Critical Health

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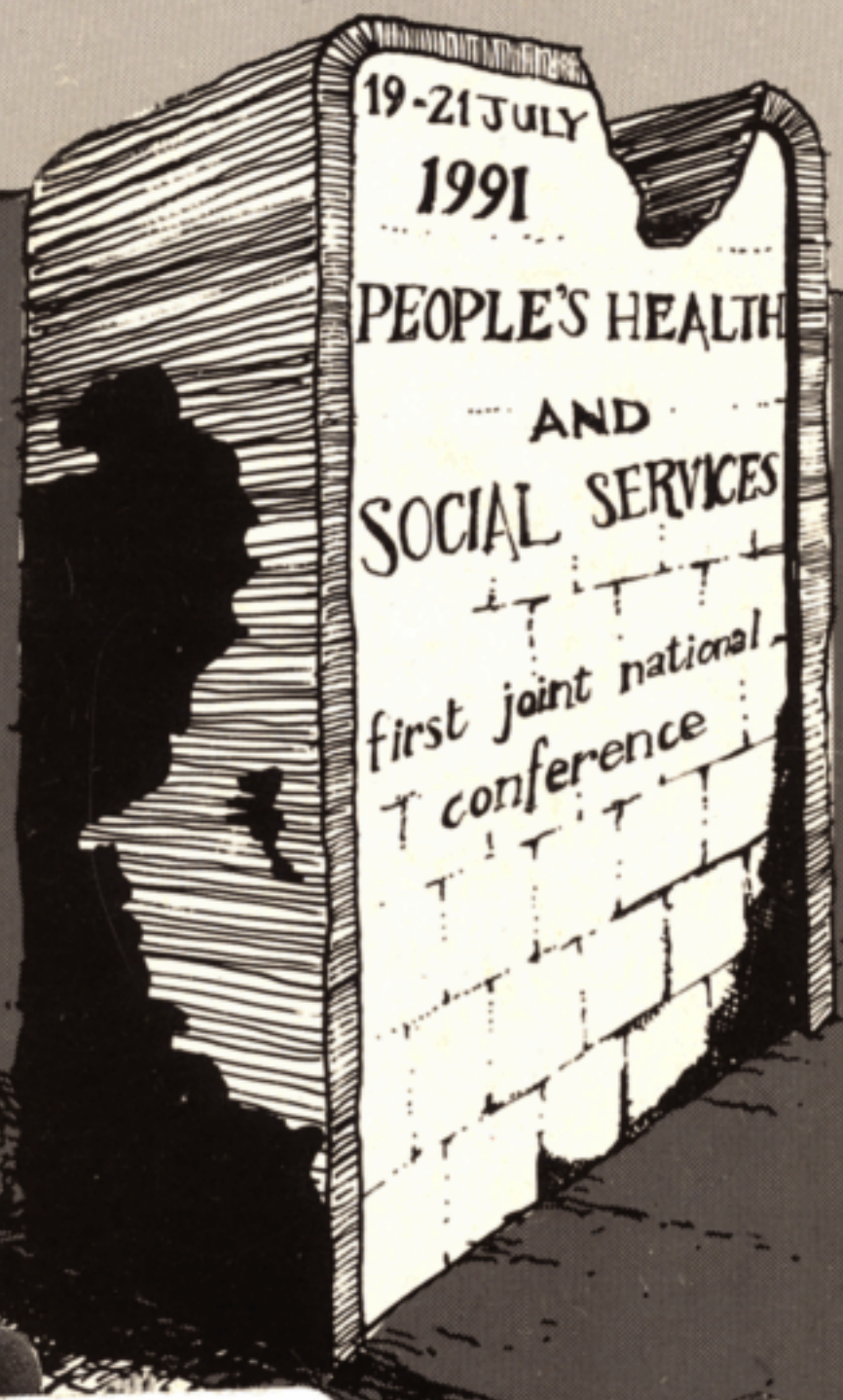


conference edition

Contents

Typesetting by Critical Health

Thanks to Ant Philbrick for the graphics in the section breaks and the cover. Critical Health is published by an editorial collective: P.O. Box 16250, Doornfontein, 2038. Tel. (011) 484 3078. The Critical Health editorial collective is: Sharon Fonn, Malcolm Steinberg, Shereen Usdin, Raymond de Swardt, George Dor, David Bruce, Ismail Vawda, Laetitia Rispel, Clifford Panter, Ahmed Valli. The views expressed in this publication are not neceessarily those of the editorial collective

A Step Forward for Unity and Policy

This edition of Critical Health reflects the proceedings of the first watershed joint national conference of progressive health organisations which took place in July 1991.

The health and welfare of South Africans are closely linked but there are conflicting ideas as to how health and social services should be provided in the future. Although discussion often revolves around what is best for the country, proposals usually come from groups with very different interests and perspectives, and often come from elites who have no experience of conditions on the ground. A conference which tried to address these problems took place in Cape Town in July 1991. It was entitled ''The People's Health and Social Services - First Joint National Conference''.

An exceptionally wide range of people participated. There were health and welfare professionals, including private practitioners, academics and senior administrators. A large proportion of participants were primary health care and advice office workers, who are not professionally registered, but who are deeply involved in providing care to those who need it most. The range extended further, from economists to community activists. Most would consider themselves affiliated to the progressive movement, that is, political organisations representing the disenfranchised.

The conference had two aims - promoting unity and developing policy. It was hosted by the Health Workers' Society (HWS), the National Medical and Dental Association (NAMDA), the Organisation for Appropriate Social Services in Southern Africa (OASSSA), the Progressive Primary Health Network (PPHCN), and the South African Health Workers Congress (SAHWCO). All of these organisations (with the exception of PPHCN, which is a network of health projects and does not have individual members) have been debating for some time whether to unite into a single organisation, representing the majority of progressive health and welfare

workers in the country. The debate culminated in a decision at the conference to unite into one body in early 1992.

The second aim - developing policy - was pursued in 19 workshops which ran in parallel. In each workshop, people with very different experiences and perspectives focussed on an area of common concern. Participants identified what they felt were the major defects of the current system, what solutions were possible, and how these could be implemented. While there was consensus on many issues, differences of opinion were also explored. It is not possible here to do justice to the depth and scope of discussion. However, a few points from some of the workshops illustrate this diversity.

For example, delegates in the workshop on ''Regulation, registration and statutory control'' in theme A, workshop 4 asserted that existing restrictions on practice were mainly aimed at protecting the established professions, and were largely inappropriate to South Africa. These restriction should be changed to suit community needs, through a process of dialogue between clinicians, academics and communities.

The workshop on ''Financing health care'' (A5) concluded that a tax-funded national health service was desirable in the long term, but many participants felt that national health insurance should be implemented to provide the necessary finance in the interim.

Another workshop discussed priorities in welfare spending, and the relative importance of public and private sector welfare financing (A6). Voluntary welfare organisations should be encouraged, but the state was responsible for ensuring a comprehensive net of social services.

In Theme B ''Integrating traditional healing and PHC'' was examined in one workshop (B3) in which traditional healers were among the participants. Participants in the workshop were often divided in their perceptions of the relative merits of traditional and western medicine. There was agreement on the need for some form of registration of traditional healers but also a concern that such a system should be separate from the system of registration for Western doctors.

On the issue of redistributing health personnel (B4) participants identified an imbalance not only between urban and rural areas, but also between personnel in the private and public sectors as well as between providers of curative and preventive care. Amongst their recommendations was that there should be compulsory community service and incen

tives for working in underserved areas.

One workshop discussed the need to prepare health personnel for the AIDS epidemic (B5). Not only did health workers need to be able to counsel and treat people with AIDS, but they also had to come to terms with their own anxieties. Another workshop focussed on the role of Primary Health Care in AIDS prevention (C1). PHC workers need to engage with the problem of encouraging people to change their sexual behaviour.

Eight workshops were grouped under the theme of integrating specialised programs into comprehensive primary health care (Theme C). Discussions about child health emphasised the impact of social disruption and deprivation on children, whose health suffered most severely from poor housing, lack of access to health services, malnutrition and other features of poverty and neglect (C2). Children's rights were frequently violated. While children had many pressing needs, including, access to comprehensive care, interventions like nutritional support and health education were feasible in the short term.

In C7 union-based health care initiatives were examined. The strengths and weaknesses of state-provided services, medical benefit schemes and medical aid schemes were compared. Medical benefit schemes were used by many union members, and were said to give members greater control over the form of health care provided. It was important to optimise the quality of care, and to consider how union-based schemes could link to a future national health service.

The impact of political repression on health care was examined, drawing on the experience of the Emergency Services Groups (C8). There were still former political prisoners and detainees in need of counseling and health care. Political and criminal violence such as vigilante attacks and taxi wars impact on the lives of many who lack access to trauma care; local trauma units were suggested.

The conference revealed that there are feasible ways of ensuring that South Africans receive the health and social services that they need. No single blueprint emerged, but there was consensus on key issues. Firstly, there is an urgent need for improved services, with the state ensuring that everyone has access to care of a reasonable quality. Secondly, resource constraints necessitate more efficient ways of delivering care, many of which have been shown to work in this country and abroad. Thirdly, policy should be developed democratically, with participation of all interested

parties, especially the public. Democracy should be built within the health and welfare systems, giving more of a say to non-professional health care providers.

The present government may claim to believe in all of these principles, but, in the experience of conference participants, it merely pays lip service to them. As the country becomes a democracy, people previously excluded from decision-making will have much more influence. Within the field of health the new united organisation will be able to play a valuable role in expressing their concerns.

Acknowledgements:

The committee would like to acknowledge the assistance of Field Sportswear, Helga Johannes, Making Music Promotions, Pablo Navaro, Southern Women, Thevi Pillay, the University of the Western Cape, Zhauns, and Critical Health. A very special thanks to the following for freely giving their time and services: Akhbar Khan, Community Education Computer Services, Health for All Resource Service, Masizame Creche, Radiopage, Regional Coordinators, Standard Bank, UWC Radio Society, workshop facilitators and the many volunteers. Finally we would like to specially acknowledge the financial contribution of the Henry J. Kaiser Family Foundation. Without these contributions and the enthusiasm of several hundred participants, this conference and its important results, would never have happened.

The Conference Committee

Max Bachmann
Greg Hussey
Raksha Makan
Fuad Moerat
Mike O'Brien
Sandi O'Dowd
Hannes Potgieter
Louis Reynolds
Joan Westaway
Merrick Zwarenstein

A Note from Critical Health

This weekend conference brought together about a thousand people from different areas of health and welfare, including a number of community activists and unionists. In a spirit of unity, organisations merged their annual conferences together to allow crucial debate to be taken forward at an unfragmented forum. This was indeed historical.

Trying to place words on paper to capture the essence and vitality of the workshops is difficult. Some workshop reports are longer than others. Some have managed to put across the intensity of discussion better than others. What we have tried to do at Critical Health while editing the proceedings is to not lose the heart of those discussions. It has not been an easy task. We hope that this edition truly reflects the energy, the various opinions and the importance of the conference.

The editorial collective of Critical Health would like to thank the conference organisers, especially Raksha Makan, for their help in getting this edition together. Finally we would like to thank all the writers and contributors who submitted their reports to us, and who helped with editing.

Critical Health

Messages of Support

The following messages of support were received from organisations around the country. They have been shortened.

African National Congress (ANC)

We recognise that the struggle for health has been a long and arduous one, and the issues for conference areweighty and difficult, but democratic transformation of all services must now occur. We wish you speedy and constructive decisions on laying the basis for a democratic, non-racial and non-sexist national health system for our country

Cyril Ramaphosa
Secretary General

Pan Africanist Congress (PAC) of Azania

The health crisis in this country cannot be solved unless national liberation is won. Only in this way can the masses of our people participate in the development of a National Health Service. The PAC Secretariat sends fraternal greetings and full support for your deliberations on this vital issue of health care in Azania.

Dr. Selva Samaan
Secretary for Health

Congress of South African Trade Unions (COSATU)

South African laws, customs and practices deprive the majority of its people of basic health rights. The Unity Forum is a logical and good process for all democratic health forces in the country. COSATU takes this opportunity to extend fraternal greetings to your First Joint National Conference.

Jay Naidoo
General Secretary

South Africa Communist Party (SACP)

I congratulate all of you in successfully bringing together progressive health organisations and individuals concerned with the future of health in South Africa. We are confident that your historic conference will lay the organisational and policy foundations for the challenges which lie ahead in the health sector.

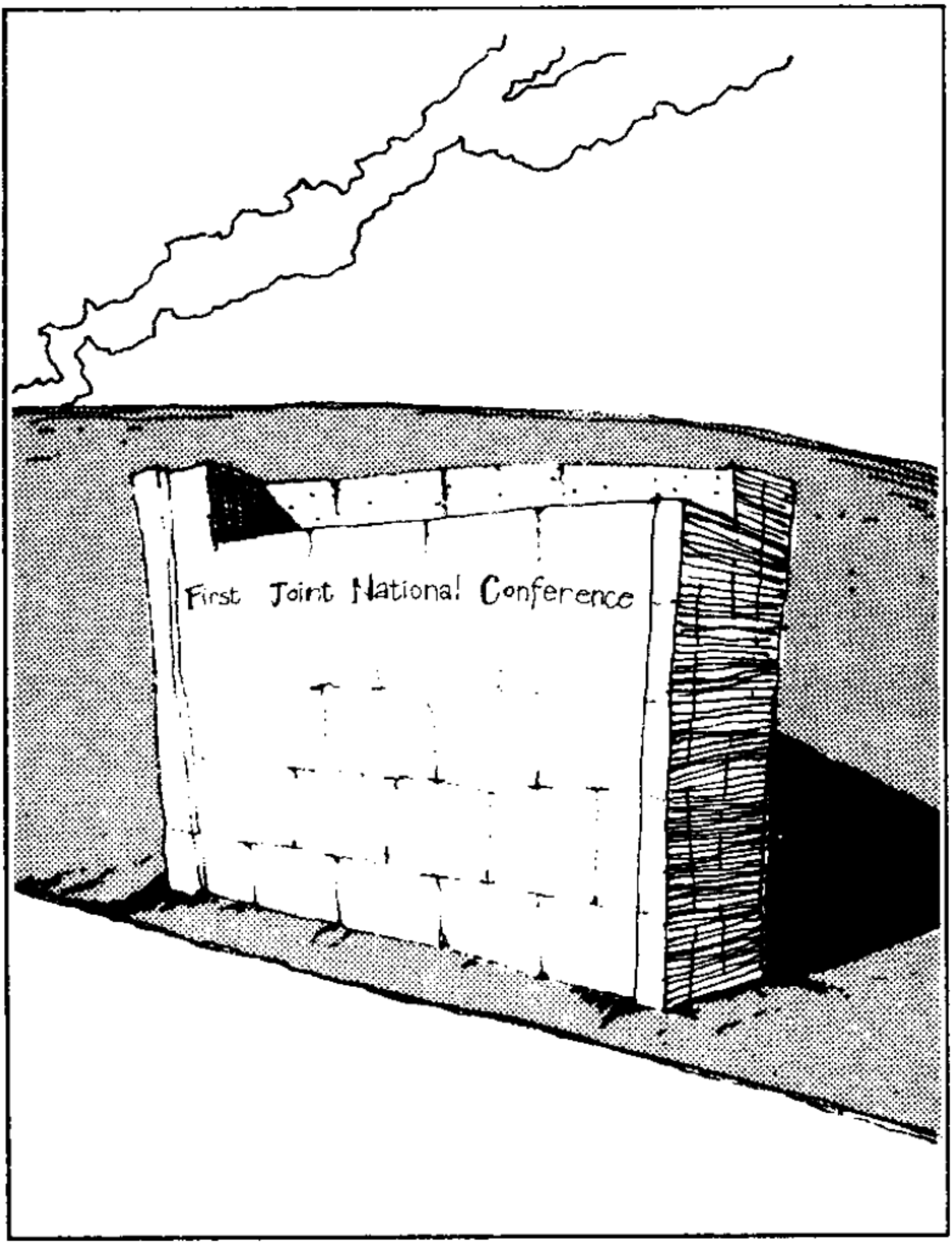
Joe Slovo
General Secretary

The following organisations also sent messages of support:

New Unity Movement
ANC Health Department
Islamic Medical Association of South Africa
Social Workers Forum

SECTION I

Opening Addresses



Welcome Address

by Albertina Sisulu, President ANC Women's League

Albertina Sisulu

Comrades, I am a health worker. But I am a health worker AND a person who is struggling for the freedom of the people in this country. Before I address you, I'll have to give myself time to salute you, and I think you will support me. Amandla!

It is indeed an honour and a pleasure to address you on this occasion of the First Joint National Conference of progressive health organisations. When you are a health worker your wish is to see your work progressing. I am happy that I am addressing you on this occasion of joining hands to fight for the lives of the people. That is your work - to promote health. At the same time I cannot pat my shoulder and say you have done well because there are still those who will have to follow up what you are doing now. But some of you who are my grandchildren, in fact, have done a lot of the work so far. Congratulations.

The struggle for health

Our struggle to unite health workers has been, and still is, a major task given the history of Apartheid and the divisions forced upon us. Our task is a mammoth one, but it is an honourable one. When we achieve the democratisation of health services we will have effectively placed health in the hands of the people. We have reached that decisive point in our struggle where we can ill afford the practice of simply discussing and debating matters of principle. We must find practical methods of implementing the decisions we make. I am aware of the wonderful work being done by SAHWCO and NAMDA and many others in setting up clinics in squatter communities. We have to look practically at what is possible to advance, especially primary health care, with the limited resources at our disposal. Given the need for housing, job creation and other essential services, the funds needed to build an equitable health infrastructure may not be immediately available. In addition we have the added burden of privatisation which has a negative impact on the health of the poor.

Unification and plan of action

You will discuss unification of progressive health organisations. It must be done in conjunction with a program of action which should have a time frame for dismantling the old services and building a new system. The unity of health workers is therefore essential.

Democratic participation

We are committed to democracy, and by our understanding of that, we mean the participation of communities in planning and implementing health policies. If our commitment is sincere we will arm our communities with the necessary knowledge to enable them to take informed and sober decisions about health care. I am advocating a move away from the old style of work where we take good ideas, beautifully typed and bound, and do nothing to ensure that the affected communities debate the issues, and feel part of the process.

Consultation and false hope

Our first step in ensuring true democratic participation is making all the

facts known to our communities. In that way we will avoid building false hopes which may frustrate our people.

I speak to you as a health professional who has had to work within an approach to health designed by British colonial rule and Apartheid. When we sit together and formulate a health policy, let us put the people first. We must therefore concentrate on the process of change in health care which will have to be gradual because of the nature of the service. We must work for equality. We must place emphasis on preventative, rather than curative health care. We must ensure we provide health care that is affordable.

Issues for health workers to address

You have come this far and united us all. I wish that your deliberations will deliver a constructive program of action. Comrades, a plan of action does not necessarily mean that you must go about organising people to fight. A program of action, as far as health is concerned, is consultation - to understand exactly what the people need and how you can provide them with appropriate health care. This is very important. If you don't know what they need then how can you provide them with health care? They will not follow you. An important part of being a health worker means you getting down and understanding the health needs of the people, for example, health care in informal settlements.

Health in informal settlements

Shacks are being demolished time and time again. It is often in winter that the government thinks of destroying shacks. We should have been the first people to say to the government: "Stop", because we are the promoters of health. Children in these settlements play in dirty water and drink this dirty water. The result is diarrhoea and vomiting. Because we don't have enough health centres, these children often die before they get to hospitals, which are many kilometres from where they stay. In addition medicine prices are so expensive that nobody can afford them. If your child gets ill at night,

pray that your child dies in your arms, rather than in the street, while you are looking for transport. People in shack settlements die like flies. They die from violence and the conditions under which they have to live. I hope and wish that from your deliberations we will be able to decide on what should be done.

Health workers and facilities

Health workers are the backbone of the nation. There is no nation without health. The health centres that we do have do not operate 24 hours a day. What is expected of people who get sick at night? Must they just die? Ambulances take hours before they get to you. In addition they charge high prices to transport people to a hospital. Most of our people cannot afford that. Far more health centres open 24 hours are required.

The way forward

I don't think that there is anyone here who could come up and say that as far as our province is concerned, we have enough health centres. If so, I would say what is happening with AIDS? Has enough work been started on that particular issue? However, I am glad to say that there are two areas, Alexandra and Tembisa, which I can congratulate and say that they have done well as far as health is concerned. They have put up health services. They have even attended to the question of the ambulances that are not coming when they are called.

But that depends on the workers, on the people whose work it is to promote life, whose work it is to see that people are being treated until their conditions are improved. Without proper conditions for people there will be no real quality of life.

I am happy at least something is being done because you are here today to take resolutions and initiate action.

Thank you, comrades.

Albertina Sisulu

Keynote Address: Primary Health Care at the Margins

by Erika Sutter

Erika Sutter

Introduction

Primary health care is based on two pillars:

Accessibility of institutional health services, from district hospital to mobile clinics, and

Community involvement in its own health care.

Both are essential to achieve "Health for All". The establishment of health facilities is relatively easy, provided resources are available. But real community involvement is harder to achieve, because it requires special skills and a favourable environment.

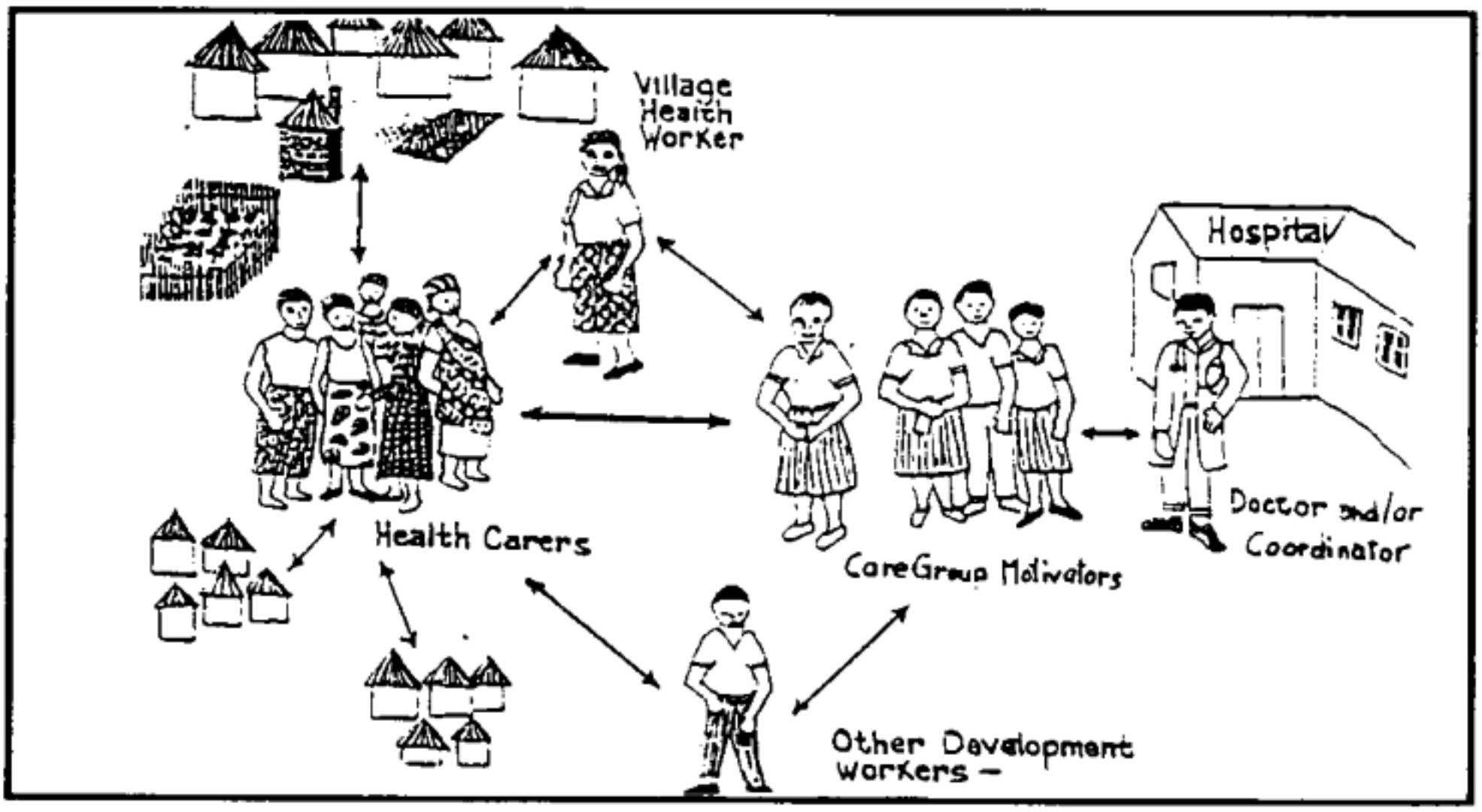


Figure 1. Organisation of the Care Group

We should like to illustrate this by presenting a community project in a marginal situation, and then to discuss the interaction at this peripheral level between the local health institutions and the local community.

The Elim Care Group Project is located in Gazankulu, a remote homeland in the northern Transvaal. It involves the people most deprived of their rights, jobs and recognition: women in poor communities. The project started in 1976, when we realised that trachoma could only be controlled by the community itself.

Operating at the margin calls for crossing the borders beyond health towards community development. It also involves challenging the rigid structures of health institutions.

I. The Care Groups

This picture (figure 1) shows the organisation of the Care Group Project: the coordinator and the care group motivators, based at the hospital, and the groups in the communities.

The coordinator, a doctor or any other suitable person , trains the motivators and administers the project.

The care group motivators are the key persons of the project. They are usually assistant nurses or Community Health Workers

(CHWs). We found this type of health worker to be more effective than people who have had longer training, who often have difficulty in bridging the educational gap.

The motivators visit the groups for ongoing training, facilitate the building of awareness of community problems, and stimulate the people's own skills in problem solving.

When we started we had little knowledge about community health. All of us had to learn the hard way, most of all the motivators. They had to develop their methods of group guidance with all too little training, and with more harassment than support from the nursing professionals. Through trial and error, the motivators' skills grew far beyond those of their counterparts who remained in the hospital wards. They have not only become health educators but also community developers in a wide sense.

The motivators form the main link between the community and the local hospital, but they often feel that they are hopelessly sandwiched between the demands of the groups and those of the coordinator.

The care groups are unpaid volunteers, working within their own communities. They were initially established with the objective of reducing blindness from trachoma within the area.

In general, a selective, disease centred approach is a bad approach. But this disease of poverty and poor hygiene turned out to be an ideal stepping stone from which to start up health awareness and community action in the field of health and development. This was probably because the disease was well known and people were worried about it.

At the beginning, most members of the group were mainly interested in preventing trachoma in their own families. Their motivation to share knowledge and eye ointment with their neighbours was essentially to protect their own children from infection. Contrary to what I expected, we found that for most poor people, their own family comes first. The sense of caring for the well being of the whole community developed later.

There were some notable exceptions to the rule, like one group of people who cared for the old and sick in their community.

Although at first the groups were concerned mainly about their own families, they succeeded in motivating their own community towards improvement of environmental and personal hygiene. Surveys on hygienic practices and prevalence of trachoma confirmed that there was a real change. People started to use individual face cloths instead of the family rag, dug refuse pits and toilets to reduce the fly population. Consequently,

the prevalence of trachoma decreased from 30% to 10%.

As their awareness and interest in health grew, the groups started many other activities, such as child nutrition, oral rehydration, dry land vegetable growing, fuel saving mud stoves, peanut bulk-buying schemes and many more. Lately, some have also become engaged in income generating cooperatives, thus addressing the root causes of ill health, namely poverty.

We had expected that the poorest of the poor would join the groups in good numbers. However, surveys have shown that most of the members came from the middle social strata of the local society. Of course, in a very poor community, even those people live at, just above or even below the poverty line. Few of the very poor joined, because most of them have no energy left for extras, as they need all their resources for survival. The more affluent, on the other hand, are hardly touched by diseases of poverty and see no reason for concern.

The groups had many successes, statistically measurable ones as well as an unmeasurable enhancement of human values. The project has grown in Gazankulu to a total of 193 groups, comprising 8 800 women. There are also groups in Venda, Lebowa and Kangwane.

Naturally there were failures as well, from which we learned more than from successes. The list below summarises some of our experiences:

The Care Group Project; Problems and Mode of Action

PROBLEMS:

- Insufficient training of Motivators
- Groups self-centred and subsequently alienated from community
- Dependency from outside
- Interference from outside

REQUIREMENTS:

- Sensitive approach:
  - cannot be ordered
  - cannot be pushed for time
- Respect:
  - own human dignity
  - own skills

EFFECTIVE WHEN:

- Find own solution to one's problems
- Allowed full responsibility for their project
- Supported by
  - community
  - tribal authority
  - health services

We had problems with the proper training of the motivators. Some of the groups became self-centred, others too dependent on outside input.

Interference from outside led to discouragement: for example, political unrest in 1990, or interference from professionals who did not understand the way the groups functioned.

Working with community groups therefore requires a sensitive approach and respect for the rural women's dignity and skills. Groups can't be ordered around, nor can they be pushed for time.

This, in short, is the history of the Care Groups. We now come to the relationship between them and the health services.

II. The Care Groups and Health Services

The two main pillars of PHC, health services and community involvement, are often diametrically opposed in their methods for achieving the common aim, health for all. This can create conflicts which are not easy to resolve.

Some of the conflict areas are listed above. They have been felt at all levels of the Care Group Project. The reactions of the Care Groups are a good indication of community feelings towards health services. I will not comment much on the community side of the table.

1. The Time Factor:

It is urgent that the medical services should expand rapidly to make them accessible to all.

Figure 2. `I had to learn that people do not want to be used'.

On the other hand, community action is a slow process, from awareness building to finding solutions and finally suitable action. It requires long term planning.

I often wanted to push the Care Groups to proceed faster, but Selina said: ''Wait, they are not ready yet''.

2. Organisation:

The health services are based on the professional hierarchy which coordinates service delivery. Decision making is thus top-down and from outside the community. The community is expected to respond favourably to

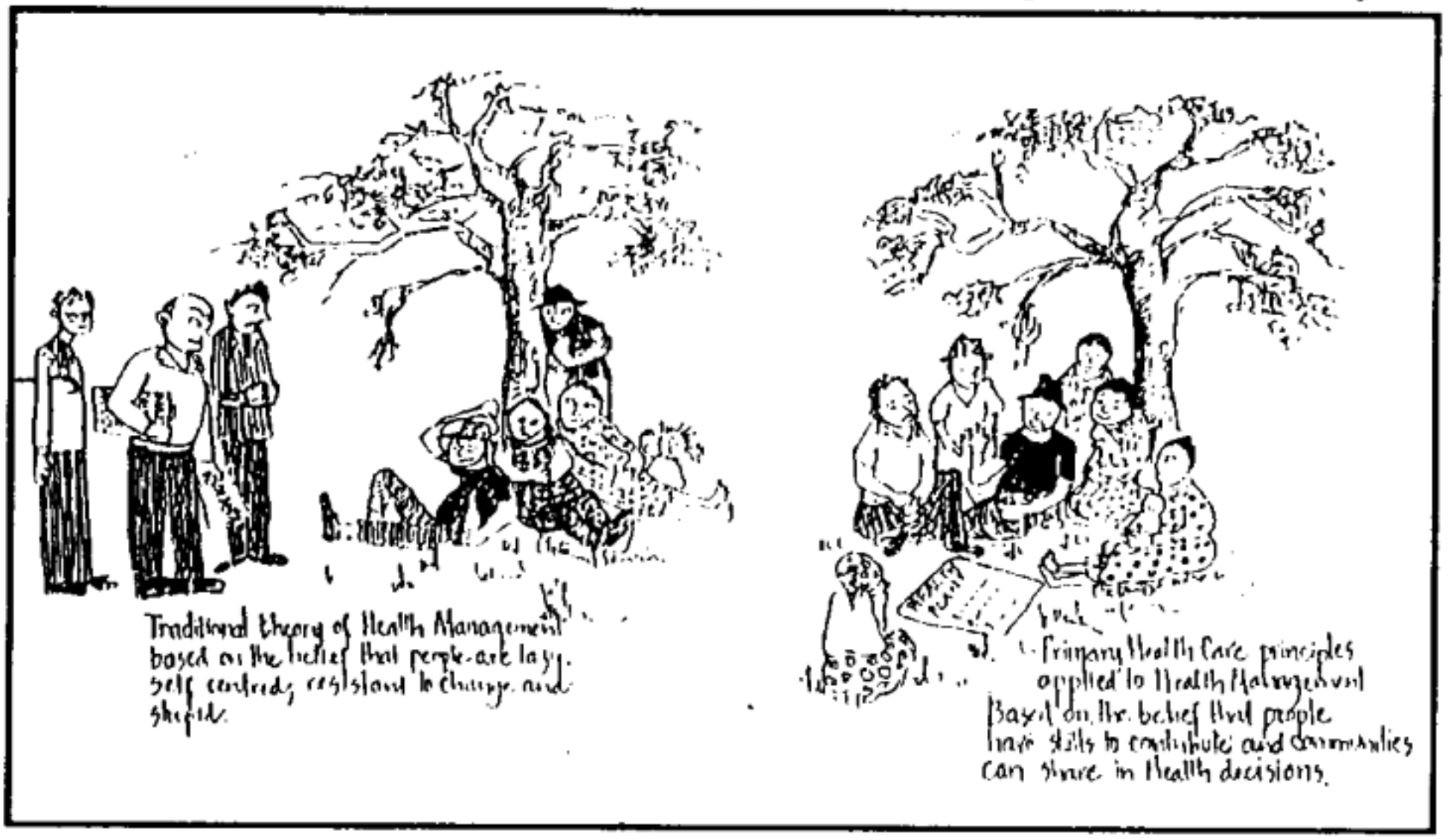


Figure 3. Top down approach vs. bottom up approach

health interventions.

Community involvement must, however, come from the people and is therefore a democratic process. The community has its own needs. It expects the health services to respect them and attend to them. Community priorities may not correspond with the health services' objectives.

This is illustrated by my experience (figure 2). I had in mind to build a well organised and functioning blindness prevention programme. I wanted to use people for my own goals. I had to learn that people do not want to be used. To accept the Care Groups' decisions and demands was not always easy. I had the medical expertise, but I had to accept that people have their own priorities and their own way of exercising their skills.

The hierarchy of expertise was basically accepted by the groups, but all of us had difficulties with the hierarchy of power in the nursing profession, imposed by the Nursing Council regulations. Our motivators became much too skilled and independent, and began to challenge their inferior position in the nursing hierarchy. The nursing administration was, and still is, at a loss in dealing with them, especially regarding career structure and salaries. They just don't fit the system (figure 3).

3. Resources

The community itself does not possess the necessary resources, for example, vaccines or medical expertise and infrastructure to implement a PHC programme. Hence outside input is needed. However, this is bound to create dependency on foreign resources. To foster self-reliance, the community should have control over as many as possible of the resources, with emphasis on tapping their own resources first, before accepting outside help.

To allow people to find their own ways and means is time consuming. It is easier to work with people who are dependent on you and will agree to all of your suggestions and orders. But then it is not the people's project and it will collapse sooner rather than later. It cannot be emphasised enough that we professionals must always be on guard against attitudes and actions of our own that might create dependency. Usually this happens unwittingly, without anyone noticing it before it is too late.

4. Contents:

For us health professionals, health is the highest priority and we think that it is the same for the community. In reality the people have other problems,

PRIMARY HEALTH CARE OBJECTIVES

(figure 4)

CENTRAL	PERIPHERAL
Health Services	Community Involvement Empowerment
TIME	
1. There is a strategy of rapid expansion	Long slow process Long-term view
ORGANISATION	
2. Professional hierarchy Coordinated service delivery External decision making top-down Demands community response tohealth service needs	Democratic process Own answers to own problems Demands health service response to community needs
RESOURCES	
3. Medical infrastructure Outside inputs create dependency	Few outside resources Community control of resources breaks dependency
CONTENTS	
4. Health highest priority Little liaison with other departments	Health low priority Seen as part of overall community problems
HUMAN DEVELOPMENT	
5. Managerial skills Education Training para-medicals	Leadership Awareness building of social and political causes of ill health Development of own skills
POLITICAL	
6. Political will at top Reallocation of resources to PHC	Support of community initiative Just distribution of national resources

like water, wood, jobs. People do not think in "boxes" as we do. In real life everything is interrelated.

A multidisciplinary approach is thus essential. It does not only win the community's cooperation, but is a prerequisite for achieving an improvement in health. This is easier said than done. My own experience in Gazankulu has been that it is extremely difficult to get different government departments to work together. For example, it was some time before the agricultural extension officers began to help the Care Groups with their vegetable plots.

5. Human development

Medical services view education as the best means to achieve health for all. Managerial skills are improved and para-medicals, such as CHWs, are trained in great numbers to make the health services accessible to all. Village health workers (VHWs) should then provide the link between the people and the health services, and activate community participation. This does not always work. If not carefully watched, it may even stifle local leadership, and hamper awareness-building and the development of skills in the community.

For most government services, human development means providing the sort of knowledge and resources the government deems fit - ultimately for its own, and not the community's benefit. As they see it, the more people are dependent, the better. Real development is felt as a threat (figure 5). The traditional attitude in health service management is that people are stupid and lazy and have to be told and pushed. The Care Groups have proved that this is not so.

6. Political

To be able to implement PHC meaningfully, it is essential that there is the political will at the top to reallocate resources in favour of PHC. Likewise, the people's initiative should be supported by the village authorities in order to allow unfettered involvement of the community in its own health care. But most important of all: unless the prevailing hostile environment in our rural areas (and urban slums) is replaced by a just distribution of national resources (political, economic or land), health has no chance.

III. Conclusion

Care Groups have become an integral part of PHC in Gazankulu and Venda, while at the same time they have retained their own dynamics. Here, marginalised health workers (motivators) are working with marginalised people (women) in a marginalised area (homeland). Meeting at the fringes has fostered in professionals sensitivity and respect towards people at the grass-roots. This has allowed the bridging of the incompatibilities between the all-too-often insensitive steamroller approach of the health services, and the slow, step-by-step model of action in communities. In this process, both low grade health workers and oppressed women have come out of their marginalisation, to be people in their own right, with self-confidence and self-respect, working together for a common goal: Health by the people for the people.

Erika Sutter is a doctor who has worked with Care Groups since 1976.
She retired from working with them in 1984.
She teaches community eye care at the Swiss Tropical Institute and International Centre for Eye Health in London

Health care and repression

The current situation of violence and covert repression continues to constitute a threat to the physical and mental health of oppressed people. This workshop was conceptualised by health care workers who have been concerned by the effects of repression and have been involved in providing medical and counselling services for activists and their families.

The Unity Conference provided an opportunity to draw on a range of health care workers to review the health consequences of the changing nature of repression and to discuss whether this demanded alternative methods of intervention.

Critical questions were raised around whether work relating to political repression and violence should be seen as distinct from primary mental health care.

· Do the effects of torture and other forms of political repression on the mental health of our activists demand specialist treatment, or can they be subsumed under the auspices of primary mental health care?

· How do we define a constituency for this work?

· Should it include subjection to sexual harassment, racism and civil violence or should it be restricted to the ex-political prisoner and returning exile constituency?

The workshop was more a process of grappling with the issues and debates within a changing socio-political context than a compilation of a coherent programme for repression-related work.

Current situation

We have been left with a substantial legacy of ill-health as a consequence

of repression. The system has produced a wide range of damaging experiences which include: detention without trial, banning and restriction orders, and political imprisonment. More recently the state has relied more on covert forms of repression such as hit squad murders, vigilante attacks on civilians, and harassment of activists and their families. Political repression continues to play a role in undermining the physical and mental health of political activists and their families. At the same time it also impacts on the lives of ordinary civilians in our communities and townships, for example, taxi-wars in the Western Cape, attacks on train commuters, and random vigilante killings.

The consequences of such repression are uneven and varied and have affected both individuals and families to differing degrees over time. During the State of Emergency, for example, activists were injured in political protests, harassed, forced to live on the run or go into exile, or detained. Their family life was often severely disrupted. More recently political prisoners have been released and exiles are returning. Activists are now exposed to more covert forms of repression and have to be constantly wary of assassination.

The above all contribute to the prevailing culture of violence. While this in itself is something which needs to be addressed the focus of health care workers has tended to be limited to work with ex-detainees, ex-political prisoners and their families and, more recently, returning exiles.

The Emergency Services Group

Over the past five years the Emergency Services Group (ESG) has addressed the health effects of politically-related repression. ESG is an umbrella body that draws together the resources of professionals in the medical and counselling disciplines who are members of progressive organisations. This network has made possible the delivery of crisis medical and counselling interventions on a voluntary basis. ESG has also been actively involved in political campaigns, training of lay health workers, and producing resource booklets.

The approach of ESG is based on a critical understanding of apartheid and its impact on physical and mental health. The work done by

ESG has been based on a particular set of principles and assumptions. Amongst these:

- that not all need help. It has been up to individuals and their families to initiate the contact with our volunteer network. Activists deal with their stressful experiences differently - responses range from intense feelings of fear and despair to renewed militancy or hostility against the regime.
- that ESG work involves a security risk both for activists who use the clinic services, as well as the service itself which has been subject to police raids and harassment.
- that the eligibility of health care workers to be involved in the delivery of such services rests on their political credibility; they should not only be professionally competent but also politically committed.

Policy proposals

Advocacy

As health organisations move towards unity we re-affirm the demand: Mental Health for All. Within the new Unity structure we should continue to be concerned with advocacy, prevention, treatment and education and training around repression.

Training

The forum proposed that a non-traditional style of practice be incorporated into existing formal training of professionals for example, nurses, social workers etc. Curricula should include work with survivors of political repression and violence as a specialist section. Linked to training was the issue of evaluation and supervision: that volunteers as a group reflect and assess their experience in order that new theory, methods and models are developed which in turn inform our practice.

Trauma rehabilitation centre

There is a need for specialist care facilities preferably funded by a democratic government. Such a facility could be organised along the lines of a rehabilitation centre for torture survivors.

Networking

The workshop acknowledged that the strength of ESG lay in its interdisciplinary approach - the manner in which its volunteers collapsed the boundaries between clinical medicine, social work, psychiatry and psychology. ESG would continue to draw on and liaise with a wide range of community organisations and political structures.

Programme

The workshop agreed that the constituency for this work in the long term should be ex-political prisoners and returning exiles and that survivors of civil conflict should remain a target group for the medium term.

Much discussion focussed around our constituency in the rural and outlying areas. Such areas are notoriously neglected as far as resources and services are concerned. Difficulties in providing services relating to accessing organisations in rural areas, transport of health-care workers to outlying communities and consistency in the development of such services. Often rural communities get ''once-off'' services from urban organisations and are then abandoned. Two mutually inclusive strategies were suggested: that we extend services to rural areas at the request of community structures by teams of medics, counsellors and social workers going out on a roster basis. At the same time local health workers should be recruited to develop services.

Resources and services need to be made available from state institutions. The services offered by progressive social service organisations can realistically only fill the gaps.

Participants of the workshop resolved that a sub-group within the new proposed health in unity organisation should continue to address the challenges of ongoing political repression.

Report compiled by Merran Welsh (ESG).

Critical Health

Critical Health is a quarterly publication dealing with health and politics in South Africa. It has been published for the last 10 years and has contributed to debates on progressive aspects of health and health care. *Critical Health* reflects the concerns and issues currently facing those seeking alternatives in South Africa.

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