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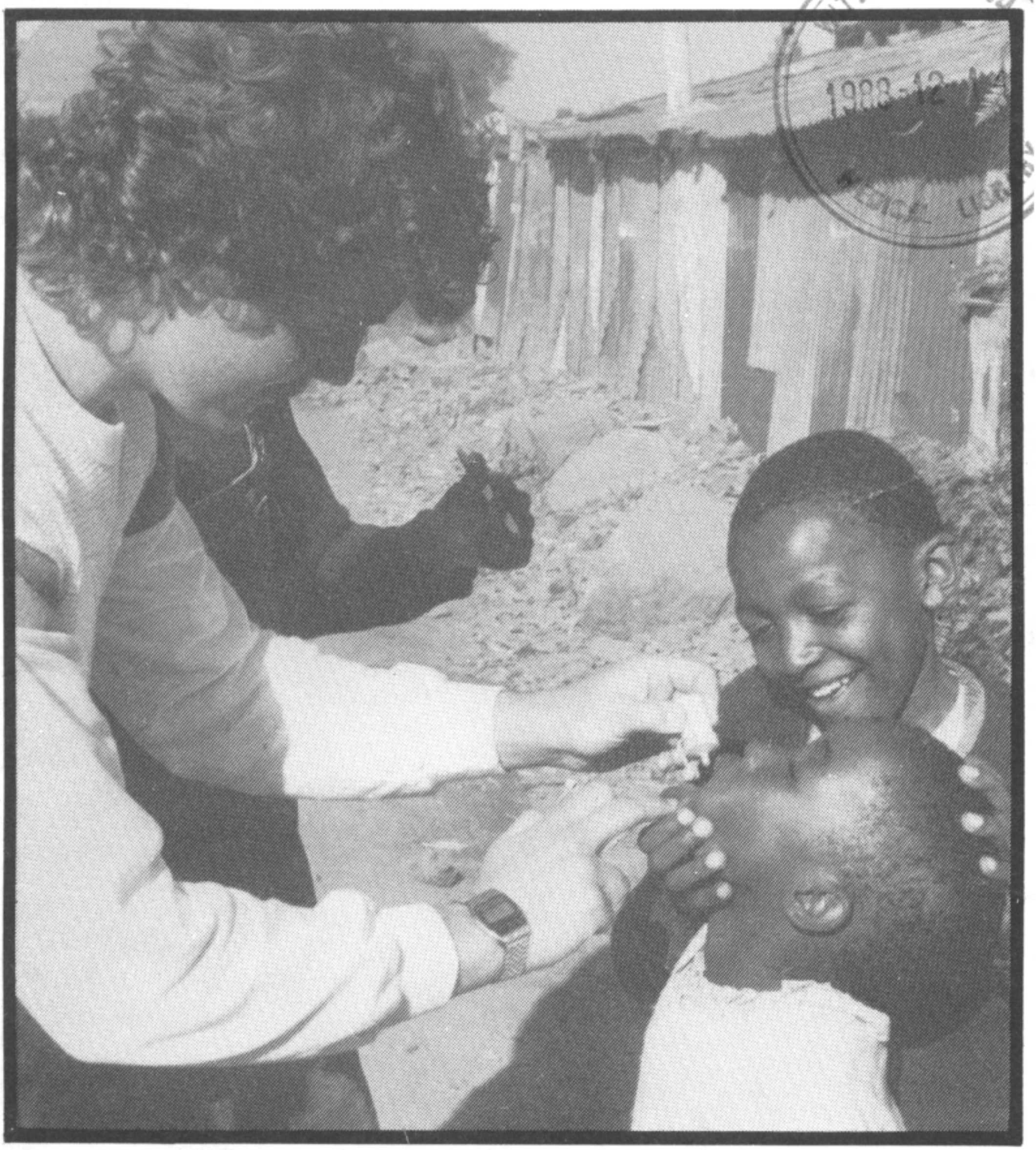


Community health projects

EDITORIAL

South Africa's various influx control measures have contributed towards shifting the responsibility for social services onto areas and bodies outside the central state. Furthermore,the rural areas, including those under "homeland" governments, are not equipped to meet the social service needs of their inhabitants - residents, commuters and migrants.

Inequalities in the allocation of resources, fragmentation into "ethnically"-based structures, and a lack of co-ordination and co-operation especially within the health services, render most health services in rural areas grossly inadequate. Most are badly planned and executed, do not provide sufficient preventive and promotive services, are ill-equipped, and often do not enjoy credibility amongst the people whom they are designed to serve.

Under such conditions, various privately organised health services have been initiated in a number of areas, some responding to an urgently expressed need of the local population, others with the aim of developing examples of an alternative health care system, and some combining both these aspects.

Examples of such privately (but often communally) organised health services are given in the first section of this issue. These examples highlight the different approaches, problems and achievements of alternative health projects.

The Bochum women's care groups provide a supreme example of community participation, where health care is placed in the hands of those who bear most of the responsibility for caring in the community.

To a lesser extent, active community participation is also evident from the Manzimahle project at Cala, Transkei, although in this case there are more "expert" advisors involved, allowing for a greater stratification of health workers.

The Muldersdrift Clinic gives insight into the problems of organising an extremely scattered, unorganised and isolated group of people. It also provides an example of medical student involvement in community health. The report by the students further reflects the step-by-step, trial-and-error path of setting up democratic structures in health care, where no such structures previously existed.

The article on Gelukspan Hospital gives an interesting breakdown of disease and death figures according to areas with different histories and conditions. It also draws attention to the

extensive primary (preventive) health care services needed in a growing population where children and young people form the majority.

To some extent, the same is true of the Health Workers' Association's involvement in the health service run at the squatter camp of Chicken Farm in Nancefield, Soweto. The HWA started off with a service for under-five children who, in terms of ill health, bear the brunt of poor living conditions. The article on this health service focuses on the relationship between oppression, poverty and disease.

The article on the Driefontein Clinic highlights the role which the struggle for an appropriate health service played in the Driefontein residents' resistance to threatened forced removal. Whereas in most other examples mentioned, state health showed little or no interest in the alternatively organised health projects, state health has expressed a keen interest in taking over aspects of the Driefontein Clinic. One could possibly conclude that, in the case of Driefontein, the state is eager to remedy its bruised credibility.

Both the articles on KwaNdebele and on rural repression are reports of workshops held to impart skills to people serving their communities. The skills passed on in this way include first aid, counselling, legal advice, and writing articles for the press.

Farm labourers in South Africa form one of the most exploited, isolated, unorganised and legally powerless groups of workers. Correspondingly, health services for these workers are virtually non-existent, being inaccessible and too expensive. The article on farm labour focuses on their working and living conditions, legal rights and existing health services.

Migrant workers who are also hostel dwellers, are similarly divided and isolated, but many of them are organised into trade unions, and, since last year, also in hostel dwellers' associations (such as the Western Cape Hostel Dwellers' Association). Being organised, they are able to lend more strength to their demands for better living conditions. Their organisation has also provided the basis for improved social relationships - both within the hostels, and with residents of the surrounding township.

This issue serves to document the efforts of different communities to meet their health needs. In some cases this involves setting up health projects, often with assistance from outside organisations. We hope that this issue will help document the problems and possibilities of such work.

HEALTH SERVICES PROVIDED BY VOLUNTARY ORGANISATIONS

Bochum women take charge of health problems

Should they do the state's work?

In South Africa, state-run health services for the black community are of a poor standard. In rural and peri-urban areas, the services are especially bad. Communities have sometimes responded to the lack of services by attempting to set up their own health services in order to provide some form of community facilities. Is this response feasible, appropriate, or desirable?

In most societies, basic health services are provided by the state. Along with the provision of education and housing services, they represent the degree of commitment by a society to providing social wefare services.

If resources are available, the lack of provision of health and welfare services reflects a decision by those with political power to rather spend public money on other things, such as the police, army or the bureaucracies necessary to maintian separate services, such as in South Africa at present.

How have different organisations responded to the lack of services provided?

Voluntary organisations and resource groups have responded to the health needs of communities in many different ways. Some of these approaches are discussed in this issue of CRITICAL HEALTH.

In some cases organisations have funded services privately, but have not instituted any major changes in how the service functions or how it relates to the community.

Many of the liberal, charitable organisations have had this approach. They see their function as helping relieve acute needs by providing services, but do not attempt to change those features of the society which maintian ill-health and the poor distribution of resources.

In other cases, organisations have worked with the community in trying to develop appropriate local health services which meet the needs and desires of the community and are controlled by them. This approach has been tried, for example, at Driefontein, and is discussed in this issue.

What are the common problems?

Whatever approaches are tried, many initiatives still hit up against the same problems. One of the major problems is providing more than just immediate curative services.

This problem usually arises because of the pressure of work. The lack of services often means that when services are provided they are swamped with patients and are understaffed and overworked. Patients want to be treated and so there is no time to institute preventive programmes.

This may be aggravated by inexperience in providing health services on the part of both communities and health workers. It may also be due to lack of commitment to establishing a more progressive type of service, by those providing it.

Often, attempts are made to involve the community by electing a health committee. It is hoped that the presence of such a committee will help ensure community participation.

A common problem is the difficulty of establishing these committees, and furthermore, ensuring that they are democratic. These structures often become dominated by prominent people in a community, or by a particular interest group, but they rarely represent the majority of the people that need the service. The articles about Cala and Muldersdrift raise issues in relation to committee stuctures.

Furthermore, activities in a number of areas over the last few years have shown that democratic health structures are unlikely to be established if there is not a strong, democratic and progressive organisation in existence in the community concerned.

Such organisations are able to give direction to health groups and insure their accountability to the broader community. Without the involvement of other progressive community structures, the activity and direction of health and similar committees will often largely be determined by the specific interests of the committee members, and not the interests of the community at large.

Finally, there are problems which result from the "temporary" nature of health services provided by voluntary groups. Voluntary organisations are unlikely to have access to unlimited amounts of funds. They recognise that the state should fund such services in the long run.

One role of the voluntary organisations and community structures should be, therefore, to define the nature of the services required and how they should relate to and be controlled by the community. Together, they may be able to pressurise the state to provide the services in the manner already defined by the progressive health and community organisations.

There is very little experience of taking on these struggles, and both community and resource/voluntary organisations have demonstrated the difficulties of tackling them. Yet experience must be gained and victories won.

The Health Workers' Association has provided a clinic service to Chicken Farm squatters since 1983

Suggested guidelines for discussion

There are no easy solutions to the problems which have been isolated above. Some guidelines are presented below; they serve merely to raise issues for discussion, and hopefully to stimulate debate amongst those actively involved in providing such services and those within progressive community organisations.

Health workers in services provided by voluntary organisations, must purposely attempt to draw attention to the relation between ill-health and the structure of society, through the educational and training components of the service.

Without this, the service will play no part in making people aware of the need for changes in society and its structure, in order to promote health.

Voluntary organisations and the health services provided by them should set up working relationships with existing progressive organisations in the community. This is currently being attempted for example, in Alexandra.

The voluntary organisations and resource groups cannot provide an appropriate service in isolation. They need direction and guidance from progressive organisations. Many health issues require political solutions and the progressive organisations need to be involved in determining the appropriate strategies for overcoming the particular problems in a community.

Furthermore, those structures set up and operating in the community should assist in strengthening democratic organisations. They should provide people with experience in making decisions and controlling the things that affect their lives. Health committees can play some part in providing this training ground.

Within the services provided, it will be necessary for democratic working structures to be established. At the simplest level, this may be a commitment to ensuring that skills and responsibilities are shared, that decisions are taken collectively, and that structures continually ensure the participation by all.

The structures that are set up to facilitate community control must be shown to work effectively, with a commitment to ensuring the progressive development of the service.

The service can help to identify key issues which require further action in order to promote health, such as improved housing and water supply. The link between poor health and the lack of facilities can be used by progressive organisations to demand better facilities generally in a community.

Skills and information derived from health work can be used for other activities and can play a part in putting pressure on the state to provide the services required.

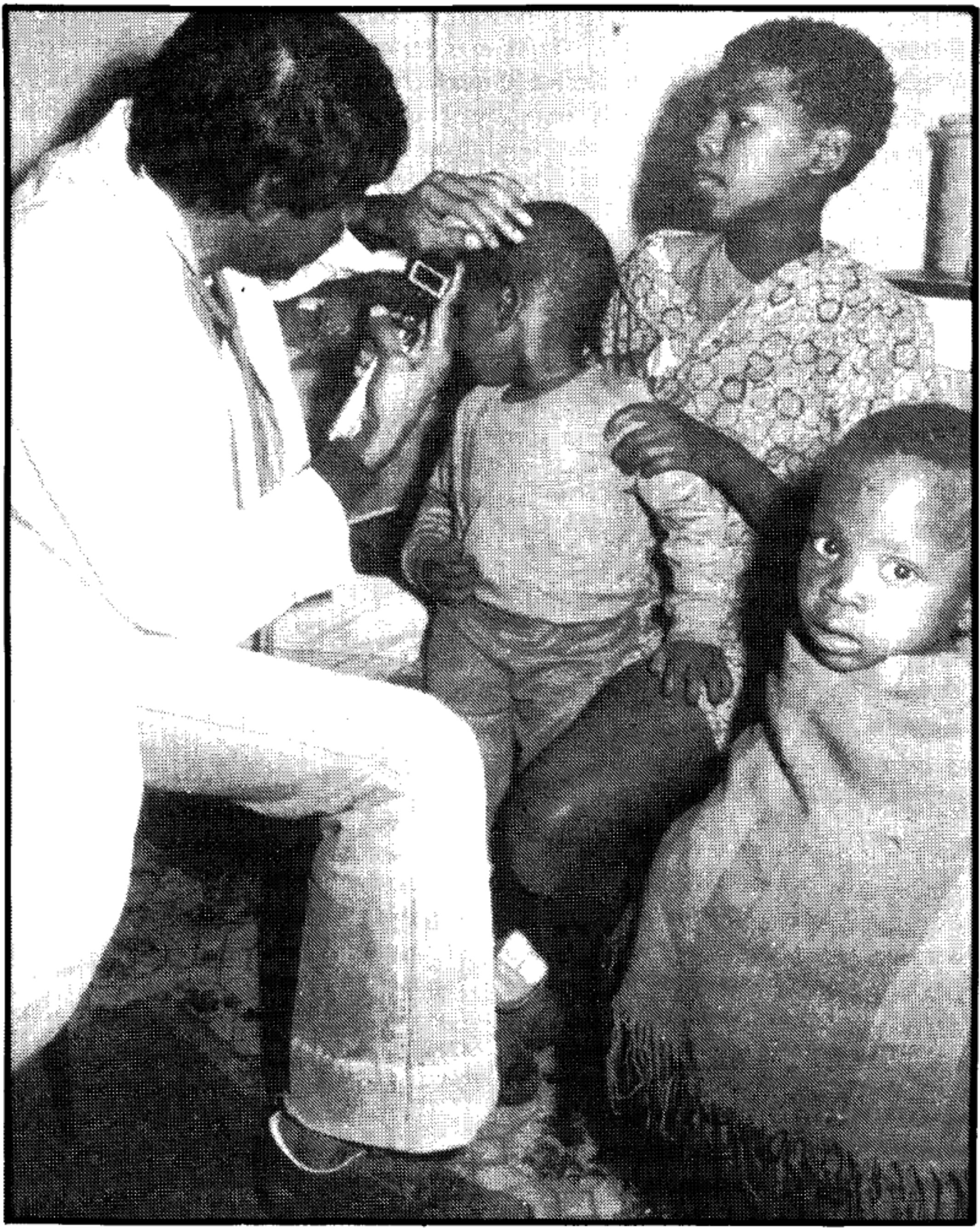
Progressive organisations should also ensure that when the state does provide services, these are still controlled by the community. The link between health organisations and political organisations is essential, especially if one begins to tackle the bigger problems (outside of the service itself) that affect health in the community.

Conclusion

This article has hopefully raised some issues for those involved with voluntary organisations to consider. It is not meant to be a complete list of problems, nor to prescribe solutions. It is presented partly in the hope that such issues will be considered when reading through other articles in this issue of CRITICAL HEALTH.

Its primary intention is, however, to stimulate debate about how those of us working in voluntary organisations and in democratic organisations can work together, and lay the foundation for an alternative service provided by the state in a society which values health for all as a basic right.

Anthony Zwi



Squatters of Chicken Farm receive medical relief from Baragwanath doctors

CRITICAL HEALTH is sure its readers would value learning more about the services in your community, and the structures set up to facilitate community control. Please write to us about your ideas and experiences.

COMMUNITY HEALTH WORK AT BOCHUM

Vegetable gardening is part of the health education

Bochum is a rural area of scattered villages and crowded resettlement areas in the northern Transvaal.

There are no health services nearby, apart from a "hospital" which is largely avoided because it lacks qualified doctors or proper equipment. Serious cases are therefore forced to make use of Pietersburg hospital. But people try to avoid even this hospital if they can, because of the alienating way in which they are treated by hospital staff. On various occasions, people claim hospital staff have accused patients of being "dirty", and therefore having brought about their illness themselves.

Because of the great distance involved and the lack of transport, (villagers have to walk 20 km to Pietersburg), relatives are often unable to visit patients.

A few years ago, the Environmental Development Agency (EDA) became involved in primary health care work in the area.

Here, an EDA field worker, who is also a trained nurse, talks about her experiences.

Deciding to run courses

EDA got involved in Bochum through a concerned social worker and a health programme was started.

Meetings were held with women's groups to discuss problems experienced in their everyday lives. It was felt that there was a need for health courses and workshops on a number of these problems.

Planning a course

This is an example of how we run a course:

After discussions on health problems that people experience, we choose a disease on which to focus, eg the Mamolele women wanted to start with diarrhoea and vomiting.

I then go back to our office and spend a week planning a course. I use relevant information and material from our resource centre and read and produce my own notes.

At the end of the week, I go back to Bochum, and this is how the course runs, provided there are no obstacles:

Day one

It is important to always approach the matter in a sensitive way, drawing on the women's knowledge, experiences and ideas about the subject. For example, diarrhoea and vomiting is often thought to be caused by witchcraft or small creatures that enter the rectum.

On this day, we talk about how the women see and understand the causes and symptoms, and discuss their traditional remedies. Although many of these remedies are harmless, some are bad.

Day two

I explain the causes, signs and symptoms of the illness using my notes and referring to a text book if need be. I also do demonstrations together with the women, eg: what happens in the body when there is diarrhoea, and how dehydration comes about. Sometimes we use models, such as of the eye and ear.

Day three

The women revise the previous day's discussion and some produce their own step-by-step notes. Most of the women cannot read or write but they participate in discussions and demonstrations.

Because the causes of the disease are now familiar, we use that information to discuss how we can prevent it. The women take down notes on preventive measures.

Day four

The women choose "helpers" - women who will be responsible for treating sick people. In cases where medicines are required, they will be responsible for handling them.
Further discussions are held on what we did during the past few days.

The women also devise and act out dramas on how to identify and treat the disease. A song is composed about the course. Sometimes it is a variation on one of the village songs.

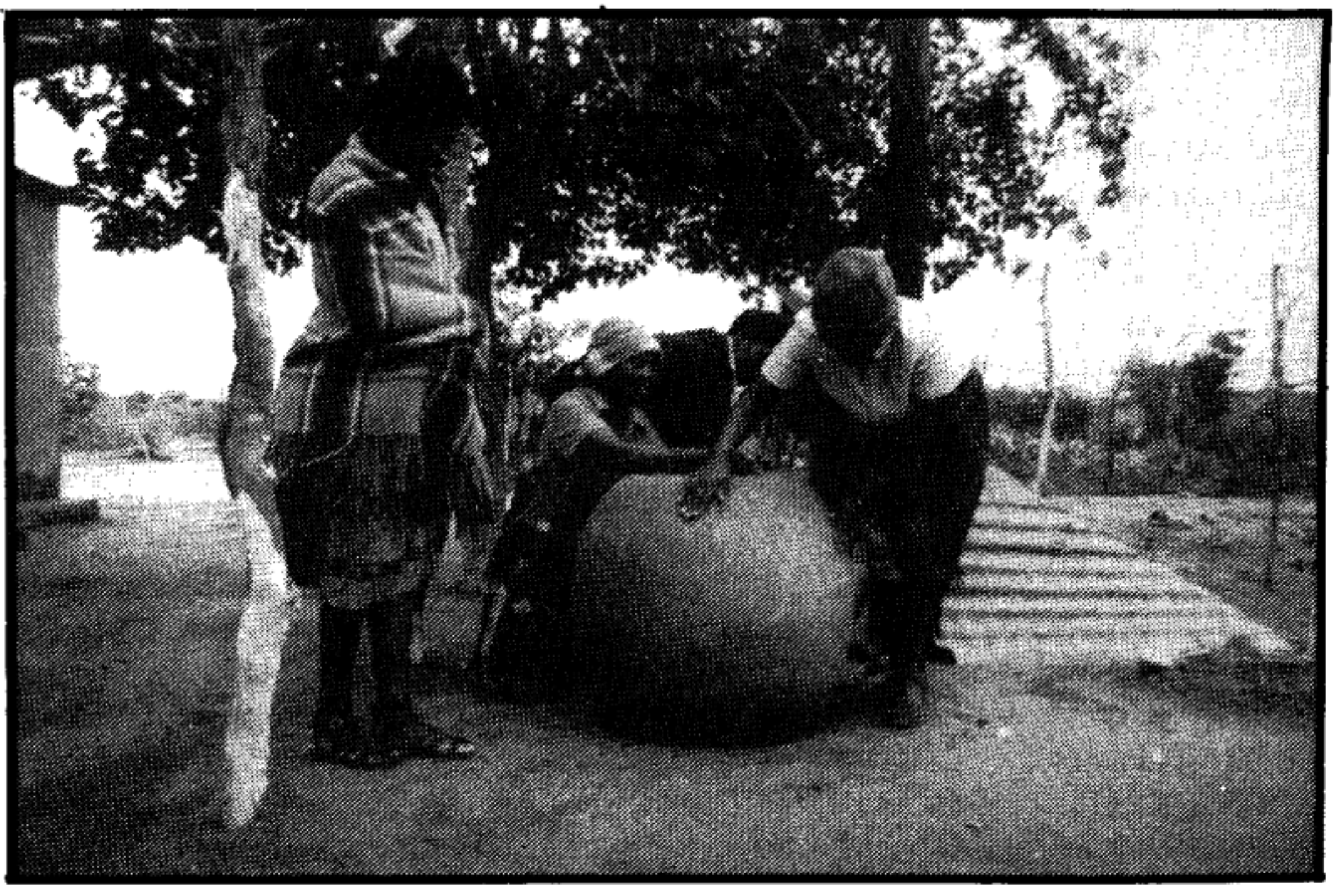
Day Five

The dramas and song continue until I leave in the afternoon.

On my next visit I do follow-up work on the course, not only within the women's groups but among the other villagers. Most villagers feel that they benefit a lot from these health programmes.

Besides health courses, we sometimes hold discussions on nutrition in relation to health, and I give suggestions for nutritious dishes. I encourage the women to do homestead gardening and to grow their own vegetables.

We have also discussed breast-feeding and other problems concerning women's health. We hope to continue these discussions in the future and look at issues such as abortion and lower abdominal pains, in detail.



Bochum women make a water storage vessel

MANZIMAHLE VILLAGE HEALTH WORKER PROJECT - CALA DISTRICT TRANSKEI

The Health Care Trust, a Cape Town based group of health workers, talks about its project in the Cala district of Transkei.

Introduction

Village Health Worker (VHW) projects became popular mainly through the success of the Chinese "barefoot doctor" schemes. We must, however, remind ourselves that in a country such as China, the training of barefoot doctors to work in their rural village, was part of a total restructuring of society and not merely the health care system.

This is obviously not the case in South Africa. Therefore when setting up such schemes, we should bear the following in mind:

- VHWs should not be used to patch up a government's inadequate services
- VHWs should not be seen as a second best substitute for doctors. They should be part of a health team whose work is equally important and often more difficult and varied than the conventional doctor's, as is preventive work in the broadest sense.

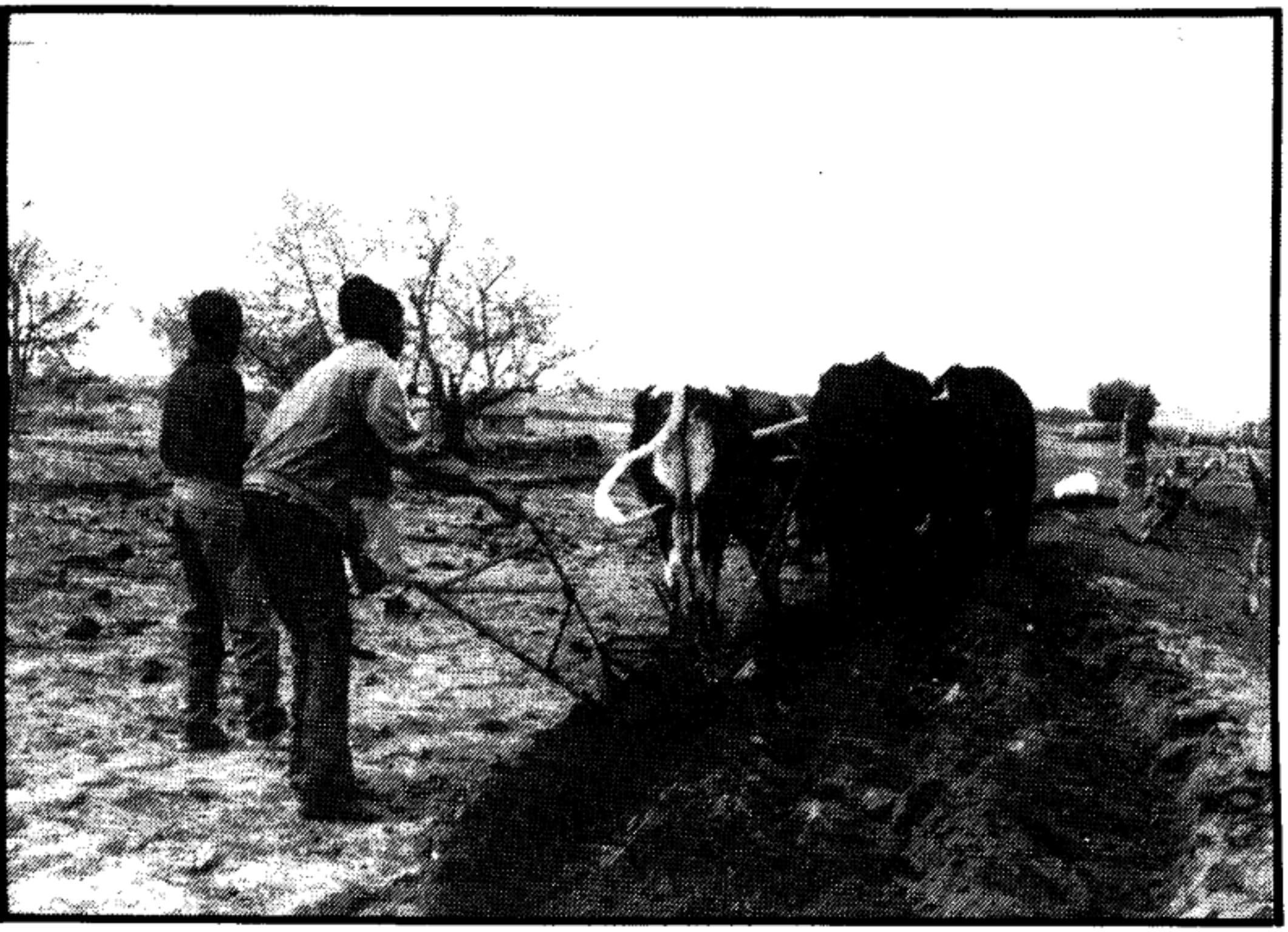
In our country VHW projects operate where few, or no health care services are provided. In these areas, there is little, if any possibility of meeting the basic needs of people such as water supplies, sanitation, housing, food or adequate land to cultivate, education in the form of schooling and literacy or work opportunities.

In other words, VHS projects work mainly within the limitations of South Africa's "bantustan" system.

It is well known that the health of people is far more determined by politics and power groups, by distribution of land and wealth, than it is by the knowledge and treatment of disease. Health workers and health projects that hope to provide for healthy lives must be committed to bringing about a healthier distribution of wealth and power.

When the Health Care Trust (HCT) started this project, people involved never believed that it could change the health care situation in South Africa or contribute towards political change.

Its main aim was to try to work towards alternative approaches in the broad field of health. Through involvement in projects, HCT wanted to test whether and how these approaches would work in practice. With this in mind, we will look at the problems our project has encountered in the six years of its existence.



There is little, if any possibility of meeting people's basic needs

Why did the project start?

After a conference at the University of Cape Town on the "Economics of Health Care in South Africa", which focused on health conditions in the rural areas, health professionals felt that something more practical should be done about the situation.

Therefore the idea of training health auxiliaries in the form of VHWs was considered. HCT was set up by SAMST to employ a doctor to choose a village in a rural area where a pilot VWH project could be started.

The idea was to set up similar projects in other areas if this prior project was successful. At the time there were other health projects in existence e.g. the Valley Trust, Elim Care Groups and some VHW projects in Ciskei and Kwazulu.

Most of these projects, except for the Valley Trust, were extensions of government run health services. The policy of the HCT was to remain independent of the state health service's control and give " ... a new direction in medical care". We will see whether this was accomplished.

How did the project operate?

A village called Manzimahle in the Cala district of Transkei was chosen for the pilot project. Manzimahle is about 20 km from Cala, and has about 3 000 inhabitants. It has a clinic built by the community and run by the Transkei Health Department. There is one primary school.

Permission was granted by the Health Department of Transkei for HCT to work in the area. The Medical Superintendent and matrons of Cala Hospital had shown interest in supporting the project. The headman of Manzimahle gave his permission and the community agreed to the project.

Fourteen VHWs were elected at a community meeting. At first glance this looks like a democratic process; but it turned out that most were of a "higher class" and "respected" in the community or were relatives or friends of the headman and sub- headmen.

A co-ordinating committee consisting of the hospital hierarchy, representatives from the VHWs, the clinic sisters and the VHW trainers was set up. The role of this committee was:

- to give support to the trainers in the form of lesson preparation and reading and discussion in relation to the project
- to help with evaluation for the project and of the VHWs
- to plan future projects and strategies together with the trainers and VHWs

VHW projects operate where few, or no health care services are provided

Training of VHWs

The work of the VHWs was to be mainly preventive. The Transkei Department of Health tried to enforce this by laying down, in a written document, limitations on what curative skills the VHWs could carry out and what they could stock in their First Aid boxes.

The training was carried out by the doctor and the staff nurse employed by HCT. The VHWs were divided into three groups geographically, because Manzimahle is a very scattered village.

Weekly lessons were given to each group on common diseases in the area e.g. malnutrition, diarrhoea, TB, ringworm, scabies, headaches, upper respiratory tract infections, strokes, heart attacks, infectious diseases of childhood, tetanus, meningitis, fractures, poisoning, fits and also on immunisation and the road to health chart.

The VHWs have created their own songs on various diseases for teaching and learning purposes. Each VHW has a file of handouts and notes on lessons.

Apart from the lessons, the VHWs do home visits where they give advice about personal hygiene and prevention of disease. They treat some of the minor ailments and refer others to the clinic or hospital.

The VHWs played an important part in organising and encouraging the building of pit latrines and vegetable gardens. A rotating fencing loan system was started with financial aid from HCT. A spring protection project is still in progress.

Up until this point, on the surface, the project seemed to be going very well.

The Transkei Department of Health was happy that an agency was helping to improve its inadequate health services. The hospital administrative staff were being given credit for this.

The headman and sub-headmen were satisfied that their village was being improved and the VHWs were genuinely enjoying their newly acquired knowledge and status. None of the existing power structures were being threatened. In fact their status and credibility were being enhanced.

Problems started to surface after both the Medical Superintendent and the HCT doctor left the project at about the same time. The two staff nurses who had worked with the HCT doctor left soon afterwards and a new staff nurse was employed to run the project. HCT had by this stage appointed an independent outsider to evaluate the project.

The evaluation

The main problems that emerged were the following:

- There was a great deal of tension between the VHWs and the clinic staff. This was largely due to the common attitude of "professionals" who did not accept and recognise the capabilities of "non-professionals".

- There was not enough support and training for the newly employed trainer from the hospital staff or from HCT.
- The co-ordinating committee was not functioning at all. After the Medical Superintendent and the doctor left, the matrons were overtly obstructive and hostile towards the staff nurse.
  This was probably because the matrons resented a staff nurse, trained by them, having relative autonomy over a project which was not directly under their control. Previously the project had been, in their eyes, under the control of a doctor and this was acceptable to them.
- The fining system of the headman especially when related to health issues e.g. the building of toilets, could turn the VHWs into "rural police".
- The HCT policy was regarded by most people i.e. hospital staff villagers and the trainer, as being vague with no clear direction.
- The project was largely isolated from other community projects and progressive organisations.

Some of these problems remain unsolved e.g. the attitude of the matrons and the establishment of an effective co-ordinating committee.

The autocratic rule of the headman and his Tribal Authorities Board remains unchallenged. The "board" had exploited the issue of building toilets for its own purposes and fined people R20 for not having toilets.

The trainer and the VHWs challenged this fining system. They argued that this defeated their purpose. People who are already impoverished would have even less money to buy material for building a toilet as well as less money for food, seeds, clothing, etc. Therefore they would end up less healthy than before.

Another useful tactic used by the trainer and VHWs was to include sub-headmen actively in the committees e.g. fencing and spring protection committees. We have noticed that since they have been actively involved in the project, they have become more amicable and are supportive rather than hostile towards the project.

The relationship between the clinic staff and VHWs improved after a number of discussions between the two groups had taken place in the presence of the evaluator and trainer. There is still a good working relationship between them.

The HCT policy was redrafted by Trustees and employees and explained and discussed in detail with the VHWs, the hospital staff and villagers at a community meeting. There seemed to be no problems or objections.

A co-ordinator was employed to draw up and carry out a relevant training course for the trainer and to give support in the form of working with her and helping with problem solving. Later a co-worker was employed as well.

The project is no longer totally isolated. Visits have been made to other projects and vice versa. There is also a network of community workers from various non-governmental organisations in Transkei which has been meeting on a regular basis for about two years.

The purpose is to share ideas, knowledge and skills and to discuss problems and possible solutions. Although this group is not without problems, it has served well to break the feeling of isolation.

Problems experienced since the evaluation

The hospital hierarchy blocked and prevented our first attempt to expand to another village and tried to put an end to the Manzimahle project. This however, was strongly opposed by the community as well as the VHWs and clinic sisters. As a result, the attempt failed.

This was a high point of the project as HCT did not itself intervene. It was entirely the decision of the villagers. The project at this stage seemed to be making some headway in getting greater community participation.

VHW's played an important part in encouraging and organising vegetable gardens

The murder of Batandwa Ndondo

Our most devastating setback was the murder of Batandwa, the new VHW co-ordinator, in September 1985. This came at a time when the project was gaining strength daily and was ready to expand again.

The project now continues on a day to day basis, but the strength that had been built, has suffered. The plans to expand have been thwarted for a while.

Probably because of the type of person Batandwa was, and because of the complete unexpectedness and the extreme brutality of his murder, we have been too shocked and slow to replace him. We have finally decided that the previous co-ordinator should return to bridge the gap until a new co-ordinator is employed.

The trainers and villagers are too fearful and suspicious to discuss the issue of his murder in depth. They have responded by continuing with the spring protection and their daily living. His death has also, obviously, had an effect at a broader political level.

Conclusion

This paper has attempted to show the difficulties of putting ideas for an alternative health system into practice, especially in an extremely repressive system. All went well until a section of the ruling class was threatened. The clearest example of this is the response and actions of the hospital hierarchy.

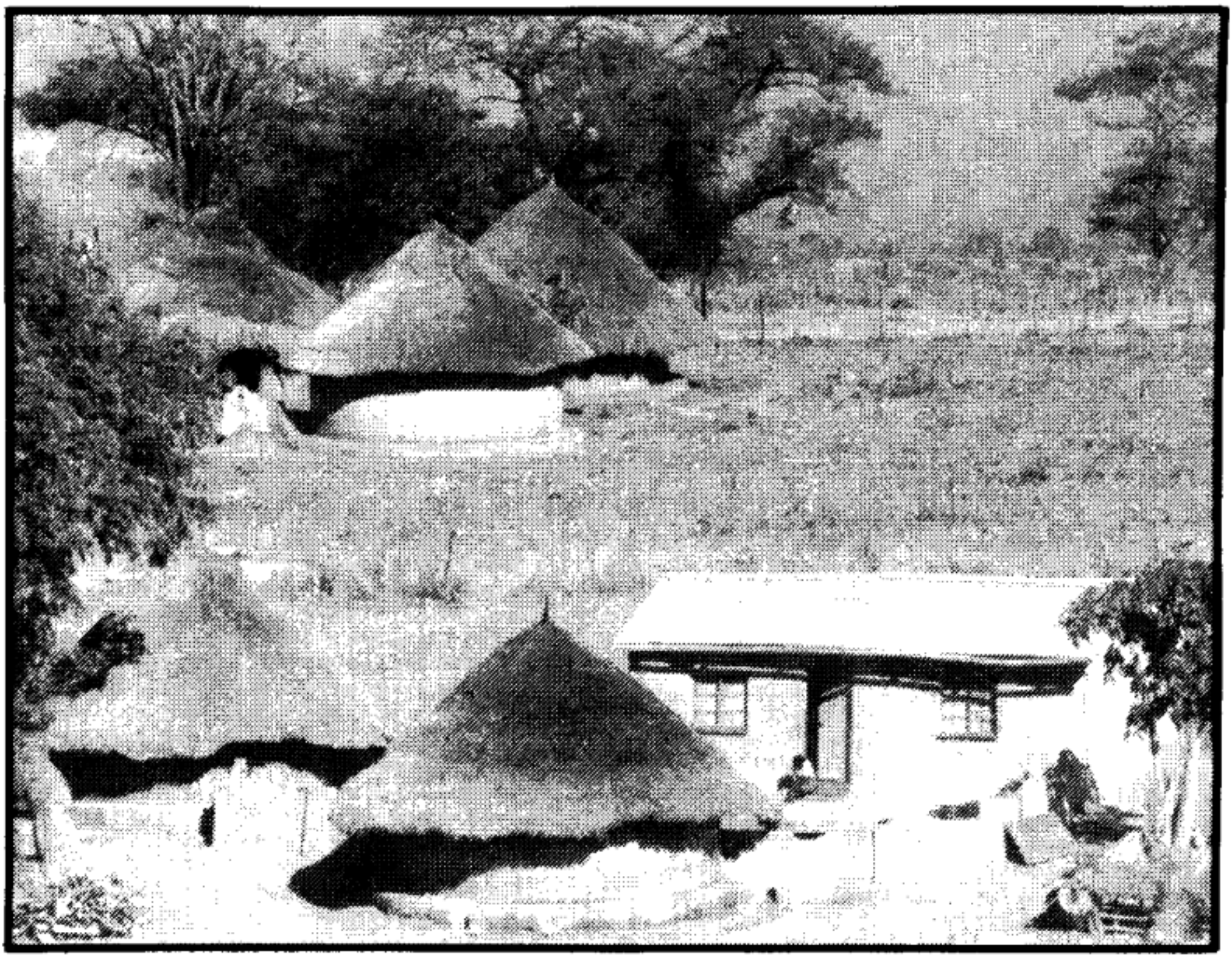
Although the project has experienced many problems, and although HCT was not too clear on its ideas in the beginning, ideas have developed and evolved as conditions in the country as a whole have developed.

Although many of us try to ignore the "independence" of the Transkei and other bantustans, over the years this has affected the way in which organisations relate to the bantustans.

Greater attention needs to be given to forging closer links with the rural areas. Rural health or "development" projects are one way of strengthening such links.

VHW projects that do not address the socio-economic problems, but extend health knowledge and skills into the community, are important and should exist.

They become a problem and a reactionary force when they use their skills and position to become yet another oppressive force within an already oppressive system. This can easily happen if aims and objectives are not clear in the first place and if we are not aware that this problem can develop.



Greater attention needs to be given to forging closer links with rural areas

THE DRIEFONTEIN COMMUNITY HEALTH CLINIC

The Driefontein residents' opposition to forced removals has a long history. The attempt to maintain and establish community facilities and services has formed a large part of this struggle. This article, by the Driefontein Health Advisory Committee, deals with the establishment of one such service, the Driefontein Clinic, and its role in the community before and after the reprieve.

Driefontein - area and history

Driefontein is the settlement area of a black community of some 10 000 - 15 000 persons. The settlement is situated in a rural and isolated area in the south-eastern Transvaal, approximately 350 km from Johannesburg. The town closest to Driefontein is Piet Retief which is about 50 km away from the area.

Driefontein came into being in 1912 when a farm was bought and divided into plots which were then sold to individual black farmers. Since the early 1960's this "black spot" has been under threat of removal by the South African government.

The community has strongly opposed the removal plans. Over the years it has had numerous meetings with the relevant authorities, outlining its opposition to the proposed removal. Driefontein gained international attention in 1983, when the chairperson of the Council Board of Directors of the community, Saul Mkhize, was shot by a policeman during a meeting to discuss the removal threat.

The reprieve

International and national pressure, together with a change in government attitude, led to a reprieve by the South African government at the end of 1985. This reprieve now allows the community to get on with its development and plan for its future. Over the years, the community has become democratically organized and committees have been established to represent the community on various issues including health.

Infrastructure and services - before the reprieve

Health care has long been perceived as a problem by the community. Until recently, no curative health services were available and only occasionally did immunization teams visit the area. Antenatal care and delivery services were non-existent, with mothers having to travel 50 km to Piet Retief for delivery or to

attend an antenatal clinic some kilometers outside Driefontein. There are no ambulance services, and badly maintained roads have made transportation difficult.

A major arena of the battle against removals has always centered on "development" issues, such as water, roads, health and schooling. In areas where the people are resisting removal, the government has always allowed essential services to degenerate, and in many cases it has stopped the services completely.

In Magopa for example, the buses to town were stopped, the water pumps were removed and the schools were smashed down. In Driefontein the government's actions were less destructive but they also had devastating effects. Old people could not get pensions and young people were not issued with reference books. The community's plans to extend their schools (with money which had been collected) were vetoed. The local commissioner refused to use thousands of rands which he held in trust for the community, to fix the appalling roads.

The roads could not be used in the wet season and people were unable to get out of Driefontein, even for medical emergencies.

Initiatives to build a clinic

Despite these difficulties, the community established a health committee in 1978 and started raising funds to build a clinic and a house for a primary health care sister. These were completed in the late 1970's. However, several attempts to obtain a sister through the State Health service failed.

It was therefore decided to raise funds through non-government organizations to provide a health service for the community. A Driefontein Health Advisory Committee was established in Johannesburg to help raise funds for the project and to act as an advisory body to the Driefontein Clinic Committee.

In September 1985, the clinic opened with a fully trained primary health care sister who had moved to Driefontein, and with the clinic being fully equipped. Doctors are at present voluntarily visiting the clinic every two weeks. At the beginning of 1986, a second nursing sister started working at the clinic.

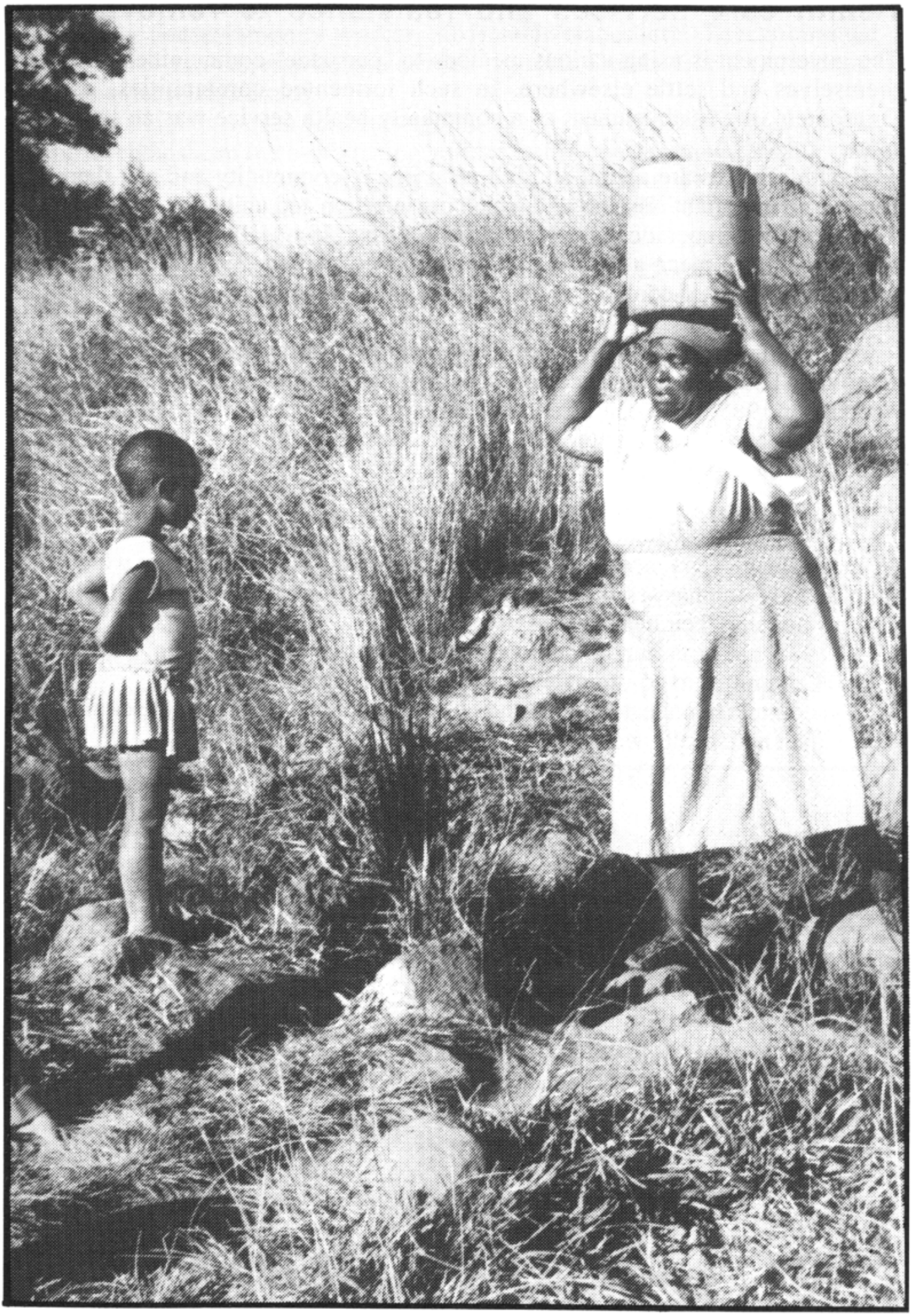
Although the clinic is still in its infancy, some 20 to 40 people are seen daily. With the arrival of the second sister, baby clinics, immunization, family planning and antenatal care are being developed. There are plans to train village health workers, and so develop and infrastructure in the community to promote health and strengthen community organisation and development.

The Driefontein Community Health Clinic has now been functioning for nearly a year.

So what is unusual about the health care project?

The Driefontein Health Care Project has a number of important features. These will be discussed under the following headings:

1) Health care services and resistance to removal
2) Community participation
3) Funding the health service with non-government funds
4) Problems relating to the geographical isolation of the Health Centre
5) The reponsibilities of the State Health Service and the DCHC



Collecting water from a spring at Driefontein

Health care services and resistance to removal

The government is using various methods to "persuade" communities to uproot themselves and settle elsewhere. In such tormented communities, as was Driefontein, the establishment of a community health service was an important issue.

Health services are a vital and felt need in any community and can therefore become an important issue around which organization and unity can be developed. This calls for democratic ways of working together. If a health service can finally be set up, it will mean a victory for the people concerned. Such an achievement would promote self-confidence and bolster the community's resolve to continue the stuggle.

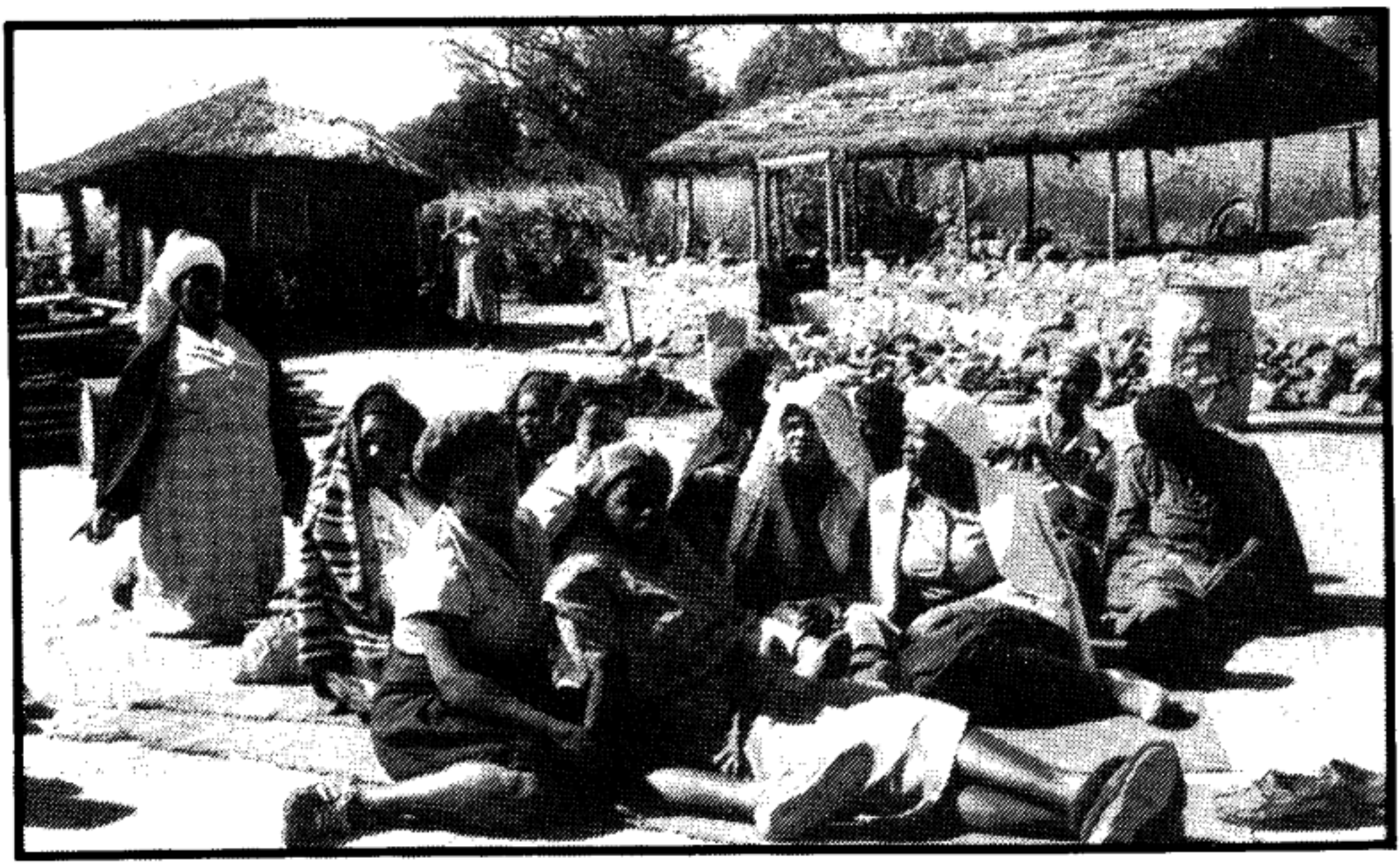
At Driefontein, there were many issues which contributed to the resistance to removal. The Health Service was but one, albeit an important one. On 21 September 1985, the Health Centre in Driefontein was officially opened. At the same time and occasion, thousands of community members and supporters celebrated the reprieve on the removal.

Community participation

Primary Health Care workers often refer to the Alma Ata Declaration which very significantly emphasises the concept of community participation in establishing and maintaining their health care service.

In 1978 the community democratically elected a Driefontein Community Clinic Committee to co-ordinate the struggle for a health service.

The committee collected funds and co-ordinated the building of the clinic and a house the clinic health worker.



Driefontein women discussing the new clinic

An advisory committee was later established, consisting of three doctors, a social worker and community worker, all from Johannesburg. This committee meets regularly and liaises with and advises the local Driefontein committee on health and other related issues.

Since the clinic has been functioning, the local committee has tended to lose some of its enthusiasm in co-ordinating various issues concerning the health care sevice. This could possibly be expected after a long hard struggle. However both the advisory committee and the primary health care nurse at the clinic made mistakes in their relationships with the community committee. The project concept is a new experience to most people involved in this sevice, and much is being learned and has been learned in the minefield of communications.

Funding the health service with non-government funds.

Various international sponsoring agencies have provided funding to equip the clinic, pay staff salaries and maintain the service.

Major organising costs are for primary health care drugs and salaries. The lack of any ambulance service also makes it necessary to find funding for a transportation service for critically ill patients. With continually rising inflation, the estimated yearly budget is in the region of R90 000.

This may seem a large amount; however it represents a per capita expenditure of approximately R6-00 for the primary health care service.

Even though R6-00 per capita expenditure is low, (KwaZulu R19-00, TPA R57-00) the possibility of raising R90 000 plus per year on a long term basis becomes problematic.

This problem raises the important question of establishing and maintaining services which should be the responsibility of the state.

Problems relating to the Health Centre's isolation

There are also some specific problems relating to the isolation of the clinic.

Surrounding hospitals (50 km) are not very sympathetic to referrals from the clinic sisters. Patients are occasionally turned away. The clinic never receives any feedback or communication on the treatment or progress of referred patients.

The absence of an ambulance service makes it extremely difficult to transport critically ill patients to the hospital.

The primary health care nurse who lives at the clinic is on constant 24-hour call to the community. It has proved very difficult to recruit adequately trained health workers to assist and to share the duties of the staff in the clinic.

Doctors from Johannesburg visit the clinic on a fortnightly basis. This means approximately 7-8 hours of travelling every time. It is almost impossible to enlist the co-operation of sympathetic and committed doctors from the local towns. These visits cannot provide an adequate back up and support system for the clinic staff.

The Responsibilities of the State Health Service and the Driefontein Community Health Centre

Clearly the long term future of the Driefontein community clinic is dependent on state health assistance. Most of the sponsors made it clear that the state should ultimately sponsor the Driefontein Health Sevice.

The track record of State Health Services to the Driefontein community is dismal. The long history of the removal issue and the negative actions of state authorities have led the community to distrust any state intervention by the community.

The State Health authorities have shown an unusual enthusiasm and interest in the clinic. They have supplied immunization; family planning drugs, devices etc and and medication for tuberculosis. They are assisting the clinic committee in building a better ventilated pit latrine. They have also expressed a keen interest to pay the nursing salaries, provide a range of primary health care drugs and even to build a new modern clinic with adequate obstetric facilities.

Indeed the State Health's response has been surprising and interesting.

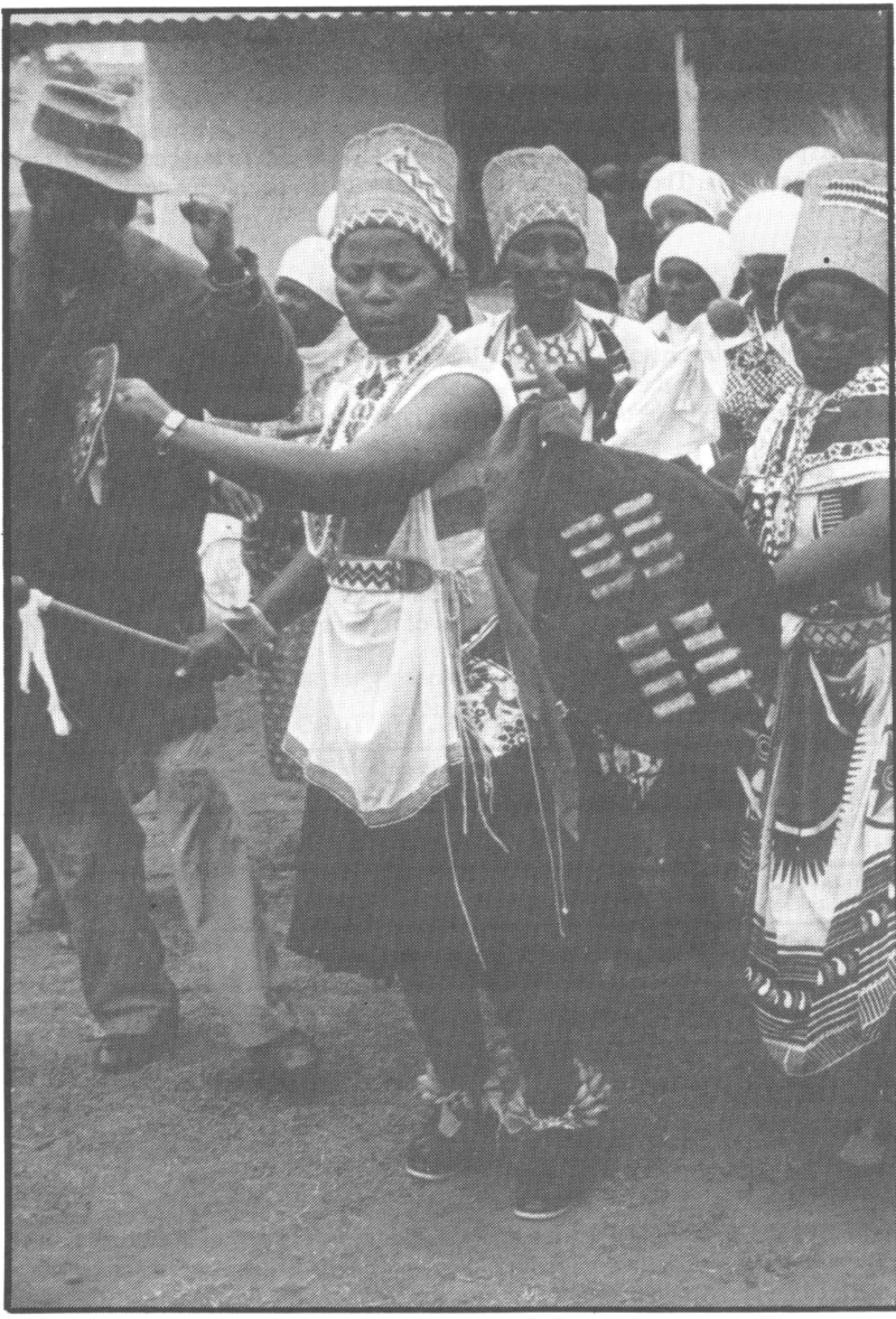
The Driefontein Community Clinic Committee has reservations concerning the response of State Health.

Ultimately the most important question concerning the involvement of State Health is the extent to which it will control the clinic and prevent the community from doing so.

Traditionally, in South Africa, health services in the black communities are extremely authoritarian and oppressive. Could the Driefontein model be any different?

There are no quick answers or solutions to these questions. The relationships with the state authorities will need careful consideration and negotiation.

In conclusion, the Driefontein Health Care Project experience is determined by the interrelation of community participation and involvement, NGO sponsorship and a changing political climate and State Health reponsibilities. The future is unclear, the potential exciting and challenging.



Driefontein women dancing to celebrate the new clinic

GELUKSPAN HOSPITAL

Gelukspan Hospital is situated in the Ditsobotla District in the central region of Bophuthatswana. The hospital serves two-thirds of the people living in that area.

Villages in the Ditsobotla District

The people of the Ditsobotla District live in three kinds of villages.

Firstly, there are the traditional villages of the old reserves. Some of them can be dated back to the last century. These villages are ruled according to traditional customs.

Secondly, there are villages which have been recently set up as resettlement areas as a result of the apartheid policy of the South African government.

Thirdly, there are trust areas which are resettlements which have been established over 50 years ago.

Of these three kinds of villages, the recent resettlements are worst off in terms of ill health. This can be shown by figures of infant and child death rates compiled in 1983:

VITAL STATISTICS FOR THE HEALTH WARD (1983)

	Trust areas	Resettlements	Traditional areas	Health ward
Infant mortality rate	43,1	65,0	34,4	41,1
Neonatal mortality rate	17,2	20,3	13,7	15,3
Child mortality rate 1 - 4 years	8,2	17,9	7,5	9,5
Under - 5 mortality	17,6	29,8	14,2	17,5
No. of persons per household	7,3	6,8	6,9	7,0

How people make a living

People in the Ditsobola District make a living by agriculture, cattle raising, migrant labour, and daily commuting to nearby South African urban areas. In the District itself, the major employers are the agricultural projects, and the civil service.

Agriculture

The main crops that people usually cultivate are maize, sunflowers, and sorghum. But agriculture in the area has been badly affected by the continuous drought since 1981. There are two major agricultural projects at Mooifontein and Setlagole, in which mostly maize and sunflowers are cultivated.

Livestock

Whereas under half of the households with under-five children own land, over three-quarters of the households possessed livestock such as cows, sheep, horses, goats, donkeys, pigs, turkeys, geese chickens. (1980 survey).

Employment

According to the 1980 census, only one-third of the people in the area, mostly men, are in some form of employment. Most of these are employed outside of Bophuthatswana as contract workers, or they commute every day to places of employment in South Africa.

Social problems

This is what makes the Ditsobotla people a society of women, children, and old people. The traditional extended family is more and more being replaced by nuclear families. Where these social relations are destroyed, problems of alcoholism, rape, abandonment of dependants, and marital problems surface.

Added to these problems are the problems of unemployment and poverty. These are especially serious, considering that the inequalities of apartheid do not provide any social welfare and social security benefits.

Health services in the past

The health services in the Gelukspan Health Ward date back to the 1940's. Before that, most of the health needs were met by self- care, traditional healers and the health services in the surrounding South African urban areas.

In the 1940's, the Catholic Church started a mission clinic in Kraaipan village and in the 1950's, a clinic was started in Mareetsane.

In 1951, a third clinic was started in Gelukspan; this clinic was extended into a hospital in 1960, and over the years, new wards and departments were added to the initial building. Until "independence" in 1977, the hospital remained a mission hospital run by the Dutch Reformed Church.

The hospital was greatly understaffed. It was mostly run by nurses with occasional support from general practitioners and doctors from hospitals in Mafeking or Itsoseng.

The health service now

With "independence" in 1977, the financial support became more predictable and staff needs were met more appropriately, but a shortage of trained nursing staff remained.

A community extension service was started with a mobile clinic in two villages (1977). In 1985, 13 villages were covered at least once a month by a mobile station. Seven villages were covered by fixed clinics, and all the villages are visited on a regular basis (most on a monthly basis) by a mobile under-five clinic.

In this clinic, health education, immunisations, and growth monitoring together with nutritional support is provided free-of- charge.

The health services also provide services by a TB case-finding team, a dental team, social welfare offices, environmental health services, school health services, eye team, community psychiatric services, and services for the handicapped in the community.

Health needs

A great number of the clinical problems relate to either maternal or child ill health. The same applies to the type of services offered by the community health services, where the major thrust of activities is directed at maternal and child health.

About half of the people coming to attend the services go to under-five child clinics, school health services and family planning services.

Most of the research that is done in the district is aimed at finding out the needs of mothers and children. Services try to meet these needs. Much of the health education is on appropriate home care of children (nutrition, oral rehydration); at the same time, people are encouraged to attend preventive and promotive services.

When children are admitted to the hospital, mothers are encouraged to be admitted with the child, not only when they are breast-feeding (as stipulated by the Department of Health) but also when the child has got diarrhoeal disease, malnutrition, a life-threatening condition or when the health worker thinks the mother could benefit from health education in the ward.

Health education

Health education is well structured and practised daily in hospital wards with lectures, demonstrations and songs. But there are no clear guidelines on what to teach, how to teach and when to teach. It is up to the individual clinic or team to develop its own programme. There is thus no proper co-ordination.

Community participation

The community is involved mostly through members of clinic committees which

have been set up in the villages. The selection, composition and efficiency of these clinic committees varies from village to village. Some limit their work to logistic support to the visiting health teams, while others are more active in home visiting and health promoting activities, for example the development of vegetable gardens.

Major health problems

At the end of 1983, all clinic communities and a number of health workers were asked to write down the ten major problems in order of priority; both groups agreed on six problems as major problems although with different priorities.

Several studies carried out in the health ward emphasize the importance of malnutrition - diarrhoea - respiratory tract infections as an important cause of death and illness of under- five children.

Caring for children

In 1980, a random sample of 493 children under 6 years from 352 mothers were studied; 32 percent of these children did not receive personal care from their mothers but from a grandmother, an aunt or both; another 32 percent were taken care of only by their mothers; the remaining 34 percent of the children had more than one caretaker in charge of them of whom one was the mother.

Problems of ante-natal health care

In view of the fact that the population of the Ditsobotla District is growing rapidly, health care of mothers and children becomes very important. The Gelukspan Health Ward offers extensive ante-natal care. Yet it seems that the average attendance has dropped slightly.

In 1980, the reasons given for not attending ante-natal care services were: lack of transport or great distance, no clinic or hospital present, attendance by General Practitioner.

The reasons given for delivering at home (1980) were similar: lack of transport or great distance to clinic, the baby came too fast, there were no health services available, or there were no problems experienced.

Breastfeeding

The relationship between breastfeeding and diarrhoeal diseases in children was studied in 1984. Of all children admitted with caretakers because of diarrhoeal diseases, only seven percent of under-five children, or 19,2 percent of children under six months of age were exclusively breastfed.

Diet of under-five children

Maize, bread and milk are the three most commonly given foods. Only 12 percent of the children eat vegetables daily; 10 percent never eat them.

Growth monitoring and food supplements

Growth monitoring is done in the under-five clinics. The nutritional status of children is assessed by weight and arm circumference. Mothers are explained the meaning of the growth charts and the nutritional status of their children.

Food supplements are provided free of charge when the upper mid-arm circumference is less than 13,5 cm or when the weight of the child is faltering.

In 1982, 6,3 percent of underfive children were getting food supplements; this rate is lowest for children less than 12 months (1,1 percent) and the highest for children between 24 and 36 months (11,1 percent); for children between 12 and 23 months, 10,2 percent were on food supplements.

Oral rehydration

Oral rehydration therapy has been encouraged since 1981, both for home therapy and for therapy of children hospitalised with diarrhoeal diseases but no dehydration. Dehydrated children are admitted to hospital and as a rule, they are treated by intravenous rehydration.

Mothers are taught about the salt-sugar solution (SSS) for rehydration, which they can prepare at home. They are taught to give one cup for every loose bowel action; and are explained the signs of dehydration and what to do when this develops.

Knowledge about the salt-sugar solution and about dehydration was assessed in 1984. It was found that 66 of 400 care-takers (16,5 percent) knew how to prepare SSS, regardless of whether a clinic was within reach.

It seems that care-takers knowing how to prepare the salt-sugar solution often recognise death as a complication of diarrhoeal diseases.

But most care-takers did not recognise dehydration as a complication of diarrhoea. Only two care-takers in the whole sample knew at least two signs of dehydration. All the others knew none or only one.

It was concluded that care-takers recognising death and dehydration as a complication of diarrhoeal disease, and recent experience of diarrhoeal disease in the household, were associated with a better knowledge of how to prepare the salt-sugar solution.

In 1985, a researcher found that 57 percent of care-takers knew how to prepare the salt-sugar solution.

Immunisation

In 1985, it was found that only 49 percent of the children in the age group 12-23

months were fully immunised on time, although 75 percent were fully immunised at the time of the study; ten percent received BCG immunisation too late and 16 percent received DPT/Polio usually too late but occasionally too early; the same applies to measles innoculations.

Attendance of under-five clinics

In 1984, 84,6 percent of the under-five children had a "road to health" card. This shows that there is a small number of children who are not being reached by the health services.

This was particularly true in the resettlements where only 66,4 percent of the children were in possession of a growth chart.

The total number of UFC clinic visits has increased from 1246 in 1980 to 20519 in 1985.

THE FRED CLARKE CLINIC IN CHICKEN FARM

Since 1983, The Health Workers' Association has provided a clinic service to squatters living in Chicken Farm, Soweto. In the following article, the HWA outlines some of the problems of dealing with ill-health, when this ill-health is caused by repressive influx measures, poor wages, inadequate and insecure living conditions, and extortionist local authorities.

Squatters of Orlando become squatters of Chicken Farm

Chicken Farm has become the home of some 300 families. The first people to settle in this squatter camp came in July 1983, when officials of the West Rand Administration Board (WRAB) moved into Orlando and demolished the shacks which housed more than 200 so- called "illegals". After their houses were demolished, these families, most of them with babies and young children, had to sleep in the open.

Their plight was taken up by the Witwatersrand Council of Churches (WCC), which put up tents to house the affected families. The WCC also sent a memorandum to WRAB requesting:

- not to make more families homeless
- to provide alternative housing for the homeless people

How the Health Workers' Association became involved

The Baragwanath Branch of the HWA began working among the squatters after many articles in the press drew attention to their plight. Meetings were held with interested organisations to find out whether the HWA had enough resources and medically trained people to sustain a health programme over a long time period. The initial aims of this programme were:

- to make health services available to the people squatting on Chicken Farm
- to provide health services mainly to children and adult emergencies
- to provide health services until the end of winter (1983) and to then reasess the situation
- to try and set up liaison committees in the community
- to try and persuade WRAB to rehouse the families

Besides providing a health service, the HWA has also been involved in:

- distributing clothes
- helping the squatters with problems relating to pensions, disability grants, maternity benefits etc.
- documenting health and social problems of the squatter population

The HWA was able to carry out this programme because it had the support of community organisation, doctors, pharmacists, health workers, sports bodies and businesses.

At present, the HWA runs one clinic service per week, where mostly children are examined and treated. On another week-day, health education talks are given, focusing on political and organisational aspects of living conditions in relation to health.

The squatter community

The squatter community is not a settled one. Every week, new families move in. New shacks are built in between established shacks, so that the shacks now form continuous rows. This means that there is just about no flow of air possible inside each shack; for windows of old shacks that previously opened out to the side, had to be closed up.

The continuous stream of newcomers also means more overcrowding, less privacy, and more pressure on already inadequate sanitation facilities.

The new squatters come from various parts of Soweto and therefore it takes some time for a community spirit to develop.

Living conditions

Each family is housed in one shack regardless of the number of members. The shacks are not fit for people to live in, because:

- the 3x3 metre shacks are too small for the average of five people who inhabit them
- the shacks provide no privacy
- there is no provision for running water in the shacks themselves; the community of approximately 1 500 people has to share four taps for drinking, and four areas far washing clothes.
- for these 1 500 or so people, there are only three areas for toilets. One of these is a bucket toilet. The other two are flushing toilets, which are continuously blocked. The sewerage water from these blocked toilets runs across the paths between shacks where children play.
- constructed of sheets of corrugated iron, the insides of the shacks become very hot in summer and very cold in winter
- there is no flooring, no ceiling, no insulation
- there are no recreational facilities

All these conditions create serious health hazards for the people living at Chicken Farm. The HWA believes that health is directly related to people's socio-economic and political conditions. That is why the HWA sees its role first and foremost as making people aware that good health is their right, and that health is a political issue.

Health education discussions form an important part of the health service that the HWA provides. The HWA acknowledges that the clinic in itself can only provide temporary relief; any lasting solution rests squarely with the government and its regional administration agencies.

The community of approximately 1500 has to share four taps

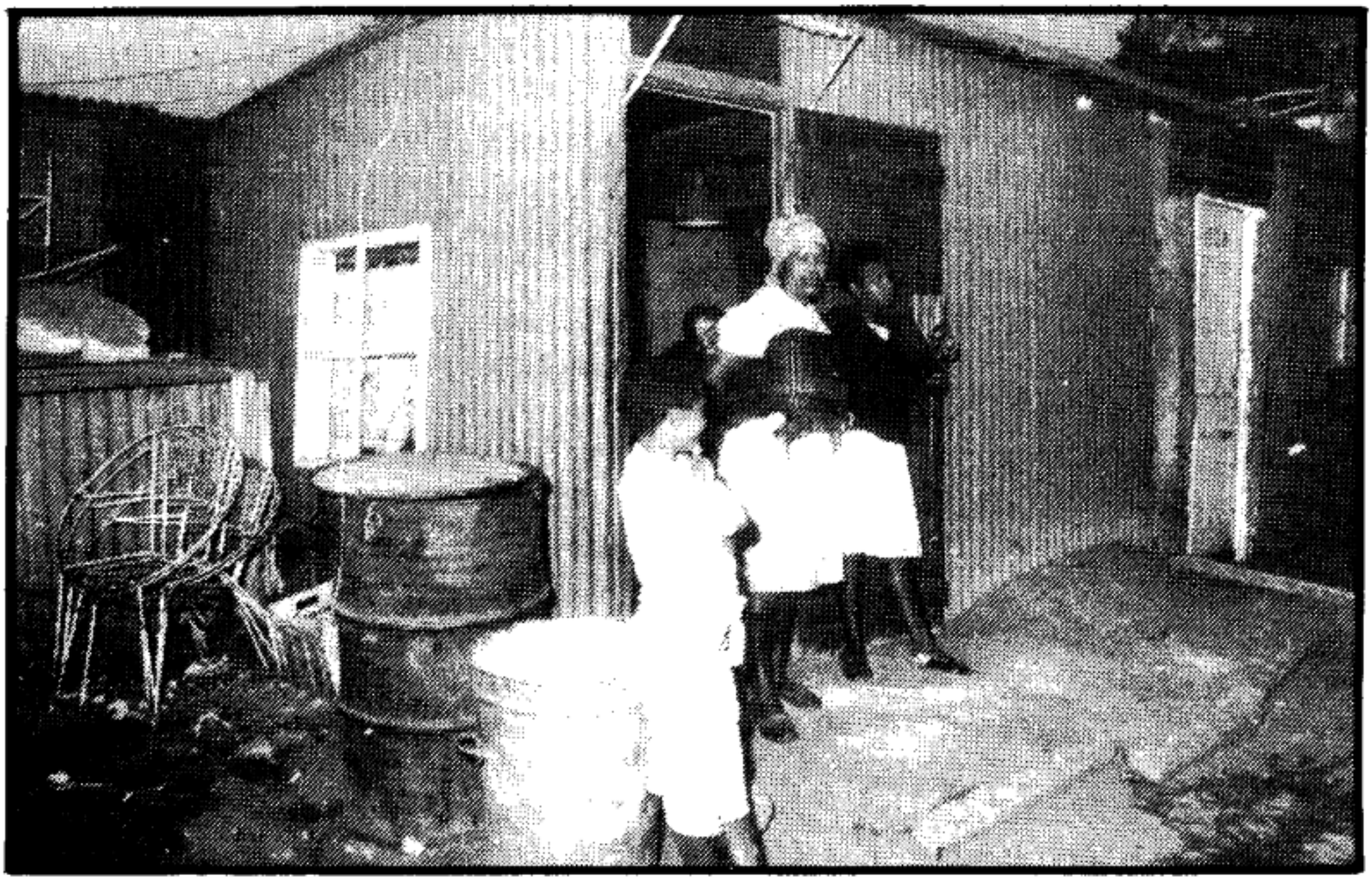
The ill-health profile of Chicken Farm's slum conditions

During the first 13 months of the clinic's existence, 542 patients were examined and treated.

Most of the children were found to have illnesses that were either directly caused by unsatisfactory living conditions or aggravated by them. Disease spectrum includes the following: Upper respiratory tract infection 177; Pharingitis 53; Tonsillitis 58; Ear infections 30; Pneumonia/Bronchitis 47; Skin conditions 55; Gastorenteritis 59; Malnutrition 11; Burns 9; Worm infestation 15; Eye infections 6; Referrals to Baragwanath 12.

Fees for services that do not exist

Each family pays the Soweto City Council R20 to R35 per month. It is claimed that R15 of this amount is spent on services. But these services do not exist. No further taps and toilets are provided, blocked toilets are not being repaired, and there is no rubbish removal service.



The 3 x 3 metre shacks are too small for the average of 5 people who inhabit them

Exhorbitant rents

The different rentals (anything between R20 and R45) point to the possibility of corruption and bribery among municipal officials. The same applies to the differing amounts of money that people are made to pay to be able to get a shack in the first place. Newcomers at the moment pay anything between R200 and R600 just for permission from a councillor to build a shack (not including the buiding materials or the monthly rentals and "service" fees).

The R20 to R35 rental which people have to pay for each shack, seems exorbitant compared to the average of R36 which other Soweto residents pay monthly for a four-roomed house.

No security

With the new Abolition of Influx Control Bill, millions of people, and especially squatters, will be worse off than under the old pass laws. The old influx control

laws are now being replaced by new laws on citizenship rights and housing.

Instead of controlling people's movement from rural into urban areas, the government now wants to strictly control the conditions within the urban areas. One researcher gave an example of this new policy: "It is okay for more than 500 000 squatters to live in Winterveld outside Pretoria, but they cannot occupy the open plains of Sandton". (Weekly Mail, 4-10 June 1986.)

This is all done in the name of good health standards. One of the aims of these laws is, as it says, "To combat nuisances such as disorderly squatting, slums, and conditions that contain a health hazard".

The laws affecting squatters will become stricter. Seeing that there is a severe housing shortage in the urban areas (the official waiting list for houses in Soweto alone is more than 20 000 families) many people are forced to become squatters, and fall under the new tough restrictions.

To be a lawful resident in South Africa, a person would have to have a housing or lodger's permit, or a job. This means that people awaiting houses in urban areas could be forcibly moved to a homeland.

Squatters in urban areas are therefore very insecure. Their shacks could be demolished at any stage, and they could be deported at any time. Under the new law, the Minister (of Constitutional Development) can prohibit a landowner from allowing people to settle on his land.

This is exactly what happened recently at E.T. Tshabalala's Mshengu squatter camp in Mofolo, Soweto. Most people at the Mofolo squatter camp, like those at Chicken Farm, are people who have lived in the urban area for a long time, but have not been able to get houses. Most of the Mofolo squatters were sub-tenants of Soweto households who grew tired of living in overcrowded conditions, together with their landlords or with tenants, and wanted a house of their own.

Organisation

As long as there are great housing shortages in urban areas, there will be squatters. Under these conditions, no government programme of "orderly urbanisation" will be able to eradicate squatting communities. Oriel Monogoaha, a Soweto squatter leader in the 1940's, once said, "The government is like a man who has a cornfield which is invaded by birds. We squatters are the birds. The government sends its policemen to chase us away and we move off to occupy another spot. We shall see whether it is the farmer or the birds who get tired first." (Weekly Mail 16-22 May 1986).

Even though the people of Chicken Farm have to pay a high price, both in terms of money and in terms of living in bad conditions and poor health, they are happy to have found a place to live. They have paid dearly for just the permission to live there.

They will therefore fight for what is theirs by right. At the moment, the squatter community is becoming organised to demand better housing and sanitation for their money, and to expose bribery and corruption among the authorities. And if their right to live there is threatened, their struggle will not end there.

THE EPIDEMICS OF REPRESSION

In the last two months, outbreaks of epidemics have been reported from various parts of the country. A polio epidemic was feared in Johannesburg's Alexandra Township, many children suffering from measles died in Kwa Zulu hospitals, and there are no signs that the number of deaths from TB in South Africa is on the decrease.

Tuberculosis

It has been reported recently that Cape Town is in the grip of a TB epidemic. About 700 new cases are reported each month, and the figure is increasing. Of those 700, 400 are reported from the area where most of the Crossroads refugees live. (Star 10.7.86)

Treatment for those affected is very difficult in the present political situation. People are afraid to go out and come to the clinics. Clinic attendance rates have dropped markedly since the outbreak of violence in the area.

Measles

In May and June this year, an outbreak of measles in Kwa Zulu reached epidemic proportions. 23 children, most of them under the age of three, died, mainly from complications following the disease. At Ngwelezane Hospital in Empangeni alone, 84 children were admitted for treatment in June.
At St Mary's in Melmoth, 9 children have died.

A spokesperson from Clairwood Hospital in Durban, reports that the 80 to 100 beds in the special fever ward have been constantly occupied by measles patients.

Most health officials who have commented on this issue have blamed the outbreak of the epidemic on the lack of education about immunisation. What they do not mention are the living and working conditions of people, and the inadequate health services and transport facilities in rural areas.

Conditions of overcrowding, inadequate housing and sanitation and malnutrition are the greatest factors in the spread of communicable diseases.

In addition, the nearest health service might be some distance away, and with inadequate transport facilities and the high cost of transport, people might find it difficult to get there to be immunised.

IMMUNISATION CAMPAIGN IN ALEXANDRA

The polio immunisation campaign undertaken by staff and volunteers of the Alexandra Health Centre was started with different assumptions to those of Kwa Zulu health officials.

Polio is spread via the faecal-oral route. It can be prevented by adequate sanitation, extensive immunisation, and good co- ordination between the various health authorities and services. But none of these existed previously in the case of Alexandra township.

The superintendent of Alexandra Health Centre, Dr Tim Wilson, attributes the outbreak of polio to the "appalling sanitation" in the township whereby every 15 to 20 people have to share a latrine bucket which is emptied only twice a week.

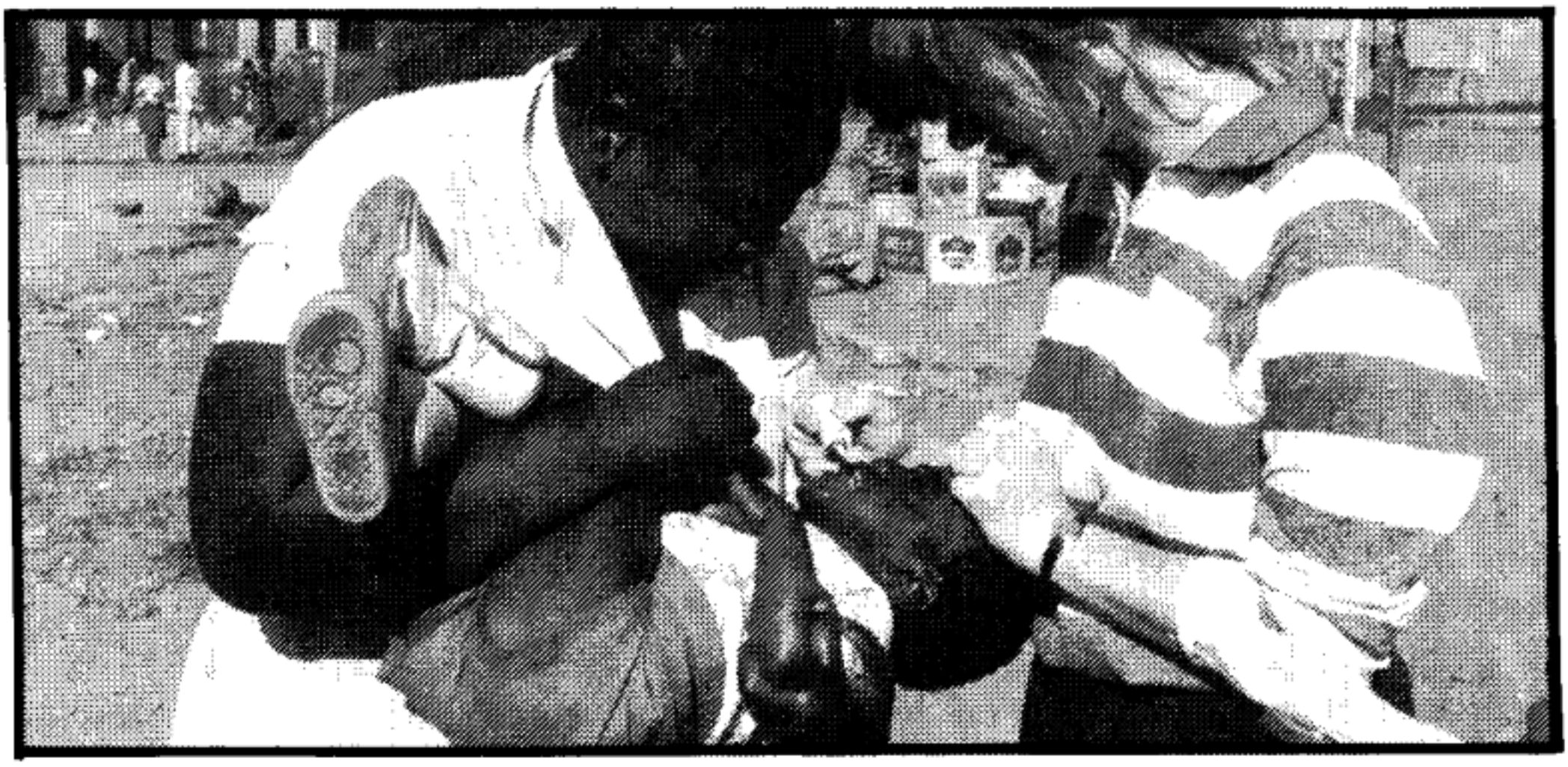
The fear of a polio epidemic was raised when five people from Alexandra were diagnosed as having contracted the disease in June. This fear is all the more real if one considers that for every case of paralytic polio, there are at least 100 infected cases.

Immediately, health workers from the Alexandra Health Centre and volunteers were organised into teams to take the immunisation to the people. The ten teams went on a house-to-house immunisation campaign. They aimed to reach over 15 000 children under the age of five in the township.

The immunisation campaign was carried out from the middle to the end of June - a time in which political tensions were extremely high.

Even though a sixth case of polio was diagnosed during this time, the epidemic can be said to be over.

At the end of July, a second immunisation campaign was started. This time, children were immunised against polio, measles, and diphteria/whooping cough/tetanus.



Health services are taken to the people of Alexandra

The following interviews were carried out in order to explain the issues of community participation in the immunisation campaign.

Medical students involved in the campaign, spoke to Peter Barren, the co-ordinator of the Alexandra Immunisation Campaign; to Willie Lekoloane, a member of the Alexandra Youth Organisation, which is involved in the campaign; and to a member of the Nusas Health Directive (NHD).

What is the relationship between the Alex community and the University, particularly Medical School?

NHD: The relationship has developed mainly over the last few months because of certain events, namely the Alex funeral at the beginning of this year, which many students attended.

Also, the recent polio immunisation and an on-and-off contact between the community organisations and NUSAS Health Directive have fostered this relationship.

So although the University as such has no special links with the community, student organisations have had the opportunity of building ties and creating a fair amount of credibility.

What is the advantage of working with the Alex community organisations?

Barren: I think people accepted the campaign better and trusted our motives more. We were also seen by them to be moving from our "ivory tower" into people's yards and we also probably stimulated people to come to the clinic.

How is the clinic percieved by the community?

Barren: The clinic is seen in a good light as it is now working with the community and has the interests of the community at heart. Before the community organisations got involved, the clinic was thought to be government-owned. It was only after we got involved that more people were told and now realise that the clinic is not government controlled.

What were the objectives of the previous June '86 immunisation campaign?

Barren: There were three major objectives. Firstly, we wanted to avert a possible polio epidemic. Secondly, we felt it would be important to get involved directly with the community and this gave us the opportunity to do just that. And also, we wanted to reach people not normally reached, to take the health services to the people, rather than wait for them to come through the door.

How was the last immunisation campaign seen by the community?

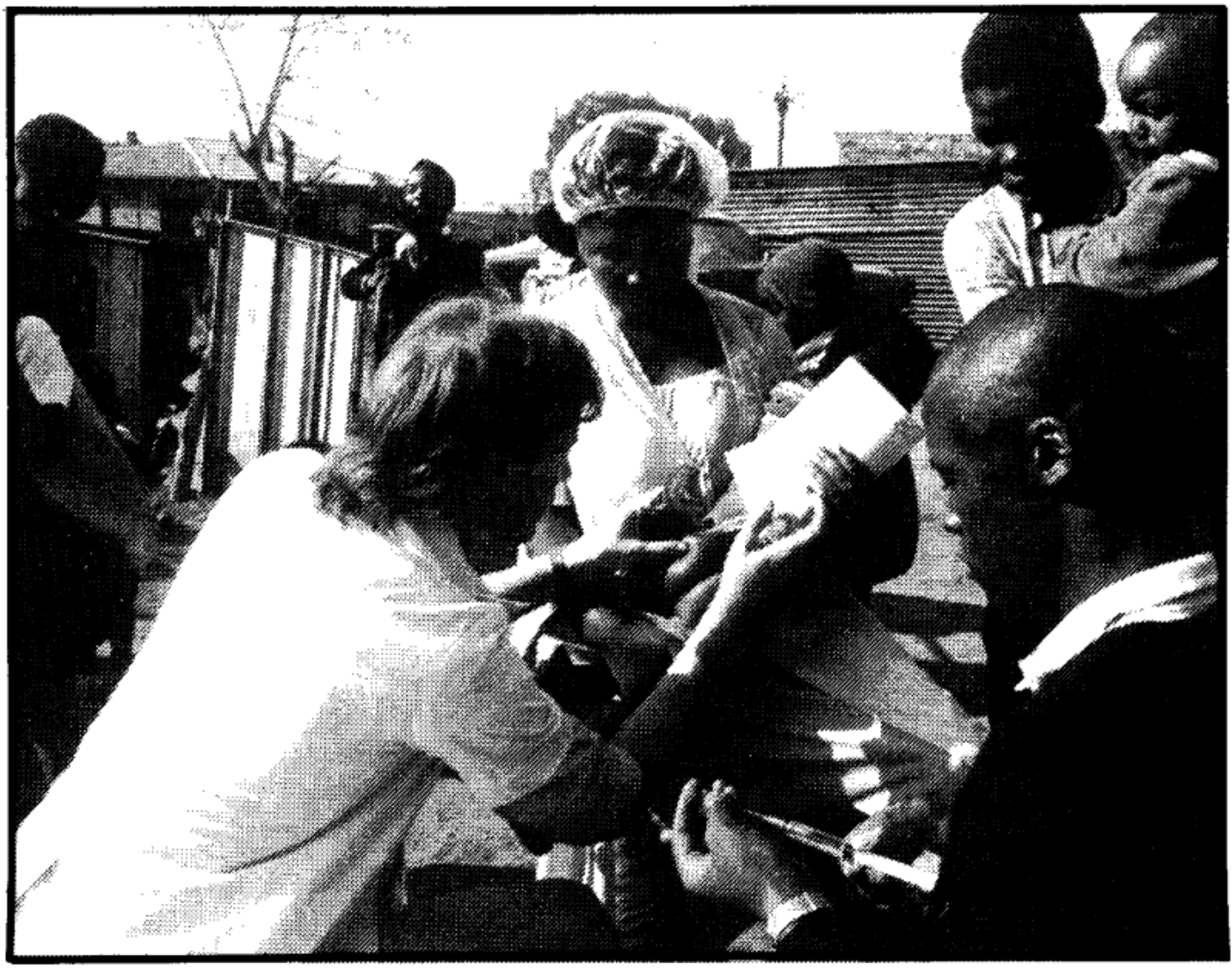
Lekoloane: I think they accepted it as something special and people accepted it with open hands. There was no opposition to it and no negative incidents. Considering this, I think it was well accepted.

What is different about this campaign?

Barren: We are completing a full polio immunisation programme and are going to do more comprehensive immunisation with the DWT and measles immunisations included. We are also going to give out "Road to Health" charts to lay the basis for growth monitoring. And this will introduce people to the clinic further.

Why is it important for students to participate?

Barren: There are three aspects to that question. In terms of the clinic, it helps to alleviate gross staff shortages by using other people who have the appropriate skills. From the community perspective, it is nice for students to be seen to be showing concern and working in the community. Finally, from the students' point of view, they begin to appreciate the conditions of life in Alexandra in addition to doing something useful.



Medical student involvement in the immunisation campaign

Lekoloane: It is important for Wits students to get involved so that students can understand why we are getting sick. It is especially important for whites to learn what is happening and how we live. There are only a few white people getting involved and either they don't take time to inform other whites, or other whites just don't care.

How does the State of Emergency affect community organisation functioning?

Lekoloane: No meetings can be held. We can no longer work easily to provide what our people want. Functioning is therefore affected by the State of Emergency.

What is the implication of the State of Emergency for this campaign?

Barren: Previously, we were able to consult with community organisations quite easily, but now, leaders have disappeared for one reason or the other, so that is obviously a setback for the programme.

What are the roles of the Alex community organisations and how do they function?

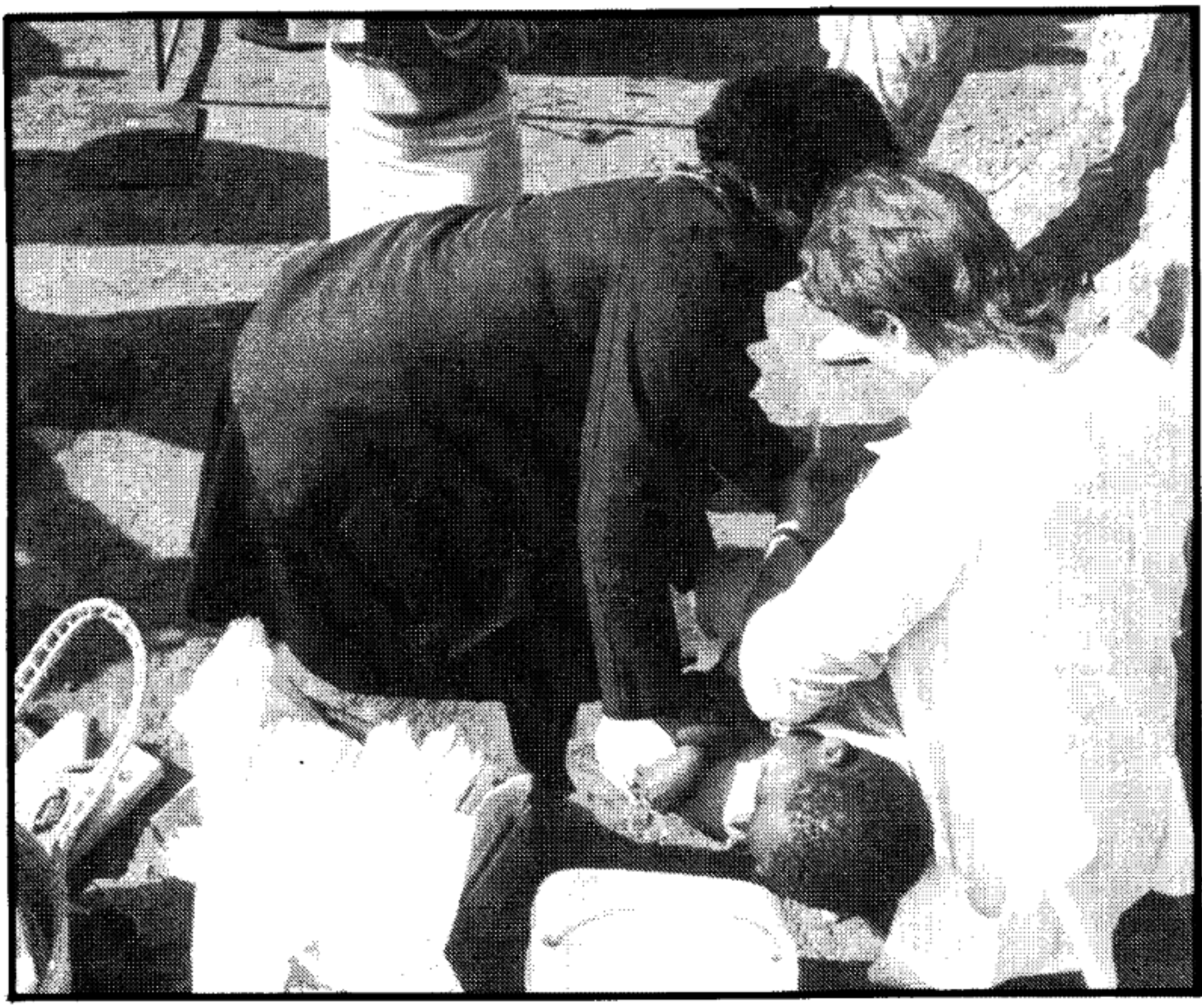
Lekoloane: Different organisations do different things. Some organisations bring youth together through music, drama, and, to an extent, by discussing politics. Most organisations, due to circumstances and current times, are involved with politics.

The community is suffering from the conditions they live in, therefore community organisations address the urgent needs of the people within Alexandra. In fact, in townships all over South Africa, the building of street, block, and area committees are some ways people in organisations are taking control of life in the townships.

What are some specific organisations, for example Alexandra Youth Congress (AYCO) and Alex Civic Association (ACA), doing?

Lekoloane: AYCO works in conjunction with ACA where necessary, otherwise alone. In such areas as crime prevention campaigns, AYCO and ACA work together. For example, if street committees report a crime, perhaps members of an organisation would investigate the crime. If the person is caught, he or she would be tried by the people in the People's Court.

AYCO has also been helping to clear bucket sewerage systems and to build parks. Some members have also learnt first aid skills and are able to deliver first aid where necessary. AYCO organises meetings and rallies and helps in the organisation of mass funerals.



Health workers and volunteers aimed to reach over 15000 children under 5 years

Why is NUSAS Health Directive taking up and involving itself in the campaign?

NHD: The NUSAS Health Directive is an organisation made up of medical and allied medical students. We feel that as a student organisation, we need to understand the way that apartheid has affected the health of people and therefore be involved in practical work which addresses health needs of communities.

At Medical School, we never really have the opportunity of applying our skills in an appropriate way and we see the Alex immunisation campaign as a way of gaining practical experience in the provision of adequate health care.

But we do not see this as simply a form of charity, since this kind of work is a way of furthering the relationships between future health workers, the community, and their organisations.

Since we were approached by the Alexandra Clinic and the local community organisations, we feel that when we do offer our skills as a service, it should be under the direction and guidance of the people's organisations in the township.

As future health professionals, we should also begin to challenge the reasons why in 1986 the children of Alex are living under the threat of a polio epidemic.

MULDERSDRIFT CLINIC

Muldersdrift is a farming area 40 km north east of Johannesburg. A clinic run by Wits medical students during the 1970's and early 1980's, was forced to close, and a completely inadequate health service for people in the area existed until a new clinic was opened in 1984.

The report that follows was written by the students involved in this project. It discusses the approaches, the difficulties, and the successes in the attempt to get the people of Muldersdrift involved in running their own health service.

Muldersdrift clinic is staffed by a rotating group of doctors and medical students

Poor wages, poor living conditions, poor health

About 39 000 people (8 000 whites and 31 000 blacks) live in the magisterial district of Muldersdrift. The area is divided up into about 700 small-holdings. Most of the black people in the area are farm labourers and are very poor. Some of them earn as little as R20.00 per month. An average of six people share a hut or shanty, but in some cases there are as many as fifteen.

Most of the diseases that these people suffer from are related to poverty: marasmus, kwashiorkor, small-for-age babies, gastro- enteritis, and other infections.

Until recently, the Transvaal board for the development of peri- urban areas (now the regional services council for the area) was responsible for health services in Muldersdrift. However, before the clinic was opened, the only health service within 20 kilometers was one nurse, who immunised at schools and a few farms.

A recent study shows that before opening the clinic, only 29 percent of the children in the area had ever received a diphtheria/polio vaccination. Figures for the other vaccinations were just as low. The nearest hospital is 20 kilometres away in Krugersdorp.

This gives some idea of the inadequacy of health services before the new clinic service opened. It also shows how badly resources are distributed. Right on the doorstep of the metropolitan area of Johannesburg, farm labourers did not have access to the most basic health services.

The new Muldersdrift Clinic

In April 1984, the new Muldersdrift Clinic opened with the aid of private funding. It is open each Saturday morning and is staffed by a rotating group of medical students and doctors.
The clinic provides a paediatric service and family planning facilities.

The clinic staff realised that a problem with student-initiated projects was that these often ran out of steam. That is one of the reasons why it was important to involve the community in the clinic project. Community volunteers could be taught to staff the clinic and to take over much of the administration. In this way, the clinic could carry on in the long run even if individual students withdrew from the project.

Discussions with groups of women were held to find out their needs, criticisms and suggestions regarding the clinic. At the same time, individuals were encouraged to take part actively in all aspects of its functioning.

One woman became the mainstay of clinic operations almost immediately. She said she needed to be paid if she was to help. Although we hoped the clinic could be run by unpaid volunteers, we decided to pay her.

Meanwhile, another woman who had been working in the area, went for training as a family planning motivator by State Health. Although we had hoped she would provide broader services such as health education, growth monitoring

and immunisation recall, she has only been involved in family planning. This is because she had to fill her "quota" of new clients and perhaps also because of limited skills, confidence and back-up support.

Problems with our approach

At this stage, we found out that there were several poblems with our approach. Firstly, we only focused on the clinic itself. Secondly, we did not leave enough opportunities for the community to become fully involved in decision-making and guidance of the health care which we delivered.

There is no real community organisation which could challenge any of the social, economic and political factors affecting health. Only a few volunteers came forward and those that did, did not stay long. It became more and more questionable whether we could expect members of such a poor community to volunteer to work at the clinic without being paid.

We also got very frustrated at not being able to change the overall health of the community, to establish a good working relationship with the community and to find out exactly what its needs and opinions were.

Now we see that we need to pay clinic workers if we are to keep their support. We also started a new approach to community participation.

Forming a clinic committee

Several studies on the clinic showed that the clinic in itself could not tackle problems which caused ill health in the first place - namely, problems of unemployment, low wages, and poor living conditions.

Bearing this in mind, we had to rethink and change our approach to community involvement.

The idea of forming a committee was put forward. This committee, we hoped, would represent the various geographical areas, classes and sexes of the community, and would thus represent its needs adequately. We thought the committee might canvass the needs and opinions of the community and work with the students towards solving various problems.

These problems related to all matters of daily life which affect health, for instance living conditions, income, etc.; and to matters of the delivery of health care in the clinic and the mobile family planning service (run by State Health).

The idea was discussed at the Saturday morning clinic over some months. People generally agreed that it was a good idea to form such a committee.

At two meetings (which were both attended by about 20 people), our idea of looking at health in terms of people's living and working conditions was discussed. We also discussed general health problems, and the possible role of the committee.

It was decided that two things needed to be done in the near future:

- the community would have to put forward its feelings about the working of the clinic

- we would try to extend the clinic's opening hours to include a morning in the middle of the week for those mothers who worked on Saturdays.

A date was set for the third meeting but before it occurred, we realised that there were a number of problems. We called the meeting off, with the agreement of committee members of the clinic. The major problems that we saw were:

- The committee was too small and did not represent the whole community in terms of class, age and area; (also, committee members were not elected).
- The committee was not democratic; it was dominated by clinic workers, a priest and a schoolmaster.
- In the six weeks of its existence, the committee had made very few gains; members of the committee had not managed to communicate at all with each other. Without phones or transport, and without resources, information, contacts, or organizational skills, our group could not possibly work properly.

In addition, students had very little contact with the community, which meant support and exchange of ideas would have been very limited.

A new approach

So, in order to involve more people, we prepared for a "mass" meeting. About 70 women attended the meeting and it turned out to be very constructive in many ways:

- People could exchange ideas and express grievances freely.
- By doing so in the large group, a sense of community may have begun to form, something which hadn't happened before because the people live far distances from each other and have no forms of organisation.
- We, the students, learned a great deal about people's lives and hardships.
- Many people felt that unity amongst the community and with the students was a starting point towards solving problems.

We ourselves can address only very few of the problems. People know this. They feel that despite this, it would be very useful to continue with the project and the new approach.

Many people are prevented from attending the clinic by employers. Outspokeness makes people lose their jobs on the spot, so taking part in this project is very dangerous for the very people we wish to help.

Comments, criticism and assistance would be warmly welcomed.

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THE HEALTH CONDITIONS OF FARM LABOURERS

In the following section, CRITICAL HEALTH focuses on the position of farmworkers.

Farmworkers are one of the largest and most exploited sections of the labour force in South Africa, and face a variety of occupational diseases and injuries due to poor working conditions. Similarly, poor living conditions expose them to a variety of health problems.

The first article in this section looks at the kinds of conditions farm labourers are forced to live and work under. It shows how these conditions are related to the health problems experienced in farming communities.

It also looks at the position of farmworkers under South African law.

In the second section, CRITICAL HEALTH talks to Dr Prakash Vallabh, of the Health Workers Association, on the Jacksonsdrift Clinic project.

He points to the problems that people living on farms in the Jacksonsdrift area experience, and the difficulties involved in trying to set up a viable health service there.

Most importantly, it points to the advantages of setting up a comprehensive and alternative, community-based health service.

THE POSITION OF FARMWORKERS

"It's camouflaged slave labour"

Farm labourers are trapped by a variety of laws to remain on white farms. They have little control over the conditions under which they work, and few prospects of changing those conditions. This is due to their disadvantaged position under the law and their difficulty in joining trade unions.

Most of the time farmworkers remain "out of sight and out of mind" of the public eye. Occasionally, newspaper articles or research highlight the daily experience of living and working conditions, which are often sub-human.

Women and children are paid less than men for doing the same work

LIVING CONDITIONS AND THEIR EFFECT ON HEALTH

General health problems

The health, general welfare and safety of farmworkers cannot be separated from their living and working conditions.

While it is possible to differentiate between general health problems arising from poor living conditions, and occupational diseases and health hazards arising from poor working conditions, the two are interrelated and often reinforce each other.

The health implications of inadequate living conditions and conditions of service, are many and varied.

Poor wages

Firstly, farmworkers in South Africa receive extremely low cash wages. Despite the provision of housing, rations and land (in some cases), the overall wage structure remains inadequate. Some farm labourers receive no cash wages at all or amounts as low as R6.00 a month. Others receive an average of R25.00 to R45.00 a month. (Farm Labour Report 1982).

Further, women and children are paid less than men for doing the same work, while casual or seasonal labourers are paid at lower rates than workers employed full-time.

The lower salaries in particular do not even enable workers to supplement inadequate rations. Malnutrition is thus rife amongst farm workers and their families. As a result, children particularly are susceptible to measles, chest infections and gastro-enteritis.

Often the reason given for the payment of low wages is that workers receive payment in kind. Yet research has revealed that over the last twenty years, farm workers have seen a drop in the value of their wages and thus in their living conditions generally.

One of the major reasons for this decline in living conditions has been the abolition of squatting and labour tenancy on white farms. This has made the farmworker totally dependent on the wages paid by the farmer.

Employment conditions

Similarly, with respect to hours of work, annual leave and sick leave, the worker is at the mercy of the farmer's goodwill. There is no common law right to public holidays, sickpay or leave pay, nor is there a legal limit to the farmworker's working hours.

The common practice appears to be dawn-to-dusk with an hour off for breakfast and lunch respectively. However, because there are no regulations, the farmworker

is open to abuses by the farmer. It has been found that some workers may work 70 hours in one week.

Annual leave and public holidays are regarded by most farmers as privileges and not rights. There are no legal provisions regulating this.

Most farmworkers are compelled to work when they are sick, or have to forfeit part of their wages for not being at work while ill.

It is not surprising therefore, that many farmworkers suffer from psychosomatic diseases resulting from excessive stress, exhaustion and monotony.

Housing

Another reason farmers give for paying low wages is that they provide housing for their workers. However, the quality of housing is extremely poor.

While conditions on farms may vary, the general picture is one of overcrowding, poor ventilation and inadequate sanitation. Toilets, washing facilities and running water are often not provided.

One farmer, commenting on his labourers' living conditions, said: "... they prefer to live in these conditions. They are happy. To you and me they are shocking. This is absolute filth as far as we are concerned. Our conscience does worry us sometimes, but we have bigger problems, like finance" (Sunday Tribune, 12/11/78).

Farmers fail to ensure regular medical check-ups and immunisation for children

Water supply and sanitation

The health implications of such conditions are many and obvious. In 1980, a study of farm labour accomodation facilities on 20 farms, found that the water supply came directly from a natural source (dam, borehole, river). In no case was the water purified, processed, monitored, screened or subjected to any form of sur veillance. In only 5 of the 20 cases was water piped directly from the source to the point of supply, where it was available on tap. On the remaining 15 farms the water was carried from the source to the point of supply.

Under such circumstances water can easily become contaminated, either from seepage or from human and animal excreta. This is especially likely to occur where farming settlements are located on the banks of rivers or dams and where there are inadequate sewerage facilities. The lack of adequate facilities results in personal ablutions, washing of clothes and recreation taking place in the communal drinking water supply.

Bacteria which thrive on such conditions are those of cholera and typhoid - diseases already reaching epidemic proportions in South Africa. Other diseases which spread through contaminated water and through insects which breed in it, are malaria and trachoma. These diseases spread rapidly through farming communities.

WORKING CONDITIONS AND THEIR EFFECT ON THE HEALTH AND SAFETY OF FARMWORKERS

"The right to work productively in a safe and healthy environment is a fundamental human right. Work should not be a source of misery and disease" (Farm Labour Report, 1982).

Recent trends in agricultural development have led to an increase in mechanisation and an increase in the use of chemical substances.

There is little research into the various agricultural health hazards, and how to minimize them. At the same time, there are no measures to enforce the use of adequate machine guards, masks and protective clothing. As a result, farmworkers are exposed to a variety of occupational injuries and diseases.

An estimated 300 farm workers die each year and approximately 2 000 are permanently disabled (Farm Labour Report, 1982). Accidents on machinery such as harversters, threshers and reapers are largely due to a lack of adequate training in the use of the machinery, and inadequate safety guards and protective clothing.

Chemicals

The increasing use of fertilisers, weed killers, insecticides and other chemical substances, expose farmworkers to the toxic effects of such substances. The effects can range from dizziness and nausea to brain damage and even death.

As is the case with machinery, there is little or no procedure for monitoring the safe use of chemicals.

A report in The Star (22/9/80) notes that "With respect to pesticides there is the strictest control to manufacturer and even to seller - but when it gets to the farm, the road is open ...".

In The Rand Daily Mail (20/2/85) a professor of pharmacology was quoted as saying "Deadly pesticides are being used on farms with criminal carelessness".

Further, it was noted by an official from the Poison Information Centre that "...South Africa's death rate from agricultural poisoning is at least 20 times higher than in the US or Europe" (RDM 21/2/85). This was found to be linked to the use of unskilled labour and the reluctance to follow preventative and safety precautions in handling powerful poisons.

Farmworkers are trapped by a variety of laws to remain on white farms

Other health hazards

In addition, there are a variety of diseases associated with the handling of animals by humans. Examples of these diseases are anthrax, glands, rabies, malta fever and tetanus. Despite the prevalence of such diseases in agriculture, very few are listed in the schedule attached to the Workmen's Compensation Act as compensatable diseases.

Other examples of diseases are those caused by agricultural dusts such as chronic bronchitis and emphyzema. Excessive noise may result in total or partial deafness. Illness and even death, associated with the temperature extremes under which workers are forced to labour, are not uncommon occurences in the lives of farmworkers.

Assault and abuse is widespread, particularly in the case of child labour. Numerous press reports have highlighted case histories of brutalities inflicted by farmers as "punishment" on workers. Clearly, assault can be regarded as one of the health hazards for workers.

Compensation

Farmworkers have only recently been brought within the scope of The Workmen's Compensation Act. While they are legally entitled to claim compensation from the state, their common law right to sue the farmer for damages is severely limited. Further, because of the extremely low wages paid to farmworkers, compensation which is calculated as part of the wage, is negligible.

Inadequate Health Services

One of the biggest factors leading to disease and death of adults and children working on farms, is the lack of rural clinics and adequate health services. Farmers generally show a lack of concern for the health and welfare of their workers.

Where services do exist, the low wages and lack of transport prevent most people from using them. Failure to ensure regular medical check-ups and immunisation programmes for children, perpetuates the cycle of ill-health in many of South Africa's farming communities.

The position of farmworkers under the law

The question arises as to how such conditions are allowed to exist. The key to understanding this is to look very broadly at the positon of farmworkers under the law.

Historically, farmworkers have largely been excluded from South Africa's industrial relations legislation. They have been specifically excluded from the many acts which set out minimum health and working conditions, such as The Labour Relations Act; Wage Act; Minimum Conditions of Employment Bill.

Legislation which has been introduced over the last decade or so to protect the wages and working conditions of industrial workers, has not been applied to farm labourers.

The state's response to conditions of farmworkers

In 1982 the National Manpower Commission was appointed by the Minister of Manpower, to look into the conditions of farm labourers and domestic workers.

The commission called for interested groups around the country, who had recommendations to make regarding the position of farmworkers, to submit information.

Amongst several detailed submissions was the Farm Labour Report. This detailed a multitude of abuses in the system controlling farm labour and made recommendations to the commission.

The most interesting aspect of this commission is that nothing has come of it, despite its initiation four years ago.

The possibility of re-examining the legal position of farm workers was received with hositility by farmers' organisations. The following quote suggests that the state has bowed to the interests of the farmers: "The object of the investigation", stated the minister, "was to protect agriculture from malicious attacks ... and to report on the particular problems with which agriculture is burdened in relation to the availability and stability of a sufficient number of workers." (Farm Labour and the Law, 1984).

The need for organisation

Farmworkers are not legally prevented from joining trade unions. However, their biggest constraint is victimisation. There is no law preventing the victimisation of farmworkers by farmers.

Unless farm workers are able to organise effectively, improved living and working conditions will remain remote.

The best watchdog of farmworker intersts are farmwokers themselves.

General recommendations for farmworkers

- **Wages be competative with other sectors**
- **Security on the farms for workers and their families, whilst economically active and in retirement**
- **Decent housing**
- **Compulsory education for workers' children**
- **Incentives in the form of grazing rights and available land**
- **Social security and welfare grants commensurate with workers in other sectors**
- **The right to free association and collective bargaining**
- **Enforceable written contracts**

(Farm Labour Report, 1982, p4)

Recommendations regarding general health care

- Existing regulations dealing with the provision of sanitation, washing facilities, and running water be properly enforced
- That there be minimum conditions of service for farmworkers including provisions for sick leave and maternity leave
- That existing health regulations be extended so as to make employers part responsible for:
  *Regular dental and medical check-ups and immunisation of their employees and dependents
  *Transport to and from clinics and hospitals
  *Maintaining basic first-aid facilities on each farm
- That the Department of Health and the Department of Manpower liaise with regard to extending primary health care services and subsidising medical clinics in these areas.

(Farm Labour Report, 1982, p25)

The following sources were used in the above article:

1. FARM LABOUR REPORT (1982) - Submission to Manpower Commission on farm labour by the Farm Labour Project

2. Bachmeyer, D and Vogel, W; "Farm labour in South Africa with specific reference to child labour", Community Medicine Project, 1983 (unpublished)

3. Ballot, N and van Niekerk, M; "The health hazards of farming", Community Medicine Project Project, 1981 (unpublished)

4. Haysom, N and Thompson, C; "Farm Labour and the Law", Carnegie Conference Paper No 84; 1984

5. De Klerk, M; "Maize Farm Employment" in SALB; 9(2); 1983

6. Selected newspaper articles

THE JACKSONSDRIFT CLINIC PROJECT

CRITICAL HEALTH interviewed Dr Prakash Vallabh from the Health Workers Association, on the Jacksonsdrift Clinic Project

Could you please give us some background to Jacksonsdrift Clinic?

In the late 1970's, medical students at Wits started a project in Eldorado Park. The people there needed the service, but not as desperately as the farmworkers. So Jacksonsdrift was chosen.

Can you tell us a bit about the area?

Jacksonsdrift is a farming area about 25 kilometers from Johannesburg. There are approximately 10 000 farmworkers and their families living there. These people are not migrants in the classic sense, but they don't qualify for Section 10 rights. The farms are therefore their permanent homes.

The majority of people work on dairy or vegetable farms. Some of the big farms are owned by Anglo American, and are easier to organise. We work mainly with the smaller farms which are privately owned and where workers are more vulnerable.

What are some of the general problems you come across in working with these farmworkers?

Firstly the farmworkers are in a very vulnerable position legally. They can't go and work in the cities and they have nowhere else to go and make a living. Therefore they are subject to abuse and assault. They can't report these cases for fear of losing their homes on the farms.

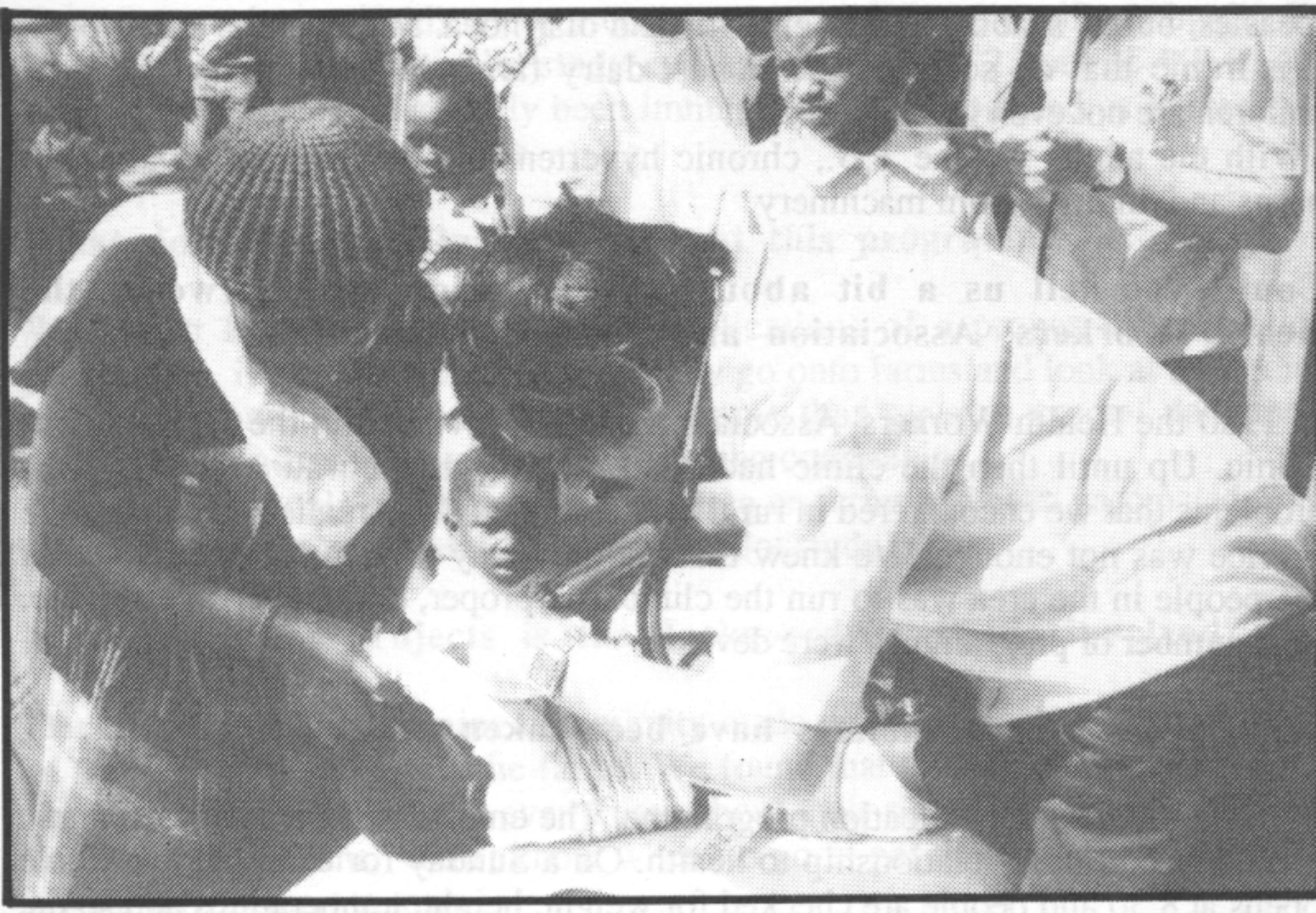
Secondly, accomodation is tied up with employment. So if the labourer dies, the family loses its accomodation.

Thirdly, their salaries are very low which means they live in a state of poverty. There is little chance of ever improving their position.

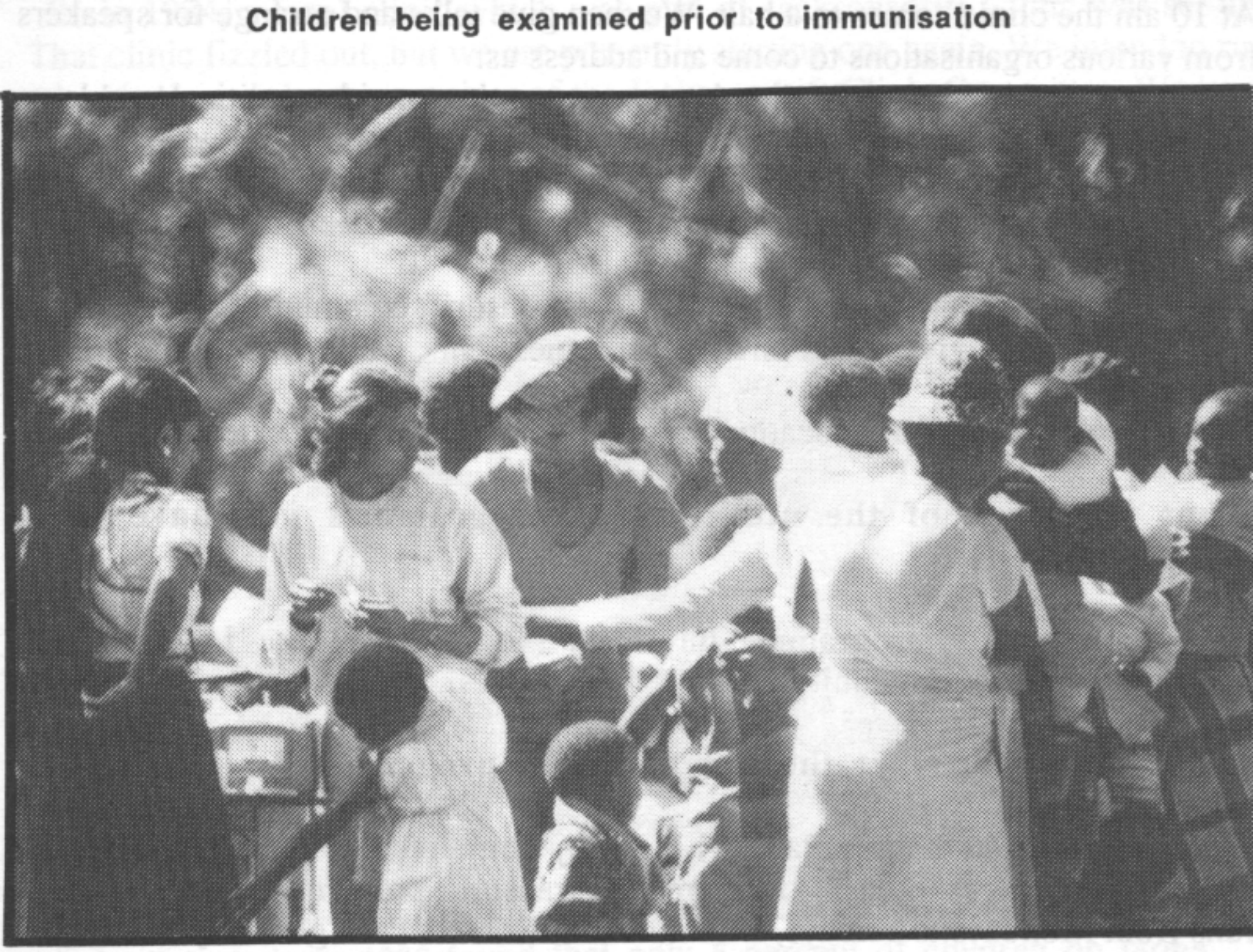
Fourthly, schooling for their children is extremely inadequate. There are two schools in the Jacksonsdrift area. One has been set up by the Rand Waterboard and is open only to children of those workers who work for the company. The other is a semi-state run school. However, the majority of kids only go up to form 2.

What are some of the main health problems you encounter?

Well, firstly, we see about 60 percent adults and 40 percent children. With the children, the most common health problems are upper respiratory tract infection,



Children being examined prior to immunisation



Jacksonsdrift medical project - immunisation

measles, burns, scabies, gastro-enteritis and diarrhoea. Malnutrition is rampant. It is ironic that on some of the richest dairy farms in the country, workers' children are not even given free milk!

With the adults we see T.B., chronic hypertension, diabetes, osteo-arthritis, burns and injuries from machinery.

Could you tell us a bit about the relationship between the Health Workers' Association and Jacksonsdrift Clinic?

In 1980 the Health Workers' Association became involved in the Jacksonsdrift Clinic. Up until then the clinic had been running as a curative service. The problems that we encountered in rural health care made us realise that a curative service was not enough. We knew that the only way to gain the confidence of the people in the area was to run the clinic as a proper, comprehensive service. So a number of programmes were devised.

What types of programmes have been taken up at the clinic?

We started a health education programme. The emphasis is on socio-economic problems and their relationship to health. On a Sunday for example, the clinic opens at 8.30 and people are checked for weight, height, temperatures and so on. At 10 am the clinic comes to a halt. We then give talks and arrange for speakers from various organisations to come and address us.

Issues range from infant-feeding in the community to wider political problems and their relationship to health. We look, for example, at how and why diseases like T.B. and malnutrition become rampant in South Africa. We also discuss national political problems such as the crisis in education and problems in Soweto.

In the last few months, people from the Jacksonsdrift community formed a committee which gives talks on relevant issues. This, we feel, is an important development.

So you can see that our education programme is ongoing and extensive.

What are some of the other major programmes you have been involved in?

Our second major programme has been (and still is) the immunisation programme in the community.

What made you start the immunisation programme?

There is clinic at Kibler Park where they immunise. But, it is too far for farmworkers to get to easily as there are transport problems. Also, the clinic runs from Mondays to Fridays, and most farmworkers can't get away from work during those times.

There was a sister who apparently went out in a mobile clinic to immunise.

But we weren't sure if this was correct because children were still getting ill. So in 1982, we conducted a pilot study and found that only 23 out of 419 in our population sample had actually been immunised. This prompted us to start our own immunisation programme.

What do you see as important about this programme?

Well apart from the obvious health implications of a proper immunisation programme, it gave us a chance to actually go onto farms and look at the socio-economic conditions there. The programme thus gave us crucial data for a general socio-economic profile of the farming community.

We found that only eight percent of children on farms had been vaccinated. This was close to the five percent found in our pilot study.

In which other projects is the Jacksonsdrift Clinic involved?

Our contact with the farming community made us aware of the plight of many of the old people living on the farms. We found that they didn't know anything about pensions - they didn't even know about their rights to claim them! They couldn't fill in forms, didn't know where to go to get them from, or could not afford the transport to town.

So in 1984, a legal clinic which was part of Jacksonsdrift Clinic was set up. That clinic fizzled out, but we are presently starting one again. We intend to run a legal clinic under the auspices of the Jacksonsdrift Clinic Committee. We have clerks to sort out simple problems such as pensions, documents for people, disability grants and so on.

A pilot study in 1982 found that only 5 percent of children on farms had been vaccinated

Any other programmes?

We also have a family planning service run by our clinic. We find teenage pregnancies and sexually transmitted diseases a big problem. So we give contraceptives, have an antenatal clinic and are currently researching the possibilty of a pap smear programme, which we intend to do in the future.

What are some of problems the Health Workers' Association faces in running Jacksonsdrift Clinic - in terms of your own organisation?

We have been running the programme for about six years on a weekly basis. There are problems of sustaining the interest of members of the HWA. Also because we only go out once a week, it is difficult to establish structures in the community easily. We have to debate whether in fact our involvement makes the community more dependent or independent.

What problems do you face in terms of farmers' attitudes towards you?

They seem quite happy for us to treat their workers only - not other workers. People can get shot if they are caught trespassing a farmer's land.

They worry about us politicising their workers. They say we are "making the farmworkers clever".

They tend to view us with suspicion because we try to make workers aware of the connection between their health problems and the conditions under which they live and work.

What are the financial problems you face?

Money has been a big problem for us but we have just been given a donation. Drugs and equipment have been donated by general practitioners. We bear the costs of transport.

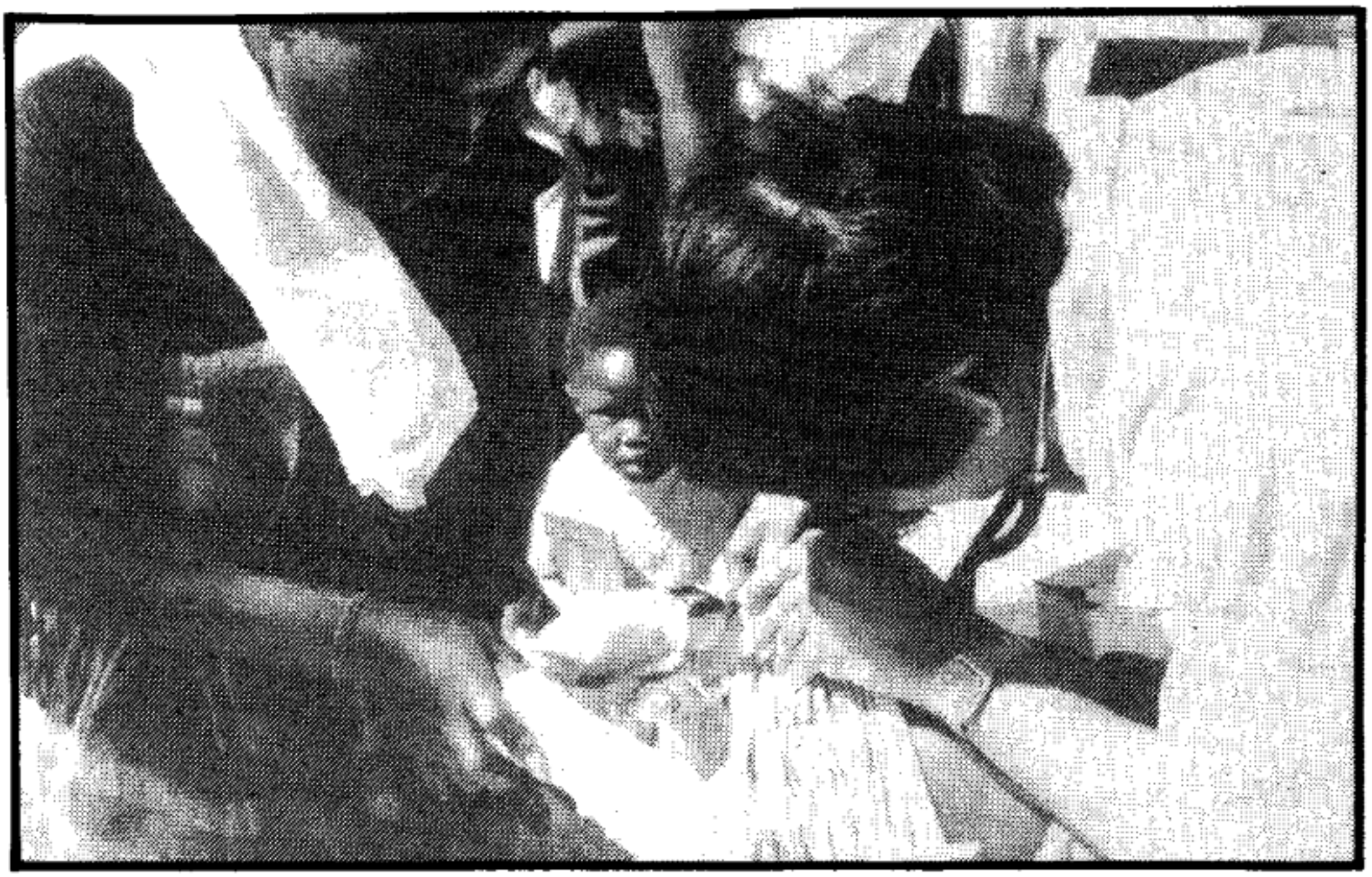
Do you see the clinic doing the work of the state in some ways?

No, not at all. Firstly, the financial burden of health care is relieved from the community.

Also, it is much more convenient, as the farmworkers do not have to worry about transport.

A third factor is that we train the community in dealing with simple cuts, burns, first aid and diarrhoea.

But most important of all we see ourselves very differently. We do not simply provide a curative service. We see ourselves as playing a conscientising role in the community.



The Jacksonsdrift clinic aims to provide a proper, comprehensive service

What do you feel are some of the major gains you've made in running Jacksonsdrift Clinic?

Firstly, we do provide a comprehensive health care service.

In addition, we feel we have made certain inroads into the community.

By us constantly talking about what is happening in the country, we feel we are making an impact in a small way.

Concerning the issue of unionisation, we are aware of the victimisation of farmworkers. However, we feel it is important to talk about the benefits of unionisation and let farmworkers express their fears about the its consequences for them.

We are also aware of the helplessness of farmworkers and their difficulties in getting involved in community structures. But let me give you an example.

The Jacksonsdrift community wanted to set up a creche: They reasearched the matter and eventually found there were too many obstacles in their way - legal problems as well as farmers refusing land. We are now looking at alternatives such as childminding, but the important point is that the community itself did the work.

What are some of the advantages for your organisation in running the clinic?

It gives us the opportunity to test ourselves and our commitment to the communities in which we work. We also feel it is extremely important organising health workers within the State of Emergency.

HOSTEL DWELLERS ORGANISE FOR BETTER LIVING CONDITIONS

The various forms of influx control and migrant labour have shaped the quality of life of thousands of men and women who come into the urban areas to look for jobs. One of the institutions closely related to migrant labour is the compound or hostel accommodation provided by industries which employ large numbers of workers.

Some figures

Amongst these employers, it is mainly the mines and the various municipalities which house workers in hostels or compounds. The mines alone house a total of 440 000 men in hostels.

Other industries, as well as the various municipalities, account for an additional 217 hostels which accommodate an estimated total of 300 000 men. (These figures do not include the number of women and children who, mostly unofficially, room in with the male hostel dwellers). Johannesburg alone has 17 hostels for municipal workers.

The size of these hostels, and the extent of overcrowding, become clear if we look at the average number of people per hostel.

In the Vaal/Reef area, there are over 200 hostels with an average of 2 000 and more persons per hostel. The largest hostels in the country are to be found in Langa (accommodating 11 941 men), Mamelodi (accommodating 11 790 men), and Diepmeadow (accommodating 10 800 men). (These figures were compiled in May 1985).

Despite the fact that this accommodation brings with it a whole range of health and social problems, the government does not plan to abolish it. On the contrary, Dr Gerrit Viljoen, Minister of Co-operation and Development, announced last year that another R11,5 million had been budgeted for the construction of six new hostels.

At the same time, the minister announced that some family units had been built. But the number of family units seems very small when compared to the thousands of people still housed in hostels. (According to the minister, 1 756 family units had been built at Worcester, Kuils River, and Langa; and 314 at Sharpeville and Boiphatong). Some of the single sex hostels which have been converted into family housing are of an appallingly low standard.

MAJOR HEALTH AND SOCIAL PROBLEMS OF HOSTEL ACCOMMODATION

Poor housing

On the whole, the hostels built by local authorities are of poorer quality compared to those built by employers. Many of the hostels have no proper floors or ceilings. In many cases, there are no doors to individual rooms, and ventilation is inadequate. The majority of hostels do not have electricity for lighting and other energy needs. There are hardly any places to lock money or other possessions.

Mine compound toilets

Overcrowding

The official figures of inmates per hostel show that most hostels are full, but not overcrowded. However, these figures do not take into account that facilities are inadequate, and that hostel inmates often include wives and children of men who officially live in the hostels. In actual fact, the degree of overcrowding is alarming.

In some cases, one finds up to 14 people sharing a room sized 2m x 3,75m. Children of migrants, when visiting the city, often sleep under their parents' beds. It is therefore not surprising, given the high incidence of TB in the Transkei (which is the home of most migrants in Cape Town), that this disease is a major health problem amongst Cape Town's black population.

Apart from TB, any communicable disease is likely to spread very easily and quickly in conditions of overcrowding. Upper respiratory tract infections, as well as skin diseases, are very frequent.

In addition, the limited and inadequate facilities, and the lack of privacy, cause a great deal of stress and tension among hostel residents.

Sanitation and water supply

Most of the ablution blocks in hostels are in very bad condition. In most instances, 22-25 people were found to share one toilet. This inevitably causes problems of blockages and leakages. There is the added problem of poor maintenance by the local authorities who are very slow in responding to emergency calls. Showers are few and provide only cold water. Because of the toilet problems, many of the showers have been converted by residents into open toilets.

This has serious health implications. The supply of water and washing facilities for clothes and utensils is also inadequate. One or two taps are supposed to serve each block. This leads to queues, and it does not encourage cleanliness.

Under these conditions, hostel inmates cannot wash themselves and their clothes as thouroughly and often as they would need to. The health problems arising from this are skin problems, enteric infections, and urinary tract infections.

Fuel

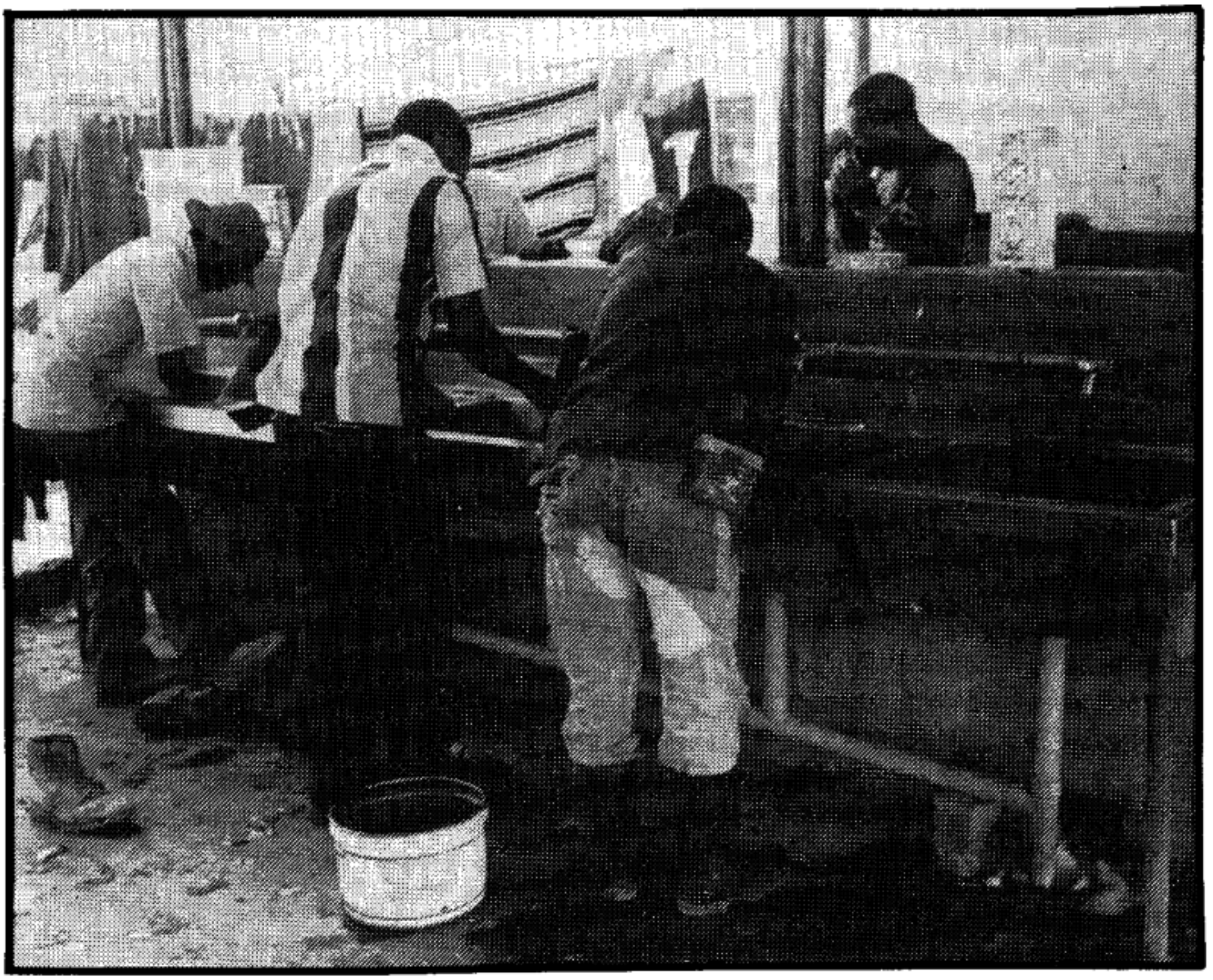
The lack of electricity forces people to use paraffin as the main source of energy for both cooking and lighting. Under conditions of overcrowding, this leads to the following health hazards:

- Burns occur during cooking and from lamps. This affects small children in particular.
- Paraffin poisoning of children due to lack of safe storage out of reach of children
- Pollution due to impure paraffin, and the lack of adequate cooking facilities with chimneys and ventilation. Food is prepared in rooms in which there are up to 18 persons. In addition, many hostel inmates are heavy smokers. All this makes the pollution level intolerable, especially for small children and unborn babies. This kind of pollution also aggravates upper respiratory tract infections and causes coughing.

Recreation

There are virtually no facilities for entertainment, both in the hostels and in the surrounding townships. There is thus hardly any outlet for people to relax and entertain themselves and their friends except through drinking and smoking in overcrowded shebeens within the hostels or in nearby townships.

The health hazards are predictable: there is a high incidence of alcohol abuse and sexually transmitted diseases. Apart from these obvious health hazards, there are social problems resulting from boredom and depression. People find it difficult to establish friendly and responsible relationships with other people around them.



The supply of water and washing facilities in hostels is usually inadequate

Family life

Women and children are officially "non-existent" in most hostels. But, in fact, they are a reality of hostel life. There are many children who are born and bred in these squalid conditions, and others who come for regular visits. There are also "partners of convenience" who have moved in with some men for mutual benefit.

A study of the Nyanga hostel found that 79 percent of the men were married, and that every second man in the hostel was living with a woman with one or more children. Some of the health problems of these families are tied up with their illegal status, which limits their access to health facilities. As a result,

- Immunisation coverage is very low
- Ante-natal care and family planning is relatively poor, given the requirement to give address or registration, and the fear of being detected
- Psychological and emotional deprivations and strains occur because of family disorganisation and lack of privacy
- There is a high incidence of violence and sexual assault on girls and women, as well as child abuse.

The struggle for better living conditions

It was the affected workers themselves who first started to do something about their living conditions. In June 1985, hostel dwellers in the Western Cape formed an organisation which was initially named "Western Cape Men's Hostel Association". Later, the organisation was re-named "Western Cape Hostel Dwellers' Association" (WCHDA) in acknowledgement of the role of women in the hostels.

One of the major goals of the organisation is to press for the right of workers to live with their families near to their places of work.

Other aims are:

- to work for full residence and employment rights, and an end to the present contract system
- to work for an upgrading of facilities and amenities
- to encourage and provide opportunity for adult education and cultural activities
- to develop good relationships with fellow residents who already live with their families in townships.

The organisation works in close co-operation with existing trade unions.

The WCHDA started out in Nyanga, Langa, Guguletu and Umfuleni, and is spreading to other townships in the Western Cape.

THE HOSTEL DWELLERS' HEALTH CARE PROJECT

Existing State Health services for hostel dwellers

All hostels (whether those of the mines, the municipality, or industry) at present fall under municipal jurisdiction, as far as public health aspects are concerned. Municipal health inspectors are supposed to visit the hostels regularly.

Emergency care is provided by teams trained in first aid, at or near the site of the accident. Local hospitals provide the back- up service. For curative care, hostel dwellers are supposed to go to the factory health services, to local general practitioners, or to local hospitals.

All these services are grossly inadequate; but the areas most neglected are preventive care (health screening, immunisation, family planning) and health education.

That is the reason why a health project was set up, which works in close co-operation with the WCHDA. The main aim of this project is to deal with the problems of hostel dwellers, with the active participation of those involved, so that the project will become a community effort and will strengthen the demands for a better deal from the authorities.

The health project's main thrust is a health education programme which focuses on the causes and the prevention of diseases, and self-help groups and techniques.

A training programme is to enable elected members of the community to take charge of health care in the hostels. This training programme includes health

education, first aid, treatment of certain ailments, referral procedures, immunisation and oral rehydration promotion, and counselling skills.

An awareness programme regarding family relations is to deal with the effects of family disorganisation.

A WORKSHOP ON RURAL REPRESSION

Earlier this year, a workshop on rural repression was held by service groups. It was attended by many groups from rural communities who do not have easy access to lawyers, doctors and journalists operating in towns and cities. The following is a report of this workshop and of the way in which certain survival skills were taught and learnt.

Aims of the workshop

The aims of the workshop were:
- to publicise the problems faced by rural people
- to provide resources for people from rural areas, in the form of skills training, contact with resource people and written material
- to build up links between people from different parts of the country

Legal advice

In the first session, a lawyer talked about the basic legal rights for rural communities. He looked at topics such as:
- what to do when a person is arrested
- how to take statements from a person maltreated by the police and how to build up a dossier of events that could be useful in legal action
- the role of witnesses and ways in which the community could handle crises on its own when there was no lawyer
- what to do when a person has been assaulted, the importance of record-keeping on assault victims, and the importance of knowing that there are stiplulated times during which assaulted people could lay charges against the police.
- the benefits and dangers of laying a charge
- what the Emergency regulations say - that police and SADF do not have the right to assault people - the only right they have is to arrest them.

Emergency first aid

In the session on health care in emergency situations, members of a health group based in the Cape showed a video on first aid with special focus on unrest victims. The video showed how to give first aid to people who have:
- bleeding wounds
- broken limbs
- wounds from buckshot, birdshot and rubber bullets - how to identify wounds caused by each of these burns
- problems with tear gas

The video also showed how to give mouth-to-mouth resusitation and external cardiac massage.
Two doctors demonstrated first aid in a crisis situation and talked about resources needed to cope with a medical crisis.
They demonstrated how to:
- stop bleeding and how to bandage
- assess various levels of unconsciousness
- keep a clear airway on an unconscious person
- make a detailed check on an unconscious person so as to identify the injured parts.

After the demonstration of first aid on a bleeding person, workshop participants practised how to stop bleeding and how to bandage.

This was followed by a demonstration of a First Aid Kit. A discussion was then held on how communities could forge links with progressive doctors and nursing staff in their areas. Crisis centres have been set up in various areas and sympathetic doctors volunteer to be on stand-by during crisis periods.

Media

The next item on the programme was a workshop on how to prepare press statements, how to contact journalists and how to publicise news from rural areas.

Two journalists pointed out problems faced by journalists working for commercial newspapers. These problems were a result of the nature/structure and interests/aims of the newspaper industry. They cited the following major problems:

PROFITS - Commercial newspapers are firstly geared to sell at a profit. To pay for the costs of production, the newspaper agency tries to get companies to advertise in the newspapers. These companies have a great influence in shaping the contents of a newspaper.

DEADLINES - Newspapers have to set deadlines and if they fail to keep them, circulation is affected. This in turn affects profits. Deadlines are a problem especially for people in rural areas where communication links are difficult. Telephones are often out of order, which means news from these areas is often old by the time it reaches daily newspapers.

CENSORSHIP - Laws affecting the newspaper industry are major constraints in both gathering and publishing information. These laws are broadly defined and vague which makes it very difficult to know when a published story constitutes an offence. These laws are:
- The Police Act
- Prisons Act
- Internal Security Act and laws affecting detainees

The State of Emergency was mentioned as one of the laws that affected news gathering. According to the Emergency regulations:
- newspapers are not allowed to publish names of detainees until they have been confirmed by police

- no pictures can be taken in areas in which a State of Emergency has been declared
- newspapers are not allowed to report on the movements of the SADF

New Emergency regulations

Under the new Emergency regulations passed in June this year, restrictions are even tighter. As far as gathering and distributing news is concerned, the following new regulations apply in addition to those already mentioned:

- Any person who makes, possesses, distributes, displays or utters subversive statements will be guilty of an offence.
- The Minister or any authorised person can seize one or all copies of a publication which, in his opinion, contains a subversive statement or any other information which is or may be detrimental to public safety, order, or the ending of the State of Emergency. Offenders include people who make, write, import, print, publish or distribute such publications.
- It is prohibited to publish any utterance by any office-bearer of 118 specified organisations in six Cape magisterial districts. (Organisations include the UDF, AZAPO, COSATU, DPSC, ECC, NUSAS and RMC)

Relationship with press

Communities and organisatons firstly have to decide whether they want publicity for a specific event. Secondly, they have to decide on the target readership - in other words whom they want to inform:

- the local community - make contact with local newspaper
- national - make contact with national weeklies
- international - make contact with foreign journalists

If the local community was the main target-readership, it would be best to make contact with the local newspaper. If this was not possible for source reasons, the community would try and print pamphlets and circulate them in the community.

Contacts with other groupings could also be important. Such groupings could include:

- church
- Red Cross
- Amnesty International and others

Press statements

People were divided into groups according to areas they came from, to prepare press statements about important issues in their areas. The groups were concerned with the following issues:

- Communities threatened with removals and incorporation into Bantustans.
- Election disputes
- Education crisis

- Police harassment/State of Emergency
- Chiefs and witchcraft
- Use of vigilantes

Some of the groups read out their press statements for comments and to check if they were detailed enough.

Comments on the workshop

The workshop was a success in that it met all of its objectives. It provided people from different organisations with enough information and skills to arrange such workshops in their own areas with the view of transferring the skills and information to people who need them most.

The workshop itself created a link between different organisations.

CRITICAL HEALTH will supply, on request, the names and addresses of service organisations who were involved in this workshop, or of any organisations working in the broad field of health, education, and social welfare.

If you need the contact address of any such organisation, write to:

CRITICAL HEALTH
P.O. Box 16250
Doornfontein
2028

REPRESSION AND CONFLICT: LIFE IN KWANDEBELE

The South African government, amidst growing opposition, recently confirmed its plan to make KwaNdebele an "independent homeland" in December this year.

This plan has been shaken by the resolution of the KwaNdebele Legislative Assembly to cancel the proposed independence. To date, however, the South African government has not issued an official reponse.

Opposition to independence, and to the incoporation of Moutse into the territory, has reached such proportions that KwaNdebele has become one of South Africa's worst troublespots.

The credibility of Skhosana's homeland government has been shaken by the violence perpetrated by him and the group of vigilantes launched by him. Since the beginning of this year, residents have seen a reign of terror which, they fear, will become permanent if the "homeland" gains independence.

The following article provides some information about the opposition to independence, and police and vigilante violence.

But more particularly, this article tries to show how exactly this affects people's daily lives, what additional problems they are facing, and how they are grappling to come to terms with these problems.

The wrangle over Moutse

The area north of Pretoria known as KwaNdebele started as half a dozen resettlement camps. The area is very poor with hardly any infrastructure.

For its viability as a so-called independent homeland, KwaNdebele would need fertile land, roads, rail roads, hospitals, schools and other facilities.

The district of Moutse, which is much better off, has 66 000 hectares of rich farming land, tarred roads, over 60 schools and a hospital. Coal has been found in Moutse 1 and 3. These are exactly the facilities which KwaNdebele needs, and that is the reason why Moutse is to be incorporated into KwaNdebele.

In October 1980, the South African government proclaimed that the Moutse district was to be excised from an area governed by the Lebowa Legislative Assembly. The area was then placed under the control of the Pretoria government. Moutse community leaders rejected the plan outright.

In December 1985, the South African government proclaimed the incorporation of Moutse into KwaNdebele. Ever since then, police and vigilante violence have become the order of the day.

The "choice" of Moutse residents: starvation or violence

The incorporation plan carried out by the Pretoria government is relatively new. Long before these plans were tabled, the government saw Moutse as a "black spot" and had planned to remove Moutse residents to Tweefontein, Saliesloot and Kwaggasfontein.

These resettlement areas are bleak, infertile and carry hardly any water. They are far away from places of employment and there is no public transport. The people were to be housed in tents, with tin toilets.

Ever since the incorporation plan was hatched, the government put it to Moutse residents to either have their area incorporated into KwaNdebele, or to face removals. By giving Moutse residents this "choice" the government is saying that the removals are "voluntary".

These options, however, do not offer Moutse residents any choice. Both options were forced on the people without allowing them any say in the matter. And both options give Moutse residents little chance of surviving: removals mean unemployment, poverty and starvation, while incorporation means falling prey to police and vigilante violence.

Even those people who did move, did so under great pressure and violence. Under threats from police and vigilantes, some residents signed papers. From the beginning of this year, residents of Moutse district were moved, often at gunpoint, in hippos and government removal trucks, and under heavily armed police presence.

Moving from Moutsé to KwaNdebele, January 1986

Moutse's opposition to incorporation

The incorporation of Moutse was a slap in the face to Moutse residents.

Even the people of Ndebele tradition in Moutse, who are in the minority, are opposed to the incorporation of Moutse into KwaNdebele, and plans for KwaNdebele's "independence". The present King Mabhokho and his two sons, Prince James Mahlangu (who is the chairperson of the Ndzundza Tribal Authority) and Prince Jabu Mahlangu have openly opposed the government of Simon Skhosana, Chief Minister of KwaNdebele. They are joined in their stance by the Sotho-speaking Chief Tlokwe Mathebe, the senior chief in Moutse.

Tribal authorities in the Moutse district first tried peaceful means of expressing their opposition to incorporation. Report- back meetings called by the tribal authorities were banned or dispersed. In May this year, Prince James Mahlangu presented certain demands to parliament. He asked that:

- the Mbokotho vigilante group should disband
- the Homeland Legislative Assembly should not accept independence; instead, it should discuss the issue with all Ndebeles
- The 23 MP's who represent the Ndzundza Mabhokho Tribal Authority should resign from their seats for not having discussed the independence issue with the community.

Moutse residents did not get any reply to these grievances.

There are many reasons why Moutse people reject incorporation into KwaNdebele. First and foremost, they do not want to live under the violence which they experienced at the hands of Skhosana and his collaborators.

They object to KwaNdebele's rule of the whip, whereby women have no right to vote, tribal courts mete out floggings, male circumcision is compulsory, and school children will be taught in the medium of Ndebele, and will fall under the Ndebele system of education.

The citizenship issue is of concern to the Moutse people and others opposing independence. It is likely that people living in an "independent" KwaNdebele will share the fate of residents of other "independent" homelands (Transkei, Bophuthatswana, Venda and Ciskei), as far as South African citizenship is concerned. To get South African citizenship, people from these areas need to prove that they are permanently and lawfully living in the Republic of South Africa.

Moutse residents further fear that their privately owned or designated trust land will be nationalised without compensation in Skhosana's KwaNdebele.

Migrant workers stand to lose their jobs if they refuse to obtain Ndebele contract stamps. Moutse people have reason to believe that business licenses will be issued only to Skhosana's chosen few. And the Tribal Authorities fear that they will lose the coal mining rights at Kwarrielaagte.

Police and vigilante violence

As the scheduled date for the incorporation drew closer, both police violence and the determination of the people to oppose incorporation, grew.

Since November last year, police have allegedly broken up meetings and fired shots. At one such meeting, Moutse residents retaliated. The police allegedly responded by carrying out house- to-house searches, by beating and torturing residents, ransacking houses, and by arresting scores of people. The assaults, random shootings and killings and ransacking of homes are continuing.

It appears that police violence has increasingly been replaced by vigilante violence. The vigilante Mbokhotho gang was launched at the end of January this year. It is headed by Chief Minister Skhosana himself, with the late KwaNdebele Minister of Interior, Peter Ntuli, as vice-president.

The gang, made up mainly of shop owners and businessmen, was set up to stamp out all opposition to independence. Their job, in Skhosana's own words, is to recruit members and to supervise action against "trouble makers".

According to Skhosana, the gang numbers between 800 and 900 men. They carry out a campaign of terror and violence against all opponents of Skhosana's rule. Residents have suffered abductions, beatings, assaults, killings and mutilation at the hand of the vigilantes.

Moutse residents and others opposed to independence have been rendered defenceless victims in the face of such brutal terror. The only path open to them is to form strong organisations to ward off violence and injustice on all possible levels. Area committees and youth groups are working together to find ways of combatting terror and violence.

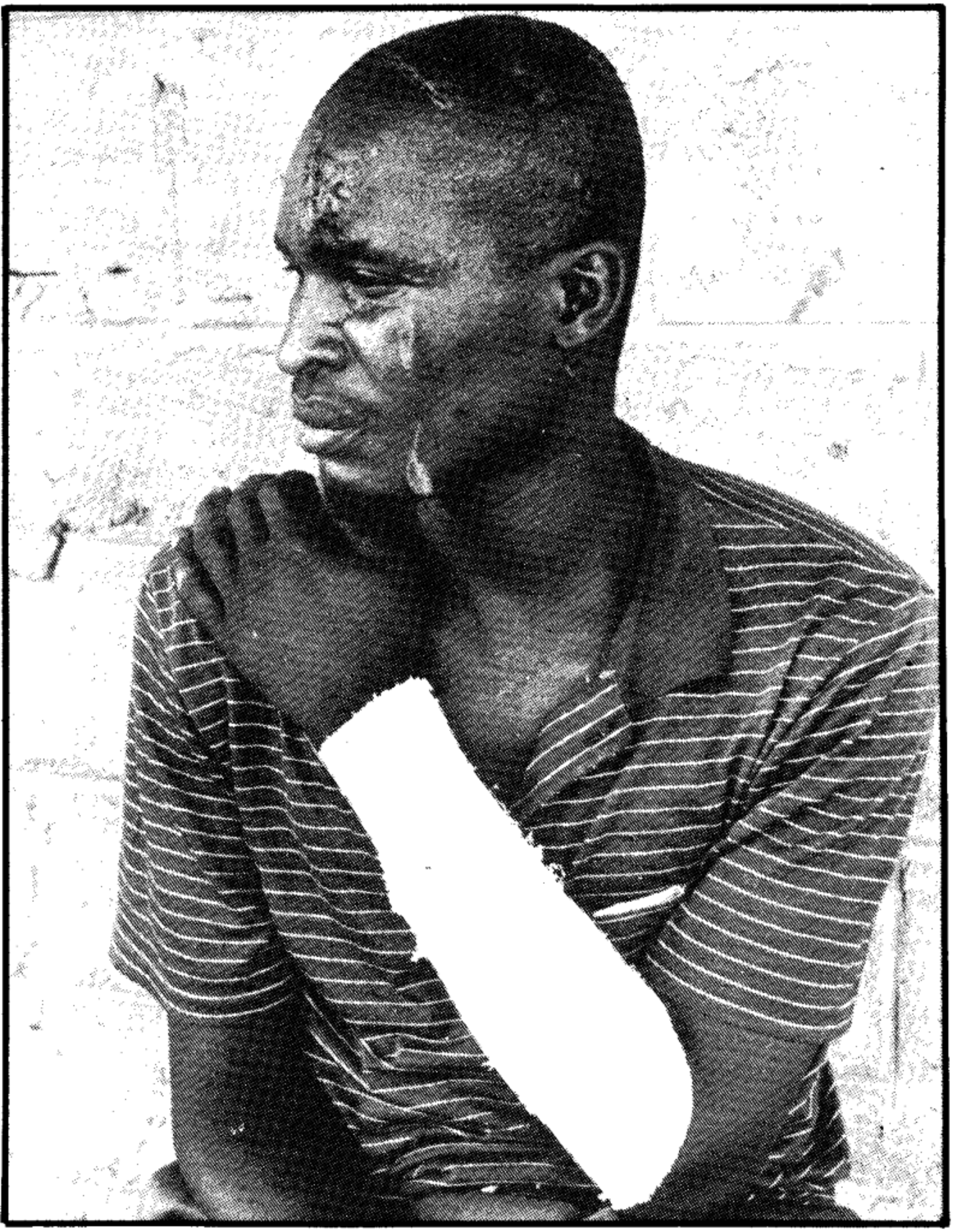
Their opposition and actions have shown results: the opposition to independence is growing, and recently, the majority of the KwaNdebele Legislative Assembly called for independence plans to be cancelled. The demands of Moutse community leaders have been taken up by KwaNdebele civil servants and workers. A stayaway was heeded by both groups recently. Secondary school children are boycotting schools and many businesses of independence-supporters have been burned down.

The State of Emergency in KwaNdebele

Shortly after the stayaway, tough restrictions were placed on individuals and organisations, in the wake of the State of Emergency. Police Commissioner Brigadier C M van Niekerk ordered special measures for the KwaNdebele area. The most far-reaching of these regulations say that:

- Persons of schoolgoing age may only be in KwaNdebele if their parents are permanent residents, or if these students can prove that they have enrolled at an educational institution. Those students who fulfil these requirements are not allowed to move out of the magisterial district where their parents live or where they themselves go to school.
- To stay in the area of KwaNdebele, people must have either a permanent home or a legal job.

- There is a curfew between 9pm and 5am which applies to everybody, except those people who are moving to and from work and those who have special permission.
- There are curbs on publicising or distributing news on the actions of members of the KwaNdebele forces.



A victim of a vigilante attack

What people in Moutse have to live with

People in the Moutse district live under extreme stress. They have been under threat of forced removal and of losing a limited degree of self-determination through incorporation into KwaNdebele. They are in constant fear of vigilante attacks, KwaNdebele and South African police violence, and reprisals from local white farmers.

Having to live with these fears has prompted some Moutse residents to take part in a workshop to identify problems of people, and to learn how to listen to them and support them.

Within the overall problems of police and vigilante violence and the threat of removal or incoporation, the workshop participants pointed to the following problems in their communities:

- inadequate housing and water supply
- inadequate health facilities
- high infant mortality rate
- conditions of poverty: hunger, lack of clothing, money problems, debts, high prices
- inadequate pensions and difficulties in obtaining pensions
- difficulties with employment: even those who do have jobs face problems regarding contracts, and harassment by employers
- problems related to schooling and education: inadequate schooling, people being expelled from school because of involvement in organisations, and being unable to defend their rights
- the tribal system, which brings conflicts in loyalty. Some tribal chiefs harass and exploit people, possibly with backing and reward from the government
- fear of witchcraft: people are manipulated through fear. Events such as lightning are explained through witchcraft
- oppression of women: women are kept subservient to men. Married women's role in organisations is limited because they are expected to run the household and care for children
- break-down of family relationships: There is a great deal of separation and divorce. This often happens if one partner is involved in an organisation and the other one is not involved, and does not share an understanding of the organisational work. There is also a break-down in parent-child relationships for similar reasons. Often, parents become very anxious if their children become involved. The discomfort at home often becomes so great that the child can no longer stay there. This brings about a conflict of loyalty to parents and family on the one hand, and organisational work on the other
- indifference and fear: these are two of the main problems in organising people

All these stress factors result in feelings of fear, insecurity, conflict, hatred, aggression, despair, loneliness, bitterness and powerlessness. Many people are depressed, anxious, bewildered and angry. There are few ways of helping these people. For those who are organisationally involved, there is support from fellow members. But there is no way of dealing with severe psychological or psychiatric symptoms.

Residents of Moutse attacked by vigilantes

Taking statements from residents of Moutse

Coming to grips with the problems

In the beginning, the workshop participants found it very difficult to accept that they could not offer immediate relief and help the people in their community who have serious problems.

The participants' first reponse to any of these problems was to look for immediate solutions. At the same time, though, they realised that it was not realistic to offer immediate solutions; that they would only disappoint people who sought help if they made promises that they could not possibly carry out.

Workshop participants learnt that it is, first of all, very important to listen to the person who is facing a crisis. The next step would be to get the person concerned to say what he or she would do about the situation. Then the listener would take up these suggestions and put them before the person concerned as possible "options" or "choices".

But even so, the individual's options or choices are very limited. They can become "choices" only within the wider framework of organisational work, when it comes to making policy decisions and choosing strategies of how to go about addressing problems which the community is facing.

HEALTH SERVICES IN MOUTSE

KwaNdebele, without Moutse, does not have any hospital. The "homeland" gained a hospital only with the incorporation of the Moutse district. The superintendent of Philadelphia Hospital was recently appointed secretary for Health in KwaNdebele. He then questioned the entire hospital staff as to their allegiance to the KwaNdebele government.

Co-inciding with this development, various Moutse residents who became victims of police and vigilante violence, have reported that they were turned away by hospital staff when they came to Philadelphia Hospital for treatment.

Another recent incident has made people mistrust the health services in the area. Thomas Mnayakeni (18) of Vlaklaagte was shot and wounded in the arm and leg during a skirmish. He was put into an ambulance which, it seemed, was bound for Philadelphia Hospital. That was the last time he was seen; he has disappeared without trace. People close to him have searched for him high and low. They went to all the surrounding police stations, hospitals and mortuaries but there was no trace of him anywhere.

BOOK REVIEW

THE STRUGGLE FOR HEALTH - MEDICINE AND THE POLITICS OF UNDERDEVELOPMENT

By David Sanders with Richard Carver, MacMillan, London, 1985

Go out and buy a copy of Sander's book now! This is a fine, readable book which is articulate, clear and presents a coherent argument about underdevelopment and health.

It is not an academic book but is a practical approach to understanding real day to day problems about health and the struggle to achieve it in the underdeveloped world.

It is a book which is relevant to all health and development workers and students, and should be a key reading for community and worker activists and organisers who want to know something about the struggle for health.

Themes

The book was originally planned as a guide to volunteers about to work in health services in underdeveloped countries.

It became a broader project, focusing on a clear and concise approach to the problems of maintaining and promoting health in the underdeveloped world, and the role of health workers in the struggle to overcome those obstacles to health that lie in the structure of society.

Sanders states that "this book is dedicated to the proposition that problems of health, development and underdevelopment are intimately linked. It is for that reason that it might sometimes read like a lesson in history or politics rather than a health- care manual. There is no reason to apologise for this. For too long health has been widely looked upon as an issue apart from the real problems in society. The time has come to redress the balance."

This book certainly plays a part in this task.

THE STRUGGLE FOR HEALTH explores the rates and types of disease which are so common in the underdeveloped world. The discrepancy between the health of the population of the rich versus those in the poor countries is clearly pointed out with the help of lucid tables and photographs.

The diseases of underdevelopment also occur in the West and are not dependent on a "tropical" climate. Rather, they relate to social conditions, the lack of provision of adequate water, housing, education and health services.

The association between social class and health is made clearly; it is the poor in any country who suffer most deprivations and thus most ill-health.

How were the countries of the West able to overcome their health problems while the countries of the underdeveloped world are still struggling to achieve this?

Part of the explanation lies in an understanding of colonialism, imperialism and underdevelopment and the effects of these on the world. It is also important to note that in the West, the promotion of health did not result purely from industrialisation but depended very much on popular pressure.

Through the organisation of communities and workers, sufficient pressure was placed on the state to improve the environmental conditions which led to ill-health.

Although the debate of these issues is brief and at times superficial, it is a useful introduction to the concepts involved in underdevelopment and health.

Chapter 4 draws attention to the role of the health services in making Western penetration acceptable to the local inhabitants of the underdeveloped world. Health services drew the local inhabitants closer to the colonists, but also protected the colonists themselves from the ravages of disease.

Chapter 5 is titled "Medicine, Business and the State" and it analyses the major strands in Western medicine today. The question of inappropriate health care systems, the class position of doctors, and misguided priorities for research are tackled and explored.

The reproduction of professionalism, victim blaming, and women and health all receive attention from Sanders' sharp, albeit brief, coverage of these issues. The activities in underdeveloped countries of the private health sector, big business and the drugs, baby-food and medical supplies industries are well presented.

Can the medical sector play a part in promoting health? This section of the book draws primarily on experiences from China and Cuba, and raises issues about the appropriate training of health personnel, in particular, the barefoot doctor and village health worker.

Sanders argues that these levels of health personnel, combined with adequate political commitment, can achieve major changes in the restructuring of the health status of the community. Unfortunately, more recent data on the kinds of health problems experienced in Tanzania or newly independent Mozambique are not presented.

The final chapter looks briefly at the role of the "concerned health worker". Sanders indicates that health workers may come into a situation with many constraints - including culture, language, training, and social class - all of which make it more difficult to work directly with the poor.

Such workers will always be "outsiders" regardless of how well-up they are with the latest WHO publications or how familiar they are with primary health care jargon, unless they become part of a move to overcome the origins of ill-health in society.

He argues that changes in health and health care can ultimately only be made by the people in the communities themselves. Concerned health workers can, however, play a part by acting in solidarity with the community and by making their skills available to the poorest and most oppressed.

Health workers should encourage democratic control over the provision of health care and be willing to submit to the will of the majority. They should attempt to demystify medical knowledge and practice and should play a role in

breaking down hierarchies within the health sector, and promoting democratisation within health institutions.

Yet another role for progressive workers is the collection of statistics and facts, which, if coupled with information about relevant social conditions, may play a part in providing communities with the information they require to confront the state over health issues.

In the developed countries, struggles against cuts in health care, the provision of information about the state of ill-health in the underdeveloped countries, and the education of colleagues about the social origins of poor health are all important activites.

Sanders concludes that "it is here that the concerned health worker and all those concerned with health could introduce the issue of how ill-health is produced in our societies - and how any struggle for progressive social change and against the old order and power structures is also a struggle for health".

Conclusion

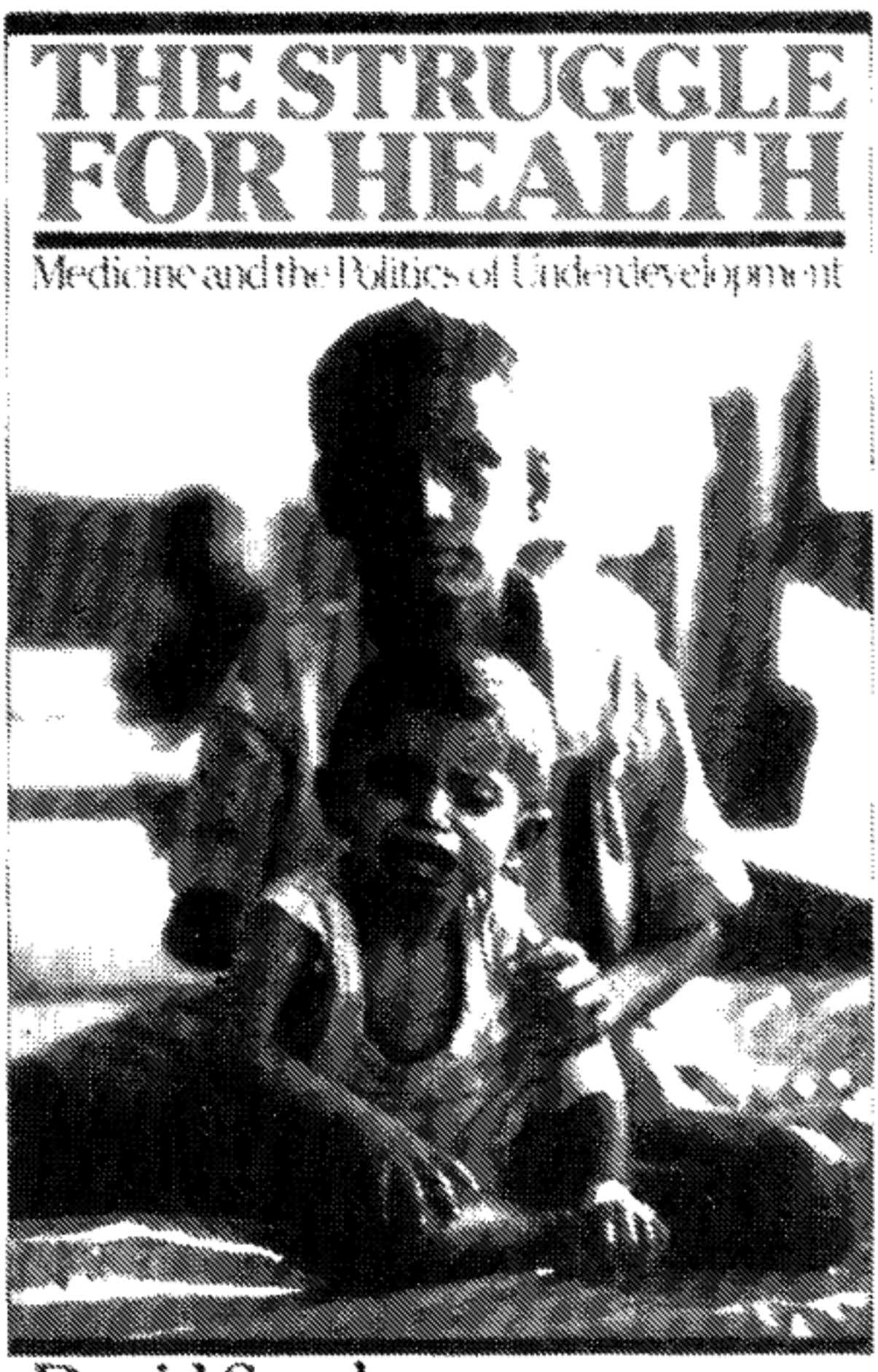
This as a very useful book which all concerned health workers and activists, and every medical and nursing student should read. The book is not without flaws: at times the text is too superficial to be of much help to the uninformed reader, and those interested in learning about the finer points of debate around an issue will have to consult other texts.

This is not important as the book aims to be an introductory text and not an erudite discussion of the political economy of health.

There are some places where illustrations do not fit well with the text and where lables on illustrations are not very clear. However, the generally well chosen and plentiful supply of graphics, tables, and illustrations make this book very readable and useful for group discussions and workshops on the struggle for health.

Fortunately the book has been heavily subsidised to enable everybody to afford their own copy - a great benefit in these times when buying books is becoming the preserve of the rich!

Anthony Zwi



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FIRST AID BOOKLET AND VIDEO

During the State of Emergency declared in South Africa last year, Health Care Trust was called upon for assistance with first aid and emergency treatment. As a result of this, an emergency treatment team was set up comprising medical doctors (NAMDA), nurses (Health Care Trust and Nurses Support Group) and paramedical personnel.

Unfortunately, this structure was affected by the repression of the time and became virtually ineffective. Once again, Health Care Trust was approached by the communities to conduct first aid programmes. However, the request was for these programmes to be more localised.

The first group trained was the Ulwazi Christian Students. Requests were also received from outlying areas such as Beaufort West, Saldanha Bay, Worcester, etc. As the demand grew it became more and more difficult for Health Care Trust to conduct intensive programmes within each area.

With this problem in mind, we consulted the Ulwazi Christian Students and looked at how they could possibly pass on their newly acquired skills to their community. The idea of producing media on how to treat different injuries came about.

After further exploring this idea, it was decided to produce a booklet. This group was given the responsibility of writing on issues such as burns, teargas, etc. This booklet was to serve as a reference book for groups with whom it was difficult to have direct contact.

The Health Care Trust found that the booklet was not adequately addressing the needs of communities, especially in the outlying areas. Practical demonstration was essential, and it was then decided that a video would meet this need.

The video and booklet were first produced in Afrikaans as this is the medium of the outlying areas. It has now been translated into English.

The first aid booklet is available at 15 cents each.
The video is available at R30,00 in Afrikaans, English and Xhosa.

Both are available from the Health Care Trust office,
41 Scott Rd
Observatory
Cape Town
7925

NOODHULP IN KRISISTYD

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The President of the Republic
of South Africa
P.W. Botha
Union Building
Pretoria
Republic of South Africa

June 18, 1986

Your Excellency,

At the international seminar organized by ICHP/CINPROS on June 16/17, 1986 in Geneva, Switzerland entitled "Health Professionals Ethical Problems in Situations where Human Rights are Violated", members of our commission and other participants considered the current trends of human rights in South Africa in the light of the system of apartheid and the declaration of the nationwide state of emergency, and they expressed their belief that abuses of human rights by government or its agents are never justifiable under any circumstances, whether in peacetime, or in response to civil unrest.

Our commission has been greatly concerned by evidence of increasing violence and torture, whether in police custody, in detention, in public places, or in the home. We believe that certain features of the legal system encourage these abuses of human rights by the South African police forces and other law enforcement agencies. We wish to draw attention in particular to the acceptance by the South African courts of evidence obtained under torture, which we consider to be a breach of the principles of fair trial. Also, we wish to protest against the abuse of prosecution under criminal proceedures or civil law in cases of extra-judiciary killing or maiming.

The work of health professionals has been obstructed and distorted by interference with normal medical practices such as has happened recently in the clinic of Alexandra and Crossroads, or by harassment as in the case of Dr. Wendy Orr and the nurses of Bharagwanath hospital. This violates

both the rights of the patients and of the health workers.

We call on you to end the national state of oppression and to guarantee health professionals the freedom to work in accordance with ethical guidelines established by international medical, dental and nursing organizations which are based, in turn, on the United Nations Declaration of Human Rights, the UN Standard Rules for the Treatment of Prisoners, and the UN Principles of Medical Ethics (see annex appended).

We shall continue to support all those health professionals and organizations in South Africa who courageously maintain their professional standards and ethics based on the human rights of their patients.

We condemn those health professionals and organizations who participate in torture, whether under orders of the government or not, or who condone or camouflage its practice for any reason.

We urgently request that the health professionals presently in detention be released. We would particularly request information about the wherabouts and well-being of

Dr. Vijay Ramlakan (Durban)
Dr. Dhlomo (Durban)
Dr. M.M. Motala (Durban)
Dr. V. Chitty (Durban)
Ms. Oomie Jhetham (medical student, University of Natal)
Dr. R.A.M. Saloojee (Johannesburg)
Dr. Francis Hlahla (Mahwelereng)
Dr. Fabien Ribeiro (Pretoria)
Dr. Abubaker Asvat (Johannesburg)
Mr. Saths Cooper (clinical psychologist, Durban)

We are looking forward to a reply at your earlist convenience.

With respects,

Yours sincerely,

Dr. Paulo Parra
Secretary General

Dr. Arnt Meyer-Lie
President

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CRITICAL HEALTH aims to:

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