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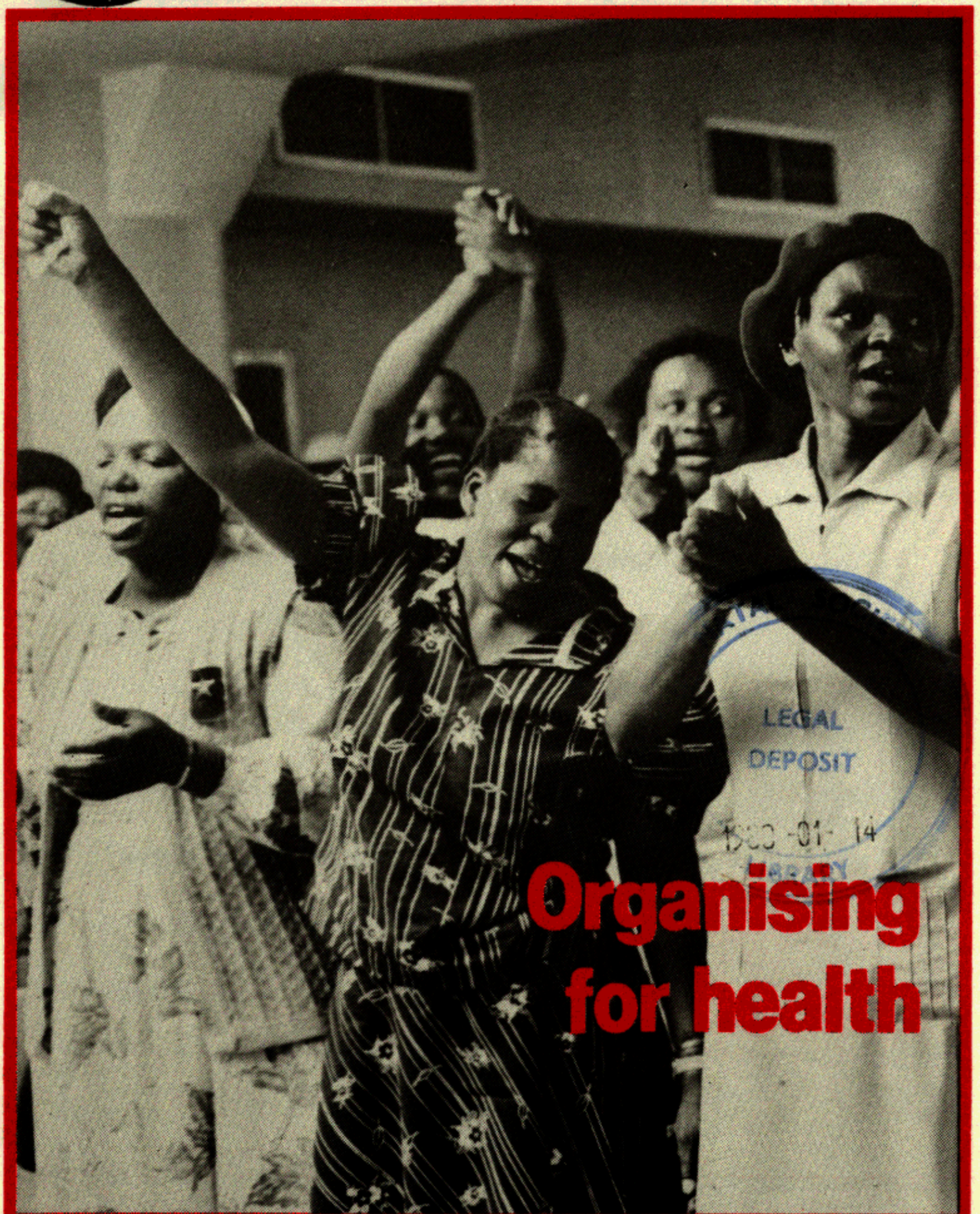
Critical Health

Number 21 December 1987



Organising for health

Critical Health

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Contents

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Editorial

This issue of *Critical Health* focuses on worker and community organisation around health care and on struggles for the re-organisation of the health sector. The process of producing this issue involved consulting those organisations on their current work towards, and their envisaged role within a National Health Service. Most of these organisations are presently faced with the unequal distribution, inaccessibility and low standards of health care facilities. Nevertheless, they have initiated steps to formulate and actively demonstrate primary health care approaches different from those envisaged by the State.

Presently, debates are taking place on evolving criteria for *progressive* primary health care. The first article in this issue, 'The Struggle for Health' contributes some criteria to the discussion. Taking the struggle for justice and community empowerment as guidelines, the article distinguishes between community supportive and community oppressive programmes.

An example of a community supportive programme can be found in the objectives of the Sarmcol Workers' Co-operative. The article on this co-operative shows how progressive worker organisation is carried over from the workplace to the community. Both the health profile and the organisational forms of the Sarmcol workers show the close interrelation between living and working conditions.

Health as a political demand, tied to people's living and working conditions and the attainment of political rights, is also recognised in the Freedom Charter. However, health demands in the Freedom Charter are only minimum demands for progressive health workers and other organisations. A Health Charter Campaign was therefore initiated to take the demands of the Freedom Charter further.

The Freedom Charter has been adopted by the newly established National Education, Health and Allied Workers' Union (NEHAWU). The problems faced by the Union are largely the problems of non- classified workers in the health sector.

Excessive divisions in the health sector affect not only health workers, but also the people whom they serve. This is one of the concerns voiced by disabled people. In addition to the generally inadequate and unequal nature of health care services, they find that health professionals do not meet their health care needs. Disabled People South Africa (DPSA) therefore calls for the inclusion of an experienced disabled person in the health team.

Community involvement in mental health care is emphasised by the

Organisation for Appropriate Social Services in South Africa (OASSSA). Like DPSA, they advocate the inclusion of experienced lay people in the health team - in this case, as counsellors.

This view is endorsed by Maforah's work relating to the improvement of mental health services at Bophelong in Bophuthatswana. She recommends that mental health professionals collaborate with indigenous healers in treating psychological symptoms and that the curricula of psychological and psychiatric courses be adapted to better reflect the needs of local conditions.

While all these organisations have contributed to the development of new, alternative approaches to primary health care and health worker organisation, they emphasise that these alternatives need to be accompanied by broader political changes. Unless this happens, the 'new' health worker could degenerate into a typical civil servant geared to pacify the oppressed. Primary health care programmes should not only work towards improving people's health status, but also increase people's control over their own health conditions and the delivery of health care.

The struggle for health

This article focusses on the struggle for health from the perspective of the political economy of health. The "political economy of health" refers to those political and economic factors that influence people's health. Previously, the idea was marketed that ill health was a misfortune that scientific medicine was in a position to combat. This view is now discredited. It is clearly recognised that ill health, in both developed and underdeveloped countries, is largely a product of the social and economic organisation of society.

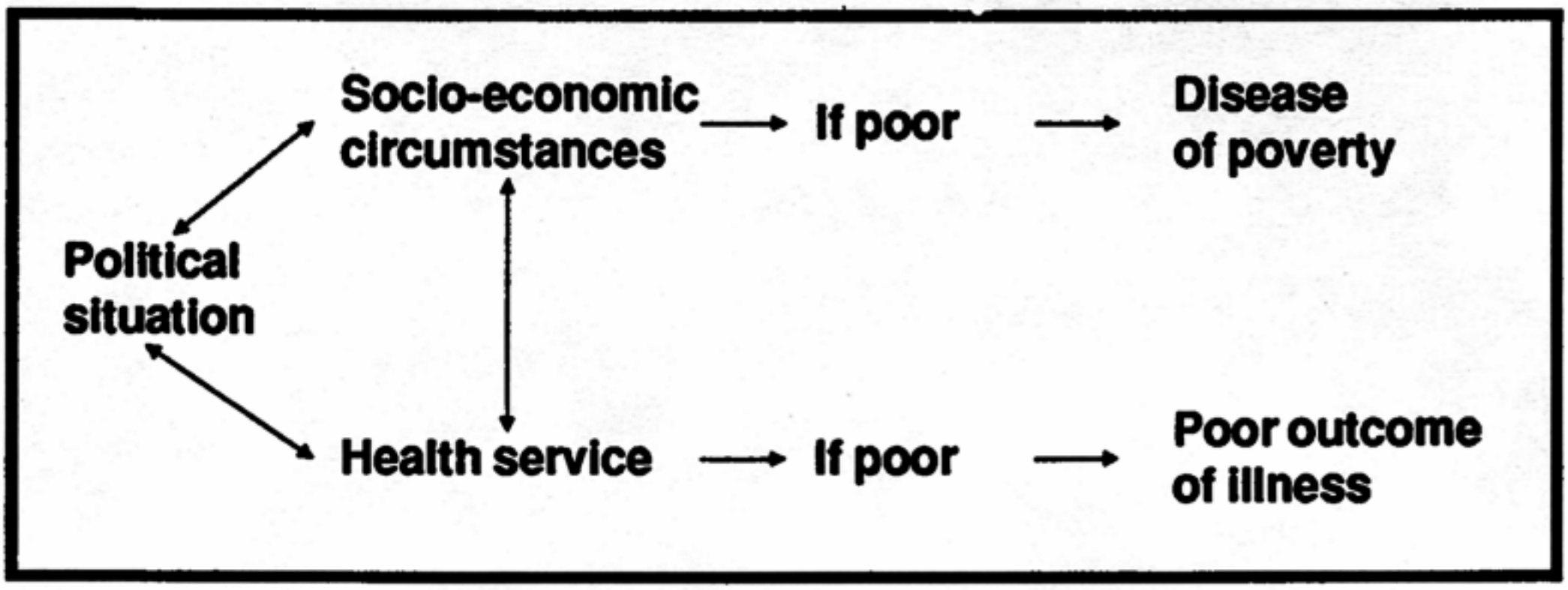
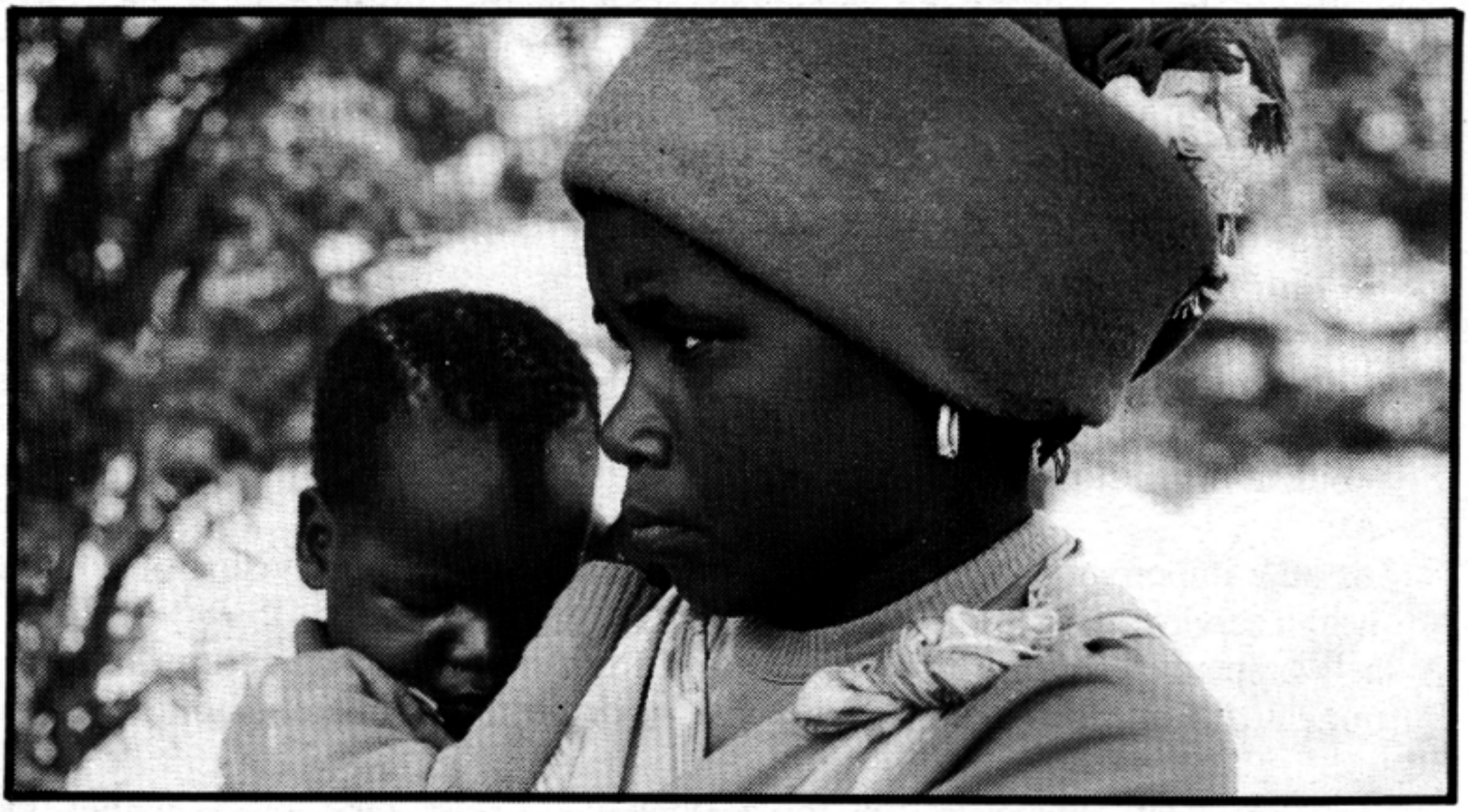


Figure 1: The political economy of health

Figure 1. depicts the political economy of health. It indicates that inadequate socio-economic circumstances lead to diseases of poverty, such as tuberculosis and typhoid, while excesses lead to the diseases of affluence, such as coronary artery disease. Socio-economic circumstance explains why people get ill in the first place, while the nature of the health service often explains the outcome of the episode of illness. Thus, because health services in the developing world are often inadequate and inappropriate, diseases that are simple to treat, such as diarrhoea and pneumonia, are killers. Needless to say, people's socio-economic circumstance and the health services they receive are themselves primarily influenced by the political situation. This applies both to world politics and the politics within countries.



Child blinded by measles: Because of inadequate health services, diseases simple to cure may become killers

In South Africa, the gross national product is large enough to drastically reduce both the prevalence of the diseases of poverty, and the often negative outcome resulting from the inadequate health services provided to many South Africans. The politics of class and racial oppression work together to block needed change, and thereby ensure that the injustices of our society are expressed in the health status of our people.

What is the end point being aimed for?

This article will focus on the health service aspect referred to in figure 1. This health service end point was well defined some 30 years ago at the Congress of the People:

"A preventive health scheme shall be run by the state;
free medical care and hospitalisation shall be provided for all,
with special care for mothers and young children." [1]

Today we recognise that the only way to meet these criteria is through a national health service that follows the progressive primary health care approach. A national health service (NHS) refers to a single, nation-wide, state-run health system, with centralised co-ordination and decentralised implementation of policy.

We need to understand that the commitment to a national health service is based not only on the grounds of social equity, but also on those of

cost-efficiency. In spite of the attempts to popularise privatisation, an NHS remains the most efficient mechanism for the use of health sector resources.

What is the nature of the struggle for health?

The struggle for health is clearly rooted in, and forms part of, the broader struggle in our society. This struggle is aiming to:

* promote discussion about, and planning of, the health service for a future South Africa;
* institute important changes now that are compatible with our vision of a future health service;
* help prepare the ground for the future transformation of the health service;
* mitigate the impact that state repression has on the health of communities.

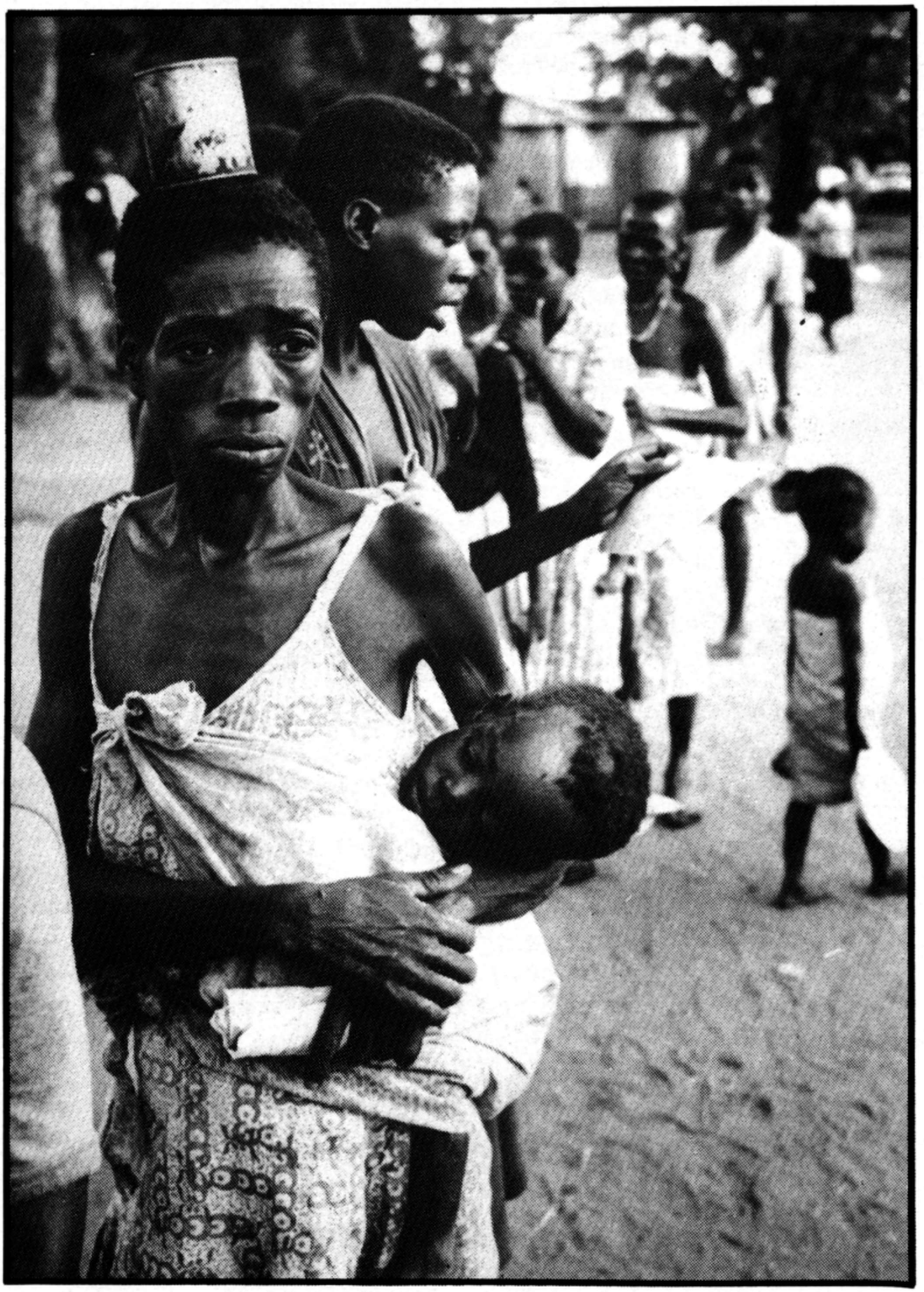
The practical expression of these objectives must take place within the framework of the broad democratic struggle. This is where the struggle for a peoples' health service will be won or lost. At the same time, we need to recognise that health and health care issues have much to offer community organisation. For example, community organisations may mobilise around, and gain credibility from, their concern with health issues. Similarly, an understanding of the political economy of health can contribute to a clearer understanding of the political economy of our society as a whole.

However, health and health service issues have not yet played their full part, either in the struggle for democracy or in the struggle for appropriate health care.

What is meant by the practice of primary health care (PHC)?

The Declaration of Alma-Ata,[2] which defined primary health care (PHC) and launched the worldwide commitment to it as the means for attaining the goal of "Health for All by the Year 2000", is essentially a political statement. There are three central elements to the definition of PHC, the attainment of which require political will and commitment.[3,4,5,6] They are:

* An attack on the socio-economic causes at the root of poverty.
* A redistribution of health sector resources to ensure equity, universal access, and the provision of essential health care to all; and to make community health care the main focus of the health service.
* The supportive and progressive practice of health care.



The injustices of our society are expressed in the health status of our people

It is important to clarify what is meant by the concept of "progressive practice". Simply working on the right sort of area, does not neccessarily mean that work is being done in the right way. The process itself is crucial.

David Werner, in a review of a number of programmes in Central America, all of which were assumed to be concerned with primary health care, suggested that the programmes fell somewhere along a continuum between the two diametrically opposing poles of being community supportive or community oppressive, where:

> "*Community supportive* programmes are those which favourably influence the long range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making and self reliance at the community level, and that build on human dignity."

In contrast, he refers to:

> "*Community oppressive* programmes which, while invariably paying lip service to the other aspects of community input are fundamentally authoritarian, paternalistic, or are carried out in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; and those which, in the long run, are crippling to the dynamics of the community." 7

A UNICEF/WHO joint committee on health policy[4] took this understanding further by looking at the process in different socio-political circumstances. They pointed out that in politically unfavourable situations of repression and economic and social control, the state will tend to run a community oppressive health service, with excellent care for the rich and second-class care for the poor.

The services provided for the poor are then often marketed as being good services, so that with the uninformed satisfaction of the poor, the potentially explosive effects of perpetuating such inequality is neutralised.

Primary health care is therefore a process that can be practiced in a community oppressive way. This can occur if we try to force an unpopular service on people, if we behave in an elitist and arrogant fashion, or if our pattern of community participation makes lackeys of communities. We need to remember that the goals of PHC are social justice, a reorientation of health services and community empowerment.

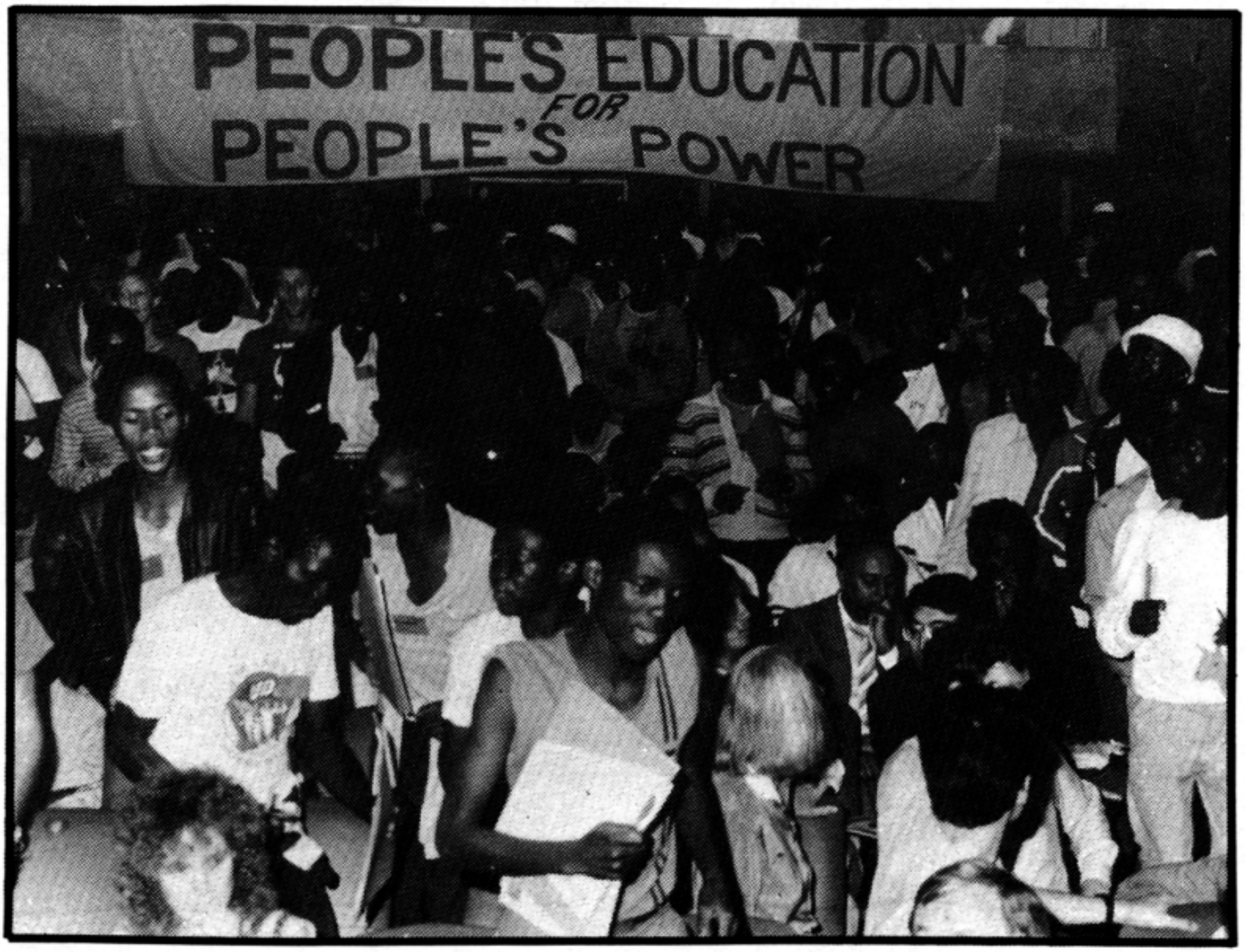
What are the threats to the struggle for health?

The major threats to the struggle for health are those factors that threaten our broader democratic struggle. However, what is not as well known are the more

specific threats to health from within the health sector. Increasing privatisation and the worsening fragmentation of health services pose the best known threats. In the future there will be difficulties in transforming the health service due to factors such as the demands of the affluent and of the health professionals.

We need to do all we can to oppose these threats, but there is another threat - the threat posed by our inadequacies as progressive health workers. As we are not always familiar with the meaning of progressive health work, we may practice in a way that contradicts our political beliefs. This may occur in the services we build, in how we interact with community organisations, in our training of health workers, or in our care of an individual patient.

Another expression of our inadequacy is that health and health care issues are not playing their full role in the democratic struggle. Communities are familiar with problems of housing and education and with potential solutions to these problems. They do not however, have the same insight and vision into their health and health care needs. Unless this happens, the health service that emerges will never become a true national health service based on the primary health care approach. This must surely be the biggest threat in the struggle for health.



Communities are familiar with problems of housing and education. They do not, however, have the same insight and vision into their health and health care needs

Conclusion

What has been discussed in this paper is background and philosophy. It will only be of help if the concepts are translated into concrete plans of action and implemented successfully. We all have an idea of what needs to be done, the urgency is to make it all happen in practice.

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This is a shortened version of a paper delivered at a health care workshop, October 1987 by Eric Buch, Centre for the Study of Health Policy.

The Sarmcol Workers Co-operative health project

In the Sarmcol Workers' Co-operative, structures of progressive worker organisation have been carried over from the workplace into the community. The following project description focuses on the role of health within those organisational strategies, structures and objectives.

The Sarmcol Workers' Co-operative is based in the Howick district (Natal). It was formed in 1985 when workers were dismissed on a mass scale after a dispute with the management of the BTR Sarmcol factory. The health project is only one of the projects of SAWCO. The others include culture, media, bulk-buying, agriculture and a T-shirt printing production unit. All the projects function on a co-operative basis.

SAWCO is affiliated to MAWU - Metal and Allied Worker's Union, (now part of NUMSA - National Union of Metalworkers of South Africa) and hence to COSATU. SAWCO is represented at the local union branch, which in turn is represented both regionally and nationally within NUMSA'S structures.

Health problems in the area

Mpophomeni, a township outside of Howick, forms the centre point of the activities of SAWCO, but the projects extend far beyond this area. The homes of most of the workers are in the rural areas which surround Howick, extending as far as Impendle and Wartburg.

The causes of ill health in the area are similar to the causes of ill health in many other areas. Factors such as the maldistribution of health care, low standard of any primary health care programmes in the area, and the inaccessibility of health care services contribute to poor health. The particular conditions in the region may have added another dimension to the determination of the health status of the community.

Unemployment

In May 1985, approximately 950 workers from BTR Sarmcol were dismissed. The mass dismissals resulted in loss of income to some 950 families. With the average size of a family being 7, approximately 6 650 people have been affected directly by the dismissals.

There is little or no other employment - as BTR Sarmcol is the major employer in the area. The population of Mpophomeni itself is in the region of 15 000 and by far the majority of people in the township are unemployed.

Thus health problems in the area are related to the dismissals and their wider consequences.

Poor nutrition and stress

For the strikers and their families, the only access to food has been a weekly food parcel issued by the union. The nutritional status of the community at large is poor. A study carried out by the union showed that 25% of children under 12 years of age are undernourished. A "road to health" programme and a supplementary feeding programme is being carried out by SAWCO.

The political and economic environment in which the people of Mpophomeni and the surrounding areas live, contributes to a high level of psychological stress. The stresses of poverty are exacerbated by fears of physical attack - either in the form of arbitrary detention by police or armed attacks by Inkatha vigilantes. Following an attack on Mpophomeni in which 4 people were killed and over 20 injured in December 1986, the health committee has dealt with several stress-related mental problems affecting family members of those killed or threatened. Approximately 30% of Sarmcol strikers screened in October 1986 were found to have elevated blood pressures.

Principles in organising around health issues

The principles on which the health project is based are in line with those of NUMSA and COSATU i.e. democratic control by workers and people who constitute the co-operative.

The objectives of the health programme are to organise around health issues, creating the space for members of the community to take control over their own health care. It is necessary to distinguish between a "self help" primary health care programme, which improves standards of living and health status, and a progressive health care programme which improves standards of living, health status and increases people's control over their own health conditions and the delivery of

25% of children under 12 years of age are undernourished

health care. It is with the latter approach that structural changes in the health care system can be made.

The Health Committee

Initially, the health committee was formed to co-ordinate screenings for malnutrition amongst the families of unemployed workers. The aim was to identify and control malnutrition in the area. A longer term objective was to develop a "community health worker" scheme.

During 1986, screenings were held. The health committee has a monthly follow-up programme currently in progress, and has also taken responsibility for other aspects of the communities' health. A portion of the adults were screened and, where necessary, referred and/or treated. Other activities of the health committee include home and hospital visits, referrals to the clinic/hospital and so on. A supplementary feeding programme has been started for children who have been identified as undernourished and the follow-up programme is co-ordinated by the health committee.

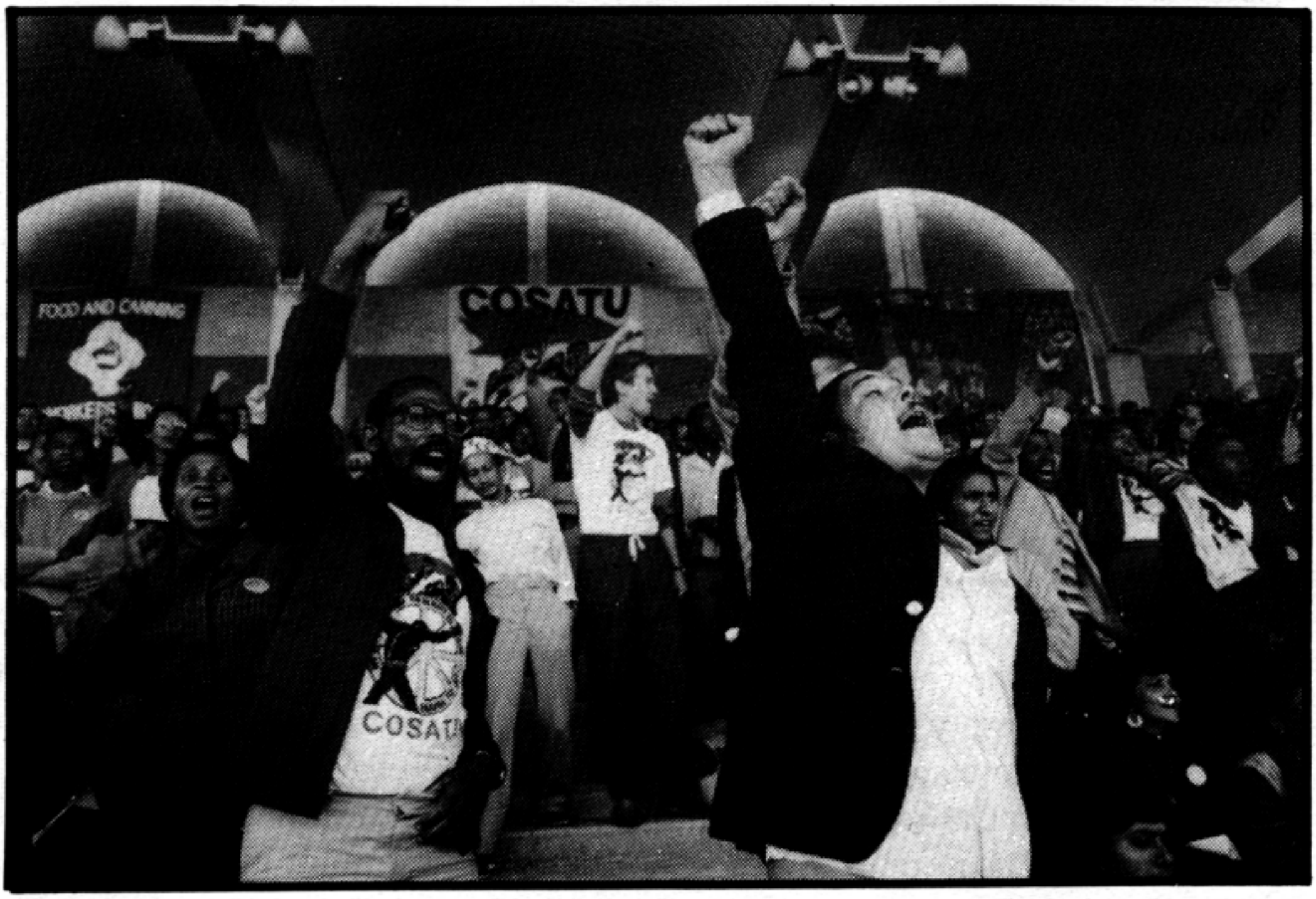
Training and experience of the Health Committee

The health committee has been trained in various aspects of health care and has gained experience in a broad variety of health issues. The foundation for developing a scheme involving community health workers has been laid. More importantly, members of the community have begun to entrust the health committee with their health problems.

The functioning of the existing project has given people the confidence to draw up immediate and future plans and strategies. This was done through a series of workshops and meetings of the SAWCO committee. Initial plans involve training a core group of health activists in two specific areas: organisational skills and health-related issues. It is clear that without an organisational base, health progammes could (and do) disappear into a vacuum.

Health within worker and community organisation

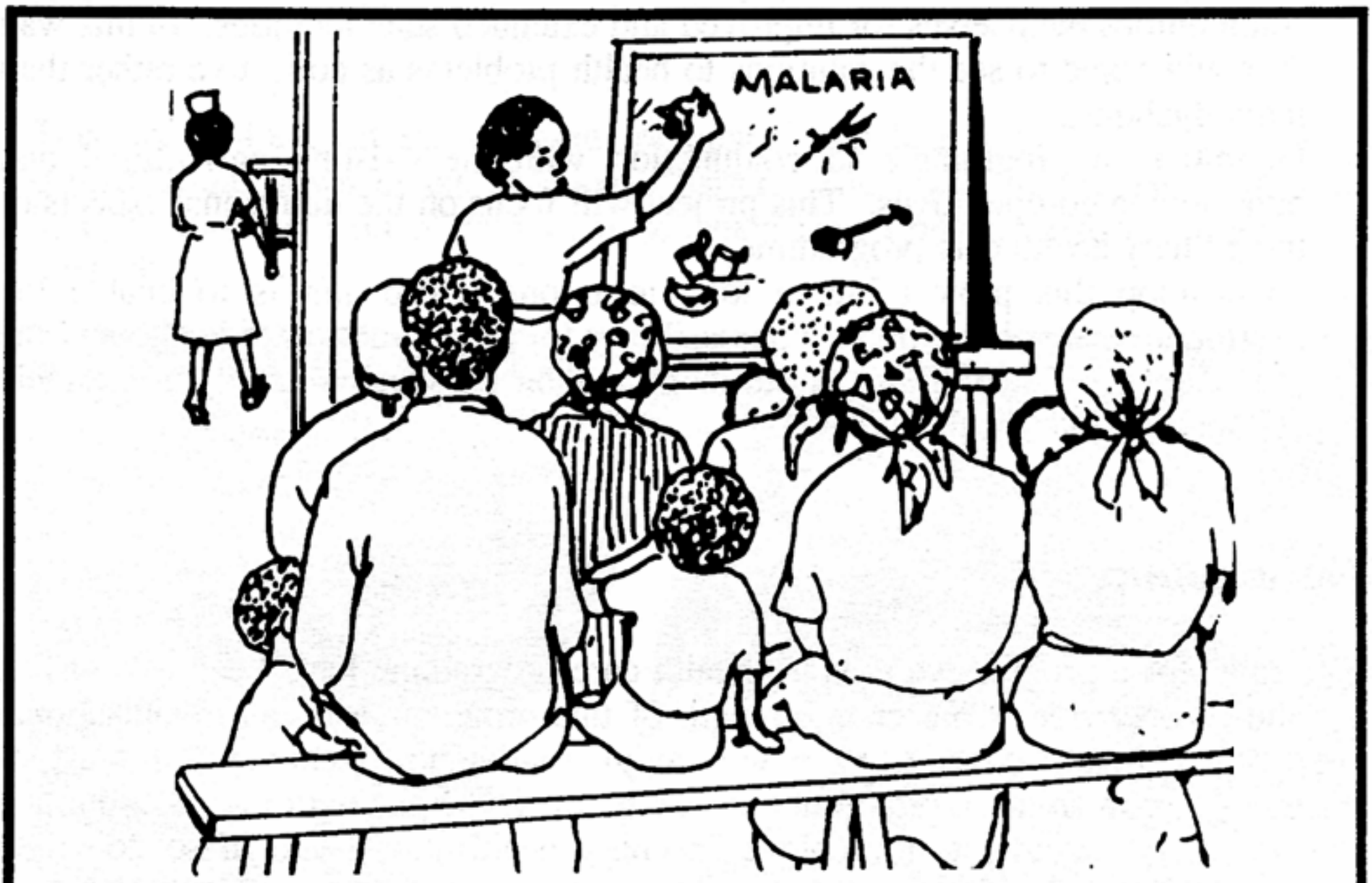
SAWCO has been in operation for over a year and during this time, structures have been set up which have proved appropriate for dealing with the issues at hand in a democratic way. SAWCO's relationship to NUMSA and COSATU is of great



SAWCO's relationship to COSATU is of great importance

importance to the project. The co-operative was established from a well-organised base which began in the factory. This organisation has been taken into the co-operative and to the community at large. Health issues are used to strengthen this organisational base, rather than used to initiate organisation as is the case in many primary health care projects.

Future plans



The Health Committee is to participate in training

Future plans for the health project can be summarised as follows:

- To train the existing health committee in aspects of primary health care. Areas such as safe water supplies, nutritional education and agricultural projects were identified as areas which required input from the health committee. The health committee is to participate in training in order to deal with these types of problems. Projects will only be initiated after consultation with the people involved, ensuring that their particular needs are met. Plans and strategies for each area will differ accordingly.
- To work through existing democratic structures and in consultation with members of the community. This will follow once the initial training has been completed. Training programmes and projects will be initiated with the intention of handing over the responsibility for health care to the community.

- To continue with the curative aspect of the health project. This will involve arranging for sympathetic doctors to make their services available in areas which are poorly serviced by state and provincial health services (as was previously done with the screening programme). This progamme will involve ensuring that the health committee and newly trained people are able to make decisions regarding referrals and on conditions they can prevent or treat themselves.

  SAWCO and the health committee are aware that improved health care in these communities will also require an enormous increase in the number of clinics and other referral points for the population. Demands will be made by the communities themselves for improved and extended state facilities. In this way they will come to see the solutions to health problems as collective rather than individual ones.
- To initiate a programme in conjunction with the existing agricultural and bulk-buying co-operatives. This project will focus on the nutritional aspects of the primary health care programme.
- To develop this project into a long term one. The aim is to enable the communities involved to take responsibility for the promotion of health and the prevention of ill health; and not to increase their reliance on largely unavailable and inaccessible "health experts".

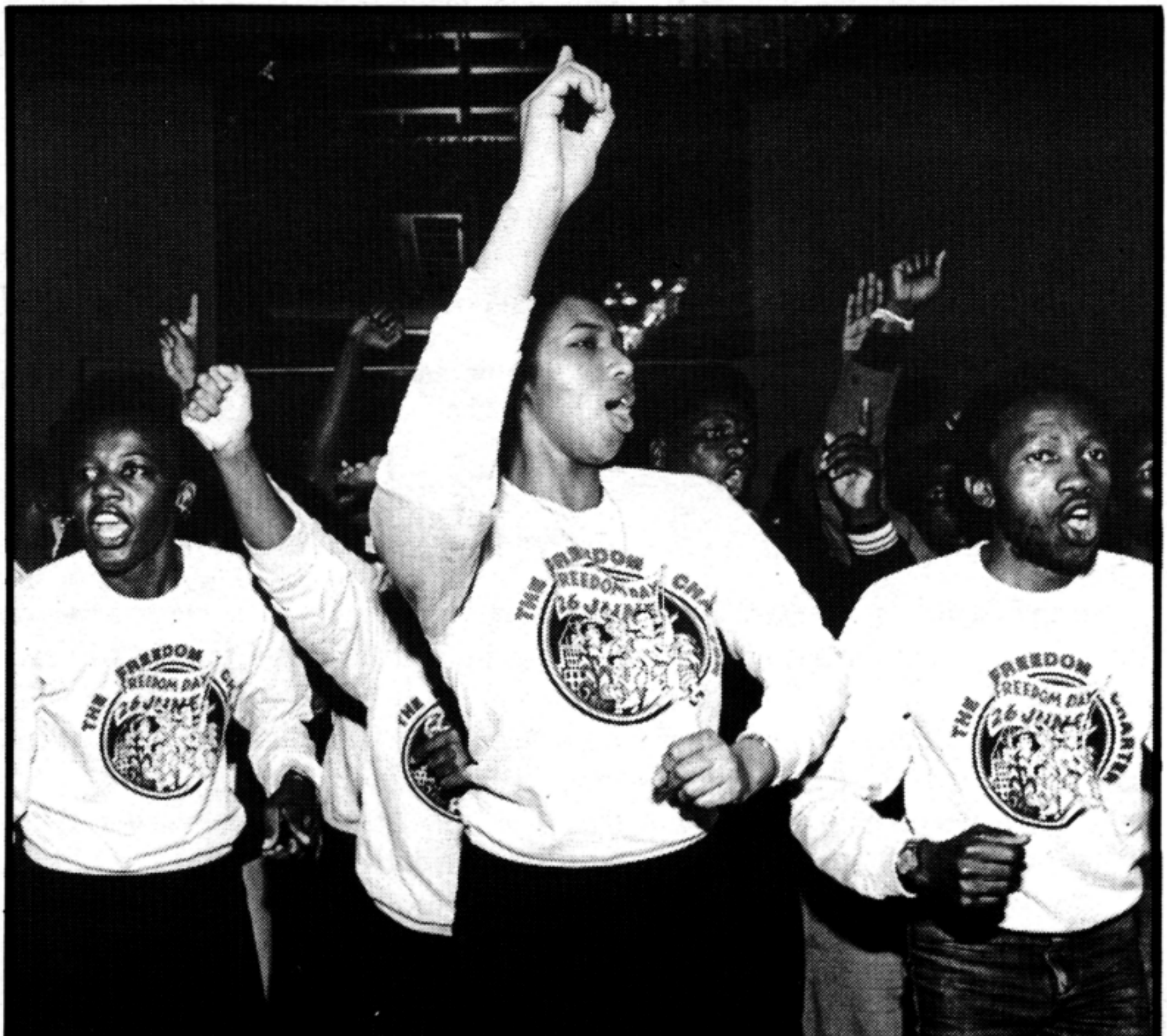
Conclusion

The roots for a progressive primary health care programme have been established for the co-operative. The main strength of this programme is the organisational base which already exists. Any view of an alternative health care system must, of necessity, begin from an organisational base. SAWCO has both the potential and the necessary ingredients to achieve "primary health care", and in so doing, to improve the health status of whole communities and their awareness of health conditions.

Industrial Health Unit
University of Natal

Health and the Freedom Charter

This article looks at the struggle for appropriate health care in relation to the demands laid down in the Freedom Charter. The Freedom Charter, it is argued here, constitutes a set of minimum demands which progressive organisations are now taking further.



The Health Charter Campaign

Progressive organisations operating within the health field have embarked on a campaign to develop a Health Charter. This process entails:

- educating people about the economic, social and political aspects of health and health care;
- co-operating with civic, youth, womens' and workers' organisations in mobilising people around health issues;
- collecting and collating their demands on health care needs and priorities, on the allocation of resources for health care, and on the structure of a health care delivery system which is to address those needs and priorities.

The Health Charter campaign was launched in 1985. Organisations represented on the Committee in the Transvaal include NAMDA, HWA and OASSSA. The campaign is supported by other organisations in other provinces, such as the HWS in the Western Cape and NEHAWU in the Orange Free State.

For its tasks of education and mobilisation, representatives on the Committee have, as an initial step, circulated the health demands in the Freedom Charter for discussion.

The political nature of health care

The Freedom Charter formulates health as a *political* demand. It indicates that good health is conditional upon the provision of adequate housing; on the State's commitment to preventive, accessible, equitable and appropriate health care; on adequate social security provision; and on the repeal of the migrant labour system.

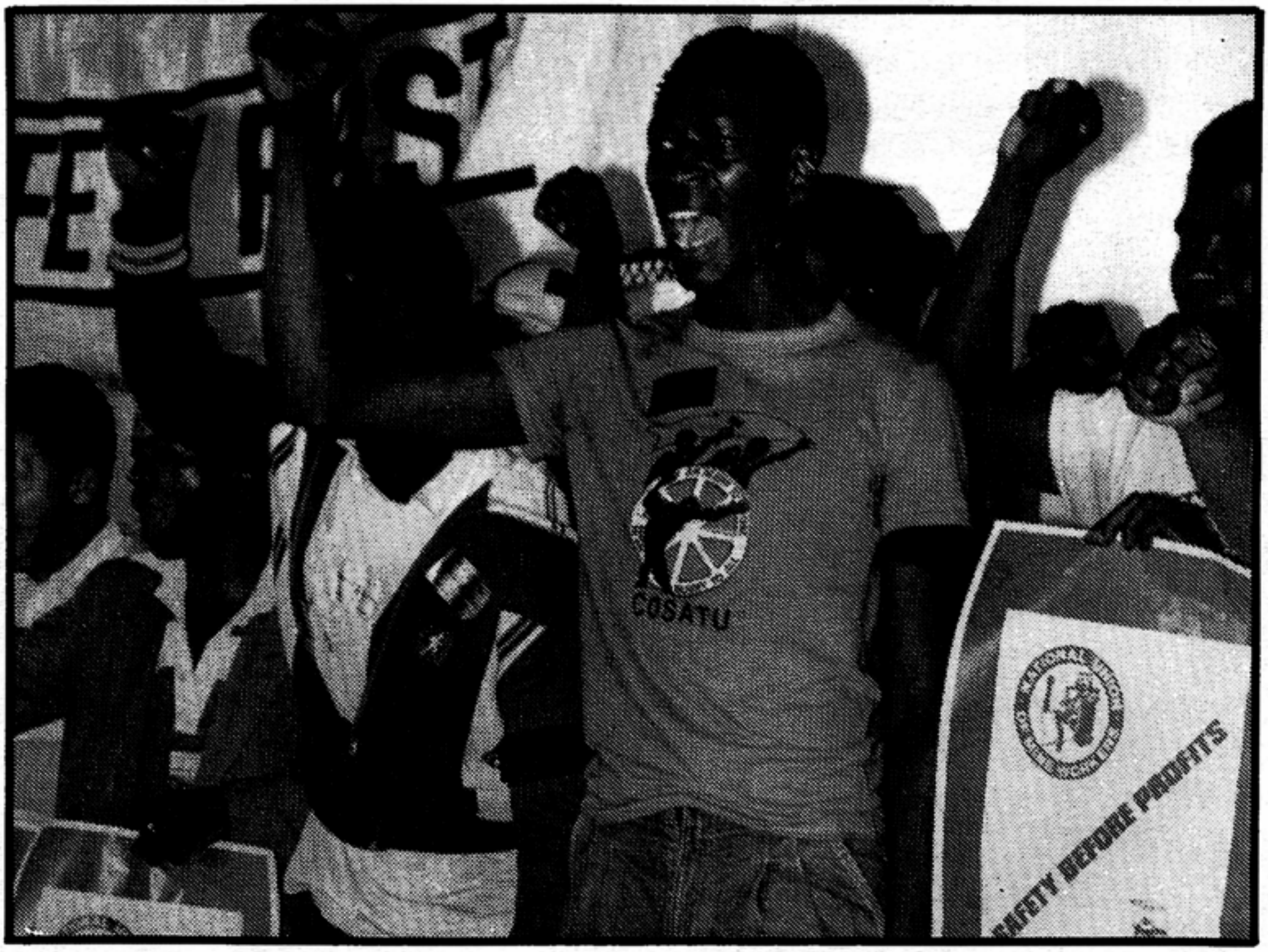
In linking health to all these social and political demands, it becomes clear that the present curative-oriented health care which is accessible mainly to those who can afford it, will not fulfill even the minimum demands set out in the Freedom Charter.

People will not be satisfied with piecemeal reforms which concentrate on isolated aspects of the living and working conditions facing the majority of South Africans.

Good health achieved in conjunction with other social and political factors, can only become a reality through political transformation.

This transformation, along with the establishment of an integrated national health care system is not to be pushed into the realm of a distant future.

At present, there are struggles in each area surrounding the health field: rent boycotts, demands for decent housing, resistance to forced evictions and removals, struggles in education, worker action for a healthy and safe workplace, negotiations for maternity and paternity rights, and for childcare facilities



Worker action for a healthy and safe workplace

Why a Health Charter?

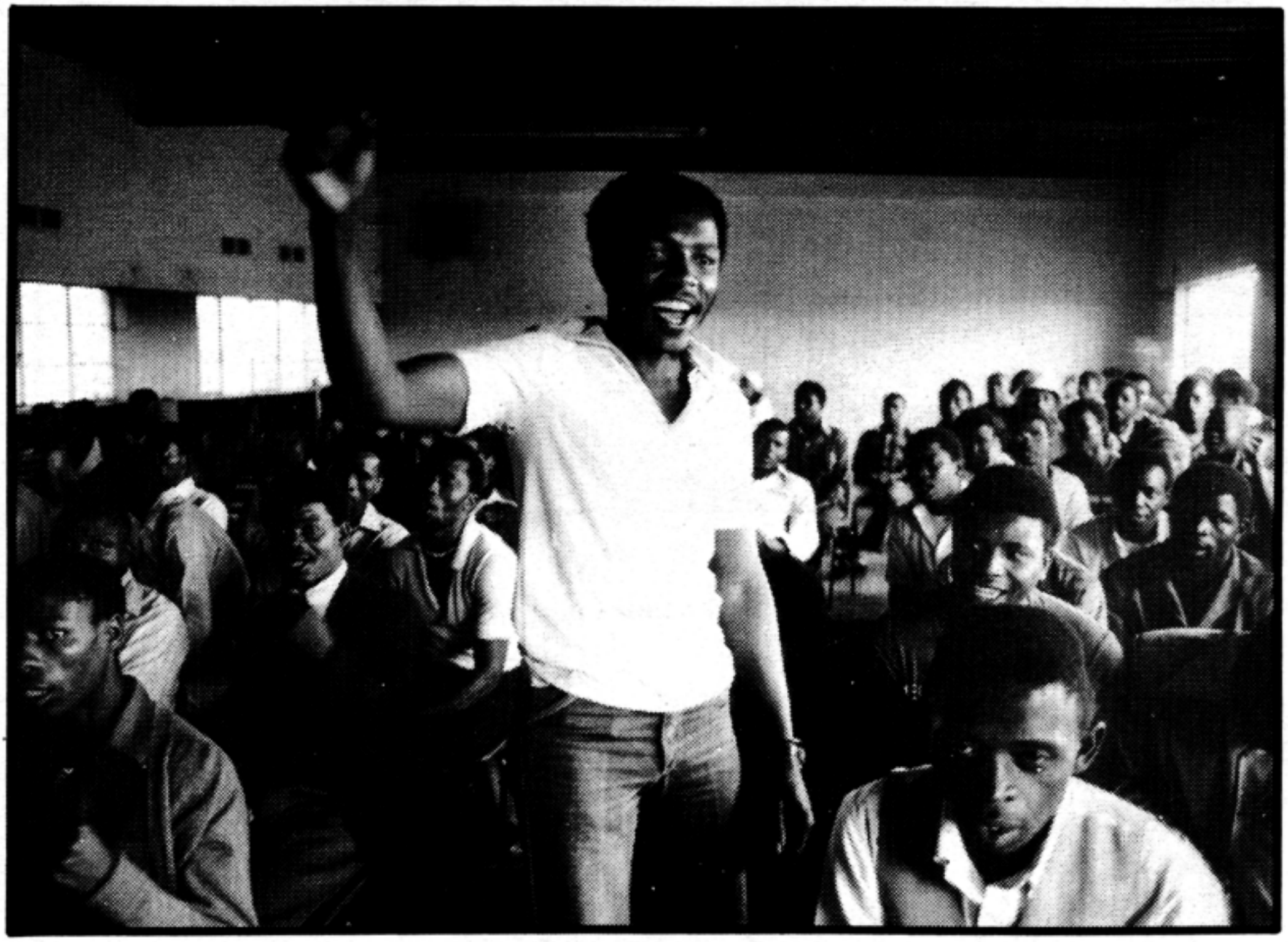
The question arises as to why progressive (health) organisations have thought it necessary to work towards a Health Charter over and above the demands of the Freedom Charter.

The Freedom Charter of 1955 reflects the state of opposition politics at the time, based on a broad class alliance. The creation of unity amongst sectors of different classes was of utmost importance, and the set of minimum demands laid down in the Freedom Charter is an expression of this lowest common denominator. To have addressed particular concrete problems of transformation at that time would have posed a threat to that unity.

Searching for more defined guidelines for transformation, however, is what characterises the state of progressive organisations today. Several of these organisations have therefore set about amending the demands of the Freedom Charter in cases where the latter were perceived to be vague (e.g. in the Women's Charter, the Education Charter, and the recently proposed Worker's Charter).

What is at issue in re-thinking and re-formulating minimum demands, is not

only those demands in themselves, but the *process* by which they become decided on, laid down, circulated and amended. The Freedom Charter and the process of its formulation have often been criticised for insufficient consultation; for having been decided on, in its final form, by a small committee; for insufficient worker representation; for lack of debate at the Convention; and for the process of simple acclamation, without presentation of a rival programme. All these aspects of the critique can be remedied today as worker, civic, youth and women's organisations are developing basic principles and practices of democratic participation, representation and accountability.



Organisations are developiing basic principles and practices of democratic participation, representation and accountability

The challenge for health organisations

Thus, on the whole, conditions today are such that a set of minimum demands *can* be productively used as an organising, mobilising tool.

The challenge for progressive organisations in the health field lies in taking the debate around minimum and maximum standards to the broadest levels of their structures. In a field as hierarchically structured and divided as the health sector, this is a particularly difficult task as these divisions may be partly reflected in health

organisations themselves. Progressive health organisations will have to concern themselves with class divisions in the health sector if their demands around the re-allocation of resources and establishment of alternative structures within the health care delivery system, are to be specified and crystallised. For inasmuch as the health demands of the Freedom Charter have become acceptable to a broad class range of health workers and administrators as *maximum* demands, they are only *minimum* demands to progressive health workers and users.

Maximum standards for some are minimum standards to others

Today, many diseases are recognised to be caused by the sufferer's working and living conditions, and the prevention of those diseases is recognised to be linked to an improvement in living and working conditions. But official medical opinion would go this far and no further. This insight is *not* carried over into a reallocation of the overall budget to health, and in preventive, appropriate, primary health in particular; it is *not* carried over into creating a *unified*, integrated, centrally co-ordinated health system in this country. People are individually made responsible for the cause and the cure of their illness.

The White Paper on Privatisation and Deregulation tabled before the last session of Parliament refers to primary health care as a more cost-effective type of health care delivery; but as long as there is no political, social and financial commitment to the establishment of primary health care, the emphasis on primary health care remains mere lip-service.

These are just a few examples which show that the common denominator created by broad demands (which are minimum demands for the majority of people and maximum demands for the ruling group within the health sector) will not come any closer to creating an appropriate, accessible and affordable health service.

Conclusion

Demanding change without addressing particular problems of transformation (for instance the role of the various classes during and after the process) could have the effect of leaving intact some of the present structures. Political change in itself is not sufficient. This is evident from the examples of health care delivery systems in Cuba and Nicaragua which - despite the achievement of some of the goals of the national liberation struggles - remain largely urban-based, curative, hospital-centred and dominated by health professionals. In South Africa, it will require more than the removal of apartheid policies and inequalities to attain health for all. The renewed mobilisation around health care needs and demands is a realisation of this.

FREEDOM CHARTER

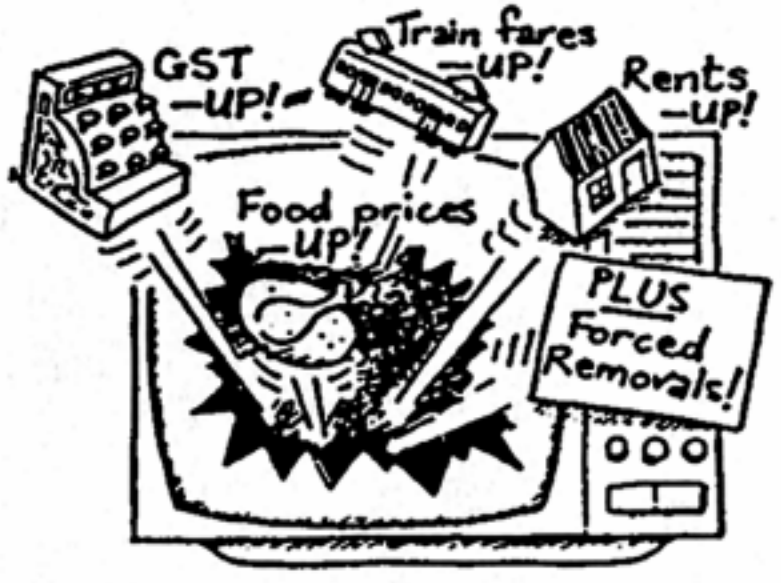
THE STATE SHALL PROVIDE PROPER HOUSING FOR ALL

THE RIGHTS OF PREGNANT WOMEN AT WORK MUST BE PROTECTED

THERE SHALL BE HOUSES, SECURITY AND COMFORT!

All people shall have the right to live where they choose, to be decently housed, and to bring up t heir families in comfort and security;
Unused housing space to be made available to the people;
Rent and prices shall be lowered, food plentiful and no one shall go hungry;
A preventive health scheme shall be run by the state;
Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children;
Slums shall be demolished and new suburbs built where all shall have transport, roads, ligting, plaving fields, creches and social centres;
The aged, the orphans, the disabled and the sick shall be cared for by the state;
Rest, leisure and recreation shall be the right of all;
Fenced locations and ghettoes shall be abolished and laws which break up families shall be repealed.

- A SAFE AND HEALTHY JOB IS YOUR RIGHT.
- PEOPLE NOT PROFITS.
- WORKERS FIGHT BACK.



HEALTH CHARTER

END TO INFLUX CONTROL AND FORCED RESETTLEMENTS WHICH SEPARATES AND UPROOTS FAMILIES.

Interview with the National Education and Health Allied Workers Union

Recently, *Critical Health* interviewed MONDE MDITSHWA and SAM PHOLOTHO of the National Education and Health Allied Workers Union (NEHAWU):

Q: How many members do you have so far?

Monde: We have 9 500 signed-up members and we are growing daily. NEHAWU organises workers in the public sector: in hospitals, clinics and creches, where we do not enjoy stop-order facilities. This means that it is difficult for us to be sure of the true extent of our support, which we estimate at present to be approximately 12 500.

Q: How many women, how many men?

Sam: About 70 - 80% of our members are women.

Q: How many classified, how many non-classified members? *

Monde: Most of our members are non-classified. We are strongest in the Witwatersrand region, including Baragwanath hospital, Natalspruit (where we are presently involved in a strike over an unfair dismissal), Rietfontein, Tembisa, the Hillbrow Hospital and the Johannesburg General. We also have a significant degree of support from the H.F. Verwoerd Hospital in Pretoria, Leratong Hospital, MEDUNSA and a number of other smaller private and state-controlled clinics.

The union is strongest in the Witwatersrand, at hospitals including Baragwanath

**Classified workers have a specific technical skill or qualification and are employed in permanent posts. Most of them are given supervisory positions, for instance matrons, inspectors, storemen and others.*

Non-classified workers are either temporary workers or contract workers. They usually do manual jobs.

Q: What are the working conditions of workers in Provincial Hospitals?

Monde: The bulk of our membership consists of temporary workers. Their main problem is job insecurity in that they are only given twenty-four hours notice of dismissal. Another grievance is that they can be transferred to different positions at will: for example a gardener can be a porter and so forth.

More serious of course, is their low wage. Very few of our members earn more than R300 per month and most receive wages of R280 and less. They have no medical aid and no pension.

Q: What are the working conditions of workers in private hospitals?

Monde: I recently had a meeting with workers from the Milpark Clinic. Most of them are paid R160 per month and also have no job security. Management also deducts R20 from their salary for food, which consists of pap and a piece of chicken

every day. Sometimes, for example on Fridays, when the patients eat chicken, the workers are given the bones that are left over. When they complain, they are invariably told that they are not paying for the food and should be grateful for what they receive. There is a law that managements may not deduct more than 5% off a salary for food. R20 is certainly more than 5% of R160.

Q: What are the specific problems of women workers in the hospital sector?

Monde: The most important problem is the maternity question. Given that most of our members are non-classified and have no job security, a woman who has a baby has no guarantee that she will get her job back when she is able to return to work. Women are not able to take time off to look after sick children.

Sam: In fact there are always problems when sick leave is taken. Even when a worker presents a medical certificate, he or she is given the third degree and suspected of lying or bribing the doctor. Union members especially are suspected of taking time off to go to meetings or seminars.

Monde: Depending on the supervisor, problems of sexual harassment also exist, although this is admittedly not very widespread, but it is a problem that we occasionally come across in relation to women.

Most of the women workers in the hospital sector are non-classified and have no job security

Q: What are the greatest problems facing non-classified workers?

Monde: Essentially, as I have mentioned, lack of job security and low wages. Another important issue is the extent to which workers are taxed.
Sam: Workers are taxed very heavily on their wages, the average worker takes home between R230 and R240 per month after taxation.

Q: What are the greatest problems facing nurses and paramedical staff (e.g. radiographers, physiotherapists etc)?

Monde: Nurses have serious problems of low wages and overwork. The regimentation and authoritarianism of the hospital system is also an unpleasant factor of their lives. Nurses are supposed to be professionals but they are treated badly.

Q: According to what job grading system do workers get categorised and paid?

Monde: We have no information on how workers are graded and when we have asked for this information we have been told that it is classified information and it is denied us.

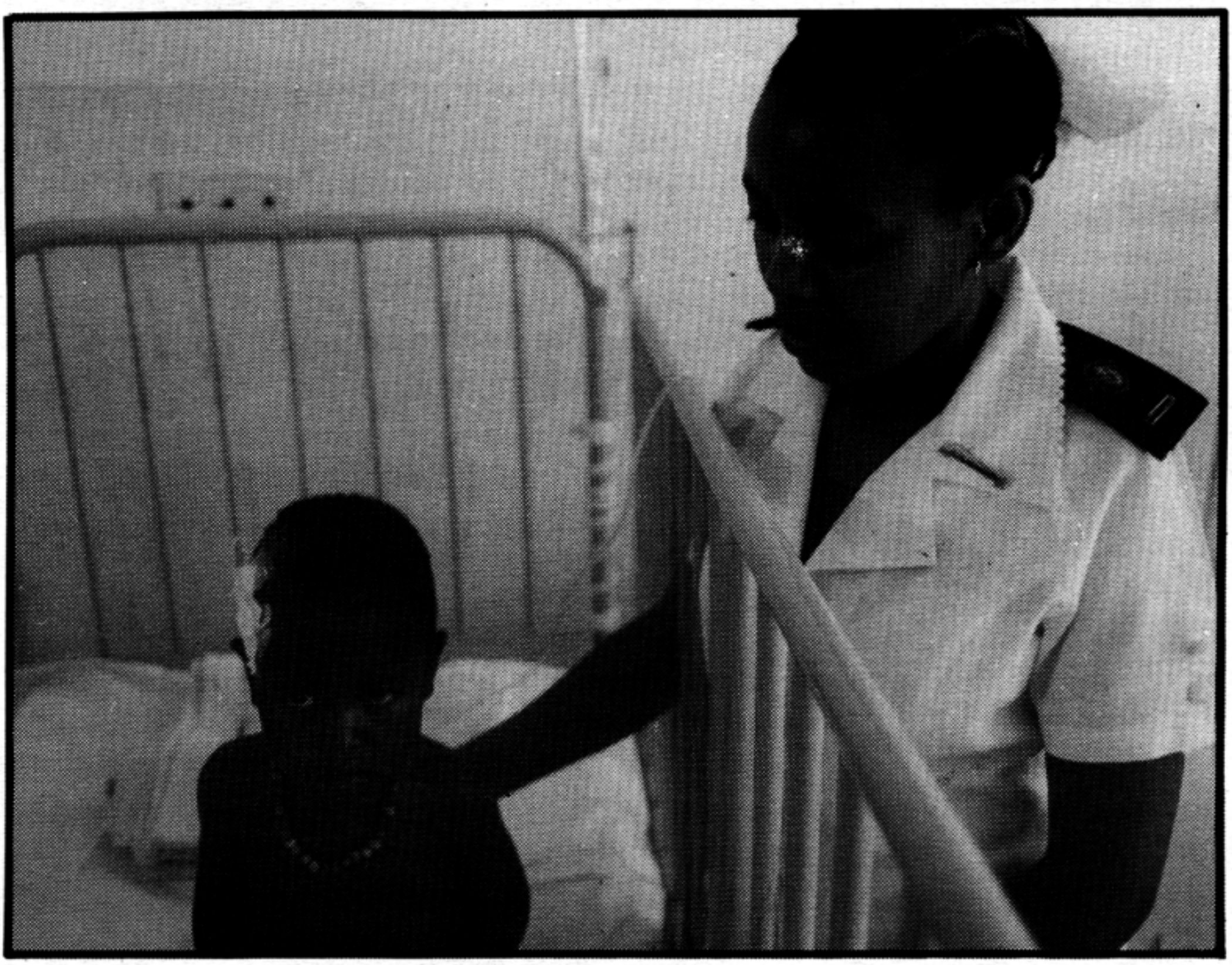
Q: Have there been any recent retrenchments?

Monde: Unlike the situation in factories, retrenchments have not been very common in hospitals and educational institutions. On the other hand, unfair dismissals are very frequent.

Q: Has the government's privatisation move become noticeable in terms of retrenchment and reshuffling of hospital workers?

Monde: Not yet, but there are definitely rumbles that suggest it is in the pipeline. Obviously we reject privatisation and its effect on our members. It is going to shift responsibility from the government to the private sector. Can you imagine health in the hands of capital?

It is likely to become far too expensive for most black people and we fear that a large percentage of our members will lose their jobs. We have no guarantee at present that jobs will be saved, we are waiting for something concrete to happen before we do anything.



Nurses have serious problems of low wages and overwork

Q: Is the local-rate-of-pay method of differential wage payment still in effect?

Sam: Provincial hospitals are controlled by Pretoria, therefore the rate of pay is uniform, depending on the grade of each worker. The situation is different in the so-called homelands where each homeland has its own Health and Education authorities.

Q: Are there different strategies to organise hospital workers of private and provincial hopitals?

Sam: We have not yet found any need to employ different strategies.
Monde: The attitudes of administrations seem to be similiar but we have found it easier to put pressure on managements in the private sector because they are more definable. In provincial hospitals, superintendants commonly disclaim responsibility for decisions, blaming them on higher authorities in Pretoria.

Q: What does the distinction between classified and non-classified hospital workers mean for organising?

Monde: Because of the conditions in which non-classified workers find themselves, they are more eager and therefore easier to organise - they have little to lose. Classified workers on the other hand, (and we are talking of nurses here) despite their low wages and long working hours, are used to more secure jobs and small privileges.

The politicised elements amongst classified workers are likely, however, to join the union. It is encouraging that many of the key spokespeople for the workers in Natalspruit are clerks and nursing assistants.

Sam: We want the nurses on our side, we want them to embark on solidarity action.

Monde: At Natalspruit, you should have seen the nurses walking past the strikers on their way to work, holding their little bags primly in their hands, but it was pointed out to us that some of these very nurses had relatives amongst the temporary workers on strike. Whatever differences there are, we feel are artificial - we regard them as workers.

At Shifa Clinic, a number of nursing sisters went on strike to protest the retrenchment of 20 of their colleagues

Sam: Yes, nurse assistants' wages are the same as those of non- classified workers and some temporary staff earn more than nurses' assistants. In factories, some workers get better salaries than teachers. This distinction between classified and non-classified labour does not benefit the workers.

Monde: Take Shifa Clinic in Durban, a number of nursing sisters went on strike to protest the retrenchment of thirty of their colleagues. Management withdrew from its original position claiming that the retrenchment of all thirty was necessary because of a lack of profit. An outside party was called in to check the situation; they found that the clinic was indeed suffering from a lack of profitability but a compromise was reached and only 17 nurses were finally retrenched.

A number of workers, including nursing sisters have recently joined the union from the King Edward Hospital. We don't feel that there is any material difference in the conditions of nurses from that region and nurses in the Witwatersrand region. But as I have said the issue is not yet resolved, we are still discussing the possibility of actively attempting to recruit classified workers such as nurses.

Q: How does the union go about bridging any differences in consciousness, interests and demands of classified and non-classified staff?

Monde: We don't believe that there are any substantial or restrictive differences in the consciousness, interests and demands of non-classified workers and classified workers such as nurses and clerks.

Q: Does the union aim to exert any influence on nurses' training?

Monde: This question is a bit premature at the moment as we do not have all that many nurses in our union. We intend, however, to work towards establishing in-house training for workers in the future and to run our own seminars and workshops, the content of which we will determine in conjunction with progressive health organisations.

Q: From what kind of (job) backgrounds do the organisers come?

Monde: Some are retrenched shopstewards or shopstewards who volunteered to become organisers; others are activists who have worked in other progressive organisations and because of their potential, have been drawn into the union.

Sam: I have been a trade unionist for a long time, since the days of SACTU way back in the 1950's, until SACTU was forced to operate outside the country. I was the last president of SACTU in 1965.

During the great repression in the early 1960's when organisations such as the ANC and PAC were banned, the trade unions were not spared. Even if not banned, repression and restrictions forced SACTU to operate from the outside until 1965-1973 when strikes cropped up in Durban and 1976 when people tried to revive the trade union movement. I was a member of GAWU which helped to form the sector unions.

Q: How is liaison between workers of different hospitals achieved?

Sam: We have general meetings consisting of workers from different hospitals. In the past, health workers were organised by SAAWU, GAWU, HWU in Durban and also HWU in the Western Cape. NEHAWU has now taken over the function of organising these workers. We therefore have representatives from different hospitals, from private clinics, old-age homes and universities attending these meetings.

Q: How does the Union ensure representation from the bottom up?

Sam: Each department chooses its own shop-steward to monitor the grievances of workers. Two stewards from each establishment form shop-steward councils.

According to our constitution, 250 members may form a branch. The Branch Executive Committee is then selected from the shop-steward councils - it consists of one member from each establishment. The Branch Executive Committee also has a Branch Secretary who is not necessarily a health worker, but is paid by the union.

Various branches form Regional Executive Committees, who will also have a secretary, a chairperson, a vice-chairperson and a treasurer. The upper body is the Central Executive Committee, consisting of a chairperson, president, treasurer and regional secretary.

Q: How are the various categories of hospital workers represented (e.g. proportional representation according to category/department)?

Sam: We don't have all that many different categories represented. The onus at present, is on the classified worker to identify with the non-classified worker.

Q: What other unions operate in the health sector?

Sam: As far as I know, there are no other unions operating in the Transvaal.

Q: What was the rationale for forging education and health workers into one union?

Sam: The rationale was that most hospitals have universities attached to them and the majority of workers in the non- classified category here are cleaners.

Q: Please outline some of the steps in the preparation of the launch

Sam: We started by appointing the Health and Allied Workers Union of Durban as the Convener Union. This was the decision of COSATU's Central Executive Committee. A steering committee was formed consisting of five delegates from GAWU, SAAWU, HAWU and HWA.

We met in Tudor Mansions for the first time on 19 March 1987. The Committee was given a mandate to select the union colours (green, red and black), the logo and the draft of the constitution.

27 June 1987 was then selected as the launching date.

Q: What has NEHAWU'S interaction with SANA (South African Nurses Association) been like?

Sam: We have not made any advances to SANA so far but I foresee problems in meeting SANA because it is a government organisation. I do not think that we will have much contact with it. Perhaps in the future we may approach them.

Q: At which hospitals is the new union recognised?

Monde: We are not yet recognised in the provincial hospitals. Recognition is going to be a battle.

Q: Are any recognition agreements under law?

Monde: Outside the health sector, we have recognition agreements with the University of Bloemfontein and we are negotiating an agreement with the University of the Witwatersrand. We also have a recognition agreement with AMA (Affiliated Medical Adminstrators).

In Durban we have a de facto recognition agreement with Shifa Clinic and we are presently negotiating agreements with MEDSCHEME and with the Morningside Clinic.

Q: What have managements' reponses been to the new union?

Monde: Mixed. The attitude of provincial hospitals has been largely negative. Some private hospitals have responded in a more liberal way, whilst others have adopted a wait-and-see approach.

In the educational sector, in the so-called liberal universities, managements have taken a more open position towards the union. We have a substantial membership there. As regards the bush universities, there are problems there, but we have not met with an outrightly negative attitude so far.

Q: Has the new union had to deal with any disputes up to now?

Monde: There have been no general disputes. We are, however, involved in negotiating day-to-day issues. Administrations or managements are often willing to discuss issues with us.

Sam: As long as they are not forced to recognise us officially.

Q: Are there any legislative changes under way to give trade union rights to workers in essential services?

Monde: Not as yet, but we look forward to the day when workers in essential services are incorporated within the ambit of the Labour Relations Act.

Disabled people in a reorganised health care structure

This article identifies the definition of disability and an action and prevention programme. It draws attention to the health care needs of disabled people, including the need for disabled people to become members of the health team.

Disabled People South Africa (DPSA) is a national organisation of people with disabilities. It functions as an umbrella body for self-help groups.

Aims and objectives

In contrast to charity/welfare organisations, DPSA is a non- racial, democratic movement of disabled people from both rural and urban areas of South Africa, who come together to speak for themselves, about issues which affect them. This same trend is mirrored in the whole Disability Rights Movement (DRM) represented internationally by Disabled People International (DPI).

DPSA's aim at all times is to fight for equality and full participation in every sphere of our society. The handicaps which stand as barriers to this are addressed by DPSA (and member self-help groups).

Definitions

The World Health Organisation (WHO) makes the following distinction in definition:

> *Impairment*: Any loss or abnormality of psychological, physiological, or anatomical structure or function.
> *Disability*: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal

for a human being.
Handicap: A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal, depending on age, sex, social and cultural factors, for that individual."

(UN Action Progam, 1983:3)

Disabled people and health

In the present health system that is predominantly based on curative medicine (and a society based on the "myth of the normal healthy body"), disabled people are generally seen, at best, as long term inconveniences to the medical system, and at worst as medical failures.

The majority of disabled people in the present South African health care system face two levels of discrimination: first their long term needs are inadequately catered for (whatever the colour of their skin); secondly, whatever facilities (for long and short term care) there are, they differ in quantity and quality paralleling levels of racial discrimination.

World Action Program

The need for a re-evaluation of the global policy with respect to disabled peoples, led the United Nations, together with Disabled People International (DPI), to draw up a WORLD PROGRAM OF ACTION CONCERNING DISABLED PERSONS. The objectives of which are to be implemented by all countries during the United Nations DECADE OF DISABLED PERSONS 1983-1992.

This program identifies three levels of action:

1. Prevention (primary and secondary)
2. Rehabilitation
3. Equalization of Opportunity

Primary prevention

This looks at the precautions needed to avoid the initial impairment by the following means:

a) ... avoidance of war; improvement of the educational, economic and social status of the least privileged groups; identification of types of impairment and their causes within defined geographical areas;

introduction of specific intervention measures through better nutritional practices; improvement of health services, early detection and diagnosis; pre-natal and post-natal care; proper health care instruction, including patient and physician education; family planning; legislation and regulations; modification of life-styles; selective placement services; education regarding environmental hazards and the fostering of better informed and strengthened families and communities.

Nutrition intervention programmes are an aspect of primary prevention

(b) To the extent that development takes place, old hazards are reduced and new ones arise. These changing circumstances require a shift in strategy, such as nutrition intervention programmes directed at specific population groups most at risk owing to vitamin A deficiency; improved medical care for the aging; training and regulations to reduce accidents in industry,in agriculture, on the roads and in the home; the control of environmental pollution and of the use and abuse of drugs and alcohol. In this connection, the WHO strategy for Health for All by the Year 2000 through primary health care should be given proper attention.

(UN Action Program, 1983:A)

Secondary prevention

This looks at measures which:

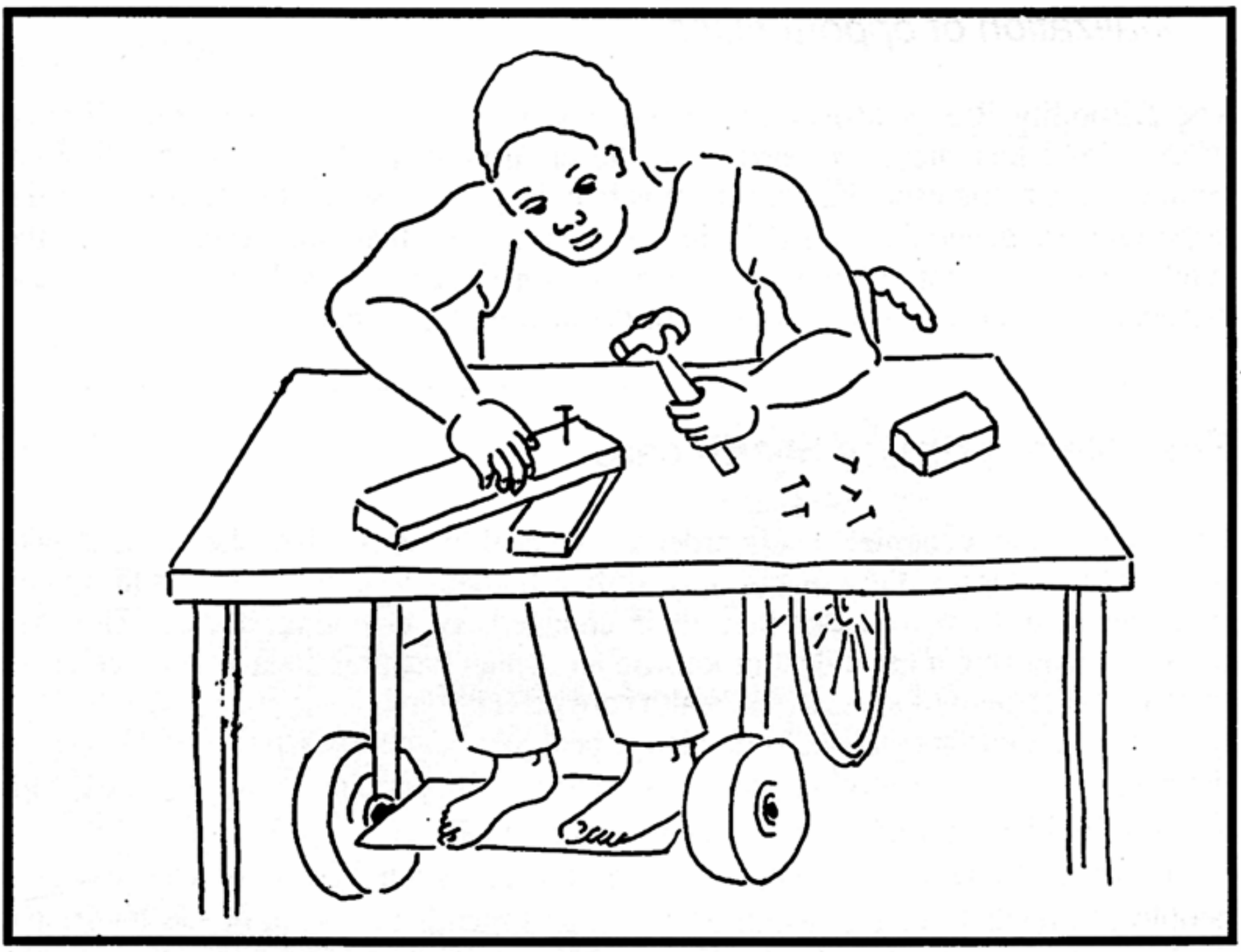
> 14. ... should be taken for the earliest possible detection of the symptoms and signs of impairment, to be followed immediately by the necessary curative or remedial action which can prevent disability or at least lead to significant reductions in its severity and permanence. For early detection it is important to ensure adequate education and orientation of families and technical assistance to them by medical social services."
>
> *(UN Action Program, 1983:4)*

Rehabilitation

The areas included under this section of the World Programme of Action are seen generally in the aims (although not the practice) of Rehabilitation in most developed countries.

However the programme goes on to stress that:

> 17. Important resources for rehabilitation exist in the families of disabled persons and in their communities. In helping disabled persons, every effort should be made to keep their families together, to enable them to live in their own communities and to support family and community groups who are working with this objective. In planning rehabilitation and supportive programmes, it is essential to take into account the customs and structures of the family and community and to promote their abilites to respond to the needs of the disabled individual.
>
> 18. Services for disabled persons, should be provided, whenever possible, within the existing social, health, education and labour structures of society. These include all levels of health care; primary, secondary and higher education; general programmes of vocational training and placement in employment; and measures of social security and social services. Rehabilitation services are aimed at facilitating the participation of disabled persons in regular community services and activities. Rehabilitation should take place in the natural environment, supported by community-based services and specialized institutions. Large institutions should be avoided. Specialized institutions, where they are necessary, should be organized so as to ensure an early and lasting integration of disabled persons into society.



Rehabilitation services are aimed at facilitating the participation of disabled persons in regular community services and activities

19. Rehabilitation programmes should make it possible for disabled persons to take part in designing and organizing the services that they and their families consider necessary. Procedures for the participation of disabled persons in the decision-making relating to their rehabilitation should be provided for within the system. When people such as the severely mentally disabled may not be able to represent themselves adequately in decisions affecting their lives, family members or legally-designated agents should take part in planning and decision-making.

20. Efforts should be increased to develop rehabilitation services integrated in other services and make them more readily available. These should not rely on imported costly equipment, raw material and technology. The transfer of technology among nations should be enhanced and should concentrate on methods that are functional and relate to prevailing conditions.

(UN Action Program, 1983: 5,6)

Equalization of opportunities

The Disability Rights Movement recognizes that rehabilitation is a time limited process, and that there are barriers in the environment which handicap disabled people. It is recognised that "a person is handicapped when he or she is denied the opportunities generally available in the community that are necessary for the fundamental elements of living ..." (*UN Action Program, 1983:6*). One of these elements is equal access to all aspects of the health care system.

The role of primary health care

Disabled people recognize that in order to live healthy active lives they need to take responsibility for the daily functioning of their bodies. In order to do this they need to understand how to look after their changed, or changing bodies. This has involved acquiring a great deal of knowledge which has traditionally been believed to be in the domain of specialized health care professionals.

This acquired "specialised" knowledge becomes "common sense" knowledge for the person with the disability, and is not generally understood by the average health care professional, nor adequately taught by specialists.

There is therefore an urgent need for the inclusion of experienced disabled people as members of the health team - not as members of one of the traditional medical or paramedical professionals already in the "team", but as co-ordinators and facilitators between each of these members and the "newly" disabled person. Because disabled people actually *live with* their particular disability, their ability to teach and share knowledge (and their understanding of why this knowledge must be shared) is far more successful than highly- trained, over-burdened professionals.

DPSA's call for health for all

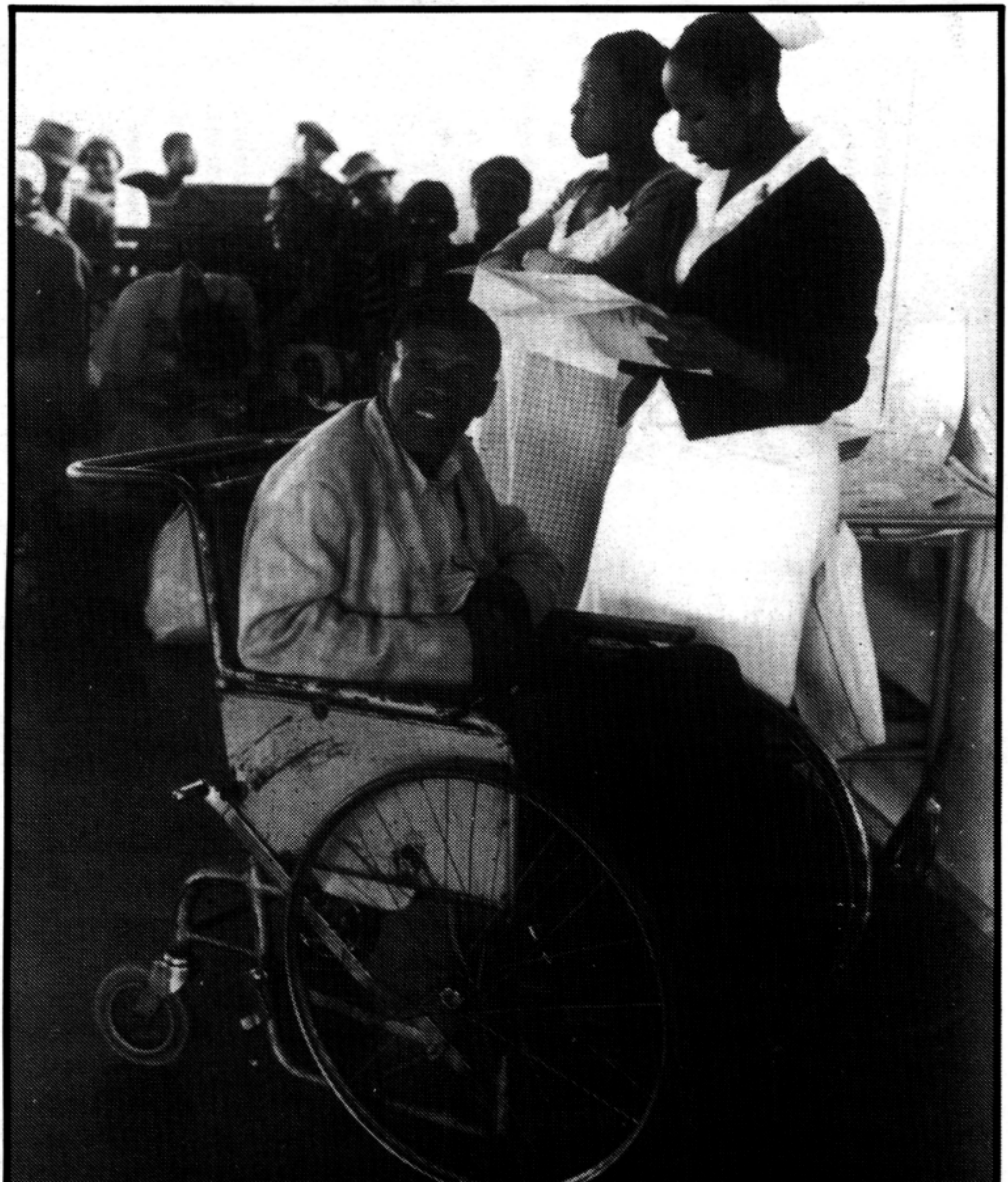
As people with disabilties looking at a new health care structure, we call for:

1. Non-racial and effective health services for all disabled people in both urban and rural areas;
2. Health services for people with disabilities to be available in the normal service delivery system;
3. A move away from the emphasis on highly trained health professionals as the only service deliveries.
   This involves a recognition of the desperate need throughout the country for rehabilitation assistants;
4. A recognition of the contribution of experienced disabled people as paid workers in the health care system.

Reference:

United Nations Decade of Disabled Persons, 1983-1992: World Program of Action Concerning Disabled Persons, United Nations, New York, 1983.

Kathy Jagoe
August 1987



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The paper for a changing South Africa.

Primary mental health care

There is often confusion about the concept of primary mental health care as it has taken on different meanings and labels in the past. For example, primary mental health care has often been incorrectly equated with community psychology. Community psychology is a very diverse field and although it involves community care, its interventions are varied and often involve only curative care.

Perhaps a working definition of primary mental health care is the front line contact of mental health workers with fellow community members, and their interventions in common psyhological difficulties on a curative and preventative level. It is involved with the promotion of mental health and the prevention of mental illness. Important in primary mental health care is the accessibility of services and accountability of primary mental health care workers to their communities.

Organisation for Appropriate Social Services in South Africa (Oasssa)

OASSSA, which consists of psychologists, psychiatrists, social workers and other mental health workers, is attempting to develop expertise in the field of primary mental health care.

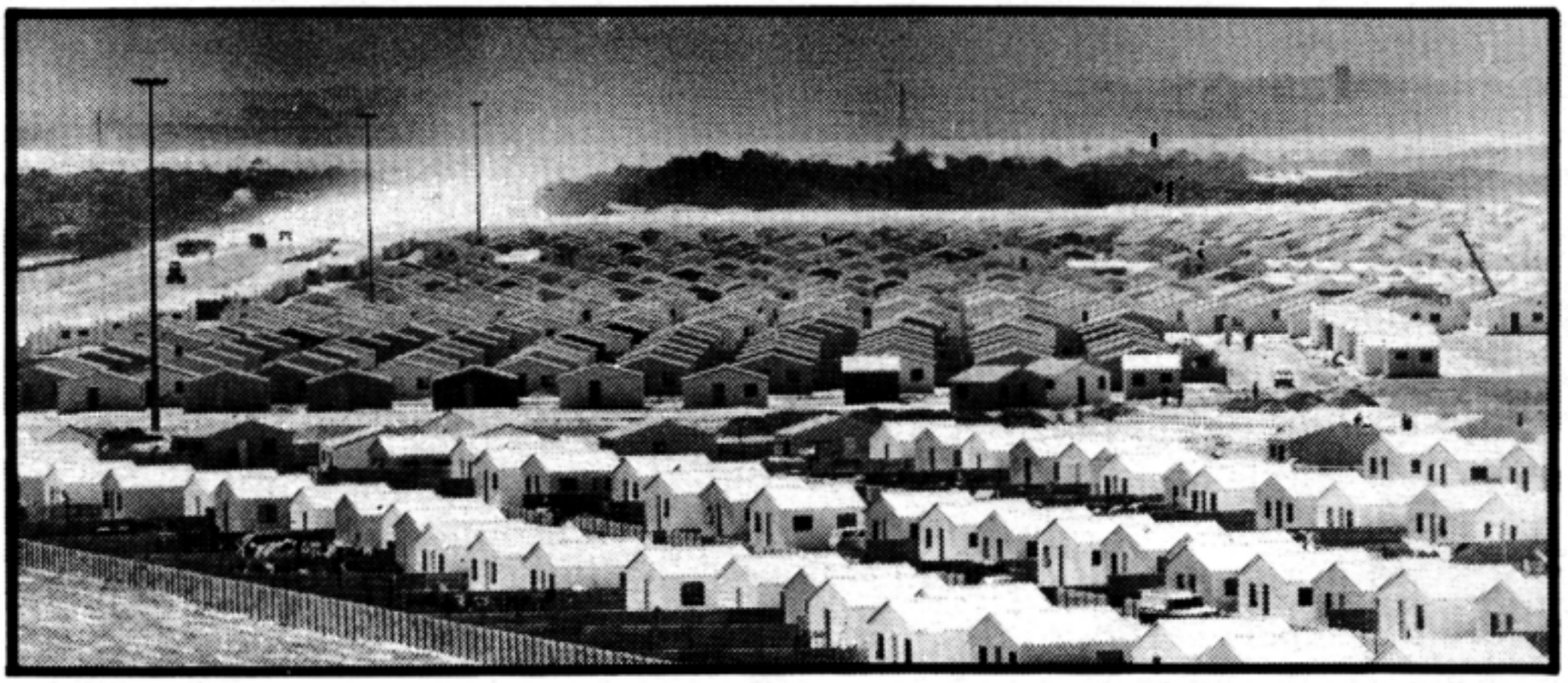
OASSSA has attempted to deal with psychological issues that affect the majority of the population, with the aim of exploring and extending primary mental health care, as well as providing immediate services such as education and training.

Research and training

Because of the lack of psychological knowledge in the general population, for example of the psychological effects of stress, the effect of detention and torture, the effects of early separation of mothers and infants, OASSSA is engaging in

research in these areas to provide information to affected people, which will enable them to take greater control over their mental health and mental health needs.

Because of the great shortage of mental health professionals, particularly in the black townships and the rural areas, OASSSA, in conjunction with other organisations, has developed a training course to train lay counsellers from these areas.



There is a great shortage of mental health professionals in the townships.

The training has changed and is still being developed to meet the specific needs of the trainees. If trainees are aware of particular problems in these areas, associated feelings and stresses may be explored in order to learn how best to deal with them. Trainees are thus trained in basic counselling skills and to differentiate between psychological problems which they can and cannot deal with, in order to identify when it is appropriate to refer a person to a psychologist or psychiatrist.

It is hoped to extend this programme and perhaps in a future health care system, greater use will be made of lay counsellers living in different areas, who, knowing the problems within their communities, will be able to intervene at an early stage.

New approaches

New therapies have had to be developed to deal with specific problems in South Africa. For example, OASSSA, in conjunction with DPSC, counsels detainees on a daily basis, for which the one-off session has been developed.

In a one-off session, there is no specific time limit, so a session may take a couple of hours, the length of the session being determined by the client's need. During this time, therapist and client try to achieve some form of resolution to a particular problem or difficulty.

Other brief term interventions are also being explored.

The political situation

Fundamental to all working the mental health field is the recognition that the political situation in South Africa directly affects the mental health of its population in an adverse way.

Apartheid engenders numerous psychological difficulties, but few psychological services for the majority of the people. There are sufficient psychological services for white and privileged people but very scant services for the black and working class populations. In the rural areas, psychiatric services are almost non-existent. Consideration of a future mental health care delivery system must therefore be done within the context of the transformation of our society. However a start may be made towards improving psychological services by developing primary mental health care.

Community involvement

Primary mental health essentially involves an emphasis on community involvement, a better distribution of services, a stress on prevention and a multi-disciplinary approach. This implies that:

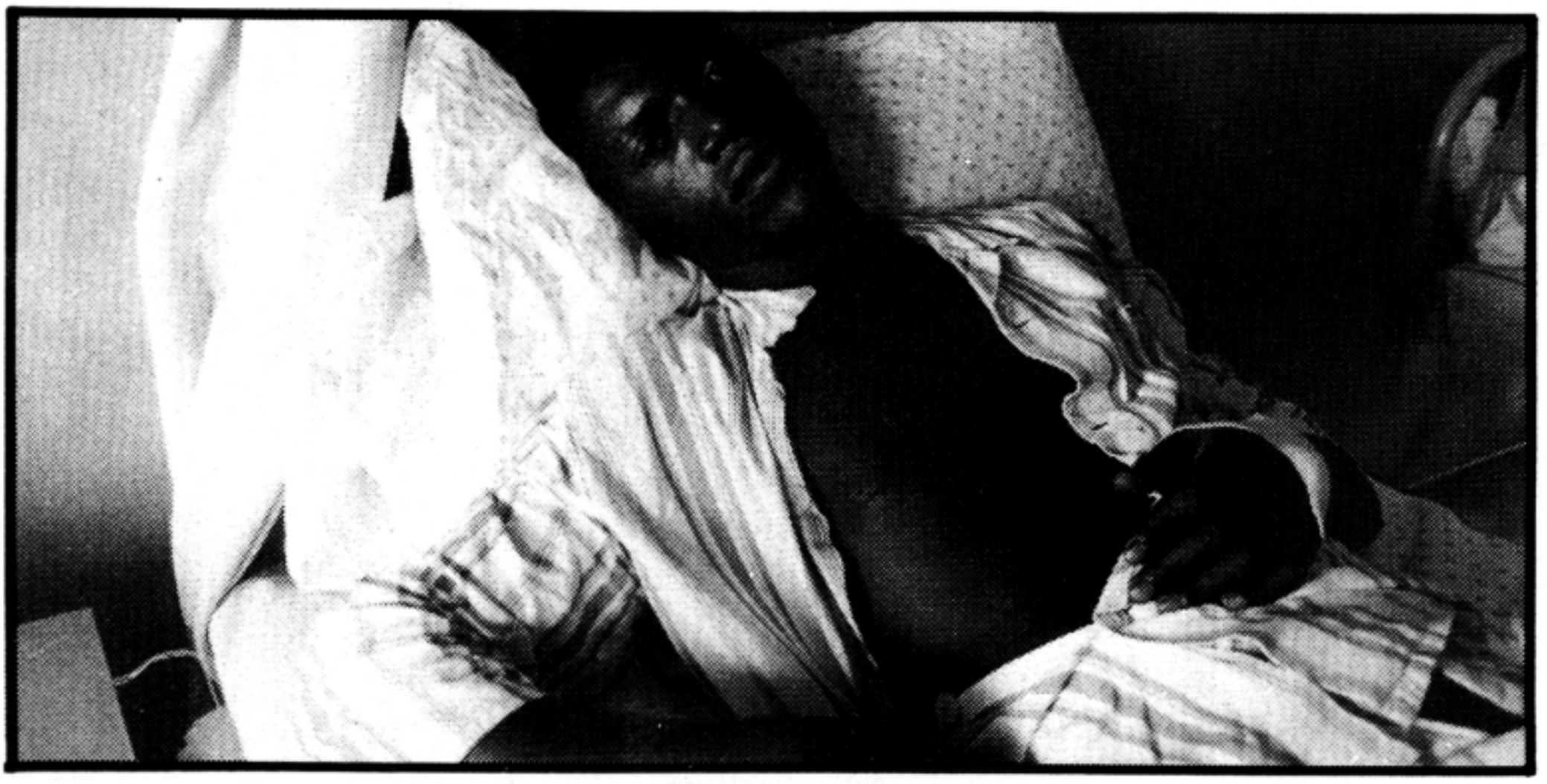
(a) Mental health centres should be accessible to the community and not on the outskirts of residential areas. Too often people fear the mentally ill and like to put institutions and centres on the outskirts of towns so that no one has to be reminded that people do have psychological difficulties.
(b) Mental health difficulties differ in every geographical area and therefore require different solutions. Also if democracy is to be achieved, it has to pervade all spheres of life, including mental health. Thus it is essential that there is active participation by the community in their mental health care.
(c) Prevention as well as cure must be the focus. This means that mental health workers must look at how to promote mental health and not just learn how to deal with psychological difficulties.
(d) Appropriate interventions need to be applied. This may mean developing new types of psychotherapy and removing ECT as a form of treatment.
(e) Mental health must be seen as only one part of health care, in addition to sufficient food, good water, shelter etc.

Medical and psychological training

Too often there is a separation of related disciplines e.g. medicine and psychology. The result is that doctors sometimes know little about how the mind and our emotions affect our body and our health; and psychologists know little about the

body and how it may affect an individual's behaviour. The result is that there is enormous specialisation and common problems are not easily dealt with.

It is estimated that 1 in 12 times a medical doctor sees a patient, the person will be suffering from severe anxiety and depression. Thus, if health workers are to be trained, it is vital that their training includes an understanding of mental health and psychological treatment or counselling skills. It is of course crucial that doctors also learn these skills and take the issue of mental health more seriously.



It is estimated that 1 in 12 times a medical doctor sees a patient, the person will be suffering from severe anxiety or depression

The community mental health worker

One way we can develop primary mental health care in South Africa is to learn from the experiences of other developing countries e.g. Nicaragua. There, individuals in communities are trained to become mental health workers.

The major task of a primary mental health worker in Nicaragua, is to detect at an early stage if someone is experiencing a psychological problem. Early detection ensures that the problem does not get worse. The mental health worker is also able to counsel those with emotional problems and to provide support for families who are under stress.

The psychiatric nurse also has a valuable contribution to make in primary mental health care. He/she should preferably work in a mental health centre in a community, and would for instance help to deal with patients who have been discharged from a psychiatric hospital. By being in continual contact with the patient and his/her relatives, the nurse would be trained to recognise if there is a relapse or to monitor the side effects of drug therapy.

The present government talks about prevention but allocates a small percentage

of the health budget to it. However, primary mental health care requires sufficient material, financial and training resources as well as rhetoric.

Finally, as has been the case in Nicaragua, the success of any primary mental health project is dependant on the strong desire of mental health workers to develop psychological skills, their lack of rigidity, their ability to initiate projects which promote mental health (for example, programmes to help people cope with the stress of parenting) and their accountability to the community.

Political and social transformation

An effective primary mental health care delivery system can only be achieved in South Africa by a transformation in the political, social and economic spheres. This would also entail a transformation in the present health services. Primary mental health care is not seen in a vacuum, and the struggle for an effective, accessible, accountable primary mental health care service is part of the larger struggle for a non-racial, unified, democratic South Africa.

The struggle for an effective primary mental health care service is part of a broader struggle for a democratic South Africa

(The work of G Marsh and M Meacher - "The Primary Health Care Team: The Way Forward for Mental Health Care" and S Walt and P Vaughan - "An Introduction to the Primary Health Care Approach in Developing Countries" are central to many ideas of this article.)

Lloyd Vogelman and Julie Green
Oasssa

Community participation in mental health: a case study

Bophelong, the only state hospital offering psychiatric services in Bophuthatswana, is situated in the Molopo Region, about 12 kilometres from Mmabatho.

Although this hospital is built in a semi-urban area, the majority of the population it serves is concentrated in the rural areas. There are about 46 villages varying in distance from Bophelong by about 5 to 150 kilometres, together with the urban populations of Mafikeng, Mmabatho and Danville, which are also served by it.

A close look at services provided at Bophelong indicates serious staff shortages and inadequate financial resources. The specialized mental health services which do exist are insufficient to meet the needs of people who suffer from symptoms of mental, neurological and associated social malfunction. This means that the hospital serves an essentially custodial function and therapeutic and preventive approaches are neglected.

This article investigates potential community participation in both the promotion of mental health and the institution of preventive programmes in Bophelong. The first part describes existing services, while the second part makes recommendations for community participation.

Description of existing professional services at Bophelong

Psychiatric and psychological services

Bophelong's psychiatric section has two full-time, and one part- time professional psychiatrist. These three psychiatrists are expatriates (Ugandan, Israeli and Indian) who are not fully familiar with the local language and culture, which makes

effective psychotherapy extremely difficult. The major part of psychiatric work therefore is limited to diagnostic and curative (medical) treatment.

There is only one psychologist providing professional services in psycho-social diagnosis and treatment. Like the psychiatrists, the psychologist is also an expatriate (Iranian), which again means that psychotherapeutic work may only be attempted with those patients able to understand English. This factor prevents the provision of psychotherapeutic services to the majority of clients, who are Tswana.

There are two fully qualified staff members who are mainly involved in casework. The high caseload makes it difficult for them to practice other methods of social work, such as group and community work.

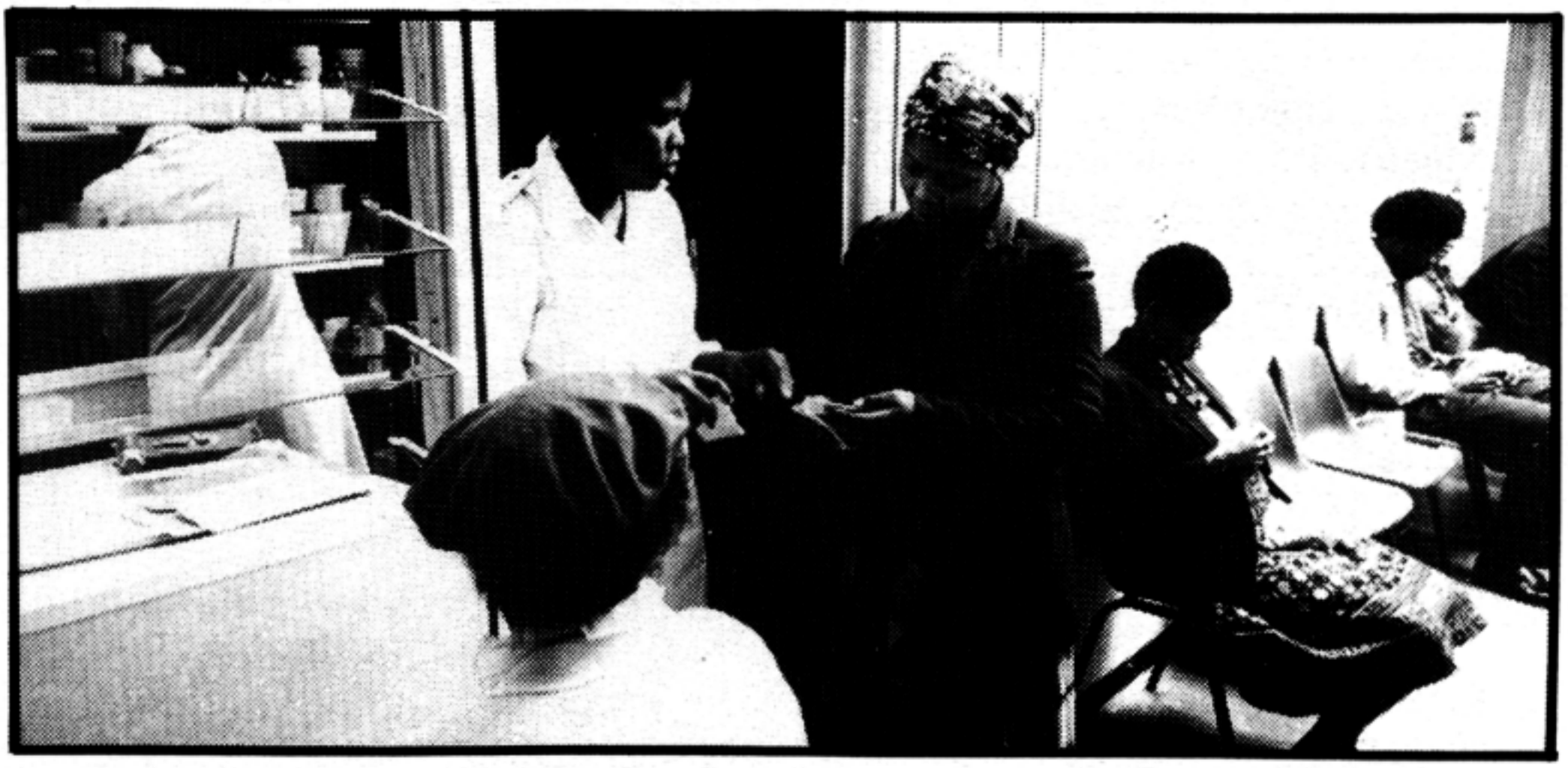
Nursing services

Nursing services are offered by thirty-eight registered psychiatric nurses, assisted by a small number of enrolled and assistant nurses.

As the hospital is also a training centre for psychiatric nurses, the student nurses in block training are periodically allocated to the psychiatric units for their practical experience.

Psychiatric commmunity services form another aspect of the nursing services. These services include:

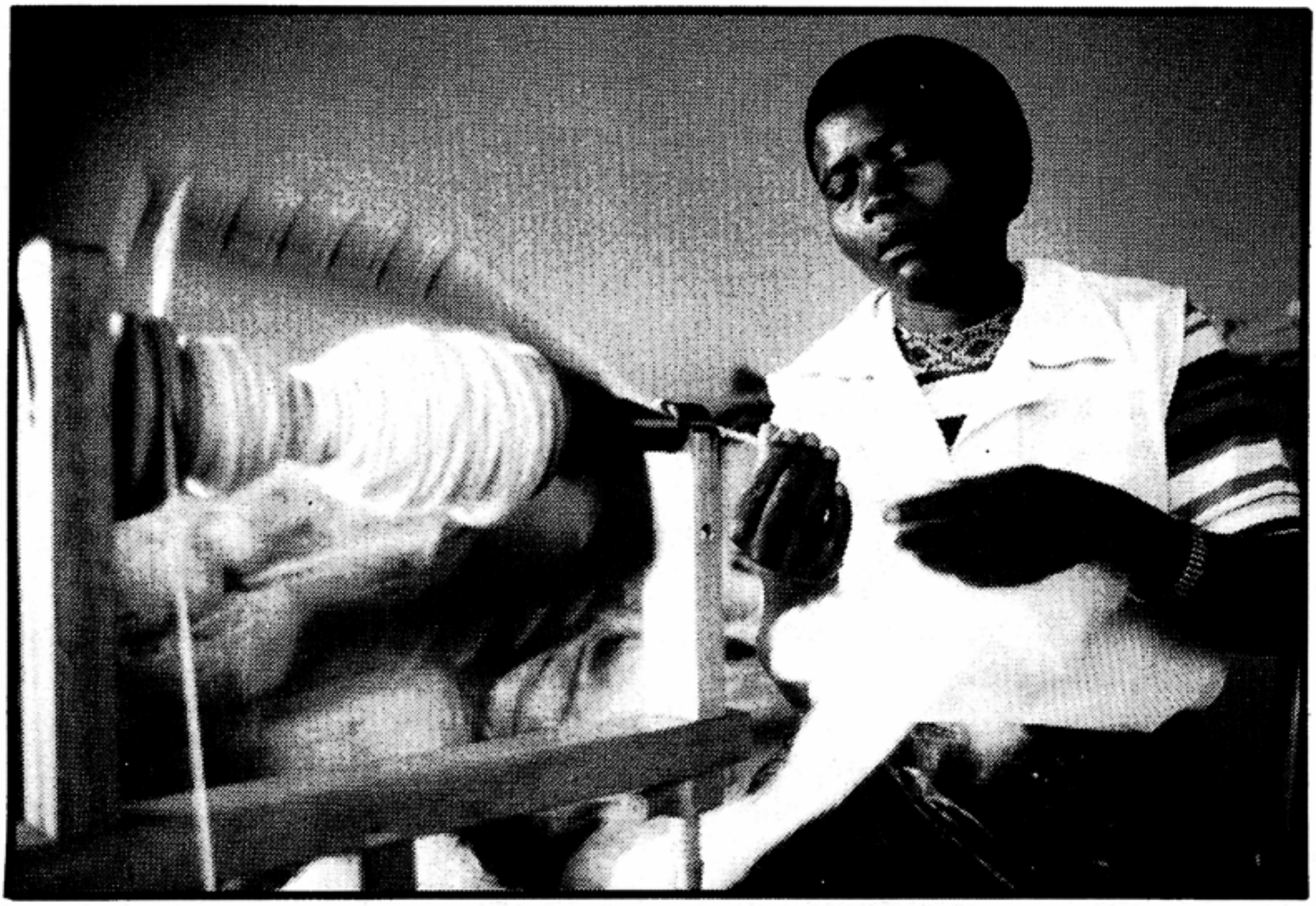
- the spread of information regarding available psychological and health resources, and communal facilities;
- the co-ordination of hospital services with those of other organisations;
- the initiation of group therapy programmes and home visits for the after-care and follow-up of patients



Nursing services are offered by 38 registered psychiatric nurses, assisted by a small number of enrolled and assistant nurses

The success of these programmes is limited by staff shortages, transport problems and the long distances to be covered between villages and the hospital.

Occupational therapy



The occupational therapy department provides recreational and craft activities

The occupational therapy department is headed by one professional occupational therapist. This professional is assisted by a registered psychiatric nurse and five nursing assistants, who are called work instructors. The main function of this group is to provide recreational and craft activities. The hospital is presently experiencing difficulties in financing this department and patients are therefore seldom fully occupied due to insufficient supplies of the necessary materials.

Shortcomings in primary prevention

Shortcomings in primary prevention are attributable to the following factors:

- an acute shortage of human and financial resources;
- the lack of co-ordination of health services with firstly, voluntary groups such as church or youth groups, and secondly, other government departments such as the Education and Manpower Departments.

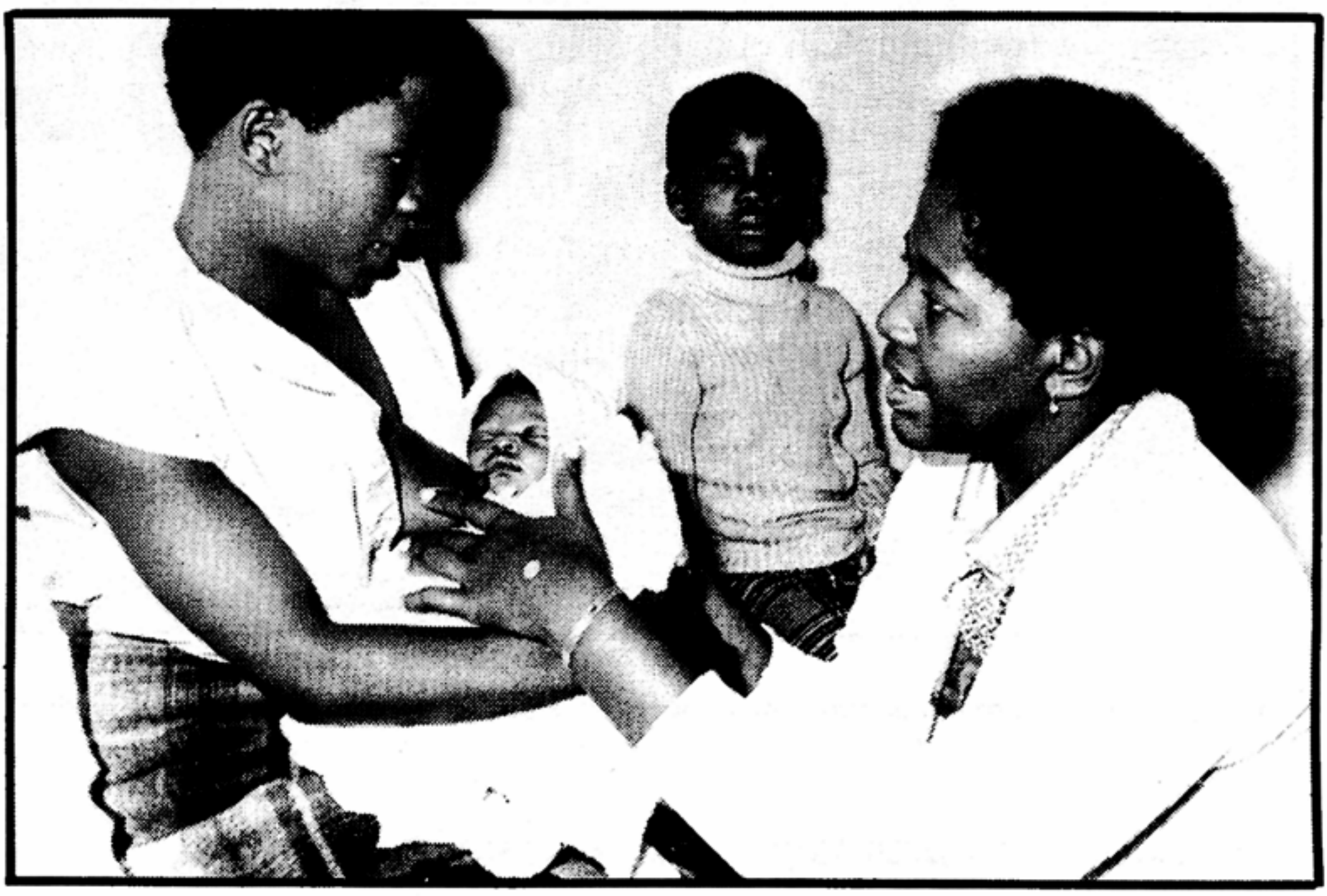
People, moreover, only come into contact with mental health education indirectly when they approach the health services for some other reason such as maternal and child welfare or through occasional health talks.

Secondary prevention

Secondary prevention is only minimally practiced. Population screening is not available. As a result, disorders which could have been treated at an early stage, are left until they require prolonged hospitalization and intensive treatment techniques. There are no crisis intervention units and the people who would normally come into contact with people in crisis, are not fully trained in dealing with such situations.

Early diagnosis is hampered by a lack of general mental health education, both on the part of the general public and on the part of other professionals outside the field of mental health. This means that the latter are unable to anticipate mental disorders arising from stressful situations, or to recognize symptoms.

Early referral is further hampered by the inaccessibility of services. Although there are health centres in the more populated rural areas, many of the centres are staffed by nurses who are not psychiatrically trained, so that a large number of cases have to be referred to the hospital.



Many people come into contact with mental health education indirectly when they approach the health services for reasons such as maternal and child welfare

Tertiary care

At the tertiary level, there are no opportunities for ex-patients to be eased back into society through transitional facilities. This situation results in an increasing number of relapses and re-admissions on the part of mentally-vulnerable patients. The two main causes for this absence of transitional facilities are lack of money and planning. Adequate coordination and planning with alternative sources could help to counterbalance the lack of available funds.

Recommendations for community participation

In order for preventive and promotive programmes to be successful, the communities' participation is vital. Communities should be involved right from the planning stage of programmes. They should be encouraged to identify their own mental health needs and priorities, and be advised on how they themselves can solve their own mental health problems.

The participation of the community in preventive and promotive programmes is vital

The use of non-professionals in crisis intervention

With limited training, proper consultation and adequate supervision, mental health workers (including volunteers) could be of assistance in handling crisis situations.

The input of mental health workers could improve mental health care at little cost and with the least disturbance of traditional home functioning and child-bearing practices

They could be trained in crisis intervention techniques and behaviour modification methods. The aim of the training would be to equip such workers to distinguish cases of serious mental illness from short-term problems. The training should enable mental health workers to deal with short-term problems while providing first aid to those who suffer serious symptoms, until they can be seen by mental health professionals.

The input of mental health workers could improve mental health care at little cost and with the least disturbance of traditional home functioning and child-rearing practices. Such services would increase referral and support facilities, a problem presently facing the mental health institution.

Research and education

A Crisis Intervention Clinic consisting of staff from Bophelong and the University of Bophuthatswana, could be established at the university. This unit would act as a consultative centre for commmunity health workers. Research into community mental health needs and solutions, in keeping with prevalent cultural and social attitudes, would be initiated from this clinic and the faculties involved. Findings from such research activities would provide a curriculum which would lead to a unique training facility for professionals in Bophuthatswana.

It is important that the community be actively involved in undertaking such

fact-finding endeavours so that they are motivated to participate in the actual preventive programmes.

Mental health education is an essential aspect of prevention. As a result of negative attitudes regarding the mentally ill in Bophuthatswana, participation in mental health issues is unlikely to be spontaneous. Mental health education should therefore aim at reducing the stigma attached to mental disorders, and at encouraging community participation in preventive care and after- care supervision of the mentally ill. Such mass education would require a great deal of staff input and time.

Community leaders as a resource

Respected community leaders such as headmen, priests and teachers could be effective resources in helping to change peoples' attitudes and in motivating action. Examples of other possible strategies likely to bring about successful results are:

- The organisation of interested community members in an intensive education campaign.
- The involvement of such people in preventive and rehabilitative services.
- The formation of an active committee comprising members of the medical, business, educational and journalistic worlds, to organize mental health weeks on various aspects of mental health. The aim of such a committee would be to draw the attention of the community to the needs of the mentally ill and to raise money for community based mental health facilities, which, as pointed out earlier in the study, are grossly inadequate.
- Once this group of interested people is formed, then methods of disseminating information could be utilized. The existing means of communication available in Bophuthatswana are the television and the radio. There are also a large number of village welfare societies, womens' organizations and youth clubs which could be approached for their support.
- The collaboration of mental health professionals, eg psychiatric nurses, with headmen would also simplify the task of organizing support groups and spreading information in the villages.

Psychiatric nurses

The part which psychiatric nurses are able to play in the training and co-ordination of community health workers should not be underestimated.

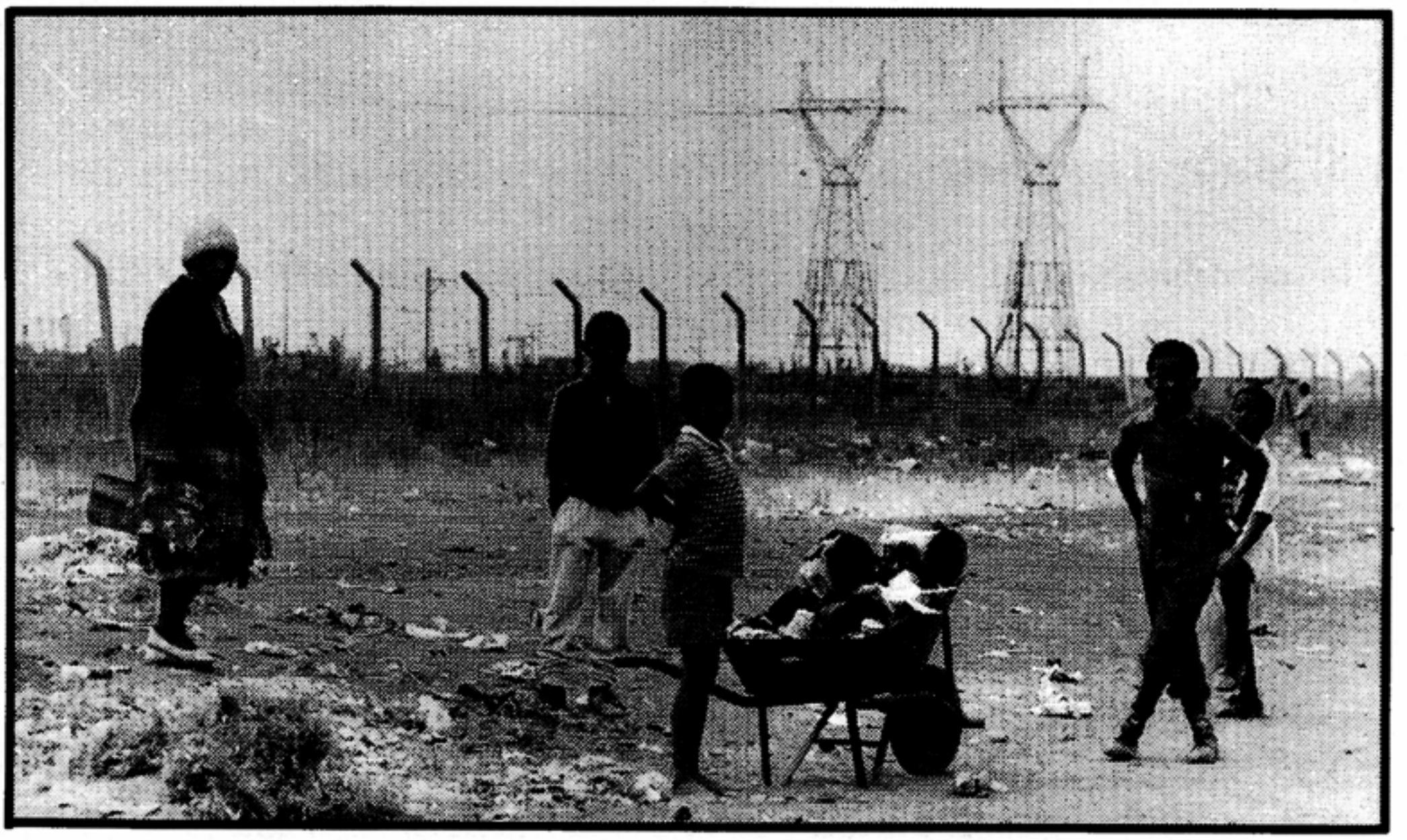
An interesting example of the role of psychiatric nurses in community-based care is provided by the development in Botswana of village-level psychiatric services.[1] There, psychiatric nurses train and supervise village health workers, who

are called Family Welfare Educators. These are chosen from the village and by the village. After an eleven-week training period, they work essentially as health educators and motivators, promoting preventive activities and giving first aid and treatment for minor ailments.

Support systems

In Bophuthatswana, there are no formal mental health networks such as marriage counselling centres, child welfare societies, mental health societies and the like, to supplement the services provided at Bophelong. Rehabilitation facilities are grossly inadequate. This situation necessitates the use of support systems.

The family can function as an important support system. In cases where it is appropriate, family cohesion should be encouraged in order to protect and maintain mental health.



Poverty, poor wages and the migrant labour system, are all seriously implicated in the fragmentation and destruction of the family life of most black people

Poverty, poor wages and the migrant labour system, are all seriously implicated in the fragmentation and destruction of the family life of most black people. Where however, extended families still exist, health and welfare services should avoid segregating and isolating family members.

With regard to the aged and especially the mentally ill, care should, if possible, be provided at home and full hospitalization avoided at all costs.

In cases where hospitalization is unavoidable, it should be as short as possible and professionals should encourage family visits to the hospital.

Diagnosis and therapy should involve the active participation of family members. Wherever possible, health care technology should be combined with family care so that, for example, the chronically ill can benefit from home care help. Through such care, the reliance on hospital care may be reduced, whilst the quality of life of the chronically ill is enhanced.

The decentralization of health services

This task would be further achieved with the decentralization of health services to the level of district clinics. The hospital could ensure that small psychiatric units with daily out-patient facilities form part of these clinics. Such units would then be under the day-to-day charge of a psychiatric nurse.

Other support systems could be provided by voluntary groups and the churches.

Indigenous healers

There are a number of factors which favour the recognition of indigenous healing:

- Findings in psychological research show that the effectiveness of the healer is based upon the extent to which the healer's value system matches the value system of the patient.
- Consistent findings in the field of community mental health have demonstrated that non-professionals in a helping role can offer equal or better services than professionals.
- Western medicine has failed to explain successfully a large variety of conditions related to specific cultural syndromes such as the "thwasa".
- Western medicine, particularly hospitalization serves to increase the feeling of alienation of the patient from his family and his community. Indigenous healing on the other hand is inextricably woven into the fabric of community.
- Western diagnosis makes little sense to western patients and even less sense to patients in a non-western culture.

Policy issues

The following alternatives which may promote the greater cohesion of the extended family and other caregivers are suggested:

- The initiation of housing programmes that provide residential accommodation that enables old people and their families to live in the same house.
- Housing for the aged should be distributed throughout the community and not be segregated far away.
- Where feasible, installation of telephones at a low rate should allow old people to communicate with their children.
- Public transportation should be financially accessible to old people so that they can visit their families frequently.
- There should be motivation in the form of remuneration or exemption from paying tax for those families staying with their old people or mentally ill persons.
- Part-time and shared jobs for women would be a positive step towards ensuring proper child-rearing practices.
- Subsidies should be made available for rehabilitation projects initiated by voluntary organizations and other support groups.
- Legislation should make provision for the participation of non- professionals in mental health practice.
- Legislation with regard to the involvement of indigenous healers in mental health should be considered.

Conclusion

In summary then, mental health institutions should become less centralized. Because of inadequate resources, the contribution of non-professionals, support systems and indigenous healers should be encouraged and incorporated into the mental health system. Furthermore, the training of mental health professionals should be designed according to the social and cultural needs of the country.

Reference

1. David I. Ben-Tovim. 'Community-based care' in WORLD HEALTH: MENTAL HEALTH, A New Day Dawns; WHO, Geneva., October 1982.

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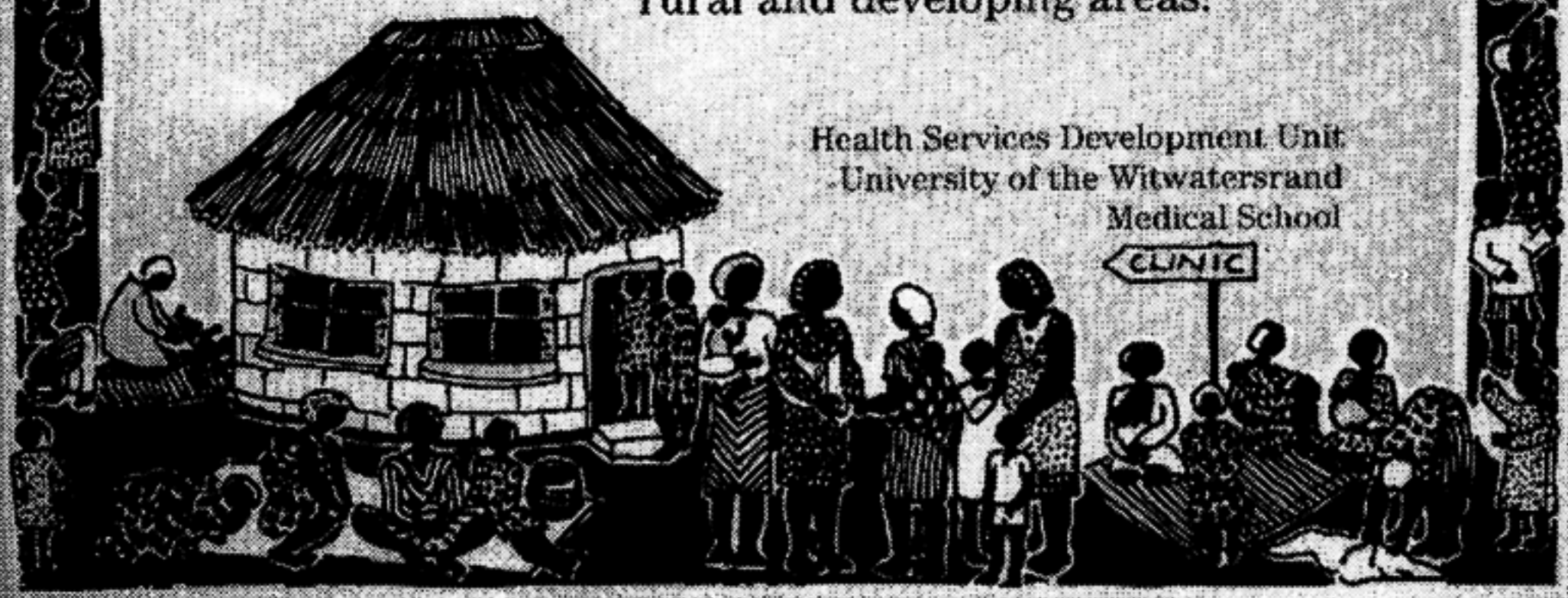
Department of Social Work
University of Bophuthatswana

Primary Clinical Care

Book 6
Sexually Transmitted Diseases

A manual of important clinical conditions for Primary Health Care Workers in rural and developing areas.

Health Services Development Unit
University of the Witwatersrand
Medical School



Book review

PRIMARY CLINICAL CARE
Book 6
Sexually Transmitted Diseases

Despite being numbered six, this is the first of a series of 15 manuals on *Primary Clinical Care* to be produced by the Health Services Development Unit of the Department of Community Health of the University of the Witwatersrand.

These manuals aim to present core medical and clinical knowledge which will enable primary health care workers to provide safe and adequate primary clinical care.

The general lay-out is easy to follow and attractive to read. Each chapter begins with a list of contents and usually ends with a summary and a series of self-evaluation exercises. There is a considerable amount of repetition but since the material is repeated in different forms this improves rather than detracts from the manual.

There are a large number of well-executed line drawings, most of which make an important contribution to an understanding of the text. There is an appropriate emphasis on social factors which contributetothe spread of sexually transmitted diseases. However there is very little on prevention, including on the use of condoms.

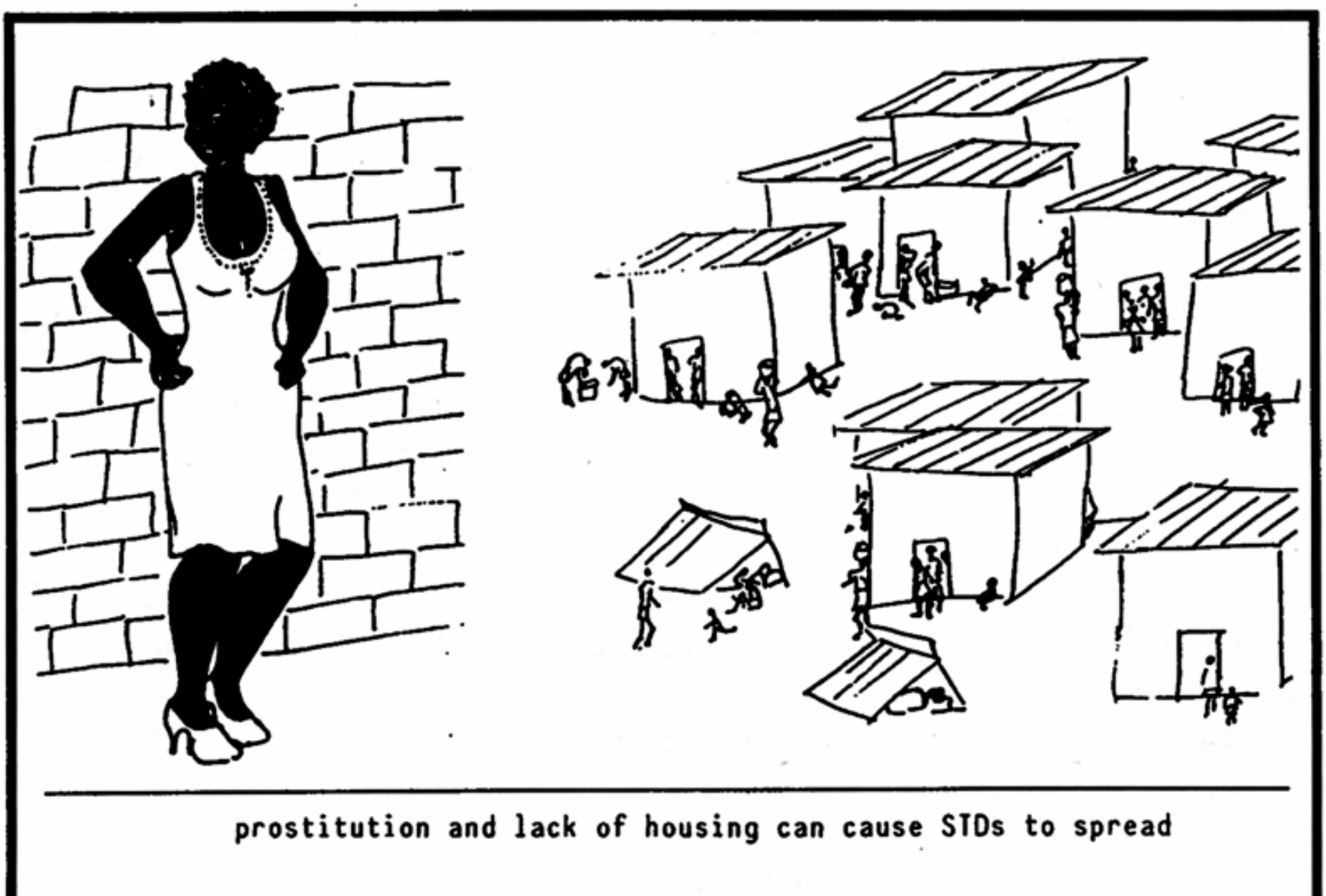
In general the content of the volume is felt to be appropriate for primary health care workers although theuse of language varies somewhat inconsistently from the unsophisticated 'sore' to words such as epididymo-orchitis. The diseases selected are well-chosen although a good case could be made out for the inclusion of a section on A.I.D.S. and Hepatitis B. It would also have been appropriate if a greater effort had been made to indicate prevalence rates so that health workers would be aware of the most likely cause of symptoms in situations where several organisms cause similar clinical features.

There are certain aspects of the content that could be misleading in the opinion of this reviewer. These include:

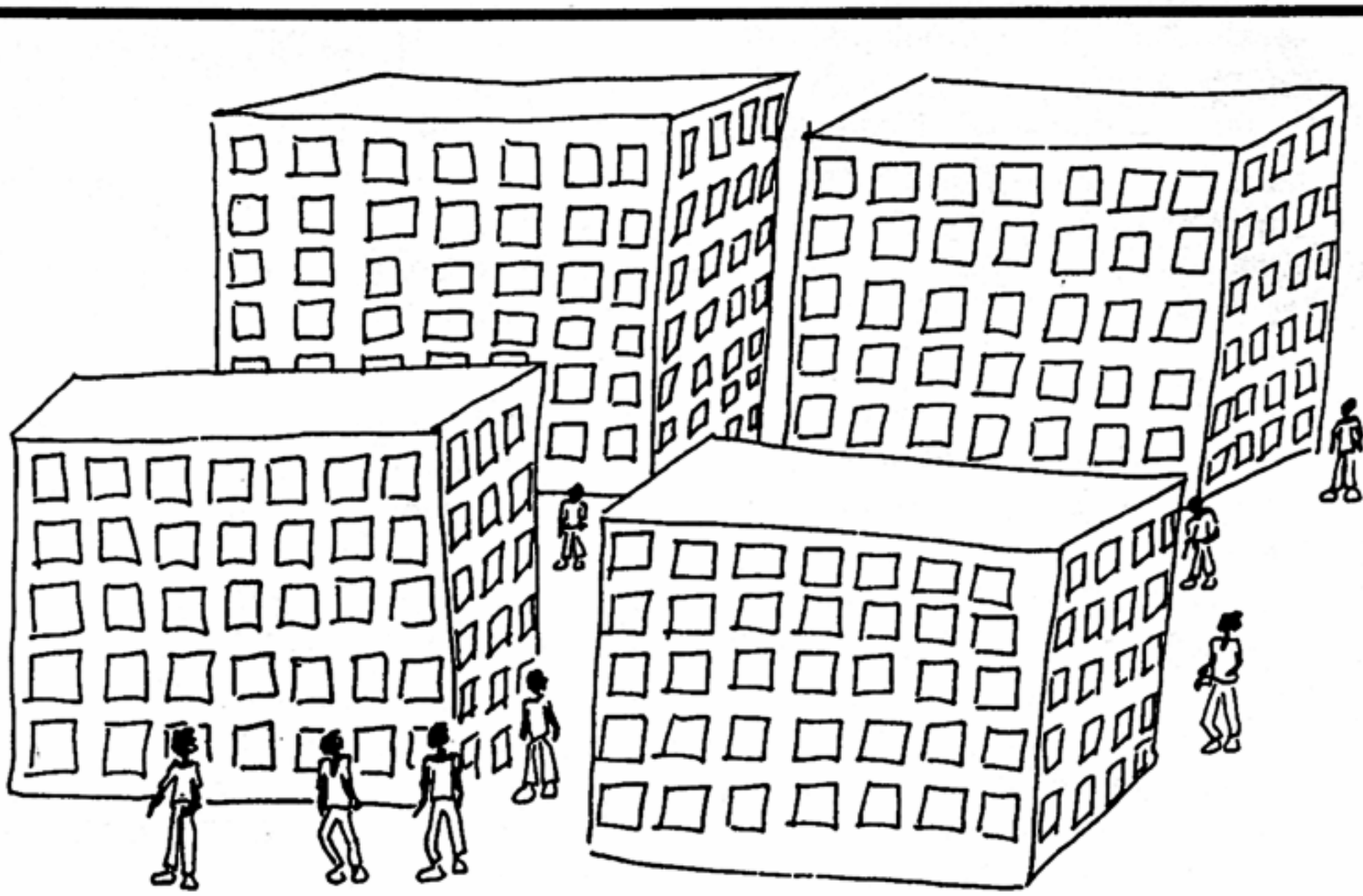
* Syphilis, chancroid, genital herpes and lymphogranuloma venereum are all

stated to be common causes of genital sores. Lymphogranuloma venereum and syphilis are a very uncommon cause of genital sores in women whereas chancroid probably occurs more frequently than all the others added together.

* Blood transfusion is listed as a cause of syphilis but this must be exceedingly rare. The possibility of the transmission of trichomonas vaginalis and gonorrhoea through the use of shared towels in the impoverished conditions in which many women live is not mentioned.
* Gonorrhoea, non gonoccal urethritis, trichomonas vaginalis and candidiasis are all stated to be common causes of discharge. from the vagina or penis but the latter two rarely, if ever, lead to penile discharge. Symptomatic vaginal discharge due to trichomonal infection is so much commoner than the others as to demand special mention lest the readers assume all these are of equal prevalence.
* The nature of the ulcer in primary syphilis is described in classical terms (single, painless) whereas it is just as likely to be multiple as it is to be single, and just as likely to be painful as it is to be painless. The most useful diagnostic feature for a chancre is the presence of associated inguinal lymph nodes which are firm, discrete and enlarged. This is not the lymphadenopathy illustrated in the text.
* Condylomata lata associated with secondary syphilis are described in the illustrations as common in axillary and inguinal sites but are very rare except in the perineal region.
* The rash in secondary syphilis is described as non-itching whereas in fact it may itch. The very useful diagnostic feature of a rash affecting palms and soles is omitted.



prostitution and lack of housing can cause STDs to spread



STDs can spread easily in migrant worker hostels and jails

* The value of a repeat test for syphilis in late pregnancy is omitted. It is important to stress that congenital syphilis is a preventable disease.
* The regime prescribed for the treatment of syphilis is benzathine penicillin 2.4 megal units or tetracycline. This is satisfactory for those who have had the disease for less than one year and who are not pregnant. However the majority of pregnant women with syphilis are diagnosed because of positive serology and there is no indication as to how long the disease has been present. In this case it is essential to treat the patient for at least three weeks. Tetracycline should not be used.
* The illustrations of chancroid and syphilis ulcers are virtually identical. Inguinal lymphadenopathy rarely occurs with chancroid in women.
* The diagram illustrating herpes is misleading in that the lesions often do not occur in clusters.
* Evidence for the value of Acyclovir ointment in the treatment of genital herpes is tenuous. Therapy more appropriate for the primary care situation is probably local antisepsis to reduce the risk of secondary infection.
* Cold sores are not usually considered amongst sexually transmitted diseases and would be better omitted.
* A regime of treatment lasting from 14-21 days is advised for lymphogranuloma venereum. In a text of this nature it would be better to be dogmatic about the exact length of time the treatment is to be given.
* The fact that more than half of the women with gonorrhoea are symptomless

should be stressed; and that men can also have the disease and be free of symptoms.

* Urethral strictures are listed as complications of gonorrhoea but it is not stated that these are excessively rare in women and can be completely prevented in men with early treatment.
* The diagnosis of trichomonas infection by microscopy is not usually based on the appearance of its structure as is suggested by the illustration, but by its characteristic movements. These are not mentioned.
* Oral contraceptives are not now thought to be aetiological factors in the causation of vaginal moniliasis.
* Painting the vagina is an effective therapy for vaginal candiasis but the importance of using adequate amounts of the dye should be stressed.
* The discharge associated with Gardnerella rarely produces a recognisable fishy odour unless 10% KOH is added to it on a slide or swab.
* Podophyllin is not contra-indicated in pregnancy as the drug acts locally. It would however be inadvisable to use it following cautery as then there is the risk of absorption.
* The treatment of mild PID is not clearly specified. It would appear that a regimen of 4 or 5 different drugs is advised.
* Inflammation of the vulva, perineum and inner thighs are not characteristic of trichomonas infections. This will occur with any excess vaginal discharge if the women does not have the facilities to keep herself clean.
* In most situations in which primary health care nurses are working, trichomonas infections are probably much commoner than gonorrhoea. Thus it is appropriate to use trichomonacides before using drugs active against the gonococcus in cases where therapy is commenced on the basis of clinical features alone.
* The management of urethral discharge in males provided in the summary is confusing. Is both penicillin AND tetracycline/erythromycin advocated in all cases?
* Metronidazole is not contra-indicated in pregnancy although it is best to avoid its use in the first 90 days.
* While it is traditional to pay lip service to treating both partners in the management of trichomonas infection, I have yet to see any evidence proving that this is of value as a routine measure. It is better to reserve treatment of the male for situations where infection is recurrent. The male should then be treated at the clinic.
* Co-trimoxazole (Bactrim/Septrin) is now packaged in two strengths, hence dosage needs to be specified.
* The advice to check for freedom from active herpes before advocating vaginal delivery is appropriate, but the means whereby a primary health care nurse can do this is not specified. Ideally vaginal cultures should be taken. This is obviously impracticable hence some rule of thumb must be suggested. Viral shedding can continue after the herpetic lesions have apparently healed.
* There are a few spelling errors or misprints: co-trimoxazole, vulva, podophyllin, gonnococcal, orally, group.

The reviewer appreciates that some of these comments may be the result of personal idiosyncracies. Few, if any, are of great significance and do not indicate problems which detract seriously from the usefulness of this manual. It can be warmly recommended for the use of the medical workers for whom it was designed.

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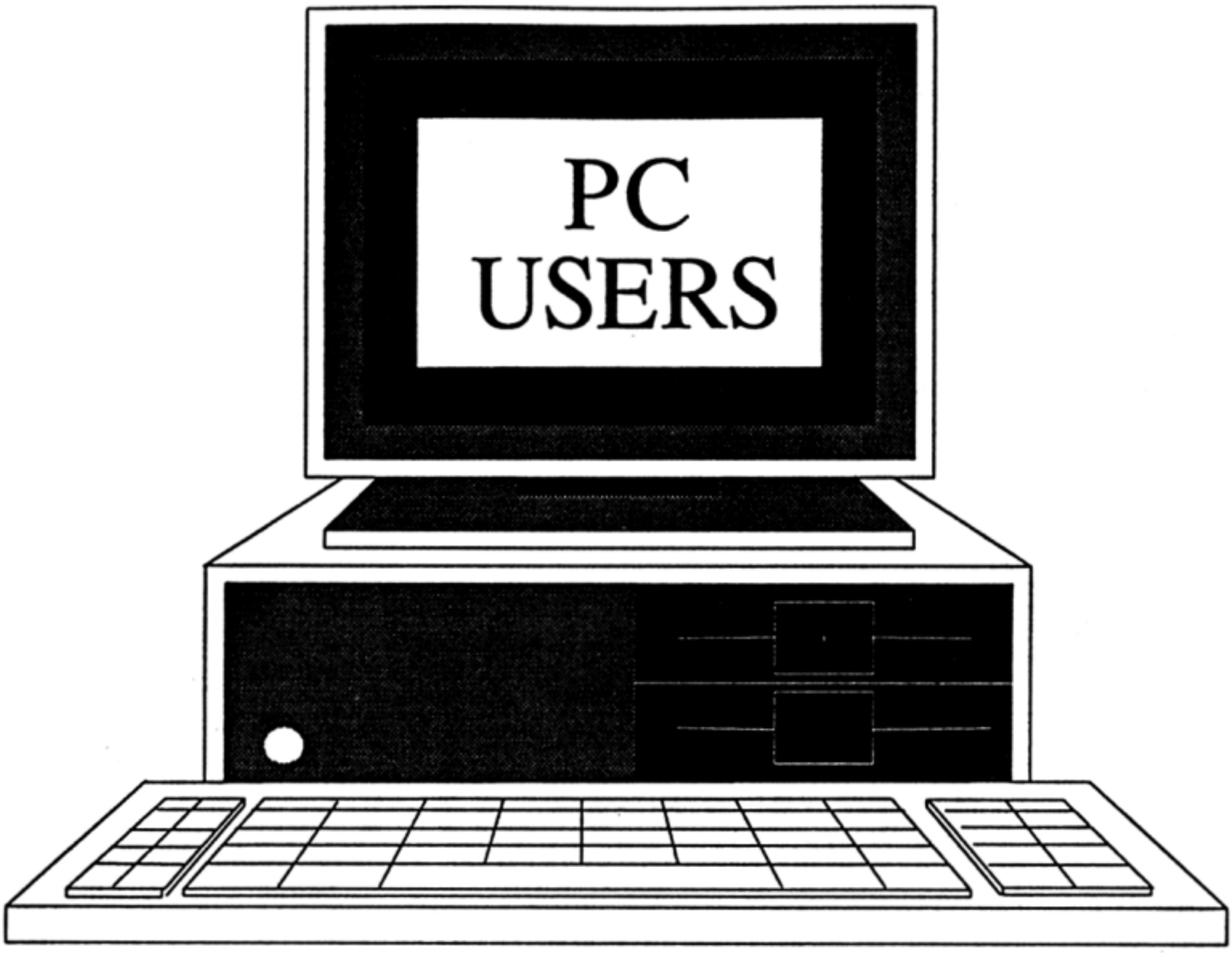

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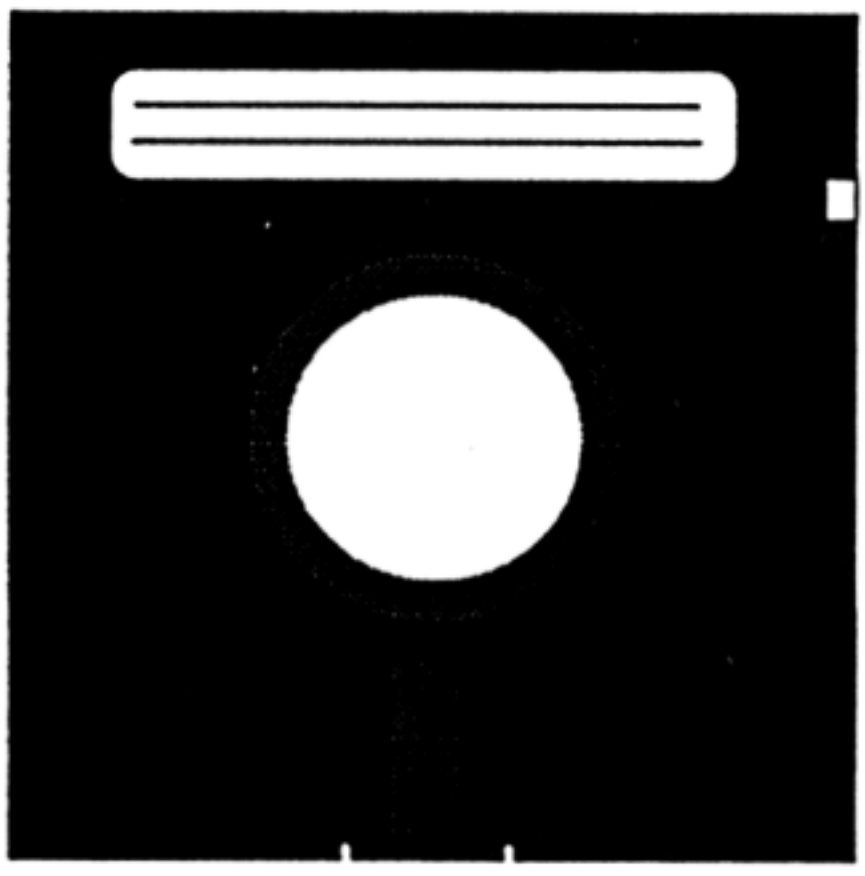

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