ordination of occupational health services, and lack of coordination between occupational and primary health care services;
- lack of union and worker participation in the development of policy, occupational health services and implementation thereof;
- the inadequately trained health workers in occupational health and hygiene; and
- the racist legislation with regard to compensation of occupational diseases.

We call on government to:

- introduce progressive legislation for the establishment of occupational health services accessible to all workers, and to integrate all legislation pertaining to occupational health and safety, in consultation with unions and workers;
- to integrate occupational health as an important component of comprehensive primary health care with an emphasis on prevention, promotion and rehabilitation;
- to ensure democratic participation by unions and workers in the formulation and implementation of occupational health policy;
- to improve and increase the training of occupational health workers includig industrial hygienists, occupational health nurses and worker representatives; and
- to revise legislation on compensation for occupational diseases and especially to remove racially discriminatory components immediately.

POLICY PROPOSAL

Mental Health

Several investigations in recent years have found that up to 4 people out of 10 are suffering from some form of mental ill-health. The situation analyses revealed concern amongst members of communities around the country about problems of mental health - drugs/alcohol abuse, violence in communities and within families, gangsterism, and widespread signs of depression, stress, and chronic anxiety. There was also worrying information that health care personnel, too, are feeling overloaded, and demoralised.

Amongst the causes of this alarming amount of mental health problems are:

- unemployment and poverty - with constant worries about feeding children, finding or paying for shelter, affording education and health care, the endless boredom, sense of worthlessness and of being an expendable failure;
- family and marital breakdown - partly due to economic maldevelopment resulting in migratory labour, and partly due to the effects of alcohol/drug abuse, lawlessness and family violence. Many families have for these reasons lost their capacity to plan and work together for a better future;
- apartheid legacy - resulting in a build up of frustration and anger. This mental ill-health is also in part the effect of oppression, imprisonment, exile, organised violence and the fostering of conflict within communities; and
- among health workers - reasons given by survey respondents were dissatisfaction about pay and conditions, unexplained promotions, not being kept informed or consulted, and feeling unappreciated.

We therefore call on the government to recognise that:

- everybody has the right to mental health;
- its policies have seriously harmed many people;
- mental health care must be an integral part of primary health care; and
- it must accept responsibility to fund and support community-based mental health care projects and facilities.

Within six months

- to mount an offensive campaign about the elements of mental health, which makes clear that drugs/alcohol and violence are signs of stress and unhappiness; and
- to effectively address the grievances of health workers.

Within one year

- to have completed basic training and reorientation of health workers so that they will assist people in their desire to restore themselves to mental health. This should become the highest priority task in regard to mental health; and
- adopt a policy of multidisciplinary teamwork that would include traditional healers and workers from churches.

Within three years

- To move psychiatric care to facilities within communities such as local hospitals.

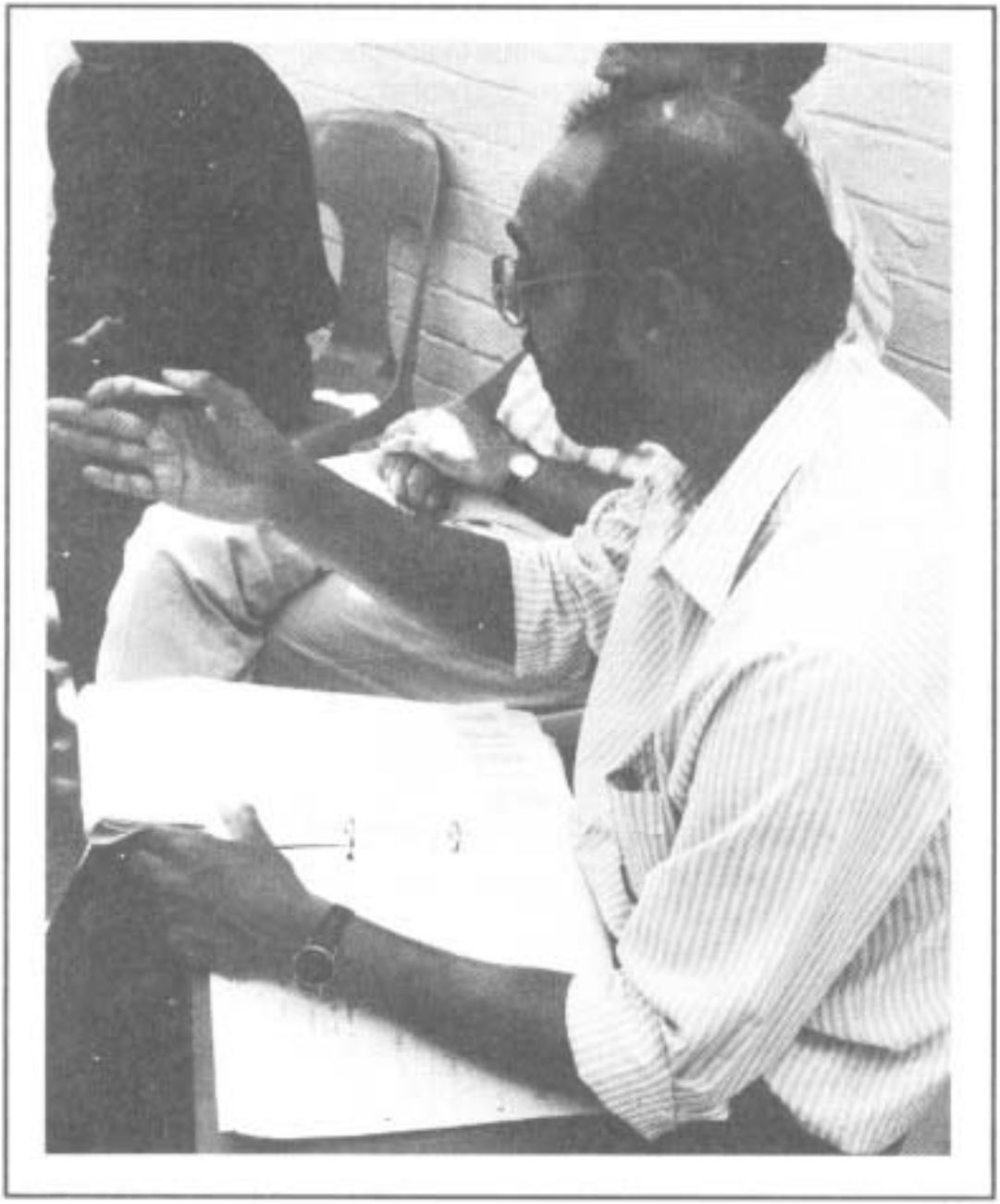
We call on health workers

Now

- to incorporate mental health promotion into their everyday work within communities and to be sensitive to people's needs and feelings.

Within one year

- to become familiar with the elements of mental health and to focus their approach on the promotion of mental health. We particularly recommend linking with or developing income generating projects in their areas as places where effective mental health intervention can take place.



POLICY PROPOSAL

Women's Health

Over the years, the health status of women, particularly black women in South Africa, has been neglected by government. This is evidenced by indicators such as the high maternal mortality rate in black women and the high incidence of cervical cancer and sexually transmitted diseases.

Women's health should be understood within a socio-economic context and not within the narrow context of women's reproductive health. The health status of women in South Africa has equally been compromised by deteriorating economic, political and social conditions. In particular, educational discrimination and migrant labour have contributed to the worsening of women's health status.

Among the Obstacles to Better Women's Health are:

- inadequate legal protection;
- gender inequality in the provision of health services;
- violence against women;
- lack of participation by women in decision-making processes;
- lack of access to appropriate information; and
- inadequate and unreliable data on women's health

We call on government to address the following issues:

- Development
  Initiate programmes which address women's needs in:
  - capacity and confidence building;
  - literacy;
  - job creation;
  - provision of adequate clean water and fuel;
  - food security; and
  - safe environment.
- Legislation
  - enshrine women's equality in the Constitution and Bill of Rights;
  - legalise abortion on demand;
  - provide legal protection for women victims of violence;
  - enact a law protecting women aginst rape in marriage;
  - provide access to child care in the workplace;
  - provide maternity benefits with job security; and
  - provide protection against occupational health hazards.
- Provision of Health Services
  - develop comprehensive women's health care services as part of the national health system;
  - give priority to screening programmes for diseases which affect women (for example, carcinoma of the cervix);
  - train and re-socialize health workers to correct their negative attitudes to women;

- end discrimination against women in access to prison health services; and
- institute affirmative action programmes for women in health training institutions

- Violence
  - fund and create women's shelters and crisis centres.
- Decision-making processes
  - increase the involvement of women at decision-making levels.
- Access to Appropriate information
  - make information easily available in all languages;
  - make radio and television available for appropriate women's health programmes; and
  - incorporate health and sex education into the school curriculum.
- Data on Women's Hea;th
  - carry out a comprehensive national situation analysis on women's health status;
  - commission participatory research that articulates women's needs; and
  - desegregate data collection and analysis by sex.

POLICY PROPOSAL

Nutrition

The situation analyses identified malnutrition as a serious threat to the health of the population, especially children. This has been aggravated by the drought. The commission recognised undernutrition as being caused by the economic inequalities reinforced by the apartheid system. This has resulted in a major part of the population being trapped in landlessness, poverty and unemployment. Inadequate sanitation, water supplies, housing and health servicers, as well as unfair labour practices have all contributed to the present nutritional crisis.
We call on the government to address these fundamental underlying causes of malnutrition.

We further call on government to:

- establish a nutrition monitoring system within the public health sector;
- identify representative sites for collecting information within an area which would reflect the nutrition status of that area;
- initiate the use of master growth cards (scattergrammes for weight for age) as an easy rapid surveillance technique to be implemented as soon as possible;
- make nutrition rehabilitation part of a comprehensive health care system;
- promote and support breastfeeding as an urgent national priority, this would include the monitoring of milk formula promotion;
- ensure that every child, under six years of age has access to nutrition support through the public health sector, and initiate school feeding programmes. Pregnant and breastfeeding women would also qualify would also qualify for support;
- reinstate food subsidies and remove VAT on specified basic foods;
- protect consumers by legislating for detailed content information to be provided on all processed food;
- make food relief and food stamps available for those who qualify (aged, destitute, disabled) with a built in developmental component; and
- establish a nutrition department within National Health which should function intersectorally and be linked to district nutrition development committees (community structures and health workers).

We recommend our organisations:

- take immediate action to advocate and mobilise for the abovementioned nutrition policies.
- make nutrition a priority issue within our organisations and advocate for resources.
- embark on a programme of breastfeeding promotion and support, including training of health personnel.
- work for the introduction of the mastercard for nutrition surveillance with immediate effect.
- investigate milk prices - why milk is unaffordable to most of the population.

- start an independent review and local monitoring of how food aid is being managed and utilised.
- ensure that nutritional status is included in any national survey into poverty.

POLICY PROPOSAL

Sexual Health and HIV/AIDS

The situation analysis exposed growing community concern about sexually transmitted diseases (STDs) and HIV/AIDS at a community level. The widespread occurrence of STDs, the stigma associated with having an STD and the unavailability of services resulting in delays in treatment also contribute to the spread of HIV infection.

With close to 400 people a day being infected with HIV virus in South Africa and a doubling time of 8.5 months, AIDS will emerge as our country's biggest health problem. The HIV/AIDS pandemic is still largely unseen at a community level - as is any concerted government effort to combat this disease.

The spread of STDs is aggravated by:

- social and economic circumstances which promote their spread - migrancy, homelessness, poverty, poor education and unemployment;
- a rigid educational system which, due to a misdirected moralism, has refused to develop an appropriate sexuality and life-skills programme;
- a racist family planning programme that has politicised all methods of contraception, including condoms; and
- a totally inadequate primary health care health service with a "hit and miss" approach to the treatment of STDs.

Specifically with regard to HIV/AIDS, the following problems were identified:

- an uncaring government which ignored the emerging pandemic because it was spreading in the marginalised communities of blacks, women and gays;
- no home based care support for persons with HIV/AIDS and their families;
- a lack of anti discrimination legislation to protect people with AIDS/HIV regarding employment, insurance, access to medication and housing; and
- gross diregard for patient rights with respect to testing and breach of confidentiality of HIV status.

This has resulted in non-government organisations (NGOs) and community based organisation (CBOs) having to develop effective intervention strategies without government support.

This conference makes the following proposals:
We call on health workers to:

- integrate the prevention and treatment of AIDS into comprehensive PHC services and not to deal with AIDS in isolation;
- practise universal infection control measures without special procedures for persons with HIV; and
- stop the indiscriminate testing of patients without informed consent and without any pre or post test counselling.

We call on government to:

- endorse the AIDS charter;
- introduce anti-discriminatory legislation to protect people with HIV/AIDS during the next session of parliament;
- introduce sexuality education into all teacher training colleges and also for existing teachers by the end of 1993;
- in consultation with parents, CBOs and NGOs, to introduce a life skills programme for all school children over 8 years of age which includes an appropriate sexuality programme;
- introduce comprehensive education on STDs , HIV/AIDS, sexuality and counselling to all categories of health workers in training;
- develop an effective mass media campaign together with non-government and community based organisations;
- immediately remove the 15% import surcharge on condoms;
- make high quality condoms available and accessible through credible organisations free of charge;
- integrate treatment programmes for sexually transmitted diseases into comprehensive PHC services in order to remove the stigma of attending such services, and to improve the counselling skills of all who work in such services. Such services should be free and confidential; and
- improve the PHC services so as to effectively support and care for people with HIV/AIDS.

The AIDS charter, launched on December 1 1992, was formulated by over 40 organisations working in the field of HIV/AIDS. It documents the rights and responsibilities of people with HIV and AIDS.

POLICY PROPOSAL

Statement on Essential Health Research

- This policy conference recognises essential health research as an important and underutilised tool in the improvement of the nation's health.
- The conference supports the need for an Essential National Health Research Policy and Programme in South Africa. Such a Programme should have the status of national policy, should be oriented to the country's priority health problems, and must be premised on the pursuit of equity and social justice.
- To achieve this, a process is necessary that effectively brings together representatives of health services at all levels, education and research institutions, and health and development NGOs, together with community leadership. Carefully determining the lead partners, and ensuring an appropriate balance of all sectors of our society, is a critical part of this.
- Key considerations:
    - by research is meant a systematic process to generate new knowledge. This capacity needs to be strengthened among all partners active in health in South Africa.
    - an ENHR programme in South Africa should pay special attention to strengthening the community's ability to effectively engage in the proc ess.
    - a South African ENHR programme should make a major investment in strengthening individual and institutional capacity in underdeveloped disciplines that include the measurement sciences, policy and manage ment sciences, and social and behavioural sciences.
    - a national essential health research programme should ensure a major investment at local and district level, as well as, the regional and national level.
- As the SAHSSO/NPPHCN Policy Conference, we will support and encourage the contribution of our human and organisational resources to the realisation of this goal.

Drugs

Motion

Noting that a national drug policy and the role of the pharmaceutical services are issues that need to be addressed urgently in order to ensure the availability and accessibility to all South Africans of affordable essential drugs of quality and their rational use.

That developments are silently taking place within the pharmaceutical sector that might lead to unilateral restructuring with grave implications for the principles of comprehensive primary health care.

That the failure of the conference to address these issues was apparently based on the questionable principle that lack of interest among participants and lack of expertise or sufficient knowledge of the issues by the organisers indicates lack of importance of the subject.

The successful addressing of many aspects of the National Health Service dealt with by the confernce cannot be complete as they are intimately linked to the existence of a national drug policy and appropriate restructuring od pharmaceutical services.

I move that this conference commission the convening of a national workshop to discuss a national drug policy and pharmaceutical services, and that such a workshop be convened not later than the first half of 1993.

Moved by Bada Pharasi
Seconded by Chimen Lalla

Critical Health

Critical Health is a quarterly journal dealing with health and politics in South Africa. It has been published for the last 14 years and has been contributing to debates on progressive aspects of health and health care. *Critical Health* reflects the concerns and issues currently facing those seeking alternatives in South Africa.

Critical Health aims to:

- provide ideas for roles that health workers can play in promoting a healthy society;
- show that good health is a basic right;
- provide a forum for debate for the discussion of health related issues;
- provide insight into the political nature of health.

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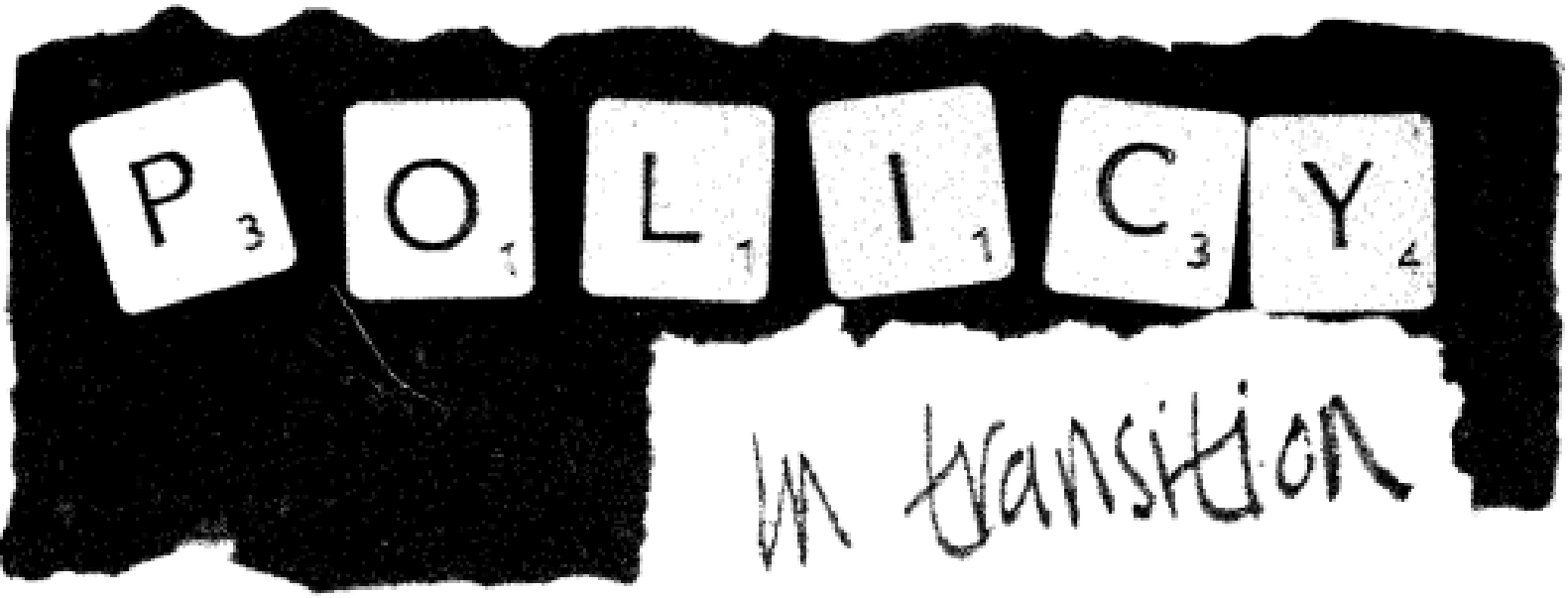

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