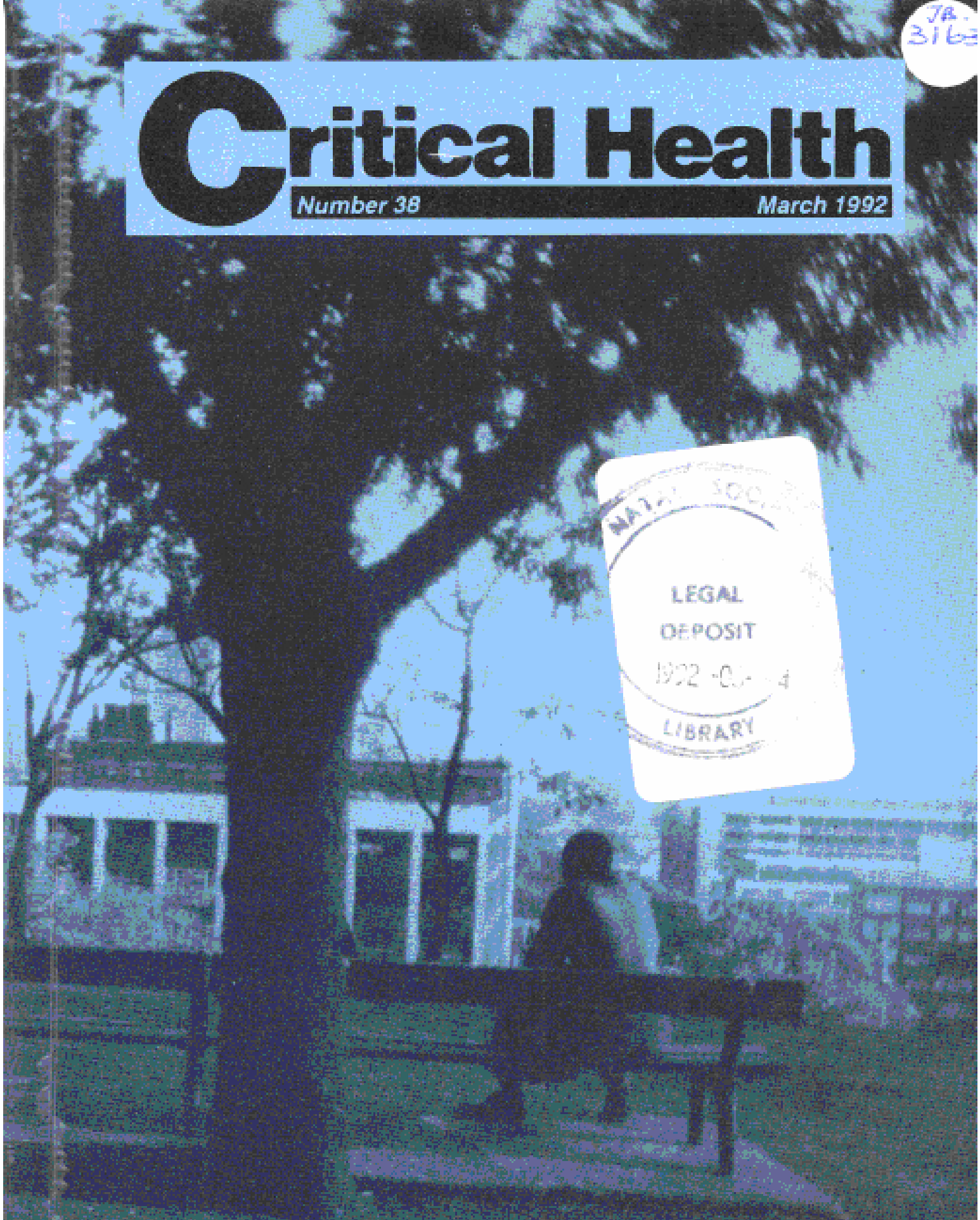
Critical Health

Number 38 March 1992



FOCUS ON WELFARE

Contents

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Editorial

Since the opening of the negotiation process, the prospect of a democratic political settlement in the near future has influenced many in the health and welfare sectors to conceptualise their role in a democratic South Africa. In issue number 35, *Critical Health* covered debates around the achievement of a national health service. In this edition our focus is on debates and issues relating to the building of a more democratic welfare sector, which is appropriate to the needs of all South Africans.

The introductory article, by Fikile Mazibuko and Rayna Taback, criticises South Africa's current model of welfare provision, which responds to human misery, hardship and disabilities along racial lines. Following a conference convened by Concerned Social Workers (CSW), South African Black Social Workers (SABSWA), Johannesburg Social Services and the Social Workers Forum (Cape Town), the article poses the alternative of a unitary non-racial welfare system, involving democracy in service delivery, which is based on the needs of the majority. The article also argues for social state intervention in the economy and for social services to act as a mechanism of redistributing wealth.

The welfare sector is generally keen to assert a specific identity and societal role for itself. This is clear from Sandra Drower's report on a regional conference convened by CSW and the School of Social Work, University of Witwatersrand, held in June last year. Drower reports that the conference adopted a broad conception of the welfare sector, encompassing aspects of health, education and housing. She also reports that conference delegates expressed concern that if welfare services were administered separately from health, education or housing, it might become isolated from aspects of government with which it has to interact.

The drafting of a welfare charter is a clear challenge to the state's policy of privatising welfare services. *Critical Health* reports on the process of the formulation of the welfare charter, noting, in particular, the consultative method involved as against the government's tendency of simply imposing policy on the welfare sector. Welfare organisations have opposed the Social Assistance Bill, which is a further expression of the rejection of the government's undemocratic approach.

Anne Letsebe and Jackie Loffell, in a joint contribution, challenge the view that, under a post-apartheid government, health and welfare should be administered in a single ministry. Social welfare would need to focus on specific problems which might be overlooked in a joint ministry. They also argue that social workers

experience discrimination in favour of the medical professions when decisions are made about the allocation of resources, promotion of personnel or cuts in finance.

Melvyn Freeman challenges this argument, suggesting that, while welfare workers are dominated in their work relations with doctors, this is not sufficient reason to separate health and welfare administratively. There are overlapping spheres between health and welfare, such as the care of mental patients, which would best be served by a single ministry. He suggests that welfare workers can overcome their domination by the medical practitioners, 'not by splitting welfare off from health, but by welfare workers asserting themselves more effectively in joint structures.'

Another issue which might be given more consideration in this debate, is the sexual division of labour between doctors and welfare workers, most of whom are women. This sexual division of labour is also evident within the medical sector, where nurses often experience domination by doctors.

One of the objectives of social welfare is to encourage democratic participation of communities in the provision of services. Francie Lund and Nozizwe Madlala give an illuminating report on their research and development project among people caring for the aged in Natal. This project involved intense consultation on what communities' needs were as regards the care of the aged. This was followed by an education programme formulated in consultation with voluntary community workers.

Jackie Loffell provides an argument in favour of forging stronger links between medical care and social welfare in her sensitive piece on the care of children with AIDS. She argues against the premature hospitalization of HIV positive patients, especially children, suggesting the alternative of community care systems and assistance to HIV positive mothers caring for their own children. In the case of destitute children infected with HIV, she argues for their placement in 'specially recruited and well supported substitute families.'

Perhaps alternative households, for example, single parent or gay households, should also be considered as possible guardians for HIV positive children. They might be more willing and better equipped than traditional families to provide this care because of their particular understanding of sexuality and AIDS.

Pumla Gobodo argues that welfare professionals need to take the cultural background of their patients into consideration in order to provide appropriate therapy. There is, however, a lack of understanding of cultural diversity within South Africa. Professionals are not trained to be sensitive to cultural differences. Many professionals are, furthermore, resistant to developing an understanding of cultures other than the dominant western culture. These obstacles need to be overcome in the process of developing more appropriate welfare services.

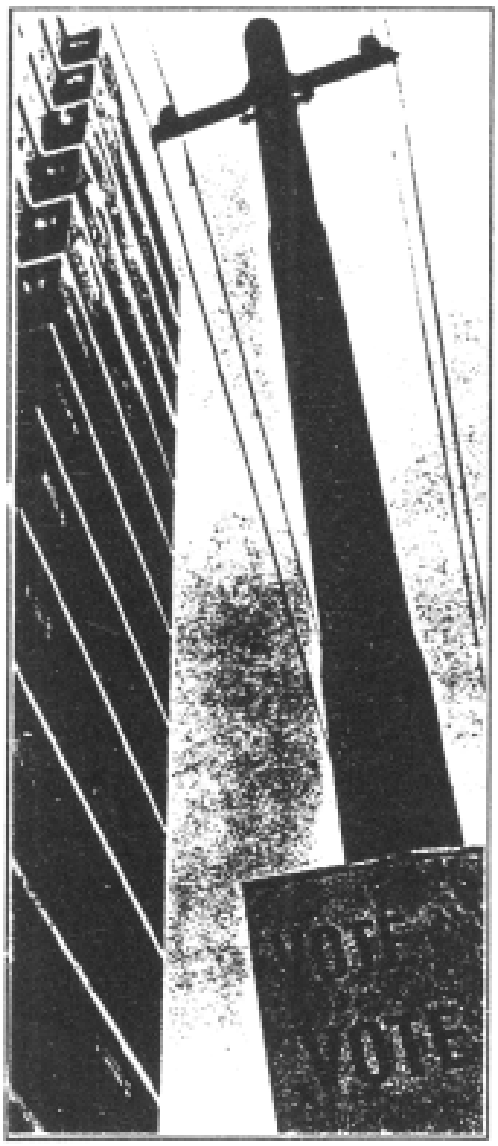
Critical Health also reports on the government's social relief fund, introduced at R220m in September 1991, for six months up to March this year and increased to R440m in this year's budget. There is widespread criticism of the patently inadequate amount set aside for social relief, especially at a time when unemployment is increasing, and poverty is worsening, to the extent that some areas are experiencing famine. The government is also criticised for showing an inability or lack of will to consult among representative consumer groups and trade unions on the distribution of the fund.

The final article written by Jean Triegaardt, discusses the escalating problem of unemployment in South Africa. A growing number of the unemployed are becoming 'unemployable,' they are unlikely to ever find jobs again. Each year, a smaller percentage of school leavers are absorbed into the labour market and there is an extremely high level of unemployment amongst youth. These trends are causing severe effects on family and social life. This, in turn, poses a major challenge to the welfare sector, which will have to find creative ways of addressing unemployment and its related problems.

The topics covered in this issue are varied and interesting, but *Critical Health* does not claim to have provided a comprehensive picture of the issues and debates in social welfare. Our intervention is merely a starting point for further debate and discussion.

Until now, each edition of *Critical Health* has focused on a different theme. This has allowed for a fairly wide coverage of issues related to each particular theme, but we have not been able to be flexible with regard to topical issues. Within the context of current political change, there are numerous debates and new developments in the health and welfare sectors. The editorial collective has, therefore, decided that each edition should focus on a theme, and include a section which will allow for coverage of urgent issues, new developments and ongoing debates. People who wish to contribute articles to this journal are encouraged to do so, but articles should not be longer than 1 500 words.

§ *Critical Health* apologises to Grant Rex and to readers, for an error in edition 35. A page of his article on primary health care at Alexandra clinic was omitted. We are rectifying the mistake by printing the article in its entirety in this edition.
§ *Critical Health* also apologises to Maurice Conradie and Hetta Pieterse for not acknowledging them as the compilers of the article "Regulation, Registration and Statutory Control" in section A4 in edition 36/37.
§ Dave Bruce left *Critical Health* at the end of 1991. We thank Dave for his contribution to the journal, and we welcome his replacement, Joe Kelly, who is a full-time member of staff.



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Towards a democratic welfare system

The welfare system in South Africa is clearly unable to meet the welfare needs of the people. It has been developed along racial lines and the current government is intent on ensuring that the state plays a minimal role in the provision of welfare. The articles in this section highlight the efforts that have been made by progressive workers in the welfare sector to conceptualise a welfare system which does meet people's needs. These include discussion and debate on democratic principles of social welfare and moves towards drafting a charter.

The Principles of Welfare

Fikile Mazibuko & Rayna Taback

Introduction

This article attempts to give a broad overview of the welfare system in South Africa. The future social welfare system will inherit the legacies of apartheid. It will have to find new solutions to old social problems. Expectations from the grassroots and marginalised people in South Africa will increase and put a lot of pressure on social welfare.

Definition of Social Welfare

Social welfare can be broadly defined as those forms of social interventions, that is, laws, programmes and benefits that are primarily concerned with promoting both the well-being of the individual and ensuring the provision of basic social needs necessary for the welfare of the population and for the functioning of the social order.

The South African Model

South Africa has a residual model of welfare based on a partnership between the state and the voluntary sector. A residual model refers to a welfare system where social welfare institutions come into play only when the normal structures of supply, that is, the family and the market break down. This model has been orientated to respond to human misery, hardship and disabilities along racial lines. It tends to leave people entrapped rather than empowered, and their basic needs are ineffectively addressed.

Structure of the South African Welfare System

In describing the South African welfare system it is important to point out that two systems of welfare co-exist. The two systems are composed of the formal welfare system and the alternative welfare sector. The formal welfare system operates within state defined parameters and with state subsidisation, whilst the alternative system is commonly associated with anti-apartheid, pro-democracy organisations and operates without state financial aid. The structure of these parallel systems are both contradictory and complementary and the auspices of each determine the opportunities and limitations of social work practice.

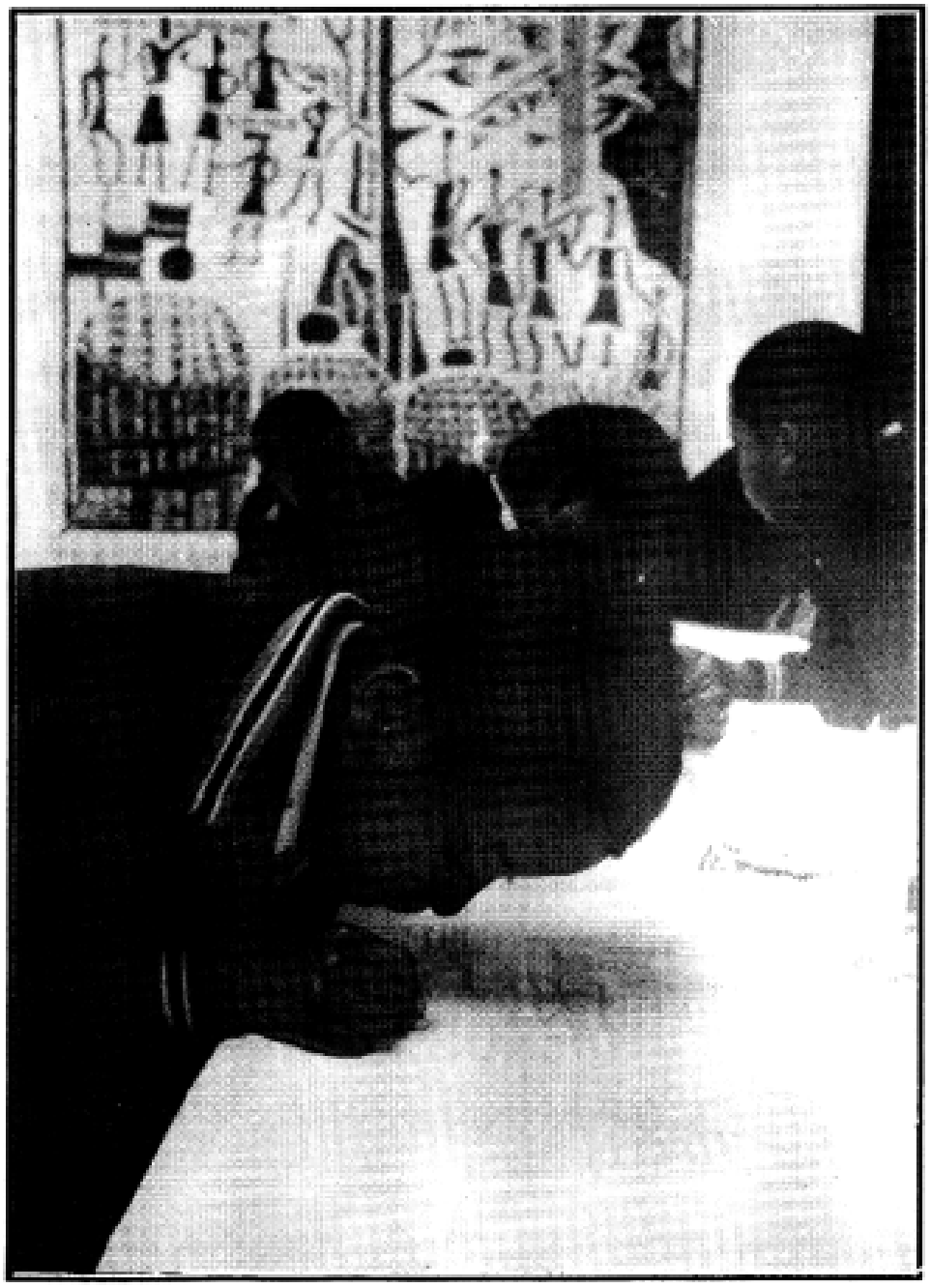
The formal welfare sector refers to:
· state structures;
· private welfare organisations;
· religious organisations; and
· private enterprise.

The alternative welfare system refers to social services that have evolved as a result of a response by anti-apartheid organisations campaigning against inadequate and inappropriate social welfare services which have entrenched apartheid.

Universal Principles and Values of Social Welfare

Social welfare is based on universal principles and values such as:
· common human needs, yet acknowledging that each person is essentially unique and different from others;
· a democratic society in which an essential attribute is the realisation of the full potential of each individual and the assumption of his/her social responsibility in society;
· the responsibility of society to provide ways in which obstacles to self-realisation can be overcome.

The primary value base underlying social welfare stresses that;
· society has an obligation to ensure that people have access to the resources, services and opportunities to meet various life tasks, alleviate distress and realise their aspirations and values, and that
· the dignity and individuality of people should be respected in the provision of societal resources.



An essential attribute of a democratic society is the realisation of the full potential of each individual. *Photo: Cedric Nunn*

Principles of the South African Welfare System

The South African welfare system is based on the principles of racial differentiation and privatisation. Welfare service and social security are channeled through state structures such as the various "own affairs" Departments of Health Services and Welfare. Welfare policy in South Africa emphasises the following:

· Differentiation, which implies racially segregated welfare services.
· Privatisation, which advocates reduced state responsibility for welfare spending, and
· Devolution of services from the central government to regional and local authority levels.

Under the present welfare system, white recipients of welfare have become a privileged elite, receiving services which are relatively sophisticated both qualitatively and quantitatively. Black persons, who make up the majority of the population in South Africa receive relatively smaller portions of the welfare budget. The following figures illustrate disparities in welfare in South Africa:

Personnel: Registered Social Workers 1988/89

	1984	1989
AFRICAN	1046	1083
COLOURED	785	831
INDIAN	351	388
WHITE	4273	4465

Source: Race Relations Survey 1989/90

Social Security: Old Age Pensions 1988/89

	Amount per month
AFRICAN	R174.70
COLOURED	224.70
INDIAN	224.70
WHITE	275.70

Source: Race Relations Survey 1989/90

The current social welfare system reflects the inequalities that are entrenched in South African society.

The Alternative Social Welfare Movement in South Africa

As part of the tricameral reform agenda, in 1985, the Department of Constitutional Development and Planning published a document entitled: "The Proposed Welfare Policy for the Republic of South Africa". This document advocated a welfare policy within the concept of "own affairs" and the principles which determine

contemporary policy in South Africa.

This policy proposal was rejected by many organisations in the welfare community. The Regional Coordinating Committees in Durban, Transvaal and the Western Cape have held numerous workshops, meetings and debates on developing an alternative welfare policy for South Africa. These organisations have made a successful attempt to put welfare on the agenda of progressive organisations.

A historical conference convened by Concerned Social Workers (CSW), South African Black Social Workers (SABSWA) (Witwatersrand), Johannesburg Social Services, and the Social Workers Forum (Cape Town) formulated goals for an alternative welfare system. These included the promotion of:

· a non-racial welfare system;
· a democratic model of social service delivery based not only on the individual's right to vote in central and local government structures, but genuine decision making over the allocation and control of resources in every sphere of life;
· a unitary welfare system for all South Africans based on the needs of the majority of the population;
· state intervention in the economy and in the provision of social security and services;
· social welfare as a mechanism through which wealth is redistributed, and
· a welfare system promoting human rights (Patel, 1989).

These are the guidelines of the activities of the structures committed to an alternative social welfare programme in South Africa.

References

Patel, L (ed.) 1989. "Towards a Democratic Welfare System: Options and Strategies", Johannesburg, Co-ordinating Committee Against the Welfare Policy

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Rayna Taback lectures in the School of Social Work at the University of the Witwatersrand. She is also a member of Concerned Social Workers.

Social Welfare, National Reconstruction and Social Development

Sandra Drower

This article is a report on the regional consultative conference convened by Concerned Social Workers and the School of Social Work, University of Witwatersrand, 21-22 June 1991

Introduction

The regional consultative conference was part of a research programme with two main purposes; firstly, to document the nature and scope of grassroots social services programmes affiliated to or in alliance with the United Democratic Front and the Congress of South African Trade Unions between 1985 and 1990, and secondly, to evolve principles, guidelines and recommendations for welfare policy in a non-racial and democratic South Africa. The study found that an alternative, authentic model of social service delivery had begun to emerge in South Africa in response to rapid social change. To facilitate conference proceedings a discussion document (Patel 1991) outlining this alternative perspective on social welfare was circulated to all delegates before the conference.

Conference Aims

The regional consultative conference was convened with the aim of stimulating further debate over social welfare policy. An important subject of discussion was the need for a major change from a racially discriminatory, piece-meal and charity

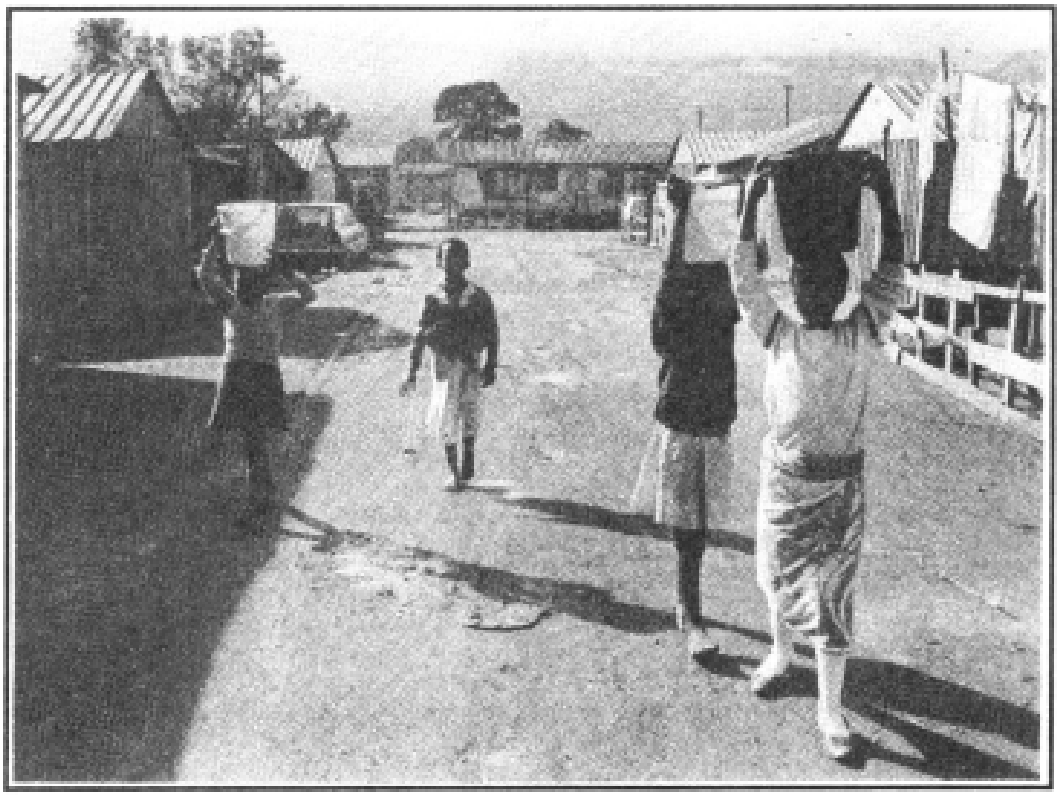
model of social welfare provision to one which recognises the role of social welfare in national reconstruction and social development. Through workshops, the conference aimed at estimating the willingness of the welfare sector to make such a change and also aimed at identifying obstacles which could impede a change in focus. The conference had to decide on practical steps to be taken by the welfare sector in an attempt to implement appropriate policies and programmes.
Delegates included representatives from academic institutions, national and regional welfare organisations, religious and political organisations, rural development projects, and state and provincial departments. Participation by such a wide range of people helped to ensure vibrant debate.

The First Plenary Session

The keynote address was delivered by Ms Terezinha da Silva, national director of social welfare (Ministry of Health) in Mozambique. Ms da Silva's address was provocative and relevant. In describing social, political and economic conditions in Mozambique, she illustrated links between social welfare policy formulation and the political economy. She raised various issues relevant to the development of social welfare policy in South Africa. These issues include the influence which foreign debt and foreign aid have on the type of social service programmes initiated and on social welfare policy formulation. She noted the severe constraints on the development of alternative social welfare policies and programmes caused by the lack of personnel, and technical and financial resources. She also mentioned the limitations placed on the development of appropriate social welfare policies and social services through social service linkages to a department of health, especially during times of acute social need.
Non-government organisations, she said, can assist in the development of social services, but the state cannot be allowed to neglect its responsibilities in social service provision.

The Workshops

Workshops were held on the second day of the conference. Morning sessions covered a range of issues and aimed to provide a forum in which different views were shared. The afternoon workshops concerned the restructuring process in social welfare with the aim of helping delegates identify practical steps towards dismantling apartheid welfare and building a unified welfare system.



The state cannot be allowed to neglect its responsibilities in social service provision. *Photo: Medico Health Project*

The workshop on the nature and philosophy of social welfare addressed four key issues, including:

a) a conception of social welfare

There was agreement that any new conception of social welfare should include equality of opportunity and affordability, recognising and accounting for the uniqueness of individual needs, and emphasis on growth and development of all. The relationship between social welfare and social development should be clarified and acknowledgement should be given to social welfare as a mechanism of redistribution and an instrument for the promotion of national reconstruction.

b) aims and objectives of social welfare policies and programmes

Aims and objectives agreed on were the need for improvement in material conditions, maximum development of human potential and the promotion of individual and collective self-reliance. Other objectives identified were the need to assist individuals and groups to achieve optimal development, building grass-roots democracy and addressing the material and mental health needs of people. Facilitating favourable economic conditions was also necessary if people's needs were to be met.

c) values underpinning social welfare policies and programmes

Participants gave various concepts such as social justice, egalitarianism, accounta-

bility, democratic participation, self-reliance, freedom, honesty, inter-dependence, tolerance and responsibility. It was acknowledged that definitions of these values are open to wide interpretation.

d) principles informing social welfare policies and programmes

Participants agreed that principles should include the promotion of national unity and social equity, participation and appropriateness. Participants suggested that specific principles addressing the need for and the role of affirmative action, and concepts of affordability, accessibility and appropriateness should be made. It was accepted that the initiative and direction of programmes and policies should originate at grassroots level, but programmes should also have an appropriate regional and national aspect.

The Role of the Government in Promoting Social Development

Participants agreed that in order to underline the responsibilities of those in power, the term "government" should be used rather than "state". Two central conclusions arose from the deliberations of this workshop; firstly, that the government should take responsibility for meeting people's basic needs, and secondly, the non-governmental welfare sector must work in partnership with the government in developmental welfare. It was acknowledged that the extent to which the government would be able to implement its responsibility, and the way it did so would rely on the prevailing political ideas, the availability of resources and on other key players involved.

A debate occurred over the scope of the welfare sector. Most participants favoured the welfare sector encompassing health, education, housing, etc, although a number of questions were raised regarding the placing of welfare within the structure of government. Some of these questions include the extent to which a single ministry encompassing broad social development policy might become an over burdened and cumbersome bureaucracy, and the extent to which welfare work might become subordinate to the health profession within such a ministry. Concern was expressed, however, that if welfare were placed separately at the administrative level, it might become isolated from aspects of government with which it has to interact.

It was resolved that effective collaboration between government and the non-government welfare sector would be achieved by a national welfare plan, for

mulated in consultation with non-governmental groups, and by joint government-community planning and co-ordination of structures at the local, regional and national level.

Development of Personnel

This workshop produced a number of objectives aimed at enhancing the training of professional and voluntary workers. These include involving consumers at all stages of service provision for maximum participation of communities, and ensuring that professionals are adequately equipped for community development work and that the benefits of inter-disciplinary team work are increased. Further objectives included the need to encourage self-awareness among workers in the field of social welfare to enable work across class and cultural barriers. The workshop also saw the need for a forum to examine the nature of professionalism in social work and the attitudes of social workers towards different categories of volunteers.

Accreditation procedures and career opportunities for workers at different levels of the welfare structure and the encouragement of the development of appropriate training were also discussed. Finding a systematic paradigm for training, incorporating different types of workers in the field of welfare was given as a priority, and agreement was reached on the formation of a Council of Social Workers to represent all social workers. This council would be open to a variety of criteria for training and practice.

Social Security and Redistribution

This workshop identified the present bureaucratic, discriminatory and inefficient structure of welfare as a primary obstacle to the just distribution of resources. It was argued that an over-arching social welfare policy and a unitary department of welfare was needed to redistribute resources effectively. It was noted that the creation of a single state department would assist in overcoming present disparities in benefits. Another primary concern was the need to create the means by which grassroots organisations would be able to participate in policy formulation so that relevant information is taken into account in the formulation of social security policies.

This workshop expressed concern over unemployment, suggesting that the

Children and the unemployed were identified as priority target groups for state attention. *Photo: Medico Health Project*

state should pay greater attention to job creation schemes. The workshop identified children and the unemployed as priority target groups, and the development of a compulsory pension scheme as an objective of priority.

Restructuring Social Welfare

The afternoon workshops all focussed on restructuring social welfare services and debated the question of organisations already involved in restructuring their services, and what was required of them in order to advance the restructuring of social services.

Many of the organisations represented, it seems, had already begun addressing the issue of racial discrimination, but most agreed that restructuring social welfare involves more than redressing racial segregation. It was found that few organisations were introducing the principles of developmental social work. However, some organisations were attempting to allow for grassroots decision making, while others had begun to review present methods of service delivery and were attempting to identify more relevant means of providing their services.

All workshops noted national unity, affirmative action, consumer participation, non-racialism, accessibility and redistribution of resources as among the objectives of a restructuring process. Obstacles to the attainment of these objective were identified, such as the slow pace of the change process, the absence of indigenous models of service delivery and of a national awareness of welfare

rights, fear of change and the fact that most white social workers (two thirds of South Africa's social workers) do not speak an African language.

The workshops on restructuring noted a number of areas for immediate attention and action, including the continued deracialisation of welfare organisations and the setting up of evaluation procedures to monitor the removal of discrimination. The workshops also found that specific time frames for the removal of discriminatory practices were necessary and the restructuring of apartheid welfare should address all levels of service provision, that is, local, regional and national.

Finally, the workshops on restructuring social welfare identified a number of areas for immediate attention and action. These include; the continued deracialisation of welfare organisation and addressing the removal of all forms of discrimination with equal vigour, and establishing evaluation procedures and specific time frames to monitor the removal of discrimination. More attention should be given to the use of advocacy and social action strategies, through the formation of pressure groups to ensure the successful demise of apartheid welfare.

Conclusion

The final plenary session was a panel discussion which highlighted the themes and issues raised during the workshops. It was clear that the conference had not only covered considerable ground but that it had succeeded in facilitating debate among a wide range of interest groups within the field of welfare. While differences of opinion had certainly arisen much was held in common. It is hoped that the welfare sector will pursue the initiative set by this regional consultative conference in order to ensure the further development of the welfare policy debate.

References:

Patel, L. 1991, "Principles, Guidelines and Recommendations for Developmental Social Welfare Policies and Programmes in a Democratic South Africa". Concerned Social Workers/ School of Social Work, University of the Witwatersrand, Johannesburg

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Government Welfare Policy

and the Welfare Charter Movement

Critical Health

Introduction

The tenth article of the African National Congress' (ANC) draft bill of rights says that "all men and women have the right to enjoy basic social, educational, economic and welfare rights." Article ten is preceded by two articles which define the rights of disabled people and the rights of children.

These items in the ANC's draft bill of rights differ from current government thinking on welfare. The government has no conception of welfare as a constitutionally guaranteed right. Its thinking is that welfare is primarily the responsibility of individuals and the communities in which they live. This is in keeping with its approach to other services and to the economy in general.

In recent years, the South African government has pursued an economic policy which involves a decrease in the size and the functions of the state. This has included, for example, the privatization of major state corporations, that is, the sale of these state bodies to the private sector. The government has also decreased its contribution to a wide range of services and placed greater responsibility on individuals to pay for their own services. In the health sector, there have been massive increases in hospital and clinic fees and the government has unashamedly allowed deterioration to occur in state hospital services.

Government Welfare Policy

In 1986, a report, commissioned by the government, recommended that there must be "a substantial reduction of the state's financial responsibility for and contribution towards social welfare services." The report further suggested that welfare services be taken over by private welfare organisations or individuals, "whether for profit or not". The state's functions, the report said, should be minimised, but

the government should still determine overall policy and regulation.

The government has shown a commitment to the findings of this report which has transcended other political changes. In his famous speech of 2 February 1990, F W de Klerk said "the state cannot possibly deal alone with all the social advancement our circumstances demand. The community at large, and especially the private sector, also have a major responsibility towards the welfare of our country and its people."

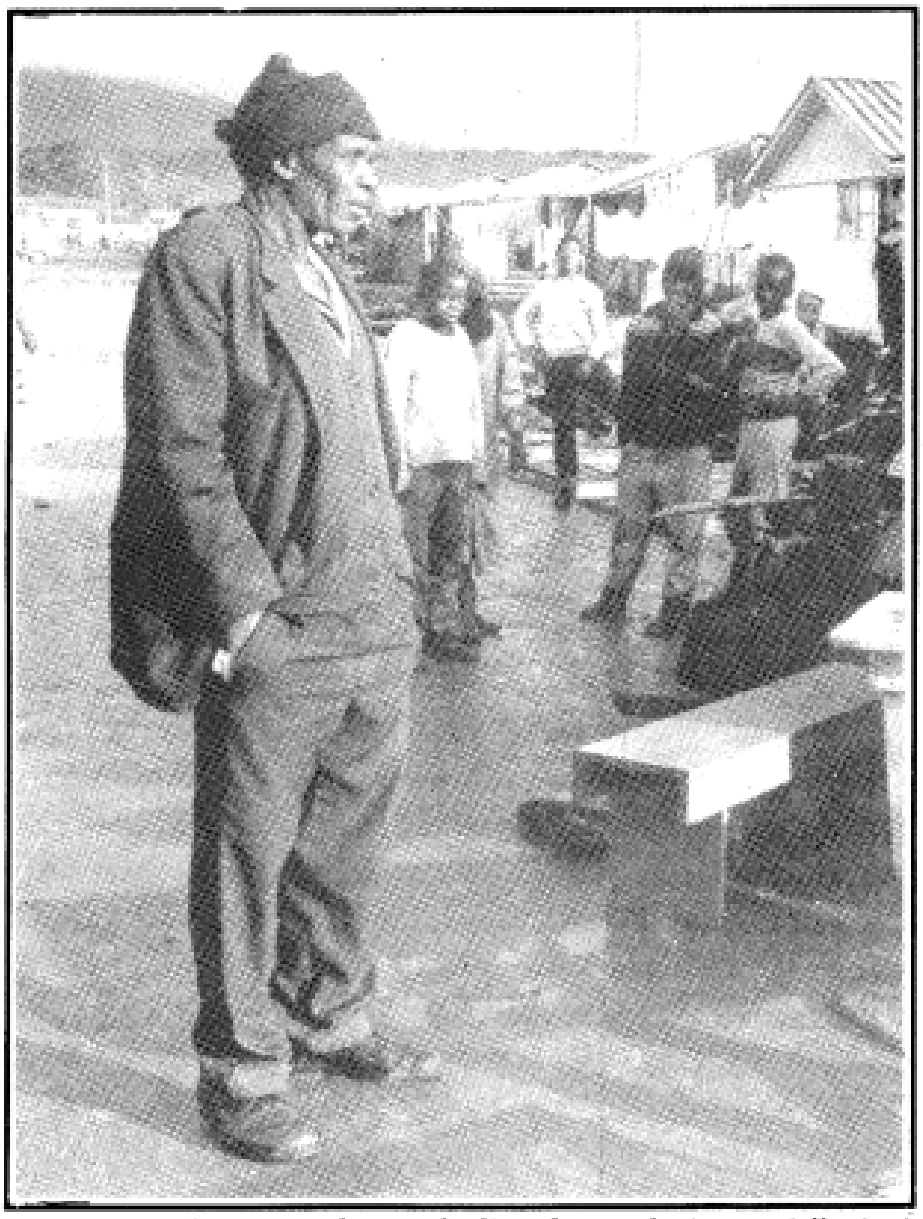
The present government has no interest in the rights of people to welfare services and the privatization of welfare services is a consistent aim of government policy. In January 1992, the Department of National Health and Population Development (DNH) released a document on the financing of welfare services. According to this document "in the first place, it is primarily the responsibility of the individual and the family to supply their own social welfare needs independently or to pay for the necessary services."

If the individual or family is incapable of providing this service, the document says, it is secondarily a community or regional responsibility. If, in turn, the latter is unable to perform welfare functions, the burden shifts to the state. The state's task is essentially one of enabling other structures to provide the necessary services. This includes passing legislation, creating structures for service delivery, and "financing primary welfare services in the private sector to ensure that, as far as possible, social welfare needs are catered for by the private sector itself."

According to Jeannette Schmid, a social worker at the National Institute for Crime Prevention and Rehabilitation of Offenders (NICRO) in Johannesburg, progressive welfare organisations do not accept "ever greater privatization of welfare". She says that welfare organisations are already struggling to survive with limited resources. They are, in addition, doing a lot of work which should be the state's responsibility. This includes monitoring of prisoners on parole or court appearances on behalf of children. Functions which the state should perform must, according to Schmid, be spelt out in a future welfare policy.

The Social Assistance Bill

The government's intention of passing the burden of providing social services onto individuals is also expressed in its attitude regarding the provision of social pensions. Thus, according to the DNH document on the financing of welfare services, "pensions should be privatized as far as possible" because of the "heavy burden on the exchequer" caused by "a considerable escalation in the number of social pensioners and persons receiving allowances". This year, the government introduced a Social Assistance Bill, which spells out the government's intention to increase the age at which women qualify for pensions from 60 to 65 years, and



How can the government expect the majority of people to contribute to their own welfare when the government is responsible for such high unemployment?
Photo: Cedric Nunn

to ensure that entitlement to social pensions is restricted to South African citizens. According to Schmid, old age pensions should be a universal right. The issue is especially important because the high rate of unemployment prevents a considerable number of people from providing for their own pensions.

Grassroots Consultation

The Social Assistance Bill also gives greater discretion to the director general of national health over the allocation of social assistance grants. This is intended to eliminate foster care grants, family allowances and state grants. Up to now, the

right of access to these grants has been entrenched in law, according to Jackie Loffell of the Johannesburg Child Welfare Society. These grants have already been whittled to a pittance over the years, but their total removal would affect aged people who take care of children, families and individuals who foster children and families whose incomes are too small for them to afford caring for their own children.

There has been widespread protest against the Social Assistance Bill and Loffell says that the direct threat to the right to these grants has been overcome . According to her, the director general indicated, in conversation with her, that the clause giving him absolute discretion in the bill has been removed.

The Social Assistance Bill and the government's intention of further privatizing social welfare services is symptomatic of its lack of consultation with welfare organisations and their clients. According to Jackie Loffell, the Social Assistance Bill should not have been introduced, because it is based on a concept of over-arching legislation, unilaterally decided on by the government. It is a concept, she says, on which there is no agreement in the welfare community. Therefore, all new legislation should be formulated through workshops held among social workers in the field.

The government has attempted to gain acceptance for its policies from progressive organisations. Rina Venter circulated the DNH document on the financing of welfare services and a document on points of departure for welfare policy to various welfare organisations for comment. Concerned Social Workers (CSW) and the South African Black Social Workers' Association (SABSWA) recently agreed not to respond to Venter's request for comment because they felt that these documents reflected established government policy. They said the government was seeking legitimacy for its policies by pretence at open discussion and consultation. Another criticism is that Dr Venter's invitation was addressed to professional welfare organisations and failed to engage the wider socio-political setting of social welfare provision. There was no invitation to a broader range of community and political groupings. The Society for Social Workers (Witwatersrand) supported these criticisms, but felt that some response should be made to her policy documents.

The Welfare Charter

A number of organisations have expressed the need to formulate democratic charters of rights with regard to welfare and welfare related issues. They are keenly concerned about the issue of consultation, and draft their charters through an

intensive process of consultation. Loffell says that "the welfare charter movement is a reaction to the thrust of state policy, the key elements of which are privatization, the entrenchment of racial structures, and the lack of participation of service consumers in policy formulation."

In 1986, CSW, the Society for Social Workers and SABSWA formed an alliance out of which a welfare policy co-ordinating committee was formed. This committee conducted research into people's access to services, discrimination and affirmative action. The committee also looked into the issue of establishing a model for social services provision, involving a social development focus.

In May 1989, at a National Welfare Policy conference held at the University of the Witwatersrand, a resolution was passed that countrywide consultation must occur with the aim of developing a welfare charter. This, according to the introduction to the draft welfare charter, "should then form the basis of a new welfare policy for South Africa."

The process of formulating the charter has taken over a year. Each affiliate of the alliance has held workshops for its own members. According to Marianne Le Roux, CSW held three workshops involving 40 to 50 people, out of which a working group of five was elected to formulate proposals to be included in the charter. These proposals were sent to the organisation's 300 members for comment. Le Roux says that welfare clients were not directly involved, but comments were sought from a wide range of political, community and consumer groups.

The charter campaign has in the main been a regional initiative of social workers in the Transvaal, but comments have been received from the Cape Town Forum and the Durban Society of Social Welfare. The welfare charter is in its finalised form, but comments have yet to be received from SABSWA.

What the Charter says

The draft charter contains sixteen items regarding welfare rights. The opening three items are key demands. These are; the demand for a unitary welfare system and the prohibition of any form of discrimination in the provision of services, an appropriate and accessible welfare system with a strong emphasis on distribution of resources to areas of greatest need, and democracy in social services.

The third item outlines a structure of grassroots participation in decision making about the allocation and distribution of resources. Significantly, while there is a demand that the state be responsible for creating effective mechanisms for such grassroots participation, there is also a clear concern that the power of the state over civic structures of welfare provision be limited. Thus, a paragraph in the item on democracy says "the state shall respect the autonomy of non-governmen-

tal welfare organisations and service groups, as contributing to the promotion of a vigorous civil society.''

The other demands of the charter may be summarised as follows:

a) the right to family and home;
b) freedom from hunger;
c) the right to shelter;
d) the right to health care;
e) the right to work;
f) the right to education;
g) the right to rest and leisure;
h) special protection to vulnerable and special interest groups, for example, children, the aged, pregnant women, the physically and mentally disabled and rural people;
i) social security;
j) a redress of imbalances by redistribution of the country's wealth through the social services;
k) ethics in the social services involving respect for client confidentiality and freedom from any arbitrary interference on his or her privacy;
l) environmental rights; and
m) the right of social workers, welfare clients and the public to organise and

Everyone has the right to shelter, freedom from hunger, access to health care, work, education, rest, and various social services. *Photo: Medico Health Project*

advocate for the promotion of their welfare needs and rights.

The welfare charter is more comprehensive than the welfare clauses within the ANC's bill of rights and elaborates on the welfare clauses in the bill of rights. A CSW spokesperson said, however, that the groups formulating the charter were concerned that it not be seen as a document of ANC aligned organisations. SABSWA, which participated in formulating the charter, is, for instance, a black consciousness aligned group.

A Charter for Disabled People

The Disabled People's Organisation of South Africa (DPSA) has made further progress in the process of consultation in the formulation of a charter by involving the disabled themselves, in addition to those giving care to them.

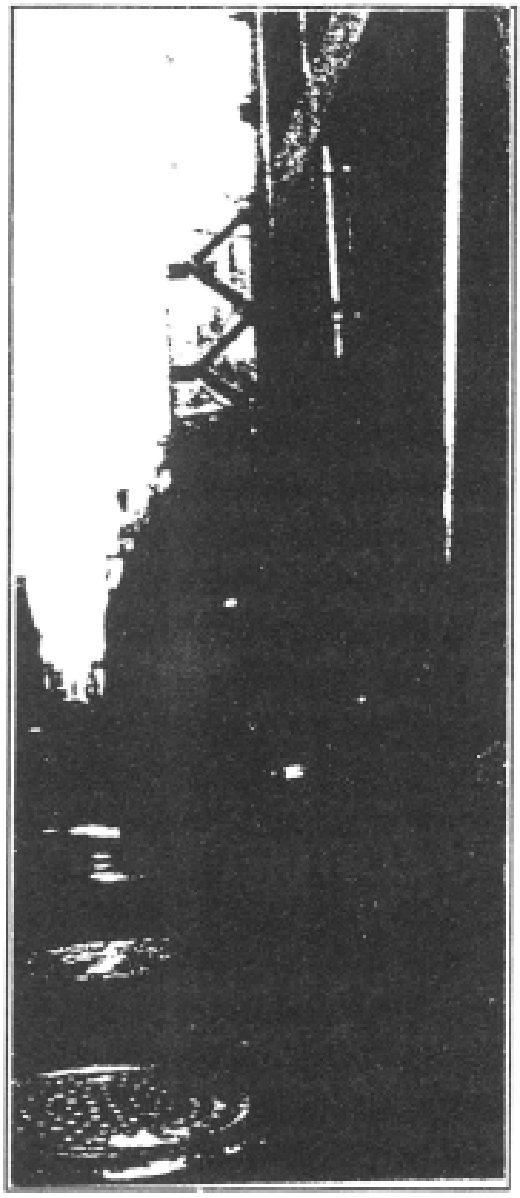
Article eight of the ANC's bill of rights was drafted without sufficient consultation with disabled people. This influenced the DPSA to embark on its own charter campaign. According to DPSA spokesman, Michael Masutha, article eight is vague and was only included in the bill of rights after DPSA approached the ANC's constitutional committee. In its present form, article eight reads as follows:

"There shall be no discrimination against disabled persons. Legislation shall provide for the progressive opening up of employment opportunities for disabled men and women, for the removal of obstacles to the enjoyment by them of public amenities and for their integration into all areas of life".

Masutha says that, in a democratic constitution, disabled people's rights cannot simply be conceived of as a mere afterthought of political decision making, as disabled people face extreme discrimination. One form of discrimination mentioned by Masutha is that the Blind Persons Act excludes blind people from the various benefits available to workers as provided for by labour legislation.

Drafting a charter for disabled people involves a process of grassroots consultation, including workshops of disabled people and their parents and guardians at the various branches of the DPSA. The process also involves introducing the concept of human rights to disabled people, and engaging them in expressing their grievances and demands. In this way people gain confidence in asserting their rights. In 1991 eight workshops were held countrywide. Once the process of workshops is completed, a drafting committee from all the regions will be elected at a drafting seminar. This committee will assemble all the demands raised in the workshops into a charter, which will be presented for adoption at a DPSA congress in September 1992.

Critical Health



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Debating health and welfare

There has been ongoing debate among welfare workers as to whether there should be a single health and welfare ministry or two separate ones. One argument is that at the administrative level health and welfare should be kept separate, because welfare needs to develop its own identity and programmes, and also because welfare workers experience domination by medical practitioners in joint structures. This argument is countered on the basis that health and welfare are interlinked and that many patients will benefit from a single ministry.

Health and Welfare:

Single or Separate Ministries?

Anne Letsebe & Jackie Loffell

Many social service personnel favour separate health and welfare ministries, rather than a combined authority. Anne Letsebe and Jackie Loffell examine central aspects of the debate, and report the views of a number of strategically located social workers.

The Case for a Single Ministry

A single health and welfare system would seem, at face value, to be the obvious choice for South Africa, as medical and welfare practitioners and their allied disciplines have, in recent years, been moving out of their airtight compartments, and have been developing a common vision. Increasingly we share a holistic language in which we speak of the promotion of the physical, emotional and social well-being of a person, families, communities and the nation.

Social workers speaking of the root causes of social problems, and doctors outlining the root causes of disease in South Africa, speak constantly of the same factors - poverty, illiteracy, homelessness, lack of basic facilities, rapid social change and associated stress, etc. Many locate the root causes of these health and welfare problems in our political situation, and look to social justice as a prerequisite for adequate health and welfare.

As a country with scarce human resources we cannot afford, it may be argued, to fragment our services. Under a new government, primary health care should be at the heart of the system, blending skills of social service workers and health workers at every level. The influx of abandoned babies into hospital beds and the AIDS crisis are two examples of areas in which a structured, unified approach would be a great advantage.

The Case against a Single Ministry

In theory, a division of health and welfare functions would cause wastefulness, and a reversion to a less enlightened, falsely dichotomous era. However, the over

whelming view of social workers interviewed in a recent survey is that combining the administration of health and welfare services would not work.

The views of key people in the field of social welfare were canvassed. Some spoke in their personal capacity, while others gave the positions of their organisations. The views presented are those of twenty four people, including representatives of professional associations of social workers, heads of social work departments, directors of national councils, and senior personnel in social welfare and health departments of the 'homelands'. The experiences of the latter were particularly illuminating, because some of them have had the experience of working both under combined health and welfare ministries and under separate ministries. The table below summarises their views on the issues of debate:

Respondents	Views supporting separate ministeries of Health & Welfare		Views supporting a joint ministry of Health & Welfare		Totals	
	No.	%	No.	%		
Professional Associations	3	100	0	0	3	100
University Heads	10	91	1	9	11	"
National Councils	6	100	0	0	6	"
Homeland Minsitries of Health&Welfare	5	100	0	0	5	

Views supporting/opposing a single ministry of health and social welfare

The view of almost all those interviewed is that health and social welfare services should be provided through separate ministries.

Why the choice of separate ministries

Respondents argued that separate ministries would achieve greater impact by focussing on social needs as such and hence rendering more effective social

welfare services. A non-racial ministry of social welfare would focus on the specific problems of social welfare which would be overlooked in a joint ministry. These include problems relating to social and emotional stress in coping with change and transition, and an urgent need for effective social security and social development programmes.

In a separate ministry, social welfare would be able to develop its own identity. In its own right, social welfare would draw on other disciplines, to best serve the needs of the people.

It is interesting to note that in Mozambique, the combination of departments of health and welfare is considered to have been a mistake, and is being reversed. Moreover, the view that health and social welfare should be in separate ministries is not new to South Africa. In 1985, when a proposed social welfare policy was investigated, the social welfare community called for a separate, non-racial ministry of social welfare .

Conflicting values

Differing perceptions of values between medical practitioners and social workers are another factor in the ambivalent relationship between the two professions. In particular, the values of self determination and respect for the integrity of service consumers in the totality of their life situations are a constant sources of conflict.

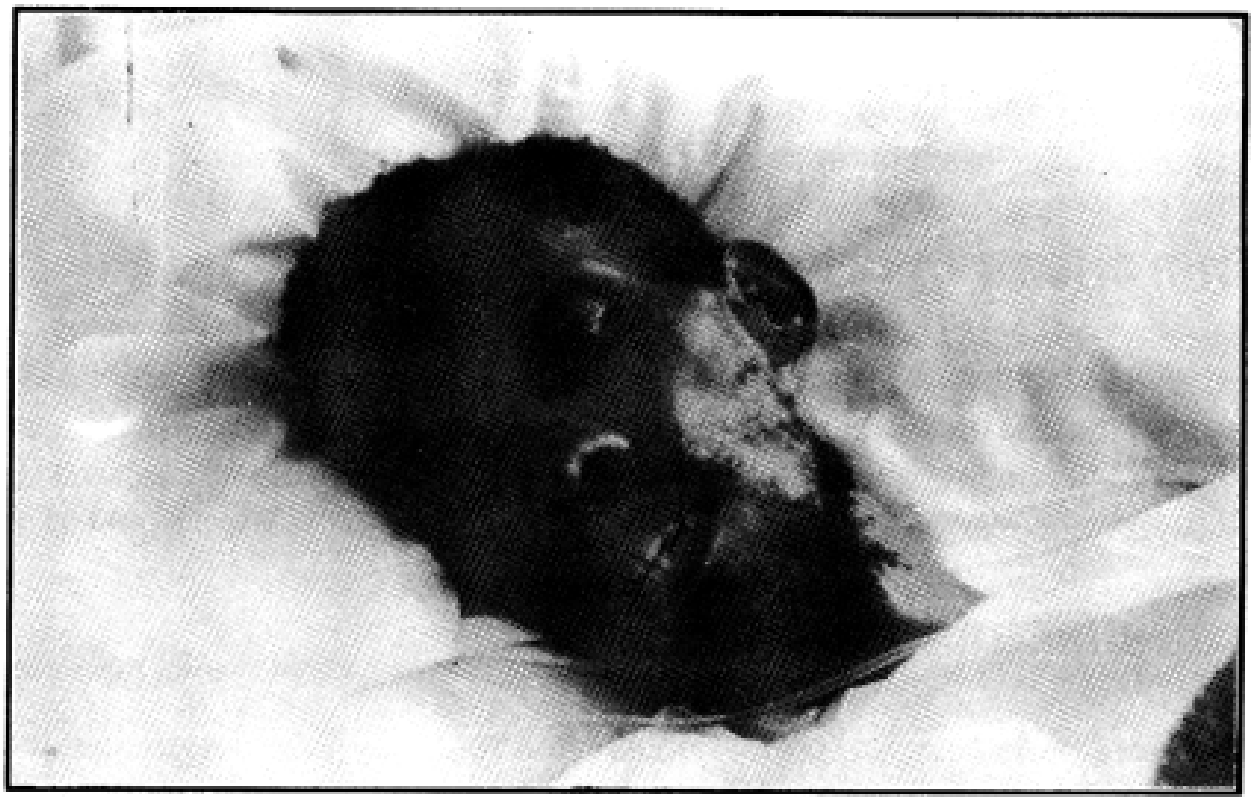
Social workers are trained to operate at the level of the client and arrive at treatment goals with the client. In this process, the primary consideration is empowering the client to make decisions about his or her life with professional help.

Even though the medical profession may be moving towards implementing the principle of empowerment, social workers continue to encounter problems with the practice of physicians. Physicians develop a treatment plan and instruct patients accordingly. While students in both professions are taught about the importance of confidentiality, the experience of some of the respondents is that it is not strictly upheld by physicians. A commonly cited example is the ward round when doctors discuss patients' diagnoses within hearing distance of the rest of the patients in the ward. This affects the privacy of patients.

Discrimination in favour of the medical profession

a)Resource Allocation

Whenever health and social welfare are found together, budgetary allocations are



Physical health issues are given priority over the broader psycho-social issues that affect patients. *Photo: Medico Health Project*

always weighted in favour of medical health. In many instances where savings have had to be made, these are often at the expense of social welfare services. However, when patients are referred to social workers, high expectations are created about what the social workers can do to alleviate their material conditions even where the resources do not exist. In the allocation of office space and transport, some respondents said, priority is given to medical services under joint administrations.

Such discrimination in the allocation of resources is perceived to undermine the effectiveness of social welfare services by limiting their scope and creativity.

b) Promotion and status of staff

According to some respondents, in cases where decisions are to be taken on issues relating to health and social welfare, the practice has invariably been to give more weight to the medical professionals. The experience of social workers working in the 'homelands' shows that where the two professions combine, senior positions are usually held by health care professionals. This affects the morale of social workers and has a direct impact on the quality of service.

Doctors' immediate power over life and death in emergency situations gives them a status and authority rooted in people's anxieties about sickness and death. A particular status is, therefore, attributed to doctors in the wider community. This

allows them to wield an unusual amount of influence over members of other disciplines. The tendency, therefore, is that physical health issues are given priority . This is certainly the case in present Department of National Health and Population Development, although it is headed by a social worker.

Differences in orientation

Interviewees felt that differences in orientation make a single ministry inconceivable. They said that the medical discipline focuses on physical health whereas the social services focus on human relationships. Although these are closely related fields, they involve separate bodies of theory and of expertise.

Multi-disciplinary team work

Social workers and medical professionals often hold very different perspectives on decision making in team work. Whereas social workers are taught the importance of co-operation, physicians are trained to command and they tend to take leadership roles in any multi-disciplinary effort. The consequence is an undermining of team effort. Thus, as one of our respondents says,"In all my twenty three years of working in a team, I have never experienced team work because the doctors always take over regardless".

All the people interviewed identified the need for co-operation between the professions, but preferred a structure of co-operation in which neither profession dominated. One-stop services at which multi-disciplinary teams could be easily accessed by clients were suggested.

Conclusion

The considerations in favour of a single health and welfare system are compelling. The reality is that when government structures bring together people concerned with physical, emotional and social health, those specialising in physical health tend to dominate.

The disadvantages identified by social workers, who are key players in the social welfare field, outweighs the perceived advantages of having health and social welfare together. Their experience suggests that the attainment of the best value from each profession will occur through separate systems. The fact that the responses are based on current experience amplifies the need for intervention

strategies to take heed of the issues raised.

There needs to be a concerted effort at developing training that will produce personnel who understand the relationship between the professions, and the contribution of the various professions to health and social services. The express aim should be to ensure that health and social services will respond fully to both the physical and the psycho-social needs of service consumers.

References

Declaration on health and welfare in Southern Africa, Maputo. Critical Health, #31/32, August, 1990, p4.

Anne Letsebe and Jackie Loffell: "Restructuring Social Services in South Africa". Critical Health #31/32, August 1990, pp 17-20.

Roberts, CS: "Conflicting Professional Values in Social Work and Medicine". Health and Social Work, National Association of Social Workers, Vol. 14, No. 3, August 1989, pp 145-224.

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Keep Health and Welfare together!

Melvyn Freeman

The author employs a mental health perspective in response to Letsebe and Loffell, and argues in favour of a single unified health and welfare department.

Introduction

The question of the structural relationship between welfare and health is a fundamental one. It affects not only the choice of whether to have a single or two ministries for health and welfare in the post-apartheid government, but also how existing health and welfare organisations define and arrange themselves. It also demarcates present and future levels of contact and co-operation between the two sectors and shapes the perception of both providers and consumers as to the nature of health and welfare.

In their article Letsebe and Loffell present the positions of a number of professional social work organisations, university social work heads, national councils and "homeland" welfare departments on the issue of whether to have one of two ministries for welfare and health. The response is, with one exception, overwhelmingly in favour of separate ministries. The authors and their respondents make a number of telling points as to why health and welfare should be separate. Given this, the task of giving the "other" side is daunting. I feel I may be accused of "not listening to the community" or being "anti-democratic" for raising an argument which, from within the field of welfare itself, seems more or less already agreed upon. These points may be made particularly because I am an outsider to welfare. However the very fact that I am not a social worker, but work in mental health which covers both health and welfare, puts me in a position to add constructively to the debate. In this short response I will show the advantages of a single structure from the mental health perspective (1). I will then briefly deal with some of the more contentious issues raised by Letsebe and Loffell on a more general level.

Mental Health - the Need for a Single Authority

Increasingly mental health is being recognised as not simply the absence of mental illness, but as a state of psychological and cognitive well-being. Physical health is generally seen as a major contributing factor to achieving this. Increasingly too there is recognition that mental health services should include curative, preventive and promotional interventions. Within this framework mental health is neither health nor welfare, but spans across the two. The question remains though whether the two aspects would be best facilitated through integrated or separate departments. I will give three examples of why I think one department would be preferable.

1. A case history in favour of a single ministry

X has a severe mental disturbance. Following a period in an institution he is discharged to "community services". At this point he hypothetically needs (at least) ongoing medication, counselling for himself and family, a disability grant and daycare centre facilities. Within separate health and welfare departments X would almost surely be given medication through the health department and a disability grant through welfare; however the remaining interventions could theoretically be administered by either department. Within a holistic approach to health care counselling and providing services which prevent relapse would certainly be acceptable **health** interventions; at the same time though these tasks are also defined **welfare** areas. A real possibility exists that these "grey" areas could either fall between the two departments and not be given any attention at all, or there could be duplication of services. X may also be given two home visits, one by the department of health to see that he is controlled on the medication given, and one by the department of welfare in order, for example, to fill in a disability grant form.

After this, X may have to go to one place at one time to get his medication and to another place at a different time to get the grant money as the two functions would be unlikely to be synchronised across departments. X would have two sets of records - as a patient within health and as a client within welfare. The information on the patient collected by one department would not necessarily be available to the other and would certainly not "filter" across departments.

Health and welfare functions need to be co-ordinated. *Photo: Medico Health Project.*

At a later stage X's condition may improve and personnel in the Department of Health may decide that he should cease to receive a disability grant. (These decisions are made by medical personnel). This decision would need to be communicated across departments and transferred into the welfare file for implementation. The chances of mistakes being made is substantial.

Within a well run single authority on the other hand a person's treatment programme could be planned within a multi-disciplinary team. Given that resources are scarce, one person, with perhaps supervision from a psychiatrist and a social worker, could combine the community health and welfare functions. All the information on the person could be kept in one file, and provision could be made so that dates and places for receiving grants could be combined with medical treatment.

An argument could be made that with sufficient co-operation between departments the same results could be achieved. In my view such co-ordination would be extremely difficult, if not impossible. This would be especially true where one person was expected to do the work of two separate Departments, with separate guidelines.

2. Defining areas of responsibility

If welfare and health were to fall into separate ministries it would be necessary to define who should be responsible for what tasks. For the purpose of this article, and because this is a likely scenario, let us presume that macro preventive and promotive tasks within mental health would fall under the authority of a department of welfare rather than health. A major problem here would be that in many rural and underserviced areas there is no social worker who has time to spend on mental health, other than perhaps dealing with disability grants (3). What little intervention does occur, is usually done by psychiatric nurses. There are certainly strong arguments to suggest that psychiatric nurses in these areas are in fact the people best placed to carry out these functions. However unless these tasks are in fact defined within the framework of the employing department (that is, health or health and welfare), they may disappear from these underserviced areas altogether. Though it could be possible for a department of welfare to "hire" people from the department of health to do certain welfare tasks, this is less rational than having a single authority planning services - especially when these tasks are not clearly either health or welfare. Moreover where personnel are overworked, it is unlikely that work from another department may be given higher priority than those of ones own department.

3. Planning services

Problems of separate ministries may also arise where policies made in one department have profound effects on the other Department. For example the department of welfare may decide that a policy of selectively discharging patients from psychiatric institutions should be pursued, and that they, as a department, would be prepared to take over much of the responsibility for these discharged people - if they were given sufficient resources to do so. As the department of health would still control the institutions, this policy would have little meaning unless the department of health agreed and discharged the relevant patients. This would mean transferring financial resources from the department of health though, and may leave some people in the department of health without employment. The department of health may resist the change for these practical reasons rather than on the merits of the policy itself. The converse is also possible. The department of health may be ready and prepared to discharge patients, but the department of welfare may feel that this was a mere dumping of patients and responsibility, that the resources which came across from the department of health would not be

sufficient, and may resist again on grounds not related to the merit of the policy.

While it is again possible to see co-operation between departments, the likelihood of success would be advanced if planning took place within a team, and agreed within one department rather than across departments.

Will welfare necessarily be compromised within a single structure?

It cannot be disputed that at present welfare is neglected relative to health services, and that medical personnel dominate welfare personnel. This may not however be reason enough to separate health and welfare. In fact it may be argued that it is necessary and strategic for welfare personnel to engage health structures directly and now.

One of the main reasons that Letsebe and Loffell give for remaining outside of health structures is the fact that health and welfare personnel "work differently" and that welfare workers are dominated in their relationships with doctors. This is indeed true and needs to change. However, this change need not necessarily occur through splitting welfare off from health, but by welfare workers asserting themselves more effectively in joint structures. For example much more power needs to be asserted from within welfare structures so that social workers can also take charge of a multi-disciplinary team rather than the doctor automatically playing this role. Rather than separating off from health structures, social workers have a responsibility to positively influence the way medical personnel operate. By disengaging welfare from health the medical model and the authoritarian nature in which much of medicine in South Africa is practised will flourish. In order to "humanise" the way medical personnel practice their profession; in order to help the medical profession see the social nature of much illness and adapt solutions accordingly; in order that medical personnel learn to listen to what their patients are saying more effectively, it is essential for very close contact with welfare to be maintained. By increasing the gap between health and welfare, health personnel will become more entrenched in their non-welfare oriented approach and patients will become **less** empowered. It is not strategic to empower the population in one aspect of their lives, yet by giving up the fight to influence the medical profession, be in part responsible for their disempowerment in another. Moreover the split is likely to mean that patients\clients themselves will cease to see themselves as whole individuals, but will see their social needs as separate from their bodies.

It is my belief that rather than setting up separate ministries for health and welfare that the kind of autonomy that welfare personnel are seeking should take place through a single ministry, but with Departments **of equal status** for Health and Welfare. This would allow welfare personnel to keep welfare issues in focus, but at the same time plan services together with health personnel.

Conclusion

The fact that welfare has not been getting a fair deal vis-a-vis health in South Africa is clearly reflected in the views of welfare personnel. This view obviously needs to be taken very seriously indeed. However the question is not straight forward when it comes to planning and implementing services where there is overlap. The possibility that interventions may be compromised by this separation should be considered very carefully before decisions are made. Though in this response the example of mental health has been used, I have little doubt that similar problems to those discussed would occur in other aspects as well. Letsebe and Loffell themselves give the examples of AIDS and foster children; physical disability, drug abuse and family abuse are others which come to mind. Also the potential for welfare to influence health personnel and the public positively should not be underestimated and further thought is needed in this regard. Placing welfare on an equal footing with health administratively within a Department of Welfare and Health, with each able to argue for its own budget and way of functioning may be a first step in this process.

Footnotes

1. Before final decisions are made it will be necessary to gauge the views of other groupings outside of welfare. The views of health personnel are as critical to this decision as those involved in welfare.
2. Depending on the resources available the person may not receive any home visits at all.
3. The social worker has no time to promote the fact that grants are available and many people who may be eligible will not receive these grants.

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Appropriateness

Welfare services in South Africa are, on the whole, not appropriate to the people they are meant to serve. This section looks at some of the improvements that are being made by progressive workers in the welfare sector. Research among people caring for the aged in Natal shows that, through a process of consultation and community involvement,can impart useful skills to people, whereby they are genuininely empowered. It is suggested that there needs to be a more humane approach to the care of children infected by HIV, or suffering from AIDS. Such an approach involves family and community care, rather than placing children in institutions and isolating them from society. It is strongly argued that professionals in the welfare sector need to be sensitive to the cultural background of their patients and clients in order to provide effective therapy.

Community Developers for Community Empowerment

Francie Lund & Nozizwe Madlala

This paper describes a research and action project involving training of lay carers of elderly people. It was done to help the South African National Council for the Aged (SANCAged) in Natal to plan their community development programme.

Research Approach and Methods

The direction and design of this project was influenced by the belief that research should, as far as possible, be useful to society by its support of welfare and community projects. The project looked at improving the ability and skills of people caring for the elderly in their homes in a context of scarce welfare resources. It involved working through existing community welfare organisations, and focused on both rural and urban areas.

We decided on this approach to the project, because of the limited resources available to welfare in South Africa, and also because we believe that community developers should not try to by-pass existing structures, but should strive to strengthen these. The rural focus was because the majority of black people in the region (that is, Natal/KwaZulu) we work in, live in rural rather than urban areas. These people are far from the main centres of welfare service.

We used a variety of research methods, starting with a literature review and visits to other regions to gain a comparative perspective. We then conducted interviews with various community service organisations, and with key decision-makers in health and welfare. We wanted to find out about policy affecting the

elderly, and about programmes being planned. This was to assess the compatibility of our programme with theirs. We interviewed the elderly themselves and the people providing them with care. We spoke to them individually and in groups at pension queues, selecting pay-points representing urban formal townships, informal townships and rural areas.

We sent postal questionnaires to people who were experienced in dealing with elderly people: the community nursing sisters employed by the Department of National Health, churches and voluntary welfare organisations.

People's Reaction

We received a very positive response to both the personal interviews and the postal questionnaires. It was quite clear that the need for some intervention was enormous. For example, the community health sisters themselves made extra copies of the questionnaire and distributed it to other people they thought would have useful information for us.

Another thing which reassured us was the consistency of the answers regarding the needs of people giving care to the aged. We would ask, 'If some kind of training or information could be provided, what would be most helpful to you?' The reply would tend to go something like this, 'We need information about the aging process. People need to understand all the things which happen when they get older; why they got shorter, why they lose their memory and why they become incontinent. We also need to know how to stop bedsores, how to keep the elderly mobile and the importance of doing so. We need more information about nutrition- the nutritional problems of the elderly and how to provide better nutrition for the elderly.'A lot of the project from this point onward focussed on these four ''felt needs''.

Intervention through Workshops

We then developed what is called a 'multiple-level intervention'. Backing this is a theory of learning which takes into account the needs of adult learners, and the outreach of training. The most effective vehicle for learning is through face-to-face contact between learner and trainer, in a workshop. So we developed a series of four workshops on the four main themes: the aging process, bedsores, mobility and nutrition.

We developed the design of the workshops and written materials with an urban group and a rural group of carers and health workers. We learned many things from them,. The community health workers at Manguzi Hospital in Ingwavuma, for instance, showed us the necessity of building into our approach the needs of rural workers who, for example, had to walk great distances between one homestead and the next. The volunteer carers at urban Kwamashu's Christian Care Centre helped us to understand the difficulties that arise when most carers are women. They had to care for the elderly in addition to their other responsibilities at home.

Both urban and rural groups taught us how they needed to have a balance, in the workshops of structured 'lessons', time for discussion of their own experiences, and the need for practical skills. They gave helpful criticism on the notes we had prepared for them to take home. They advised us on the level of English. They were particularly helpful in advising us on the regional differences in terms used in Zulu, and about Zulu terms which might be seen as offensive. They advised us to use more illustrations in our training material.

It can be seen that these workshops were built on the participatory approach. Adult learners come into the learning situation with a lot of experience, which we tried to build on. We allowed a lot of time for feedback. We tested this approach through a series of newspaper articles giving lessons around the care of the aged in the form of stories. We find, however, that it is not such a good teaching medium, and although it reaches more people, it does not reach illiterate people or people in areas which do not receive newspapers.

The workshops have been included in the Resource File which we refer to in detail below.

Intervention through newspapers

Despite the value of workshops, however, there are too few community developers to reach many people in that way. So we decided to explore communicating with people through the written mass media. We developed a series of newspaper articles around the care of the aged, in the form of stories and 'lessons'. Newspapers on their own are not a very effective teaching medium, but they do reach a lot of people. In our area, there are too many illiterate people, and there are many rural areas where no newspapers get to at all, so we moved on to the next intervention.

Logo for the manual: Caring for Elderly People: A Resource File. *Graphic: Siven Maslamoney*

Communicating by Radio

The next approach in our multiple intervention, consequently, was communication through the medium of Radio Zulu. The level of radio listenership in South Africa is extremely high, even among the very poor. Doris Hlube of the Muthande Society for the Aged, ran a good programme for us on radio, and we also had two radio phone-ins. Although we were aware that one cannot teach very well on radio, the idea was to see if community developers could use radio to create a climate of awareness about a particular social problem.

To complete the project, we compiled a Resource File, which was given to SANCAged (Natal) in April 1991 for distribution and to encourage further action.

The Resource File is a training manual in English and Zulu and is made up of three sections; four complete workshop packages, a section on organisations, and a section on educational materials. We are pleased with the process of compiling the manual, but the test of its worth will show over time.

Some Important Lessons

A number of lessons can be identified from the project, such as:
· the urgent need for simple information in both rural and urban areas regarding all aspects of caring for the aged;
· people's desire for useful skills, which for them means real empowerment;
· the importance of working through existing groups where possible to avoid causing divisions in communities.
· the need to be sensitive, in seeking volunteers, to other commitments people might have, especially women who often carry the burden of caring for their own families.
· Finally, community development on its own can never do much about the serious plight of the elderly, poverty, poor welfare services and unemployment. So community developers, as well as organising at grassroots level, must also always be making a nuisance of themselves to those with more authority than themselves - National Councils, local authorities, Regional Welfare Boards and other policy makers. In addition to strengthening the role of the care-givers, community developers have much potential in terms of this sort of lobbying for the interests of the elderly and their carers.

For further information about the Resource File contact:
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Children and AIDS -
Towards a Social Welfare Policy

Jackie Loffell

From a presentation to the Child Health Priorities Conference, Cape Town, October 1991.

The only effective way of managing the problem of children affected by AIDS is for health and welfare workers to join forces with the community. In this article the complex issues involved in formulating a humane and effective social welfare policy for dealing with children who are HIV-positive or have full blown AIDS are discussed. The ideal scenarios are considered against the obstacles we face in attaining such ideals.

1. Partnership Issues

The impact that HIV (Human Immunodeficiency Virus - the virus that can give a person AIDS) will have on almost all aspects of human existence, demands an effective response involving inter-disciplinary co-operation on an unprecedented scale. As health care and social service practitioners, we should be on the front line of preventing the spread of the virus and dealing with its consequences. While the health and social service disciplines have moved towards a much closer partnership on a number of fronts in recent years, our present challenge is to find an even greater level of co-operation. AIDS which targets the already marginalised in our society, demands that we combine skills in health care, human relationships and social development in new ways.

2. Models and Mindsets

If we concern ourselves with the expressed needs of people with AIDS, our services should be structured in a manner which includes a model of empowerment. This means programmes whereby:
- uninfected people are equipped with the knowledge and skills to protect themselves from the virus;

- those who have the virus are helped to live with it productively, with dignity, and as far as possible cared for within their own homes when illness takes hold;
- persons, families and communities are enabled to overcome ignorance and fear, and in terms of their capacities, are enabled to support those around them who are infected;
-families and friends of people with AIDS are offered support in dealing with loss and grief; and
- a strong advocacy approach is taken to counter discrimination against people with HIV, including children, and those in contact with them (CWLA, 1988; Ryan and Rowe, 1988).

2.1 Community Care: an alternative to closed institutions

We should not underestimate the obstacles we face. The usual response of the government and mainstream private welfare sector has been to set up institutions in which to house people in need, regardless of particular needs. The effect is to deprive people of assistance in functioning fully as members of their communities. Government financing systems for institutional care greatly outweighs those for community based care. However, a start is being made against placing affected people in institutions and thereby, marganilising them. We have to counter any temptation to prematurely hospitalise HIV positive patients by single-mindedly developing community care systems.

2.1.1. How are we doing so far?

On a recent broadcast of "Agenda", Natal doctors cited some horrifying facts about mounting numbers of destitute children , some 10 % of whom have tested HIV-positive, and have been kept in hospital for as long as 2.5 years in hospital. This in done at great cost. For instance, doctors at Johannesburg Hospital, where a similar problem is developing, have mentioned R300-R350 per day for the cost of a bed alone. Many more such children are being cared for in large institutions and state places of safety. For a fraction of the cost involved, we could be placing these children in specially recruited and well-supported substitute families; or better still, helping their own mothers to care for them. To do so we have to free ourselves of our strong attachment to institutions. We need to break from our health and welfare compartments and undertake joint planning of services. If we continue to operate as we presently do, the desperately under-financed state of our family support services and our foster care system will cripple our efforts to address the AIDS crisis.

3. Target Groups

Children for whom we are called on to plan services include the following:
- those whose parents require education in order to prevent contracting the virus;
- those whose parents or other care givers are ill with or have died from AIDS;
- infants without care givers who are testing HIV positive;
- older children who test positive or who are ill with AIDS (these may include, for example, child sex abuse victims and sexually active adolescents);
- special risk groups such as street children;
- those not at special risk but requiring age-appropriate life skills education, including AIDS related information (that is, the broad population of children).

Our starting point for approaching all these target groups, is that these services should be provided primarily within the family and community, with hospitals and residential care facilities serving, as far as possible, as inter-disciplinary resource centres and as bases for supportive services.

It must be made clear that HIV positive children pose no risk of infection to others in normal daily contact. *Photo: Cedric Nunn*

3.1 Creation of a positive climate

We need to be assertive in creating a social climate in which people are accommodating to those with HIV who pose no risk of infection to others or to themselves. School, pre-school educare facilities and family service organisations need to be provided with the necessary knowledge and understanding to forestall any tendency to discriminate. These institutions need to become outreach and education resource centres in their own right. It must be clear that HIV infected people pose no risk of infection to others in normal daily contact.

3.2 Support for people with AIDS and their children

Programmes combining medical care, education, counselling, comfort and financial aid (White, 1990) can go far to improving the quality of life for children and families affected by AIDS. We have a lot to learn from programmes elsewhere in Africa such as those run by The AIDS Support Organisation (TASO) in Uganda, which provides information, counselling and support to infected people and their families, with HIV positive people serving as an integral part of the organisation's work force (Hampton, 1990). The organisation assists families as far as possible to care for their own sick with full access to medical services and to hospitalisation when necessary. Where children stand to be orphaned, the organisation assists parents plan for their care. The organisation also helps parents identify relatives or friends who will care for their children when they pass away. TASO provides information to potential foster parents so as to overcome the fears and stigma associated with AIDS, and provides material and financial help to them once they have taken the children into their homes.

3.2.1 Programmes of support for women and HIV infected babies

Support for women with HIV and for mothers and their babies is a key aspect of a family support approach. Women's support groups have proved themselves to be most resourceful. (Taylor, 1990). Existing pre- and post-natal care facilities, with the necessary expansions and adaptations, are a natural base for preventive education and for information and support for infected mothers and their children. Active outreach and practical help including financial aid to vulnerable groups of women, such as teenagers and those who are homeless or destitute, could help

contain growing incidence of abandoned infants, enabling more mothers to care for their own children if they are sufficiently healthy to do so.

3.3 Formal foster care or adoptive placement

A network of well supported foster homes for children with special needs - children with HIV, children whose parents are incapacitated and children who are abandoned or orphaned is needed. This would involve substantial financial investment in active outreach and education. It would also involve locating, preparing and supporting people with the ability to deal with the pain of not knowing for months or even years whether or not a baby is actually carrying the virus, to face the prospect of terminal illness in infected children, to deal in their own homes with the difficult features of paediatric AIDS, and to cope with grief. The churches and religious groupings are likely to be in touch with such people. Religious groupings also offer a sense of meaning for sickness, suffering, and death, and a support system for providers of care. In the USA the health care professions have also shown themselves to be an important source of foster families for children with the virus.

3.4 Home-based employment for child care workers

Allied to and overlapping with traditional models of substitute family care is the concept of salaried persons who in their own homes provide therapeutic care for children with special needs, which could include children with HIV. The concept has many precedents in specialist foster family programmes which operate successfully in various parts of the world. A major ingredient promoting success in these schemes is provision for respite care - families who become well known to all children in a particular network of people providing care will take in a child for a brief period while the family acting as the main provider of care takes a much-needed break. Such programmes combine the advantages of hospital and children's home care (team support, training and time off for staff) with those of life in a normal family environment. They do, however, require more financial input than conventional foster care but considerably less than hospitals or children's homes, and could provide much needed employment.

3.5 Residential care issues

It is important that admission policies to residential care do not discriminate

There is a need to encourage the placing of HIV positive children in a normal community and environment, and not isolating them in hospitals. *Photo: Cedric Nunn*

against those carrying the virus, especially in the case of children who cannot be cared for by their own or substitute families and for whom the placement of choice is residential care. High-risk behaviour needs to be identified for what it is to avoid paranoia developing and children's homes being perceived as a source of infection. Encouraging behaviour which counters victim blaming and dealing with the impact on all concerned when a child becomes ill or dies, are among the challenges facing staff and volunteers. In dealing with infected children who use intravenous drugs or are sexually active and whose behaviour cannot be effectively controlled, we may in the long term have to consider providing, preferably on a very limited basis, some specialised residential facilities (Wilson, 1990).

4. Some Problematic Areas

4.1 Testing

For child welfare organisations testing of certain categories of children, for the purposes of appropriate planning for their future and dealing with prospective adoptive and foster families is important. The most clear-cut category in this

respect comprise children under 3 years who have been abandoned or formally released for non-disclosure adoption. (Non-disclosure adoption when a mother signs papers giving up her child for adoption without knowing who the adoptive parents are. A disclosed adoption, on the other hand, occurs when a mother consents to her child being adopted by parents she knows). Other categories are not so clear. A positive diagnosis in a situation of compulsory testing often introduces many problems with which we may not be able to help the children concerned effectively, but consideration has to be given to the possible risks to non-infected children including those who are in care against their own wishes and those of their parents.

4.2 Confidentiality

Although there must be strict rules of confidentiality, there is considerable difficulty as regards securing support systems for foster and adoptive families. Thus, were we to succeed in recruiting foster families or home-based child care workers for infected children, community support will be the life-blood of such arrangements. We have to walk a tight-rope between using firm measures to protect privacy while building in the support of selected people who can reasonably handle information, and make all-out efforts of removing the stigma of the disease. We must aim for a situation in which a child's HIV status is no more of a confidentiality problem than his having chicken-pox. We must move as far along that route as we are able.

4.3 Infection control procedures

The Johannesburg Child Welfare Society has set out to educate staff and foster parents in infection control procedures based on those propagated by the Centre for Disease Control in the USA (CWLA, 1988). This should enable staff to feel secure in the knowledge, that even the minute chances of contracting HIV in the course of giving care and contact with infected colleagues, would be eliminated. At present, we find the measures difficult to implement because:

a) their use is expensive, requiring a very large scale disposable gloves (experts suggest that plastic ones are unreliable and that the expensive latex type should be used). The cost of household bleach is also a problem. Whereas large agencies could manage these costs, we wonder if attempts at propagating these measures among impoverished parents, and pensioners who form the majority of foster care providers in our townships,are realistic.

b) emphasis on these measures to prevent the theoretically possible but extremely

unlikely transmission of HIV via, for example, through cleaning up a grazed knee or a bleeding nose may in fact create more fear than security, and detract from the messages about how one is really likely to contract the disease.

Perhaps we would have to find the money for the materials, or health workers could assist in developing effective guidelines. Guidelines which are affordable and easy to implement in the South African context.

5. Developing and Supporting Providers of Care

Every strategy we use in designing services for families and children must include plans for equipping management, staff and community providers of care with the knowledge and skill they will require. The provision of support systems needed by those who will daily face the crises arising from positive testings, and the emotional tasks involved in confronting sickness, disability, death and grief is vital. In all these processes we will need each other's skills, insights and support.

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References

Child Welfare League of America: "Report of the CWLA Task Force on Children and HIV Infection, " Washington, CWLA, 1988

Hampton J.: Living Positively with AIDS - The AIDS Support Organisation (TASO), Uganda", Strategies for Hope Services, Action Aid, London, 1990.

Panos Dossier: "AIDS and the Third World", London, Panos Institute, 1988.

Ryan, C.C. and Rowe, M.J.: "AIDS: Legal and Ethical Issues", Social Casework, Family Service America, June 1988.

Spence, C.: Facing the challenge of AIDS - an integrated model of care", London Lighthouse, November, 1988.

Taylor, D.: "Testing Positive", Health-sharing, Canada, Spring 1990.

Wilson, A.G.C.: " Paediatric AIDS: Issues for Consideration". AIDS Centre, SAIMR, Johannesburg, 1990.

Psycho-pathology and Culture

Pumla Gobodo

Most professionals in the welfare sector come from an elite in society while most of the people needing to make use of welfare services are black, from both urban working class and rural areas. Professionals and the recipients of welfare services, therefore, often speak different languages and have different cultural backgrounds. The training that professionals have received has generally failed to address these differences. As such, the services offered are often inappropriate to the needs of patients and recipients of welfare services.

The following article looks at the cultural issues that need to be addressed in order to improve appropriateness and effectiveness. The article focuses on mental illness and the interaction between psychologists and their patients. The issues raised are, nevertheless, relevant to various welfare and health settings. These include, for example, relationships between social workers and clients, doctors and patients and administrative personnel and recipients of pensions and grants.

Race and Culture in the Treatment of Mental Illness

Cultural and racial factors have strongly influenced the cause, definition and treatment of mental illness in South Africa. Definition and treatment have been imposed from one culture upon another. This has led to poor understanding as well as inappropriate treatment of mental illness. The challenge is to adapt therapeutic practices so that they can be used across cultures.

For example, it is often assumed that the reason that some African people drop out of therapy at an early stage is due to their preference for diviners or traditional healers. It is, however, necessary to see these patients in a different light, namely that current therapeutic practices are not always appropriate for all cultures. We should not, therefore, try to place all cultures in South Africa into an

imaginary melting pot and, in so doing, ignore cultural differences. We should rather study these differences and adapt therapeutic methods accordingly.

A major barrier to the implementation of effective cross-cultural treatment has been the lack of understanding of African cultures. This raises the crucial need for research which must be aimed at improving our understanding of cultural differences, as well as establishing guidelines for therapists who deal with patients from culturally diverse groups. In other words, we need to spell out precisely how we will be able to take cultural factors into account when making diagnoses and how we can then take the best course of action.

Some psychologists, including a number of black psychologists, have expressed the view that cross-cultural studies are worthless. There are a number of reasons for this resistant attitude, including the fact that a large number of studies are racially biased.

Racist Theories of Black Culture

Some studies have been used to suggest that blacks are genetically inferior. Other studies have tried to argue that the moral nature of the black person is degenerate. In some instances, researchers have done studies as a ''good favour'' to black people who supposedly cannot define their own philosophy. A particular researcher, for example, clearly revealed his motive to ''civilise, educate and raise the Bantu''. Studies which make prejudiced generalisations about ''black behaviour'' have been used to perpetuate racial segregation.

Various studies of mental illness have focussed on locating the causes of illness in the people themselves rather than in the social conditions in which people find themselves. Overcrowding, poor schooling, unemployment, poverty, low self-esteem and hopelessness are, for example, important causes of emotional disorder among black people.

On the other hand, a lot of positive work has been done in culturally diverse communities. People who deny the usefulness of cross-cultural studies have failed to take this into account. Their perspective, in turn, imposes a narrow cultural and class point of view that is not appropriate the majority of Africans in South Africa. With few exceptions, the techniques that are used in the training and practice of clinicians are derived from the dominant minority culture, yet a high percentage of black patients come from urban and rural working class backgrounds. This article argues for the need to address the importance of cultural sensitivity in clinical practice with black people. Their culture is different to the culture of our training. If black clinicians fail to acknowledge the importance of culture, they

Overcrowding, unemployment, low self-esteem, poverty are important causes of emotional disorder among black people. *Photo: Medico Health Project*

may fall into the category of black intellectuals who distance themselves from and sever links with their own racial community.

Black culture and modernist rejection of it

Most of the resistance to cultural studies is based on the belief that African culture is obsolete. There is an assumption that, because of education and enlightenment, we now share the same value system as the whites of this country as well as people anywhere else. This attitude ignores the fact that, no matter how "civilised" we may claim to be, we will still be regulated, in part, by our original culture.

The traditional culture or world view of Africans changes with technology and progress, but the underlying patterns of a particular culture are passed from generation to generation. They are not simply "forgotten" or "left behind" merely because of time. There is continuity of history in the lives of human beings. The broad cultural structure provides some firm ground and rootedness for individuals. Some individuals may be very badly affected if they lose this connectedness to their cultural base.

It is important not to deny one's roots and not to become affixed to them either. The problem as I see it is that many Africans, professionals included, in

their path "away" from oppression, make the mistake of denying the value of their own culture by associating this culture with everything that is past, oppressive and enslaving. I am not suggesting, however, that Africans should stay in their cultures and not integrate with other cultures. I believe Africans should take from other cultures what they need and what compliments their own.

Culture and Communication in Therapy

Racial and cultural factors can lead to a lack of communication between therapists and their patients and, as such, can impede clinical processes. Language, itself, is a cultural medium of communication. The meaning surrounding the use of a particular language in the consulting room may, for example, exclude one of the two people from the cultural experience of the language used. The use of language can, therefore, lead to communication problems and this can hamper the building of rapport between therapists and patients. Black people may, furthermore, lack the necessary verbal skills for "talk therapy", not because of the limitations of their language, but because of the subtle variations in the way that language is used.

The lack of precision in cross-cultural psychology in South Africa has led to mis-communication and poor diagnoses. Clear and appropriate communication is crucial in arriving at correct diagnoses and it thus seems logical that therapists should have an awareness of the background of their patients. This is not only a problem across black and white culture but within black culture itself.

African Tradition and Perceptions

The following example illustrates this point. A young unmarried professional woman was referred to me for "persistent vaginal irritation", for which no physiological cause was found. She was involved in a relationship with a man with whom she was very happy. She claimed that there were no problems in their sex life, but questioning revealed that her partner was not circumcised. The practice of circumcision varies within African culture and she came from a group that practices circumcision. She felt "unclean" and guilty that a woman of her age could sleep with an uncircumcised man.

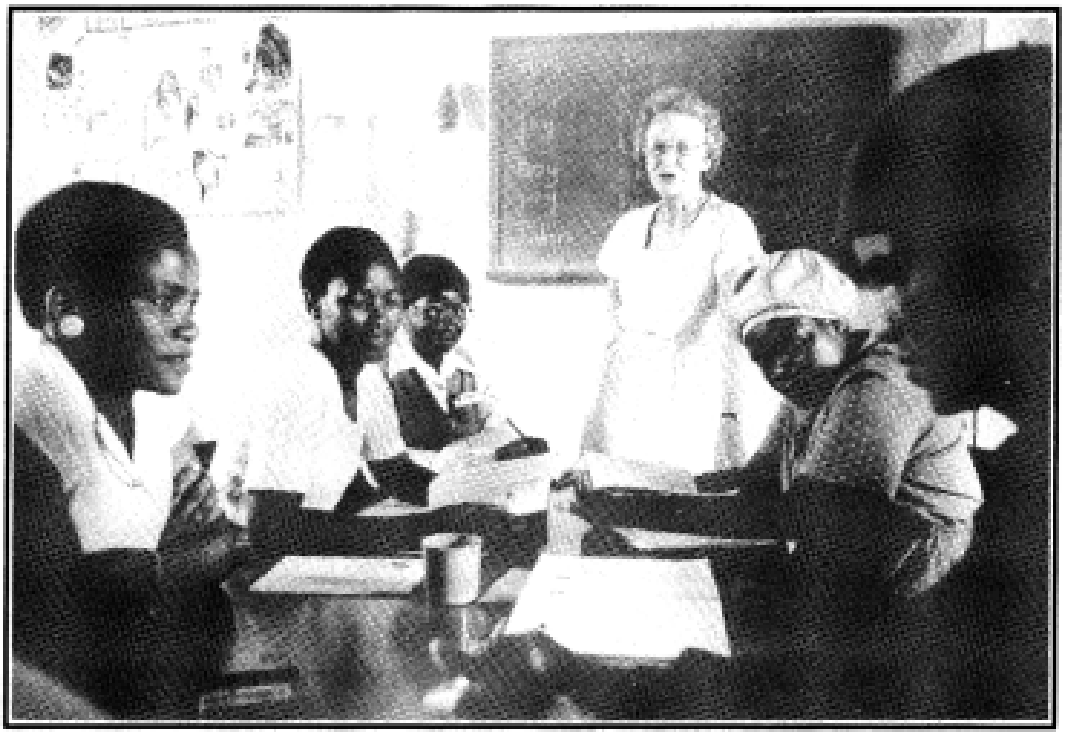
There was no doubt that culture played an important role in her experience of the problem. Having been socialised into a culture in which the definition of

manhood includes circumcision, her perception of her own womanhood was partially compromised. Culture can be defined as a set of symbols and meanings in terms of which individuals orientate themselves to each other and to the world. This means that a therapist who is ignorant of and insensitive to his or her patient's cultural orientation will not be able to build rapport with that patient.

When evaluating patients, clinicians must be aware of the cultural differences in the way in which psychopathology is expressed. "Hearing voices" is an appropriate experience in certain cultures. Clinicians should be mindful of this cultural fact and a therapist must not assume that his or her patient who hears voices is having "hallucinations" without taking the patient's cultural background into account.

On the other hand, clinicians must not exclude pathology whenever culture is evident. For example, although beliefs in witchcraft are common amongst most African people, overlooking the possibility for a disorder to exist poses the risk of excluding illness in a patient who is actually suffering from delusion. However, although belief in witchcraft might coexist with delusion, the belief itself does not constitute a delusion. So here again, if the clinician does not consider culture, he or she may misinterpret normal cultural behaviour to be abnormal.

Culture should be considered in the evaluation of patients from culturally diverse backgrounds, but it is also important not to "over-diagnose" culture. For example, I once gave a test to a patient in Xhosa so that he would be free to give



A white person may be symbolically perceived as master, authority, better, powerful and/or enemy. *Photo: unknown*

responses in his home language, but he insisted on giving his responses in English. So my "over-awareness" of racial/cultural differences was tantamount to stereotyping the patient.

The cultural dimension will vary, depending on whether a patient comes from a rural area, where culture is defined by traditions which are presumably relatively intact, or from an urban area, where cultural assimilation patterns are more complex. The challenge for the therapist is to be able to make the distinction between these two groups, and also to be able to discern individual dimensions within these variations.

There must be clear communication, verbal and non-verbal, between therapist and patient. If verbal and non-verbal messages are misconstrued, there are likely to be problems with proper assessment. Generally black therapists will be more sensitive to the cultural nuances of their black patients, but breakdown in communication sometimes occurs between therapists and patients from the same cultural environment.

In a racially charged society like ours, white therapists might need to work harder than their black counterparts in clinical work with black patients. This is because skin colour has enormous significance, both at the symbolic and the social levels. A white person may be symbolically perceived as master, authority, better, powerful and/or enemy. This has social consequences, in that a black patient may have an orientation towards a white therapist based on respect, subservience, fear, discomfort and/or hatred.

Notwithstanding the position of the patient or the therapist, it is the responsibility of the therapist, as the professional to whom the patient has come for help, to deal with the racial and cultural dynamics. Otherwise the therapist must refer the patient to another clinician.

It is possible that a white therapist may engage in therapy with a black patient in a manner that defies our normal day to day tensions and biases. It is also conceivable that a black therapist might be psychologically removed from what a patient represents in terms of his or her culture. It is, therefore, my contention that a white therapist may be able to empathise and share in his or her black patient's existential world just as much as, or sometimes even more than, a black therapist.

In the final analysis, the therapist is responsible for being creative and ready to adapt in an appropriate manner. It would be counter-productive for therapists to be so culturally sensitive as to end up using this sensitivity to impose stereotypes on individuals. Therefore, it is necessary for both black and white therapists to recognise culture and to be aware of individual dynamics and differences within each culture.

Conclusion

In the discussion of cross cultural psychology in South Africa, we have seen that diagnosis and treatment are strongly influenced by the variables of race, class and ethnicity, yet all these variables do not preclude the possibility for constructive communication. This will, however, be difficult in a country where racism is institutionalized and in which class differentiation is becoming more deeply entrenched.

As professionals, we have a responsibility to our patients and to society to accept and respect the diversity of human nature. It is not the differences in themselves that prevent us from helping our patients, but it is our attitudes towards these differences. Thus, in opening ourselves to an attitude of acceptance and respect of one another's differences, we are legitimising and validating the true humanity of the other, and this is an important starting point in doing therapy.

Each individual's culture in South Africa should maintain its own uniqueness and remain distinguishable but contribute to a wholeness that is richer than the separate parts. Psychology provides the opportunity for us to broaden our perspective about individuals who are different from ourselves, to a point that goes beyond mere ''cultural awareness''. If we are able to discern the cultural dimensions of our patients' general orientation to the world, we will be more effective in diagnosing and treating psychopathology in our patients.

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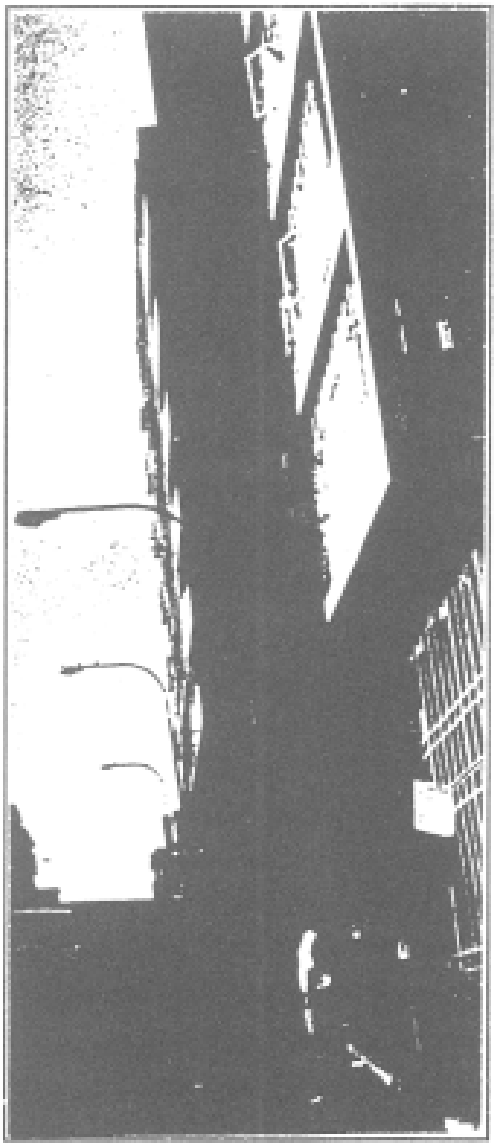

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Crisis Areas

The government's economic policies have played a major role in the massive increase in unemployment and poverty in South Africa. When it introduced VAT, the government also established a poverty relief fund. This is clearly an acknowledgement of the hardships that VAT will inflict on the poor. The fund is, however, inadequate and inaccessible. It will not counteract the negative effects of VAT and other economic policies. The increasing level of unemployment and, in particular, the growing number of 'unemployable' people is leading to further poverty and various social problems. This presents enormous challenges to workers in the welfare sector.

Taxation and Poverty Relief

Critical Health

Critical Health looks at VAT and its effects on poverty, with particular emphasis on the government's own attempt to deal with this problem through its so-called poverty relief fund. Critical Health also considers the response of a number of welfare organisations to the fund and the way in which it is being implemented. We thank the Community Resource and Information Centre (CRIC) for their assistance in writing this article.

From GST to VAT

At the end of September last year, the government replaced General Sales Tax (GST) with Valued Added Tax (VAT). There are a number of goods and services for which one did not pay GST, but workers and the unemployed now have to pay VAT on almost all consumer items. These include foodstuffs, such as meat, eggs and vegetables, and medicines and stamps. VAT is charged on services and is included in electricity and water bills and telephone accounts. VAT is payable on professional services such as those provided by doctors, dentists and lawyers.

As a result of these changes, the expected increase in the cost of living for the working class is almost 5%. In other words, a family which spends, for example, R700 per month will now have to find an extra R21 to buy the same goods and services as before. On the other hand, the capitalist class stands to gain substantially from the introduction of VAT. Unlike GST, VAT is not charged on capital goods. As a result, big business will save up to R7 billion a year.

VAT: Taking from the Pockets of Consumers

The introduction of VAT reflects a long standing policy on the part of the government to shift the burden of taxation from big business and high income earners to workers and the unemployed. It has shifted its emphasis from company and individual income taxes to consumer taxes such as GST and VAT. Income tax

on individuals is calculated in such a way that low income earners pay a lower percentage of their income than high earners. A consumer tax, on the other hand, is charged at the same rate to rich and poor. It is significant that a consumer tax is one of the few ways in which the unemployed can be taxed.

The change in government tax policy has had dramatic results. Between the late 1970s and the middle of the 1980s, government revenue from individual taxes increased from 30% to 60%. Before 1978, GST did not exist, but, by the mid 1980s, its contribution to government revenue was 30%.

Economic Policy and Taxation

The government's approach to tax must be seen within the context of its broader economic strategy. It is moving rapidly towards a free market economy, at all costs. It is decreasing the role of the state, deregulating the economy and pursuing a rigid monetary policy. This approach is contributing to a massive increase in unemployment as well as a decline in the availability and quality of a wide range of services.

The government is also cutting food and transport subsidies. In 1991, it stopped the subsidy on brown bread altogether. We are now experiencing spiralling prices for bread as well as increasing bus and train fares. The working class is thus being forced to find the extra money for VAT at a time when living standards are being attacked from all sides.

In the months immediately before VAT was implemented, the government did all it could to obscure the reality of the effects of this tax. It embarked on an extensive propaganda campaign to convince South Africans that VAT is in their interests. It spent R10 million to argue that VAT is a "fair" tax and that it is difficult for companies to cheat by evading payment. It tried to assure the public that the benefits to big business will be passed on to consumers in the form of lower prices.

The government, however, knew from the outset that VAT was going to bring hardship to the majority in South Africa, but it suggested that the needy should be specifically targeted. According to van Heerden, the chief director of tax policy development in the Department of Finance, "experience has shown that a country's tax system is not an efficient manner of rendering assistance to the lower income groups and that target-orientated rendering of assistance outside the tax system is more beneficial."

This view is based on the argument that, if a consumer tax is not charged on basic items such as meat and vegetables, the rich also do not pay tax on these items.

The Financial Mail sums this up as "misplaced subsidies that have little real relevance for the needy". But, this line of reasoning entails that, in order to ensure that the rich pay, everyone else must pay as well. The government and big business are conveniently forgetting that the government has moved away from income taxes, by means of which the rich are taxed proportionately more, to consumer taxes, where rich and poor are taxed equally. In other words, changes in tax policy have benefited the rich and now it is being argued that, in order to tax the rich, the poor also need to be taxed.

The Poverty Relief Fund

It is clear that the government was intent on introducing VAT irrespective of its effects on the poor. It announced a poverty relief fund to cushion the effects of VAT on the needy and set aside R220 million in the 1991/92 budget for this purpose. This money was to be spent when VAT replaced GST, in other words, during the last six months of the 1991/92 financial year. The government stated that the fund was for food assistance, which would be provided by government departments and non-governmental organisations.

In comparison with other government expenditure, an extremely small amount of money was allocated to the fund. In the same budget, the government made R380 million available for secret security activities. It had just spent R100 million to fight Swapo in the Namibian election. The government is spending R68 million over 3 years merely to put VAT into operation. This brings the government's commitment to poverty relief into question. It is likely that it was more concerned with preventing opposition to VAT than assisting the poor.

The government, moreover, set aside a smaller amount to the fund than what it expected to gain from the poor as a result of the change from GST to VAT. According to the Bureau for Market Research, Unisa, there are more than 16 million people in South Africa who live below the minimum subsistence level. These people will have paid the government roughly an additional R500 million in the 1991/92 budget year as a result of the change to VAT. In other words, the government's intention is to give with one hand and take a lot more with the other.

The amount that each needy person can expect to receive is also clearly inadequate. According to a report commissioned by the government, the more than 16 million people below the minimum subsistence level were considered to be "deserving of the first call on any assistance". A fund of R220 million over six months means that only R2.25 is available for each person every month.

This figure, however, includes the cost of administering the fund as well as transporting and distributing the food. The amount available for food is, therefore, even less than R2.25 per person.

Poverty Relief: Who Needs it?

The government has, in fact, chosen not to make the fund available to all those in need of assistance. It has specifically targeted the more than two million people who are already showing physical signs of nutritional deficiency. The fund only provides an amount of R15,94 for each of these people every month and, again, only a portion of this amount is available for food.

Ina Perlman, from Operation Hunger, says that the fund is barely sufficient for a bag of maize meal and does not cover the Department of Health's recommendation of a food parcel of R30,00 per person a month.

The other 14 million people "deserving" assistance have not been catered for and are expected to suffer as a result of VAT, without getting a cent in the form of relief. This includes one and a half million people who receive inadequate state grants as well as a number of aged who do not receive any grants at all, many of whom also experience nutritional deficieny. The total number of people who suffer nutritional deficiency is estimated to be about three and a half million and

Marching against VAT. *Photo: Dario Fossate*

it is certain that VAT will contribute to a growth in this figure.

The Response to VAT

At its national congress in July last year, the Congress of South African Trade Unions (Cosatu) decided to actively oppose the introduction of VAT. It convened a VAT summit in August, which was attended by a wide range of trade union, political, consumer, health and welfare organisations. This led to the formation of the Co-ordinating Committee on VAT (VCC), which represents a broad alliance of organisations from very different backgrounds, but all united in their opposition to VAT.

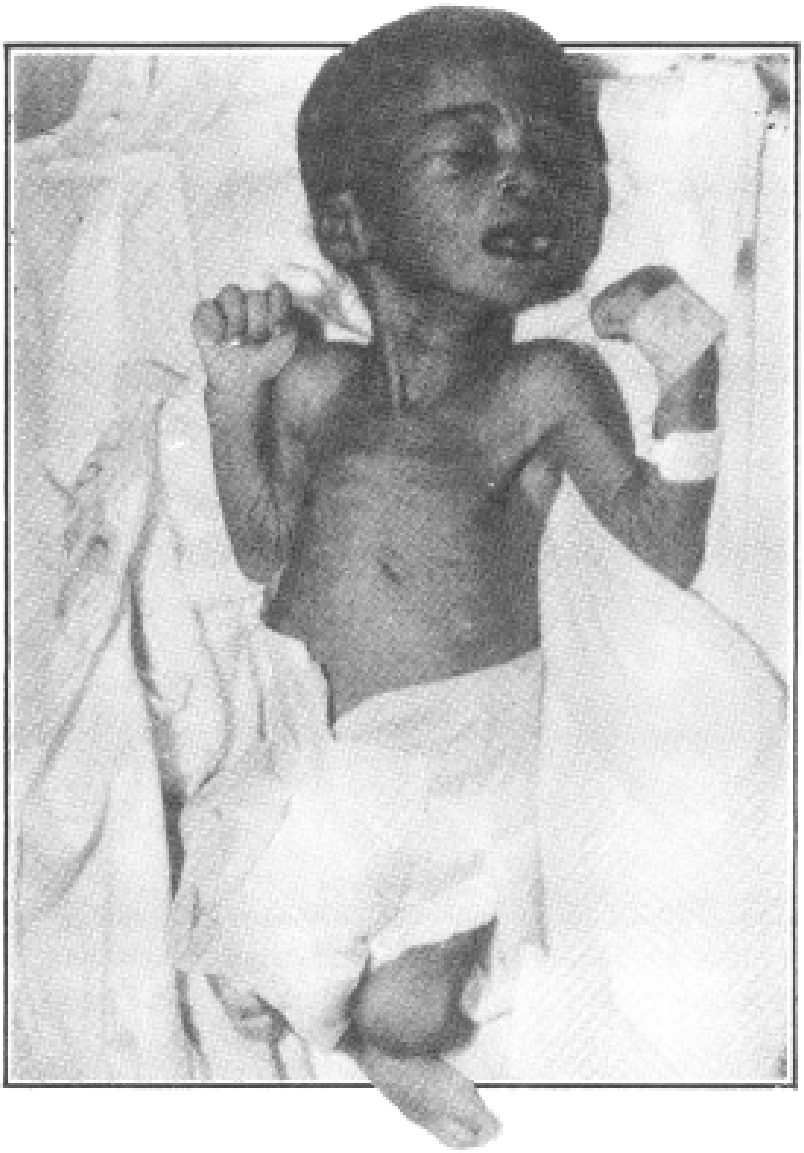
The VCC called for a postponement of VAT and for negotiations on the way in which VAT should be implemented. It demanded that VAT should not be charged on basic foods, medicines, medical services, electricity and water charges. It also called for adequate amounts to be made available for poverty relief and for negotiations on poverty relief programmes. The demands were accompanied by various forms of mass action including marches throughout the country which involved more than 100 000 people.

Immediately after the Cosatu congress, the South African Chamber of Commerce (SACOB) called for an increase in the poverty relief fund to R1,2 billion. It recognised the potential for massive opposition and said, ''unless a suitable programme is announced, the implementation of VAT stands under threat.'' It argued that an amount of R1,2 billion ''would be highly visible and, to an extent, would defuse some of the opposition that is building up towards VAT.'' It said, however, that the R220 million allocated for 1991/92 should remain unchanged, that the larger amount should only be made available in 1992/93 and that the fund should be reassessed in 1992/93. Big business was clearly prepared to manipulate the fund so as to allow for the smooth introduction of VAT.

The government refused to agree to the postponement of VAT. It made a few minor compromises and, thereafter, it was not prepared to negotiate around the issue. It also failed to set up adequate mechanisms to distribute the money in the relief fund.

Government Intransigence

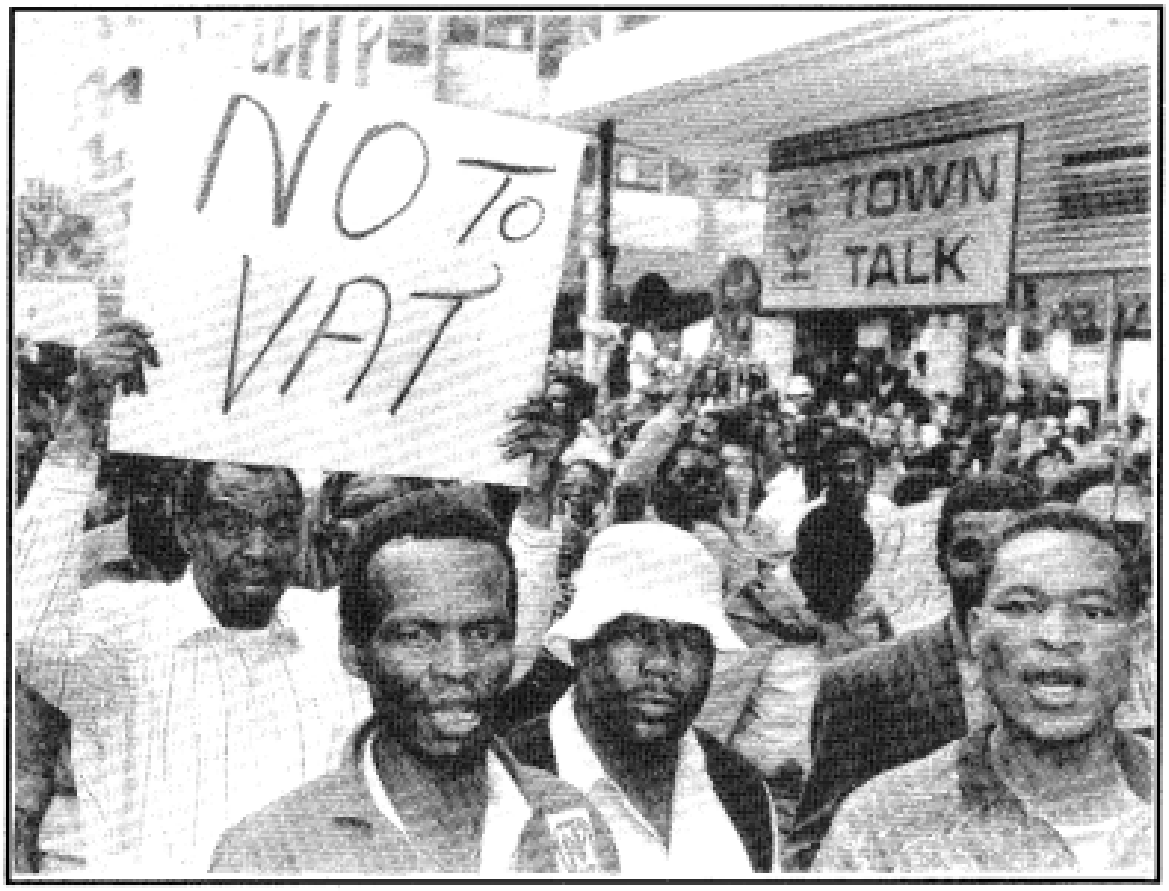
In the 1991/92 budget speech, the minister of finance, Barend du Plessis, expressed reservations about whether the available infrastructure could efficiently target aid. By the middle of August, the Department of Health had still not approached non-



There is likely to be an increase in the levels of malnutrition. *Photo: Medico Health Project*

governmental organisations such as Operation Hunger and World Vision. It, nevertheless, said that it intended to rely mostly on the private sector and did not envisage any significant increase in the number of public servants. It hastily convened a forum for non-governmental organisations at the beginning of September. However, by the end of September, the department was in no position to ensure the adequate distribution of the poverty relief fund.

The government had shown its true colours. It had previously assured the public that the introduction of VAT would be accompanied by a fund with the organisational backing to distribute food to the needy. On the one hand, it managed to make the necessary changes for the switch to VAT, but, on the other, it failed dismally to prepare the ground for distribution of the fund. Despite massive opposition, it went ahead with its unshakeable commitment to introducing VAT at the end of September. In terms of its very dubious commitment to poverty relief,



Large profits are being made by food producers at various stages of production and distribution. *Photo: Dario Fossate*

it merely agreed to refrain from charging VAT on eight basic food items for a period of six months. The food items are milk, mielies, mielie rice, samp, dry beans, rice, lentils and tinned pilchards.

The Effects of VAT

The introduction of VAT has been disastrous for workers and the unemployed. There have been massive increases in the price of a wide range of goods and services. The soaring price of foodstuffs has been particularly devastating. The inflation rate for food has been consistently above 25% ever since the introduction of VAT. This is far higher than the average rate of inflation for all items, which has been in the region of 16%.

The increases are due mainly to the direct effect of charging VAT on goods and services for which one did not pay GST, but there have been other factors as well. Retailers have taken advantage of the uncertainty surrounding the implementation of the new tax and prices shot up in August and September, before the implementation date. Contrary to government and big business propaganda, large

scale producers have not lowered the price of their products in response to the savings they have made on capital goods purchases. In terms of food, it appears as if large profits are being made at various stages of production and distribution.

According to Ina Perlman, the recent price increases, unemployment and the emerging drought are causing more families to fall below minimum living standards to the point where they can not afford even basic food items such as meat, milk, eggs, poultry and margarine. Operation Hunger's evaluation of household budgets shows that many people are being forced to cut food expenses in order to pay for other expenses such as rent, service charges and school fees. In these households, up to 80% of food consumption is made up of maize.

Over the years, Operation Hunger has worked in areas in which nutritional standards had improved and people had acquired an independent capacity for feeding their families. In 70% of these areas, there has been a reversal of the situation. About 90% of school feeding schemes are no longer supplying maize, but parents are increasingly unable to afford it. Mrs Perlman estimated that, by December 1992, an additional two to two and a half million people will be in need of some food subsidy.

The Poverty of the Fund and Bureaucratic Constraints on its Distribution

A wide range of problems have been raised in terms of the poverty relief fund itself. It has been unable to and is unlikely to reach remote rural areas. There has also been criticism that the fund has been set up specifically to provide food aid and that it will not meet the need for long term development work in communities. A World Vision spokesperson, Esrom Matambunye, said that the largest part of World Vision's poverty relief work involves social development as opposed to food aid. According to Matambunye, the R220 million fund is grossly insufficient to meet the massive investment requirements for intensive development of communities. World Vision's executive director, John Allwood, said the poverty relief fund is not "a proper undergirding of long-term sustainable development in a creative way, which would enhance the production of food and improve the supply of food to those who need it most."

The fund is, furthermore, not even fulfilling its narrow role of providing food to the needy. Allwood referred to the implementation of the fund as a "camel", because it has not proved to be "a response to an immediate crisis, with the quick

delivery systems and decision-making normally associated with a relief project.''

In February this year, the minister of national health, Rina Venter, announced that only R16 million had been spent. Another R10 million had been allocated to various organisations. In other words, only 12% of the original R220 million has been approved for distribution so far.

In Port Elizabeth, 68 organisations surveyed by Operation Hunger said that they were promised funds last year and, of these, only eight have received funds after 5 months of waiting. In the Western Cape, organisations have experienced similar difficulties. Only three out of 14 organisations, which had applied for support last year, had received funds by the end of February.

One reason for the delay in distribution is the government's unwillingness to set up a distribution network which bypasses the bureaucratic maze of the apartheid system. According to Perlman, Operation Hunger did not previously receive state funding, but, with the announcement of the R220 million fund, the organisation reconsidered whether it should apply for state funds. The regional structures of the organisation unanimously decided that Operation Hunger should apply, but should only accept assistance on condition that the money is distributed directly from Pretoria.

Operation Hunger sent a letter of application for funds to the minister of national health. It made a modest request for R58 million to feed almost two million people for up to eight months. It pointed out that the organisation has more than 6 000 feeding schemes and 15 000 development points. It would, therefore, be impossible to receive funds through the various homeland administrations and regional government structures. The minister failed to respond for at least three months. After public prompting by Operation Hunger, she said that she thought the organisation wanted to bypass regional government structures so that it did not have to account for funds. She made this claim despite Operation Hunger's submission of a full schedule of expenses. In February, the minister finally agreed that Operation Hunger could apply for funds at a national level. Operation Hunger has since received R10 million from the department of national health, an amount which should cover just over a month of poverty relief work.

However, it seems that, even if the funds were directly allocated from Pretoria, they would not reach all the organisations involved in poverty relief. According to a spokeswoman for the Black Consumer Union, which has eight associations involved in food and development work, the consumer body has not applied for funds. Application forms are too complicated for its volunteer workers to understand and the consumer union does not have personnel who can assist them.

Moreover, many voluntary organisations involved in community work do not have fund raising numbers. This is an official requirement for the receipt of

funds and many applications have been refused for this reason. The same source also said that the government has not set coherent criteria for deciding which organisations should receive a share of the poverty relief fund. She claims, for example, that a hospital in northern Natal received money from the poverty relief fund despite the fact that it is not involved in poverty relief work.

The Need for an Independent Trust Fund

World Vision has not applied for funds because the organisation does not wish to bear the responsibility for delivering state funds. John Allwood argued that "as soon as you become a conduit of state funds, then delivery of funds is liable to state mechanisms, including auditors, parliament and evaluators. World Vision prefers evaluations by community groups."

The organisation feels that the most effective structure for the distribution of poverty relief funds is an independent trust, administered by representatives of various non-governmental welfare and development organisations. An independent trust would be more impartial than government, which still supports elements of apartheid, such as separate departments of health. A trust of this nature would be able to operate more freely than a government department, which is bound by regulations.

A trust was agreed upon at the forum for non-governmental organisations, convened by the government, in September last year. It was intended that this trust would involve both government and non-governmental organisations. Allwood said, however, that the government has subsequently decided to retain authority over the relief fund, even though it relies on non-governmental organisations to distribute the fund.

Conclusion

VAT, we have argued, together with other aspects of government economic policy, is having a devastating impact on workers and the unemployed. The continuing recession and drought are making the situation even worse. Nonetheless, the government and the Department of National Health, in particular, have

done very little to ensure the development of adequate poverty relief measures.

South Africans have continued to resist VAT. On 4 and 5 November last year, more than three and a half million people stayed away from work. The government has, however, failed to respond to repeated demands by the VCC for the reopening of negotiations on VAT.

In his budget speech in March, Barend du Plessis highlighted the government's continued lack of commitment to poverty relief. He announced an allocation of R440 million to the relief fund for the 1992/93 financial year. This amount is for the full twelve months, whereas the allocation of R220 million in 1991/92 was for a six month period. In other words, the same number of rands has been made available for each month. However, the amount of food that can be bought with these rands will decrease as the months go by, due to the effect of inflation on the buying power of the rand.

The government is also intent on charging VAT on the eight basic food items which it temporarily excluded from the VAT net last year. This is despite the fact that there is still no adequate poverty relief network. Cosatu and the ANC have indicated that they would resist the charging of VAT on these items.*

Critical Health

*At the time of publiction, there were indications that the government may extend the period during which VAT is not charged on these foodstuffs. But, if it does so, it is almost certain that this extension will not be for more than a few months, although no official indication has been given as to the time limit of this concession. Rina Venter has announced (once again) that negotiations are being planned around the distribution of the funds.

Unemployment in South Africa:

Dilemmas and Challenges for the 1990s

Jean Triegaardt

The development of capitalism in South Africa has always been associated with high levels of unemployment, but unemployment has increased alarmingly in the past two decades. This has serious consequences, including poverty, escalating violence and the slow destruction of the social fabric of South African society.

Dimensions of Unemployment

There has been a lot of controversy about the number of unemployed people in South Africa. Different authors have arrived at vastly different estimates depending on their ideological positions and their definitions of unemployment. The government body, Central Statistical Service (CSS), has presented low figures in the past. It has more recently accepted that its figures are inaccurate. In August 1990, it stopped releasing official unemployment statistics for Africans because its "estimated unemployment rate reflected an unaccountable continuous decrease, not in accordance with other related indicators."

There is now a greater degree of agreement that the number of unemployed is enormous. In May 1991, the special adviser to the Minister of Finance, Japie Jacobs, said that about 4,6 million people were not employed in the formal sector. This is more than 40% of the economically active population. (These figures exclude the so-called independent states).

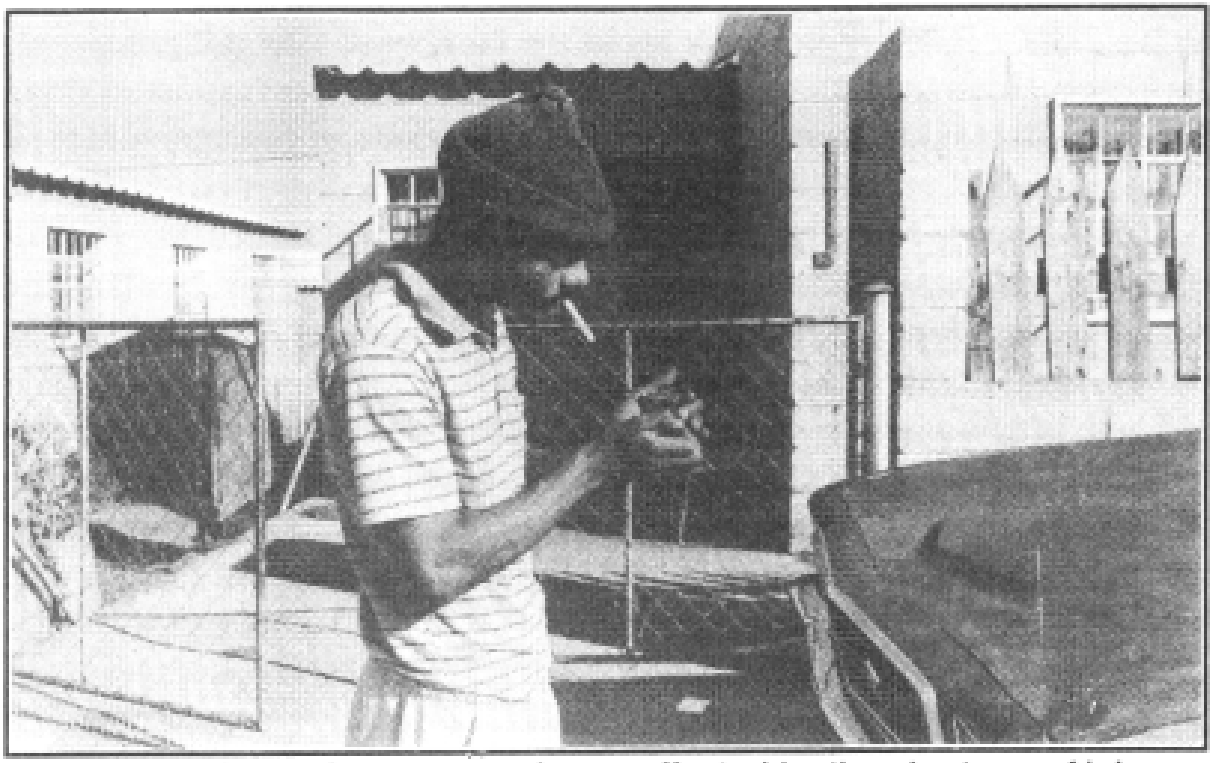
The first report on the 1991 census has been released. It states that almost 2 million South Africans said that they were unemployed. A growing number of people said they were self-employed, the number being almost twice as high as that

in 1980. These figures confirm the severe shortage of jobs in the formal sector and consequent growth in the informal sector, as well as the simultaneous increase in the number of people not employed in either the formal or informal sectors.

The government now concedes that unemployment is entrenched and that it is a structural problem. Structural unemployment refers to that proportion of the workforce which is permanently unemployed. Another type of unemployment is cyclical unemployment. This relates to cyclical changes in the economy, and refers to those workers who are retrenched during an economic downturn and who may be able to find jobs once the economy improves.

Structural unemployment is clearly the most serious form of unemployment and poverty arises from this form. Cyclical unemployment can also lead to severe hardship, especially during economic downturns of long duration. Cyclical unemployment can, furthermore, lead to structural employment. Workers who have generally been able to find employment during economic upturns may, at some point, no longer be able to find jobs and become permanently unemployed.

In South Africa, structural unemployment is becoming an ever increasing problem. Each year, the number of economically active people entering the labour force increases, but the number of available jobs is diminishing. Between 1975 and 1988, the South African labour force increased by 3,9 million, whereas employment grew in total by 0,9 million. High rates of population growth impact heavily on the level of unemployment, but the underlying problem is that the economy is not generating the necessary employment opportunities. In 1990, only 7 out of every 100 job seekers managed to find work.



Large numbers of young people are effected by the shortage of jobs.
Photo: Cedric Nunn.

South Africa is, furthermore, in a deep and long economic downturn. Retrenchments are on the increase and, in the last two years, about 150 000 jobs have been lost. An estimated 1 200 jobs are being lost daily. In some cases, retrenched workers may be entering a period of cyclical unemployment, but, in others, the workers being retrenched in this downturn will join the pool of permanently unemployed.

Large numbers of young people are affected by the diminishing pool of jobs. Research conducted in three Cape Town townships, namely Mitchell's Plain, Hanover Park and Manenberg, revealed that almost a third of a sample of 150 unemployed fell into the 15 to 24 year age group. These findings are confirmed by the 1988 National Manpower Commission (NMC) report, which notes that a "breakdown of unemployment by age indicates that it predominantly occurs where workers are under the age of thirty years."

The Consequences of Unemployment

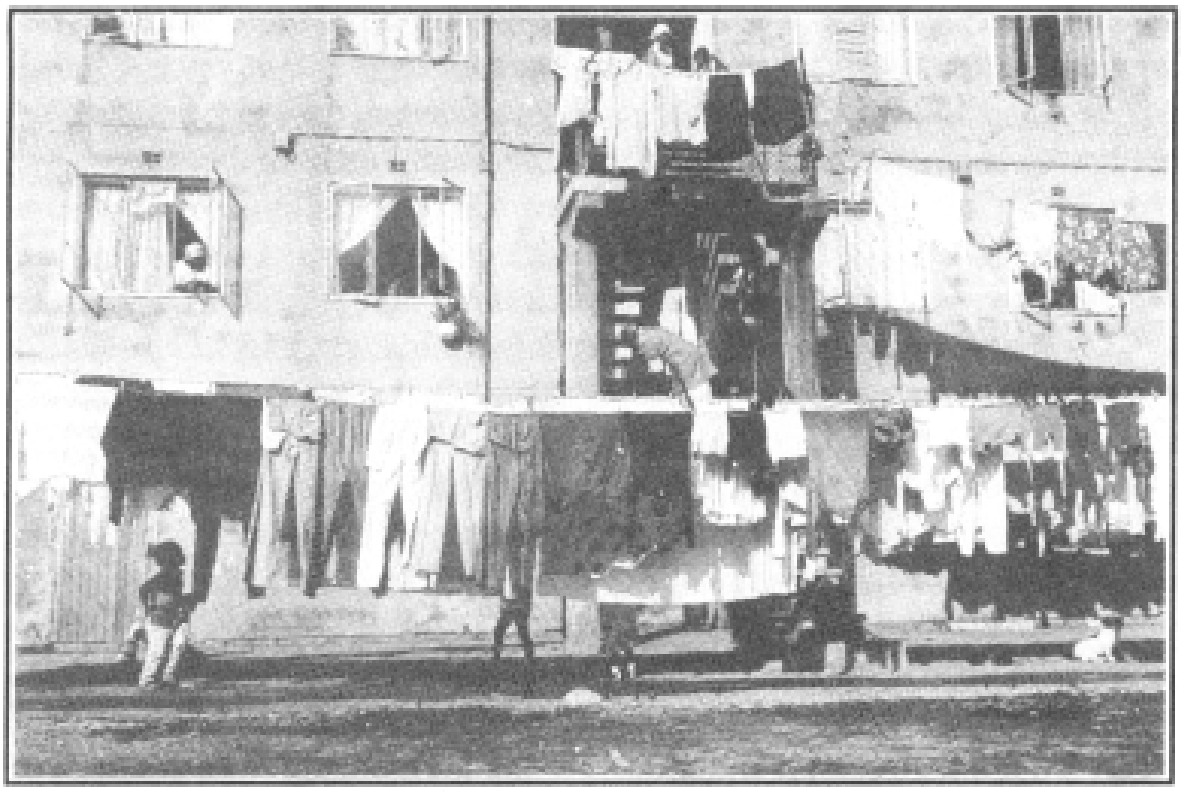
Unemployment results in economic deprivation, emotional and psychological stress, social and family problems. A survey of 620 households conducted in Atlantis in 1986, revealed the devastating consequences of unemployment. Atlantis is a "coloured" township 45 kilometres from Cape Town. In more than half the 620 households surveyed, people were in some kind of financial difficulty; at least one major account (rent payments, water and/or electricity) was in arrears. The overall unemployment rate for Atlantis was 27% and the youth unemployment rate was 47%.

A study in Cape Town of 13 unemployed individuals revealed feelings of depression, worthlessness, pessimism, desperation and apathy. Research of 150 involuntary unemployed workers, that is, people who want to work, showed that almost all of them (92%) found unemployment tough. The consequences of unemployment had various effects on individuals and families. Individuals experienced feelings of being under-valued, of despair, fatalism and anger. Families experienced discord as a result of rejection of the unemployed head of household, intra-family conflict, despair and even violence.

A 20-year old woman living at home described the following feelings:

"I feel very miserable. If I work, my father does not beat me up and call me good-for-nothing! He sometimes does not want me to stay under his roof".

This woman experienced misery, rejection, violence and the threat of eviction from a parent. Her situation was stressful and traumatic, typical of the devastation experienced by many unemployed people.



High rates of unemployment in Atlantis often affects rent, water and/or electricity payments. *Photo: Medico Health Project*

The present context and the challenges

Politicians make policy and planning decisions on unemployment in conjunction with economists. Historically, social workers have not been involved in major economic decisions on the unemployed, nor have they advocated the cause of the poor and unemployed.

The social worker's role has been defined by a number of forces which perpetuated their non-involvement in political, economic and social conditions.

Since the 1980s, the state has promoted privatisation of social welfare in order to relinquish its responsibility for the welfare sector (Patel, 1988). This shift of responsibility has resulted in the welfare sector's frenetic activity to compete for dwindling resources from the community and the business sector. This exacerbates the existing fragmentation of the welfare sector.

The state also promotes the concept of 'self-help' in communities, but impoverished communities do not have the resources to sustain themselves.

State training programmes provided by the Department of Manpower for the unemployed are targeted at those who are cyclically unemployed, but not those

who are structurally unemployed (NMC, 1988).

In summary, unemployment is on the increase and this increases the burden on welfare services; the welfare sector has to compete for dwindling resources; racial divisions continue to plague the provision of welfare services because of the 'own affairs' concept' social workers have been socialised generally into accepting that they cannot contribute to economic and political decision-making; training programmes by the Department of Manpower are accessible to cyclically unemployed workers and not structurally unemployed workers; impoverished communities are urged to be self-reliant; and the government is reluctant to be the major partner in the provision of financial resources to the poor and unemployed.

Conclusion

Social workers have a major responsibility to promote the cause of the unemployed and poor.

Presently, racial divisions permeate the allocation of resources in the welfare sector and there is uneven access to skills and training for the unemployed. All these discriminatory measures need to be eradicated. Such attempts can be facilitated by a non-racial department of welfare with its own budget. A cooperative relationship can be maintained with a department of personpower on mutual

Waiting for jobs. *Photo: Cedric Nunn*

concerns of the unemployed. In addition, social workers must promote social justice in the workplace and fight for adequate resources for welfare clients. Professional organisations for social workers have the responsibility to promote the cause of human dignity by contributing to decision-making on issues such as Value-Added Tax (VAT), poverty relief programmes and other political and economic issues related to welfare. Social work training institutions have the responsibility to teach students about social policy issues encompassing economic and political concerns, and social developmental issues.

A South African economist (Bromberger, 1990) has noted that: "if a major part of this unemployment is involuntary - that is to say - most of the jobless are job-seekers, or at least job-wanters, their unemployment must represent a colossal frustration of human potential, hopes and desires."

Here lies the challenge for social workers in the 1990s.

Jean D. Triegaardt is an executive member of Concerned Social Workers. She lectures in the School of Social Work, University of the Witwatersrand,

PHC, Alexandra Health Centre

and some implications for an NHS in South Africa

Grant Rex

Introduction

In 1978 the World Health Organisation hosted a major intergovernmental conference at Alma Ata in the Soviet Union. The Alma Ata declaration, which emerged from the conference, outlined the basic principles of primary health care (PHC).

Underlying the concept of PHC is the idea that the main roots of poor health lie in living conditions and the environment, and particularly, in poverty, inequity and the inadequate distribution of resources. Part of the process of PHC implementation therefore involves encouraging people to play a greater part in the protection and improvement of their own health.

Furthermore, a PHC service must provide not only curative care, but also incorporate preventive, promotive and rehabilitative interventions such as health education, proper nutrition, and basic sanitation. A PHC based approach therefore involves combining and integrating a range of strategies for the improvement of health. The provision of basic services for the whole population is emphasised, rather than highly specialised and technologically sophisticated medical care.

Central to PHC are the principles that:

* the first line of contact between populations and their health services should be the provision of PHC;
* that PHC should be practical, scientifically sound and socially acceptable;
* that a health team approach rather than a doctor based service should be relied on.

Subsequent to Alma Ata there has been widespread international acceptance of the PHC approach. However, the achievements of many PHC services in terms of improving health, have not lived up to the expectations of many of those who were originally committed to the idea.

In South Africa the debate around developing an adequate national health service (NHS) has focused on a variety of issues such as the respective roles of public and private health sectors, the financing of health services, the need to deracialise services, and the issue of privatisation. While these issues are fundamental to the provision of decent health services, there is an important need to place Alma Ata and PHC back on the agenda.

This article will address certain issues related to the development of PHC services as the "first-line" component of an NHS. Where applicable, the experience of the Alexandra Health Centre (AHC), the largest non-governmental organisation (NGO) health service in South Africa, will be used as a point of reference.

PHC and existing state structure

The implementation of a PHC based approach would necessitate the creation of a national network of comprehensive PHC centres, providing the first line of contact between the community and the NHS. At present, tertiary hospitals see 30% of all outpatients treated by the government health services. If a PHC network were to be established, it would substantially relieve, if not eliminate, the load on the tertiary hospitals.

However, ultimately the relationship between PHC centres and tertiary hospitals, should be a mutually supportive one. The PHC service would have to provide an integrated referral system. Developing such a system would require the thorough deracialisation and rationalisation of existing government services.

The budget for secondary and tertiary care should be allocated to the primary level which would then purchase tertiary hospital services on a market related basis. This "democratisation" of finances would discourage the tertiary hospitals from wasting scarce resources on problems with low social relevance.

With regard to the training of nurses and doctors, the acceptance of a PHC based approach would require a reorientation towards emphasising the social relevance and appropriateness of medical education. Medical schools, and nursing colleges, for example, should also be under pressure to provide appropriate training. Anomalies like language illiteracy, rural neglect, and sexism, must be addressed with more urgency, not only in curricula, but also via other means such as the nature of student selection criteria.

Relationship to the private sector

Despite the fact that it consumes a disproportionately large amount of the total financial resources spent on health in South Africa, it is unlikely that we will be able to do away with the private sector. For one thing it is likely that people will assert that patients should retain the right to buy medical services if they so choose.

In view of this, the question of the relationship of the private sector to an NHS arises. Linked to this is the question of the standard of care which can be delivered by an NHS, and especially by a nursing based service as is the case in a PHC network.

For many, a doctor based service is a prerequisite for adequate standards of scientific health care delivery and cannot be compromised. For others, if due attention is paid to the relationship between doctors and PHC nurses (PHCNs), adequate standards can be maintained in a nursing based service.

There are obviously conflicting views around the question of the quality of care provided by PCHNs in comparison to that provided by doctors. However, the benefit of having a PHCN, who speaks the language of the patient and is not profit orientated, undeniably diminishes the importance of whatever difference there may be in standards of health care delivery.

There have been points in its history when the AHC has been substantially dependent on PHC nurses (PHCNs) and functioned adequately. In Alexandra township a large proportion of residents, if they can afford it, make use of both private services and the AHC. Private doctors and the AHC co-exist on a competitive basis. There appears to be no reason why a PHC service should not function effectively in a competitive relationship with the private sector.

However, for the PHC service to be truly competitive, the private sector will have to take fuller responsibility for paying their own costs. One aspect of this is the cost of training health personnel. A tax on the private sector for health personnel used could be one way of getting the private sector to carry more of this burden.

Financial implications of the Alex experience

The AHC is located in the largest urban area in South Africa. It has a close working relationship with Wits University medical school, including the contribution of final year students. Due to its unique nature at present, it also manages to secure

various other benefits. These factors would obviously not operate to the advantage of PHC centres in a nationwide network. Nevertheless the AHC can still be seen to provide us with a basis for generalising about the financing of PHC nationally.

In 1988/ 89 South Africa spent R242.00 per capita, 5.8% of its GNP, on health care. Roughly half of this money was spent by the government and half in the private sector. This means that in 1988/ 89, the South Africa government had in the region of R120.00 to spend on health care for every man, woman and child.

The World Health Organisation recommends that each government spend 25% of its health budget on PHC. If the South African government were to allocate 25% of its health budget to PHC, this would imply that, using the 1988/ 89 figures, there would be R30 for PHC for each person in the country.

Population estimates for Alex vary between 200 000 and 250 000. A 25% allocation from the state health care budget (that is, R30 per person) would therefore provide R6-7.5 million for PHC in Alex. In 1989/ 90 the AHC spent R4 million, apart from capital development. The implication is that an allocation of 25% of present governmental expenditure to PHC would be easily sufficient to finance a national network of comprehensive PHC centres.

This would require long term planning with particular attention to the training of human capital development, such as the training of PHCNs, health educators, administrators, and other technical staff. These challenges would require an additional financial commitment from the state. Nevertheless they cannot be brushed aside on financial grounds alone.

The question of accountability

In the absence of a strong democratically elected local authority, the AHC has been controlled by a management board, 6 of the 13 members of which are elected at an Annual General Meeting (AGM) at which all Alexandra residents are entitled to vote. Of the remaining 7 places on the board, 1 is elected by the AHC staff, 3 are carried over from the previous board, and 3 are appointed by Wits University for historical reasons.

The AGMs are advertised through the local civic association. Advertising includes a mass distribution of 10 000 pamphlets and well placed adverts in the *Sowetan*. While this has worked reasonably well with increasing attendance at AGMs to over 500 in 1990, there are obvious limits to this type of control. In particular, it does not extend to participation in day to day management or to decisions of a more technical nature.

The size of the Alexandra community obviously places restrictions on

democratic participation. However, the experience of the AHC seems to indicate that this is not the only obstacle to more thoroughgoing involvement. For one thing the organisation of a modern technological service is made more cost efficient by serving a fairly large community. Furthermore because of a shortage of management skills the number of PHC centres would have to be restricted. By implication the basic PHC unit would have to be a certain minimum size. Economic factors might therefore determine the size of PHC units. This may undermine the possibility of more democratic community participation.

In addition, community control may conflict with democratic management of health workers employed by the board. The AHC experience has highlighted the conflict of interests between health workers and the community they serve. This confirms the need for management to be accountable to the community, and for worker interests to be protected by union organisation.

The present form of community participation at the AHC is an interim arrangement, a response to an undemocratic Apartheid based local authority. The AHC experience suggests that democratically elected representatives can develop expertise in health policy, and thereby have a more meaningful say in the actual direction health care delivery moves in. The onus then shifts onto the local authority to deepen democracy by mechanisms such as regular report backs, recall, etc. While this in no way precludes the possibility of direct participation in decision making in several areas of health care delivery, it seems that indirect decision making via full-time elected representatives, whether at local authority or health centre level, is likely to be the mainstay of meaningful participation for some time to come.

Conclusion

In this article an attempt has been made to identify some of the areas in which debate and more importantly research needs to move if PHC is going to be properly integrated into a future NHS. Of particular importance is the question of financing the training of PHC personnel; budget allocation to a PHC network based NHS; the problem of standards for a nursing based service; and the challenge of deepening community participation in decision making. On the basis of the framework outlined it would also seem that rather than neglecting PHC as a basis for the future NHS, this should form the mainstay of current research agendas.

Grant Rex is a general practitioner working for the Alexandra Health Centre.

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The Health Services Development Unit (HSDU), in partnership with the local community and health services of the Tintswalo area, in the rural Eastern Transvaal, is expanding its programmes in Education and Health Systems Development.

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Critical Health

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