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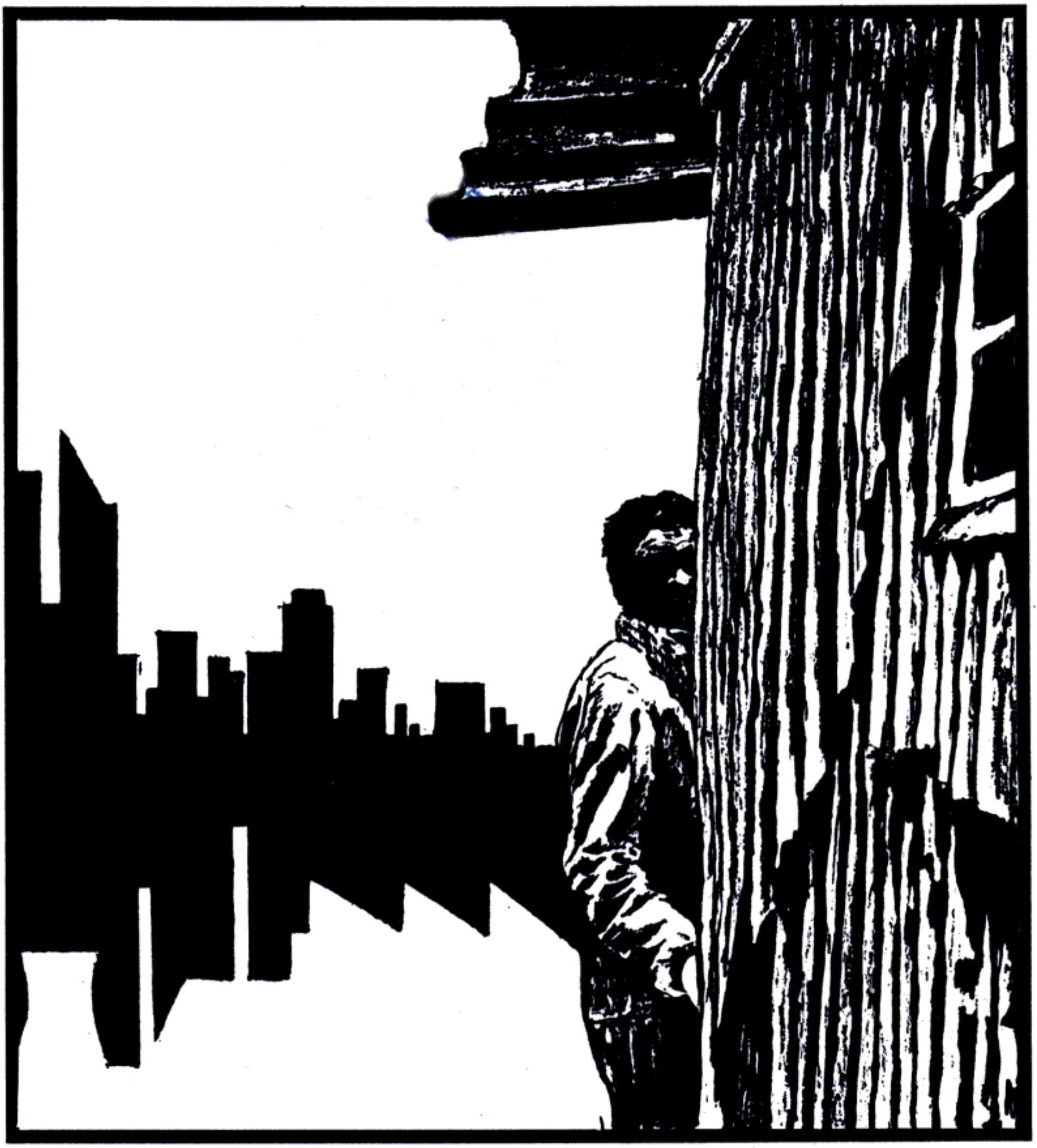

Health in the cities

Critical Health

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Contents

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Editorial

Urban areas in South Africa are growing rapidly. This growth is partially a result of the continuing movement of people from the rural areas, into the cities but also the result of the natural population increase. While many people come to the metropoles to escape rural poverty, life in the cities and their surrounding areas can be harsh. Increasing urban populations are cause for concern but much of the problem has to do with apartheid and the segregation of facilities.

Historically, the state has refused to acknowledge the permanence of black urban dwellers, despite the need for their labour. This has resulted in the lack of facilities provided for blacks in urban areas. For example, there is an underutilization of many white health facilities while those reserved for black South Africans are overcrowded. Although all hospitals are underfinanced by the state, it is the black facilities that receive the least attention.

This issue of Critical Health examines the health impact of apartheid's response to the settlement of black South Africans in urban areas. The edition begins with an historical background to urbanisation and examines some of the present solutions being posed by the state.

Removals have long been part of the state's response to black urbanisation and the plan to remove the settled community of Oukasie, is a more recent example. In the face of increasing national and international concern at the inhumanity of removal policies, an attempt has been made to legitimise the removal by using unhealthy conditions as a pretext. The article on the case of Oukasie illustrates how health has been used to legitimise repression. Another article illustrates the way repressive action which affects health has been used as a weapon to break a community's resolve; the article on environmental health services in townships focuses on the situation in Soweto where, in an attempt to break the rent boycott, essential services were cut off. The repercussions of this action on the health of the community is examined and basic standards for infrastructure in townships are suggested.

Actstop has highlighted some of the problems faced by people living in the "grey area" of Hillbrow, Johannesburg, and the impact of segregated facilities on their lives.

The Mass Democratic Movement's defiance campaign publicised the problems of segregation and in effect declared the cities open to all. The campaign was launched with black patients arriving at the white hospitals for treatment. The aims and achievements of this campaign are evaluated in an article by NAMDA, one of the health organisations involved in the co-ordination of the campaign.

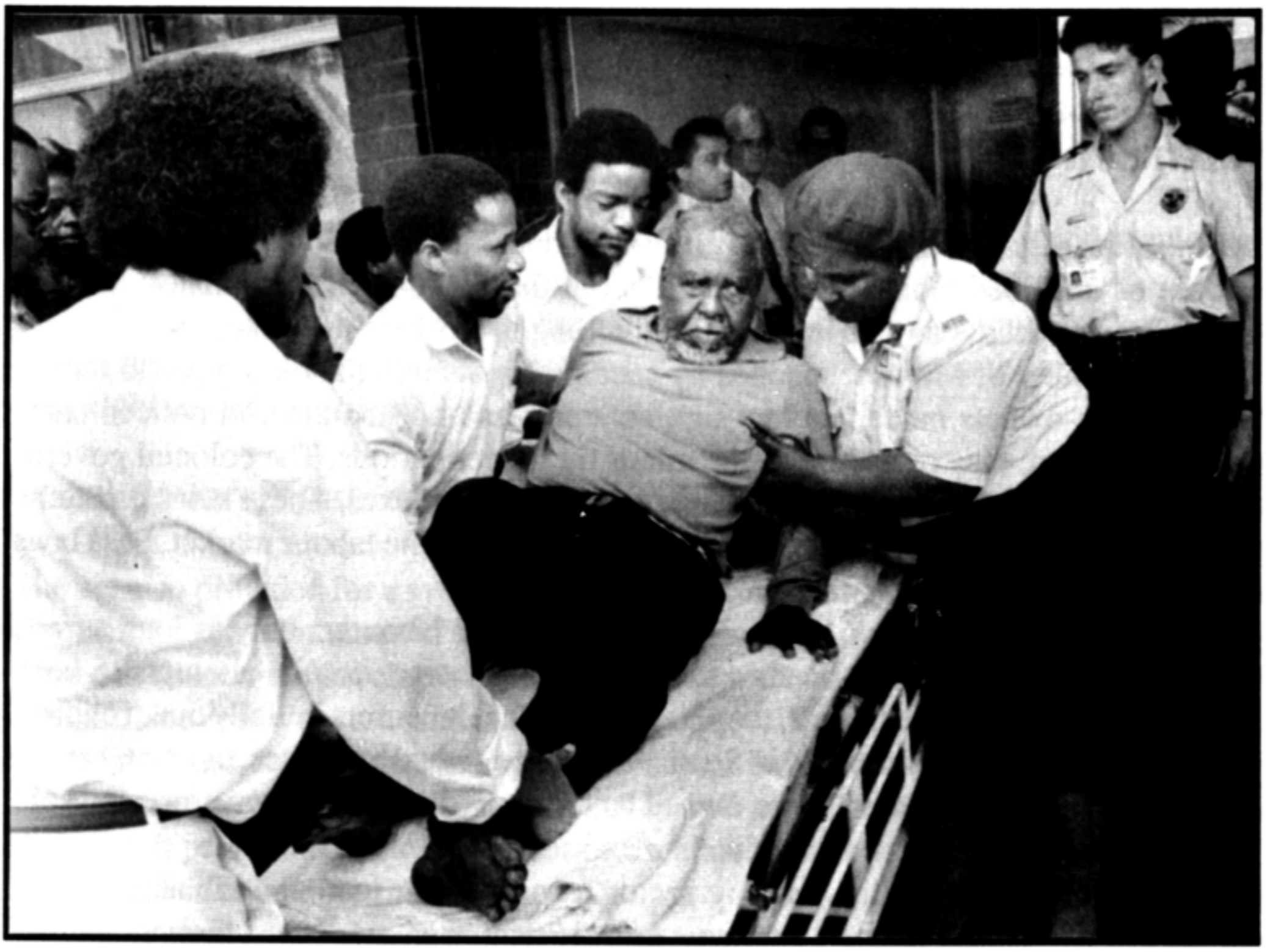
While apartheid has had an impact on both the physical and mental well being of South Africa, the defiance campaign and the numerous community organisations

formed to resist apartheid are testimony to people's resilience. The article on the Manenberg Research project on mental health, stresses the importance of working through community structures in the research process, and the importance of empowering the community when investigating the effects of apartheid on mental health. The article examines what is meant by progressive participatory research.

The edition also raises aspects of city life that are not usually highlighted but nonetheless have a major impact on health; pollution in urban areas, interpersonal violence and marketing strategies used to promote harmful products are discussed in three separate articles.

This edition of Critical Health has explored some aspects of urban health care as well as community responses to specific problems. While we have focussed on certain areas, this does not detract from the importance of those not covered such as urban primary health care, child care and the spread of sexually transmitted diseases.

Finally, this edition illustrates the importance of health as an area of struggle, inseparable from other factors (ranging from wages to water supplies) making up the fabric of our lives.



Health as an area of struggle - a patient is admitted to the "whites only" Addington Hospital in Durban during the Mass Democratic Movement's defiance campaign.

Urbanisation: an historical perspective

The particular racial nature of capitalist development in South Africa has resulted in a unique process of urbanisation. Legislation has been enacted and implemented in the interests of the white race group and the capitalist class and this has resulted in geographically distinct residential areas for the different race groups. Most of the white areas are, in contrast with most black areas, well developed and financially well off. The process has not, however, been without its contradictions for the ruling bloc. Furthermore, the black majority has resisted urbanisation policies in a variety of ways. This article traces the historical development of urbanisation in South Africa with specific references to these contradictions and also outlines areas of resistance.

The mining industry

Urbanisation began on a large scale with the development of the mining industry. A large amount of unskilled labour was required but at this stage African societies still had relatively easy access to land and were not willing to work on the mines.

The Chamber of Mines responded by sending agents into the rural areas to recruit labour. Mine-owners made workers sign contracts and housed them in policed compounds to ensure they remained on the mines for longer periods. The colonial governments and Boer republics introduced hut, poll and labour taxes. These taxes had to be paid in cash, forcing increasing numbers of Africans into the labour market. Pass laws were introduced to restrict people to their area of work.

The majority of Africans, however, worked as wage labourers only as long as was necessary to meet their cash needs and then returned home, despite attempts to keep them on the mines. In other words, they became migrant labourers initially out of choice.

By the 1900s, most of the land in South Africa was owned by whites, but many of the African families that lived on white-owned land still produced their own crops and sold what they did not need.

The developing capitalist farming sector required both land and labour and was opposed to Africans producing their own crops. Small-scale Afrikaans farmers, threatened by competition from African farmers, favoured a restriction on the number of Africans per farm in the hope of obtaining labour. Mine-owners began to recognise that

a migrant labour force could be more advantageous to them than a permanent urban workforce. They encouraged the establishment of African "reserves" because migrant labourers could be paid low wages, just enough for their own needs, as long as their families still had access to land for subsistence farming. All these interests are represented in the 1913 Land Act.

Over the subsequent decades Africans were dispossessed of their remaining land and forced into overcrowded and rapidly deteriorating "reserves" where it became increasingly impossible to survive. As a result, more people were forced to seek permanent employment in the urban areas.

Segregation

Other than the compounds for mine workers, there was little formal accommodation for African workers in the urban areas. Workers stayed in multiracial slums, informal shack settlements and backyard shacks on white properties. Health conditions were poor and bubonic plague, smallpox, TB and influenza spread through overcrowded areas. The authorities feared that these diseases would spread to more affluent white areas. There was also an increasing militancy amongst African urban residents. These factors contributed to a situation where Africans were only tolerated in urban areas if their labour was required. Their status was that of visitors or ''temporary sojourners''.

The Urban Areas Act of 1923 provided for the clearance of mixed residential areas and the creation of seperate "locations" for Africans. This was largely to prevent solidarity within the working class developing across racial divisions. Africans were further restricted in that they could not own property in freehold in the urban areas and their right to trade was curtailed.

Local government

The act also provided for a system of local government along segregated lines. African townships were administered by white local authorities. Africans were, however, expected to finance the development of the townships themselves. Each white municipality had a Native Revenue Account, the income of which was obtained from sorghum beer production and sales, fines and rents. This was the sole source of revenue for the development of housing and infrastructure as well as the provision of basic services in the townships. As the rate of urbanisation escalated, this revenue became increasingly inadequate to meet township needs.

The Urban Areas Act also controlled the rate of urbanisation by restricting the number of Africans in urban areas according to the availability of work. Arrival in an urban area had to be reported, employment of Africans had to be registered and those

unable to find jobs were to leave within 14 days. These regulations were applied systematically for the first time in 1938. Pass laws, which were developed to force Africans into urban areas to provide labour, were thus used for the restriction of their numbers in these very areas.

National Party rule

During the second world war the rapid expansion of industry and the subsequent severe labour shortage resulted in the suspension of influx control enforcement and a massive influx of Africans into the cities.

Large industrialists perceived an increased need for a skilled and permanent African urban labour force. The National Party, however, campaigned for the 1948 elections around the issue of ''oorstrooming'' (flooding). An emerging Afrikaner capitalist class was still dependent on cheap, rather than skilled, labour. White workers were threatened by competition in the labour market and white farmers were losing labour because they paid wages well below those in the urban areas. They all had an interest in preventing the establishment of a permanent skilled labour force.

On coming to power, the Nationalists tightened influx control legislation and the state machinery started to ruthlessly enforce it. Under the ''Section 10'' provisions Africans not born in an urban area were denied the right to live there unless they had lived there continuously for 15 years or worked for the same employer for 10 years. The maximum time allowed in urban areas was reduced from 14 days to 72 hours. Passes were to be introduced to women for the first time and all Africans had to carry passes at all times. Pass laws were a major focus of resistance in the 1950s but defiance was accompanied by harsh state repression.

Legislation making reference to acceptable health standards was used to justify removals; the Prevention of Illegal Squatting Act enabled the state to demolish structures without the obligation to provide alternative accommodation or compensation.

Labour bureaux

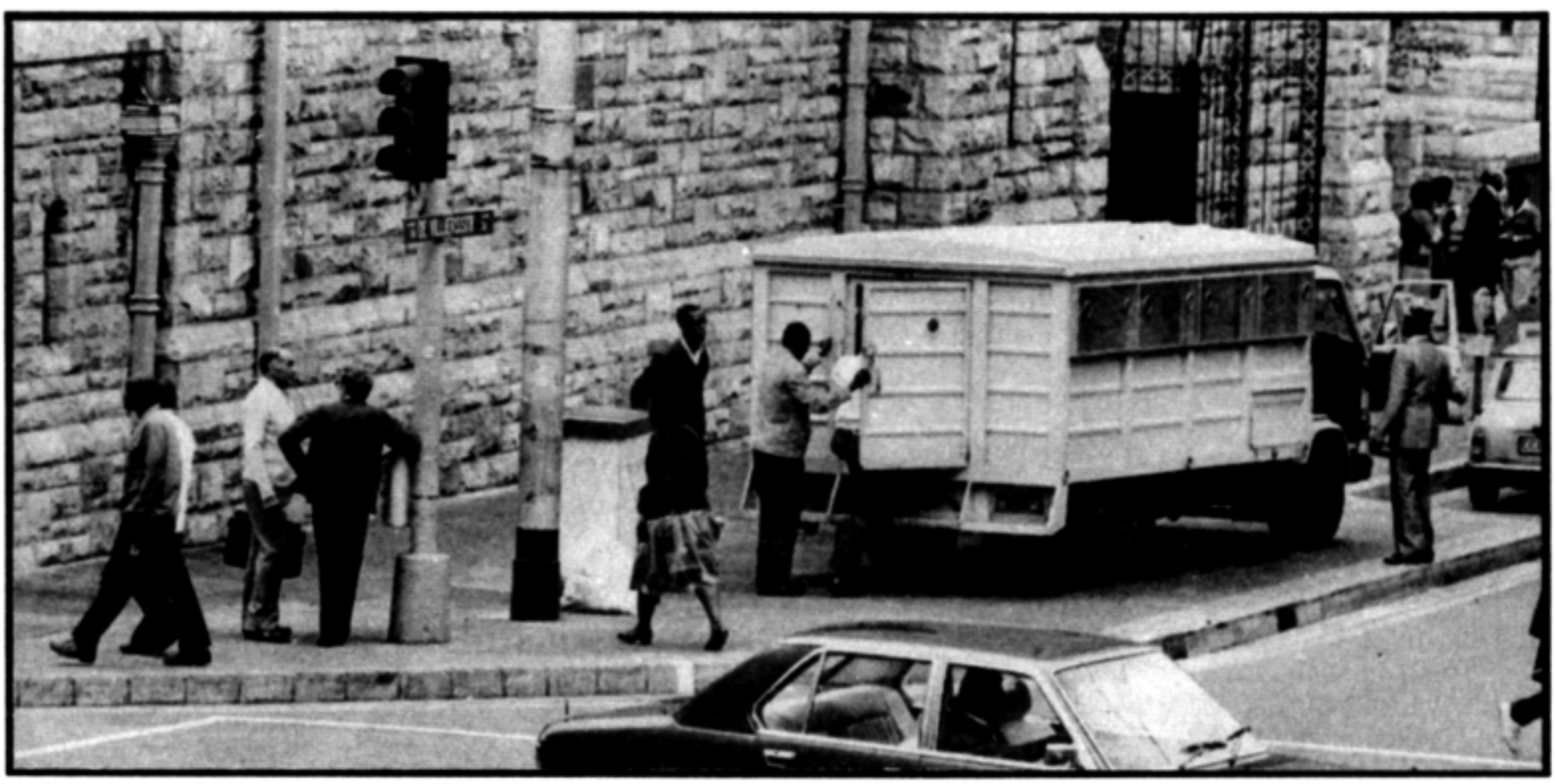
Influx control was also intended to redirect labour to the low wage farming and mining sectors. An extensive network of labour bureaux was established to channel labour to areas of shortage. People without urban residence rights who were looking for employment had to register with these bureaux.

In the early years of Nationalist rule, however, the urban presence of a small proportion of African workers was accepted as necessary to meet the labour needs of industry. It was for this reason that "Section 10" rights were granted to a restricted number of people who were already effectively permanently urbanised.

Ironically, the Apartheid state was responsible for large scale development of the townships, taking significant steps to meet the housing needs of those with urban residence rights. A services levy was imposed on employers, payable to the Native Revenue Account for use in the townships. Central government spending on housing increased dramatically and a national housing fund was established. The fund received a yearly allocation from the treasury and granted loans to local authorities. The loans were to be used for the building of small "economic" housing units and were to be repaid through house rents. It was during this period that most of the houses in townships such as Soweto, Daveyton and Umlazi were built.

The creation of bantustans

Despite the repressive measures used, the state was relatively unsuccessful in limiting the numbers entering the cities and in the 1960s the National Party embarked on an extensive programme of social engineering to reverse African urbanisation. Africans, allocated to different ethnic groups, were thereby defined to be citizens of different bantustans. It was intended that Africans would eventually be settled in their territorially segregated areas which would become economically and politically independent units separate from white South Africa. Policy dictated that urban labour requirements should increasingly be met by contract workers from the bantustans who would commute to work on a daily basis or live in single sex hostels for the duration of their contracts. Extensive steps were taken to stimulate the development of industry in the "border" regions, adjacent to the bantustans.



Pass raids in central Johannesburg - the hated pass laws were introduced to control the movement and settlement of black people in urban areas.

From the late 1960s the state decreased its contribution to housing in the urban areas. In the early 1970s, newly created Bantu Affairs Administration Boards took over township administration from the white local authorities. The boards redirected employer levies to the departments responsible for influx control and large amounts of income obtained from sorghum beer were used to finance housing development in the bantustans. Revenue for use in the townships was almost entirely derived from house rents and service charges to residents and the Administration Boards rapidly slid into financial crisis.

Restructuring

In the 1970s there was widespread re-emergence of resistance, which included worker strikes as well as student and community action. The South African economy, moreover, experienced serious problems. The capitalist class required increasing numbers of skilled labourers to operate machinery and the urbanisation and education policies of the Nationalist government resulted in a severe skilled labour shortage. Furthermore the predominantly white consumer market became saturated and demand for goods dropped. The low wage urban African population was unable to make a significant contribution to consumerism. For these reasons, there was an increased demand for a more skilled and stable urban workforce.

Kwa-Ndebele residents celebrate the rejection of independence - bantustan policies have been rejected by the majority of South Africans.

The National Party was forced to respond to this crisis and has embarked on a restructuring of apartheid in the hope of restoring capitalist profitability as well as crushing resistance. It has come to accept the inevitability of a permanent urban African population, but insists on segregated residential areas administered by racially defined local authorities.

In the late 1970s, Community Councils were introduced in the townships. In the early 1980s, these were replaced by the Black Local Authorities which eventually took over all the functions of the Administration Boards. The government was responding to political resistance by attempting to establish a form of representative government at the local level, but these structures failed to win political legitimacy.

The government was also searching for a solution to the financial crisis of the Administration Boards. The townships are expected to be financially self-sufficient and the councils and local authorities were saddled with the task of raising income. The monthly charge to residents for house rents and services is the only major source of potential income available to them. Since the late 1970s, service charges have been increasing well above the rate of inflation. Residents refused to pay the monthly charges and forced councillors to resign. A rent boycott was started in the Vaal in 1984 and spread to numerous other townships nation-wide. By 1986, Black Local Authorities had collapsed in large parts of the country. Although the state has managed to revive most of these authorities, it is clear that the present structure is unworkable for both financial and political reasons.

The Group Areas Act of 1950 enforced the development of separate residential areas for ''coloureds'' and Indians and allowed for the creation of ''coloured'' and Indian local government structures. Most of these structures exist today as advisory bodies to white municipalities, but they do have the option to apply for autonomous status. One of the reasons why these bodies have not applied for autonomy is that they would then have to be self-financing. Once again, income would have to be obtained almost entirely from residents.

White municipalities, however, are able to generate large proportions of their income through rates imposed on the commercial concerns and industries that fall within their boundaries. These, in turn, rely on black spending power and labour and in this way black residents contribute substantially to white municipalities.

Regional Services Councils

The Regional Services Councils (RSCs) represent an attempt to overcome the obvious financial weaknesses of present local government structure. They raise income through levies on employers and use this income for development in all areas within their region. The RSCs allow for some redistribution to poorer communities but also allow for the continued existence of racially segregated local authorities within their regions. They

are therefore additional costly structures that are responsible for tasks that could be undertaken by non-racial local authorities.

The means of control of the rate of urbanisation has also changed in the present era of restructuring. In 1986, the government abolished influx control and replaced the pass document with a uniform identity document for all racial groups. This legislation has, however, been replaced in 1988 with the Prevention of Illegal Squatting Amendment Act through which millions of South Africans are potentially vulnerable to removal. The control of urbanisation on an overtly racist basis, which attracted widespread condemnation, has been replaced with a more subtle strategy of "orderly urbanisation". This "reform", however, has the potential to adversely affect large numbers of people without access to formal housing.

In the 1980s the state has effectively handed over the task of housing provision to the private sector. Africans were granted 99-year leasehold rights and have recently been granted freehold rights. The state is now selling off its present housing stock. All new houses are being built by the private sector, at prices unaffordable to the majority of Africans and at a rate that is too slow to meet housing needs.

Health implications

Urbanisation in South Africa has had serious consequences for the health of the majority of the population in both urban and rural areas. Workers were exposed on the mines to a variety of infectious and occupational diseases and the migrant labour system facilitated the spread of infectious diseases into rural areas. The combined effects of land dispossession and increasingly strict enforcement of influx control led to overcrowding in economically unviable bantustans. This has resulted in widespread malnutrition and lowered capacities to recover from infectious diseases.

In the racially segregated cities, African infant mortality rates have been far higher than those for white infants. Furthermore, the rate of decline of these rates for African infants has slowed down.

The lack of provision of housing in the urban areas is leading to further overcrowding in the townships as well the formation of a large urban squatter population. The present method of financing of the black local authorities, together with increasing levels of unemployment, is resulting in enormous financial pressure being placed on township residents. Urban squatter communities face an insecure future.

These current trends in urbanisation, when seen in conjunction with the deteriorating and increasingly expensive state health service, can only be anticipated to have a negative impact on health in the urban areas.

By G. Dor of the Community Resource and Information Centre (CRIC)

Health and removals: the case of Oukasie

What "disestablishment" means for Oukasie

On 17 October 1986 the residents of Oukasie (90 km north/west of Johannesburg) woke up to find that their 55 year old, 12 000 strong township no longer legally existed. It had been "disestablished". A special government gazette had been issued in terms of section 37 (2) of the Black Communities Act, 1984 (as amended). This section provides that the Minister of Constitutional Development and Planning may disestablish an area "whenever it appears to him that the conditions under which people are living in a development area ... are such that unless such development area ... is altered or disestablished, the health or safety of the public generally or of any group of persons may be endangered".

The implication of the disestablishment for Oukasie residents was that the land that had formally been reserved for black occupation was no longer. The residents had overnight become squatters in their own township.

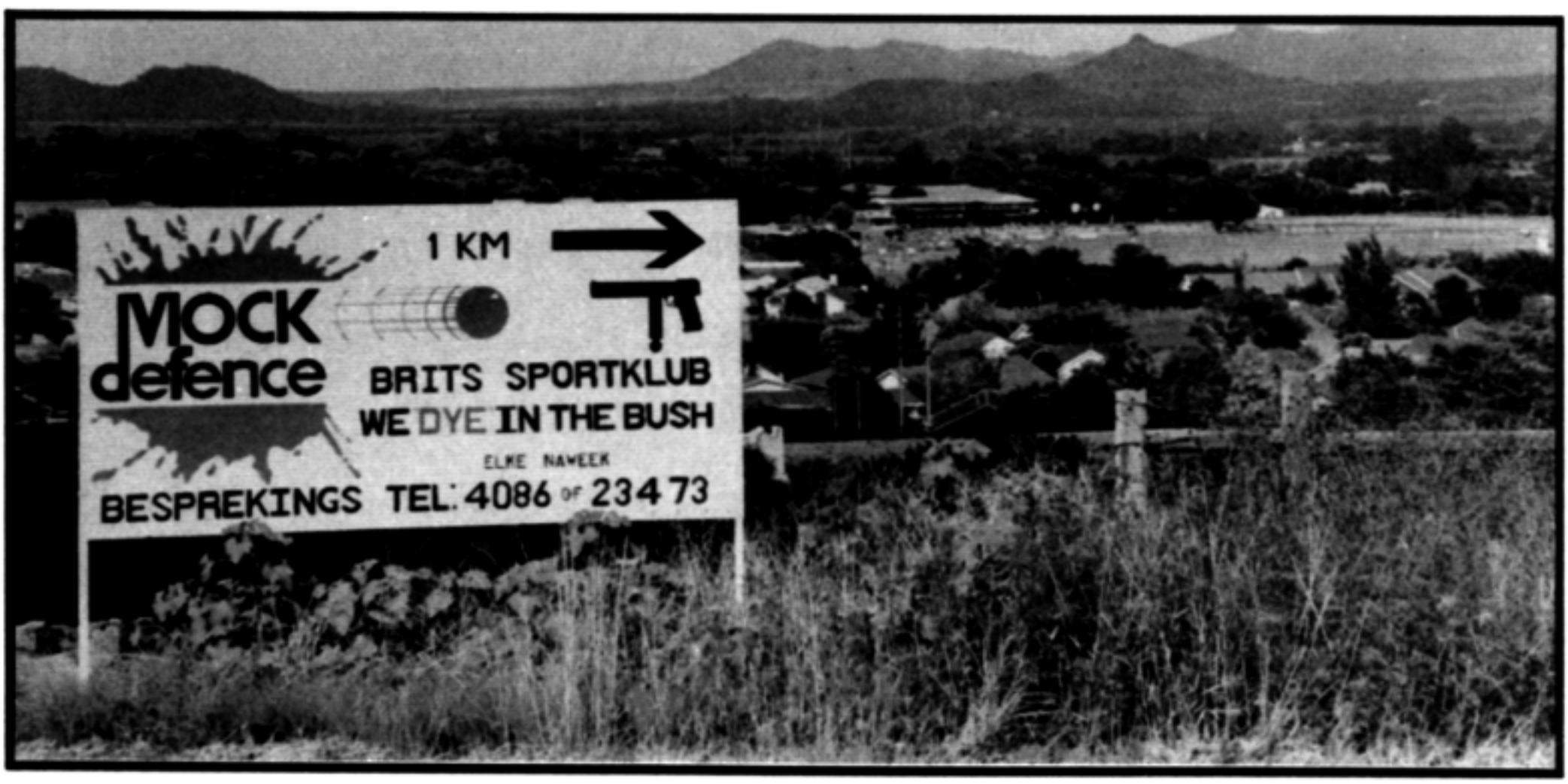
"Lethlabile? We are not going there." - Residents of Oukasie, a well established community, were told that for humanitarian reasons, they were to be removed to the resettlement town of Lethlabile.

The then Minister of Constitutional Development and Planning, Mr Chris Heunis, released a press statement arguing that the disestablishment was an humane act. The residents according to the Minister had to be moved to the resettlement town, Lethlabile, 25 kilometres north on the borders of Bophuthatswana because after "several years of negotiation with the former community council of the township ... it had been decided that the hygienic conditions there and the astronomic costs involved in upgrading the town did not make its continued use a viable proposition".

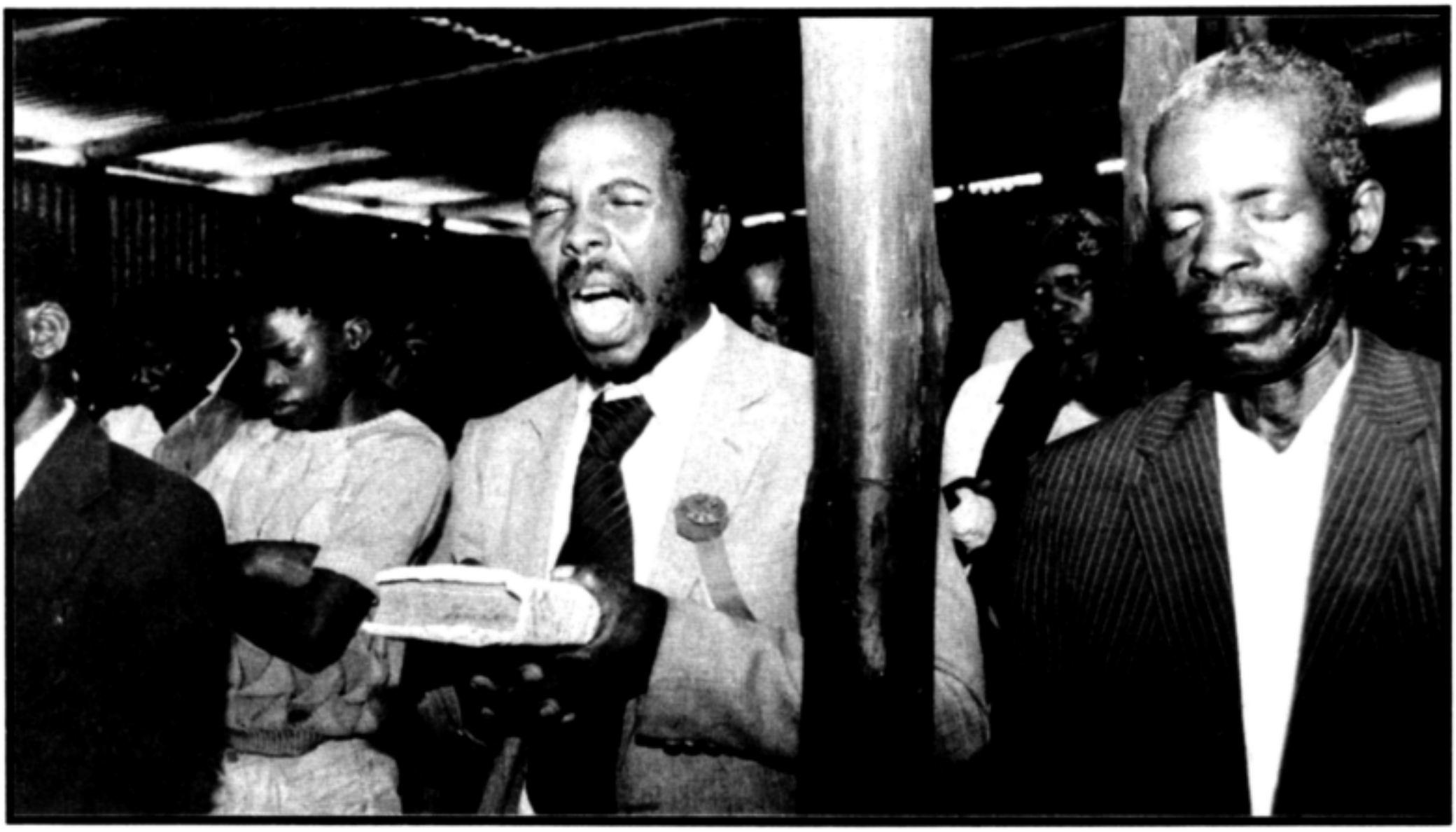
Health conditions were thus presented as a primary factor motivating and legitimating the Oukasie removal. The question that emerges, and the one that this article will focus on, is the extent to which the health conditions were and are a legitimate pretext for the removal and ultimate destruction of Oukasie. In order to answer this question, it is necessary to first give a brief history of the Oukasie removal.

Health conditions as a pretext for removal?

The removal was first mooted in the 1950s and then put on ice until the mid-1960s. In the early seventies the removal plan was partially realised when approximately 200 families were moved to Mothutlung, about 20 kilometres north east of Brits, in Bophuthatswana. The local Brits paper captured the real reason for this removal with a front page story that read: "Die Brits lokasie wat 'n seeroog was vir Brits en langs een van ons mooi woonbuurtes gelee is, sal eersdaags nie meer ons dorp ontsier nie" (Brits Pos, 10 April 1970). (The Brits location, which was an eyesore for Brits and situated next to one of our pretty suburbs, will soon no longer spoil our town.)



The white residents of Brits believed that the township of Oukasie spoilt their suburbs.



Residents pray for a stay of the removal at an Oukasie church service.

The plan to remove the whole of Oukasie was again dropped, but was revived with a great deal of vigour by the local city council in the mid-seventies. In 1976 the campaign by the local council to remove Oukasie took a significant step forward when the Department of Bantu Administration and Development bought 400 hectares of the farm Nuutgedacht (now called Lethlabile) for the specific purpose of providing an alternative site for Oukasie residents.

The rationale behind this planned removal had nothing to do with improving the health of Oukasie residents, but rather with satisfying the racist desires of the local town council to have the black residents of Brits as far away as was feasible. This is starkly illustrated by every annual report of the mayor from 1976 up until 1983. Under a section headed ''Bantus'' or ''Swartmense'', depending on the year, the annual report emphasised that ''Die Raad het gedurende die jaar sy pogings volgehou om die Brits Swartwoongebied wat 'n belemmering inhou vir die ontwikkeling van Blanke woongebiede to laat verskuif'' (Mayor's Annual Report, Brits, 1981-1982). (The Council saw the black township as an obstacle to the development of the white areas and kept up their attempts, throughout the year, to remove it.)

The desire of white Brits residents to remove Oukasie was intensified by the changing pattern of the area in the seventies. In the late sixties the area was declared a decentralisation point and in line with the increased employment opportunities there was a substantial influx of black and white residents into the Brits area. A new middle class white suburb, Elandsrand, was built next door to Oukasie. There is no doubt that Elandsrand residents would like to witness the demise of Oukasie. The whites of Brits

Oukasie residents sign affadavits protesting the removal and authorising the community's Brits Action Committee to represent them legally in any removal proceedings.

would go up as transport would be much more expensive (many residents walk the two kilometres to the town centre) and the cost of food is almost certainly a lot higher in Lethlabile. Finally, those residents with corrugated iron houses, the majority of remaining residents, receive no compensation for their homes when they move. They would have to rebuild their homes in Lethlabile and this could be a costly exercise. Another finding was that residents had built up a very strong attachment to the area, despite the lack of an infrastructure. Oukasie was ''home''. A move to Lethlabile was perceived as a profound and totally unacceptable uprooting and dislocation which could lead to significant psychological stress.

Conclusion

In conclusion, it is clear that the familiar justification used by the state for moving and thereby destroying communities, ie. hygienic conditions, is very suspect and should be treated as such. One response is to carry out well conducted surveys that can be used to scientifically challenge the government's propaganda and help raise awareness of the situation so as to increase the power of resistance.

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Environmental health services in townships: some lessons from Soweto

Three years ago Soweto, like many other townships, embarked on a rent boycott. The boycott developed in response to rising rent and service costs which, under deteriorating socio-economic conditions, became increasingly less affordable.

Other issues related to housing and environmental health services heightened public dissatisfaction. There was an overall housing shortage, as well as a controversial government charge for the transfer of home ownership to tenants of long standing. As far as water supply and sanitation services (ie. sewerage and refuse removal) were concerned, the existing infrastructures were inadequate and poorly maintained. These services were nevertheless expensive.*

The local authority in Soweto tried unsuccessfully to break the rent boycott. One of its methods was to disrupt services intentionally and unnecessarily. The water supply was cut frequently and for prolonged periods. Sewerage pipes were left blocked and leaking and refuse was removed irregularly or not at all. It is apparent that the intention of these cuts was to cause residents so much discomfort that they would have to start paying rents again.

The Soweto Delegation emerged recently to represent the community in discussion directed at resolving the rent crisis. One of the Soweto Delegation's decisions at the end of last year was to commission PLANACT, a service organisation concerned with urban development, to evaluate housing and service provision in Soweto. PLANACT in turn requested the Centre for the Study of Health Policy to assess whether water and sanitation services in Soweto constituted a hazard for the health of Sowetans.

** It should be noted that the high service costs are linked to the separate tax base of Soweto and Johannesburg. Whereas taxes in Johannesburg benefit substantially from township labour and purchasing power, these taxes support Johannesburg services alone. In effect, therefore, Johannesburg rates are subsidized by Soweto residents, and Soweto services are underfunded.*

This paper briefly describes the Centre's findings. It explains how the health hazards caused by inadequate water supply, sewerage and refuse removal infrastructures were compounded in Soweto by the local authority's deliberate policy of disruption. As the findings are applicable to other townships in similar positions, suggestions are made as to how communities could respond to the disruption of already inadequate services.

Inadequate service infrastructure, service disruption and health risks in Soweto

PLANACT'S report indicated that the service infrastructure in Soweto was inadequate for the population served. It emphasised that the existing inadequacies were exaggerated by service disruption by the local authority. There is no formal data on the overall health effects of this disruption. Yet, as explained below, it is obvious that the service disruption must indeed have constituted a health hazard.

The frequent and prolonged cuts in water supply seriously reduced the availability of water in Soweto. Residents had to walk far to fetch limited water from distant supplies. In addition, the water shortage affected the functioning of the sewerage system. Toilets could not be flushed normally but had to have water poured into the cisterns by hand. This meant that often toilets were not flushed after each use. Consequently pipes blocked and then leaked and overflowed, contaminating yards and streets. This problem was aggravated by the long delay before repairs were made.

Due to prolonged cuts in water supply residents had to walk far to fetch limited water from distant supplies.

Unprotected refuse pollutes water and exposes children playing amongst the refuse to injuries.

When water supply and sewerage systems break down the spread of infectious diseases will increase. Less water is used for washing hands, bodies, clothes, food and cooking utensils and thus, although the initial quality of the water is good, the risk is greater that water-borne diseases (diarrhoeas) and water-washed diseases (diarrhoeas and dysenteries, worm infestations and a wide range of skin and eye infections, including lice and louse-borne infections) will be transmitted. As diarrhoea is a killer of children in developing countries, its certainly increased incidence in Soweto should be viewed with particular concern.

The risk of outbreaks of serious diseases such as poliomyelitis and typhoid is also increased by cuts in water supply. Food-borne diseases, including food poisoning, may arise since food maybe cooked less frequently and left standing longer.

Excreta-related infections may ensue from contamination of the environment by leaked sewage. These diseases include both the water-washed diseases mentioned above and infestation by the beef and pork tapeworms. Diseases transmitted by flies will also increase, particularly as flies can be expected to breed more readily in leaked sewage and piles of rotting refuse.

Although household refuse collection had improved by the time of the report, bins were in bad condition and few had lids. There was little attempt to clean up the unprotected piles of refuse which occurred in most open spaces. The fly problem associated with open refuse has already been mentioned; rats also breed more readily in such conditions and the threat of rat-borne diseases may be expected to increase. Unprotected refuse also increases the danger (especially to children) of poisoning and injuries, pollutes water, and poses a fire risk. The polluting effect of sewage and refuse

The bucket system for human waste removal: this system is an unacceptable health hazard.

is worsened when poor drainage allows stormwater to lie in stagnant pools.

In addition to the physical effects of service disruption one may add the effects of mental and social stress. Daily life is filled with difficulties and indignities. Although it is difficult to quantify the effects of such stresses, it is no doubt that the community's mental and social health was seriously compromised by the poor water and sanitation services. It would appear, too, that those most at risk were the elderly, the disabled and mothers of young children.

The local authority's policy of service disruption thus threatened the physical, mental and social health of the Soweto community. Unless Soweto is different from the rest of the world, one may say with a fair degree of certainty that this disruption led to an increased disease prevalence. In the interests of health, therefore, residents of Soweto and other townships need to address the problems of poor services and service disruption.

A basic infrastructure at affordable costs

In order to protect a community from the health hazards described above there should be:

- an uninterrupted, plentiful flow of good quality water, supplied by tap to each property;
- a water-borne sewerage system or, in smaller townships, a suitable alternative (note

that the bucket system is hazardous and should always be opposed);
- regular and frequent removal of both household and community refuse, together with the provision of sufficient well-constructed bins.

Although the communities have such services in name, poor maintenance of the infrastructure (eg delayed repairs) is still a major problem. The opinion of an engineer would be useful in the evaluation of water and sanitation services because of the complexity of the technical details.

Without the above services, appropriately designed and efficiently maintained, urban populations face unacceptable health risks. It must be mentioned that many other environmental factors have an impact on health, for example, road construction, electricity supply, stormwater drainage and housing. Demands focussing on water and sanitation thus address only the most urgent of such factors.

Not only must basic services be adequate: these services must be provided at reasonable and affordable prices. In Soweto, whilst residents accept that there should be service charges, there is great resentment that the currently poor services should be provided at such excessive cost. Arriving at a charge which is fair depends on proper community consultation and involvement in planning. In Soweto, as in other townships, it may depend also on a restructuring of the unequal tax base.

Community action in response to service cuts

The residents of townships where services have been cut in response to a rent crisis may react in a number of ways to this threat to their health. Firstly, residents may choose to organise around the issue of health risks arising from service disruption. Secondly, they may decide to negotiate with the relevant local authority, if this seems an appropriate strategy under prevailing conditions. Thirdly, they may consider taking legal action against the local authority. The following are the legal issues which are relevant to the last two alternatives.

Health authorities are governed by The Health Act, No 63 of 1977. This act describes the duties of local authorities and Medical Officers of Health. Their duties include the protection of health and prevention of diseases, such as those arising from poor water and sanitation (sewerage and refuse removal) services.

Under Section 20 of the Act, local authorities are expected to take all possible steps to keep the environment safe and hygienic, and to improve poor conditions. Intentional disruption of services therefore clearly contravenes the Act. Under Section 23, the Medical Officer of Health is expected to keep himself or herself informed of health conditions and to report unsatisfactory developments to the local authority. If s/he neglects this duty to protect the community against environmental health hazards, s/he is in contravention of this Act.

Therefore, if services have been disrupted intentionally, the community could make use of these legal obligations to negotiate that such disruptions be stopped and to pressure for improved service infrastructure and maintenance. Similarly, legal arguments can be used to remind the Medical Officer of Health of his/her duties. It must be remembered too, that should either the local authority or Medical Officer of Health fail to comply, Sections 14 and 15 of the Health Act require intervention by higher authorities, namely the provincial administrator and Secretary of Health.

The community may also consider taking direct legal action against the various health authorities: it may be possible either to lay charges against them in the event of neglect of their duties in terms of the law. However, the legal issues are complicated and, to our knowledge, have not been tested in court. Expert legal opinion should thus be sought by any community wanting to take a case to court. Threats of legal action nevertheless remain a strong bargaining point.

Reference

1. The Soweto Rent Boycott: a report by PLANACT. March 1989. Commissioned by the Soweto Delegation.
(This report is available at R10 from PLANACT, First Floor Scotch Corner, 7a Rockey Street, Yeoville, 2198. Telephone 648-2107.)

By Erich Buch and Jane Doherty
Centre for the Study of Health Policy
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The orderly urbanisation policy and the plight of the urban poor

The urban Witwatersrand has changed dramatically over the years. The new actors in the urban environment are the squatters and the poor.

Homeless people are vulnerable and powerless. The government's orderly urbanisation policy should be applying urgent methods to alleviate the existing crisis of the homeless. Instead, the processes and policies are making some things worse. The squatter, slums, health and building standards laws and the immediately apparent obstacles around land may yet ensure that many poor people do not have access to permanent and affordable land and shelter.

This article, written by the Community Research and Information Network (CRIN) and the Black Sash Urban Removals and Homelessness group, looks at the implementation and consequences of the urbanisation policy and suggests some urgent recommendations in response to the serious situation.

It is estimated that 1,6 to 2,4 million people in the PWV area presently live unlawfully in shacks, garages and informal settlements. There is a need for between 300 000 to 450 000 additional housing units (equal to roughly half the existing number of 650 000 units).

The above figures are probably underestimates in that they do not include all people wanting homes; domestic workers who presently live with their families unlawfully in servants' quarters, people living on farms and smallholdings, people living in hostels who would like to have their families from rural areas with them and the estimated 70 000 people living unlawfully in the "grey" areas.

The number of homeless people is not explained by the mass migration to the PWV since influx control was lifted. Our case studies (which began before the lifting of influx control) show that the majority of homeless people are the result of the natural growth of the existing population. (Their present living conditions are the result of years of neglect on the part of the authorities since housing development in the region was frozen

in the 1950s). Many others have been here for between 5 and 15 years, indicating the failure of influx control to prevent people moving to the cities for a long period before it was abolished.

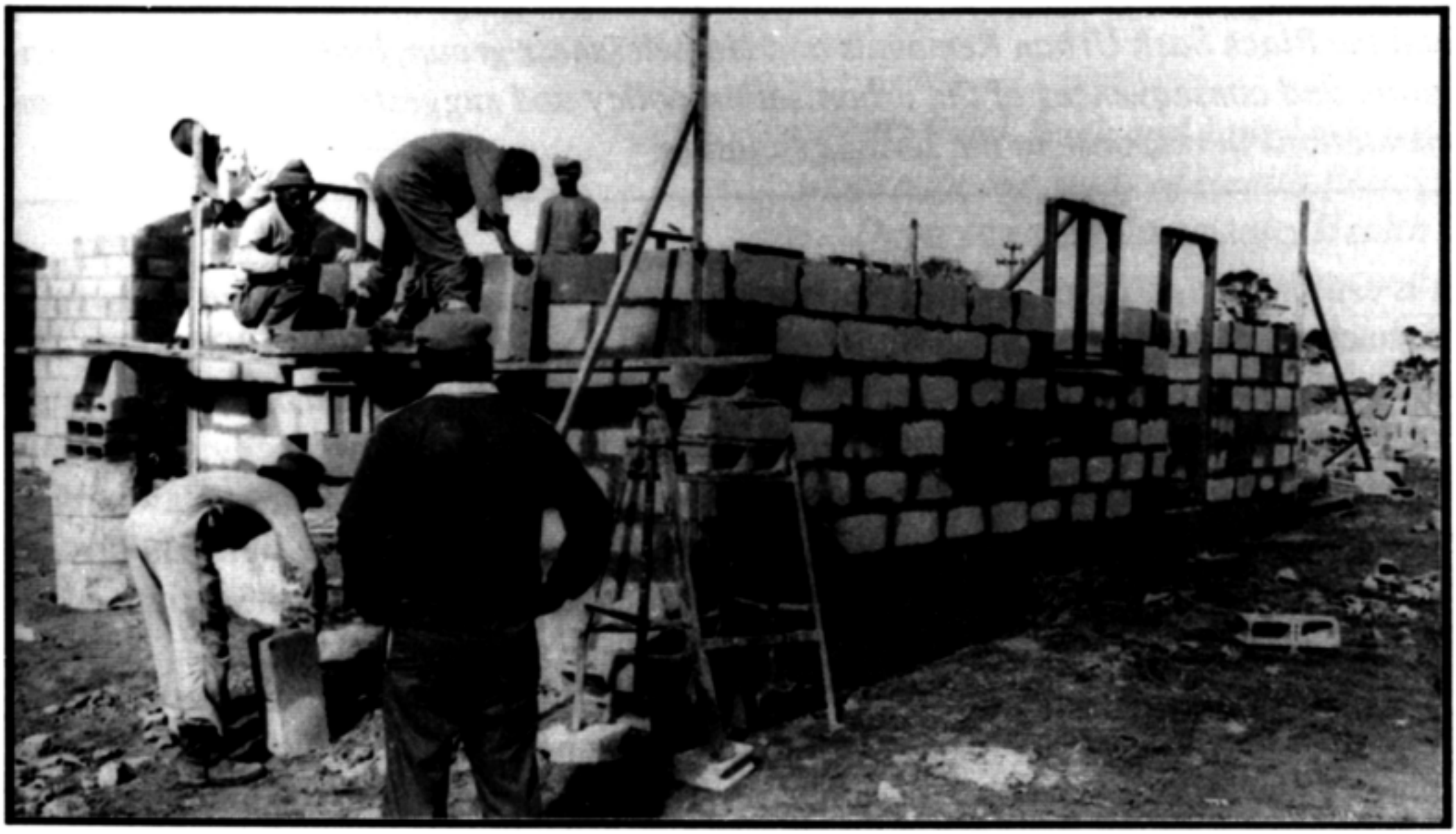
A further increase in population on the Witwatersrand will have radical implications if the needs of such people are not addressed. It is expected that in the next 11 years, the black population may increase at the rate of 5% annually, while all other groups may increase at the rate of 1% - 1,5% annually. At present there are about 5,5 million people living in the region. This will increase to about 8 million by the year 2 000.

Income figures of homeless people vary greatly. We found most homeless families of six persons have a monthly income of between R150 - R400. Most people requiring a place to live will not even be able to buy serviced stands costing R6 000, let alone privatised housing at R20 000 and more.

Failure of the government's orderly urbanisation policy to adequately meet this challenge will have obvious consequences. Besides land invasion, there will be stress placed on already overburdened services - housing, health, education, childcare, transport and recreation.

The present urbanisation policy and its implementation

Two features of the government's White Paper on Urbanisation (1986) illustrate its "orderly urbanisation" policy.



There is an urgent need for up to 450 000 housing units in the PWV area alone.

Much of the housing being built at present is unaffordable to many people.

1. Positive features

These include the acceptance of the permanence of black people in white urban areas (with the abolition of influx control); the recognition that land has to be made available, and that existing housing standards have to be reviewed (which implies a potential acceptance of informal housing).

2. Control elements

Residential segregation is to be maintained (the Group Areas Act stays); central government maintains control over the amount and situation of land to be allocated (the Land Acts are not abolished). Strong measures are used to prevent squatting: the punitive provisions in squatting legislation were tightened in 1989 and greater control of slums is planned with the slums legislation currently being amended. The principle that black local authorities and residents must pay the full costs of land, services and housing is also firmly established.

Implementation of government urban policy and its problems

An announcement by the Minister of Constitutional Development and Planning in June 1988 identified substantial amounts of land (for the first time since the 1950s) for black urban residential development. If all this land (some 42 600 ha) was immediately available for occupation, some 3 million people would find a place to live. There are, however, major obstacles to this.

Firstly, not all this land is suitable for development, being too expensive, and because portions of it are of dolomite stone. Secondly, much of the land is too far for easy and affordable access to urban facilities. It is, therefore, too costly to service cheaply enough for poor people who are, in terms of the policy, expected to pay for the full costs of it. Thirdly, land set aside is insufficient.

In addition, substantial resources for the upgrading of existing townships, mainly through the Regional Services Councils (RSC), has occurred. To date there has been no indication of whether and how funds from this source are to assist informal settlement. Also, the private sector and organisations such as the South African Housing Trust are participating in the housing delivery process at the upper and middle income levels. Some, although very limited, recognition of the need for basic site and service schemes with tenure has occurred.

In the south

Of a total of 66 000 stands made available for black residential development in the south, only 5 300 (approximately 8%) fall into the category for poor people. Another 25 000 of the total will be developed by the SA Housing Trust and may cost R13 - R18 000 for the site and house.

The first Section two 6A areas (for informal settlement in terms of the Prevention of Illegal Squatting Act) are being developed. Orange Farm, developed by the Transvaal Provincial Administration, has 4 300 stands of 210 square metres each, costing R500 to buy or R10 to rent. Services charges cost about R13,50 per month. While there is one tap per thirty sites, graded roads, a bin per unit and rubbish removal, there is no electricity. At Evaton North, developed by the Evaton City Council, there are 1 000 stands, each with water and a toilet, at a cost of R7 500 per stand, plus service charges ranging from R50 per month. High mast lighting is provided.

Official estimates are of 30 807 shacks in this area - with about 185 000 people needing a lawful place to live. It is unlikely that more than 30% of these can afford the privatised housing being made available - indeed, some will be displaced by this housing since they are living on the land that is to be developed. In addition, it is proposed that squatters from the north, in Alexandra and Sandton, be relocated to Orange Farm.

In the West

Land was identified for the expansion of Soweto but has been found to contain dolomite, making large portions of it unsuitable for residence. The opening of 621 ha in the west at Rietvalei, south of Kagiso, which would have included some sites for squatters from Roodepoort and Krugersdorp, has fallen through because mining titles apply which do not permit the use of most of this land for residential development. The small portion left is badly located and expensive to develop. Official figures, however unreliable, indicate an immediate need for some 55 302 dwellings for some 331 812 people on the near West Rand.

In the East

An informal settlement of approximately 5 000 stands is being opened in the east at Rietfontein. At the time of writing, shackdwellers from Dunusa/Pola Park (next to Thokoza) and also from Katlehong are moving here, further away from work opportunities.

The urbanisation policy at work

1. Privatisation of housing

Since the early 1980s the government has claimed that the provision of housing for blacks is the responsibility of the private sector. Developers have snatched up what land has been made available to supply houses costing in excess of R20 000. At least 70% of the region's population cannot afford these houses.

In situations such as Alexandra, where compulsory upgrading is being applied, the system for the privatisation of housing may result in people losing their existing homes through inability to pay for them. They, together with tenants in the yards and shackdwellers, will not find a place to live in Alexandra, or anywhere else close by, as no land for low-income settlement has been identified in the north.

2. "Negotiated" resettlement

Although forced removals are no longer government policy, it is clear that people are going to be moved. For example, it is stated policy that squatters at Weilers'Farm are to be moved to Orange Farm. People will be squeezed out of Alexandra and are being told they can go to the already quoto-filled Orange Farm about 50 km south from where they currently live, since no land for black informal settlement has been identified in the

north. Squatters from Thokoza, Katlehong and Mshenguville are reported to be due for removal. 1 000 stands at Orange Farm have been set aside for Mshenguville families. (There are about 3 000 families in Mshenguville.)

There are no known instances to date of plans to upgrade existing informal settlements outside of black areas. There have been reports, however, that ''emergency camps'' in Soweto, such as Tladi, will be upgraded.

3. The emphasis on the creation of "viable" urban communities

The implication of this is that urban residents must pay the full costs of land (services and housing) and that black local authorities must be financially viable, administratively sound and politically acceptable. This fits in with the constitutional proposals to include blacks living in white areas into the parliamentary structures.

This strategy involves the upgrading of historically neglected existing areas, such as Alexandra. It is policy too, that new development areas be incorporated into existing local authority areas. Low-income people within their jurisdiction would, in time, have to be upgraded to conform to local authority standards. The costs of this would have to be borne by the local authority and residents. Furthermore, the rent paying capacity of low-income people would be low. These factors have led to the resistance of local authorities being saddled with informally housed settlers, who are going to be a drain on resources and will adversely affect middle class hopes and image.

The poor will be unable in most instances to afford compulsory upgrading. Already the costs being levied on the residents at Orange Farm, for pitifully little services, are 3,5 times that paid for by citizens of amply serviced Johannesburg. The residents of these areas will be vulnerable again - this time to eviction for non-payment of costs they cannot afford. Some consequences of this process of squeezing out the poor are possible boycotts, and further invasion of land as people leave the untenable circumstances they find themselves in to try to find shelter for themselves and their families. The following high-priority issues need to be identified and addressed:

- land: faster delivery in greater quantity, closer to the urban areas;
- affordability of land and services: reassessment of the principle of ''viable'' local authorities; engagement of central government, province and Regional Service Councils in subsidies;
- access to finance for housing and land: consideration of one-off subsidies for serviced land;
- legitimation of existing informal settlements and access to financing for upgrading these, where possible, where they have developed.

The obvious bottom line in the accommodation of homeless people on the Witwatersrand is the removal of discriminatory land acts and the Group Areas Act. While this may help alleviate market distortions, it will not in itself be the answer to the gigantic

housing shortage, nor will it meet the challenge of large-scale urbanisation within the region.

As a result of the historically unequal distribution of resources as well as land speculation (i.e. buying land at low cost and then selling it for very high prices when it becomes urgently needed), the high cost of land puts housing way out of reach of even middle let alone low income homeless people. Active intervention by government is required to acquire land and to stop further speculation, e.g. by price freezing, vacant land tax and land banking.

Furthermore, because of the high prices at which land will be acquired, consideration should be given to subsidizing it and the cost of infrastructure, so that people can buy land and be able to retain it. In the present circumstances it is more than likely that many people may lose their newly-acquired homes through inability to maintain payments even of the initial costs and service charges, let alone costs of upgrading in time.

Unless steps such as those suggested above are put in motion, we face the prospect of large-scale, uncontrolled invasion of land throughout the region, conflict between squatters/tenants and landowners and officials, and general insecurity among the homeless and the settled population. The consequences of this are huge both in terms of health (increased curative and preventative measures) and in social terms (crime and instability).

Further reading

1. *Informal Settlers: South Africa's New City Builders*. Ann Bernstein, Optima. Vol 37 (No.1): pages 18 et seq.
2. *Nearly an A-Z Guide to Homelessness on the Witwatersrand*: Black Sash Urban Removals and Homelessness Group and Community Research and Information Network, February 1989, pages 8-11.

This article is adapted from the "Nearly A-Z Guide to Homelessness on the Witwatersrand" compiled by Community Research and Information Network (CRIN) and Black Sash Urban Removals and Homelessness Group.

Key policy issues for South Africa's rapidly urbanising population

- The state and local authorities must acknowledge the real size and growth of urban and peri-urban populations.

- The state must provide accurate predictions of population trends as well as intra-urban differentials (i.e. the different health care needs in different communities and classes) to adequately allocate resources.

- There is a need to breakdown local authority fragmentation from multiple single-race councils into one local authority in each metropolitan area, for efficient functioning.

- There is a need to reduce the number of teaching hospitals in each metropolitan area and to desegregate all hospitals.

- There is a need for a national health service to cope with the health needs of impoverished, unemployed and indigent people that cannot afford private health care. The state should not allow the public sector to deteriorate by the selling off of hospitals to the private sector or by loss of personnel to the private sector.

- Curative and preventative components of health care should not be fragmented into provincial and local government departments. Local authorities should provide both components.

- Local authorities need to accept responsibility for the provision of adequate water, sanitation, waste disposal and electrification of areas under their jurisdiction as important health requirements.

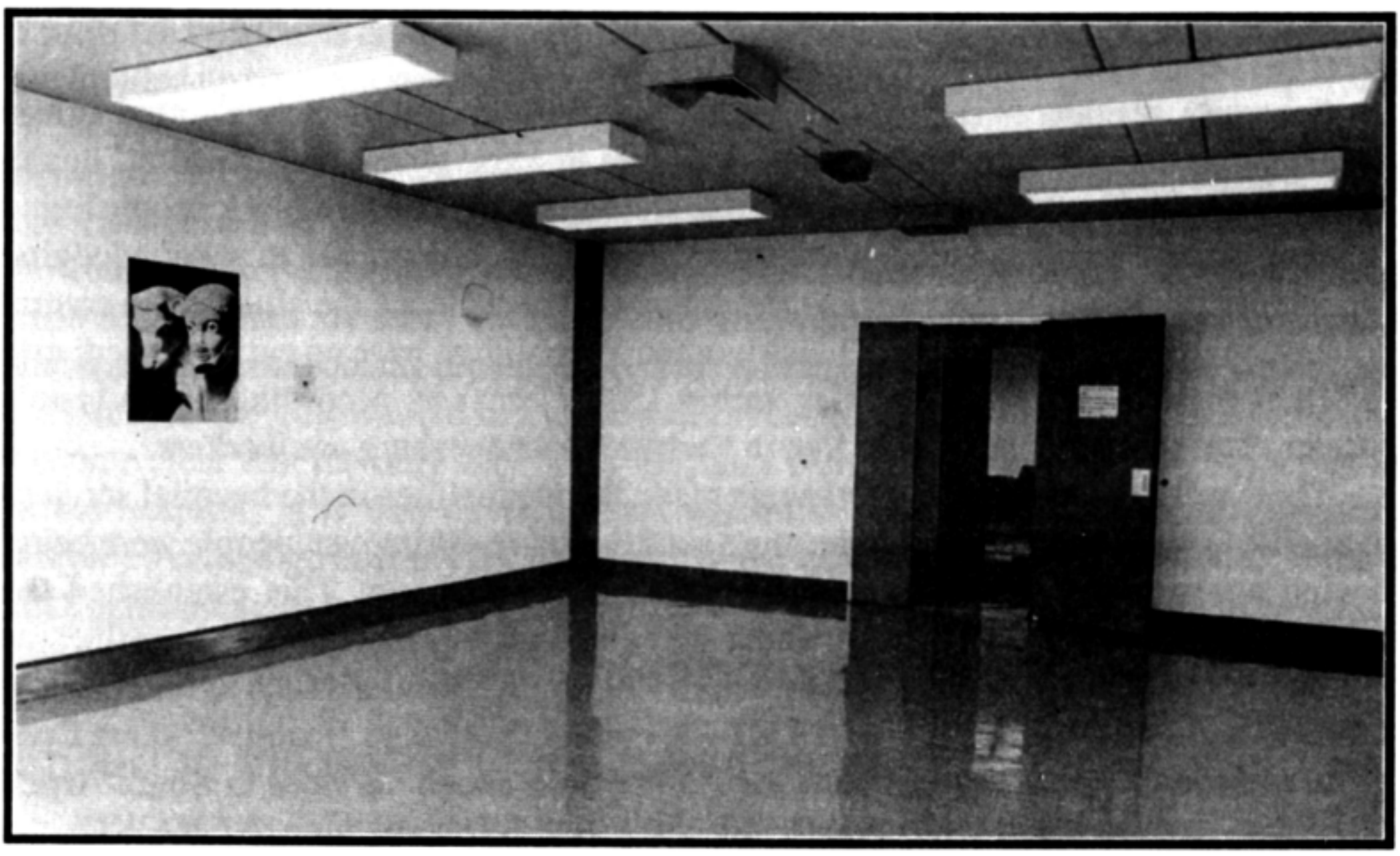
(These points have been collated by Max Price, Centre for the Study of Health Policy.)

The hospital defiance campaign

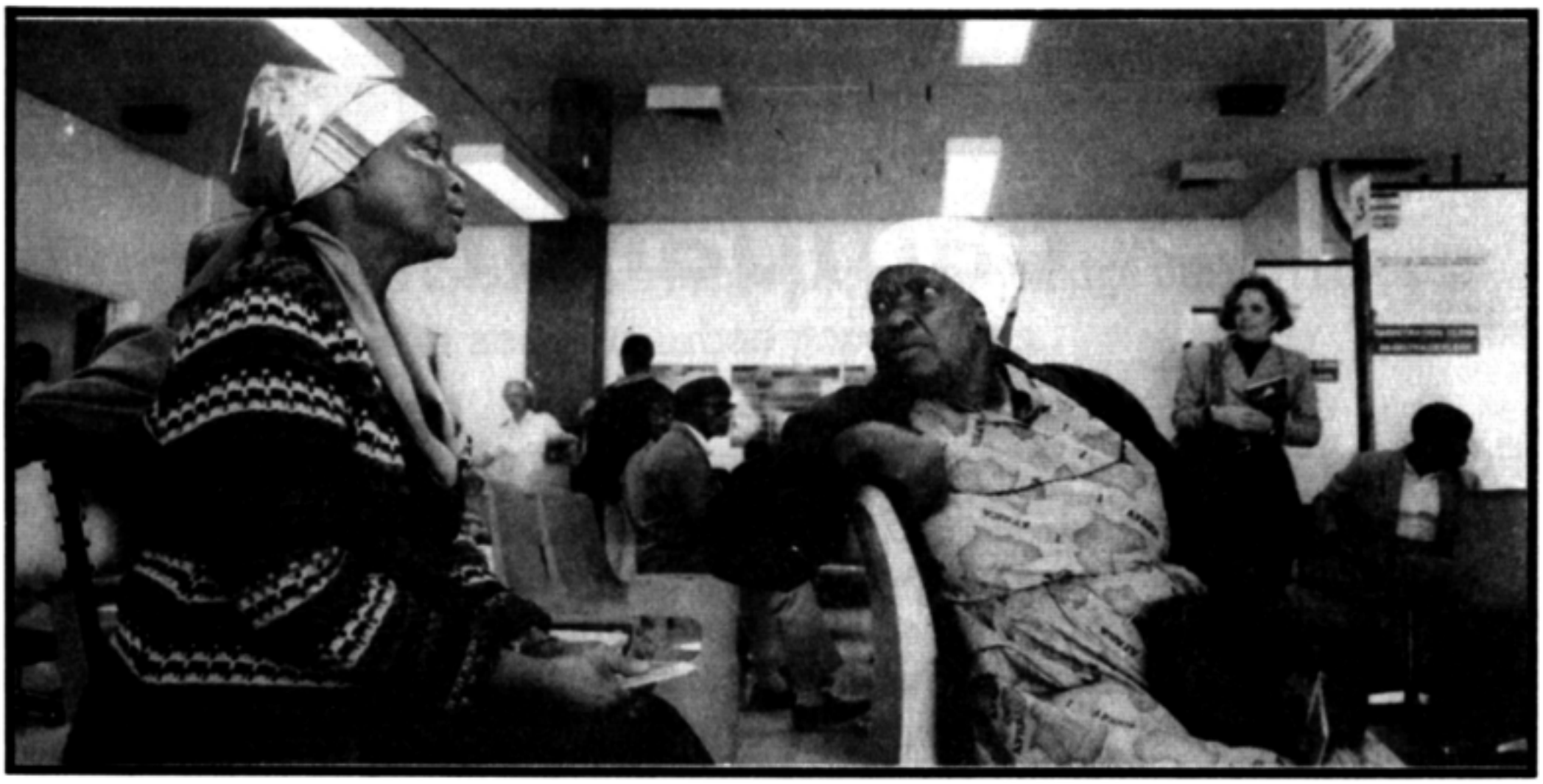
Fundamental problems in the health services

The removal of the pass laws and the poverty of the rural areas has resulted in the rapid influx of hundreds of thousands of blacks to the urban areas. Yet, there has been no recognition by the authorities that this escalation in urbanisation has required an expansion of health services. Overcrowding and lack of financing for all hospitals, and black hospitals in particular, as well as the fragmentation of the public health sector into own affairs and general affairs, and into 10 homeland departments of health have to be urgently addressed.

This article briefly describes the Mass Democratic Movement's defiance campaign around segregated hospitals and argues that if the desegregation campaign is successful, it will logically lead to changes in the more fundamental issues mentioned above.



An empty ward at the white Johannesburg Hospital - thousands of blacks living close to this hospital must travel to overcrowded black hospitals in other areas to receive treatment.



Black patients present themselves for treatment at the "white" Johannesburg Hospital - the campaign declared all segregated facilities open to all.

Reasons for the defiance campaign

Firstly, the authorities, as mentioned above, have not expanded the health services to meet the needs of a rapidly expanding urban population.

Secondly, residential segregation has broken down in certain ''white'' group areas and large communities of black people now live in areas where only ''white'' health facilities are provided. The state refuses to acknowledge the needs of black people living in these ''grey'' areas and to plan accordingly as this would amount to acknowledging the victory of these residents against the apartheid laws. Hence the situation in central Johannesburg where thousands of black women and children have no curative paediatric facilities and no maternity facilities within 15 km because, according to the state's master plan, the only blacks who live in ''white'' Johannesburg are workers.

These relatively recent developments made the inequalities in the hospital services available to blacks and whites all the more starkly visible. Moreover, people were being denied access to the nearest hospital because of their colour. This established the background consciousness against which the campaign was launched.

The campaign was co-ordinated by health worker organisations such as the National Medical and Dental Association (NAMDA), the South African Health Workers Congress (SAHWCO), the Organisation for Appropriate Social Services in South Africa (OASSSA), the National Education Health and Allied Workers Union (NEHAWU), the Concerned Social Workers (CSW) and the South African Black Social Workers Association (SABSWA), together with the broad mass democratic movement.

Immediate objectives of the campaign

1. To publicise the fact that hospitals are still segregated despite claims by Minister De Klerk that apartheid is being done away with. This objective has been successfully met.
2. To get a "foot in the door" of the white hospitals and to ensure that some black patients would be seen and admitted to these hospitals. This objective has also been achieved and demonstrates the power of the Mass Democratic Movement to defy racist legislation.
3. To achieve the de facto integration of the hospitals.
4. To force the government to declare publicly that the hospitals will be open to all races.

The last two objectives have not yet been achieved but the campaign will be taken forward until they are.

The broader implications of the campaign

If these immediate objectives are achieved, how will this campaign lead to an attack on the apartheid administrative structures and the inequality in resource allocation?

According to the tricameral constitution, health and hospital services fall under "Own Affairs". Each own affairs administration has its own budget for hospital services which should be spent exclusively on a single "race" group. Clearly, this can only be done if the hospital is either used exclusively by a single "race" group, or if the patients are divided up between sections of the hospital so that one can calculate what proportion of the hospital budget has to be paid by each department of health. Thus, desegregation of the hospitals would make the tricameralisation of health care unworkable and prevent the transfer of hospitals to own affairs administrations.

Furthermore, if the hospitals are desegregated, patients are likely to use the least crowded hospital in their vicinity. Thus the white hospitals which are presently underutilized will become crowded too. This is likely to lead to concern from whites and pressure on the government to increase resources to these hospitals. However, it will become clear that the only way black hospitals can be made comparably attractive to white hospitals is if they receive equal resources per patient. This could therefore become a campaign not only for equalising health care in the townships and the "white" metropolitan areas but also for raising the level of funding for health care in general.

Ensuring the safety of the participants

The campaign targeted only a few hospitals: 4 in the Transvaal and 4 in Natal. The reason why only these hospitals were chosen was to ensure protection and support for patients

presenting themselves at these hospitals. Asking sick people to participate in a political campaign, where the potential for police intervention and violence is significant, has obvious ethical problems. It was important to ensure that patients would be escorted by high profile people, that the press would be present wherever the patients were, and that diplomats and international figures would be able to observe how the state responded to the black patients. This was achieved by limiting the focus of the campaign to selected hospitals. This does not, of course, mean that only those 8 hospitals will be targeted in the future.

Placing health on the political agenda of the MDM

Health has never been high on the political agenda of progressive organisations (aside from the health worker organisations). However, this seems to be changing. Recently, we have seen anti-apartheid groups taking up health issues. This was perhaps the highlight of the campaign, for this is what will remain after the campaign quietens. This is another reason for focussing this first mass health campaign on issues that were straightforward and easy for everyone to understand; issues that no-one could possibly disagree with.

Once health achieves recognition as a political issue, alongside housing, education, land rights and others, then we can begin to mobilise people further around the more complex issues such as the quality of care they receive, access to health services, inequality, and democracy in health care.

By the National Medical and Dental Association (NAMDA), Southern Transvaal.

HEALTH LINES

NAMDA and SAHWCO are encouraging doctors to refer their patients, when necessary and with the patient's consent, to white hospitals if convenient for patients (i.e. if the hospital is closer to where they live or less crowded).

When doing so, doctors have been advised to phone the hospital and inform the appropriate doctor of the transfer. A note should be made of the reason for referral, the patient's name, the referring doctor's name as well as that of the doctor spoken to, and the date and time of the conversation.

If any hospital worker refuses to treat or admit the patient, the referring doctor should contact one of the health lines below, with the details.

The patient, in the meantime, should be treated at another hospital and the above mentioned organisations will follow up the incident as well as monitor the situation in general.

Tel: 011-294060

Tel: 011- 3374775

Health issues in the inner city

Actstop is an organisation campaigning for thousands of ''illegals'' battling for low-cost accommodation in Johannesburg. The biggest challenge at present is to improve the quality of life in city centres and other areas. To this end Actstop has helped tenants form flat committees which discuss the various problems faced by black tenants living in the city centre. Health has become a major concern as more and more people move into the cities with their children.

Actstop has set up a working committee with organisations like the South African Health Workers Congress (SAHWCO) and the National Medical and Dental Association (NAMDA). The aim of the committee is to investigate the quality of life and the physical condition of buildings in and around Johannesburg.

Tenants have become increasingly aware that if they do not do something about the dilapidated and rundown buildings that they live in, the landlords certainly won't.

''It is up to us to fight for the right to a just and equitable society and to fight for the right to bring our children up in a healthy environment,'' said one of the tenants on the committee.

Evictions and poor maintenance are health hazards

Actstop has had some dealings with the Johannesburg City Health Department where complaints about conditions of buildings are usually reported. The health department can only act against flat owners if they violate any municipal by-laws. They do, however, have the power to declare a building a slum and have it shut down and the people moved out. This only serves to exacerbate the housing shortage.

Dr Nicky Padayachee of the Johannesburg City Health Department says that in all his ten years of office, he has no knowledge of any building in Johannesburg being declared a slum. ''We would much rather impress on the owner to fix up the premises and to do so in such a way as to allow the people to remain in the building''.

More conservative residents of Johannesburg claim the influx of black people into the city centre increases infectious diseases. However, the increasing number of black people making their home in Johannesburg has not caused any notable increase in infectious diseases, and this is backed up the city's Health Department.

Dr Padyachee says, however, that there is every likelihood that there has been a notable increase in social diseases such as alcohol abuse, wife battering, child abuse and sexually transmitted disease. This is not just a feature of the influx of black people into the city centre but rather a symptom of inner cities world-wide and also of massive unemployment.

In the interests of public health, flat owners should be required to provide for the maintenance of buildings and facilities. Poor maintenance of buildings has caused many problems. At Export House in Bree Street, a seven year old boy climbed into the lift shaft and was crushed to death.

In Milton Court, Pritchard Street, at least 60 tenants share one bathroom and toilet. In the winter months braziers are used in the more dilapidated buildings for heat, which increases the possibility of carbon monoxide poisoning.

Often tenants are without flushing toilets for weeks on end and have to resort to the age old bucket system. Actstop believes it is nothing short of a miracle that there actually has been no serious outbreaks of disease in some of the buildings they are involved in.

Evictions can also cause health problems. This year, several people were evicted from a building in Berea. Actstop supplied tents for the people but these were pulled down almost immediately by the police. The evictees were later moved to a church where there were not enough toilets, and living space was at a premium. Evictions often occur during the winter and families are left on the street in freezing weather.

Angry residents protest against the eviction of 12 black families from a block of flats in Hillbrow. In defiance, they then moved the belongings of the families back into the flats.

Actstop meets with tenants' committee to discuss the problems of living in "grey areas" under apartheid.

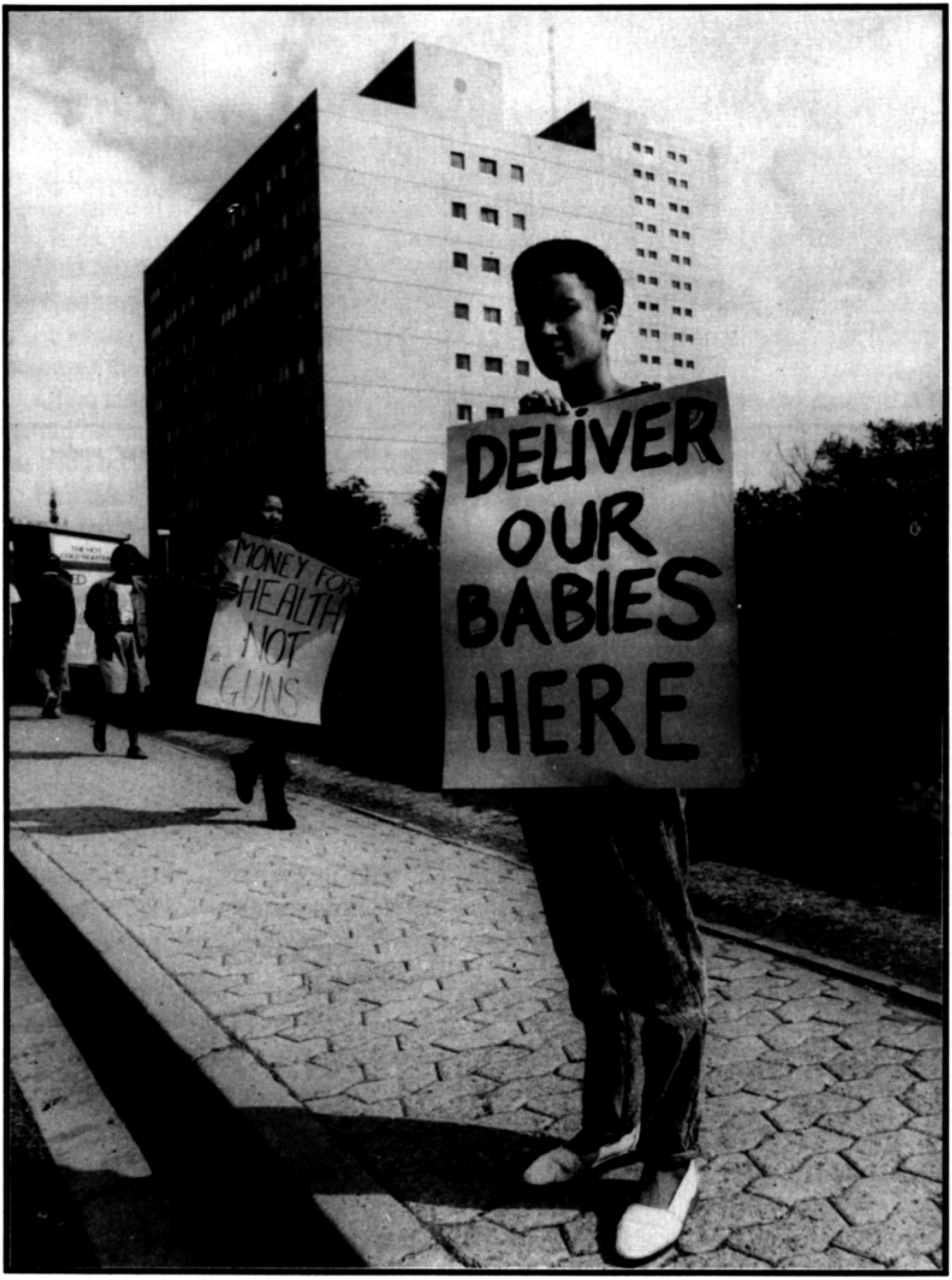
Access to medical facilities

One of the major concerns of black people living in the inner city is access to medical facilities. There is no provincial hospital in the Johannesburg city centre that has a pre-natal and paediatric facility for black inner city dwellers. The nearest hospital for these facilities is Baragwanath Hospital in Soweto which is at least 20 kilometres away. Many tenants living in Johannesburg are unaware that Hillbrow Hospital does not offer these facilities. One local resident said that she had a hospital behind her and one diagonally across the road. "I just assumed in an emergency (she is seven months pregnant) that they would take me to the nearest one."

The ongoing defiance campaign has highlighted the inadequate facilities offered to the majority of the population. Actstop has actively encouraged black people living in Johannesburg to go to the "white" Johannesburg General Hospital should they need medical attention.

Living conditions and apartheid

Actstop believes that the authorities, far from trying to alleviate the problem, have exacerbated it with their latest creation of "grey areas" which will only lead to more overcrowding and a decline in the standard of health. Apartheid has caused a housing shortage, and a lack of education and health facilities for the majority of the population. It is only through the abolition of the Group Areas Act and all other discriminatory laws that the tremendous demand for black housing will abate and living conditions improve.



The Mass Democratic Movement's defiance campaign - protesting outside the Johannesburg Hospital.

Urban marketing to promote disease or health?

Marketing is used to increase the profitability of a company but has the potential to promote health. This article, written by Derek Yach of the Centre for Epidemiological Research in Southern Africa, Medical Research Council, examines marketing trends aimed at the growing black urban population.

New marketing strategies

The marketing of certain products which could have a negative effect on health if used excessively or inappropriately, includes new strategies to stress the safe use of these products. For example, the Red Meat Board recently collaborated on a marketing campaign with the Heart Foundation. The Board agreed to remove visible fat and promote leaner cuts of meat. Similarly, the South African Breweries have started supporting programmes aimed at addressing the safe use of alcohol. These products are being increasingly and aggressively marketed in the growing urban environment and are not hazardous to health unless abused.

In sharp contrast, tobacco with its strong addictive properties, is a major consumer product that is harmful when used as intended. This article will focus on tobacco advertising.

Advertising to recruit smokers or to change brands?

The tobacco industry claims that advertising results in people changing brands and not in the recruitment of new smokers. Several studies, however, show that this is untrue and that the industry needs to advertise in order to recruit new smokers to replace those who quit or die. Studies investigating the impact of both alcohol and tobacco advertisements have found that advertising reinforces consumption of these products, makes it hard for

A clear example of the dangers of sponsorship and dependency was seen in Rembrandt's recent threats to withdraw its funding to the Cape Town City Orchestra because of Cape Town City Council's plans to introduce smoking restrictions in restaurants. Sponsorship by the tobacco industry is aimed not at promoting the welfare of society, but ensuring that publicity is obtained that would enhance the use of its products.

Undermining the health of people in the townships

Over the last few years there has been a steady and sustained increase in the proportion of tobacco advertising revenue being directed at township populations. In 1987, while tobacco advertising constituted 5,3% of all revenue spent on advertising, it made up 16% of radio advertising, 16,3% of billboard advertising, and 56,3% of cinema advertising. The impact of tobacco marketing in South Africa has resulted in 60% of men and 40% of boys (by the age of 15 years) becoming smokers in Cape Town townships. The favourite brands of both groups was similar to the brands advertised on major billboards and radio in those townships. Already the impact of tobacco products on health has been documented in South Africa. By the year 2 000 and beyond, considerable cigarette-related early deaths will occur among the black and "coloured" population.

1. Radio

Radio advertising is a very powerful way of influencing the black market. It is independent of urban/rural status, is relatively cheap, repetitive and is not affected by whether people can read or not.

2. Billboards

Billboard advertising is increasingly sited on South African Transport Services (SATS) properties in the major municipalities. In Cape Town, billboards advertising tobacco products are appearing on all the major transport routes to and from the townships and suburbs. This is in strong contradiction to recent City Council legislation which has committed itself to eliminating tobacco advertising throughout the city.

3. Cinema and print media

Cinema attendance information clearly shows that adverts in cinemas are directed at youth despite denials by the tobacco industry. While the percentage of tobacco advertising in magazines is still relatively low, with increased readership, particularly

This advert clearly illustrates the move towards marketing strategies aimed at the black urban population.

in the black population, it already reaches a very large proportion of the population. By 1987, three of the top ten selling newspapers in the country were specifically aimed at the black population. All of these - *City Press*, *Sowetan* and *Ilanga*, had readership figures of over 120 000 per edition.

Profits at the expense of the health of township residents

The effect of targeting the townships has already been profitable for the tobacco industry. The black market share of household expenditure for cigarettes has increased from 19,7% in 1970, to 33,7% in 1985. Importantly, the location of outlets where cigarettes and tobacco products are predominantly bought shows how successful the industry has been in ensuring township penetration of sales. 72,5% of cigarettes and tobacco products bought by black consumers in 1985 were purchased in the township (as opposed to the city centre) compared to 46,6% for perishable foods, 25% for toiletries and 2,3% for refrigerators and stoves.

Time for action!

The time has clearly come for strong action. One short-term approach suggests that health warnings be placed on all adverts. In South Africa the voluntary agreement between the Tobacco Industry and the government has resulted in a virtually invisible warning on cigarette packets with no health warning attached to advertisements.

In the USA, a further short-term proposal ensures that tobacco adverts contain no photographs or graphics except the company, brand name, price, tar and nicotine level with a health warning.

Further, tobacco advertising should be banned from all billboards, and tobacco companies should not be allowed to advertise indirectly or sponsor sports events.

Calls for a complete ban on tobacco advertising and all forms of tobacco promotion have been made by various health-related organisations internationally. Such international calls have already resulted in 30 countries partly or completely banning the promotion of tobacco products. In South Africa these calls have yet to have an impact.

Advertising alone will not be sufficient to increase the quit rate and stop the number of new smokers entering the industry. Advertising is not the sole cause of adolescent smoking. The reality is that there are many causes and it is necessary to have a coordinated plan which includes a ban on cigarettes, an increase in the overall price of cigarettes and an extensive education programme. (In South Africa, the price of cigarettes has fallen well behind the consumer price index, making them relatively cheaper than many other products.)

Adverts like this one, placed over the steps onto the black train platforms, have successfully targeted the black township population.

Conclusion

The rapidly urbanising areas of South Africa are providing growing opportunities for the marketing of products such as tobacco, which are hazardous to health. Strong measures are needed to curtail their use. There is an urgent need for counter advertising to be used throughout the townships. For this to be successful, smoking needs to be recognised as a threat. Such counter advertising could make use of the major transport media in the country including buses and taxis.

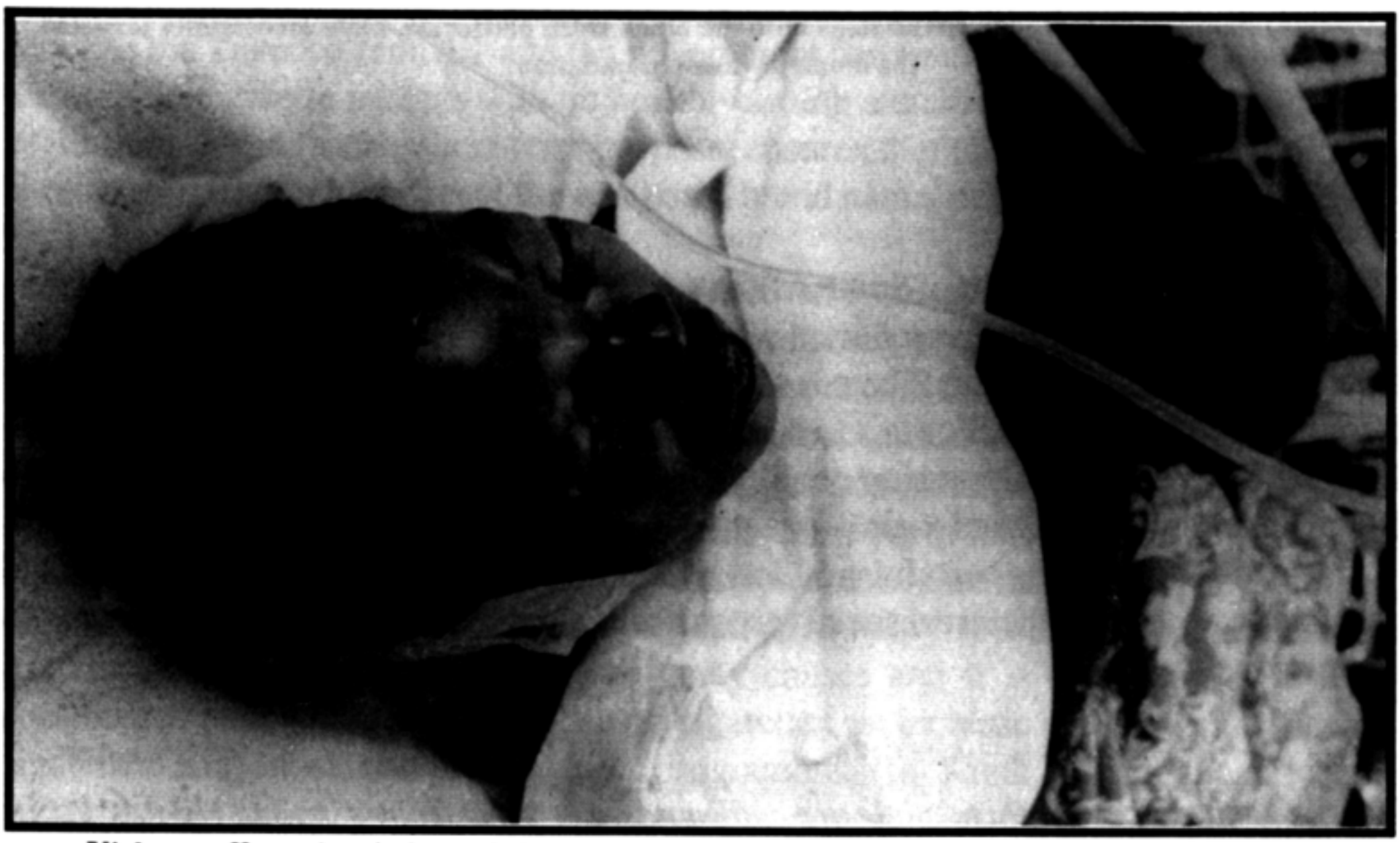
Instead of advertising harmful products, marketing and advertising companies could go a long way to meet their real social responsibility by promoting products that lead to a better quality of life.

Detailed references for this article are available on request from: Critical Health, P.O. Box 16250, Doornfontein, 2028.

Studying violence in a South African city

Violence exacts an enormous cost not only in terms of personal pain and suffering, loss of income and needless expense, but also because of the huge burden it places on the health care services, diverting them from other, more fundamental concerns with people's health. The greatest social cost of violence is not economic, but rather the loss of self-respect in both the perpetrators and the victims, and the disruption it causes to family life and social norms.

This article, by members of the Health Psychology Unit at the University of South Africa, briefly examines trauma as a public health problem and explores possible explanations for violence. An approach to research into violence in South Africa is briefly described, where ways of bringing together theoretical knowledge and people's common sense ideas are explored.



Violence affects the victim and the perpetrator, as well as the family and the broader social community.

Trauma as a public health problem

In South Africa, trauma causes approximately 16% of all deaths, second only to circulatory diseases, which give rise to about 21% of deaths.(1)

An unfortunate aspect of South African health statistics is that they are specific about race, but very vague about other important variables such as income, education level, place of residence and other indicators of social class. However, since other data are unavailable, the analysis that follows is based on the ''official'' race classifications, which uses terms such as white, ''coloured'', African and Asian.

Trauma patterns

Comparing causes of non-natural deaths in African and white males reveals some interesting differences.

Cause	Population group			
	African	White	"Coloured"	Asian
Homicide	39	5	39	14
Suicide	3	20	3	13
Motor accidents	20	42	24	37
Other	38	33	34	36
Total	100	100	100	100

Causes of deaths in males as a percentage of all causes, by population group.

1. African males are nearly eight times as likely as white males to die a violent death by homicide (murder).
2. Suicide is seven times more frequent among white than among African males. This raises important questions about the quality of life of South African whites, speculatively raising the possibility that suicide is part of the price of the oppressive system in South Africa.
3. Motor vehicle accidents claim twice as many white lives as African lives. (Not reflected in these data is the fact that most African motor vehicle fatalities involve pedestrians, while most white deaths are of vehicle occupants.)

These mortality trends are strongly supported by another set of data gathered by our Unit on non-fatal traumatic brain injury in Johannesburg: 70% of white brain injuries were caused by motor vehicle accidents, but only 27% of African brain injuries. On the other hand, interpersonal violence accounted for 51% of African brain injuries, but only 10% of those in whites. Among "coloured" people, motor vehicle accidents accounted for 49% of brain injuries and interpersonal violence for 40%. (All traumatic brain injury data are for males and females combined.)

The significance of violence in South Africa

An important question for those concerned with prevention and health education is whether apartheid contributes to the exceptionally high rate of interpersonal violence among African and "coloured" people. There are many reasons to expect that this is so. There is wide agreement that racial domination and oppression create very sharp differences between the living conditions of the oppressed and the oppressor and an exceptionally high level of violence.

Franz Fanon, the famous psychiatrist, documented the violence of colonial Algeria during the 1950s and notes the differences in the level of violence in parts of the city in which the French settlers lived, and under the slum conditions of the majority of Algerians.

Fanon observed that oppressed people tend to internalise the violence of the oppressor, making the cruelty and viciousness of the system their own.

A student of Fanon, Hussein Bulhan, writes that if the oppressed person "cannot defend his personality in the larger social arena, he must defend what is left of it in his last refuge .. namely, in the circle of his family and friends," so that the slightest challenge to personhood or dignity leads to "a volcanic eruption of repressed aggression, a welling up of accumulated anger".

Structural and cultural explanations of violence

Fanon's suggestions are known as the "colonial model of violence" which combines elements of the structural and the cultural explanations of social violence.

Structural factors are poverty, poor education, police abuse, court injustices and poor living conditions, all of which are found in urban slums throughout the world and in "subcultures" in which violence flourishes. In South Africa the situation is worsened by the high level of apartheid-related violence.

Cultural factors identified by Fanon are a feeling of inferiority produced by the negation of the culture of the oppressed people and an internalisation of the oppressors'

claim that the former are a ''bad lot''. Another contributing factor to the violence may be that the men in such groups ''lack the economic resources that are the most important conventional way of obtaining respect as a man''. (Austin, 1983.)

Equality and dignity as a means of reducing violence

If the colonial model is true, one would expect violence to decrease in societies in which there is steady progress towards liberation, the achievement of equal dignity and respect for all, and the redistribution of resources so that they become available to all members of the society, and not only to those of the ruling class.

Research has pointed to a relationship between the living conditions of a community and the level of violence.

Recent work by Roy Austin of the University of Pennsylvania looks at violence rates in the Caribbean island of St.Vincent, which began its independence process from Britain in 1969, achieving full independence in 1979. Data shows that between 1969 - 1973, both imprisonment rates and prosecutions for crimes of violence declined significantly.

He also looked at the effects of the Black Power movement in the United States in the 1970s on comparative white-black arrest and victimisation trends. Again, it was found that the movement towards equality, improvement in self-image and increased political power produced a decline in the differentially high rates of violence amongst black people.

These findings suggest that progress towards a non-racial democracy and the development of a new sense of self-respect and self-worth among the oppressed people in South Africa, may in themselves lead to a reduction in the very high urban rates of interpersonal violence. However, the geographic and cultural differences between the societies studied prevent definite comparisons and conclusions.

Violence research in South Africa

Health care workers and social scientists in South Africa have become increasingly aware of the problems created in our society by violence. There is an urgent need to understand the triggers for violence, the feelings of assailants and victims and the psychological costs of violence. This understanding will allow the development of appropriate preventive measures and programmes and will enable communities to explore ways in which their organisations can come to grips with the problem and its solutions.

The Health Psychology Unit's study of violence

To find out how much trauma there is in the Johannesburg-Soweto area and the geographical and social class distributions of the trauma, the unit's field workers are concluding a long series of hospital visits and casualty watches in order to document trauma cases seen by hospitals during defined sampling periods. Using this information, the unit will be able to develop incidence rates for trauma in geographical areas and social classes.

Psychological aspects of violence

How do the victims of violence make sense of what has happened to them? How do they account for the attacks against them, often by people they know well? Answers to these questions may be useful not only in understanding the victim's world, but also that of the perpetrators of violence. There is clear evidence of a relationship between being the victim of a violent crime at one time, and being the perpetrator at others. Accordingly, victimisation is an important indicator of violent behaviour. A large number of interviews have been held with victims of violence to ascertain the triggers of interpersonal violence; the victim's explanation for the assailant's behaviour; whether drugs or alcohol played a role and whether there were socio-political reasons such as racial hatred, poverty or political "unrest".

We will then be able to see if there is a relationship between different explanations and variables such as class and place of residence. This will allow us to relate the various structural, cultural and psychosocial explanations to one another.

Conclusion

The incidence and causes of violence can be studied in a way that will help progressive scientists and community organisations to take steps to help prevent it. We believe that by understanding the common-sense explanations for violence in a South African city, as perceived by the people who experience the violence themselves, will provide a more accurate analysis and ultimately, should improve the chances of their participation in attempts to alter the conditions that put them at risk.

References

1. All mortality data come from *Review of South African Mortality*, 1984, published by the Medical Research Council in May 1987.

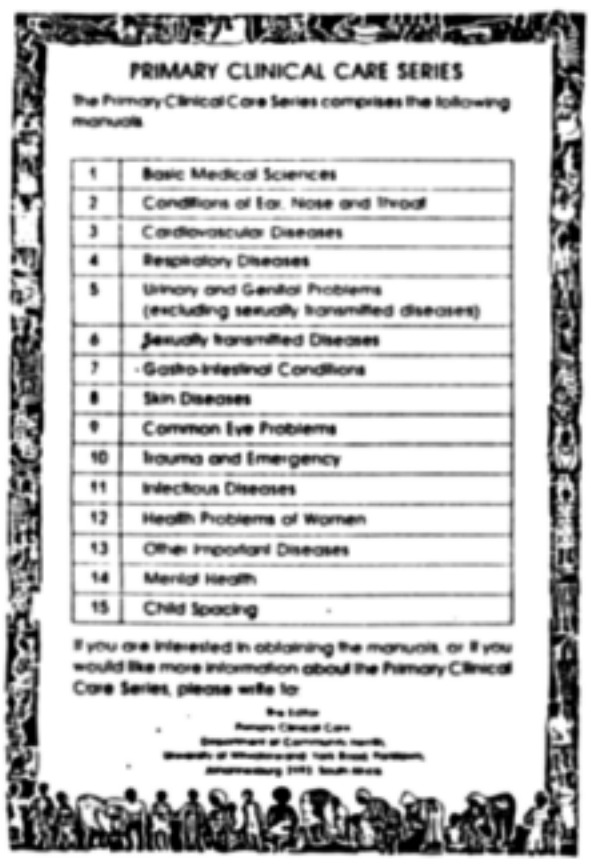
By Victor Nell and Alex Butchart
Health Psychology Unit
University of South Africa.

(**Note:** For space reasons the length of this article has been reduced. The complete text, together with detailed references are available on request from Critical Health, P.O. Box 16250, Doornfontein, 2028.)

A New Manual for Primary Health Care Workers

The Health Services Development Unit is a rural outreach programme of the Community Health Department of the University of the Witwatersrand. The unit is primarily involved with the training and development of mid level primary health care (PHC) workers and trains teachers of PHC workers.
This manual is especially relevant for PHC workers in Africa because:

- **These manuals are for health workers being trained to deliver primary health care within rural and developing areas of Africa.**
- **We have written the manual for health workers who do not have English as a home language.**
- **The manual contains the core medical and clinical knowledge necessary for health workers to provide safe and adequate primary health care.**
- **The manual has a built-in self learning process which will help learners in primary health care to study a lot by themselves.**
- **The manual is written for primary health care workers who live and work in difficult and stressfull conditions.**
- **The manual also discusses the social, economic, political and cultural influences on health and health care.**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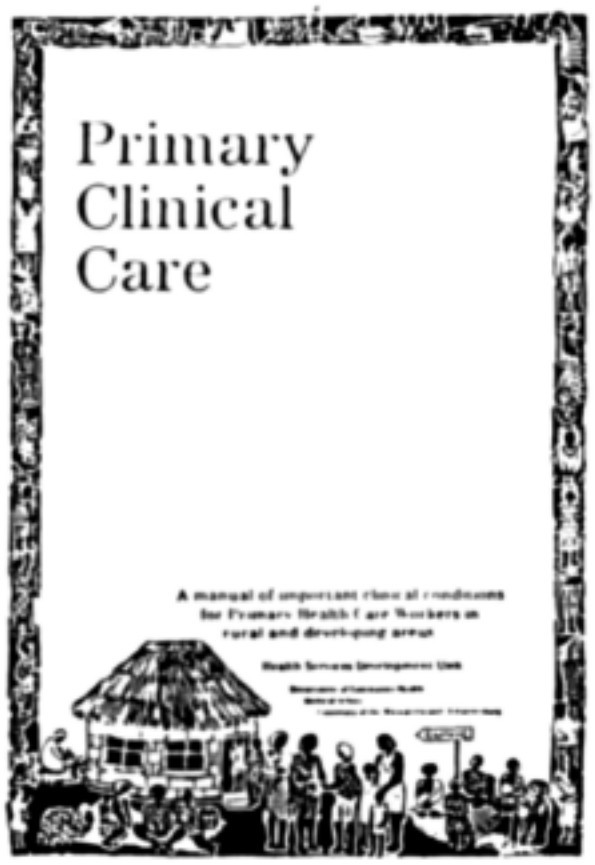


Each book in this manual sells for approximately R10.00 (excluding postage). *Cheaper (subsidised) prices are available for Primary Health Care workers and students.* For information and orders write to Dr C Evian, Primary Clinical Care, HSDU, Dept Com Health, Wits Medical School, York Rd, 2193. Please quote the number/s of the books required.

Disease over our cities

Take a drive across the Eastern Transvaal Highveld at dawn and witness one of the enduring legacies of industrialisation in South Africa: a thick black ribbon across the horizon that is made up of more soot, sulphur dioxide and other noxious gases than exists in most other parts of the world.

Media coverage

A series of articles in the media have recently suggested that some of the most polluted air on earth hovers over cities and black townships in the Transvaal and the people who live there appear to be trapped in a haze of contradictory government policies.

The articles have painted a bleak picture of life in regions of the Eastern Transvaal Highveld, the Vaal Triangle and the Witwatersrand, citing statistics that even government officials acknowledge place these areas on top of the world-wide list of regions with the highest levels of atmospheric pollution in the world.

Statistics indicate that levels of atmospheric pollution in certain areas of South Africa are among the highest in the world.

At the same time at least three studies into the social incidence of respiratory disease have been conducted which, with varying degrees of certainty, point to increased rates of lung and chest disorders, especially amongst children, in the areas that form the industrial heartland of South Africa.

Pollution statistics

The evidence of severe pollution in the Transvaal's atmosphere is compelling. Early this year two private consultants produced a report which claims that coal-burning power stations and factories are pumping amounts of acid-rain-causing sulphur dioxide into the air that are twice those in East Germany, the country which has the highest level of air pollution in the world.

The report says emissions from 12 power stations and the Sasol fuel from coal plants in the Eastern Transvaal emit 57,7 tons of sulphur dioxide per square kilometre each year. The air over East Germany absorbs 30 tons of sulphur dioxide per year, while the next most polluted country, the United Kingdom, has 14,34 tons of the toxic gases, says the report. More menacingly, the consultants predict these levels will rise to 80 tons per year when two new power stations start operating.

These statistics apply to an area with a radius of some 80 kilometres and would even out when the atmosphere of larger areas is measured.

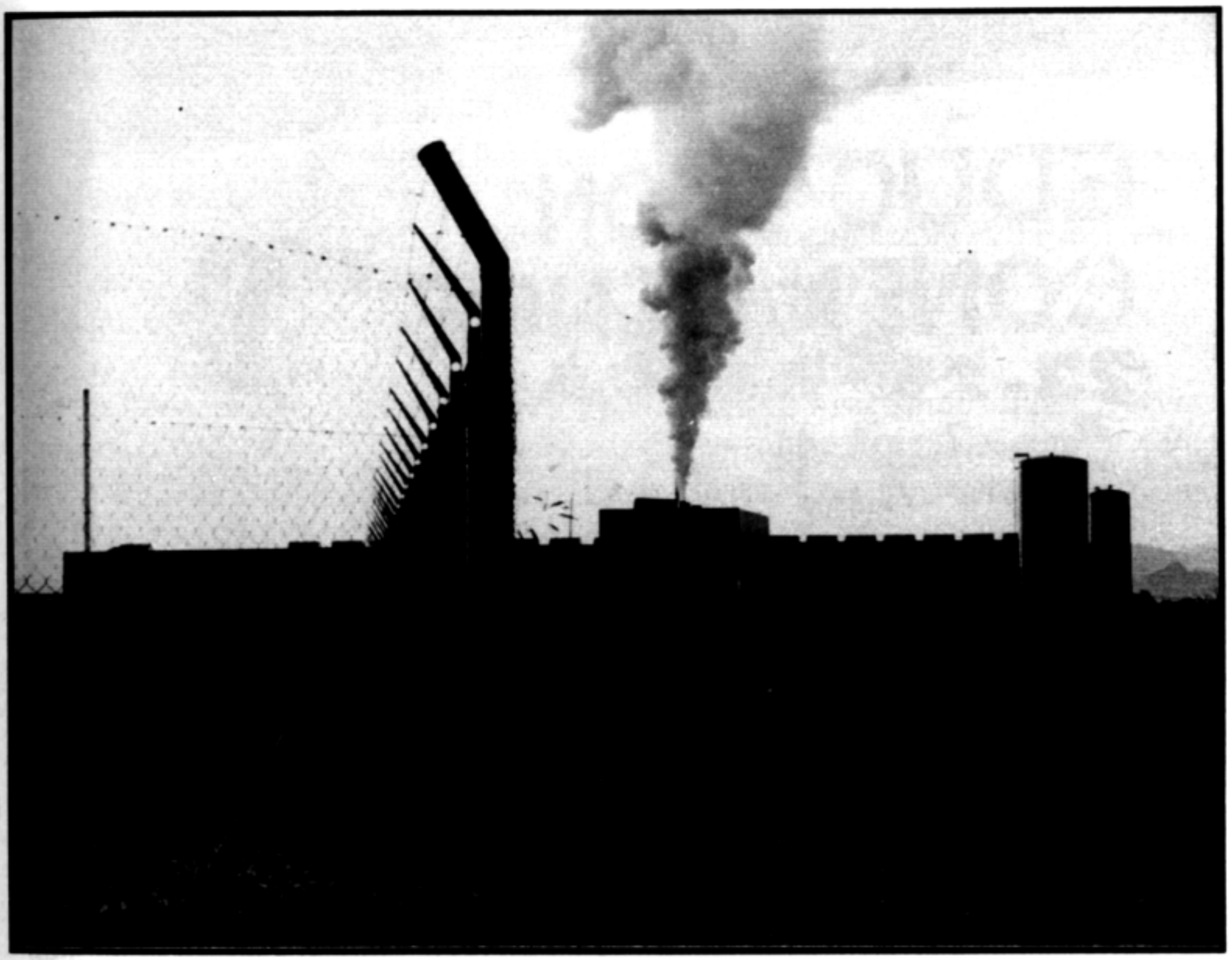
Also, says government pollution control officer Martin Lloyd, the measurements are taken close to the stacks that emit the gases and the figures would be much lower after the smoke disperses. But even the government's official figures, produced by the Council for Scientific and Industrial Research (CSIR), are cause for alarm.

Last year the report of an extensive CSIR study said sulphur dioxide levels stood at some 31 tons per square kilometre per annum. A similar warning was sounded some years ago when the World Health Organisation said that the Eastern Transvaal Highveld had more micrograms of sulphur dioxide per metre of air than any other country in the world.

Local conditions

The senario is worsened by aggravating local factors. Reports, vigorously denied by industrialists, are rife that big steel smelting works and power stations switch off the filters that inhibit the emission of gas and coal particles at night, when the colour of the smoke cannot be observed, because they are expensive to operate.

The presence of particularite matter, which increases the ability of toxic gases to enter the lungs, is also increased by the fact that most black township residents continue



The industries producing pollution should prove it is safe before they are allowed to operate, rather than the responsibility for this being placed on the public.

to use coal stoves for heating their houses because this is a much cheaper source of energy than electricity.

The Eastern Transvaal is also characterised by low-lying mists which tend to trap and concentrate the pollutants. Ecology expert and journalist James Clark says a Ph level of 2,8 has been measured in the air over parts of the region and in misty conditions this could drop to as low as 1,7. (The Ph levels of unpolluted air range from 4,2 to 5,6 with lower levels indicating an increased acidity.)

The CSIR report says the effects of pollution are worsened by the low levels of oxygen on the Highveld and the lack of air turbulence which inhibits the dispersal of dangerous gases.

Another typical climatic feature on the Highveld is the tendency for a canopy of polluted air to remain trapped over cities and townships in the region, which takes much longer than air in levels higher up in the atmosphere to disperse. In the words of the CSIR report, these factors combine to create ''an atmospheric pollution climate amongst the most adverse anywhere in the atmosphere''.

Trade unions and community organisations active in the affected areas are dealing with issues of exploitation and as such have not addressed the problem of air pollution.

The profile that emerges of the Eastern Transvaal Highveld cannot be applied exactly to the Vaal Triangle and the Witwatersrand, where much less research has been done and no equivalent figures for air pollution have been released. Observers believe the quality of air over the two areas is probably marginally better because there are not that many power stations crammed into a small area. But both the Vaal Triangle and the Witwatersrand have many more black townships which produce low-lying and dangerous pollution from coal stoves.

In 1952 a killer smog in London, which some statistics say killed 6 000 people in two weeks, contained acid levels of 1,7. General opinion amongst doctors is the smog had such devastating effects because it combined sulphur dioxide with particles of soot and carbon in a thick mist which was capable of penetrating the linings of the lungs.

Findings of studies

While the exact combination of factors and levels of pollution are not serious enough to cause a disaster on this scale, there is enough evidence of a dramatic impact on the health of residents of the affected areas. Three key studies have highlighted these dangers: a 1986 study by Prof A.M. Coetzee, of the University of Pretoria's Department of Community Health, published in the SA Medical Journal; an unpublished study

conducted in 1987 by Prof S. Zwi, from the University of the Witwatersrand's Medical School; and a section in the CSIR report on pollution over the Highveld, released in the middle of last year.

The 1986 study investigated the health of lungs of children from primary schools in Sasolburg and compared these to children from the relatively unpolluted rural towns of Parys, Heilbron and Frankfort. Although no important differences in the incidence of respiratory illness were evident from the survey, there was a significant decrease in the strength of children's lungs (as indicated by lung function tests) - especially those of boys.

Prof Zwi's study of lung disorders in polluted areas went a little further: it claimed that exposed children in the affected areas "have increased frequencies of certain respiratory symptoms such as coughing, wheezing and certain respiratory illnesses - asthma in boys and chest colds in girls".

The CSIR study was more cautious. It noted weaknesses in the previous studies which compared the health of people from polluted areas with that of people from non-polluted areas. The CSIR was especially worried that earlier studies did not take adequate steps to show that there were no other disease-causing pollutants, such as cigarette smoke, in the polluted areas and that there were no industrial pollutants in the rural areas.

Health hazards

According to Dr Bernard Fourie of the Research Institute for Environmental Diseases (RIED) in Pretoria, the results of studies by Prof Zwi and Prof Coetzee were not conclusive as they had compared lung functions of people living in polluted areas with those of people living in non-polluted control areas without rigorously demonstrating the absence of disease causing pollutants in the control regions.

For these reasons, RIED has been commissioned to undertake a major probe into the link between air pollution and respiratory diseases. Dr Fourie said the study, which is still in its planning stages, would investigate possible links between industrial contamination of the air and bronchitis, asthma and other forms of lung impairment.

"Minor ailments such as sinusitis and eye irritation, which people tend to accept as part of their day-to-day reality will also be investigated," said Fourie. While there was no indication of higher-than-normal levels of lung cancer in the Transvaal, this had not been ruled out and would form part of the study.

But ear, nose and throat specialists from the Vaal region believe the study, which will take two years to complete, is not necessary for immediate action to remedy the problem. At least three doctors said it was already blatantly clear that their patients suffered from much higher rates of chest diseases.

A doctor, who cannot be named for professional reasons, said a recent meeting of students at the Technikon in Vereeniging indicated that one in every four students who came from rural areas began to develop chest ailments after their arrival in the Vaal area. There was a great danger that repeated doses of sinusitis, blocked noses and sore throats could, if unchecked, develop into chronic cases of bronchitis and emphysema.

Another specialist noted that serious lung diseases in the area are so wide-spread that the five oxygen tents at the Sasolburg Hospital are always occupied and patients frequently transferred to Johannesburg and Pretoria for treatment.

The need for organisation and mobilisation

As in most parts of the world, indications are that little will be done to address this state of affairs until people organise themselves to put pressure on the government and its health authorities to deal with the problem. In South Africa, unlike Europe and North America which have powerful and growing ecology movements, the state has come under little pressure from the potential victims to do anything about air pollution.

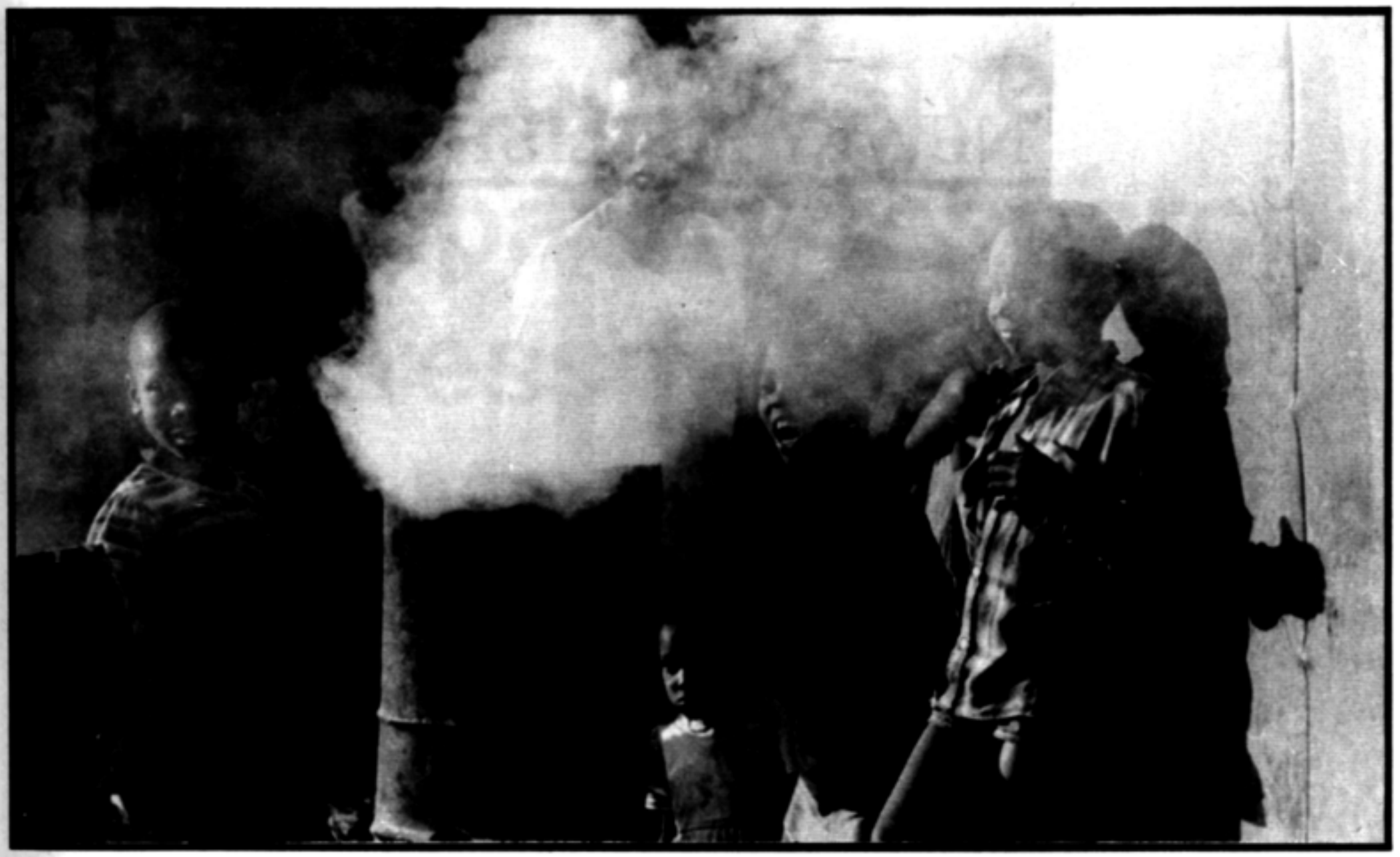
Trade unions, active in dealing with health and safety issues on the factory floor, have a strong presence in all of the affected areas. But, thus far, they have not addressed the issue of air pollution - probably because it seems to be a natural part of the environment and is overshadowed by more pressing issues of racism and exploitation.

Community organisations in the black townships even before they were emasculated by the State of Emergency, have done little to create pressure for a cleaner environment and most extra-parliamentary organisations, including the African National Congress and the Pan Africanist Congress, do not touch on the ecology in any of their policy statements. Also, a survey of the candidates standing for parliament in the September elections showed that only seven percent of the country's candidates had responded and that many politicians have little awareness of conservation concerns.

Wildlife Society director Keith Cooper said that from the small number of replies that had come in, the level of awareness was generally poor. Most of those who did respond had no connection with any conservation or environmental organisation.

Current initiatives

There are three exceptions to this rather gloomy scenario. In the Vaal Triangle a group of white housewives have formed themselves into the Air Pollution Appeal Committee (APAC) and have campaigned vigorously to highlight the problem, holding photographic exhibitions, consistantly reminding industry of their pollution record and petitioning the authorities for action to be taken. In a sense the group has already won



In many instances coal stoves, contributing to air pollution, are used because electricity is too expensive.

a small victory: the RIED study was commissioned as a direct result of pressure from APAC - although this clearly has a lot to do with the fact that Vereeniging is the constituency for State President FW De Klerk.

In Soweto there is also an organisation called the National Environment Awareness Campaign (NEAC) which highlights the fact that minimal government expenditure on houses - which do not have heaters, ceilings and insulation - causes people to rely on coal stoves which increase the levels of pollution. But while this group helps generate media publicity it appears not to have the kind of mass membership necessary for campaigns to create more direct pressure on the state.

Finally a small group of English newspapers - the *Star*, the *Natal Witness*, the *Sunday Tribune* and the *Weekly Mail* - have begun to cover air pollution and other ecological scandals with some effect. But it is plain that until this country develops a greens movement with the kind of mass clout that these parties have in Europe and America, the government and industry will have no strong inducement to clean up their act. It must be stressed, however, that the onus should be upon the industries producing the pollutants to prove that they are safe before they are allowed to operate, rather than on the public who suffer the effects.

By Eddie Koch

NEWLY PUBLISHED

Primary Clinical Care

Book 12
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Progressive participatory research: stress factors in Manenberg

Most of the segregated black areas of South African cities are overcrowded and underserviced. Life under these conditions must have an impact on the mental well being of such communities. The Manenberg Research Group, together with the community of Manenberg, undertook a survey to identify the major stresses experienced by this urban community in order to work out appropriate ways to deal with them. In this article, they draw on the research project to address the question of what makes research progressive and participatory in practice.

Manenberg - the community has worked together to establish a People's Centre with facilities to address stress in a progressive way.

Manenberg, 20 kilometres from Cape Town, houses about 60 000 of those whom the state has classified "coloured". The highly politicised Manenberg community is amongst the poorest in the Western Cape. In late 1986, churches and community organisations took up the challenge of dealing with the consequences of the wave of political repression experienced between 1984 and 1986. Together they launched a project to build a Manenberg People's Centre where those striving to empower the community could be united under one roof. The inclusion of a facility to address the psychological impact of stressors (factors causing stress) in the community was suggested. After consultation with progressive psychologists, it emerged that psychology offered few interventions that are appropriate for South African working class communities. It was from this realisation that the Manenberg Research Project was born.

Documentation and empowerment

The central aims of the Manenberg Research Project were:
- to document the material conditions that make it difficult to survive in Manenberg. This, it was hoped, would highlight the rights for which this community is striving;
- to understand people's perceptions of the problems and stressors they experience living in Manenberg, their resources and their ways of coping;
- to develop appropriate strategies within the Centre to empower the community to deal with the stressors.

Life stressors and coping strategies: central themes

Some of the central findings from the research project's community survey are highlighted below. The focus is on those life stressors about which residents expressed the greatest concern, and the most typical ways in which they sought to deal with them.

The consequences of poverty

Poverty combined with unemployment and the high cost of rent and electricity, constituted the major stressors for the community. 29% of potential wage earners were unemployed and even among those who were employed, 46% of the average-sized households, consisting of six to seven people, lived on incomes below the 1985 poverty datum line of R345.00 per month. 10% of households were totally dependent on small state pensions and grants, and only 13% earned over R801.00 per month. The generally low level of formal education decreases the chances of residents being employed in positions that pay a living wage. On average, 17% of the people had only primary school

education and 9% were illiterate. Only 2% had received education at the tertiary level.

Just over half the residents (52%) dealt with the consequences of poverty by appealing to government authorities for assistance, ie. the Rent Office, the City Council and the Department of Coloured Affairs.

The "deprived" environment

The second major stressor noted by 88% of those interviewed was termed "the dangerous environment". This included high levels of gangsterism, crime and violence, which made residents fear for their personal safety. The illegal sale and abuse of alcohol and drugs was named by 68% of those interviewed as the third stressor of major concern to the community. This was followed by the problem of grossly inadequate community facilities and the deprived physical environment such as poor roads and street lighting and the lack of medical and child care facilities.

78% of residents interviewed said that they did not have a way of dealing with these stressors and only 11% said that they turned to the police for assistance with crime. 46% of residents coped with substance abuse by speaking to a minister, a doctor, a social worker, a school principal or a trusted family member.

Interpersonal conflict

In addition to the community stressors mentioned above, 33% of residents felt that the most serious problem facing their families was conflict within the family and between marital partners. Overcrowding is one of the negative consequences of the housing shortage in Manenberg and it worsens conflict within families. On average, two to three people occupy each room (including those not designed for sleeping purposes) in each dwelling. 16% of residents said that the housing shortage was a severe stressor.

44% of residents turned to a minister, a doctor, a social worker, a school principal or a trusted family member for help with family conflicts. 93% approached government authorities for assistance with overcrowding.

Once the survey responses had been analysed, a workshop was held with community organisations to evaluate the research process and its findings. It was felt that the only major problems that had not been revealed in the survey were those of incest, child abuse and spouse battery.

The central lesson of the research project

For progressives in the social sciences, perhaps the most crucial lesson to be learned from the research project is that South African working class communities perceive

social science research to be both exploitative and irrelevant. Their experience of researchers in general, seems to have been that of privileged academics intruding on economically deprived communities, invading the privacy of residents to collect information that is neither useful nor meaningful to those being studied. More often than not researchers benefit, not those whose participation makes the findings possible.

Most of the community organisations working on the Manenberg People's Centre were not completely convinced of the need for the research project. After lengthy discussion, a mandate was given to do the research, but only in the last 9 months of this 30 month research project, was there unified acceptance of the value of this kind of work.

What makes research progressive and participatory?

Accountability

Accountability to those being researched and to the broader democratic movement is generally accepted as being the essential element that distinguishes progressive from traditional research. Clear structures must be set up to ensure accountability operates in practice.

The very first task of the research group was to define the ways in which each group involved in the Manenberg People's Centre project was to be accountable to one another. The research group was directly accountable to the body representing the community organisations coordinating the development of the centre. This involved progress report backs at all meetings of this body and consultation before making major decisions regarding the research.

The research group was to be accountable to the broader community by actively involving the community in all stages of the research, by seeking to resolve conflicts and queries through workshop discussions and by sharing the findings in ways that were useful and meaningful to the community.

Relevancy

Although the initiative for this project came from some members of the community itself, the usefulness of the research was debated throughout the project. This critique proved to be an essential test of the relevance of the research and a process through which people could work through their misgivings about social science research. Regular workshops were held to facilitate this dialogue.

It was only whilst interviewing residents that members of community organisations realised the worth of the research. They came to understand that even progressive organisations could be out of touch with the very people they aimed to represent.

Interviewers reported that in listening to people's responses they really came to understand the extent and severity of the stressors affecting those living in Manenberg. The Civic Association found the results to be of particular importance, reporting that such findings are not easily dismissed by the broader society and are therefore a credible means of bringing the plight of the oppressed to the attention of the public and particularly, the authorities. Organisations are now planning their own research for a variety of purposes.

A workshop was held to evaluate the project and the overall feeling was that it had shown the value of this type of social science research.

Participation, active sharing and non-exploitation

Residents were involved in all phases of the research, from problem definition and planning, to interviewing and evaluation of the findings. Research skills were redistributed to the community through the training of those who participated in the research process. Volunteers were trained in survey methodology and interviewing skills. Many have reported that the research skills they developed have been valuable in organisational work. (Those who completed the training and did survey interviewing were presented with certificates and their details were given to sympathetic university departments as potential employees.)

The severe shortage of adequate accomodation in Manenberg affects both the physical and psychological health of the community.

The findings were made accessible to the community through workshops in which written reports were presented and discussed thoroughly. The main findings of the door-to-door survey were written up as a pamphlet and distributed throughout Manenberg.

Furthermore, skills and experience were not shared in a top down manner from researchers to the community. Those residents who participated in the research continually evaluated the research methodology, as well as the findings. It was their active criticism that enabled the research group to avoid the pitfalls of traditional social science research. This break from a fixed research design required in traditional social science, to a dynamic method informed by practice and feedback, was one of the greatest strengths of the project.

The multiple cycles of planning, research action, feedback and clarification among those involved, showed the understanding of the residents to be just as legitimate a form of knowledge as that provided by social science. This strategy served to draw in and to sustain the participation of residents, thus increasing the relevancy of the findings for the community at large.

A decision was taken to prevent any research group member from gaining financially from the research project and it was agreed that no member could use the research to achieve an academic qualification. The research group had to be consulted and a mandate obtained before any information related to the project could be published and, where possible, papers would be written and published as a collective.

The strategies outlined above allowed the emergence and testing of a model for progressive participatory research.

Concluding comment

There is power in knowledge. Just as social science research has been used to enhance the power of the privileged, it has the potential to empower the oppressed. Thus, in striving toward national liberation in South Africa, it is important that social science be treated as a sphere in need of democratisation.

The Manenberg Research Project has demonstrated the tremendous potential of research that is conducted according to the principles of accountability, relevancy and the active sharing of skills and experience.

The next phase of the research project has just begun. The Western Cape Branch of the Organisation for Appropriate Social Services in South Africa (OASSSA) has taken responsibility for developing the Community Counselling and Training Centre (CCATC) at the Manenberg People's Centre. The function of this facility is to empower Manenberg residents to deal with the psychological consequences of life stressors. An OASSSA working group has been set up to formulate the structure and guidelines for the functioning of a co-ordinating body and a working committee for CCATC.

Social science research should be relevant and accountable to the community involved. It should empower the community rather than the researchers.

One of the functions of the co-ordinating committee will be to use the research findings to develop appropriate community interventions. At present the working group is focussing on defining the relationship between CCATC and university departments interested in service provision that is both democratic and community-based.

It is hoped that in sharing our experiences of the Manenberg Research Project, others will use and improve on this model of progressive participatory research and that this will lead to the democratisation of social science research. We have learned that the most valuable understanding of a community is reached through active and ongoing participation in that community, not in the minds of social scientists who interpret the world from the ivory towers of academia.

By Desiree Hansson, Ronelle Carolissen and Rachel Prinsloo of the CCATC working group of OASSSA

Desiree Hansson and Ronelle Carolissen are also members of the Manenberg Research Group. We would like to thank Heather Petersen, Kevin Naiker and Tish Sterling of the Manenberg Research Group for their valuable contribution.

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