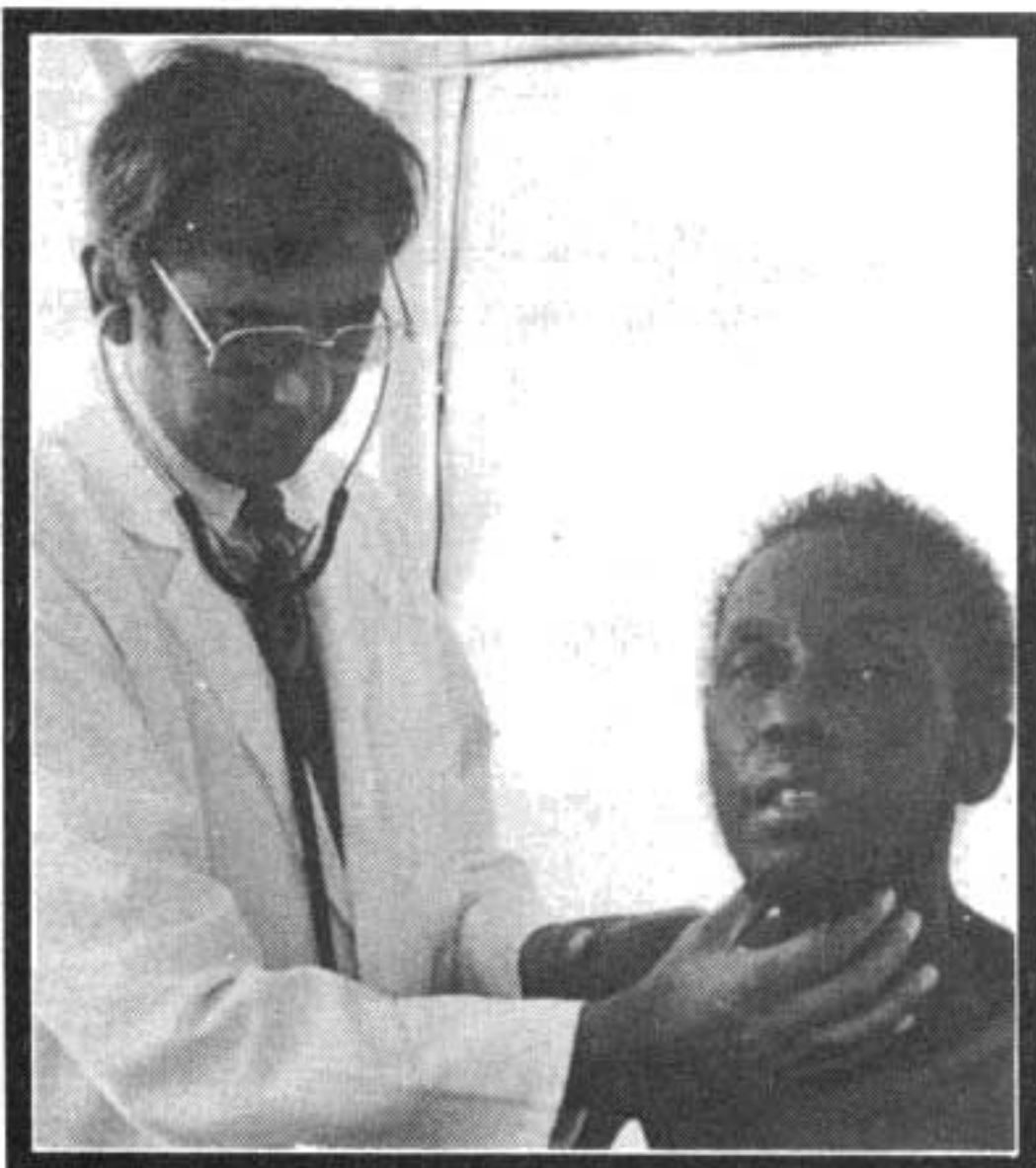
Critical Health

Number 27 August 1989



Health workers organise!

Critical Health

Number 27 August 1989

Contents

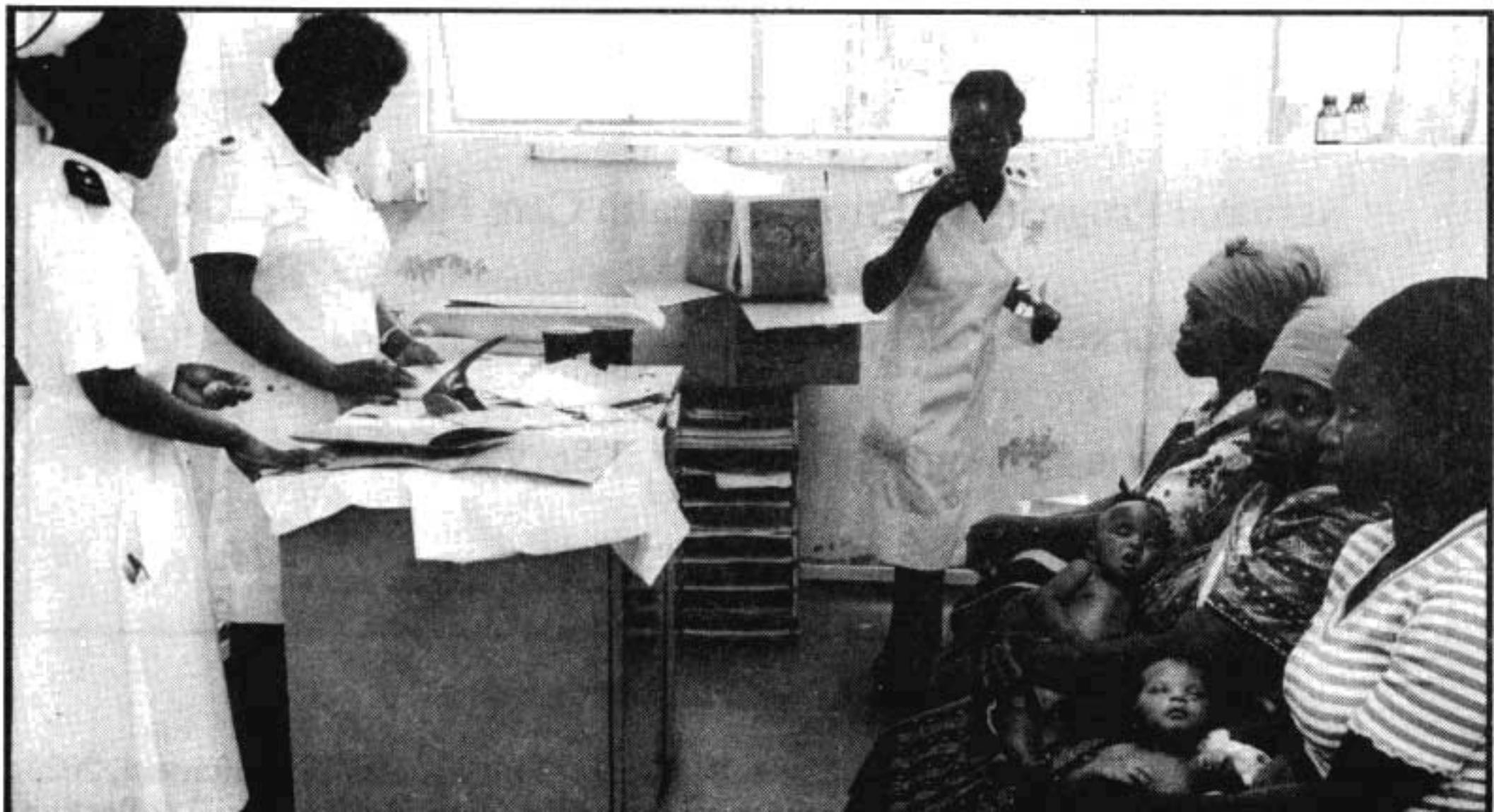
Thanks to Afrapix for photographs

Critical Health is published by an editorial collective, P O Box 16250, Doornfontein, 2028.

Editorial

There are a number of different groups organising within the health sector in South Africa - all of them united in their common abhorrence of apartheid and the effects that this system has on people's health. In March this year, the Health Workers Association (HWA) and the Health Workers Organisation (HWO) merged to form the South African Health Workers Congress (SAHWCO). This event prompted *Critical Health* to invite the different health worker organisations to reflect critically on their developments through a description of their origins and goals, a definition of the sectors within which they organise and an examination of their achievements and struggles. It was also an invitation for the different organisations to express their visions for the future. *Critical Health* hopes that the insight provided by these organisations in this edition will enlighten and encourage many of our readers, particularly those who do not yet belong to any of the organisations.

The different contributions provided clearly demonstrate that organisation within the health sector is complicated by the many different kinds of health workers from specialist doctors to unskilled domestic hospital workers. All represent different social and class interests and often express grievances that are conflicting and viewed with different priority.



A further complication and challenge has been the varying focus and priority that organisations have given to political issues affecting health workers, the economic and work problems experienced by health workers at the workplace and the health of the community at large. The position of the majority of health workers as state employees and as providers of an essential service has severely compromised the ability of health workers to show solidarity with the broader political struggles.

As individuals, health workers expressing their grievances have been faced with victimisation and intimidation by employers and "superiors". The strict hierarchies dominating the health sector make individual health workers vulnerable.

Organisation within the health sector is imperative. As part of an organisation, health workers have more strength to demand better working conditions as well as broader socio-political change.

It is apparent that a number of organisations exist, many of them overlapping in intent and function. The need for unity is clear and the way forward is being currently debated amongst the organisations themselves.

List of abbreviations

CSW - Concerned Social Workers

HWA - Health Workers Association

HWO - Health Workers Organisation

HWS - Health Workers Society

HWU - Health Workers' Union

NAMDA - National Medical and Dental Association

NEHAWU - National Education Health and Allied Workers Union

OASSSA - Organisation for Appropriate Social Services in South Africa

PPHCN - Progressive Primary Health Care Network

SAHWCO - South African Health Workers Congress

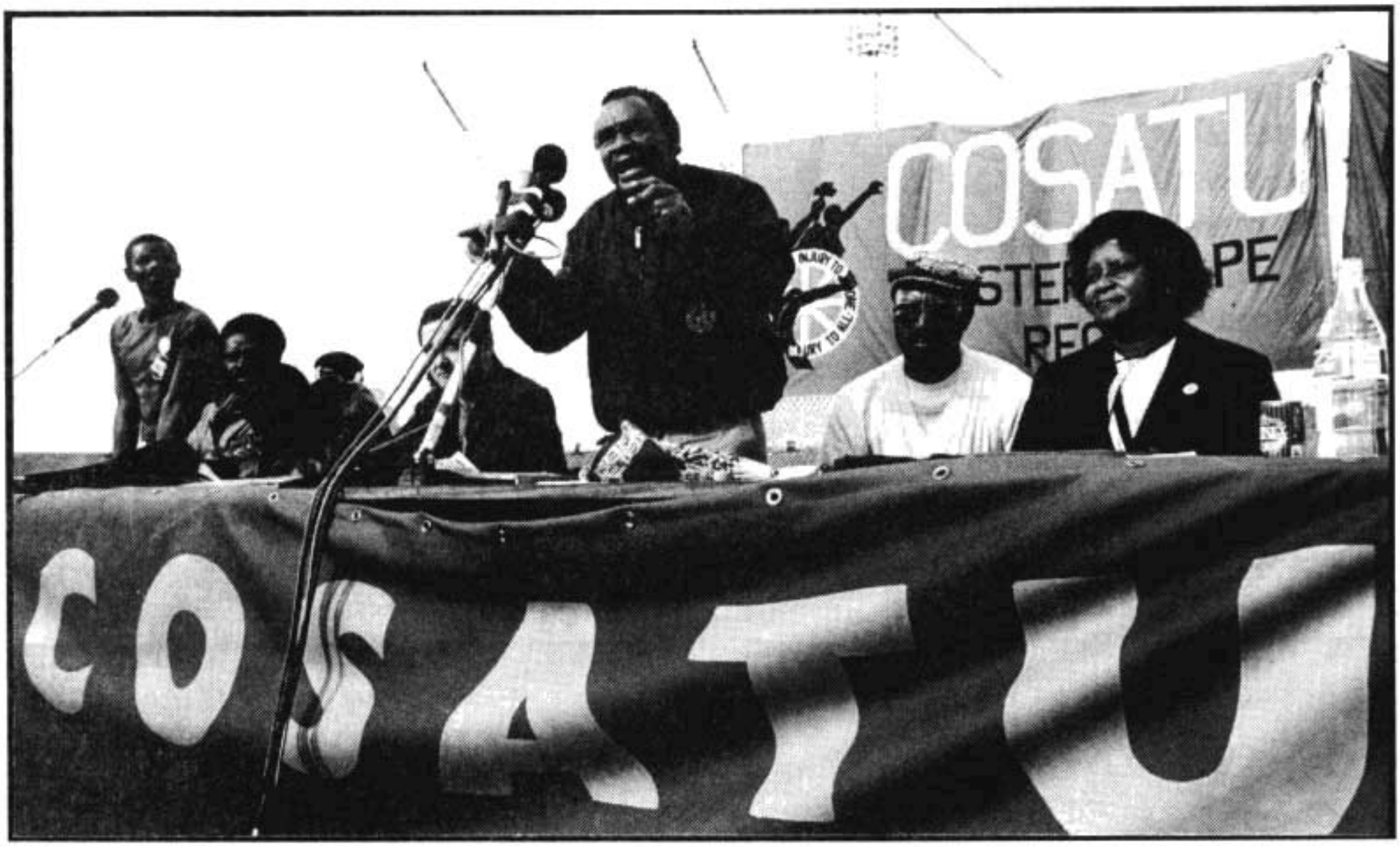
National Education Health and Allied Workers Union

NEHAWU was launched on 26 June 1987, the result of a merger between the South African Allied Workers Union (SAAWU), General Allied Workers Union (GAWU) and the Health and Allied Workers Union (HAWU). NEHAWU is affiliated to the Congress of South African Trade Unions (COSATU) and the merger was based on COSATU's principle of one industry, one union. The reason for organising the health and education sectors together is an historical one. In the process of dissolving the general unions, SAAWU and GAWU channelled members into unions already organising in the appropriate areas. Given that no unions in COSATU catered for the health and education sectors, these workers were subsequently unionised into NEHAWU.

Union structures and democratic representation

At present, NEHAWU has branches in the Cape (Cape Town, Port Elizabeth, East London, Grahamstown and King Williams Town), in Bloemfontein, Kimberley, Natal (Durban and Empangeni) and in the Transvaal (Johannesburg, Pretoria, Witbank and Nelspruit).

The members elect shop stewards from the various areas in the workplace. These shop stewards then come together to form a Shop Stewards' Local. The Local elects a



NEHAWU is affiliated to the Congress of South African Trade Unions (COSATU).

Branch Executive. All Branch Executives, except the branch secretary, are workers. This ensures that workers are in the majority in every structure. It promotes worker participation and leadership. Accountability is stressed at all times to prevent the union being steered by individuals in directions that are counter to workers' interests. Union officals must consult membership continually through the established structures.

The National Executive Committee (NEC) is elected by the union's annual national congress. Branches send one delegate per 250 members to the congress. Representation is therefore proportional to the size of the branch. The National Executive Committee consists of the president, vice-president, general secretary, treasurer, national organiser, and four additional members who take on specific tasks.

The Central Executive Committee (CEC) consists of all NEC members plus two members from each branch. The NEC can discuss policy but only the CEC, with representation from each branch, has the power to make changes in policy between the periods of National Congress.

Union membership

NEHAWU organises workers in both the public and the private health and education sector. Members are drawn from hospitals, clinics, old age homes, university workers,

colleges, schools, creches and technikons. Members also include workers in medical aid companies. At the time of the union's launch there were approximately 9 500 paid up members. This has roughly doubled. Unions organising within the public sector do not have access to stop-order facilities. This makes it difficult to collect the membership fee of R2 a month. Workers earning meagre salaries of R250 per month on average, often cannot afford to pay every month. Paid up membership is therefore difficult to assess and varies from month to month.

Members are predominantly from the public sector. The majority (about 70%) of members are drawn from the health rather than the educational sector and of this 70%, about 95% are non-classified workers. The remainder consists of workers such as nurses, clerks and radiographers. In the private sector the majority of members are also non-classified but there is a larger proportion of the other groups.

Domestic workers strike at King Edward Hospital - non-classified workers are poorly paid and vulnerable to victimisation. NEHAWU helps them to fight for better working conditions.

Problems faced by workers

Union recognition and permanent status for non-classified workers (NCWs)

NEHAWU's priority is to negotiate permanent status for NCWs as well as for recognition of unions organising in the public sector.

Non-classified workers are cleaners, cooks, security guards, laundry staff and porters. They are temporary staff, regardless of the length of time worked. In the public sector, NCWs are covered by the Public Service Act. Their job description is not clearly defined. After working for 20 years in one area they may be transferred at whim to another job or hospital at short notice with no reasons given. Many workers are victimised by their superiors in this way. They have no job security and are subject to 24 hours notice, no minimum wage and no significant benefits.

NEHAWU joined COSATU in demanding a living wage for its members.

A pension scheme exists for many NCWs; this has been an advantage in court applications where the law recognises that the worker contributing to such a scheme has much to lose by dismissal and therefore should have a right to a fair hearing. Workers still face problems of small payouts and often wait months before receiving money owed. Annual salary increases are at the discretion of their immediate superiors.

A recent strategy has been to divide workers by giving certain workers, such as porters, permanent status without salary increases. The only visible effect of their change in status has been permission to eat at a dining hall where better food is served. For this, R34 a month is deducted from their salaries as opposed to R4 a month taken from the NCWs.

The struggle for permanent status for workers includes demands for a living wage, a total revision of job description and conditions of employment and the extension of benefits such as maternity/paternity leave to all workers.

Racism in Carltonville - NEHAWU members face racial and class discrimination. The union recognises the need to link up with other organisations in order to broaden unity against apartheid.

Campaign for a living wage

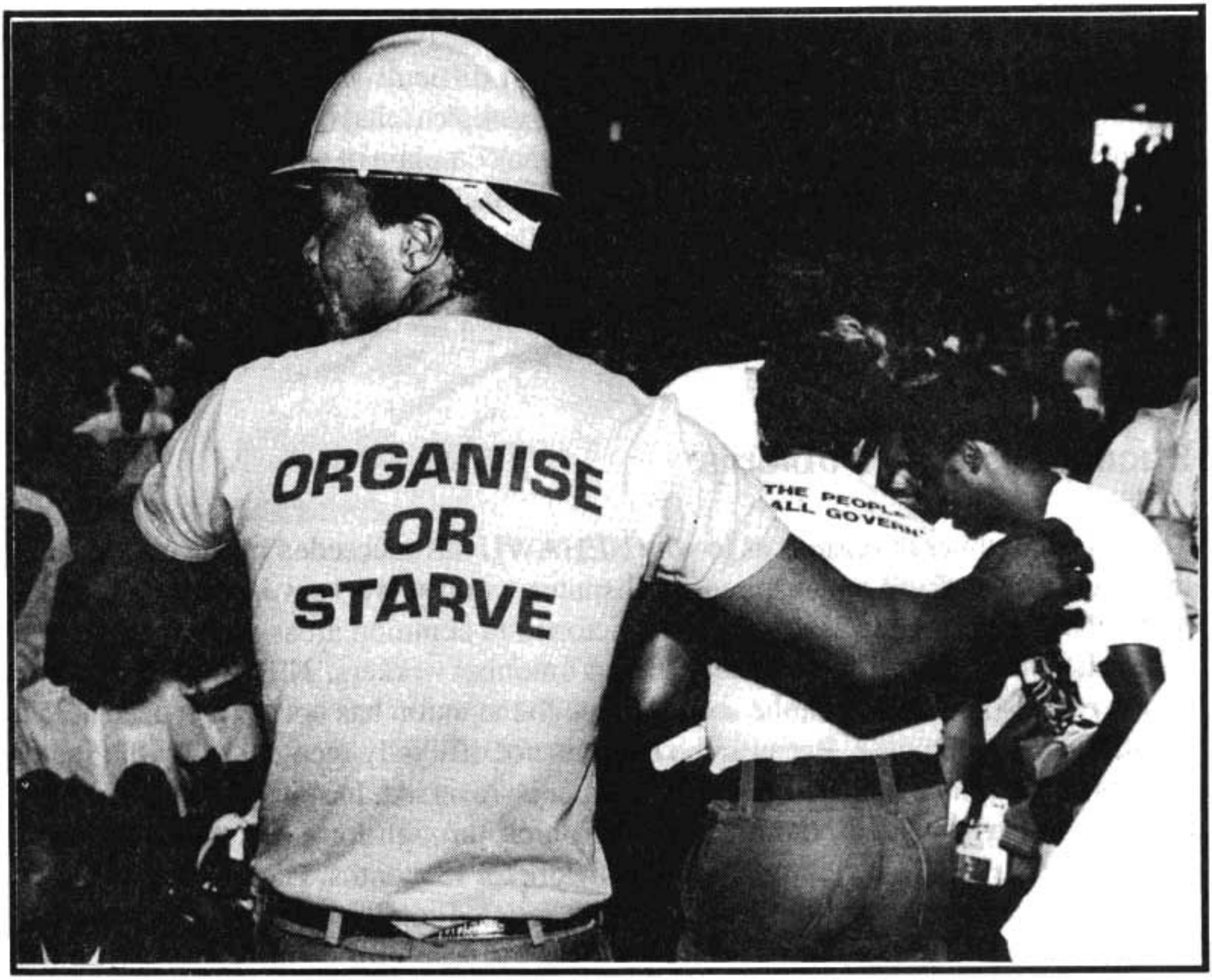
The first major campaign undertaken by NEHAWU was to challenge the government's wage freeze in the public sector. This campaign was linked to COSATU's campaign for a living wage.

Victimisation and unfair dismissals

NEHAWU has been campaigning against victimisation and an end to unfair dismissals in health and educational institutions. Workers must be given fair hearings and the right to be represented by people of their own choice, such as shop stewards or union officials.

Organising in the public vs the private sector

Negotiations in the private sector are often easier than in the public sector. The private sector has structures that are more defined. Also, because one company may own a number of hospitals and clinics, precedents can be set. NEHAWU is presently negotiating national agreements as opposed to agreements with individual hospitals. This would involve negotiating one standard agreement for all groups throughout the country.



NEHAWU has negotiated successfully for many of their members. Health workers are beginning to see that joining NEHAWU can help them to improve their working conditions.

This would mean the union would not have to negotiate "from scratch" each time. Some of the companies have agreed to this in principle but the issue of registration is being used as an obstacle. Management expresses fears that unregistered unions could "disappear" without paying legal costs of lost disputes. They argue that if the union is registered, management will at least have access to contact names and addresses.

The national democratic struggle

NEHAWU recognises that their members are discriminated against not only along class lines but also as victims of apartheid. In the public sector, the government has had a free reign for a long time and conditions of employment have been designed to cater for racial groupings. In many areas, the colour bar is still in operation and superior positions

usually go to whites, regardless of previous experience. Workers often face conservative and racist behaviour from superiors, resulting in difficult working conditions. Even permanent workers face this problem. A recent example is that of the black nursing staff employed at the white Johannesburg Hospital who complain of white colleagues having transport and creche facilities that are denied to black staff.

NEHAWU sees the need to strenthen shop floor structures but also recognises the need to link up with other organisations in the health and education sector as well as community organisations in general, in order to broaden unity against apartheid.

Successes and problems

There are a number of reasons as to why NEHAWU has succeeded in some areas more than others. Members are inspired by disputes won by workers in other industries, particularly other public sector unions. Victories in common areas such as wages and dismissals have helped to conscientise and unionise workers. NEHAWU has won a number of disputes in the public sector although the union has not always been able to consolidate the outcome. Because the union is not officially recognised by the sector, there is no guarantee that victories will not later be reversed. In spite of this, NEHAWU members have remained committed to the union through long periods of hardship. Natalspruit strikers, for example, were out of work for 13 months. The workers met every week for the entire period until the union negotiated total reinstatement to previous positions, with no unfair transfers and backpay for the entire 13 months. At Hillbrow Hospital, Johannesburg, workers got back pay for five months of dismissal and were reinstated without victimisation.

Future plans and visions

NEHAWU is still small and our horizens need to be broadened. Ideally, we would like to exist in every area where there is a hospital or a clinic. We experience problems in terms of both human and material resources. Owing to financial constraints, some of our branches share offices with other unions and may have volunteer organisers rather than paid employees.

Victories have encouraged workers to ask NEHAWU to send organisers to unorganised areas. NEHAWU could embark on joint campaigns with other health worker organisations to assist organisation in these areas. We are looking to expand our membership well beyond NCWs. The question of organising nurses, for example, is high on our agenda.

Ideally, COSATU favours moves towards one public sector union catering for all areas. Public sector unions such as POTWA (Post and Telecommunication Workers Association), SARHWU (South African Railway and Harbour Workers Union), SAAMWU (South African Allied Municipal Workers Union) and NEHAWU are in the process of discussing this issue. The possibility of a mini federation with specialised offices co-ordinating on various levels is also being discussed.

Privatisation in areas such as harbours, post, telecommunications and health is obstructing this process in that it is splitting management and weakening the unions' base.

Contact addresses

Head office
P.O. Box 7549
Johannesburg
2000
Tel: 011-299665

Pretoria
2nd Floor TAB Building
365 Struben Street
Pretoria, 0002
Tel: 012-266244

Durban
61 Ecumenical Centre
20 St Andrews Street
Durban, 4001
Tel: 031-3040940

Bloemfontein
P.O. Box 6311
Bloemfontein
9300
Tel: 051-471613

Kimberley
24 De Beers Road
Kimberley
8301
Tel: 0531-811150

East London
Stanton Building
8 Cromwell Road
East London, 5201
Tel: 0431-22185

Port Elizabeth
Court Chambers
633 Main Street
North End, P. E.
6001
Tel: c/o 041-411618

Cape Town
506 Strand Centre
37 Strand Street
Cape Town
8001
Tel: 021-235415

Nelspruit
P.O. Box 3828
Nelspruit
1200
Tel: 01311-25933

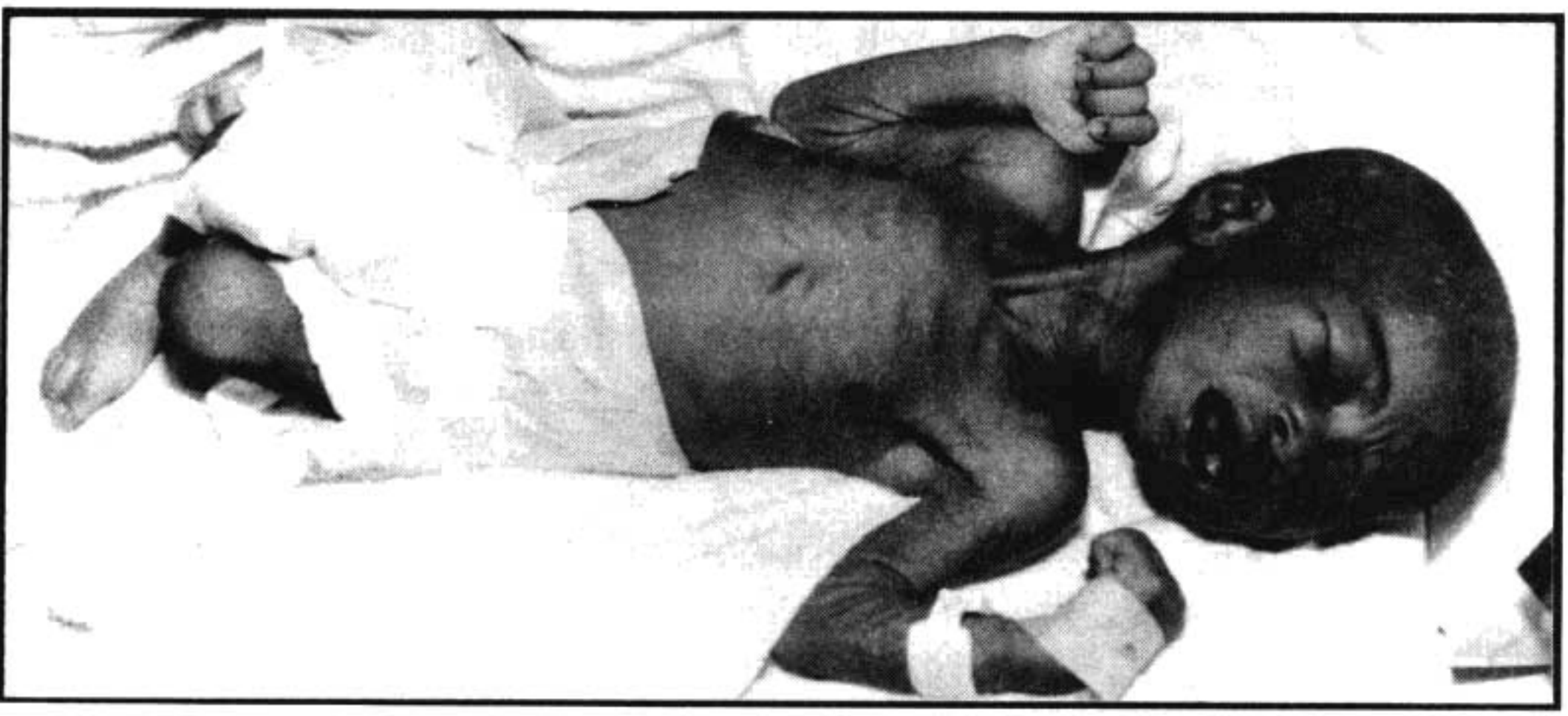
Empangeni
c/o COSATU Regional Office
Tel: 0351-21673

Interview with the South African Health Workers Congress

In March this year the Health Worker Association and Health Worker Organisation merged to form the South African Health Workers Congress (SAHWCO). Critical Health interviewed the new organisation.

Critical Health: How do you see the significance of the merger of the HWO and the HWA, given the fact that your organisations are so similar in nature and function?

SAHWCO: The merger between Health Workers Association and Health Workers Organisation to form SAHWCO is an important milestone in the general struggle for better health for all South Africans. Both organisations have for a long time been organising on the basis of the Health Worker Concept. Unfortunately, both organisations were unable to tackle apartheid health at a national level in the form of national campaigns.



Malnutrition: a disease of poverty - SAHWCO mobilises around the fact that health depends on socio-political factors, not only on the provision of hospitals and clinics.

The formation of SAHWCO will streamline our activities and allow us to be more efficient and united in addressing health matters. Take for example the Tariffs Campaign. This is an issue which affected all our communities in all the provinces. But it was only effectively taken up in Natal and very weakly addressed in the Transvaal, Orange Free State and the Cape Province.

The merger will also intensify greater debate around the health worker concept. Our people need to be made aware of alternative health systems operating in countries undergoing social transformations, for example, Nicaragua, Guatemala and Cuba. Whilst we do not believe in importing foreign systems, it would nevertheless be important to study them and apply what is good for us.

Recognising the importance of women in the struggle, SAHWCO encourages participation at all levels of the organisation and has worked with women's organisations on a number of joint health programmes.

How were other health worker organisations involved in the merger discussions?
There were three organisations in various parts of the country organising on the basis of the health worker concept; HWO (Natal), HWA (Tvl, OFS) and Health Worker Society (Western Cape). Since 1984 we have been meeting about two or three times a year as the "National Gathering of Health Workers". We learnt from each others' experience and approach to organising in the health sector. The need to form a unitary organisation based on the health worker concept was started in 1986. Unfortunately, the HWS had some problems with the ideological framework within which HWA and HWO were

prepared to organise, for example, adoption of the Freedom Charter and support for the United Democratic Front and for the National Democratic Struggle. So whilst HWS decided not to continue in the merger talks, we sincerely hope that they will reconsider at a later stage.

Are there any other important issues that led up to the merger?
Yes. Whilst the approach to organising on the basis of the health worker concept is relatively new in South Africa, it is by no means new in other countries such as Nicaragua, Guatemala, Phillipines and Mozambique. These countries have also waged bitter struggles for political independence. They also have a long term socialist outlook. We need to link up with other countries and individuals like David Werner, Vincent Navarro and other progressive health workers. This can be more effectively done through a national organisation, rather than a loose, autonomous body lacking in central co-ordination. We are already making progress in this regard.

The health sector is made up of many categories of health workers. In some countries this has resulted in the formation of multiple health worker unions and organisations. How do you see future developments in this respect within South Africa?
A cursory look at the health sector reveals no less than 12 departments in a typical hospital set up. Now, if we have to organise each sector separately, not only would we have 12 different organisations and/or unions in one institution but each one would pull in a different direction - making unity very difficult.

Incidently, this is one of the problems of trade union organisation in Britain. To have many separate unions in the health sector creates more problems at a co-ordination level.

This brings us to another very important point: the principle of "one industry, one union". In the health sector, SAHWCO has resolved to strengthen The National Education, Health and Allied Workers Union (NEHAWU) - a COSATU affiliate.

SAHWCO is not a trade union - it addresses the political economy of health. But because we have branches at hospitals, we believe we can contribute significantly towards strengthening NEHAWU. This we have been doing since 1983, when we urged health workers (especially the non-classified health workers) to join the General and Allied Workers Union (GAWU) in the Transvaal. In Natal, HWO had assisted in unionising health workers into Health and Allied Workers Union (HAWU). HAWU and GAWU merged to form NEHAWU.

Traditionally, doctors and men have tended to dominate the health sector in South Africa. As SAHWCO is open to all health workers, how does the organisation intend to ensure equal and democratic participation?
We must remember that the health sector is a microcosm of the divisions of our society

SAHWCO supports the Mass Democratic Movement in its struggle for a better, non-racial future for all South Africans.

at large. Doctors wield immense power in the health sector - by virtue of the skills they have. This power also spills over in their involvement in wider social issues. This power becomes dangerous and retrogressive if it is allowed to go on unchecked, if doctors are not accountable to progressive organisations of the people. It is clear to all that this power and privilege is gained at the expense of other health workers. We feel that doctors (and all professionals) should step down from their high pedestals and interact more with other health workers as equals, and with the community at large. Women comprise 80% of the workforce in the health sector. The oppression of women in hospitals is mirrored by their position elsewhere. We need to change this situation.

Women hold important positions at all levels of SAHWCO structures. SAHWCO is very conscious of this factor and consciously encourages women to participate at all levels and in all activities.

Developing democratic structures with emphasis on accountability would, we believe, ensure equal participation by all - women and men, doctors and other health workers.

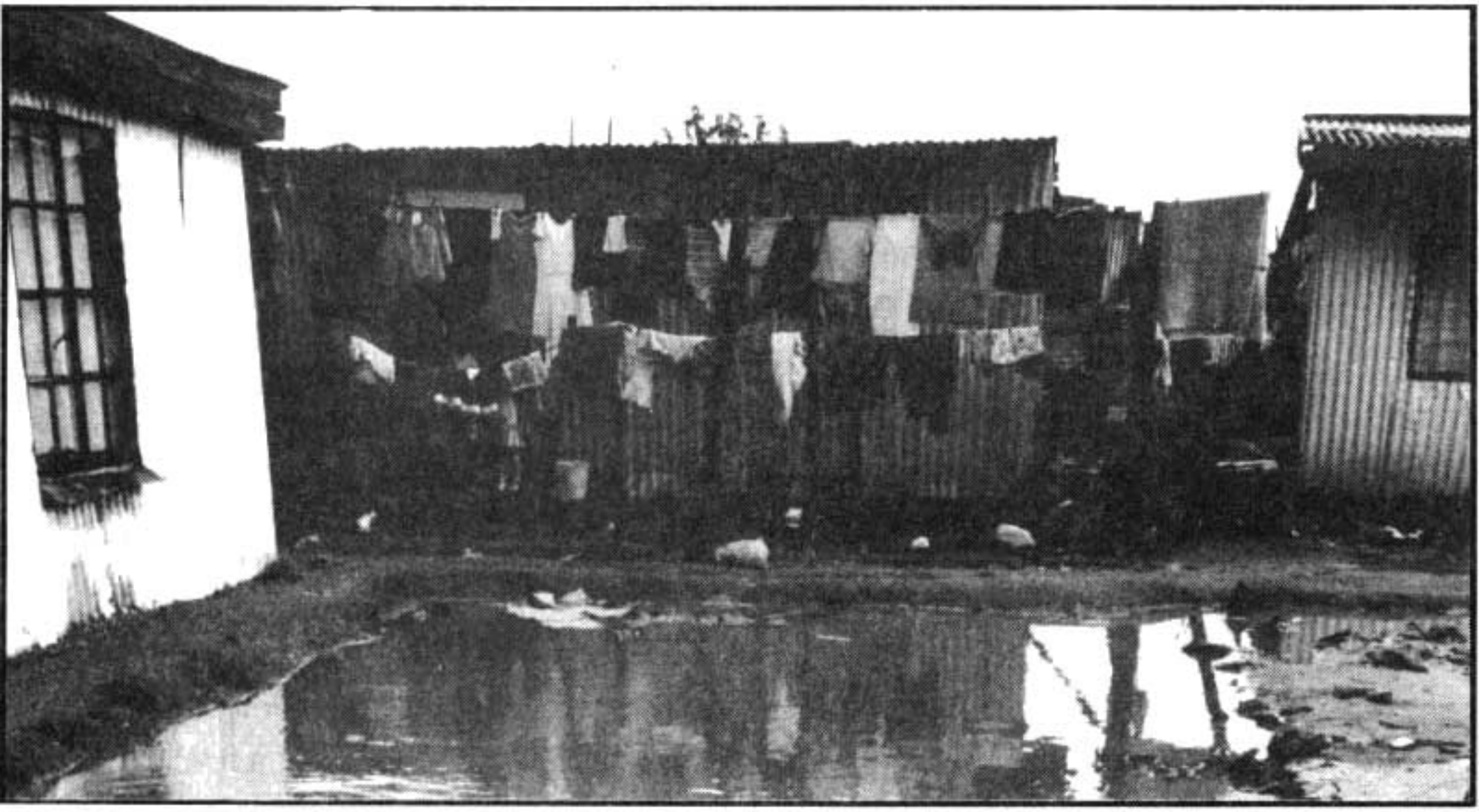
At a practical level, we have had a number of joint health programmes with organisations such as the Federation of Transvaal Women (FEDTRAW), Lenasia Women's Congress, Natal Organisation of Women. We hope to further strengthen our links with women's organisations in the future.

How do you see the organisation's structural relationship to other progressive organisations (and in particular, other health worker organisations) developing?
Generally, we have enjoyed a good relationship with progressive organisations in the community and the trade union sector.

In the community a more structured relationship exists in the form of the Community Health Committees (CHCs). The CHCs are made up of representatives from civic, women, youth, students, trade unions and progressive organisations, including ourselves. This forum discusses health problems in the community and how to tackle them. We hope to see more and stronger CHCs in the future.

In the health sector, we have been part of ongoing discussions to bring about greater unity of progressive health organisations. These organisations include NAMDA, OASSSA and NEHAWU. It is common knowledge and an historical fact that unity amongst the oppressed makes it more difficult for the oppressor to sow the seeds of distrust and confusion. United action or support for each other's programmes stands a much better chance of success. Presently, the unity talks are focussing on issues such as the unionisation of health workers into NEHAWU. SAHWCO, being a national organisation, will further facilitate the process towards unity in the health sector.

How many members are there regionally and nationally?
We are unable to answer this question accurately, as our files and equipment were confiscated by police some time ago. These were never returned. But we would guess SAHWCO would bring together approximately 1 500 to 2 000 health workers.



A flooded township street - health workers cannot separate themselves from community struggles especially those contributing to the people's health.

Will SAHWCO organise around struggles in the workplace, community health issues or other community struggles?

SAHWCO will be primarily addressing the political economy of health. We would therefore be concerned with all issues eroding the health status of our people. The total eradication of all apartheid structures in our health services remain our main goal at this point in time. But, of course, this cannot be done in isolation from the dismantling of apartheid generally.

Health workers are part of the community and cannot remain divorced from struggles waged in the community such as high rent, inadequate housing and inferior education; these are issues which directly or indirectly contribute to better health?

Workplace related problems of health workers such as poor wages, unfair dismissals and victimisation are issues we hope NEHAWU will address. We would play a supportive role and strengthen NEHAWU as we have been doing in the past.

Could you summarise the priority issues that you will cover in the short and in the long term?

SAHWCO has just been launched as a national organisation. There are many issues to be tackled. Many demands are being made on the organisation from progressive organisations and individuals.

In so far as commenting on the way forward, this was discussed at our National Executive and National Council meetings. We would obviously be continuing with our existing programmes of addressing the plight of the hunger strikers specifically and detention without trial, (together with other organisations), opposition to the increased hospital/clinic tariffs, and setting up of CHCs.

We also see ourselves addressing issues like the academic boycott, a future National Health System, the role of health and welfare in a mixed economy and training of health personnel.

SAHWCO has embarked on the Health Charter Campaign (HCC). We hope to engage health workers and authentic organisations of the people to discuss the Health Charter. The HCC would give health workers, and the community they serve, direct access to the future health system.

The health system is crumbling under apartheid. Apartheid is carrying out a "slow, quiet genocide" amongst the oppressed. All of us who are aware of this fact have not only an ethical and moral duty - but an historical duty as well - to join forces to destroy this policy before it destroys us.

SAHWCO

SOUTH AFRICAN HEALTH WORKERS CONGRESS

History

In 1979, a group of concerned doctors in the Transvaal decided to form the Transvaal Medical Society (TMS). The primary aim of this society was to organise black doctors but it soon became apparent that this was an incorrect strategy. Organising doctors alone cannot lead to a fundamental change in social relations. The only way to safeguard the interest of the masses is for the masses themselves to have dominant control of the struggle. This realisation led to the dissolution of the TMS and the subsequent establishment of the Health Workers Association (HWA), an organisation whose membership was open to all health workers.

SAHWCO maintains that all health workers, regardless of their class or status in the health sector, have an equally important role to play in the struggle for better health.

Health care should be controlled by the people who use the services.

In Natal, a similar process took place. A group of concerned health workers saw the necessity for a community-based health organisation and launched the Chatsworth Health Committee (CHC) in 1982. The CHC was open to all but had a limitation in that it was a localised organisation, confined to the Chatsworth area. The need to expand and accomodate other areas of Natal led to the formation of the Health Workers Organisation (HWO) of Natal.

In the Cape, the Health Workers Society (HWS) was formally launched in 1982 but was largely limited to the Cape Town area.

All three organisations were established independently of each other. Having made contact, however, all three organisations began meeting with a view to discussing and developing strategies to strengthen their respective organisations. With time it became apparent that there was a great deal they had in common; that although regionally based, the areas of struggle overlapped and that significantly more could be gained from a unitary organisation rather than regionally representative ones.

Unity talks were begun about two years ago but unfortunately, differences with the HWS in the Cape could not be resolved and the society decided to withdraw from the process. In the interim both HWA and HWO continued to develop. HWO extended its activities within Natal and HWA set up branches in Welkom and Bloemfontein in the Orange Free State and a branch in Cape Town.

The culmination of these unity talks was the establishment of the South African

Health Workers Congress (SAHWCO) which was officially launched on 4 March 1989. SAHWCO was launched to bring together all health workers into a unitary health organisation. It is based on the health worker concept whereby all health workers, irrespective of their job category, class or social standing, have an equally important role to play in the struggle for better health. SAHWCO was launched to help conscientise, mobilise and organise all health workers at two levels:

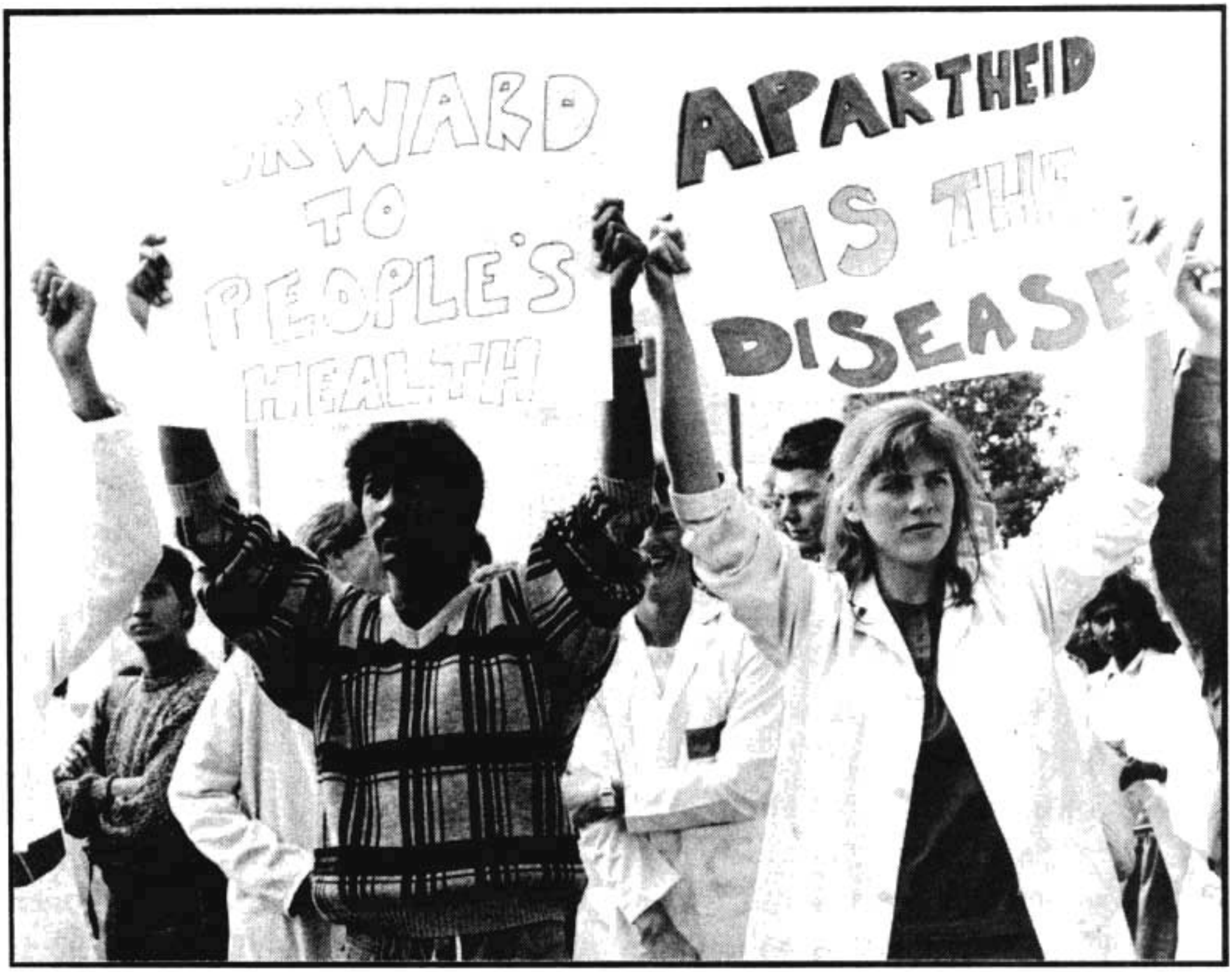
The first is at the level of the non-racial, democratic struggle. Since the primary determinants of health are social, political and economic factors, the struggle for better health cannot be viewed in isolation from the struggle for democracy.

The second is to actively get health workers involved in the struggle for a people centred health system which is democratic, accountable, affordable and accessible to the people.

Aims and objectives

- To engage in a struggle for the attainment of a non-racial, non-sexist, democratic, people centred health care system and for the attainment of the highest possible level of health care for all the people.
- To promote projects and programmes that would give priority to prevention, education and primary health care, emphasise and encourage community participation, empower communities to foster self-sufficiency.

Along the lines of the Freedom Charter, SAHWCO is fighting for a non-racial, non-sexist, democratic, people centred health system.



Medical students protest - SAHWCO also promotes the eradication of all forms of discrimination in the health sector in particular and society in general.

- To promote and implement the concept that health care be controlled by the people.
- To protect and promote the interest of the people in health and health related matters.
- To promote and maintain the equality of all health workers.
- To defend the rights of health workers wherever and whenever possible.
- To promote communication, co-operation and mutual understanding between health workers, community organisations and unions with similar interests.
- To provide a forum for discussion on health and related matters.
- To promote the eradication of all forms of exploitation, discrimination and domination in the health sector in particular and society in general.

The dismantling of the apartheid health system would not necessarily ensure the people's involvement in determining health priorities. SAHWCO firmly believes that the authentic representative organisations of the people (civics, trade unions and women's organisations) should play an active role in contributing to health planning and implementation.

A union play on injuries at work - SAHWCO believes that authentic organisations of the people (such as civics and trade unions) have an important role to play in the struggle for health.

Membership, structure and composition

In accordance with the constitution, all individuals, organisations or groups who aspire towards a just and equitable society and are willing to contribute to the struggle for better health in particular, and a better society in general, are eligible for membership of the organisation. This includes individuals formally employed within the health sector and also from the community at large. As an example, present members formally employed within the health sector include non-classified workers, doctors, radiographers, pharmacists, nurses etc. Community membership is drawn from across the spectrum and includes scholars, students, skilled and unskilled workers, activists, housewives and pensioners.

Structurally, the organisation is a national unitary type of organisation. Forming the foundation of the organisation are local branches which are managed by a branch executive. The various branches within a particular region come together to elect a Regional Executive Committee (REC) whose task is the overall co-ordination of the region and to oversee the formation of the branches. A Regional Council is formed by the Regional Executive and the Branch Executive and serves to co-ordinate and facilitate the functioning of its branches and to review, alter, reverse, prohibit or support decisions and activities of the REC. The National Executive Committee (NEC) is made up of 13 members elected at the annual congress, ten of which have specific portfolios. The NEC attends to the day-to-day running of the organisation and decisions made by the NEC are ratified by the National Council which is made up of the NEC and REC.

Our emphasis has been and will be to encourage grassroots branch participation through the RECs. In order to ensure that our programmes are always "grounded" and do not float far above the people, we see the formation of the Community Health Committees (CHC) as very important.

Campaigns and activities

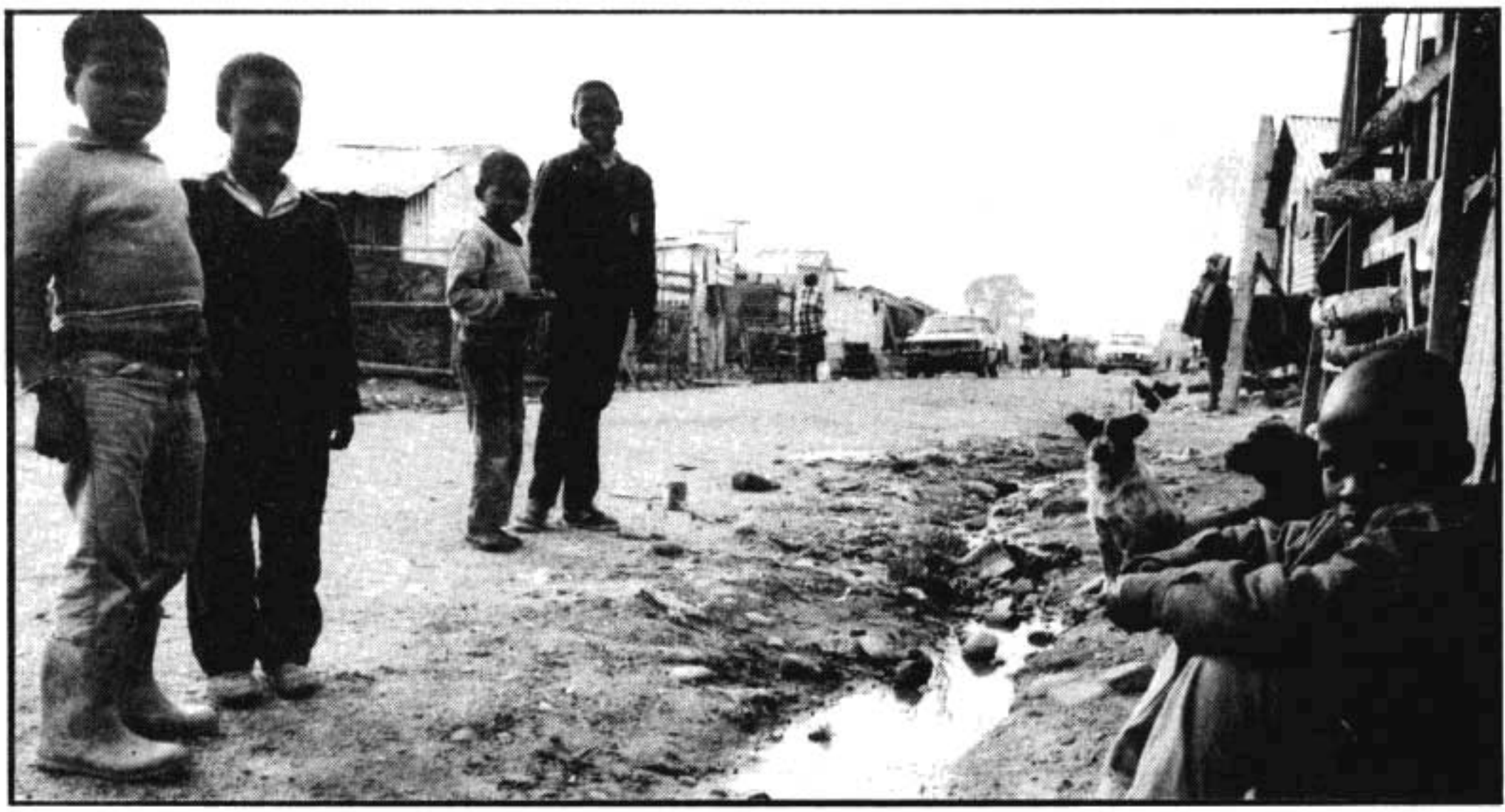
Both HWA and HWO have in the past embarked upon a number of campaigns and programmes, some of which were aimed at a specific issues while others were long term projects. SAHWCO has continued to develop these projects. The underlying theme running through them is that they are community based and aimed at community participation.

Community projects and programmes

A large number of programmes were undertaken by both HWO and HWA. The following offers an outline of the nature of our involvement within the communities. One of the essential prerequisites of any programme is that it be community based with community involvement. Some of the specific issues that have been tackled include:

Child health screening

The focus here was on the health of children up to the age of six, with the specific aim of promoting health awareness and education in the community; to identify health problems in the area and to build and strengthen the community and the organisation. The programme was conducted in Croftdente, Chatsworth in five phases over ten months. Of the children screened 24,3% were found to be malnourished. Apart from this,



No drainage systems in a Paarl East township - SAHWCO's educational programmes look at ways in which communities can address conditions affecting their health.

there were significant gains for both the community and the organisation. Parents were encouraged to continue taking a keen interest in the health of their children; a forum was established for community consultation and a significant number of community members joined the organisation or got involved in the project as volunteers.

Education programmes

These usually concentrated on a single issue at a time. The inter-relationship between sickness, poverty, political and economic factors are highlighted. Methods of assessing primary care in managing these problems are emphasised. The educational programmes include TB information, gastro-enteritis, diabetes and Aids. The crucial point here is that our approach is not a clinical one; rather we aim to place the diseases in their proper perspective and to look at ways in which affected communities can address them.

Campaign against apartheid health

The continuing deterioration in the quality of health services appears to have become an entrenched pattern in the state's approach to abdicate its responsibility in providing a free, equal and easily accessible health care system. In 1987, the crisis manifested itself in staff shortages, cutbacks on medicines and patient care and in 1988, by a significant increase in the hospital tariffs. The state has categorically stated in its revision of hospital fees that one of the principles in its approach to health care is to support the free market system and privatisation of health. It believes that curative health services should be regarded as a privilege and not a right. We reject this and believe instead that health care is a basic human right. Further, we reject the state's handling of the crisis within the health services and the high-handed manner with which such drastic measures are implemented. In 1987, HWO conducted a campaign against the staff shortages which had reached critical proportions within the Natal provincial hospitals. As a result of pressure from this campaign, a decision to restrict the number of patients seen at R.K. Kahn Hospital was reversed. This campaign was followed by a campaign against the cutback in medicines when, at a stroke of a pen, 900 drugs were removed from the hospital's dispensary.

Hospital tariffs campaign

In 1988 a campaign was initiated against the increase in hospital fees. Community participation was ensured right from the outset by consulting as widely as possible and stemming from this, an interim hospitals tariffs committee was established. The campaign was divided into different phases: concentrating on conscientising and mobilising; addressing community organisations and the community at large; a petition campaign, during which 25 000 signatures were collected; and pressuring the authorities to review the situation. Although we were unsuccessful in getting the authorities to reverse this decision, significant gains were made in respect of community participation.

Jacksondrift Project - the organisation bases its programmes on the principle of community control.

We managed to put health onto the agenda of most community organisations and in the process, established a very broad based forum for consultation.

Permanent community projects

Jacksondrift Medical Project: a health project in a farming area 25 kms from Johannesburg where there are approximately 10 000 farmworkers and their families.

Fred Clarke Clinic for squatters at Chicken Farm, Soweto: home to about 500 families.

St. Wendolins Health Project: a health project located in Marianhill on the outskirts of Durban.

Welbedacht Health Project: a health service on privately owned land on which African communities are squatting.

Moorcross Advice Centre: a comprehensive advice centre situated in Chatsworth.

It is our community projects which assist our communities in taking control of their destinies. These projects are run by committees made up of community members and a few from the health organisations who play a supportive role. Both the Fred Clarke and

Adequate health care is one of the basic rights of all people.

St Wendolins projects are both run by committees from the community who not only see to the administration but are also actively involved in primary health care and patient education.

This is not to suggest that there have not been any problems with such an approach. The most difficult task is that of ensuring community involvement. For years health has been viewed as a medical service which was the domain of professionals. Overcoming such entrenched perceptions is a long and slow process requiring perseverance and commitment.

Resources tend to be another problematic area. Suitable venues, equipment and finances are not freely available and tend to create obstacles in organising. The difficulty of recruiting a larger number of health personnel to help with the permanent projects has also been a problem. Despite these obstacles, however, we have found that our community projects have played a positive role in organising in the community.

Media

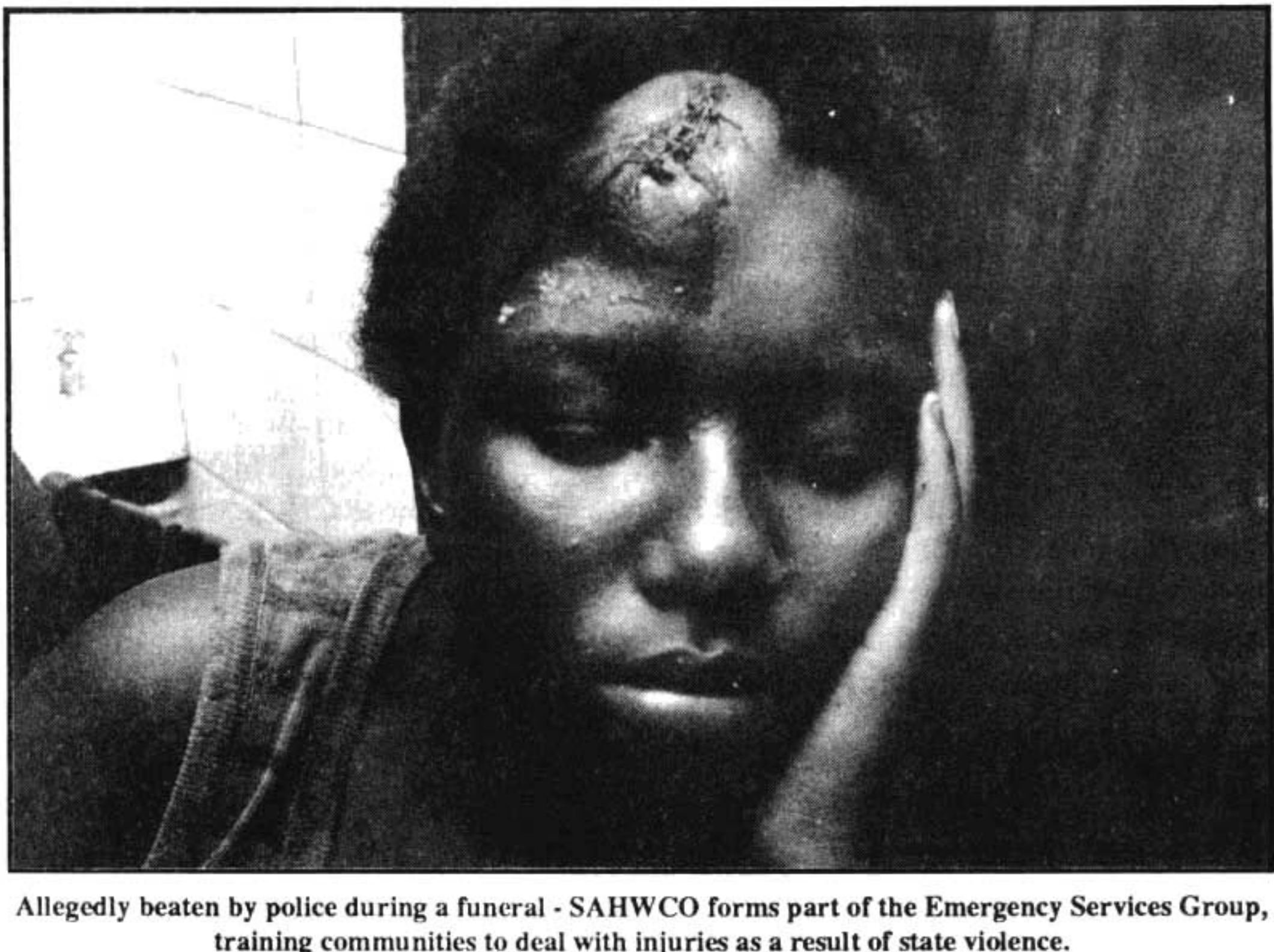
Health and disease has been made confusing and obscure by professionals. The demystification of health and disease is an extremely important activity of the organisation. Through our publications (newsletters, magazines and pamphlets) health issues have been addressed in simple language in the vernacular. Articles on primary health care are often carried and health systems in other countries evaluated.

Progressive primary health care

The primary health care approach has been considered to be one of the major answers to the dismal health system. Our involvement in the National Progressive Primary Health Care Network (PPHCN) has given us the opportunity to share our ideas and experience with other organisations.

Emergency health teams

Torture, detention without trial and the indiscriminate use of violence by the state to try and halt the progressive movement is evident to all. Those who fall victim to apartheid are afraid to make use of state services because of harassment and possible arrest. HWA was one of the first organisations to respond to this challenge by providing emergency health teams. This service has now been extended to include the Emergency Services Group (ESG), run in conjunction with other progressive groups. This involves the training of individuals in our communities to be able to deal with injuries, counselling and crisis management.



Allegedly beaten by police during a funeral - SAHWCO forms part of the Emergency Services Group, training communities to deal with injuries as a result of state violence.

Health Charter campaign

SAHWCO feels strongly that control of health, as with any other public service, must be in the hands of the people. Any future health care system must meet the demands of the masses. The Health Charter Campaign is an attempt to collect these demands and was launched in the Transvaal. The process of consultation has started. The other provinces have yet to get actively involved in this campaign.

Labour

In the early 1980s, unionisation of health workers was neglected by most unions. Amongst health workers, non-classified workers are the most exploited and economically vulnerable sector. In 1982, HWA took a decision to actively assist in the unionisation of health workers into General Allied Workers Union (GAWU) and similarly, in Natal HWO undertook to assist with unionisation into the Health and Allied Workers Union (HAWU). After the formation of the National Education Health and Allied Workers Union (NEHAWU), both HWA and HWO committed themselves to continue in assisting with the unionisation of health workers.

Organising and democracy

It is only through a truly democratic process of consultation and representation that the interest of one group can be prevented from being superimposed on that of another. The crucial question is how do we take health to the people in a democratic manner. The structural composition of the organisation ensures that the branches have community representation right through, from branches up to the NEC. Apart from this, was the need to establish firm structures within the community that would empower the masses and give them support and help in strengthening existing organisations. This need led to the formation of Community Health Committees (CHCs). These CHCs are made up of representatives from different organisations within an area and they serve as an intermediate link between health worker organisations and community organisations. It is through this structure that health can be put onto the agenda of community organisations and that the community in turn can influence and control health worker organisations.

Future plans and visions

The struggle for better health is and must be viewed as part of the mainstream political

struggle. Whilst SAHWCO will concentrate on the health sector, significant gains cannot be achieved without fundamental political changes. Therefore, the primary task of SAHWCO, whilst tackling the health issues, is to get actively involved in the National Democratic Struggle. It is the task of everyone of us to conscientise, mobilise and organise all health workers into the mainstream political struggle. As we are part of the community we must stop remaining aloof, apathetic and indifferent to the struggles within the community. Only when we achieve fundamental change on a socio-political level and have a government that is based on the will of the people and that makes decisions in consultation with the people, will we see meaningful change in all aspects of our lives, including health.

We need to strive for greater unity within the health sector. Unity talks between SAHWCO, NAMDA, OASSSA, South African Black Social Workers Association (SABSWA), CSW and NEHAWU need to be actively persued so that we can emerge with a strong united voice representing the interests of the masses.

On the labour field, SAHWCO's relationship with NEHAWU needs to be consolidated. NEHAWU is recognised by SAHWCO as the authentic labour organisation within the health sector. Attention needs to be paid as to how SAHWCO can build and strengthen NEHAWU and conversely, how NEHAWU can build and strengthen SAHWCO.

SAHWCO urgently needs to deprofessionalise and demystify health; to re-educate health workers not only in their relationship with one another, but also in the relationship between health worker and patient.

Greater emphasis needs to be placed on the training of health workers and on community projects.

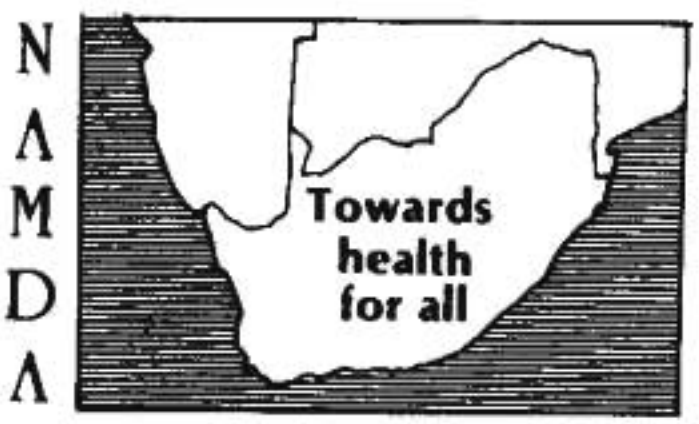
Contact addresses

Tvl & Head Office
P.O. Box 38266
Booysens
2016
Tel: (011) 3374775

Natal
P.O. Box 45277
Chatsglen
4012

OFS
P.O. Box 21195
P.O. Heyderdal
Bloemfontein
9300

Cape
P.O. Box 13186
Mowbray
7700



NAMDA

National Medical and Dental Association

NAMDA was formally launched on 5 December 1982 in Durban after a year of consultation.

Two main factors had acted as catalysts for bringing together health professionals on the broader implications of apartheid on medicine. The first factor was the medical treatment of Steve Biko and the effects on health of detention without trial, especially the physical and mental deterioration produced by solitary confinement. These made such a profound impact on the collective conscience of certain medical and dental practitioners that they took up the struggle for a re-examination of medical ethics and responsibility in this country and for the outlawing of unjust laws which led to more than fifty deaths in detention and had caused untold harm and suffering among South African citizens.

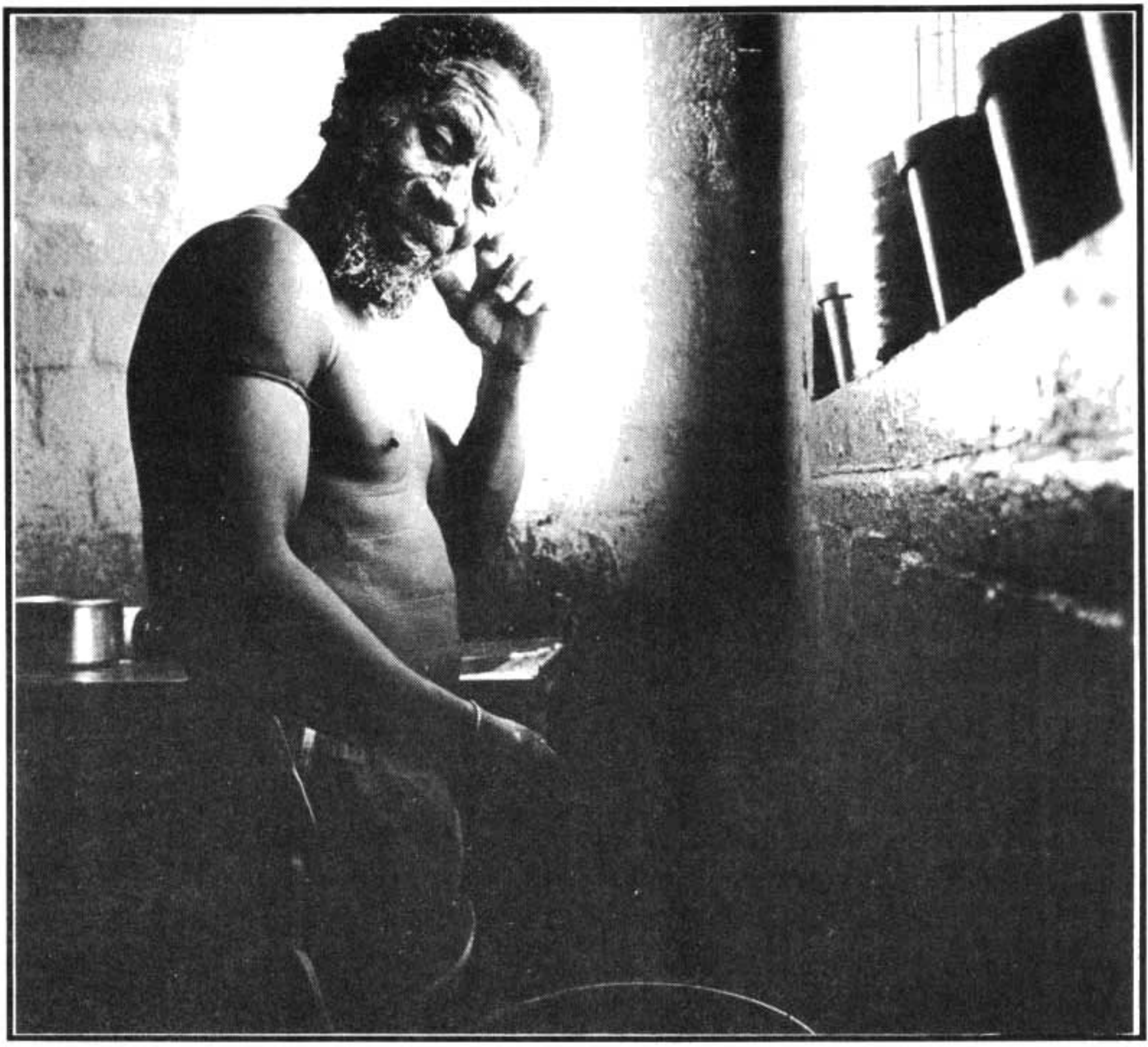
The death of Simon Marule in 1986 in prison is a stark reminder that medical treatment of detainees is still far from satisfactory. As stated by NAMDA in 1982, detention without trial can never be made acceptable. The nationwide hunger strike by over 100 detainees demanding their unconditional release or to be brought to trial is clear evidence of how strongly these detainees feel about their plight. The second factor was that progressive doctors and dentists in South Africa had long felt the need for a forum to enable them to express their views on social, political and economic factors which affect the health of the people. They recognised that the existing political, social and economic system in this country is incompatible with the attainment of good health and the eradication of disease. The health consequences of racial discrimination and economic exploitation had to be brought under constant review and fully exposed with adequate documentary backing. This, it was felt, should remain a priority for discussion, research, education and appropriate action. Our campaign on Apartheid in Health is a product of this philosophy.

NAMDA believes firmly that apartheid is the root of health problems for the majority and realises that tackling health issues in isolation from other aspects of society does not necessarily improve the well being of people in society. We have therefore identified state policy, political commitment, allocation of resources and distribution of the gross domestic product as some of the major factors responsible for the promotion of health,

disease prevention, treatment and rehabilitation. Accordingly, we demand structural changes in society which would affect not only health but also education, welfare, land distribution, income determinations, collective bargaining, agriculture, industry, law and justice and open representation in the organs of government.

NAMDA stands in stark contrast to the Medical Association of South Africa (MASA) which identifies closely with the state and refuses to vigorously take up issues which result from racial discrimination and which adversely affect health.

NAMDA endorses in its constitution the World Health Organisation's (WHO) first two principles which state that: ''The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition''.

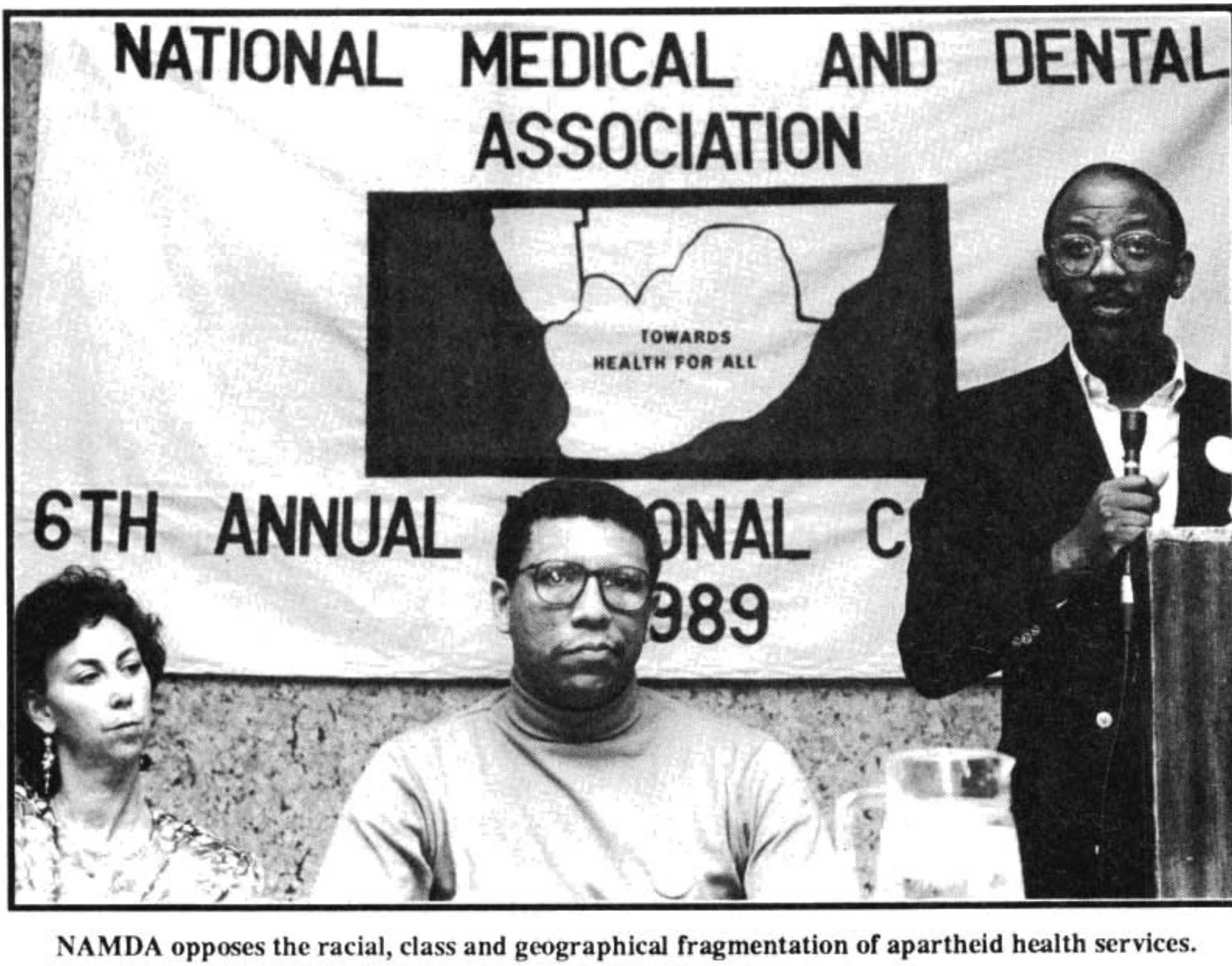


A migrant labourer washing in a Guguletu single sex hostel - NAMDA recognises that tackling health in isolation from socio-economic and political issues will not necessarily improve society's health.

Health policy

NAMDA's activities are based on a critique of apartheid health services as being fragmented along racial, geographic and class lines. We identified a neglect of Primary Health Care and a major orientation towards high-technology, curative and individual-centred medicine with an increasing shift towards privatisation of health services despite the wide disparities between rich and poor in South Africa. Our response to this is that this country needs a democratic, unified, national health system based on a sound and secure primary health care service. To this end we convened a conference in Cape Town on 6 April 1987 of Primary Health Care (PHC) workers. Out of this arose the Progressive Primary Health Care Network (PPHCN) (formally launched in Johannesburg in September 1987 and now operating autonomously from NAMDA with its own projects and structures).

In pursuit of the goal of a National Health System (NHS), NAMDA has held two national conferences focussing on the subject of a NHS and "People's Health". To date, a number of publications have appeared and workshops held to further the debate around an NHS in South Africa.



NAMDA opposes the racial, class and geographical fragmentation of apartheid health services.

Human rights

Since its formation in 1982 NAMDA has consistently opposed apartheid. NAMDA recognises the following essential characteristics of the South African state: the identification, registration, manipulation and regulation of people according to race and colour, the denial of legitimate political rights to "Africans", "Indians", and "Coloureds", the forcible uprooting of Black people from most of their land throught the operation of the Bantustan system and the Group Areas Act, unequal and racially discriminating distribution of resources including social services such as health, control of society through militarization, and response to most forms of opposition by force exerted by the security police, South African Defence Force and South African Police and the banning and repression of authentic organisations of the majority of South Africans. Apartheid is adverse and unfavourable to good health and yet MASA provides a firm and continuing stubborn defence against criticism of the medical inequities of this evil system. NAMDA, however, exposes the effects of apartheid on health and the human rights violations that have become a permanent feature of this system which has been condemned by the international community.

NAMDA had long since identified the systematic torture of detainees through interviews with released detainees at various major centres in the country. This, together with other international studies, presents overwhelming evidence of the detrimental effects of detention.

The detention of children and state violence against children has been a major feature of the South African state's repression strategy and has drawn national and international outcry. NAMDA was appalled when the MASA affiliated Paediatric Association of South Africa (PASA) published guidelines on the treatment of children in detention. We stated that the goal should be the abolition of detentions and not the improving of conditions in prison.

NAMDA's contribution in the area of human rights has been recognised by way of two international awards in 1987 and 1988 respectively. We are also one of the organisations comprising the recently established Human Rights Commission in South Africa.

Alternatives in medical education

NAMDA started addressing the problems of medical education in 1984 when it appointed a subcommittee to look at this issue. Two main problems were identified. The first was that the present system is not geared towards the necessary tasks to be performed in Primary Health Care systems and the second was that the current curriculum encourages its graduates to work in urban areas in specialist practice.

In addition, medical education in South Africa reflects apartheid in general with its race and class divisions manifesting in various inequalities. Teaching hospitals and medical schools are largely segregated and resources are not equally distributed.

Medical schools continue selecting a far greater proportion of white matriculants than black matriculants, according to criteria which favour students from the more privileged white and middle class backgrounds.

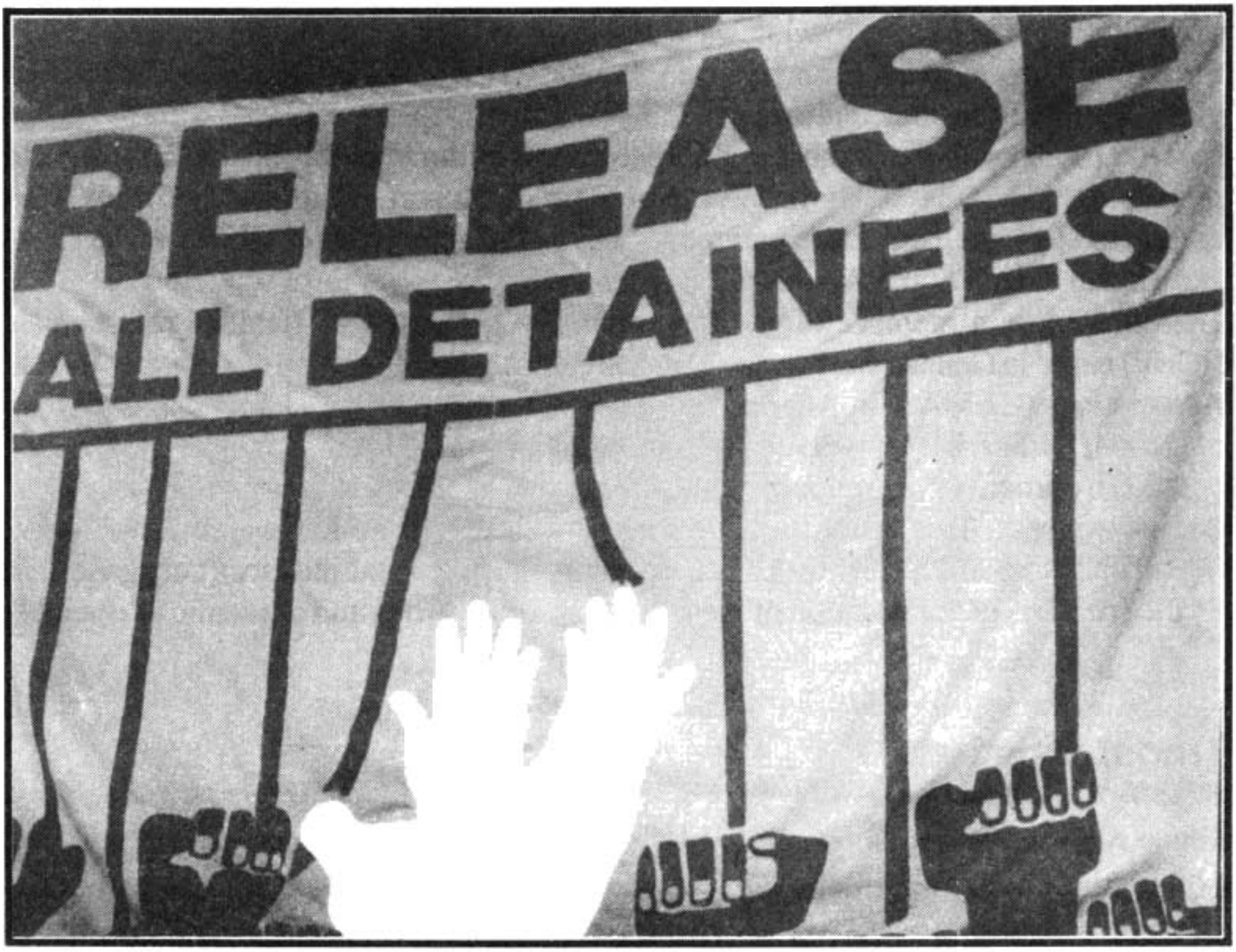
NAMDA initiated a successful conference to address this issue. The conference was held at the University of the Witwatersrand in December 1988 and resulted in the formation of regional networks to take the issue further and to examine practical ways to initiate Community-Based Medical Education (CBME) Programmes in South Africa. South African society finds itself in a period of transition. Medical education needs to align itself with the process of social change. Community-Based Medical Education may provide abasis for expanding the practice of people's education.(1)

A report of a NAMDA delegation that was invited to attend the ten-year celebrations of the Faculty of Medicine of the University of Newcastle in New South Wales, Australia (which has adopted a CBME approach) has been published by NAMDA.(2)

International

The South African health system, like other aspects of South African life, most notably the economy, is integrated with and greatly influenced by Western trends and developments.

NAMDA has received local and international recognition for its consistant exposure of human rights violations in South Africa.



Through NAMDA, doctors and dentists are able to express their views on issues directly affecting the nation's health status.

The local medical establishment tends to be sensitive to censure by progressive forces abroad and derives enormous moral support from actions of apologists of apartheid drawn from conservative ranks in the United States, England and Europe.

For example, in 1979 a delegation from the American Medical Association (AMA) paved the way for the readmission of MASA to the World Medical Association (WMA) after 12 years of isolation, by presenting a report which glorified apartheid medicine in general and MASA in particular. Using the undemocratic constitution of the WMA and with the backing of the Americans, Germans and Japanese, MASA was readmitted together with the Transkei Medical Association and a renegade group of Cuban origin based in Florida.

In addition, the WMA intended holding a conference in Cape Town in 1984, with the opening address to be delivered by the then Prime Minister, P.W. Botha. In response to that move NAMDA and other progressive health organisations, especially HWA and HWO (now SAHWCO), mounted a very successful campaign to prevent the WMA assembly from taking place in South Africa. We considered the WMA attempt to come

to South Africa as a move to whitewash apartheid medicine and to exonerate MASA of the stigma and international outcry against it over its shameful conduct in the Steve Biko affair specifically and detentions generally.

Due to our active campaigning abroad and as a direct result of the campaign to prevent the WMA assembly in 1984, a number of support groups for NAMDA have emerged. These include the Committee for Health in South Africa (CHISA), in the USA, and Health Watch South Africa, in Canada.

NAMDA is a member of the International Committee of Health Professionals (ICHP) based in Geneva and has observer status at the Confederation of African Medical Associations (CAMAS) in Africa.

NAMDA has been involved in bringing about the current flexibility towards a position by progressive groups in relation to the total isolation strategy of anti-apartheid groups overseas. This is not to suggest that there are now no longer problems in this regard. There is still a need for broad inter-organisational and intersectoral agreement on the specifics of the isolation of the regime in South Africa and academic exchanges.

Transformation

South African society is, at present, poised on the brink of change from a racist, exploitative one to a non-racial, equitable and democratic one based on the ideals of the Freedom Charter.

Learning from the experiences of other African countries, we have started examining the issues relating to a post-apartheid society including health policy issues such as the question of a NHS and issues concerning the organisation of health workers. The role of traditional healers in a post-apartheid society is also being examined as are the long term effects of repression on children and society as a whole.

In conclusion, the non-racial experience (afforded by being a member of NAMDA) so necessary for most of us who have been brought up in seperate ethnic corners of apartheid South Africa, is personally fulfilling. The camaraderie and comradeship, in the sense of belonging together, equal and sharing tasks and responsibilities, contributing towards one common objective - all of us black and white - is a unique experience.

References

1. *S.A. Medical Education - Ivory Tower or Community Based?*, Critical Health No.25, December 1988.
2. *Community-Based Medical Education*, NAMDA Special Bulletin 1, November 1988.

NAMDA has begun to examine the long term effects of repression on children as well as issues such as health care in a post-apartheid society.

Contact address

NAMDA Head Office
P.O. Box 17160
Congella
4013

Health Workers' Union

History

The Health Workers' Union (HWU) was launched in December 1985. It consisted of a few hundred workers at a small number of private health institutions in Cape Town.

In the early 1980's there had been attempts to organise health workers. There was a need for unionisation amongst health workers because of poor wages and bad working conditions. In terms of unionisation, the health sector had lagged behind other areas, chiefly because of the position of state employed health workers. The existence of recognised staff associations, e.g. the Public Servants' League (PSL), resulted in the state refusing to recognise or negotiate with other worker organisations which had state health workers as members. These staff associations had a reputation of not doing anything for the workers, of siding with the state, of being "benefits" orientated and of being run along authoritarian rather than democratic lines.

Both General Workers Union (GWU) and the South African Allied Workers Union (SAAWU) attempted to organise health workers. They found great worker interest but they faltered as the state did not afford them any form of recognition and they therefore found they could not take up the problems of health workers in any meaningful way.

There was also an attempt to take over the PSL and as a result a number of workers committees at various hospitals were taken over by progressive elements. However, in the long term this attempt faltered as it failed to develop sufficient support within the PSL as a whole.

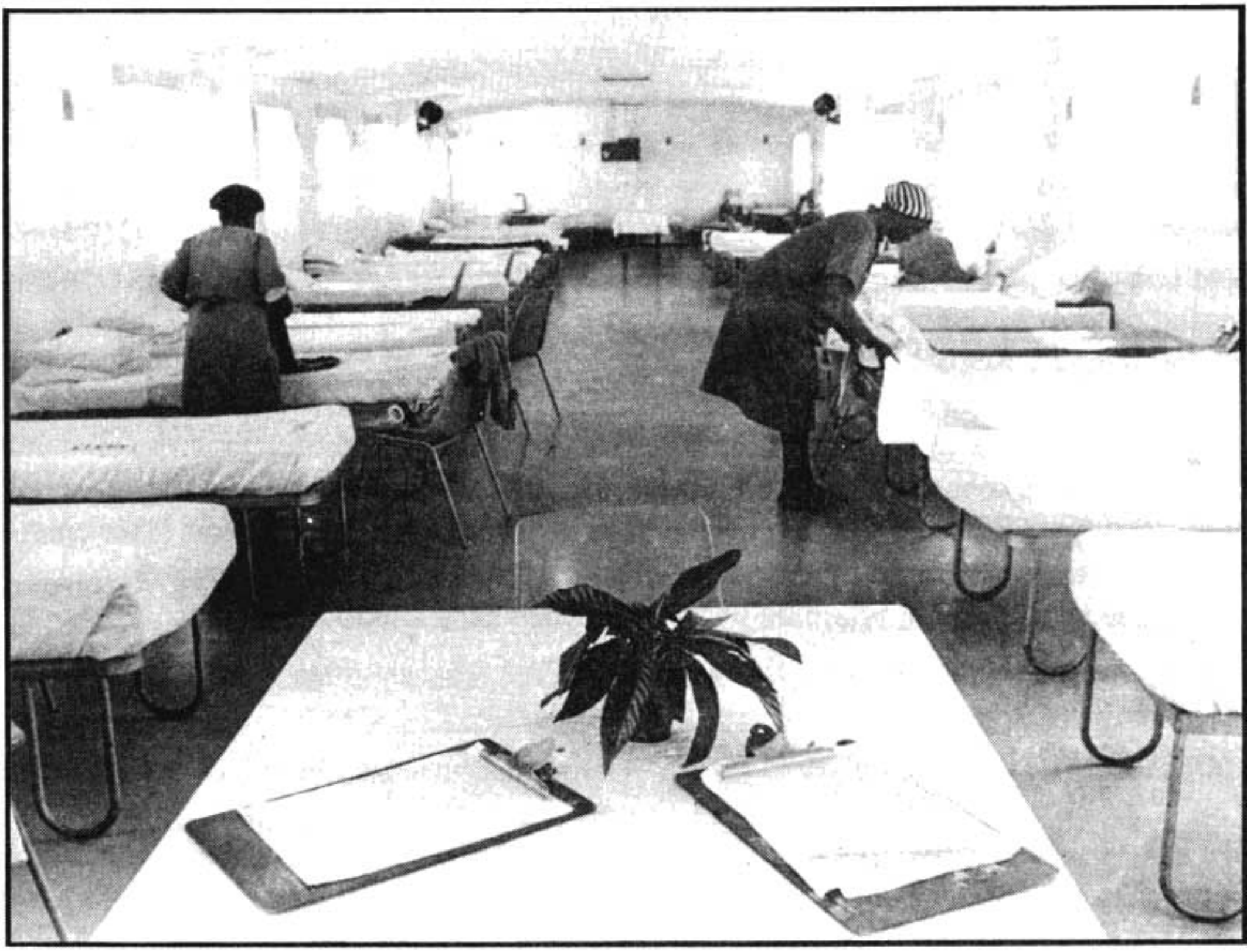
An organisation called the Health Workers Society (HWS) set up an health workers' advice office at the beginning of 1985 which tried to deal with health workers' problems on an individual basis. Through this advice office a number of workers' committees were set up at different private institutions which led to the launch, in December 1985, of the Health Workers' Union (HWU).

In September 1985, workers at Groote Schuur Hospital formed the Groote Schuur Health Workers Association. Because of the townships uprising, workers found them-

selves increasingly victimised at work and they felt the need for an organisation to protect their interests. Groote Schuur Hospital Workers Association developed tremendous support amongst the general hospital workers and by virtue of their strength forced a meeting with Management at Groote Schuur Hospital. From then on meetings were held with Management on a regular basis. Although the Association operated without official recognition, a number of local issues were successfully taken up.

Health Workers' Union now expanded rapidly into state and private hospitals, old age homes, welfare institutions, semi-state and even animal welfare institutions. Membership included mainly general workers such as cleaners, labourers and domestic staff as well as assistant nurses at a number of the private institutions. In 1987, Groote Schuur Hospital Health Workers Association joined the HWU.

In June 1987, HWU was present as an observer at the launch of the National Education Health and Allied Workers Union (NEHAWU). However, following the launch, tension developed between NEHAWU and HWU and the intention of HWU to become part of NEHAWU was withdrawn.



Hospital domestic workers - HWU recognises the importance of unionising health workers who suffer from poor wages and bad working conditions.

State hospital campaign

Towards the end of 1988 a number of work stoppages, initiated by the Groote Schuur branch, were held by state health workers. These later spread to other state hospitals. During the stoppages, which were of short duration ranging from a half to a full day, the following demands were made:

- R800 per month minimum living wage;
- a 40 hour week;
- permanent status; maternity benefits;
- recognition of the union.

A meeting was forced with the Director of Hospital Services at which a limited victory was gained in the form of a small increase in salary. No workers lost their jobs but workers at Groote Schuur were expected to work in, or have deducted from their salaries, the one day work stoppage. At present, the general unhappiness with the size of the increase and the lack of response to the other demands is under review.

The state health workers in HWU are currently consolidating their strength in the Western Cape and are exploring alliances with other unions in other parts of the country.

Structure

The HWU only exists in the Western Cape where there are approximately 4 500 members at present from about 40 institutions.

Each institution is a branch and each branch has a Shop-Steward Committee. The General Council consists of representatives from each branch and meets once a month. This is a decision-making body in between the Annual General Meetings and General Meetings. The Executive Committee is elected at the Annual General Meeting and concerns itself with the administration of the union. The Executive Committee takes emergency decisions on behalf of the union when such a need arises. Major decisions are made at General Meetings and these are held when such situations arise.

Position

We see ourselves as part of the progressive trade union movement and believe in unity of the working class. Where possible, we support action around the recognition of 1 May and 16 June as non-working days though, in the health sector, this is very difficult. We recognise and support the work of progressive health organisations but because of our own struggle, our active support is limited.

Private sector

A number of interim recognition agreements have been signed and we have stop order facilities at some of these institutions. Full recognition negotiations are in progress. Our members in this sector are covered by the Labour Relations Act and as a result a lot of issues of branches and individual workers have been successfully taken up.

Problems

These mainly involve the lack of funds. Because we are unaffiliated, access to funds is limited. The union is dependent on hand collections especially at state institutions. This has proved to be difficult in practice. A further problem related to inadequate funds is the inability to employ sufficient staff. This has resulted in an inadequate servicing of branches.

Conclusion

Since December 1985 there has been a definite growth, both in quantity and quality, of worker participation in the issues taken up by the HWU. It has been a long struggle, we are still struggling and we see ourselves struggling for a long time to come.

We feel however, that we constitute a significant factor in the health sector and an important part of the trade union movement. We do not see our struggle separate from that of other health workers, of other workers, or of the oppressed community as a whole. Whatever victory we are fighting for, will be their victory as well.

Contact address

HWU
P.O. Box 4058
Cape Town
8000
Tel: (021) 455263 or 4614035

Aspects of Rural Health Services Development

Experience from work in Mhala in the Eastern Transvaal

1982 - 1984

The Health Services Development Unit is an outreach programme of the Department of Community Health of the University of the Witwatersrand. The Unit is based in the Mhala District of the Eastern Transvaal. Its work began with a skeleton staff of 2 in 1982, becoming formally established in mid 1983. The Unit was established to work in primary health care in the fields of health services development, health manpower development and community development. This commentary covers some of the work of the Unit in the period 1982 -1984. The report covers the political economy of health and health care in Mhala, the development of some problem-specific health services, the functioning of different health care facilities, the development of a primary health care nurse training programme and an outline of the requirements for a minimum standard health service. The commentary is intended as a contribution to the debate on how to improve health and

If you would like to receive a copy, please complete the form below and send it with an amount of R12.50 to:

Health Services Development Unit
P.O. Box 2
Acornhoek
1360

Name: _____

Address: _____

_____

_____ Postal Code _____

National Progressive Primary Health Care Network

What is "Progressive Primary Health Care"?

The Progressive Primary Health Care Network is a group of health and development projects, health worker organisations and individuals who are committed to an idea which we have called Progressive Primary Health Care or P.P.H.C.

The Network is committed to working together with community organisations such as trade unions, women's organisations and all groups who believe in a democratic society.

Why can't we just talk about "Primary Health Care"?

In South Africa, the term Primary Health Care (PHC) is used to describe any sort of health care that takes place outside of hospitals, in clinics or in the community. We feel that Primary Health Care must include things other than just health care. It is important to consider things like the conditions in which communities live, who health workers are accountable to, the type of health care offered and the attitudes of health workers.

P.P.H.C is committed to changing the poor conditions in which people live, to community accountability, to comprehensive health care and to concerned health worker practice.

History

Since the international declaration of Alma-Ata many people all over the world, concerned about health, have been involved in Primary Health Care. In April 1987 the National Medical and Dental Association (NAMDA) brought together a wide range of individuals, projects and health and community-based organisations to discuss the need for a national PHC strategy.

The Network encourages people to win control over their own lives and to change the conditions in the community which affect health.

P.P.H.C. encourages health workers to show respect and concern for the people they are working with.

At this first national conference the need for a national network to promote PHC was identified. After extensive consultation at local and regional levels throughout South Africa, a second national conference was held in September 1987 and the National Progressive Primary Health Care Network was established. The network includes the five main regions of the Western and Eastern Cape, Northern and Southern Transvaal and Natal, each of which is represented on a national co-ordinating committee.

Aims and objectives of Progressive P.H.C.

In South Africa comprehensive health care is not available to many people. Rich people living in the cities get the best care and poor people in the rural areas whose need is often the greatest get the poorest health care. The problem is made worse by the fact that responsibility for health services is divided between fourteen different departments of health. Also, preventive services are separated from curative services.

P.P.H.C. is committed to equal, accessible, good health services which everyone can afford. We believe that all basic health care should take place under one roof. There should be one national health service.

Poor health is caused by conditions in the community such as low wages, bad housing, inferior education and other such things. In South Africa today, people do not

have the political rights which they could use to change these conditions.

People in the community should be involved in their own health care. They should be involved in both the planning and the running of all health programmes. This is the only way in which the needs of the people can be met. We do not believe that the present government structures such as local authorities, regional service councils and the tricameral parliament represent the wishes of the people.

P.P.H.C. is committed to consulting and working together with the community at all times. In particular, we must make sure that the needs of the poorest people are taken into account.

P.P.H.C. is committed to working together with organisations in the community like trade unions, women's organisations, youth organisations, and all other groups who believe in a democratic society.

Together we can help people to win control over their own lives and change the conditions in the community which affect health.

Health workers should use their knowledge and skills to service the needs of the people. This does not always happen. Most health workers have been trained in an authoritarian, patronising way. They often work in the same kind of system. As a result of this, health workers often behave towards people in the community in an authoritarian and paternalistic way.

P.P.H.C. is committed to working together with people as equals. Health workers should always show respect and concern for the people they are working with. They should share their knowledge with each other and the community. They should be hard working and always try to offer the best health care they can in the circumstances in which they work.

P.P.H.C. is not an easy goal to reach. To be successful, we need to work in an organised and democratic way. We need to discuss, together, the conditions in which we are working. We need to plan carefully and to evaluate our work regularly to make sure that we are reaching our goals. One way of doing this is by working within the Progressive Primary Health Care Network whose goal is to put P.P.H.C. into practice.

Aims of the National Progressive Primary Health Care Network

The aim of the National Progressive Primary Health Care Network is to promote the development of Progressive Primary Health Care in South Africa, as defined and adopted by the National Conference by:

- creating a forum for individuals and organisations involved in health care and development programmes to share their expertise and experience and to learn from each other;

- providing assistance to individuals and organisations involved in existing primary health care programmes and projects;
- offering assistance and support to individuals and organisations involved in setting up new primary health care programmes and projects and the planning of such new programmes and projects;
- conduct a national needs analysis to identify unmet needs and areas that require new initiatives;
- evaluate the need for and capacity to implement regional and local primary health programmes;
- develop a resource and organisational base (including an appropriate health information system);
- assist in initiating demonstration health and development projects in areas where there is currently a dearth of community organisations;
- working together with democratic organisations on issues related to health and health care.

Muldersdrift Clinic - the Network offers assistance and support to existing primary health care programmes and projects.

Structure of the organisation

The network comprises:
- a national conference
- a national progressive primary health care committee
- a finance committee
- members in regions.

Policy decisions, recommended by the National Conference, shall only be implemented if confirmed and approved by all regions. Decisions shall be reached at National Committee meetings on the basis of consensus. Where consensus cannot be reached by the National Committee, the issue shall be referred back to the regions. National Committee decisions shall not be implemented unless confirmed and approved by all regions. At its inaugural meeting and at its annual general meeting, a region shall elect a Regional Committee consisting of at least three members and representatives to the National Committee and Finance Committee.

Who can become a member?

Membership of the network shall be open to any individual, organisation and association who or which supports Progressive Primary Health Care as defined and adopted by the National Conference.

Contact addresses

Head Office/Durban
Suite 204
Lancet Medical Centre
74 Lorne Street
Durban, 4001
Tel: 031-311205

Western Cape
46 Sawkins Rd
Rondebosch
7700
Tel: 021-6856130

Southern Transvaal
Cavendish Chambers
183-185 Jeppe Street
Johannesburg
2000
Tel: 011-235486

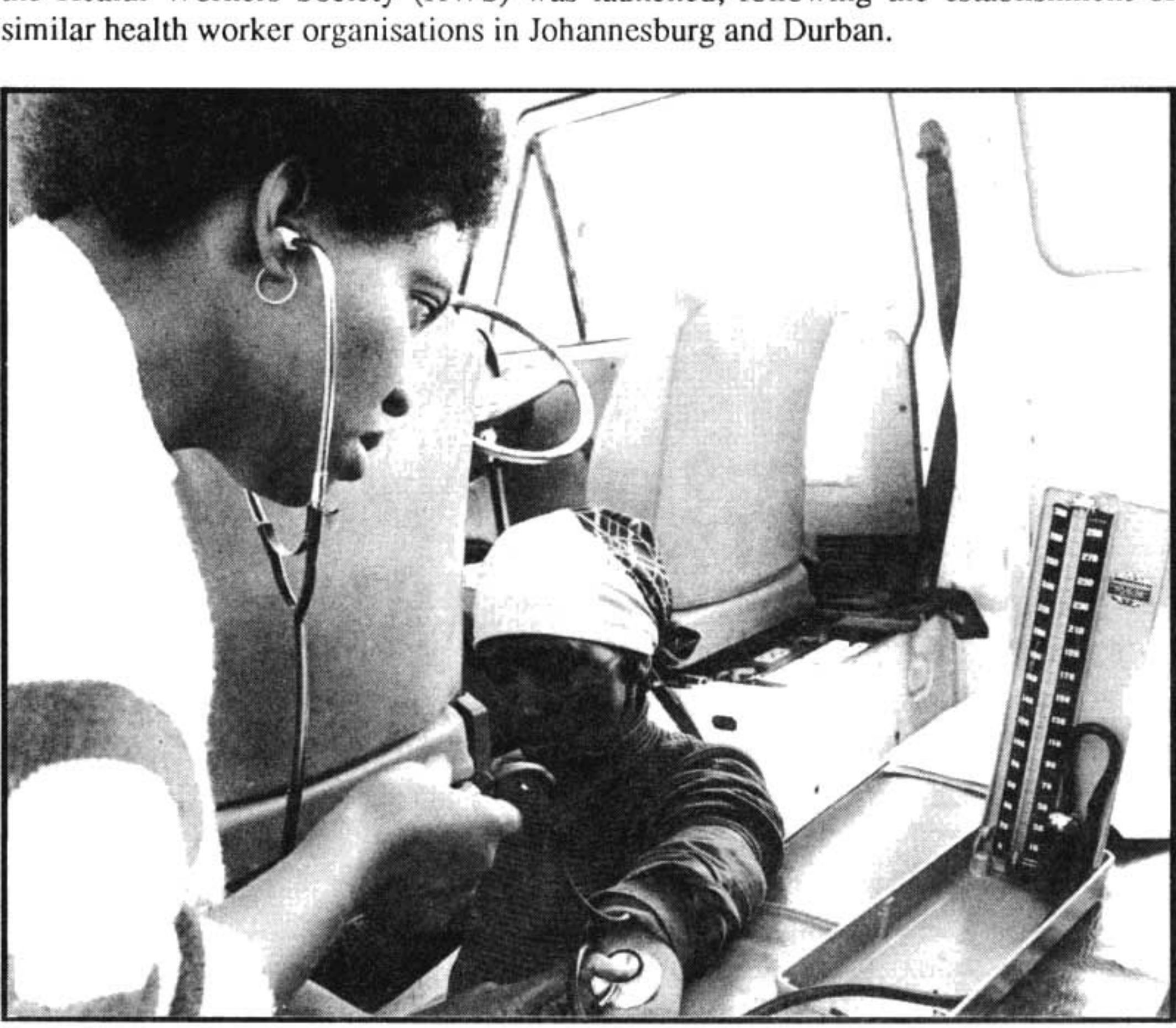
Northern Transvaal
P.O. Box 5404
Pietersburg North
0690

Eastern Cape
P.O. Box 14348
Sidwell
6001
Tel: 041-411618

Health Workers Society

The late seventies saw a resurgence of political activity throughout South Africa; the fight against oppression and exploitation was once again taken up in various ways. Trade unions and community organisations which were being established, were critically examining society and taking up the fight for better living and working conditions.

There was also a growing awareness of the problems related to health such as the inequalities in health care, the deteriorating health status of the majority of people and the exploitation of health workers. However, there was no organisation in Cape Town that could take up these issues in a critical and constructive manner. In October 1980, the Health Workers Society (HWS) was launched, following the establishment of similar health worker organisations in Johannesburg and Durban.



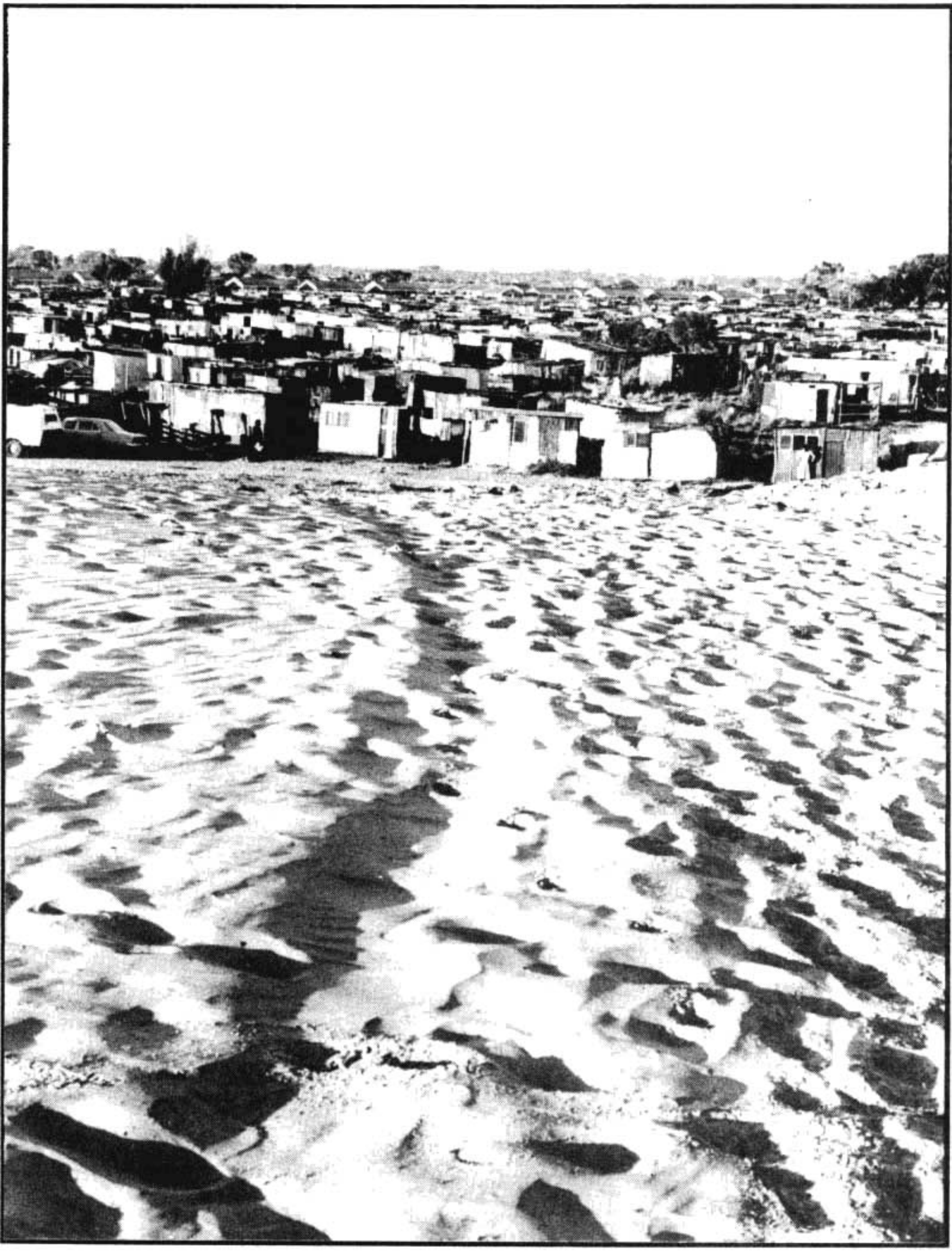
HWS acts as a supportive force for health workers, recipients of health care and communities.

Aims and objectives

- To provide an organisational base for health workers in the Western Cape.
- To promote patient care at all levels.
- To provide a forum for health discussion, opinion and education, with the emphasis on the socio-economic and political aspects of medicine in society.
- To act as a supportive force for health workers, recipients of health care and communities.

The main aim was to build a strong, progressive and democratic health worker organisation, that could effectively participate in broader struggles at a local level. It was also an attempt to critically challenge the domination of orthodox western medicine and promote the health worker concept. In addition, there was a need to develop an understanding of the political economy of health and how best to use this understanding in the community and the workplace. In practice it meant the organisation and unionisation of all health workers, meeting and organising with health workers from other organisations and centres and publishing newsletters and resource material, as well as providing the community with the assistance it requested.

HWS is committed to building and supporting community organisations where the community is actively involved in and in control of a project.



KTC squatter camp - HWS has been involved in a combined KTC-HWS project providing curative services, health worker training and the establishment of co-operatives.

Review of activities

Since its inception, HWS has been actively involved in the following inter-related issues. These have been divided into three major areas for discussion purposes.

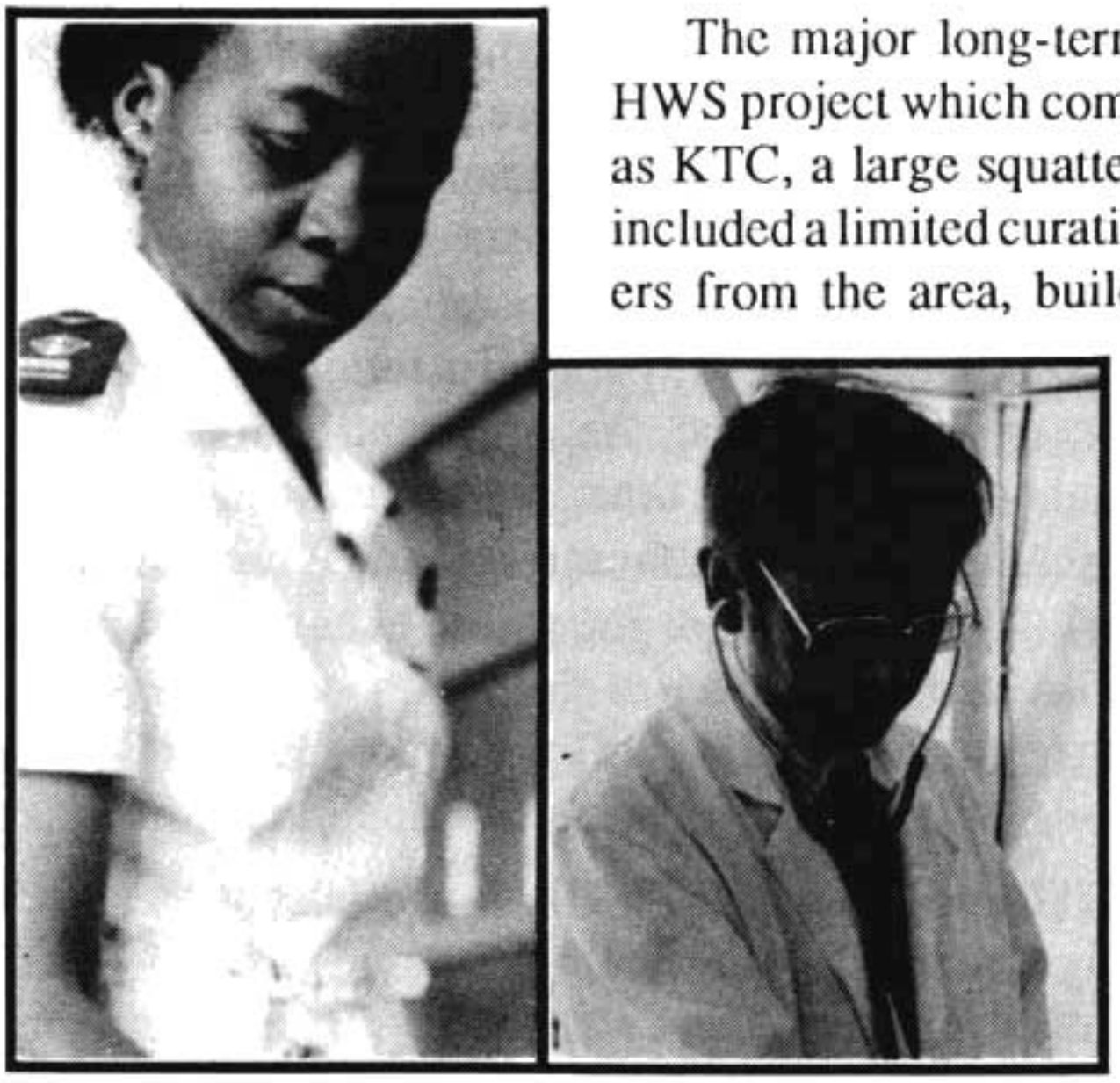
1. Community health related issues
2. Health worker issues
3. Relationship with other organisations

Community health issues

Soon after its formation, HWS organised a workshop with 18 community organisations with the objective of defining the health needs of the community. This included examining how to work towards solving these problems and how a health worker organisation should relate to such initiatives. It was from this gathering and from our own position that the commitment emerged to build and support community organisations, only where the community was in control and actively involved in a project.

Many of the projects were limited in objectives and time span and included screening projects, short term squatter medical relief work, first aid projects, providing medical services at rallies and meetings and first aid facilities at progressive sport activities, campaigns against the high cost of health care and providing resource material relating to health for organisations.

HWS joined the Cape Action League in their campaign for better housing and electricity.



Membership of HWS is open to all health workers.

The major long-term project was a combined KTC-HWS project which commenced in 1985 in the area known as KTC, a large squatter area adjacent to Guguletu. This included a limited curative service, training of health workers from the area, building of a multi-purpose resource centre and clinic and assisting with the establishment of co-operatives. Some aspects of this project were more successful than others. The general problems in the area, the Crossroads - KTC crisis with the burning down of the greater part of KTC as well as the clinic, led to the stopping of the project. During the crisis period HWS set up and ran three relief centres for the displaced people of KTC for four months. Subsequent involvement in KTC included only the training of health workers. At present HWS is involved in training health workers and having general health discussions with groups in Heideveld and Khayelitsha.

Health worker issues

A concerted attempt to organise nurses into a progressive health worker organisation was undertaken soon after the launch of HWS.

Issues discussed in workshops included the exploitation of nurses and the legislation governing their activities and training. HWS also actively campaigned against racism in the South African Nursing Association (SANA). However, it soon became evident that it was extremely difficult to organise nurses. Reasons included apathy, fear of victimisation and the bureaucratic control over nurses.

In the early eighties, attempts to organise health workers into formal trade union structures were attempted by the progressive trade unions but were unsuccessful. Attempts to get the public service organisations, such as the Public Servants League, to adopt a more progressive position also failed because of the conservative nature of these bodies. In April 1985, HWS set up the Health Workers' Advice Office, to assist health workers with specific work-related problems and in the long term, to assist in the establishment of a trade union for health workers. By December 1985, workers' committees had been set up at a number of hospitals and the Health Workers' Union

(HWU) was launched. This was the first union in the Western Cape that specifically organised health workers. At present mainly general workers are being organised. Since the launch the union has been operating completely independently of HWS, but HWS has been assisting the union when requested.

In 1986, HWS together with HWA (Health Workers Association - Transvaal) and HWO (Health Workers Organisation - Natal), arranged a national meeting in Cape Town where unionisation of health workers was discussed. An important feature of that gathering was that it brought together, for the first time, representatives of HWU, General Allied Workers Union (GAWU) and Health and Allied Workers Union (HAWU) for informal discussions.

Relationship with other organisations

Since its inception, HWS has had informal contact with HWA and later with HWO. From 1983 regular national meetings were held where common issues were debated, projects discussed and strategy planned. One issue that was frequently raised was the formation of a national health workers organisation. This subsequently became the focus of a national gathering of the three organisations in Cape Town in April 1988. At this meeting HWA and HWO made it clear that a prerequisite to being part of a national organisation was the adoption of the Freedom Charter. HWS felt that it could not be bound by this particular position. The reason for this decision is that the membership of HWS consists of individuals from different political persuasions. It was felt that our organisation should remain non-aligned as we had adopted a non-sectarian position and that we work with all progressive organisations. The focus of our activity, that is organising around health, is in itself a non-sectarian issue. In other words, an issue that should not be restricted by a particular doctrine or belief or by being affiliated to a specific grouping.

HWA and HWO subsequently formed the South African Health Workers Congress (SAHWCO) in March 1989.

In 1984, HWS formed part of NCOHO (National Committee of Health Organisations) which successfully campaigned against the World Medical Association (WMA) congress being held in South Africa. Progressive organisations held the view that such a congress, held here, would only strengthen the Medical Association's (MASA) international standing as well as create a favourable impression of health in South Africa.

HWS is also participating in the ESG (Emergency Services Group) which provides for medical services during crisis situations as well as the ongoing care of detainees through the detainees clinic. We also participate in the Western Cape Progressive Primary Health Care (PPHC) group as observers.

We were actively involved in the Cape Action League (CAL) since its inception in 1982, and were actively involved in its activities, for example the anti-election

campaign and housing and electricity campaigns. In mid 1986, HWS disaffiliated from the CAL because the membership felt that HWS as an organisation should be non-aligned and non-sectarian and thus work with all progressive organisations.

Membership

Membership is open to all working within the health sector as well as students and any person interested in promoting the aims of HWS. This is a deliberate attempt to engage the largest number of people in the health debate and to reduce the control and influence of professional groupings. There is an executive committee with subcommittees around the various projects, for example, education and training, labour and emergency services.

Future plans

We see ourselves continuing as we have in the past in an attempt to meet our objectives. We hope to expand our activities to this end. Our ultimate goal is to work towards a health system that is free from exploitation and oppression and we know that it is imperative to engage the people of South Africa in this process.

Contact address

HWS
P.O. Box 481
Salt River
7925
Tel: (G. Hussey) 021-7616167

OASSSA

ORGANISATION FOR APPROPRIATE SOCIAL SERVICES IN SOUTH AFRICA

OASSSA is a national organisation for progressive mental health and social service workers. It is an organisation committed to a free, unitary, non-racial and democratic South Africa. It recognises the link between politics and mental health, and recognises the devastating effects that apartheid has on mental health. OASSSA's work highlights these effects and tries to assist victims of apartheid as well as developing new and more appropriate models of mental health care. This article will concentrate on work and activities in the Transvaal.

History of OASSSA

In 1983 an international conference on family therapy was held at Sun City. A group of progressive psychologists saw the contradiction of a conference on family therapy in a so-called "independent homeland" which contributed to the breakdown of family life. These psychologists organised themselves into a group to protest against the conference and to highlight the plight of families in South Africa, particularly those affected by migrant labour and by the apartheid system in general. They also organised an alternative workshop entitled "Families in South Africa". This workshop explored those factors which disrupt family life in South Africa. It was the start towards finding more appropriate roles for helping professionals in South Africa.

The group which originally began as a protest against a conference, gradually developed into an organisation of progressive people concerned with mental health and social service issues. Existing mental health or social service organisations were not dealing with those issues pertinent to South Africa in the early 1980's and OASSSA was formed to fill that gap.

OASSSA started in the Transvaal in 1983. Branches were formed in the Western Cape, in Durban and in Pietermaritzburg in 1985, 1986 and 1987 respectively. Presently there are possibilities of branches forming in other areas.

Aims and objectives

OASSSA is committed to the mental health and social welfare of South Africa's people and to the development of appropriate social services. We are aware that in South Africa there are specific economic and political structures which contribute to most social and personal problems. Apartheid and economic exploitation provide the base for poor living conditions, work alienation and race and sex discrimination which are harmful to mental health. Our commitment as social service workers demands that we continually expose the effects of these conditions and participate in efforts to change the structures that underlie them. We are committed to working together with other democratic organisations which are involved in the same or similar efforts.

We need to identify and overcome the limitations which restrict our efforts. These include restrictive and unjust legislation, the isolation of the various mental health disciplines and the control of skills by a professional elite. In order properly to serve our community, we must work for a broad and unified discipline, for the sharing of knowledge and skills with the community at large and, ultimately, for an economically just and democratic society.

Progressive psychologists objected to a family therapy conference which was held at Sun City, Bophuthatswana in 1983. They felt the homeland system disrupted family life.

We therefore aim to:
- unite social workers, psychologists, psychiatrists and other social service workers who are interested in working towards appropriate social services in South Africa;
- examine and research the causes of social and personal problems as extensively and as rigorously as possible;
- service and aid progressive organisations;
- reduce disciplinary isolation and define and work towards a unified discipline of social service;
- provide a forum for the discussion of existing social services and protest actively against these where they are inappropriate;
- share our knowledge and skills as widely as possible through workshops, conferences, publications, the establishment of a resource centre and involvement in the community;
- develop models of appropriate social service and assist wherever possible with their implementation.

(These aims and objectives are quoted from the OASSSA Statement of Principles.)

Structure of OASSSA

OASSSA is a national organisation presently comprised of four branches. A national executive consisting of two elected representatives from each branch meets four times a year to discuss national policy, finance and other relevant issues. Decisions are ratified at national meetings.

Each branch has an executive which is elected at the annual general meeting. The monthly general meeting for all members is the decision-making body in the organisation, and provides the forum where issues can be debated and decisions made in a democratic way.

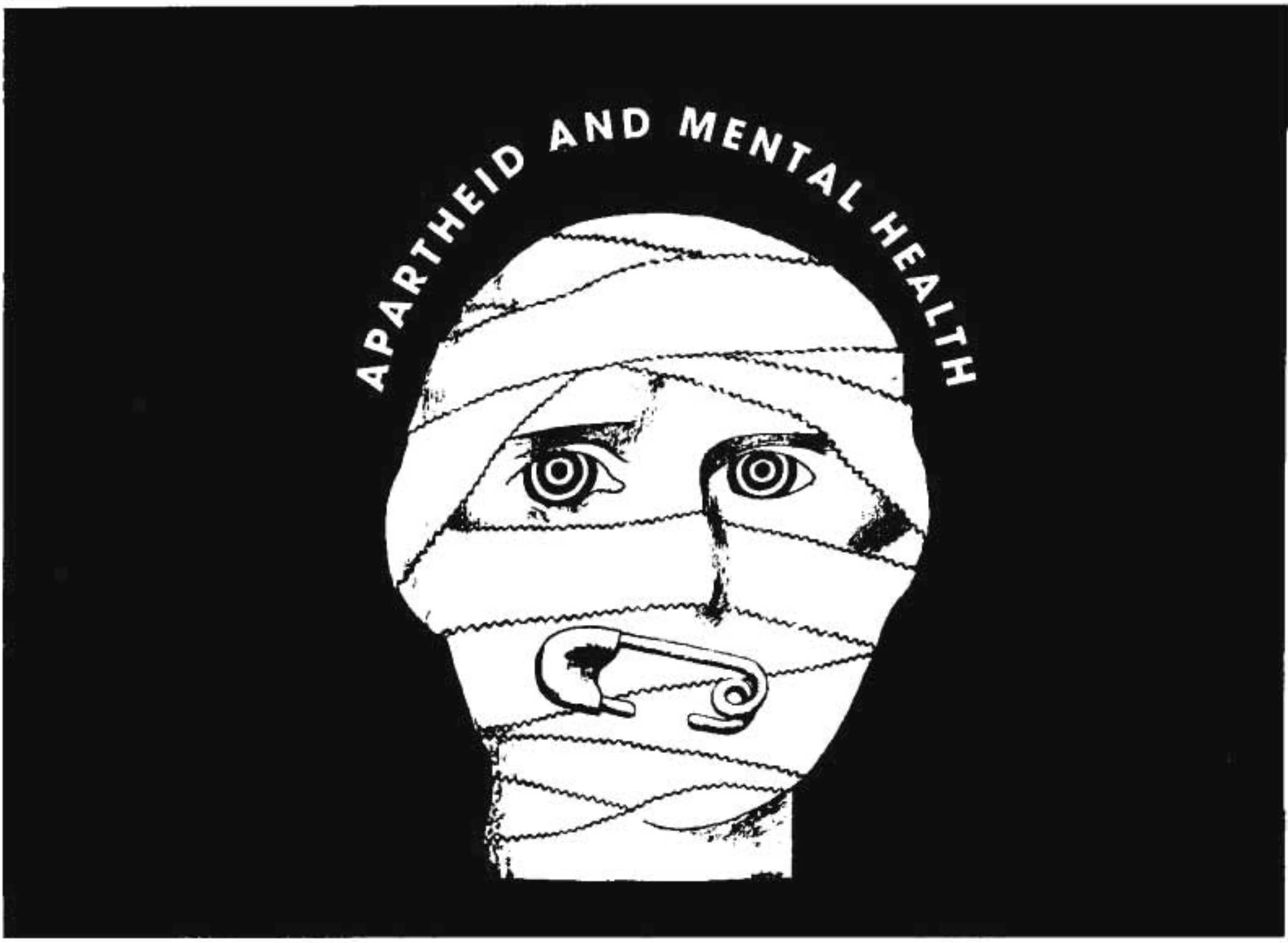
Decisions made at executive level are ratified at general meetings. There is branch autonomy to decide what work should be undertaken at a local level, but issues of national concern are discussed at national level.

Activities and campaigns

OASSSA (Tvl) is involved in the following activities and campaigns:

Detainee counselling

OASSSA (Tvl), together with Concerned Social Workers (CSW), NAMDA and other



OASSSA believes that apartheid and economic exploitation is incompatable with mental well-being.

mental health professionals help run the Detainees Counselling Service (DCS). DCS operates on a week-day basis and released detainees are seen and treated by doctors and mental health professionals. Many OASSSA members provide counselling to ex-detainees and assist in teaching study skills.

Research

OASSSA's Research Group is mainly involved in gathering information about the effects of the economic, social and political situation in South Africa on mental health. OASSSA responds to requests for research from unions, community organisations and from its own interest groups. Research that has been undertaken includes an investigation into parental rights which was used in trade union negotiations. The OASSSA Research Group is also providing information on job related stress and investigating the plight of security workers. Khanya College students in Johannesburg have been incorporated into OASSSA research projects to investigate existing social services in the townships.

Training

OASSSA members have always been involved in training people in counselling skills. Members of community organisations, church field workers and advice officers have been trained. The training not only includes imparting counselling skills, but placing mental health in its political context. A counselling training manual has been produced which provides information on counselling techniques and details common and uncommon stress responses and ways of dealing with them.

Media and education

OASSSA's Media and Education Group compiles and distributes information. OASSSA's internal education programme educates its members both politically and in terms of appropriate mental health practices. Annual conferences and occasional educational meetings are held which are open to the broader public.

OASSSA publishes a national newsletter twice a year, in addition to a more frequently appearing local newsletter. These newsletters keep members informed about happenings and meetings within the organisation, as well as current debates and articles.

This group also compiles information for communities, depending on particular needs. Pamphlets have been produced on the adverse effects of apartheid on mental health, on ways of dealing with stress caused by living in such repressive times and understanding and coping with the psychological effects of detention.

The media published by OASSSA is available, on request, from the contact addresses provided at the end of this article.

Campaigns

As part of the progressive movement, OASSSA responds to and participates in current campaigns. Presently, OASSSA (Tvl) is active in Save the Patriots and in the support of the hunger strikers.

Conclusion

As a long term aim, OASSSA is working towards adequate and appropriate mental health care for all people, with control over one's own mental health, as well as appropriate and adequate social services. OASSSA is aware of the numerous health and mental health organisations within the democratic movement and is part of the groupings working towards unity within this sector.

Together with other organisations, OASSSA helps run counselling services for ex-detainees.

Contact addresses

OASSSA (Transvaal)
607 Cavendish Chambers
183 Jeppe St
Johannesburg
Tel: 011-234714

OASSSA (Durban)
P.O. Box 17383
Congella
4013

OASSSA (Pietermaritzburg)
P.O. Box 10415
Pietermaritzburg
3200
Tel: 0331-420080

OASSSA (Western Cape)
5th Floor Leger House
Aden Avenue
Athlone, 7764
Tel: 021-6386318

By Julie Green, OASSSA, Transvaal.

Concerned Social Workers

When Concerned Social Workers (CSW) first constituted itself, we saw one of our immediate tasks as organising social workers in the greater Johannesburg area. While a number of social workers were sympathetic to attempts to challenge social work practice in South Africa and to begin to define alternatives, few of these people were prepared to actually form an organisation and this became a site of struggle itself. As a result, the organisation focussed on problems and experiences of social workers working in an unjust society. We found that many people had similar problems and had to face particular frustrations. We attempted to show people the importance of forming an organisation and the necessity of collective action and resolution of difficulties, rather than experiences remaining as isolated concerns and grievances.

Organising social workers

The task of organising social workers is to a large extent undermined by the particular ethic of professionalism that exists for most health workers in South Africa today. As with other professionals in South Africa, the codes of conduct and working are largely defined by the apartheid system itself. Not only do many social workers actually work for the state but most social workers are taught to accept values and ethics which are in fact removed from the reality of social work practice in South Africa today. Social workers, as with other health workers, tend to become overwhelmed by the enormity of problems faced by their clients and so develop a way of coping which fails to challenge in any way the causes of these problems.

Providing alternatives

While the task remains central to our everyday functioning, we have managed over the past few years to strengthen our organisation and incorporate more social workers into the group. We have been able to do this by educating social workers and by providing alternatives to the views expressed by the state around the role of social workers in our

society. By working with other progressive organisations we have also been able to put people in touch with alternative forms of organisation and to stimulate debate and discussion around the possibilities that exist for a post apartheid society. At the same time social workers have been able to participate in services and campaigns which are directly challenging the effects of repression and deprivation evident in our society.

Practising social work under repression

Because social workers work primarily with people in need, in the present South African context this often involves people who have been directly or indirectly affected by state repression. CSW has seen one of its roles as providing a service, together with other organisations, to people affected by detention, disappearances and other forms of state violence. While repression remains prevalent, CSW will continue to see itself playing an important role in this regard.

Participation within initiatives dealing with the effects of repression, has also had the important effect of raising awareness about social work practice and how skills can be used effectively.

While this activity has been undertaken by a number of members, we feel that we still need to involve more social workers in contributing to these services.

Social work in a post apartheid society

CSW will continue to see its role as contributing to a critical understanding of social work practice at present and to the development of an appropriate social work practice in a post apartheid society. We have attempted to do this in two ways. Firstly, by focussing on these topics in our official publication *In Touch*, and secondly by attempting to generate and encourage research into these areas. One of our most positive campaigns has been activity and education around the new welfare policy proposed by the government. CSW, together with other social work associations concerned with the governments initiatives, has attempted to educate ourselves about the proposals and to pressurise the government into reconsidering its plans. We have been able to generate significant opposition to the government and to provide alternatives and have also been able to contribute to a national initiative to oppose the new welfare policy.

We remain committed to educating the social worker population as a whole. This means trying to continually reach social workers who are not politically active but who, through their experiences in practice have an innate abhorrence to the devastation to people's lives as a result of the apartheid system in South Africa.

Membership, structure, campaigns and activities

Membership of CSW is open to all social workers and associated workers. The structure of CSW is based on a three tier system, which was established to facilitate the effective function and co-ordination of CSW's work and activities. The structure comprises of an executive, a council and a general forum. Members come together at general forum meetings which are held once a month. This provides both an educational and supportative forum. Members of CSW are also involved in different subgroups which operate independently of each other.The subgroups include:

The detainee service subgroup

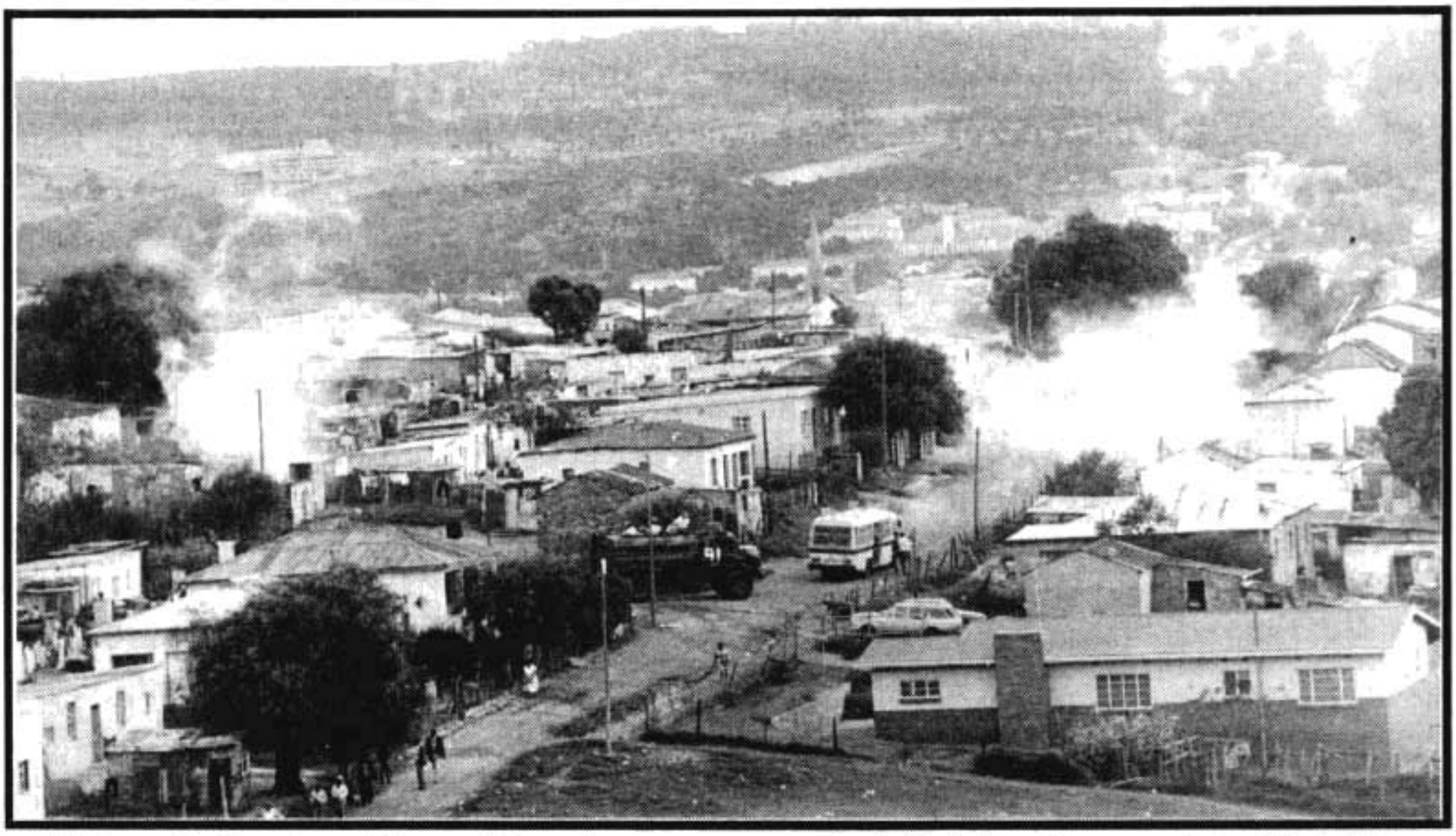
The activities of this subgroup include:
- involvement in support work at tea parties for, and visits to, families of detainees;
- counselling of ex-detainees;
- training and follow up services of social workers in the area of detention;
- active participation in campaigns around the release of all detainees.

The media subgroup

The media subgroup is responsible for producing any publication put out by CSW. A writers workshop has in the past been held for members of the media subgroup focussing on developing writing and editing skills. CSW publications include:
In Touch - a quarterly newsletter addressing relevant issues and concerns related to the social work profession as a whole;
Towards People's Welfare - by Leila Patel;
Special AGM Publication - August 1988;
Annual Report of CSW - September 1987 - September 1988;
Creche Facilities at Conferences - a handbook.
(These publications are available on request from the contact address given at the end of this article.)

Education subgroup

This group organises workshops, seminars and lectures around areas which promote the thinking and awareness of social workers in South Africa as well as addressing areas of difficulty in the social work profession. Areas that have been addressed include:
- social workers' working conditions;
- constraints and challenges in social work practice;



Violence in Joza township - social workers cannot practice in isolation from a society affected by apartheid.

- social advocacy;
- the legal rights of our clients;
- privatisation of social work services.

Welfare policy subgroup

This group functions as a response and action group around areas relating to welfare policies in South Africa. A conference was organised together with the South African Black Social Workers Association (SABSWA), Johannesburg Indian Social Welfare Association (JISWA), Society for Social Workers, and CSW in order to encourage debate around the implications of the new welfare policy. The new welfare policy was passed approximately a year ago by parliament, basing the South African system on two fundamental principles: privatisation of social welfare and the principle of racial differentiation. A further conference is to be held shortly in order to continue this debate.

Children under repression subgroup

This subgroup continues to campaign around the issue of children who are victims of repression. This was initiated by a conference in 1985. A year later, an alliance of concerned organisations was established calling for the release of all children in prison.

This subgroup has broadened its activities by becoming involved in the training of creche workers and community workers. The subgroup has also held a panel discussion on child abuse within the South African context and continues to organise around issues which are pertinent to the repression and daily living of all children in South Africa.

Research subgroup

CSW is in the process of developing a research group. While individual members are involved in research which is addressing a critical approach to social work in South Africa, this has been identified by CSW as an area which needs to be developed further. Further subgroups and activities may be developed by CSW if a need arises which falls within the aims and objectives of the organisation.

Working statement of the CSW

Our vision for South Africa

In accordance with our values we, as social workers, are concerned with the quality of life of all the people in our country. We stand for a united, non-racial and democratic South Africa where all people will receive economic, social, health and educational security. We strive to unite all social workers to work towards the removal of all forms of oppression and exploitation.

Our vision for the welfare system

As social workers we commit ourselves to a unified and equal welfare system, where services will be available to all who need them.

Our method

Proactive: We strive to work alongside individuals, groups and communities in developing together the necessary skills and resources to respond to the challenges and demands placed on everyone by the apartheid society in which we live.

Reactive: We endeavour to respond appropriately to the needs of our clients and to be sensitive to new needs emerging. In facing this challenge we seek to address such issues as people's experience of all forms of violence, poverty, unemployment and the

disruption of family life. We commit ourselves particularly to the attainment of the rights of children. We oppose any legislative measures which may be of disadvantage to our clients and colleagues.

Education, organisation and support of social workers

As social workers we need to develop an understanding of the changing sociological, economic and political factors which impinge on the people we serve. We commit ourselves to supporting social workers, especially social workers who themselves are victims of the broader structures, to challenge the constraints which restrict and limit them.

We see social work students as being actively involved in the activities of CSW and in our quest to attain these objectives.

We will also link, collaborate and unite with social work associations, welfare organisations and progressive social service groupings where appropriate.

In developing our knowledge and skills we seek to stimulate debate around alternatives to the present welfare system, so that we may respond effectively to our clients' needs.

Accountability

We are accountable to our clients who are predominantly those who experience the oppression and exploitation in South Africa. We strive for the inclusion of our clientele in the organisation and delivery of social services. Thus, we commit ourselves to actively building links with the sectors of the progressive movement which encounter welfare concerns, e.g. women's groups, health services, educational and trade union initiatives.

We believe that CSW is a dynamic organisation sensitive to the needs of our clients. Therefore this document cannot be seen as a permanent statement of our vision and method, but will evolve in response to the demands made on us as social workers by the progressive movement and social workers themselves.

Contact address

Concerned Social Workers
P.O. Box 301
Wits
2050

Critical Health back issues

Titles

A Tribute to Neil Aggett - Issue no.7,1982
Focus on Health Services - Issue no.10, 1984
Health Services: International edition - Issue no.11, 1984
Townships - Issue no.12, 1985
Health Care Under Siege - Issue no.13, 1985
Health Care: Who can afford it? - Issue no.14, 1986
Health Worker Organisation - Issue no.15, 1986
Community Health Projects - Issue no.16/17, 1986
Privatisation: health at a price - Issue no.19, 1987
New Directions in Health Care - Issue no.20, 1987
Organising for Health - Issue no.21,1987
Nursing in S.A.: The need for challenge and change - Issue no.24, 1988
S.A. Medical Education: Ivory tower or community-based? - Issue no.25,1988
Detentions and Hunger Strikes - Issue no.26, 1989

Local Price: R2.00 per copy (includes postage)
Overseas: 3 Pounds/ 4 Dollars

Dissertation Series

Health Care Beyond Apartheid - By Max Price. Diss no.8, 1987

Local Price: R4.00 (includes postage)
Overseas: 4 Pounds/5 Dollars

Enclosed please find __ __ for issue nos: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Name: _

Address:_ _

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Postal code: _ _ _ _ _ _ _ _

Send to: Critical Health, P.O. Box 16250, Doornfontein, 2028, South Africa.

SUBSCRIBE!

CRITICAL HEALTH is a quarterly publication dealing with health and politics in South Africa.

CRITICAL HEALTH aims to:

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

1988 subscription rates:

<u>LOCAL:</u>			
Students, workers			R 7.00
Salaried Individuals			R12.00
Organisations			R20.00
Donor subscriptions:	R20.00	R30.00	R50.00
<u>OVERSEAS:</u>			
Individuals			UK 8.00 pounds US 12.00 dollars
Organisations			UK 15.00 pounds US 20.00 dollars

NAME: .....

ADDRESS: .....

.....

..... postal code .....

Enclosed please find R ..... for my annual subscription.
Send to: Critical Health, P.O. Box 16250, Doornfontein.
Johannesburg, 2028.