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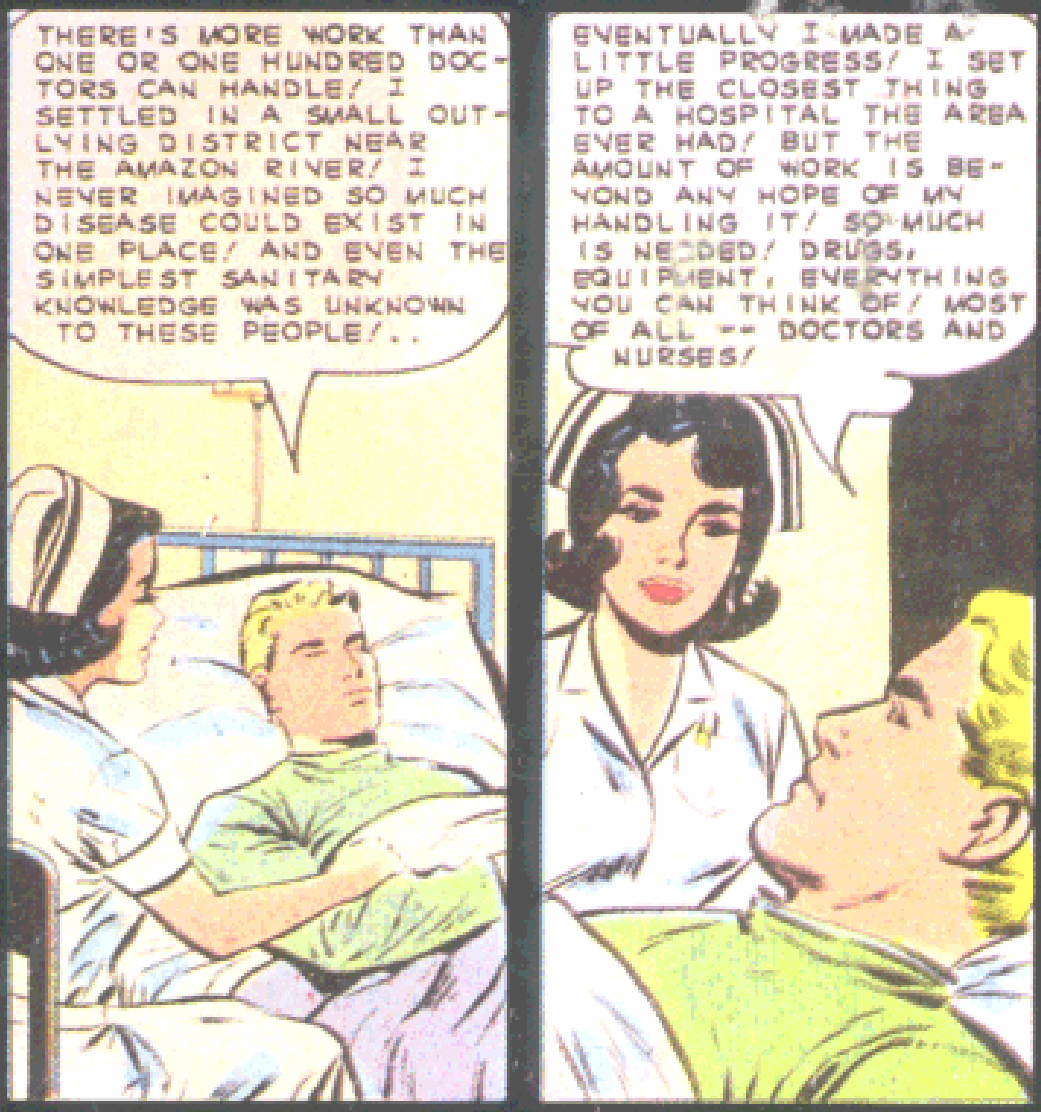

Health Workers № 2

accountability & training

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an editorial collective:
PO Box 16250
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2028
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Tel: (011) 484 3078
Fax: (011) 484 3557

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Critical Health **Number 40** **September 1992**

Health Workers N°. 2: Accountability & Training

Editorial

This is the second of two editions focusing on health workers during the current period of transformation. In the last edition, we explored the wages and working conditions of health workers and the development of more appropriate roles for health personnel. In this edition, we look at the training that is required to develop appropriate personnel and the challenges we face in ensuring that existing personnel are accountable to the communities they serve. We also debate the role that traditional healers could play in a new and improved health system.

The first section covers the need for appropriately trained health workers and new efforts to provide the necessary training. The first article evaluates the winter school recently held by the new School of Public Health at the University of the Western Cape. It was attended by 130 people, including a wide cross-section of health and welfare workers. The course covered primary health care (PHC), training PHC co-ordinators, health systems research and methods for assessing food security. Most participants felt that the school had been useful in sharpening the skills they already had and empowering them with new ideas for running their projects.

In the last edition, Marge Concha made a contribution on the need for training community based rehabilitation workers (CBRs). Now we include an evaluation of the Alexandra Health Centre's CBR training programme. The evaluation reveals different attitudes on the relationship between CBRs and other health workers. Professionals feel that CBRs should work independently and without a great deal of supervision. Most CBRs and disabled people prefer a role for CBRs which will incorporate them into the structure of a wider health care team. The Alexandra Health Centre also provides a report on its proposed school for training various types of PHC workers. It highlights aspects of the envisaged curriculum.

Fareed Abdullah argues for an occupational safety programme which gives priority to the training of occupational health workers on the factory floor. These workers need to increase awareness of occupational safety amongst all workers. To encourage leading workers to take up training in occupational safety, programmes should involve trade unions. Abdullah says they should also "link health and safety to broader education and training and job grading in the workplace".

Health services in this country have generally been developed without consultation and health personnel have become accustomed to working in this undemocratic environment. The first article is based on interviews with and contributions

from Medecins du Monde and Alexandra Clinic and stresses the need to ensure that health workers are accountable to the communities they serve. The article covers three projects, one urban, one semi-urban and one rural. It highlights the ways in which these projects have become more accountable and also raises factors which inhibit accountability.

Ivan Toms attempts to outline what a primary health care team should look like. The team should include health, administrative and development workers. He argues for the incorporation of traditional healers. The team leader should not necessarily be a medical professional, but should have the quality to empower and build other members of the team. He suggests that all health workers should be given the opportunity to receive training in team management.

David Sanders looks at some of the problems that have been encountered in Zimbabwe in the process of transforming the health system after independence. Despite the development of the rural health service, community health workers have become less appropriate to the communities they are meant to serve. Furthermore, despite more appropriate training, Zimbabwe still faces a maldistribution of personnel between rural and urban areas. Many medical doctors have resisted working in poorly paid rural areas.

The transformation of health services will not be complete until the role of traditional healers has been considered. In this section, Melvyn Freeman outlines the very different views of the medical establishment and traditional healers on the relationship between these healers and a new health system. He concludes that there are moves to seek co-operation between the modern and traditional sectors and that some accommodation between the different views is being achieved.

To complement this, we are publishing an article on changing state policy on traditional healers in Mozambique. A new law which accommodates traditional healers is about to be introduced. It covers registration and criteria to evaluate standards of conduct and professional competence.

This is followed by an article on traditional healing and the training of doctors in PHC in the Philippines. It discusses the unconventional, yet sensitive way in which progressive doctors there are relating to traditional healers.

In the general section, we include articles on aids, drought relief and the recent hospital strike. We are printing the full text of the AIDS Consortium's charter of rights for people with HIV and AIDS. A number of organisations have already endorsed the charter. The consortium is hoping to get further endorsements and is planning to launch the charter publically on or near World AIDS Day, 1 December 1992.

South Africa is suffering from an extremely severe drought and the government has failed to respond to this crisis with the necessary urgency. The first of two articles on the drought is based on an interview with Diane Cailear of the National Consultative Forum on Drought Relief. She points out that the government is guilty of poor planning and that it has not developed the necessary information to identify the people in greatest need of relief. However, she argues that various organisations have put pressure on the government and that it is now responding positively. She says that civics have a role to play on the relief committees which have been set up by the government.

This is followed by an update by Operation Hunger. This article highlights the degree of suffering as a result of the drought. According to Operation Hunger, the state bureaucracy remains a major obstacle to effective drought relief.

In the last article in this edition, we assess the hospital strike which ended in September. The government was particularly ruthless in its attempt to crush NEHAWU and, in the process, it disregarded its responsibility to provide adequate public health services. Workers were able to make many small gains during the strike, but ultimately they were unable to withstand the government's offensive. There were weaknesses in the way in which the strike was organised and there was not enough community and political support for the striking workers. It is encouraging to note that unionists are already using the lessons learnt from this strike to strenghten organisation amongst health workers.

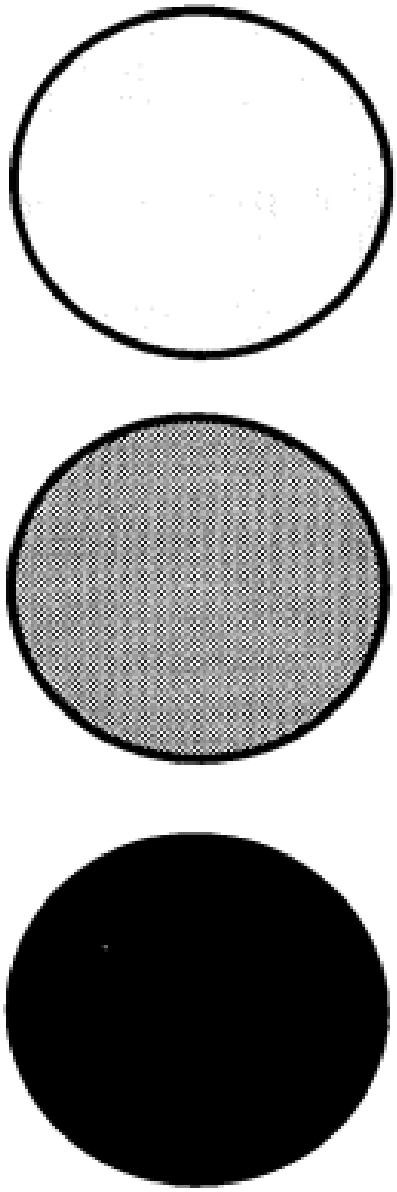
Violent political conflict has escalated in the last two years. This has contributed to rising levels of crime, rape, child abuse and other forms of violence. The next edition of *Critical Health* will focus on violence and its impact on health. We will look specifically at ways in which communities can start to counter the upward spiral of violence and the role which progressive health workers can play in assisting the victims.

SECTION

A

Appropriate Training of Personnel

A number of initiatives to make the skills of a range of health workers more appropriate for primary health care are being undertaken through the country. At the same time a call for the training of workers on the shop-floor in occupational health and safety is also voiced.



Western Cape Winter School
A Challenge for the Future

Brigid Strachan

Changes in the health sector

Current changes and needs in the health sector have led to the demand for additional skills and knowledge on the part of health personnel in a number of areas of public health. Some of the areas in which health personnel are being required to act are in the implementation of the primary health care approach, involving communities in the process of health development, assessing and prioritising health needs, managing health systems in a process of change, and planning and evaluating new health programmes. Such tasks require skills and knowledge in the important interdisciplinary area of public health.

People in the health sector as well as people in other sectors who wish to apply their skills to health and health development have expressed a demand for education and training in public health. Education and training in public health for all levels has been neglected as a result of the past orientation of the government in terms of health, health care, and health personnel education.

The Proposed Western Cape School of Public Health

The Western Cape School of Public Health (SOPH) aims to contribute to overcoming the government's negligence and to satisfying the urgent need in South Africa for appropriately trained health personnel who would form part of an infrastructure for a PHC, which is efficient and equitable, and meets the needs of those most in need. The school is a regional initiative, and is still in the process of pulling itself together in terms of joint management, curriculum and resources. However, progress is being made.

The Winter School

The Winter School, held from 29 June to 14 August, was the first teaching activity of the SOHP programme. The theme of the Winter School was "Managing Primary Health Care". The underlying purpose of the courses offered was to

provide participants with new insights into the primary health care approach, as part of the overall process of restructuring occurring at present in the health sector.

Initial ideas were developed by a Regional Winter School Committee which had representation from the five academic institutions in the region. These were; the University of Cape Town, University of Stellenbosch, University of the Western Cape, Peninsula Technikon and Cape Technikon. Administration of the programme was undertaken by the Committee to develop the SOPH, based at the University of Western Cape.

Courses Offered and Convenors

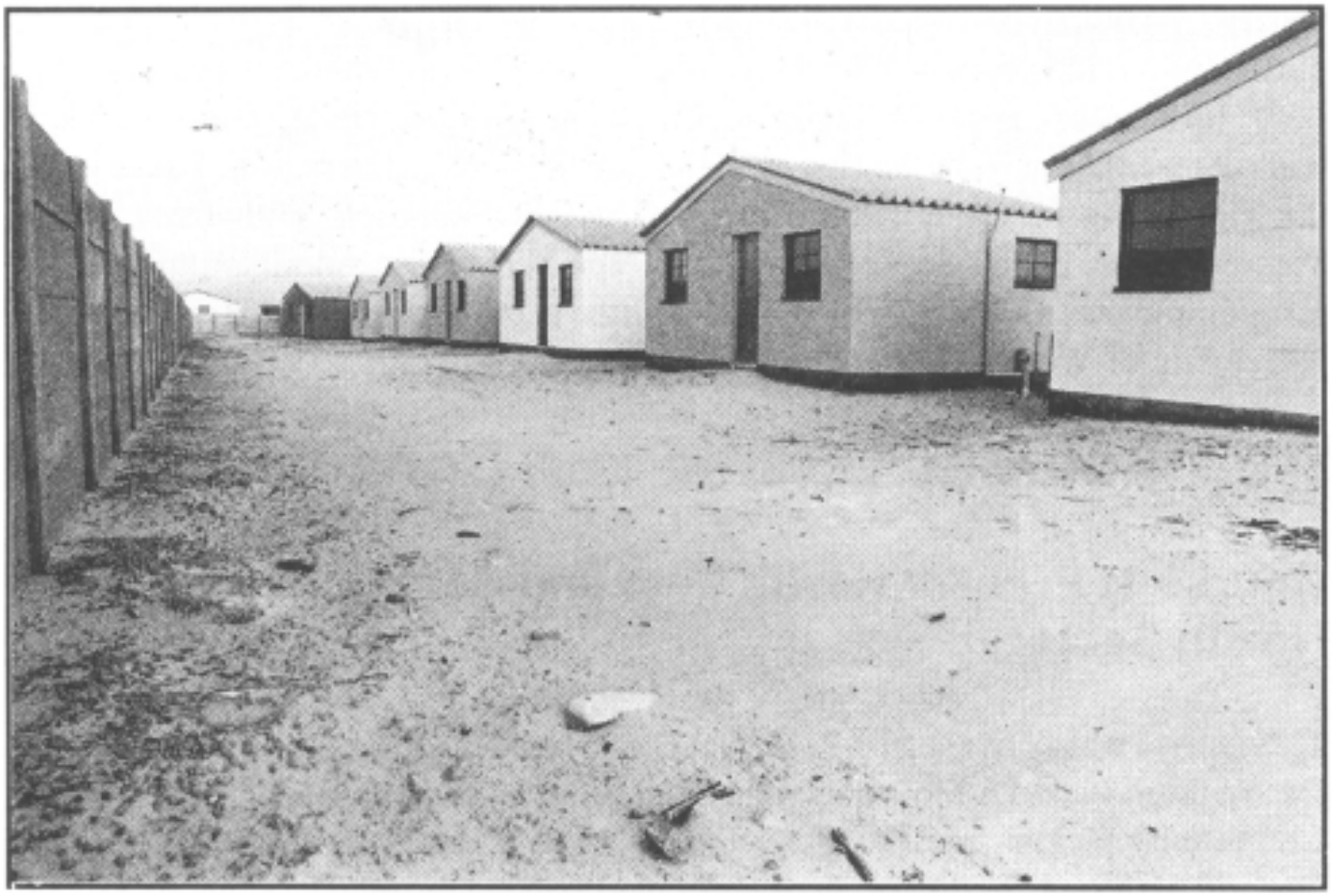
Course 1: Primary Health Care and Restructuring the Health Sector

This course was convened by Professor David Sanders of the University of Natal. Dr. William Pick, Di McIntyre and David Bourne from the UCT Department of Community Health, and Dr. Barron from the Western Cape Regional Services Council also participated in the presentation of the course. The objective of the course was to introduce participants to the key concepts, principals and debates around the PHC approach. Problems in the implementation of this approach were also discussed. There was a huge demand for this course, and only thirty participants could be accommodated. Participants were keen to gain more knowledge of PHC and how to implement PHC principles in their work situations. Participants visited Nolungile Clinic at Khayelithsha as part of their practical work.

Course 2: Training of PHC Programme Co-ordinators

This course was convened jointly by Professor Caroline Ntoane of the University of the Western Cape, Mantu Tshabalala of the National Progressive Primary Health Care Network (NPPHCN), and the African Medical Research Foundation (AMREF). The NPPHCN brought 25 of their co-ordinators from 8 regions in the country.

In total there were 40 participants from a variety of occupational backgrounds, ranging from community development workers to senior personnel in the health services. The purpose of the course was to enable health programme managers and co-ordinators to understand and apply the concepts of community based health care; to develop skills in designing and implementing training at community level; to learn skills in planning, managing and evaluating health programmes. The teaching methodology of AMREF was to involve participants



Khayelitsha. Photo: unknown

in producing their own manual as a text for Training of Facilitators for PHC. This course went on one field to Khayelitsha to "look and listen" - to observe the community.

When approached on what they liked most about this course, some participants made these remarks:

- the course has empowered me to go home and work within my community in implementing community based PHC;
- the course was inspiring;
- developed an understanding of how to develop community based program mes;
- before I came here I thought I was PHC orientated, but I have discovered that I am only starting;
- I liked the psycho-social method of teaching;
- I thought the course was revolutionary, emphasizing the social justice of PHC;
- I enjoyed the participatory learning process;
- I liked the spirit of the course;
- All our contributions were considered important and all contributed to compiling the book;

- I enjoyed sharing information and meeting people;
- The togetherness of the group;
- I gained a sense of empowerment for health for all.

Course 3: Health Systems Research for Evaluation and Management

The convenor of this course was the Medical Research Council, and was co-ordinated by Dr. Merrick Zwarenstein with Judy Katzenellenbogen and Hester van der Walt. The objective of the course was to provide participants with the methods with which to research and evaluate health systems, as part of the planning and management process. Participants were put to work on mini research projects at Nolungile Clinic in Khayelitsha, collecting data and determining how this data could improve training and management. Research results were received positively and acted upon by the clinic.

Course 4: Methodologies for Assessment of Food Security and Nutrition.

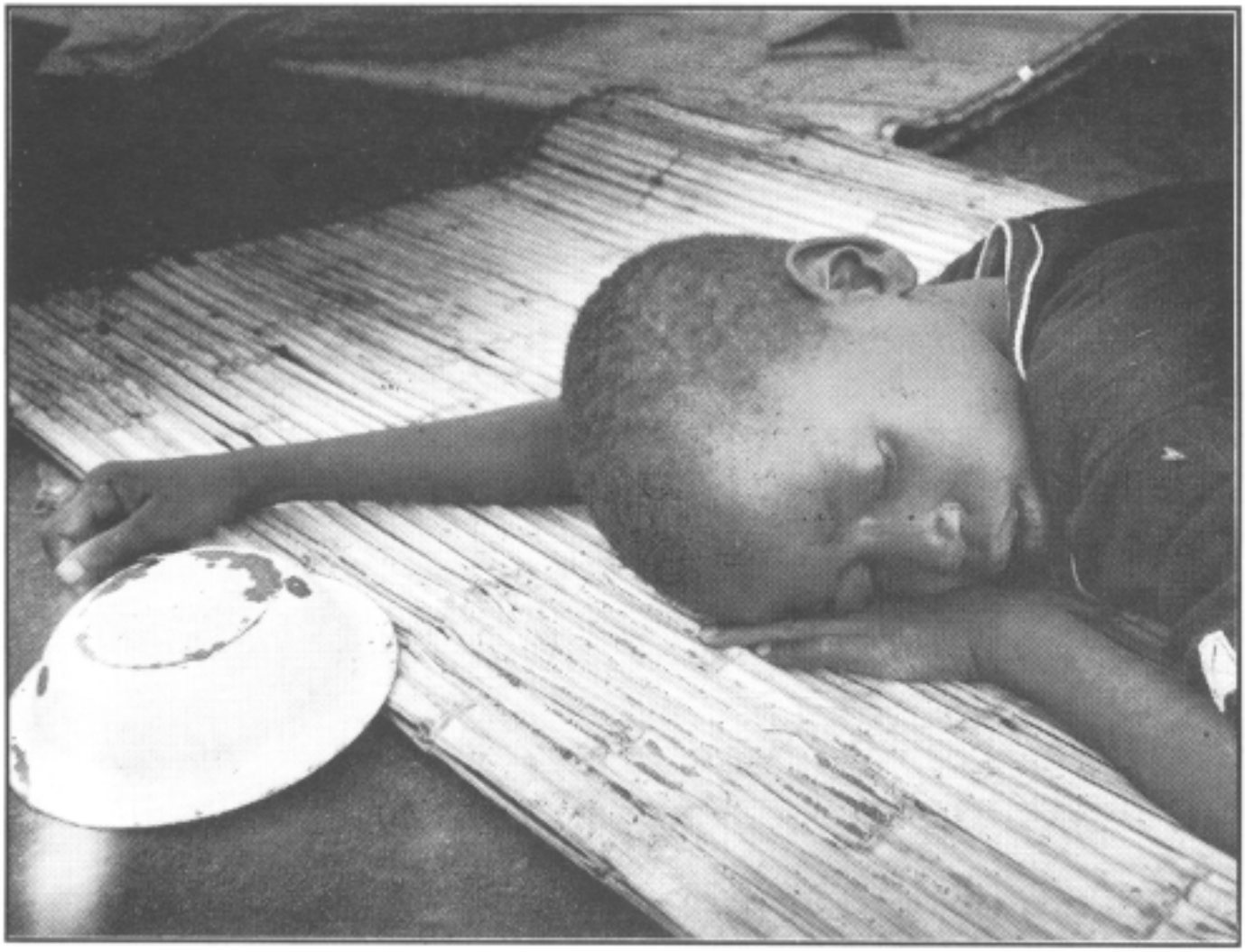
Dr Bill Bertrand and Dr Khan of the Toulane School of Public Health and Tropical Medicine, New Orleans, USA convened this course. It was hosted by Dr Bernade of the Medical Research Council Nutrition programme. This course was offered to 20 participants. The numbers participating were limited because there were too few computers.

The objective of the course was to improve applied analysis of food security (that is, people's access to food at all times) and nutrition issues for policy makers and programme managers. Participants gained skills in the area of food and nutrition surveillance using computers.

Many said that they found the course most useful having provided skills not available in South Africa. It was recommended that future collaboration should be explored with Toulane School in this area. The course produced two volumes of material and a model for a food and nutrition surveillance system in South Africa, which was submitted as a group effort to a national conference on food security in August 1992.

Course 5: Cultural Practices and Health Promotion

This was convened by Tops Guma and Jimmy Ellis of the University of the Western Cape. A lot of interest was expressed in this area, often overlooked in



Food security is a major problem in SA (see article on Drought and Poverty Relief). *Photo: unknown*

health personnel education. The objective of the course was to enable the participants to understand the implications of cultural and ethnic diversity for developing public health programmes and policies. Health and medical trainiing in this country is primarily based on a western biomedical model. Consequently, many health personnel have little understanding of other cultural perceptions of health and disease and are often dismissive of such understandings. Thus this course was important for participants to overcome the inadequacies of their own training and understanding. Participants went on two fieldvisits to Noordhoek and Elsies River.

Participants

One of the successes of the Winter School was the range of people from different regions, ages, colour, occupation and gender participating in the courses. The variation of participants broke down barriers and reinforced the idea that every health worker is important and has a crucial role top play. A hundred and thirty

people attended the various courses over seven weeks. Most of the participants were community development workers. The majority of whom were black with an even distribution of men and women.

The Challenge Ahead

Many of the participants felt that the Winter School had an important effect in inspiring them to meet the challenges ahead in the attempts to work towards a more equitable and community based health service. The Winter School showed the demand for short courses in the area of public health by different personnel working for change in the health sector. The school also showed the potential of such courses to mobilise and sharpen skills with a view to developing a health sector which is more equitable and relevant to the changing society in which we live. The challenge is to provide more and better education and training for all health sector personnel in the coming years in the relevant areas in order to facilitate the process of change and transformation currently underway. Change will not happen on its own or through instructions from above. It needs to be planned, implemented and evaluated. Most important, the right skills are needed for the job.

Brigid Strachan is on the Public Health Committee at the University of the Western Cape.

Training Community Rehabilitation Facilitators at the Alexandra Health Centre

Initial Findings from a Recent Evaluation

Huib Cornielje

This article describes the findings of an early evaluation of community based rehabilitation (CBR) training program. A new cadre of rehabilitation workers, Community Rehabilitation Facilitators (CRFs) are being trained at the Alexandra Health Centre and university clinic. Critical food for thought regarding the role of and need for such programmes is discussed, in the context of the findings of this earlier evaluation.

Background to CBR

The disabled population represents a group of people not only with neglected, but also with hidden and unacknowledged needs. These needs have recently been highlighted, but most of the rehabilitation models followed up to now have emphasized the role of professionals in a medical model. More appropriate models utilizing community based workers have been explored in rural and urban setting, but these are either not well received by professionals and academics, or they are viewed as appropriate only for the poor of this country.

The CBR Course at the Alex Health Centre

As an essential part of the CBR program, a two year training course was developed to train people as community rehabilitation facilitators (CRFs). CRFs are a new category of rehabilitation workers whose job it is to work with, and in the community to assist disabled people to overcome the difficulties they experience as a result of their handicap. As such, their job focuses mainly on assisting disabled people in overcoming the social consequences of their disability.

So far, there are two training programmes in South Africa training this category of rehabilitation facilitators, namely, one at Tintswalo Hospital in the north eastern Transvaal and one at the Alexandra Health Centre (AHC) north of Johannesburg.

The disabled population has neglected as well as hidden and unacknowledged needs. *Photo: Natasha Pincus*

The CBR course at the AHC is divided into two parts: Part one consists of a year of intensive training at the AHC; the second year is an internship spent in the student's own community. During the latter year, support is provided by the AHC with four seminars planned lasting one week each. A specific community development project is to be executed by each student. At least one seminar will emphasis the imparting of skills and knowledge to a lower category of Community Rehabilitation Workers (CRWs).

The course is a pilot project and the first of its kind in South Africa. The curriculum was drawn up and appropriate course objectives were developed utilizing the following:

1. Consultation with rehabilitative specialists;
2. Needs expressed by the community determined from a disability prevalence study conducted by the CRFs in the initial weeks of their training;
3. Six years of community development experience of the researcher.

Method of Evaluation

An initial evaluation of the CBR course was done during the first six months of 1992. It was decided to first evaluate the course objectives in terms of their appropriateness for different groups, including the students and other beneficiaries of the CBR service offered by the CRFs. This was important since the CBR program looks at social, political, environmental and cultural factors responsible for people' disabilities, and not only the medical background of disability. Traditional methods of evaluation involving professional rehabilitation workers would be inappropriate.

A danger exists in that professional values could soon be imposed in measuring non-professional input, hence the importance of community input. In a country such as South Africa, with well-established rehabilitation professions, there is a continuous quest for guaranteed standards with regard to job performance of rehabilitation professionals. This could result much later in resistance towards CBR as a philosophy and, consequently, also to community participation in evaluations of such programmes.

Supplementary vs. Complementary Role of CRFs

The evaluation of the objectives of the CBR course revealed interesting opinions regarding the role of CRFs. There is a general consensus that the CRFs can play an important role in the rehabilitation of disabled people. This role is seen as either complementary (suggesting the ability of the CRFs to work independently, without the support of a therapist), or supplementary (meaning that the CRF is part of a team of rehabilitation professionals, including therapists).

It is actually at this level that most disagreement existed between the different groups of people interviewed, including individuals in different professional groups. Questions were raised regarding the following issues:

- the supervision of CRFs
- their relatively independent role in remote areas
- their ability to solve problems on their own
- CRFs being facilitators of rehabilitation.

The last issue was particularly controversial. People on the outside with specialized areas of work, as well as lecturers, were much more of the opinion that the CRF was complementary to rehabilitation professionals. Where needed, they has to be able to work independently without too much supervision.

However, the CRFs themselves, as well as disabled people, indicated a much more supplementary role for the CRFs as part of a rehabilitation team, receiving regular supervision.

There is general concensus that CRFs can play a role in the rehabilitation of disabled people. *Photo: Natasha Pincus*

Clinical vs Developmental Skills

Among informants in general difference on these issues were less noticeable. However, individual opinions within the group of interviewed lecturers and experts regarding the importance of specific tasks showed fundamental differences. Definite differences existed as to the importance of clinical and practical skills of the CRFs. Some felt that this area was the most important area, which, as a topic, received least attention in the questionnaire (one wonders if they envisaged surrogate rehabilitation professionals). Other felt strongly that the strength of the CRFs was formed by the definite knowledge of community structures as well as the important role they could play in the area of intervening in the social consequences of disability. This social role, which in our opinion, is neglected in the training of rehabilitation professionals, could then also be explained as supplementary to traditional rehabilitation. Hence there appears to be an apparent contradiction with the generally accepted view amongst professionals

that CRFs should fulfill a complimentary function. However, we believe that it is more likely a reflection of the increasing limitations of traditional rehabilitation services in the sense that clinical rehabilitation is viewed in a vacuum, is removed from its psychological and political context.

The difference in opinion between the various interviewed groups of people concerning the role of the CRFs is important for the further planning of education and training of CRFs. Further research, particularly into this issue, should be done in the near future. The outcome should, ultimately, have serious consequences for the development of CBR services at a national level.

The drive for advocating and developing CBR services in South Africa should be seen against the background of the recognition of concerned individuals through the Rural Disability Action Group in the mid-80's. There were (and still are) severe shortages of rehabilitation personpower in remote rural and peri-urban areas. Apart from these shortages, there is the increasing awareness that rehabilitation professionals are inappropriately selected, trained and utilized. However, some caution with regard to new developments in rehabilitation is needed. It might be that CBR development will now deviate from the original motivation and that, ultimately, CBR becomes an integral part of rehabilitation services in general.

Conclusion

This early evaluation has raised a number of issues regarding the role of and training of CRFs. These have been outlined above. The time for more rhetoric has passed. What is required are open and vigorous evaluations of present CBR programmes in rural and peri-urban parts of the country. If we fail to unmask the myths about rehabilitation, South Africa will again end up with a service only for those who can afford to have a private therapist at home. On the other hand, those who advocate CBR as a service and philosophy for life will need to give evidence that it is affordable, cost-effective and of good quality. Only if criteria are met regarding affordability, efficiency and quality, can we expect CBR to be adopted as a national strategy and philosophy in the field of rehabilitation. Today, we at Alexandra don't have (as yet) such evidence.

It is up to us and others involved in the CBR movement to show evidence of success. This requires the development of performance indicators and criteria for evaluation. Old positions need to be reviewed, new directions need to be evolved. Above all, we have to continuously ask ourselves whether or not CBR is really meeting the needs of all disabled people in the country. If, and only if we receive a satisfactory answer to this question, further developments can and should take place.

Huib Cornielje is a physiotherapist at Alex Clinic

Training for Occupational Safety and Health

Fareed Abdullah

The focus of a national drive for Training for Occupational Safety and Health (OSH), this article argues, should be on increasing awareness and training workers on the shopfloor, rather than training highly skilled medical and nursing staff. The demand for these latter personnel will grow naturally with an increase in the awareness of OSH.

Training for OSH

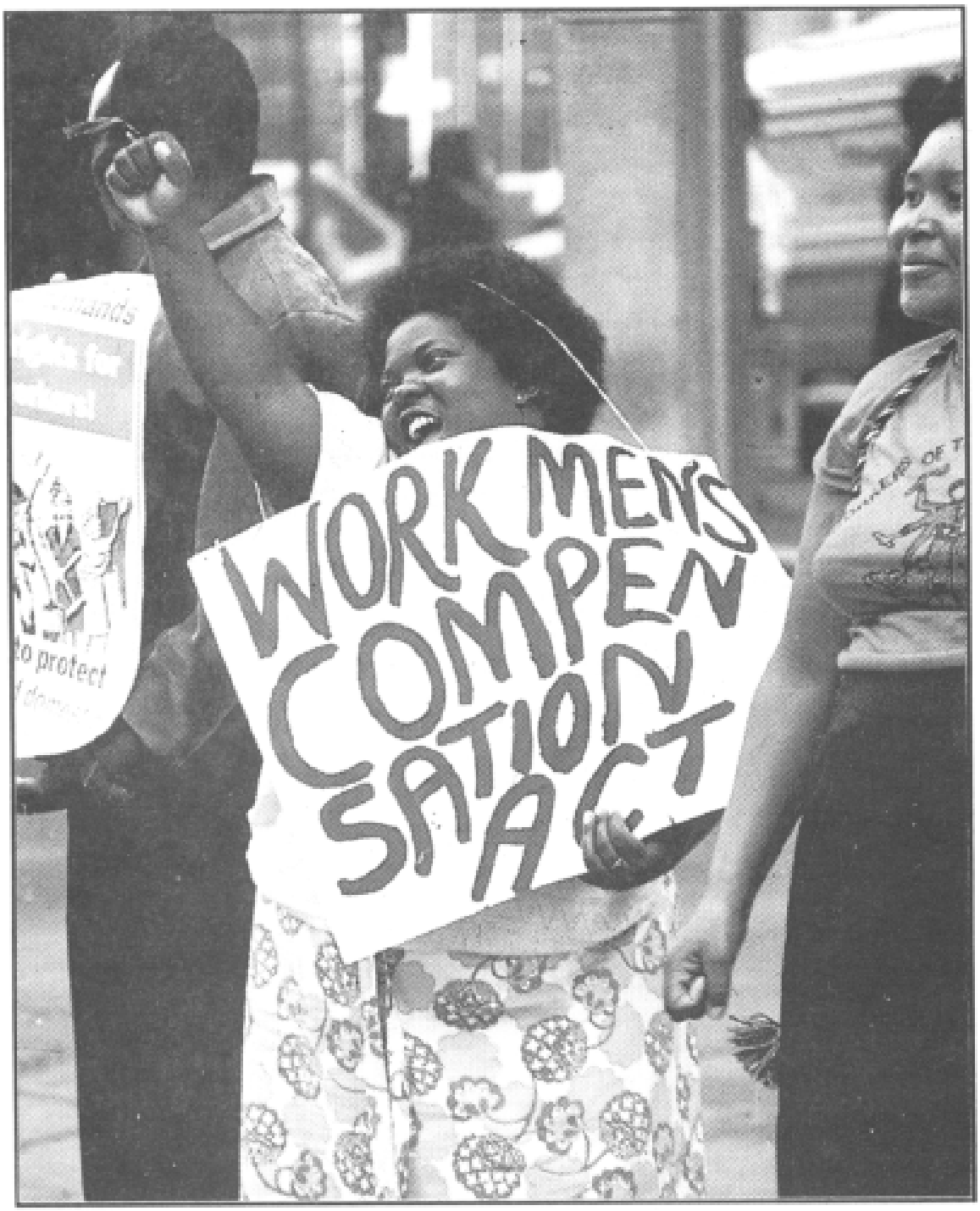
Once a democratic government is elected into office, the possibilities of making meaningful inroads into the improvement of OSH become real and we need to encourage the discussion on future strategies. Profound changes in OSH will require the personnel and skills for the implementation of these strategies. The subject of training these OHS personnel is addressed in this article.

There are three levels of training for OSH. The most obvious of these is that of training OSH professionals, that is, doctors, nurses, hygienists, physiotherapists, speech therapists, hygienists, ergonomists, safety professionals, safety engineers and occupational therapists, all of whom have an important role to play in the provision of OSH care for South African workers.

Another level at which training in OSH takes place is on the shopfloor, a task which includes:

- improving the general awareness of OSH in the workplace;
- training of health and safety representatives;
- training of workers and management in OSH;
- training of safety engineers and technicians; and
- the training of medical, nursing and allied staff

A third level at which training needs to be considered for occupational health is at the level of policy makers in the state, in companies and in trade unions as well as other bodies engaged in the development and evaluation of occupational safety and health policies. These policy makers require a specific set of skills to enable them to assist with the determination of OSH policies. However, we will not deal with the training of this group of individuals in this article.



Workers need to have sufficient knowledge of OSH in their workplace to effectively demand better conditions. *Photo: Karen Hurt*

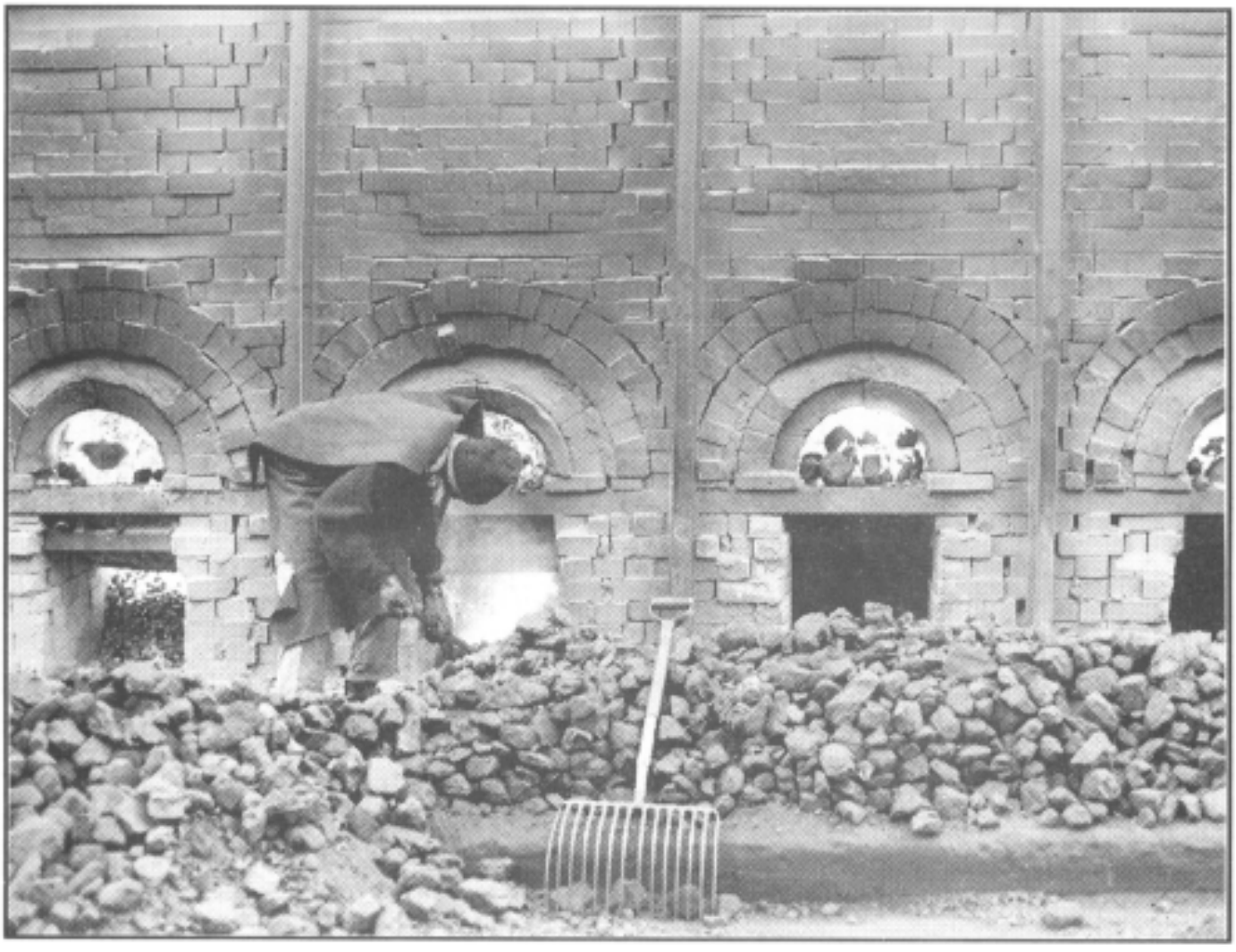
A criticism which relates to the course content of the NOSA training programme is that it tends to focus on machines and machine safety rather than the modern industrial work process. Its teaching methodology is old-fashioned and deals mainly with technical points of OSH legislation, rather than on the recognition of hazards and improvement of health and safety conditions in workplaces.

Whilst NOSA has played a role in occupational safety, claims that it is leading the world on health and safety training appear to be a little far fetched. On the whole, awareness and general knowledge of health and safety in South African workplaces is low. Health and safety standards in our workplaces are nowhere near

acceptable, and there is a need for a national drive to improve health and safety conditions.

A small amount of training is taking place through the independent trade union movement and service organizations linked to it. This training is more comprehensive and focuses on identifying safety and health hazards in the workplace and ways of improving these working conditions. Trainees at these programmes are often shop stewards with some influence on the shopfloor. On the whole, however, these individuals are lost to health and safety, either because they have no structured intervention to fit into or they are not appropriately located in the plant.

The solution to this problem lies in linking health and safety to broader education and training and job grading in the workplace. Together with progressive legislation, an infrastructure for effective measures to tackle OSH on the shopfloor can be established. Legislation and strong trade union organization is necessary for OSH improvements in our workplaces, but training is an important part of this drive. A new and creative model is needed for OSH training on the South African shopfloor. Training for OSH on the shopfloor should not be



OSH legislation must recognize hazards and improve health and safety conditions in the workplace. *Photo: Medico Health Project*

separated from education and training of workers in general; and proposals for the former must be made within a broad framework of the later.

The field of education and training for a new South Africa is vast and there are entire organizations and research projects dedicated to this investigation. We will not even attempt to summarize the issues involved. What is necessary for our purposes is to note that health and safety training on the shopfloor should not be isolated from broader strategies for education and training of workers.

NUMSA Model

One such model is the NUMSA (National Union of Metalworkers of South Africa) proposal for education and training in the engineering industry. This is the first time that a proposal on education and training has a bearing on health and safety in the country. NUMSA revises and simplifies the system of grading in the engineering sector and proposes a modular system of job grading in the engineering sector. The proposals aim to develop a highly skilled workforce, with a broad base of knowledge and skills enabling it to perform a variety of tasks, including OSH. To make up for the backlogs in apartheid education the NUMSA proposals look to integrating adult basic education, the formal schooling system and tertiary institutions such as technikons and universities.

Job grading and salary scales would then be based on the level of training (the number and levels of modules completed by a worker). This introduces a financial incentive to workers to acquire training, especially in health and safety. Should the proposals be implemented, this will inject a new desire on the part of workers to train in health and safety. Health and safety would become a core concern in our workplaces.

This training should contribute to improving workers' status n the plant in terms of their job grades. Combined with a general health and safety awareness campaign nationally, such a body of workers trained in health and safety would have a remarkable impact on OSH.

These incentives together with effective legislation on health and safety is the way forward for advancing OSH on the shopfloor. It will serve to increase the general awareness of safety and health amongst workers and management but also provide plant specific OSH skills to some of the workers in the plant. This brings us to our next area of discussion; the training of professionals in OSH.

Training of Professionals

Making recommendations for the training of occupational health professionals can become a fruitless exercise. Thus, the training of OSH professionals will take

It is a better idea to change the design of a machine to make it safe, rather than treat someone who is injured by such a machine. *Photo: unknown*

place only when there is an expressed need for it. Given the low level of awareness of OSH at present, the demand for professionals is limited. As workers' awareness of OSH increases so too will the demand for more skilled individuals increase.

Another important factor is that South African workers are more interested in the provision of basic PHC for themselves and their families rather than for a specialized occupational health care programme. This is because of the increasing cost of health care and medical aids. In a previous article, the author argued that PHC should be provided on site by employers, as a result of the collapse of the public health system (CH #33, Nov. 1990: Post apartheid OHSs - Policy Guidelines). The greater need in workplaces is for doctors and nurses with a broader base of skills, rather than for those highly skilled in OSH. A certain basic amount of training must be provided to medical and nursing staff who are located in the workplace, but care must be taken for appropriate training.

Training in OSH for hygienists, doctors and nurses in South Africa is limited and there is consequently a shortage of these professionals in the order in which they are mentioned. There is also a shortage of rehabilitation workers (physiotherapists and occupational therapists) who work in occupational health.

Only one South African university offers a Masters course in occupational

hygiene, and three other universities offer diplomas in occupational health for doctors. Most universities and nursing colleges offer a diploma in occupational health nursing. The short answer to this situation is that there is a need for more training of professionals in OSH. With more stringent legislation on the cards, the legal requirements for companies to provide improved OSH standards in their plants will increase the need for skilled occupational health professionals.

Undergraduate training of medical doctors in OSH is limited to a few hours of training in the entire six year programme. Graduates from medical schools emerge from these institutions of learning with no knowledge of the discipline of occupational medicine and a poor attitude to the discipline. Occupational medicine is relegated to the practice of completing forms for Workmen's Compensation. As a result, the bulk of occupational disease, which presents itself to general practitioners and hospital doctors, does not receive the attention that it deserves. We estimate that a large amount of occupational disease goes undiagnosed and unrecorded.

In the majority of factories where doctors are appointed on a part time basis, the focus is on non-occupational primary health care. This is mainly because workplace based services have to provide a service which is not provided by the state. A contributory factor is the absence of medical and nursing staff in OSH.

Whilst the training of medical personnel may have an important impact on the prevention of occupational illness, their main role is in the early detection and prevention of occupational illness. At present the vast majority of workplaces are not evaluated regularly for occupational hazards. Where this is being done, the services of engineers and laboratory or technically skilled workers are being used. There needs to be a major drive to train occupational hygienists throughout the country. Technikons and universities must introduce courses up to Masters level in industrial and occupational hygiene.

The curricula of engineers needs to investigate upgrading the health and safety components to them in all the major engineering disciplines. "To remove the hazard at the design stage" is the well known dictum of all occupational health workers, which should be applied. There are awesome challenges facing the occupational safety and health movement in South Africa. Training personnel and developing skills are crucial to the task of meeting those challenges.

Fareed Abdullah works for the Industrial Health Research Group at the University of Cape Town

Towards a School for PHC Personnel

at Alex Clinic and the Institute for Urban PHC

Alex Clinic

Communities have constantly changing needs and wants. As such, at the interface with the community, primary health care (PHC) should be part of a community development plan to improve the quality of life, and not just technical care.

Within this context, health workers need up-to-date technical and management skills. They also require the ability to relate to residents in the community, and to understand and support the community in both its problems and the resolution of such problems. Continuing education of health6h workers and of the community, as well as mutual education are essential tools.

Strengthening teaching and training is also essential in a health system environment such as ours, where relevant resources are directed mainly to professional groups and to the secondary and tertiary levels of health care. Apartheid health care, with its high technology and strong emphasis on privatisation, has resulted in gross neglect of PHC. Education and training should be directed at all levels of PHC workers, as well as at community members.

Such strengthening of teaching and training is a natural evolution for organizations such as the Alexandra Health Centre and University Clinic (AHC) and the Institute of Urban Primary Health Care (IUPHC), which already have a strong service and research base. The development of an education and training centre at the IUPHC to further the PHC approach is therefore proposed in an attempt to address some of the imbalances that exist.

Aims of the School

The aims of our educational activities would be to

- further the PHC approach amongst urban health workers;
- support PHC workers with appropriate training and ongoing education; and
- support community organizations involved in community development activities.

Rather than a formal school, what is proposed is a "school without walls", where we would

- carry out some of the teaching ourselves;
- encourage professional outsiders or community members to come to us for "internships" of relevance to their practical work;
- act as a promoter of new training programmes in other institutions, or initiate attempts at reforming current training of health personnel;
- engage in a process of education-communication with community members and groups that will ensure a mutual learning experience.

A competency based approach to the education and training programme would be encouraged, based on a modular system. Cooperation and joint decision-making between tutors and students around course design and content will be encouraged. A fixed curriculum should be discouraged in an attempt to most appropriately meet the needs of students.

More specifically education and training should:

- strengthen the problem solving ability of health workers, preparing them to face the challenge of performing tasks different from current activi ties, as demanded by a changing environment;
- increase their competency to carry out the job s/he is currently doing or has been hired to do;
- develop the ability to think about local realities and to cope with change in the health sector and in the community;
- strengthen the ability to relate to residents in the community and understand the multitude of factors that determine their attitudes, behaviour and illnesses;
- increase the capacity of health workers for sound decision-making to help people to improve their health conditions; and
- develop and strengthen skills to work in health teams.

Proposed Educational Programmes

The proposed programmes would fall into one of four categories:

a) basic training;
b) post-basic training;
c) management training; or
d) community education.

Health workers require the ability to relate to residents in the community.
Photo: Critical Health

Basic Training
The PHC assistant programme

This will be a one year certificate course for all levels of PHC workers, spanning a broad range of specialized areas, and focussing on understanding the PHC approach and methodology. There will be four to six months practical work in all the areas of PHC.

The training of facilitators of community-based rehabilitation together with short term programmes for geriatric PHC assistants, will become part of the training of PHC assistants. The training of a general community-support PHC assistant to educate, liaise with, and support the mobilization of the community currently being debated.

Community Speech and Hearing Therapists

As from 1993, the IUPHC, jointly with the Department of Speech and Hearing Therapy of the University of the Witwatersrand, will offer a two year diploma course in Community Speech and Hearing Therapy. The IUPHC was asked to assist in an attempt to narrow the gap between the university and communities and to develop a course appropriate to the needs of developing communities.

Post-Basic Training
Training of rehabilitation workers

Rehabilitation professionals (physiotherapists, occupational therapists, speech therapists) working in PHC are usually professionally isolated, service large numbers of people with disabilities whom they may not see frequently, and, as part of their work, need to pass on skills to families, the disabled themselves and other health workers.

The internationally recognized Bobath course, based on a neuro-department therapy (NDT) approach to cerebral palsy, was offered at the AHC, and drew fifteen physiotherapists and occupational therapists from southern Africa. The course ran for eight weeks, and demonstrated that a high level of skills can be made appropriate to the care of the majority of children with cerebral palsy at a PHC level. The course will be offered at least on a yearly basis.

Clinical training of professional nurses

Since curative and maternity care are now part of preventive and promotive primary work, there is an immediate need for both theoretical and clinic training and retraining in the clinical skills of examination, diagnosis and treatment of common disorders in adults and children.

During 1992, two modules, each attended by some eight professional nurses from local authorities in northern Johannesburg, were offered in paediatric primary care. The participants have since returned to their authorities to implement their new skills.

Similar modules are planned for 1993 around adult conditions (with emphasis on the chronic disorders such as hypertension and epilepsy) and maternity.

PHC management training

Most approaches to management of PHC services suffer, to some extent, of the perception of management activity as a separate activity within organizations. Many health workers may be called upon to perform management tasks that they do not routinely perform (a charge nurse on night or week-end duty). Crisis management exists side-by-side with strategic planning and more experimental approaches (along the lines of action science). Labour room work, for example, emphasizes technical skills, while in community work, it is necessary to bring a wealth of other skills from public relation to education, etc.

The IUPHC is trying to reduce the gap between universities and developing communities so that programmes become appropriate for those communities.
Photo: Medico Health Project

With the above in mind, the IUPHC is currently planning, together with the Wits Business School, the Portugal-based Institute of Hygiene and Tropical Medicine and the USA based Tulane Centre for International Health Development, two courses for managers of PHC centres- one for managers centring the supervisory function in the management hierarchy, and the other for more senior managers.

Community Education

Community education is not a programme on its own, but a component of the community action and development programme. It probably represents the best example of what we mean we speak of a "school without walls".

A community wide health committee, made up of community representatives elected by the civic organization, was set up on the initiative of the AHC Development Department, and forms the framework within which most community education takes place, although some education is also directed at voluntary associations and individual community members. These representatives have met

every week and report to their area committees.

The health needs are identified in the community and prioritized through a process of discussion facilitated by health workers including a nurse, a doctor and a lay health worker. When appropriate, more formal training is conducted and certificates issued. So far, the Red Cross certificated basic First Aid training, as well as workshops on road safety, paraffin poisoning, and AIDS have been held. Some workshops have been repeated at area committee level. A refuse removal campaign and a campaign to acquire a community-based hospital have also been initiated by the community representatives. This community action has involved substantial awareness raising around the structure and function of local government, with several members being more effectively able to use their knowledge relating to community health.

Conclusion

Education and training, including continuing education of community members will, to a very large extent, determine the success or failure of the PHC approach. As such, that education and training must be

- appropriate;
- ubiquitous and readily accessible in every single province of the country;
- standardized, with common national minimum standards of evaluation and certification;
- supported by state, provincial and local authority structures;
- affordable; and
- accountable to communities, to employers and to professional bodies.

Finally, education and training in PHC must help to build bridges to higher education, both between professionals and lay people, as well as amongst different categories of health workers.

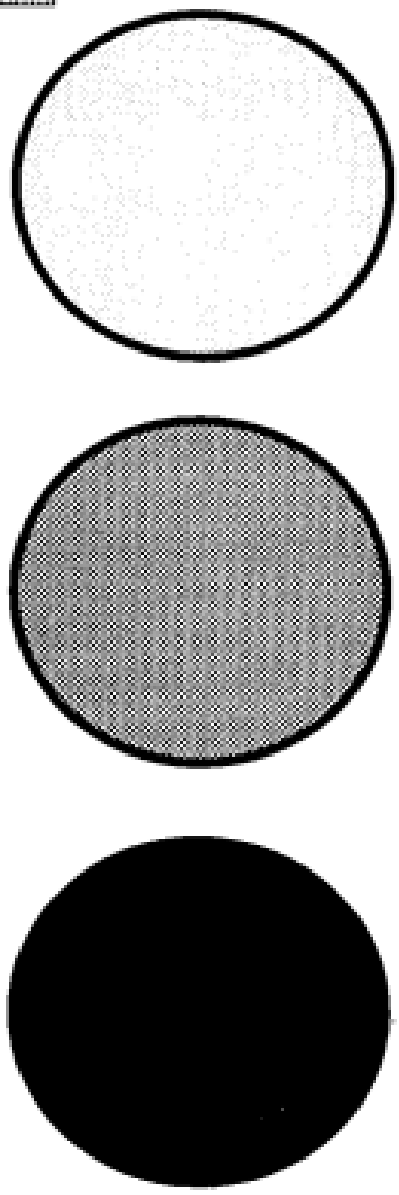
Alex Clinic

SECTION

B

Health Personnel in Transition

Broad political changes involve and affect health workers. Enormous challenges are posed for health workers who have to become accountable to the communities they serve. This section debates ways of ensuring that health workers are more accountable, and discusses the appropriate functioning of a PHC team and, lastly, political transformation in Zimbabwe and the difficulty of accommodating health personnel to these changes and meeting the population's needs for services.



The Primary Health Care Team:
What is it and who is best equipped to lead it?

Ivan Toms

The South African health system is beginning the slow transition from a hospital based model to a service that is based on Primary Health Care (PHC).

This change will and must have an impact on the role of different categories of health workers and their appropriate place and function in a PHC system of health delivery. This article discusses the function of PHC and a number of contentious issues such as the composition and leadership of the PHC team. It is not intended to be a comprehensive discussion, but rather to raise some of the principles and implications of a PHC team. Time and experience in specific contexts will develop the finer detail of the different roles and functions of the members of the PHC team.

The District

Effective planning and management of the health service in South Africa has been impossible with the fragmentation caused by 14 health departments and the provision of separate preventative and curative services.

For effective and efficient delivery of a comprehensive PHC service, most progressive health workers are in favour of a district model for this service delivery. A district is a clearly defined administrative area, which commonly has a population of between 100 000 and 500 000, where some form of local authority takes over many of the responsibilities from central government departments, and where a general hospital for referral exists. It makes up a manageable unit which is still close enough to community level for problems and constraints to be acted upon.

In South Africa we still need to develop the political and administrative boundaries of appropriate districts. The discussion in this paper will be based on a district model.

The Principles appropriate to a PHC Team
1.Team functioning

It is essential that a PHC team function as a TEAM - not simply a mixed group of individual health workers who are called a team. How the team functions is as important as the people who make up the team. Unfortunately medical and nursing training does not prepare these categories of health workers to function well in a team. Doctors are a particular problem, because they usually assume that because they are the highest qualified in high tech medicine they rightly should head the PHC team. Their training has not prepared them to fully appreciate the important and essential skills other health workers bring to the PHC team.

There needs to be a team approach which affirms and acknowledges the important role each member of the team has in improving the health of the community.

2. Intersectoral Cooperation and Health in Development

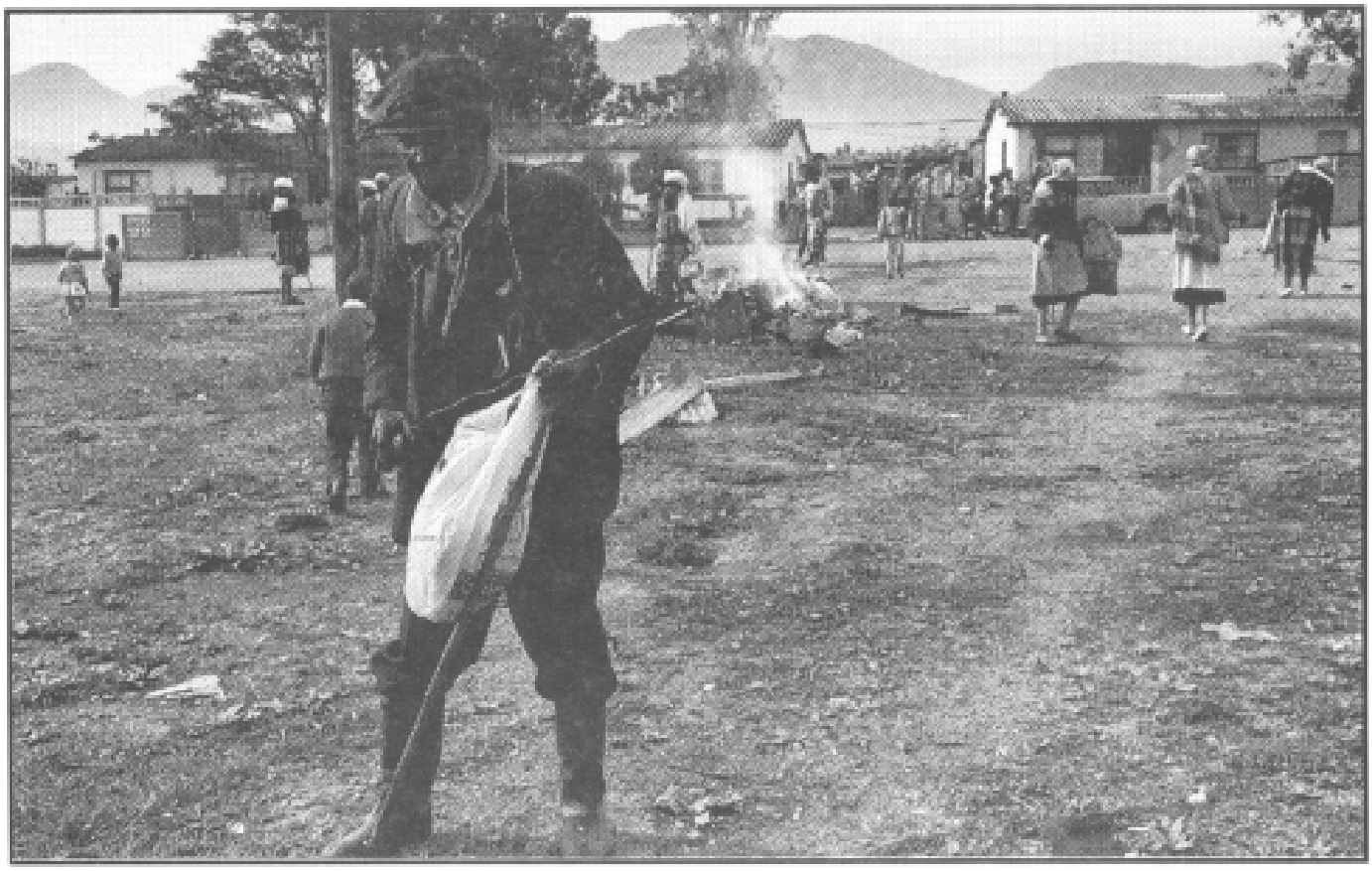
Health is intimately bound up with development. Socioeconomic improvements will directly affect the health of that community.

In most situations, the provision of clean water and sanitation will have a greater impact on the health of a community than the presence of a highly trained doctor. Roads and agriculture are sectors that also have an intimate role in improving the health of a district. The PHC team must have representatives from these other sectors, or at least efficient and clear channels of communication to the other relevant sectors.

For this to happen, the PHC team needs to work on the overall development of their district and region. Self help projects, employment generating projects (that particularly empower women) are essential to the work of the PHC team if they hope to improve the overall health of the communities they serve.

3. Community Participation

A health worker committed to PHC will try to ensure full community participation and control in planning, evaluating and refining the delivery of PHC. At the same time no health worker who has worked in a community based health service or project will deny the difficulty of developing effective community participation. It takes a great deal of time, patience and persistence. The PHC team cannot allow itself to believe that it alone must decide and control everything.



The provision of clean water and sanitation will have a greater impact on the health of a community than the presence of a doctor.
Photo: Medico Health Project

4. Equity

This principle is essential in developing a PHC system that will be acceptable to the majority of South Africans. Apartheid has entrenched inequality in access to health care. The PHC team needs to continually evaluate their progress towards an equitable PHC service.

5. Accessibility

PHC emphasizes the role of clinics which are within easy walking distance for the majority of people in the district. Accessibility is also one of the reasons why the PHC team should include community health workers (CHWs) or community based rehabilitation workers (CRWs). Because they come from the community and speak the language and can be held accountable to the community - CHWs and CRWs personalize accessible health care.

6. Management

All members of the PHC team should be trained in management. It is not only for doctors or nurses. The development of work programmes, planning, goal setting and evaluation is important for all the PHC team. Within the PHC team there will need to be a sub team which is responsible for managing the district health services.

7. Composition of the PHC Team

The composition of the PHC team varies in different countries and regions and especially at local level. Sub-teams will focus on a particular aspect of health. The team must be multidisciplinary and will consist of the following categories of health workers:

1. Community Health Workers and community based rehabilitation workers.
2. Mid level health workers (PHC nurses or medical assistants)
3. Nurses
4. Midwives
5. Doctors
6. Health inspectors/environmental health workers.
7. Physiotherapists and occupational therapists (and or mid level assistants)
8. Pharmacist and pharmacist assistant
9. Development officer
10. Traditional healers/ homeopaths/ osteopaths/ acupuncturists
11. Auxiliary staff: dentists/ oral hygienists/ optometrists/ psychologists/ social workers/ podiatrists.
12. Administrative staff

Role and Function of Different PHC Workers in the Team

While different workers and sections will have responsibility for different aspects of health, no one sub team or section should become so engrossed in the service they deliver as to lose sight of how and where it fits into the common PHC goal of improving the health of the community. Rather than detail the function of each category of worker in the PHC team, I will raise a number of the more contentious issues relating to the composition and function of different workers.

1. Community Health Workers (CHWs) and community based rehabilitation workers (CRWs)

The big debate is how much of a curative role should the CHWs play in the PHC team? The community based accountable health worker deals with health education and promotive and preventive aspects of health. Often this role is under valued by other members of the team and is often the most difficult aspect of behaviour change.

Many CHW programmes equip CHWs with varying levels of curative skill including dispensing simple medicines. This curative role is often thrust upon them because of the desperate need of the community for curative care for minor illnesses. But does this result in poor health care for poor people, while the middle class are treated by higher level health workers? Some programmes argue that by giving the CHW a curative role, they become increasingly involved in that role (with the distinction of being a healer), while the essential preventive and promotive works slips further into the background.

However, many argue that an appropriate curative role (with respect to the felt needs of their community), strengthens their effectiveness and appropriateness with regard to preventative and promotive health.

Similar questions arise about the role and function of the community based rehabilitation worker.

2. The PHC Nurse and the Medical Auxiliary/Assistant

This category of health worker is the backbone of the PHC teams. They staff the clinic or health centre and see the majority of patients who come for curative care. The debate in South Africa now is whether this level of health worker is needed - but should we move away from the PHC nurse and rather train a specific category of medical auxiliary/assistant to fill this diagnostic and curative role?

The debate is fueled by the fact that a number of medical assistants trained in other countries have returned to South Africa. Also much of the debate is a result of the territorial approach of the professions to the role of the nurse versus the doctor. Many PHC workers are unsure of the appropriateness of initiating a medical assistant training programme in South Africa, where we already have a large group of effective PHC nurses.

3. Doctors

What is the role of the doctor in the PHC team? She/he is highly skilled in high tech medicine and complicated diagnostic procedures and treatment. Their training is

What would the process be if the community wanted a say in the choice of PHC team leader? *Photo: Cedric Nunn*

very costly - both in time and money. Some would want to limit their role in the PHC team and rather use them to staff the hospitals. Others see them as integral to the team in a Community Health Centre or large clinic. Much of the debate also centres around the level of health care which is affordable and appropriate to South Africa.

Cuba went for a doctor centred PHC approach. They trained many doctors and developed ways to encourage/force them to work in the rural areas. This has resulted in very good health indicators. Others argue that doctors disempower the people and help to emphasize a curative diagnostic model. People are dependent on the professional doctor - rather than being empowered to do something about their own health.

In South Africa doctors are a very powerful lobby. The role of the doctor (both private and public service), is a key question that must be faced if we are to

develop an effective PHC team approach to health. Many doctors are in need or reorientation if they are to be effective in a PHC team.

4.Health inspectors/environmental health workers

In most areas health inspectors function as health police - trained to enforce rigid health regulations with respect to restaurants etc. Like doctors, they need reorientation and possibly retraining so as to become part of the PHC team responsible for environmental health in the community. They should become key personnel in the team as environmental factors are critical to improving the overall health of the community.

Some argue that this role should be deprofessionalised, and like some other countries we should train mid level or community based environmental health workers who might more effectively and efficiently address environmental problems.

5. Development officers

Health must be seen as an aspect of development. PHC emphasizes the importance of socioeconomic factors of ill health. Clinic based health care cannot address these issues. A district development officer as part of the PHC team will ensure that health is always drawn back to the broader developmental needs of the district and region.

6. Traditional healers

Their inclusion in the PHC team is still a matter of debate in South Africa and elsewhere. It must be acknowledged that 70% of black patients first visit a traditional healer before attending a clinic. There have been some innovative models where they are included in the health team, but their role and integration into the team remains unclear and opinions are divided.

The PHC team needs to develop a good working relationship with traditional healers in their district. There needs to be mutual respect for each other's role, and where possible traditional healers should be supported with ongoing health education. They should be encouraged and trained to diagnose and refer patients with diseases that will definitely benefit from western medical treatment (for example, dehydration, meningitis, T.B. etc) and discouraged from practices that will be harmful to the patient (for example, an enema for a child with gastro enteritis).

7. Administrative staff

This group is often relegated to the office and ignored as part of the PHC team. There are examples of innovative ways of including them in the team. What about using the driver of the mobile clinic as a part time development officer? While the PHC nurse is doing the clinic, she/he can be teaching people trench gardening or how to build pit latrines. Also she/he can be brought in to the team to give health education.

Clerks at the clinic or community health centre need to be included in the PHC team as well. They are the first contact with the sick patient - and often are the most unhelpful. By including them in the PHC team and training them to see how they can use their patient contact to further PHC, they will be much more motivated and encouraged to participate as a part of the team.

The hospital administrator/secretary in a district hospital is an essential member of the PHC team. They need to be encouraged and supported to see the important role the clinics and district services play in meeting people's health needs. A great deal of the money spent on health is used at the hospital, and therefore their involvement in planning and management of the PHC team is very important.

Environmental health is an important aspect of development.
Photo: Medico Health Project

Who Should Lead the PHC Team?

It is often assumed that the doctor will lead the team as they are "the most skilled". The prior question is: "most skilled in what"? If you want to develop a PHC team approach that is curative and hospital centred - then a doctor is probably the right person to lead the team. But if the goal is PHC committed to developmental and intersectoral work - doctors are likely to be inappropriate as the leader of the PHC team.

Similar concerns apply to nurses. Both these health professionals are trained with a curative emphasis and often includes a subliminal message that they alone know everything about health. There is a desperate need to reorientate health professionals as to their role in PHC.

The type of leader that is required is one that empowers and builds the other members of the team. They need special management training and facilitation skills.

What if the community wants a say as to the choice of the PHC team leader? How would this process happen? Would the community still be dominated by the ingrained view of health as the territory of the health professionals? As a system of community accountability of the health system is developed, the possibility of increasing the community's say in the management and leadership of the PHC team has to occur.

Conclusion

The PHC team is the key to an effective, accessible health service in South Africa. We still have a lot to learn with respect to hands on experience of the PHC team. As we develop this experience we will be able to better deal with the difficult questions of the role of the health professionals and who should lead the PHC Team. But with a team approach which does not allow professional health workers to dominate and oppress other health workers, emphasizes the development needs of the district and works with other sectors, we will be well on the way to implementing a PHC service which will really improve the health of all South Africans.

Dr. Ivan Toms is the National Coordinator:
Service Development of PPHCN

Accountability in Progressive Primary Health Care

Alex Clinic

Medicins du Monde

Critical Health

Underprovision of services, overworking of staff, and bureaucratic procedures, amongst other problems, have been the experience of many black people when seeking health care.

However, people have not been passive recipients of these harsh conditions. Over the years progressive doctors, nurses and community health groups have set up democratic appropriate primary health care projects as an alternative to that provided by the apartheid regime. The commitment to democratic principles in the provision of health care has engendered a feeling, amongst users, of the project belonging to the community. Often these health centres have served as centres of protection for political activists and people injured by state and right-wing violence. However, none of these alternative service providers have sufficient resources, labour and financial, to overcome the paucity of state health provision.

This political role, and the care health workers took to ensure that there was some community involvement in their projects hinted at the potential for accountability people are keen to see in their health services. However, it must be remembered that such projects arose in a time where there was also little space for mobilization. As such, many projects' structures did not have a strong sense of engagement of the principles of comprehensive PHC and its relation to community participation and accountability. Because of the powerful position that doctors had, for example, they assumed too many responsibilities with little delegation of roles to others. The projects could not necessarily function democratically or necessarily have been truly accountable (see CH#39 - "Progressive Structures, Doctors and Leadership"). Thus there also existed the potential to turn a project into a meaningless statement of rhetoric.

Alexandra Clinic

One attempt to go beyond the rhetoric of accountability is that of the Alexandra Clinic. In spite of the lack of democratic local or national government, the clinic has managed to establish a strong form of political control which takes the form

of a democratically elected clinic board. This is achieved at an annual general meeting at which every adult resident is entitled to vote. The result has been that in less than five years, a majority of the clinic board is now made up of residents, with the Alex Civic Organization in effective control of the clinic.

Accountability is also ensured by health workers participating in community events, and might include health workers providing first aid at political rallies or provide important information to community organisations on the impact of violence or child abuse on the health care of such victims. Health workers could also make their facilities available to the community they serve, provide support for community initiatives in health care, assist in community based research and also request community assistance in the work of progressive health workers.

Alexandra Clinic. *Photo: Critical Health*

However, even this form of accountability has its limitations. Apart from the danger that this local control could be used by the government as a strategy to entrench racial inequality and block the development of an equitable health service, this type of control does not in itself protect user interests. Representatives elected at a district or local government level from a constituency of upwards of 50 000 people are often drawn from a political or economic elite. One of the results

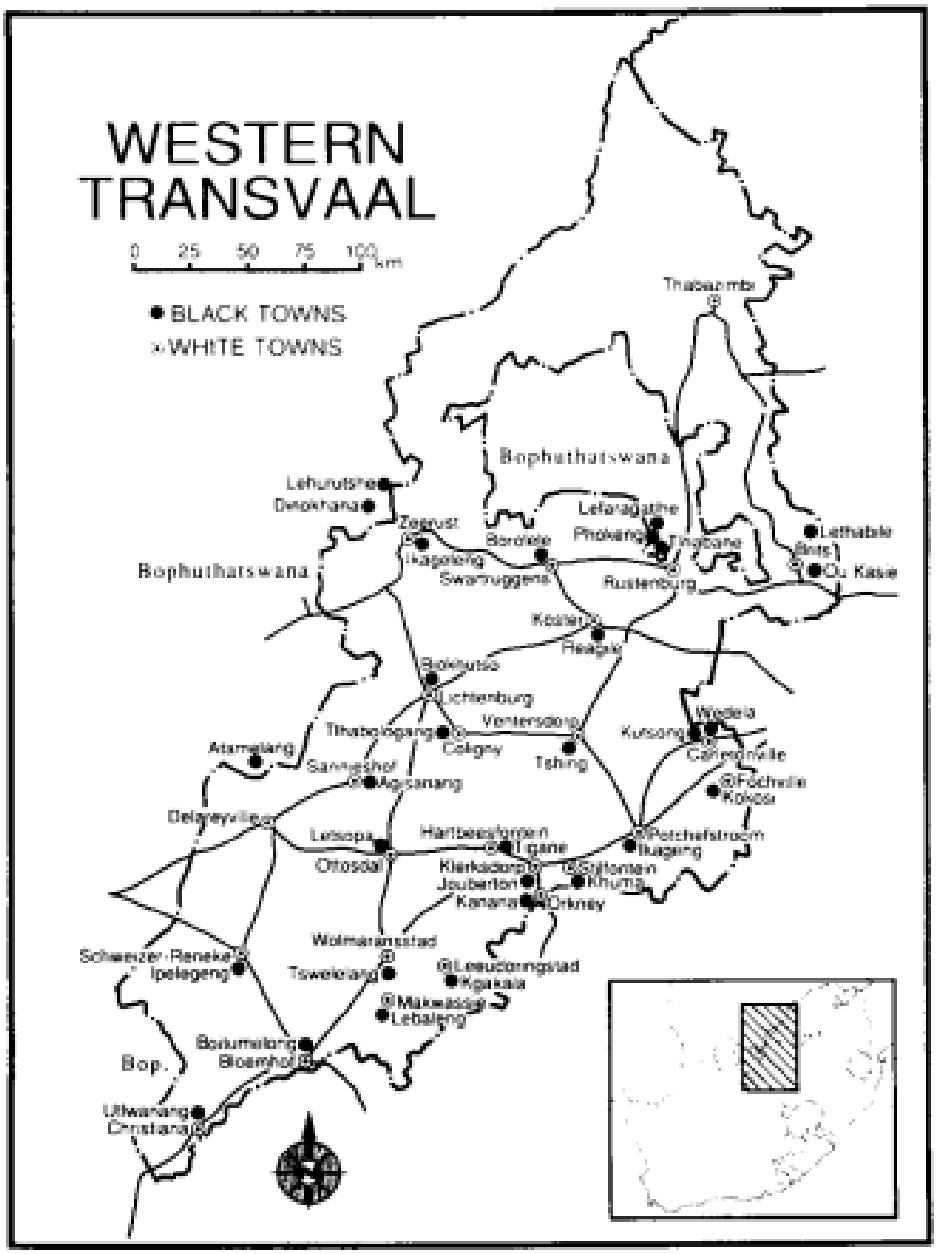
of this is that the democratically elected health service representatives are not necessarily service users and are subsequently not subject to the inefficiencies and inconvenience of the system directly. As a result, their participation often lacks the sharpness by which feedback from direct users can be characterized.

This has been reflected in the Alex experience where the recent establishment of a Civic Health Desk with representatives elected from area committee level has resulted in much more vibrant user feedback. An area committee is made up from a subdivision of the township containing 10 000 to 20 000 inhabitants. Following the establishment of a health desk with representatives from each of the area committees, there have been threats of mass action, demands for particular services and demands for training of community volunteers.

This health desk corresponds to Community Health Committees in the British National Health Service which are made up of representatives elected at ward level (a ward in the British system would correspond roughly with an area in the Alex context). As is the case in Britain, these essentially advisory structures nevertheless have significant influence over their representatives through their members' participation in sub-local authority structures like area committees or wards. Here ordinary residents are familiar with their representatives, know them personally and are not intimidated by them. This improved access means that ordinary residents have much more control over their political representative and an increase in capacity to hold them accountable.

Accountability in Rural Projects

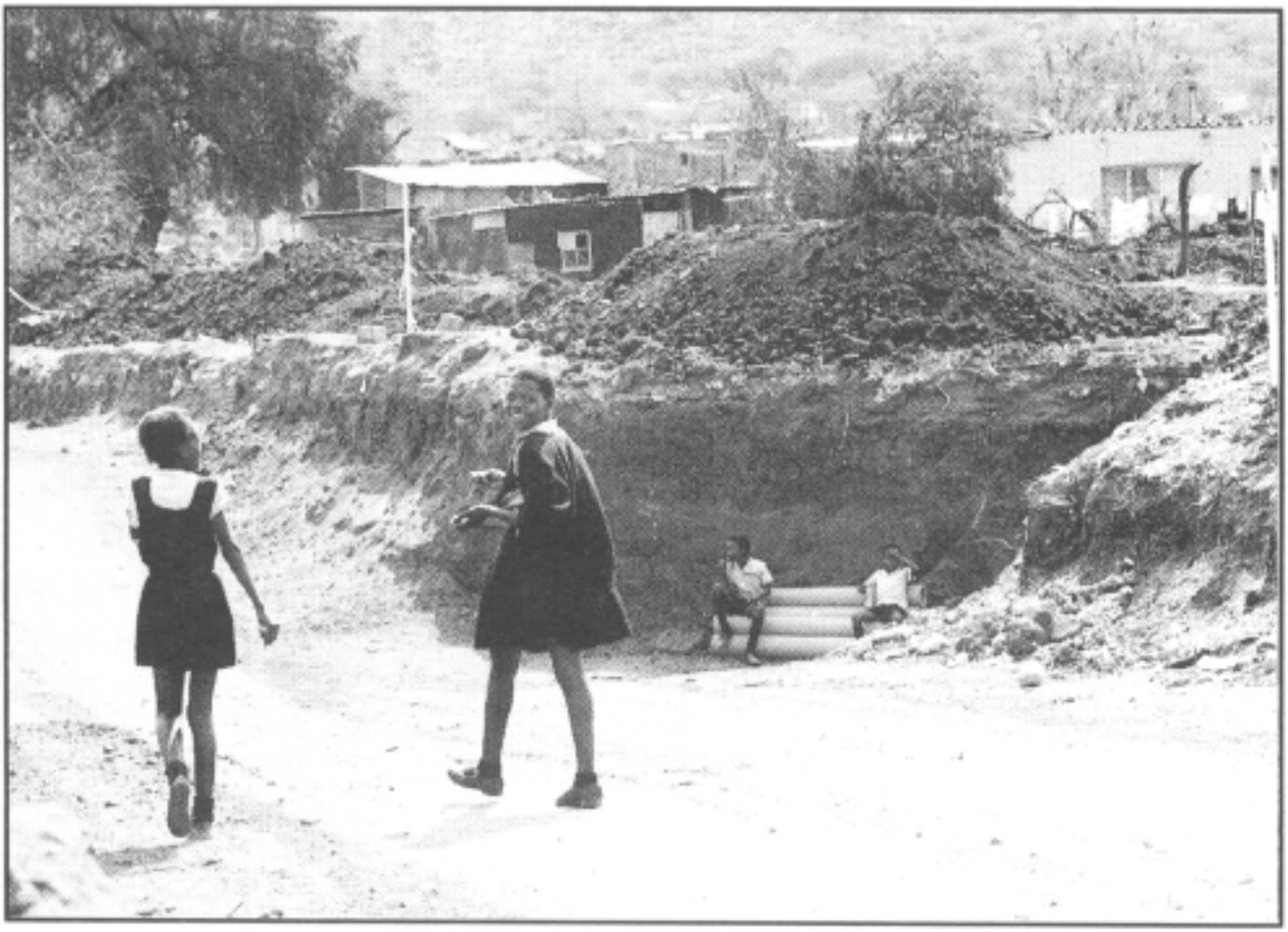
Two field workers of the French Medicines du Monde, a non governmental (NGO) health agency which has four projects in South Africa, expressed a similar view. According to these workers, community participation and accountability work best at projects set up in smaller communities. Residents of these communities tend to relate closely, and have a keen sense and knowledge of many things which affect the community. In some cases, this close association among members of these communities is backed by strong traditions of political resistance and organization against apartheid. Such organization facilitates efforts by health workers to engage these communities' (or at least that of their chosen leaders') interest in their health projects.



Strong Organization Oukasie

The Medecins du Monde workers compared the situation at two communities to illustrate their point. One of these, Oukasie (near Brits), is a peri-urban settlement with a population of about 9 000 people. The Oukasie community is one of the few surviving freehold settlements (or so-called "black spots") and has resisted forced removals since 1953. Oukasie borders on the white town of Brits, whose population is about 22 000. While little growth is predicted for Brits, it has been projected that within five years, the population of Oukasie will be 24 000. This community has an unemployment of approximately 60%. It consists mainly of shacks, and has one tap per 50 households.

At present, besides the community clinic which offers part time curative



Walking down the path of development ? The IDT is financing 1 600 sites in Oukasie. *Photo: Critical Health*

services, Oukasie has a small local authority clinic providing some preventative care. The Transvaal Provincial Authority (TPA) hospital in Brits has 52 beds and 6 maternity beds, but is only available to Oukasie residents with referral. Most patients are in fact sent to the Ga-rankuwa hospital, 15 kilometers away. There is one ambulance serving Brits and one shared between Oukasie and Lethlabile, another settlement, 25 kilometers away. The health committee identified early in 1992 curative and maternity services and transport as priorities.

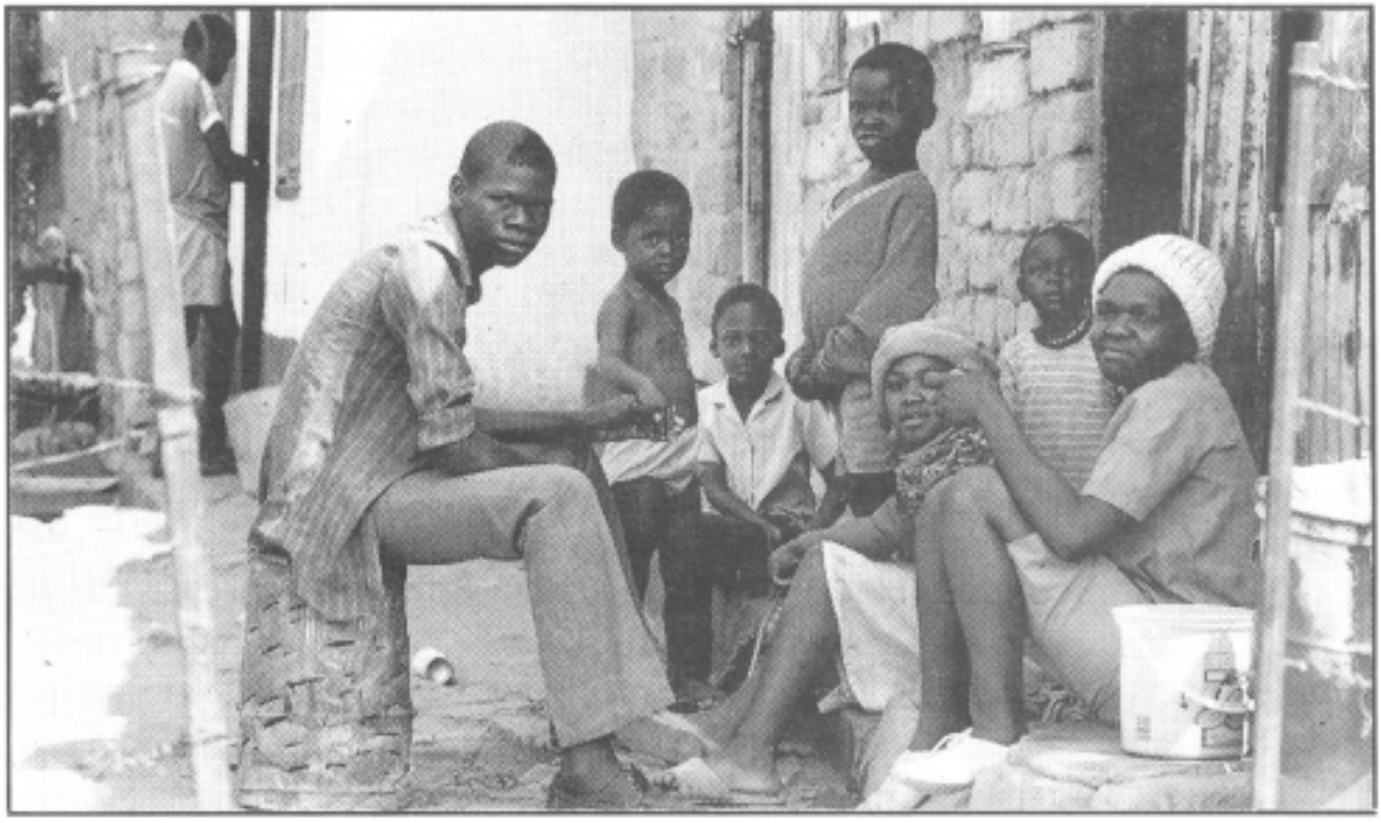
The Structure of the Civic

Today, Oukasie has a strong elected civic association with various sub-committees accountable to it. These sub-committees each specialize in education, transport, finance, health and creche facilities. The community also has a development trust to which these sub-committees are answerable. The development trust consists of people from the community and includes outside agencies from government and non-government organizations, and from local industries. Accountability is ensured by the civic association, which in co-operation with the development trust (including the Independent Development Trust (IDT)), holds a

meeting every six weeks. All the sub-committees report to this meeting. In addition, if a sub-committee deems it necessary, it may invite the chair of the civic association to a meeting on a specific issue related to its work. Direct reportage to the community occurs in the form of public meetings, held every six weeks. Sub-committees may also call on the community's support on important decisions. For instance, when Medecins du Monde approached the civic to assist in their health work, the organization was introduced at one of these public meetings. People welcomed the organization by voting in favor of their working in the community. To facilitate participation of the community at these public meetings, they are held in Tswana.

The Health Committee

The health committee's draft constitution stipulate that it should consist of ten members; two of whom represent outside service agencies and the rest of whom are elected from the community. It meets weekly. This committee has appointed one community health worker (CHW), who works at the community clinic. The responsibility of the CHW is to visit homes regularly to educate people and also to find out the needs of the community as regards their health and other problems. She also works in the community clinic two days a week, with a Medecins du Monde doctor and volunteer students from the medical school at Medunsa.



The CHW visits homes regularly to educate people and find out their health needs. *Photo: Critical Health*

Health Negotiations

In May 1992, the TPA called the Oukasie Civic to a meeting to discuss their own plans for health services in Oukasie. The meeting was also attended by representatives from the Department of National Health and Population Development, Brits City Council and the Regional Services Council.

The health committee invited advisors from Medecins du Monde, Alexandra Health Centre and the Department of Community Health of the University of Witwatersrand to a follow up meeting in June. A new structure for the delivery of preventive care was proposed by the TPA planner, Dr. van Niekerk, with the aim of correcting "unhygienic and uncontrolled behavioral patterns" in the township. Funding for capital and running costs remained unclear. What did become obvious, however, was that the TPA still regarded Oukasie and Brits as two separate entities in terms of health service planning and delivery.

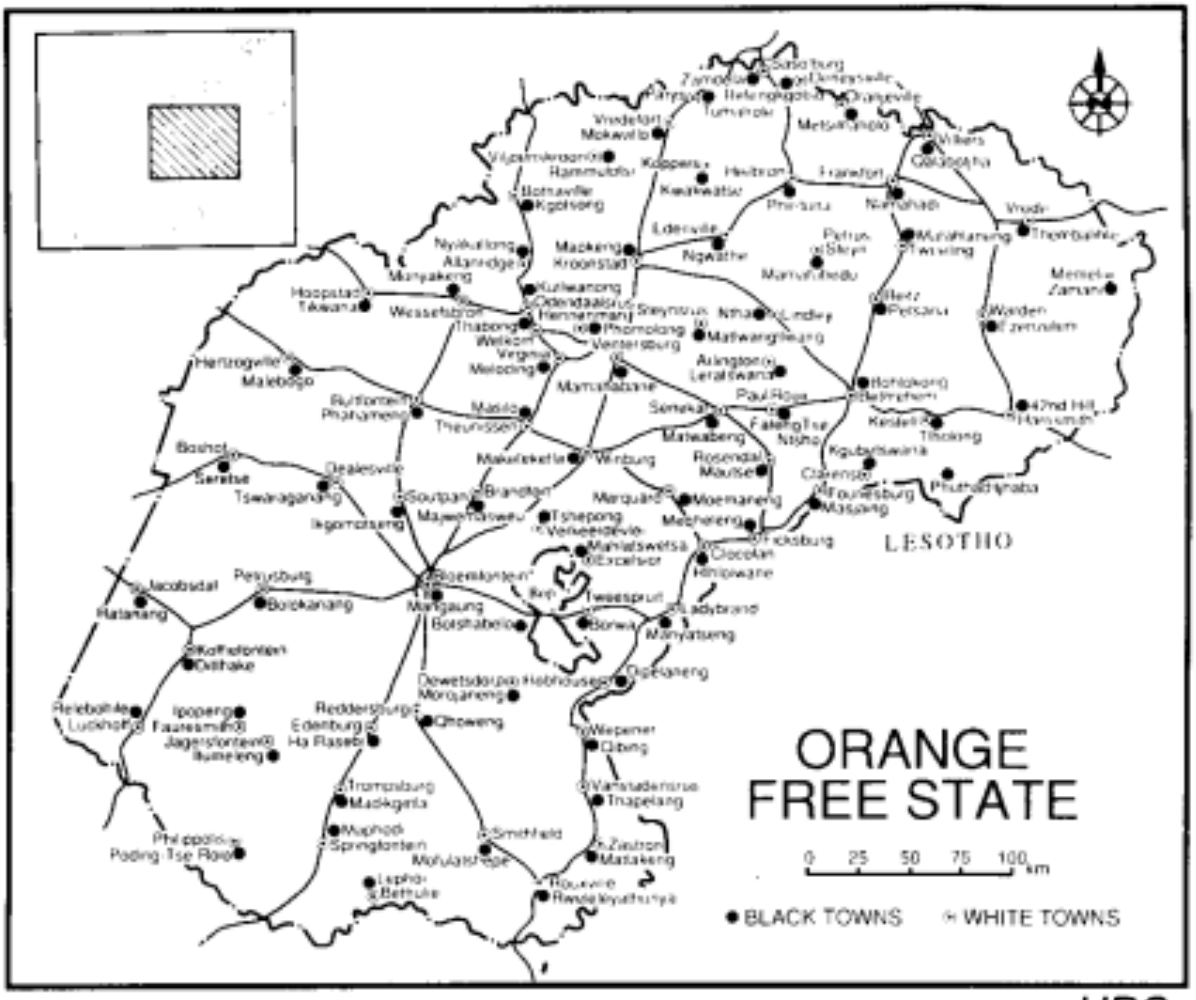
The health committee, with the assistance of its appointed consultants, responded by drawing up guidelines for integrated health service delivery in the Brits district. The TPA then postponed the next meeting indefinitely. At present, both the health committee and representatives from the Dept. of National Health are urging for these negotiations to be resumed.

In the meantime, the community clinic continues to function. Efforts have been made to strengthen the health committee by inviting the Community Based Development Programme (CBDP) to run workshops on organizational and negotiating skills in Oukasie.

Civics with Problems Botshabelo

By contrast, Botshabelo (in the Orange Free State), which was established as an apartheid dumping ground for farm workers forcibly removed from the land, is a less cohesive community. It is occupied by a dislocated population of about 250 000 from various backgrounds. A non-governmental community clinic employs 13 community health workers, an expatriate nurse and a doctor. Medecins du Monde pays their salaries.

However, because of the weak civic structures, this project has been difficult to sustain in a manner that clearly defines its accountability to the community. The community health workers are not elected by the community, although they do extensive house visits to educate and to learn from the community. The civic association was approached in November 1991 by Medecins Du Monde to assist in the restructuring of the health committee. This failed at the



HRC

time. Mismanagement and talk of corruption within the civic caused it to be dissolved early in 1992, and an interim civic committee was established until elections were held in June 1992.

In an attempt to channel skills and resources into the civic, there have recently been preliminary meetings in view of establishing a Botshabelo Development Trust. It is hoped that the skills gained through the trust will assist in restructuring the health workers' relationship to the community. One of the organisations involved in discussions around the formation of a community trust is the Kagiso Trust.

These examples from the Alexander Clinic, Oukasie and Botshabelo concern, in general, attempts to develop formal structures of consultation and accountability to the community. From the accounts presented above, the community structure best suited to facilitating this process is the civic association, which emerged in the early 1980s as a rejection of apartheid local authorities. Not only are civic associations elected bodies, but they also lead and represent communities in their struggle.

However, in circumstances of political upheaval, effective accountability can be conceived without such formalized structures. In these circumstances, people perceive accountability in terms of health workers' commitment to supporting their struggles and activities.

Protest Clinics
Braklaagte

When Medicines du Monde first started working in South Africa, for instance, it did so in the form of protest clinics, which developed in an adhoc way, either in response to police brutality or, in the case of the Winterveld clinic, as part of wider political protests. The Winterveld community established a small clinic in the 1970's, which served not only as a health centre, but also as a means of mobilizing people to protest against their incorporation into Bophuthatswana.

Another example of a protest clinic is the one established by the Braklaagte community which was incorporated into Bophuthatswana on 31 December 1988. Braklaagte is a small rural community of 10 0000 to 15 000 people. In an effort rejecting this forced incorporation, people refused to use services provided by the Bophuthatswana government. In addition, the Bophuthatswana government having appropriated the clinic that the community had built for itself in the early 1980's, people resisted, reestablishing an independent one.

In 1990, the community experienced extreme intimidation from the Bophuthatswana government culminating in January 1991 with the killings of several community members. They took temporary refuge at Zeerust (in "South Africa"), where they occupied churches until July 1991. In February 1991, Medecins du Monde was approached by the African National Congress' (ANC) health department and the National Medical and Dental Association (NAMDA) to assist the community in establishing a health care centre. Medecins du Monde employed a nurse to do relief work. It also sent two community health workers elected by the refugees for training at the Winterveld clinic. They returned in July 1991. The community provided their own facilities for the clinic, including a two roomed house from which the clinic operates.

The community has developed its own structures to run the clinic, consisting of an elected health committee made up largely of elected traditional community elders. One of these elders is a chief. Their accountability to the community is acknowledged by the leading role they perform in resisting incorporation into Bophuthatswana. All of these traditional leaders are members of the ANC. They act, through the health committee, as a key organ for ensuring health workers' commitment to the community. One of the two community health workers trained by Medecins du Monde showed disinterest in his work and was called to a meeting

Immunisation on a Thursday at Winterveld clinic. *Photo: Critical Health*

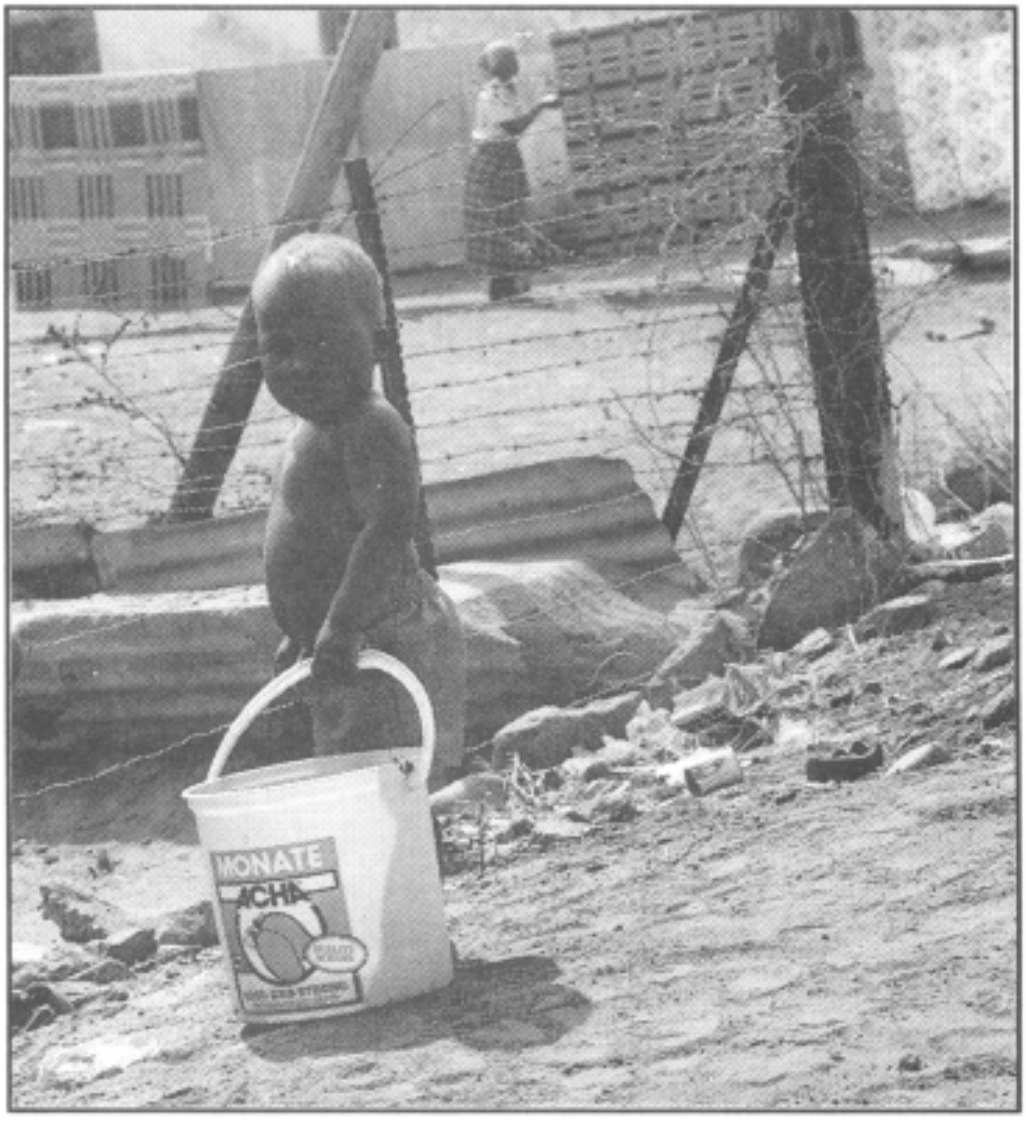
of the health committee. The worker did not attend that meeting, and the committee consequently decided to terminate his services. In another instance, a voluntary community worker decided, without consultation, to prescribe penicillin to patients. Community workers are not allowed to prescribe antibiotics. The committee received word of this from patients, and effectively disciplined that voluntary worker. When people are not happy with the service they receive, they approach the committee.

The Bophuthatswana government has persisted in intimidating health workers at the clinic, claiming that the clinic is illegal. It has attempted to dampen resistance by offering the community a state run clinic. In principle, according to Jane Mathieson, the Medecins du Monde coordinator, people would like to have

the resources such a clinic could provide. However, they have indicated to the Bophuthatswana government that they would accept its offer only if the clinic were accountable to the present health committee and if their own clinic could continue to function unhampered.

Conclusion

These experiences of progressive service providers demonstrate the importance of local control. Accountability at this level has its limitations and dangers. However, the level of consultation and accountability which has been engaged in makes a difference to user experience of services. As a result this approach is of central importance to any future democratic dispensation. On the basis of these experiences it also seems that for meaningful participation in decision making to occur, constituency sizes of not more than 25 000 in the urban context and even smaller sizes in rural areas are necessary for election of any representatives.



Around here everyone works. *Photo: Critical Health*

In addition, there are greater possibilities of exploring different and more flexible forms of accountability at local government level where constituencies are smaller. Various combinations of participation of the community in health activities, and of health workers in community activities are possible at a local level. This can deepen accountability significantly and in important directions. Accountability at central level, however, is generally not possible.

The role of central state then is rather to constructively allocate resources to local government to correct racial imbalances. Because of the scale of the problem, formulae of prioritizing or weighting budget allocation will have to be devised. However, there is still a danger that too much centralization can occur with the result that democracy and accountability to local level can become nothing more than tokenism. By implementing weighted formulae as a primary role of central government it can ensure that it is the only thing that lies outside of local control. In other words the local structures have almost total control on how the resources are used in an area. The weighted formulae ensures that central state is obliged to provide the necessary funds or resources. How these formulae are devised, however, has to be the subject of another discussion.

While centralization of political power in the South African context is necessary at a national level to guarantee the correction of historical injustices, the role of metropolitan and regional government is less clear. They can also be seen as expressions of the centralization of power. They, too, are largely inaccessible and thus have the potential to block any meaningful control from the ground. It is for this reason that they require particular analysis. With this issue is only just emerging in political debate, the contribution of health service experience may have implications, not only for the health sector, but more broadly for all forms of government service, social and otherwise.

Alexandra Clinic
Medecins du Monde
Critical Health

Health in Zimbabwe since Independence:
the Potential & Limits of Health Sector Reform

David Sanders

III Health and Health Care in 1980

Extreme income inequality, inherited from a century of British colonialism, was evident in the wide disparities in the health of Zimbabwe's people. The maldistribution of facilities was matched by a concentration in urban areas of health personnel, especially professionals. Even the distribution of lower-level auxiliaries, medical assistants, was disproportionately urban.

Economic and Social Reforms since Independence

Zimbabwe's independence saw the ushering in of a primary health care (PHC) approach designed to reduce these many disparities. After a brief post independence economic boom, much of the population experienced a decline in economic well-being. Post-independence Zimbabwe saw several economic and social reforms relevant to health instituted, although some have subsequently been eroded since the implementation of an economic structural adjustment programme.

Health Reforms
Facilities

Despite an improvement in rural access to services, the distribution of clinics is still very uneven. In the mid 1980s, the Ministry of Health (MOH) concluded an agreement with the World Bank to establish a family health project. During the first phase a number of district hospitals were selected for expansion and upgrading. While the selection of disadvantaged or populous districts was appropriate, the inclusion in the project of districts already well endowed aggravated existing inequities.

Services

Health care has been provided free since 1980 to those earning less than Z$150 per month. At that time, this covered the majority of the population, but from 1986, the minimum industrial wage has exceeded Z$150. Many workers are now excluded from the free service, despite a decrease in the value of wages since 1980. Despite the government's enthusiasm for PHC, the referral system still functions poorly. Central hospitals are still not used primarily as referral hospitals to deal with more complex or uncommon cases.

Special Programmes

Special programmes set up since 1981 are some of the achievements that we in South Africa can look to as a model. In 1981, an expanded immunization programme against infectious diseases among children and tetanus among pregnant women was initiated. This substantially increased the number of children immunized in rural areas, although vaccination coverage in the urban areas was much higher. Diarrhoeal disease control was prioritized in 1982 and by 1988 over 90% of mothers were aware of oral rehydration therapy (although only 59% knew the correct recipe). The rural-urban differential in antenatal care was also significantly reduced. Zimbabwe has also attained the highest rate of contraceptive use in sub-Saharan Africa. A nutritional programme helped to feed over 250 000 children at the peak of the 1980s drought, although the recent drought has badly affected the programme and the nutritional status of all groups.

Health Personnel
Increase in Personnel

The rise in health personnel numbers since 1980 is significant. Training programmes have also reoriented curricula towards the new health policy. New cadres, such as rehabilitation assistants, have been trained and posted to extend the delivery of basic health care. By 1987, about 7000 community based village health workers (VHWs) had been trained by the MOH, enhancing promotive and preventive care in rural areas.

Within the context of this expansion, the major areas of inequity in health personnel distribution arise in private vs public practice, urban vs rural provision and in different levels of care. This is particularly true of the more "costly" personnel.

The war is won - 1980. *Photo: Joe Alfers*

Doctors

About 60% of doctors are not in government service. This maldistribution is even greater with respect to specialists. The proportion of doctors in public service has risen by only 10% between 1980 and 1989, despite an increase of about 40% in the number of doctors graduating from the university. This difference represents the high attrition rate of graduates from government service, with less than 15% in government service five years after graduating. This maldistribution of personnel has been dealt with partially by recruitment of expatriate doctors who continue to fill the majority of provincial and district government posts.

In 1983, 67% of doctors were at central level, with only 15% at provincial level and a further 15% at district/mission hospitals. By 1988, the proportion of doctors at central level had increased to 72%, with 12% in the provinces and 16% in district and mission hospitals. This indicates little redistribution of this category of personnel. Central hospitals, which do not function as referral facilities, absorb the bulk of the high cost personnel, while rural mission and district hospitals continue to be poorly staffed and reliant on expatriate doctors.

The maldistribution of doctors has raised the criticism that the use of

academic merit alone in selecting medical students, has resulted in an urbanized, higher income profession unwilling to work outside the main centers. The 1980 policy of holding new graduates for several years in the public sector has faced opposition from the profession. In 1988/89, junior doctors went on strike against serving in what they described as the poor conditions of many rural health services. The continued orientation of many senior medical practitioners towards urban, central and private practice has also reinforced the hostility amongst medical undergraduates towards rural, public sector service, despite the reorientation of the medical curriculum and the clear need for their redeployment.

This trend among doctors applies to other categories of personnel, with an inverse relationship between the cost of personnel (salary/wage) and the distribution to rural care, to lower levels of care and to the public sector. Hence the more academically qualified, higher paid state registered nurses are concentrated in private, urban and central facilities, while state certified nurses are found in the public sector, district hospital and rural health services. Pharmacists, dentists, laboratory technicians and radiographers are also centrally located and have a high attrition rate to the private sector, while environmental health personnel are more commonly located at public sector, rural facilities.

The salary vote in the MOH has increased greatly, the greater proportion of this vote being absorbed by high cost personnel, who are still concentrated in urban, central facilities despite rural health needs and the lack of an effective referral system. The attrition to the private sector exacerbated this distortion. Within the private sector, high cost personnel trained with public funds primarily service a very small proportion of the higher income population, whose health needs are less.

Popular Involvement in the Health Sector

A central feature of the PHC approach is "community participation". The unfolding relationship, before and after political independence, between the state and the developing institutions of popular organization is central to understanding the process of popular involvement or "community participation" in all areas of social development, including health.

It is in situations where the old order and power structures are overthrown that comprehensive PHC has the best chance of succeeding. It is in such conditions that popular participation in decision-making and self reliance can grow and flourish.

Political Change and Direct Democracy

This situation was most evident in "semi-liberated" communal areas, particularly where ZANU (PF) guerrillas had been active for a long period. In these areas the party had created popular organisations, initially responsible for supporting the liberation effort, but later structured to perform essential social and economic tasks as an alternative to the Rhodesian government's rudimentary district administration. In those areas, organisations were made up of various tiers of people's councils, which were set up on village, ward, district and provincial bases. Functions of these committees at various levels differed considerably. Grassroots village committees, for instance, dealt with the day-to-day problem of helping guerrillas and providing basic services to the community. Services involving the outlay of large sums of money would be passed to higher committees.

A major gain of the revolution was the practice of direct democracy, where peasants and workers for the first time participated in the formulation, implementation and evaluation of policy. The right of the peasants and workers to control, reject and reelect representatives became a reality - a far cry not only from their previous experience where they had no vote, but also from the experience of western 'democracies' where representatives are elected infrequently to parliament or local government bodies without effective control being exercised by the electorate. This gain has persisted in certain parts of the country but has been progressively eroded with the passage of time.

The Post-Colonial State

What is the basic structure of the post-colonial state, and what is its relationship to popular organization? Far from being dismantled and supplanted by a decentralized workers' and peasants' state, a centralized hierarchical structure with permanent institutions, the security forces, civil service, judiciary, etc, has expanded since independence. Not only is the standing army much greater in size, but the civil service has also expanded. The racial character of the state has changed, rather than the essential class character of the state.

Bureaucracy and Representation

Between 1980 and 1982, district councils vested with local administrative development powers were established replacing the colonial district commissioners and chiefs. Although this system of local government is an advance over the previous structure, with ward representatives elected by popular vote and with greater

Special programmes prioritised immunisation, diarrhoeal disease control, antenantal care, nutrition and expanding the rate of contraceptive use. *Photo: Cedric Nunn*

resources than in the past, it remains an extension of the central state. Full-time local government officials are salaried by and responsible to the Ministry of Local Government and Town Planning. Councillors, although elected every few years, are neither answerable to their electorate on a day-to-day basis nor subject to recall for unsatisfactory performance. Most popular committees, particularly those more recently established, had, already by 1983, become marginal. A fragile and evolving system of direct democracy was thus supplanted by representative democracy.

In 1984, decentralized structures were set up "to facilitate popular participation" in local government. These village development committees (VIDCOs) at village level and ward development committees (WADCOs) at ward level were formed. However, these structures are less numerous and more geographically removed from the majority of villagers than were the popular committees which were in attendance at the frequent mass meetings held during 1980 and 1981 at village level.

Popular mobilization, initiated primarily in support of the national liberation struggle, was adopted in the early post independence period to confront the challenges of reconstruction and development. It has been eroded by the growth of a centralized system of local government.

The Village Health Worker Programme (VHW)

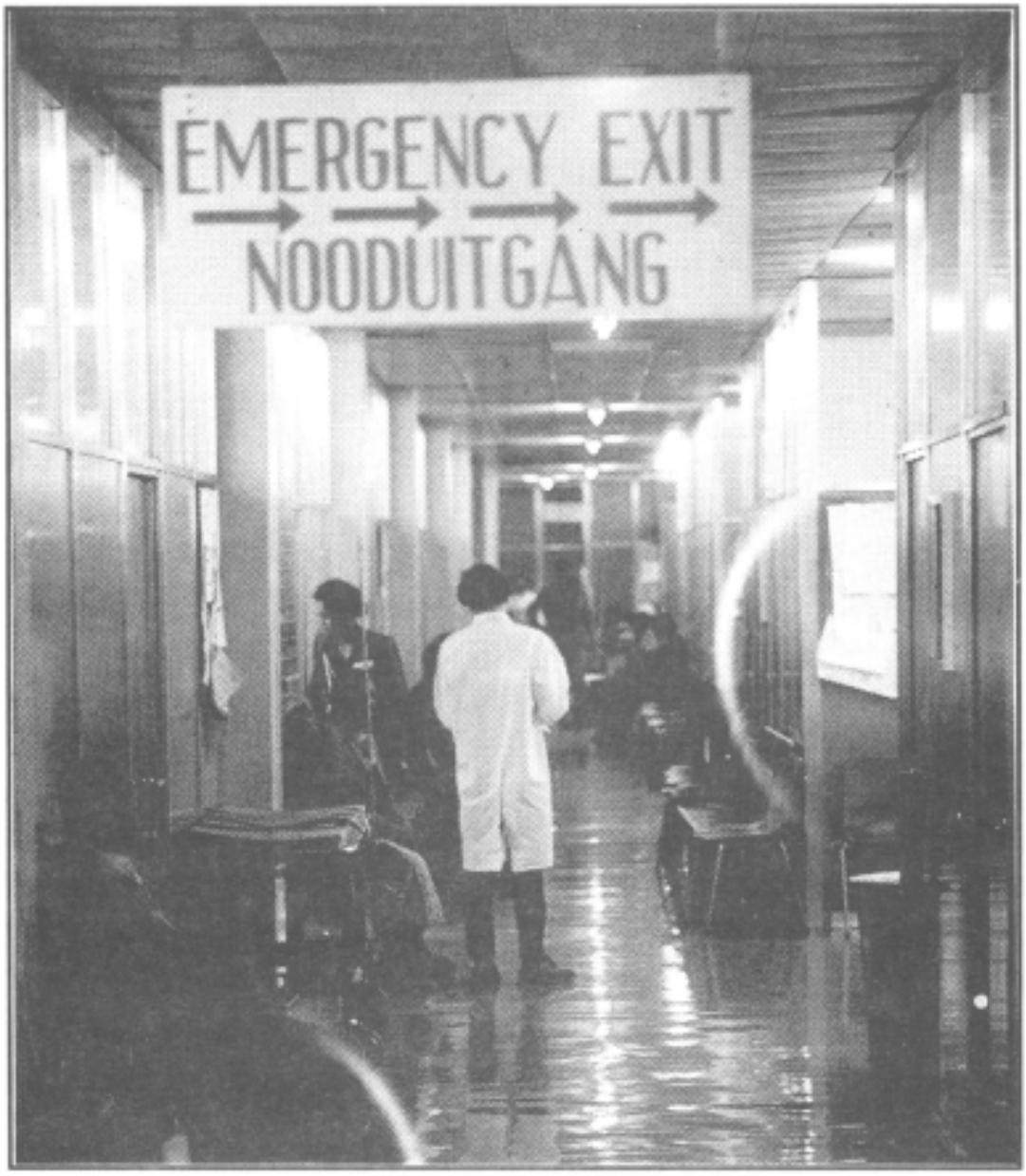
Village health worker (VHW) programmes which are democratically controlled by the poor majority can serve the function not only of extending health care to isolated communities, but also of mobilizing people to transform their conditions. In most poor communities the tendency is for the better-off and better-educated to dominate. This has implications for both the selection and control of the community based health worker. It questions the notion of "community" as an homogeneous, conflict-free group of people. Villagers are also divided among themselves, particularly where economic stratification exists, as it does in rural Zimbabwe.

Bondolfi VHWs

The beginnings of bureaucratization and the undermining of popular initiative is well illustrated by an example involving the village health worker programme. During the 1980 ceasefire, a health worker at Bondolfi Mission (Masvingo), was approached by the ZANU (PF) District Committee and asked to take on the training of popularly-elected health workers in ''nutrition, child care, hygiene, sanitation and a little home treatment''. The area was well organized into one political district with 28 branches. Each branch had a committee of 16, who were popularly elected. Of these, two were responsible for community health matters. Training commenced for 56 branch health leaders in May 1980. Their six months' training included theory and practice, the latter being done after planning with their communities. Due to the project's popularity and increasing community demand, the people decided to have an unpaid VHW for every one to three villages, resulting in the selection and training of 293 VHWs, 35 being from other districts.

Government VHWs

In late 1981, the government began training VHWs. These are supposed to be selected by their communities in consultation with the district council. In some areas there is real popular involvement in the selection of these workers. This is being done at ward level. However, in many areas it is done by the district council. In others, it is acknowledged that ''there is some nepotism, councillors choose their wives and friends''. The payment of these VHWs is made by district councils from a grant received from central government. This means that VHWs are responsible to the district councils rather than the villagers they serve, although



Most doctors are still concentrated in central hospitals. *Photo: Critical Health*

with widespread rural poverty it would be impossible for many communities to fund their own VHWs.

When the government scheme was set up, ten of the Bondolfi VHWs were taken on and trained. The government VHWs receive a more formal training, spending more time in the clinic or hospital, than the Bondolfi VHWs. Because of their lower concentration in the population, they have to cover a considerably larger area than the Bondolfi women. This means that most of them are full-time workers. The Bondolfi scheme, although still functioning, by mid-1984 involved only about 100 VHWs. There are a number of reasons for this, but as one local VHW organizer said, "When the government scheme started, and some were paid Z$33 a month, others stopped working because they were not paid".

Here again a general political problem is illustrated. In contrast to the original VHWs, who were directly selected by meetings in the villages and answerable to the local people, the government VHWs are chosen and paid by the

Direct involvement in the development of programmes has been slowly eroded. *Photo: Guy Tillim*

District Councils. These bodies are democratic, but only in a distant and representative way.

If responsibility for the VHW is delegated to a remote state structure, then the crucial element of popular mobilization is missing. The VHW is no longer directly answerable to the poor of the community and cannot be recalled by them. He or she becomes just another health service employee - more appropriate perhaps, but still answerable to an outside body.

Further developments recently have virtually eliminated the possibility of popular democratic control over the health sector through the VHW. In early 1988 the VHW scheme was "handed over" to the Ministry of Community and Cooperative Development and Women's Affairs. VHWs and Home Economics demonstrators have been combined into a single group of "village community workers" who, although notionally part time, have written conditions of service and are

regarded as civil service employees. The nature of the VHW has been qualitatively transformed. This community-selected and accountable cadre has now become a civil servant responsible to her employer. The possibility of true grassroots involvement in both defining health problems and tackling them collectively has now receded. Further, any possibility for popular democratic control of VHWs becoming a focus for democratization at all levels of the health sector now seems remote.

Democratic Control of Health Services

Health policy makers in 1980 called for greater control by, and communication between all levels of health workers within the health sector, together with community decision-making in health interventions. In practice, the democratic control of health services has been enhanced by the formation of district health teams and health executives, creating a mechanism for collective planning by health workers at the same level, as well as the exchange of ideas between health cadres and other representatives in local authorities. Social control over health care is, however, limited by a number of factors:

- representatives on decision making bodies are often the more powerful and higher income sections of the communities covered;
- no structures exist for patients to influence policy, such as ward committees;
- mass organisations (such as the co-operative and trade union movements) have played little role in the organization of health care; and
- the district health team reflects intersectoral interests, but is not necessarily democratic.

The democratization of health care also implies changing the ideology of health care, demystifying the causes of ill health, and giving people a vital role in resolving health problems. The extent to which the health sector has moved from biomedical to socioeconomic explanations for ill health, and from curative to preventive care is variable. It appears to have depended greatly on the orientation of the district and provincial health personnel. Despite programmes such as the VHW programme, consumers still appear to be poorly organized and relatively weak in expressing collective health care demands.

Health workers have a strong hierarchical organization. There are many professional associations. Some are being split into different interest groups (such as the SRN/SCN division in the nursing profession, and the many associations representing doctors). As government workers health cadres have no industrial relations body recognised in terms of the Labour Relations Act (1985) to negotiate for improved working conditions and wages. In addition, the many professional divisions in the sector weaken any coherent approach to personnel issues. Hence,

for example, while doctors use their associations to advance their own interests, as in the case of the recent doctors strike, their demands do not consider overall changes in conditions for health personnel.

Conclusion: changes in health status

Available data show that progress has been made in addressing Zimbabwe's legacy of ill-health. There has been a sharp decline in both IMR (Infant Mortality Rate) and under 5 (U5MR) since the late 1970s. Changes in morbidity are difficult to determine because of problems of comparability of available data for the period under consideration. However, there are indications of a reduction in the incidence of immunisable diseases, although there appears to have been a recent resurgence of TB in association with the rapid increase in HIV prevalence.

Levels of undernutrition appear to have declined significantly between 1980 and 1983/84, although there is less firm evidence of a decline thereafter. While the situation appears to have improved with respect to wasting, levels of stunting remain discrepantly high. The improvement in mortality and morbidity has probably resulted from an energetic expansion and reorganization of health care provision. The adverse effects of drought, recession and stabilization policies have been partially offset by aid supported relief feeding programmes. However, economic recession and structural adjustment have reduced incomes for large numbers of rural and urban households since the immediate post-independence boom. This reflects itself in continuing high levels of childhood undernutrition which seems to have remained static or improved marginally despite the health care drive.

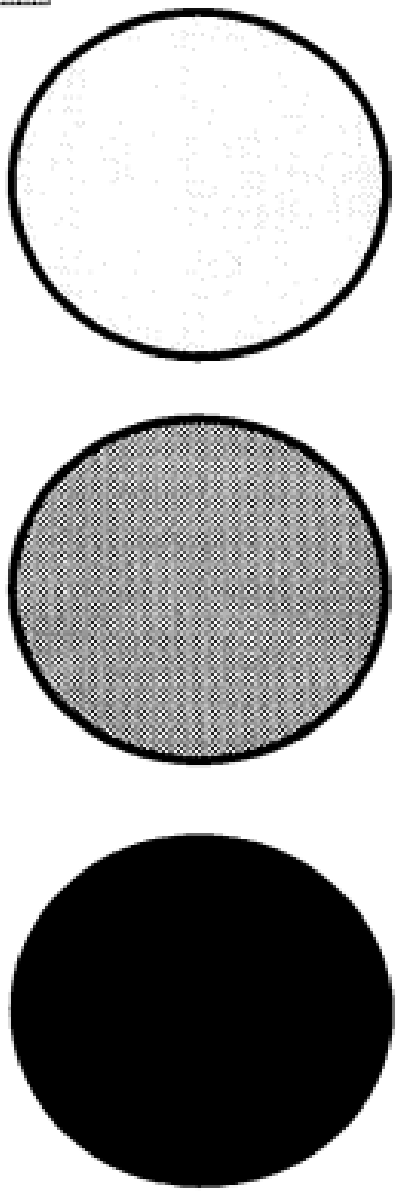
Professor David Sanders is head of the Education Development Unit at the Medical School of the University of Natal. (Durban)

SECTION

C

Accommodating Traditional Healers

A large section of the black population use traditional healers. The dominant biomedical system has to seriously evaluate this contribution to health care and recognize that both systems have shortcomings as well as advantages over each other. Ongoing discussions aimed at reaching some kind of agreement is outlined along with reports on attitudes to traditional healers in Mozambique and the Philippines.



Negotiating the Future of Traditional Healers in SA - Differences and Difficulties

Melvyn Freeman

The complexities involved in developing a policy on the future of traditional healing in health care in South Africa are elaborate and multifaceted. Agreement between the main players will not be easilyreached. There is divergence within and between the modern and traditional sectors as well as differences between political groupings. In this paper the positions of some of the major players concerned with the recognition and registration of traditional healers will be outlined, and some of the difficulties in reconciling differences will be discussed. The points of view reflected in this paper are mainly drawn from positions put forward at a conference hosted by the Centre for Health Policy entitled "Recognition and Registration of Traditional Healers - Possibilities and Problems".

Present Official Status of Traditional Healers (THs)

Officially the use of THs in South Africa is outlawed. In 1974 the Health Act forbade healers not registered with the South African Medical and Dental Council (and in 1982 amended to include those not registered with the South African Associated Health Services Professions Board) from practicing or performing any act pertaining to the medical profession. In reality, however, THs continue to practice and are generally not legally harassed by the authorities. In fact, in certain areas cooperative relationships occur between modern and traditional practitioners. For the most part, however, the modern and traditional systems operate independently with consumers choosing from whom to consult. Despite official illegality, a number of organisations organize THs. Many of these organisations are officially registered but under the Companies Act and not as health providers as such.

Differences between the Modern and Traditional Sectors

There is no single position which can be said to be the "modern health sector point of view" or the "traditional healer point of view", because differences exist within

each sector. For example, there are a substantial number of organisations which organize THs. These groupings are split by historical, geographical and political factors. There is also disagreement as to who is a bona fide TH and who is not. A tendency has developed for organisations to claim that any healer not registered with them is not a genuine healer. On the other hand, within the modern sector there are individuals who could gladly refer to THs for certain illnesses whereas others want nothing whatsoever to do with THs believing them to be complete "mumbo jumbo". In this paper the opinions put forward from the modern health sector are mainly a combination of views expressed by the Medical Association of South Africa (MASA) and the South African Medical and Dental Association (SAMDC), while the views from the traditional sector are combined views from the South African Traditional Healers Council (SATHC) and the African Traditional Healers Association (ANTHA).

Views from the Traditional Healer Perspective

THs have no doubts as to either the legitimacy or the efficacy of traditional healing. Traditional healing is believed to be part of African culture, and it is said that African healing will continue as long as African culture survives. It is pointed out that around 80% of black people in South Africa will utilize a TH as their first point of reference when they are sick. THs are also used to prevent illness and promote community harmony.

THs very often accept that in certain instances modern medicine is preferable and cure health problems which they cannot. On the other hand, they believe that their system of healing is extremely powerful and necessary. If, for example, it is divined that the reason a person is sick is because they have displeased the ancestors, then the cause must be addressed and not just the individual's physical symptoms. A person will not be truly cured without this. It is also believed that African medicines have potent healing powers, and if given by qualified people to appropriate patients, are at least as good, and in many cases, better than many modern medicines.

Training of THs very often comes following a "calling" to become a TH. This person then becomes apprenticed to an experienced healer for an unspecified period. Alternatively, some healers have knowledge passed on to them through family ties.

There are some THs who believe that their legitimacy comes from the people they serve and from their ancestor's history, and therefore do not need "modern" legislation to recognize them or to ensure that they be registered. They feel that this is not only unnecessary but may be, or may become, restricting. They think that these practices may be forced to change in some way, if registration

takes place. Many THs feel however, that current legislation is discriminatory and inhibiting and must be changed. It is said that the law impinges on people's rights and choices and constrains the development of traditional healing. Moreover it is said that there are many charlatans and "quacks" operating as THs and these should be weeded out through a process of registration. It is felt that if THs have control over issues such as the process of who should and who should not be registered: what is and what is not acceptable training; and what is not an acceptable medicine; and who should and who should not be referred to a modern doctor, then registration could become a developing rather than a limiting process for healers.

View from the Modern Health Sector

Modern medicine is founded on the technological principles of controlled experimentation, laboratory analysis and verification of diagnosis. This orientation has brought major advances in the ability to combat illnesses and, as a result, the protagonists feel very confident of the framework. Moreover, many people working in the modern health sector have experienced the consequences of traditional medicine gone wrong. The role of the SAMDC, and to a lessor degree, MASA, is to protect the public. It is thus their view that unless interventions have been scientifically evaluated, there can be no guarantee of safety and they are hence reluctant to simply recognize and accept registration of THs.

Traditional medicine hawker, Umtata. *Photo: Medico Health Project*

While showing a great deal of skepticism towards what THs do and how healers practice, many modern health personnel nonetheless do see a role for healers. It is often accepted that THs are acceptable, accessible and greatly utilized by African people and that this needs to be acknowledged. It is believed, in fact, that THs could play an important role in health care, as long as they are subjected to the methods and remedies of scientific investigation, and only carried out those interventions which have passed empirical scrutiny. For example, the herbs used by THs should be tested for their pharmacologically active as well as dangerous properties and passed or failed on the basis of scientific tests. It is also believed that the TH could play an important role in the "dissemination of correct and factual information to the population at large, particularly in respect of health education, hygiene, sanitation, family planning, and other health related matters" . In effect, THs' would embrace and promote interventions studied and accepted within the modern health framework. There is, from this perspective, no room for "superstition" in health care and such intervention is unlikely to be accepted.

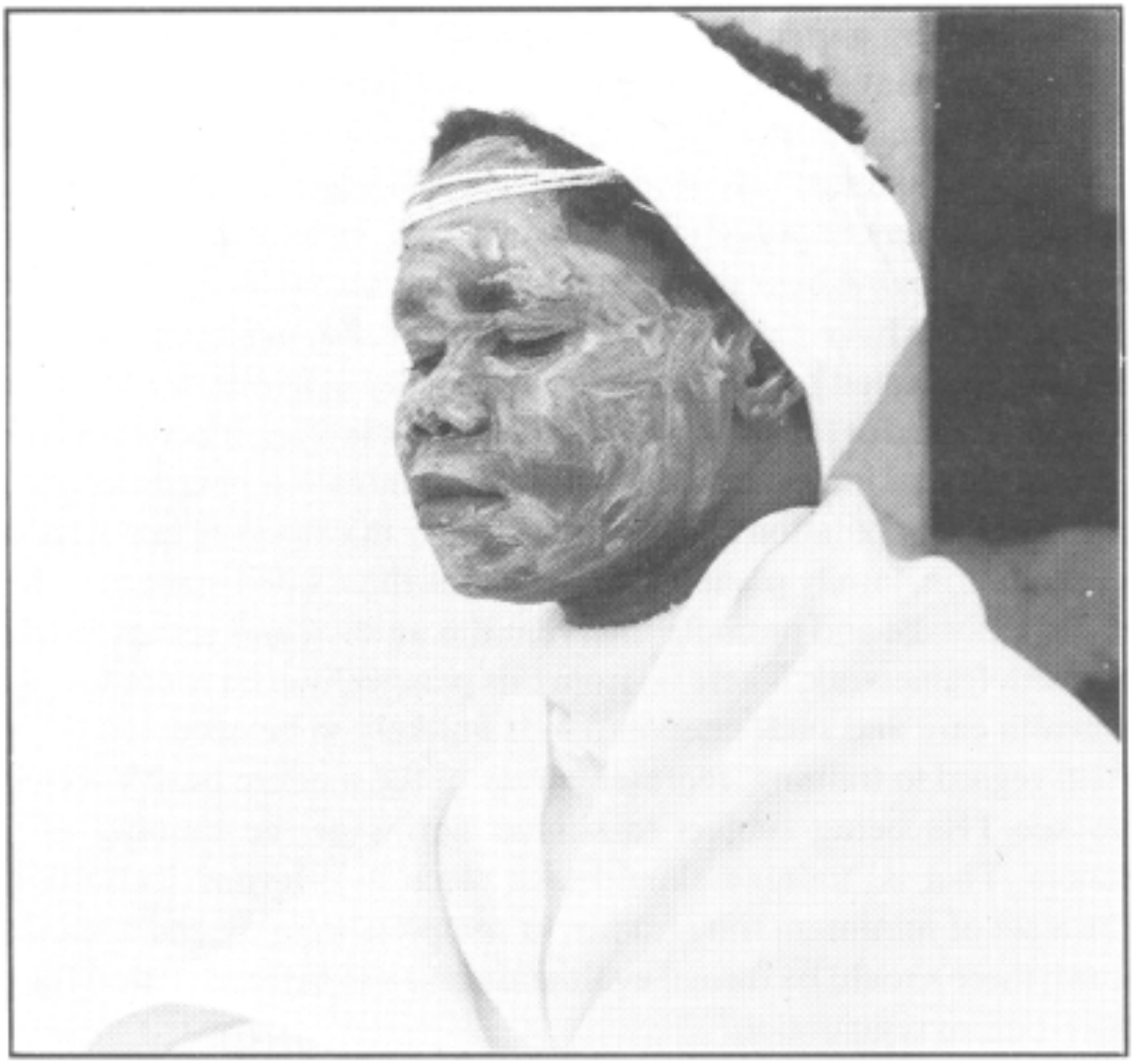
With regard to training, representatives of the modern health sector would prefer to see THs being subject to similar norms as the training of modern practitioners. That is, training should take place in a formal institution; there should be a set of minimum time frames to complete training and a standardized curriculum; there should be formal evaluation and a structured period for gaining experience before registration.

It should be clear from the above that modern and traditional healers operate from quite different worldviews. Modern medicine functions within a scientific empirical framework, whereas traditional medicine is based in African cosmology which includes the "supernatural". These differences are reflected in the reasons why a person becomes a healer/health worker: in the structure of training; in the reasons why people are perceived to be ill; in the way diagnosis is done and in the way in which treatment is given. In fact, there is not that much in common between the two systems and thus negotiating agreement is understandably rather difficult.

The Points of View of Political Parties and Organisations

The importance of what policy political parties adopt with regard to THs has implications not only in purely health terms, but also in terms of political support. For example, the antagonistic policy which the Frelimo government of Mozambique took towards THs after gaining independence in 1975 led to a lot of anger from healers and those who utilized their services. During the subsequent war with Renamo this became a rallying point for Frelimo opponents.

The view of the Nationalist Party is reflected in government policy. Current



Traditional healer, Transkei. *Photo: Medico Health Project*

legislation, as mentioned earlier, essentially disregards traditional medicine as a health care resource. Up until recently government has mainly been concerned with the health of the white population. It is not surprising therefore that THs have not been given serious consideration as a health resource. In 1990 this changed to some extent when a national plan was developed with the concept of affordable health care to all people of South Africa. THs entered into government thinking as part of this plan. As a first step they saw it as necessary to liaise and negotiate with THs on issues such as a code of ethics, standards of training, legal control and so on. As the government essentially holds similar views to that reflected by the "modern health sector" it is unclear how the negotiations will proceed. At this point some preliminary meetings have taken place, but there is little concrete progress as yet.

The ANC Health Policy Guidelines adopted at the policy conference makes no reference to THs whatsoever. Elsewhere, however, it has been stated that it is likely that the ANC would want to cooperate with THs. At the conference "Recognition and Registration of THs - Possibilities and Problems", it was said that THs would become part of the National Health Service that the ANC envisages. Nonetheless it was suggested that the ANC would push for the

registration of THs in order to monitor numbers and evaluate the quality of care given, and to allow greater cooperation between sectors. Policy, however, would not be decided unilaterally, but that much discussion was still needed with all sectors before final policy was made.

The view of the PAC is much clearer than either the Nationalist Party or the ANC. It is their view that African people have the right to express their value system unhindered, and as traditional healing and African culture are inseparable, THs should be given the same status in society as healers from the modern health sector. The PAC believes that traditional healing could cure problems where the modern sector has failed. Payment for traditional healing would come from the same or similar source of payment for care in the modern health sector. For example, medical aids would pay for traditional healing in much the same way as they paid for modern care. The PAC did not, however, have faith that the present parliament could change legislation in a way which would benefit healers. Until a majority government was in place they suggest that greater cooperation should occur between the modern and the traditional sectors at the service level.

Conclusion

There are two main similarities between the modern and traditional sectors in trying to develop a policy around traditional healing. The first concerns the way in which health and illness is conceived and treated. It is very difficult for most members of the scientific community to give legitimacy to a framework which is not based on any empirical foundation. Secondly, even if it were accepted that THs have a right to practice, the modern sector is likely to want to legitimize such practice in ways which the traditional sector may find unacceptable. For example, the modern sector may want specific criteria to be laid down as to who is a genuine healer; and where and for how long such people should be trained. These criteria are likely to be foreign and inappropriate to the traditional sector. While it is sometimes said by representatives of the modern sector that the controlling body for THs should be made up of THs, it is unlikely that such bodies will be given a carte blanche to set up and operate purely as they chose.

Perhaps more important than the problems though is that the modern and traditional sectors are now talking to each other, and are beginning to understand the problems of the other. It is also important that political parties are now seriously considering the future of THs and are beginning negotiations on the issue. While others are obviously some purely political concerns in doing this, hopefully the policy on THs in South Africa will be taken so that the health of all citizens will benefit.

Melvyn Freeman is a researcher at the Centre for Health Policy

The Mozambican Experience-
Policies on Traditional Medicine since Independence

A.M. Jurg & J. Marrato

Right after independence in Mozambique in 1975/76, the new leaders decided to follow only the rational and scientific approaches to solve the country's problems. As a consequence, traditional practices and concepts regarding health and disease in particular, but also other concepts, for example, initiation rites and lobolo were seen as backyard, non-scientific at best, and at worst as obscure and dangerous. No attempt was made to separate sorcery from traditional healing. All exercise of traditional medicine was officially prohibited and banned. A Penal Code, which had made the exercise of traditional practices illegal in the colonial period, was not modified. At community level this resulted in (mostly young) leaders burning down houses and instruments of traditional healers (THs) or simply ridiculing them in front of the community. THs went underground. On the other hand, the government nationalized all health care facilities and tried to extend the PHC services to the whole country, particularly the maternal and child health (MCH) programme.

Already in 1976, certain individuals, a number of medical students and MCH workers showed their interest and concern with traditional practices. On their own initiative they met with various traditional healers and in some areas the upgrading of Traditional Birth Attendants was started. In February 1977, at the third FRELIMO congress, a much more open discussion was held on the subject and it was agreed that the Ministry of Health would open a Unit for the Study of Traditional Medicine. The Alma Ata Conference reinforced this trend and recommended that its member states draw more attention to the beneficial aspects of traditional medicine. Worldwide this was mainly interpreted as studying the pharmacological properties of identified herbal remedies.

Tacit Acceptance

From this moment on the THs were tolerated. The government did not have an official position on whether they were in favour of traditional practices or not. Another aspect of Mozambican society, however, forced the THs to try to get

Market in Maputo. Responsibilities of Ths need to be defined.
Photo: Natasha Pincus

professional recognition. Every citizen needed documents stating his\her identity, his\her permanent residence and occupation. Without a job or profession people were considered unproductive and certainly in urban areas there was deportation to non-urban areas. THs started to demand some kind of written document to prove that they were inhabitants and professionals in a certain area. These requests were received by the local, district or provincial modern health and political authorities. It depended upon the flexibility of the person in charge whether or not a provisional registration form was provided. No national policy was adopted.

From the health perspective the THs were considered key-informants regarding medical plants. A team of ethnobotanists went to several provinces

to gather information on plant species used for their traditional properties. Field visits were however interrupted between 1982 and 1986 by the civil war. In 1986 a discussion was started within the Ministry of Health on whether or not other aspects of traditional medicine would be worth studying; on possible links with the established public health programmes and the need for adequate legislation. This led to the starting of a programme for the upgrading of Traditional Birth attendants in 1990, and to a programme on Traditional Medicine in 1991.

Organizing THs

From 1989 on, the THs started to organize themselves into a national association. In Mozambique there is a healer: population ration of roughly 1: 200, or approximately 85 000 traditional healers. Official recognition of this professional organization and its members awaits legislation which allows specifically for the practice of traditional medicine.

The Ministry of Health now supports the THs in their struggle to get the new legislation established. It recognizes that even in a pluralistic health system, traditional healers are not and should not be part of the national health service. Traditional healers constitute a separate, parallel and largely self-regulating health service that with the right approach can formally collaborate with the government in the realization of specific public health goals, such as lowering morbidity and mortality of major life-threatening diseases.

The law which restricts the healing practices of all those lacking a recognized diploma should be revised to specifically exempt curandeiros (traditional healers), provided they do not misrepresent themselves as doctors or other diploma-holding health workers. If a TH prescribes, dispenses or sells modern medicines, or engages in modern practices such as injections, then to this extent he is no longer a TH and therefore subject to all laws governing the practice of formal or modern medicine. An exception to the foregoing is when THs as a matter of public policy have been trained by recognized health professionals in the use of specific modern medicines or health practices.

Registration

THs operate in an environment which might be termed traditional legitimacy, where traditional sanctions serve to define proper behaviour. Modern health practitioners operate in an environment which might be called rational-legal legitimacy, where laws and regulations define proper behaviour.

As THs increasingly emigrate from their home communities to towns, cities or other rural areas, and as they begin to practice health care in non-traditional ways, it becomes increasingly desirable for them to operate in a rational-legal environment. when traditional sanctions can no longer operate easily, it serves the needs of the patient, the curandeiro, and society as a whole if the rights, responsibilities and professional domain of the THs are clearly defined.

It is exactly this duality which causes difficulties in defining exactly how to register THs.

All THs will be registered under the new legislation, but lack of scientific or objective information regarding the practices of various categories of traditional medical practitioners in Mozambique makes it difficult to define whether or not someone is a genuine TH. However, we believe most THs still operate within a framework of traditional legitimacy, subject to various traditional sanctions. For the latter type of THs, registration done by local administrative structures was proposed following consultation of the community.

Urban THs will only be registered through a properly constituted association of THs based on criteria of membership, including standards of conduct and professional competence. This will be developed and employed by the associations themselves.

A.M. Jurg is a Dutch biologist involved in research for the National Health Institute in Maputo and Josefa Marrato is a psychologist researching traditional concepts on mental retardation.

Training Medical Doctors in Traditional Medicine

Critical Health publishes excerpts from an interview done by the World Council of Churches' bimonthly journal *Contact* with Dr Nemuel Fajutagana of the Community Medicine Development Foundation (COMMED), a progressive health organization in the Philippines. The subject is the inadequacy of conventional medical training as a preparation for the practice of community medicine in that country.

Contact: *Can you give an example of how you were ill-prepared by your medical training for work in the community?*

Dr Fajutagana: Let me share one story. One issue that is inadequately covered in the traditional medical curriculum is health and culture, or medical anthropology. When you start in medicine you are never really introduced to your cultural context. You are given the feeling that your medical training is scientific and that it is the best. Almost as an absolute.

Later on, however, doctors will experience problems relating to people, and they will not have been prepared for this by considering cultural factors during their training. For example, as a doctor working in health services you provide people with drugs, but when you go home the people will turn around and consult their THs to ask if they should take the drugs and the TH will say "No". So eventually you find that their cupboards are full of unused drugs.

Situations such as this are critical. Are we being effective in dealing with such traditional concepts? One time I was visiting an area where there was a measles outbreak, which happens regularly in the remote areas of the Philippines and can result in 50 to 100 deaths in just three barrios (villages) over just a few months, for example. In such a village, I found people hanging dolls outside their homes in their windows. At first, they didn't tell me they were doing this.

Contact: *They didn't want to tell you?*

Dr Fatutagana: No, at first they didn't want to tell me because they thought that because I was a doctor I would tell them that this was a useless practice. But later they told me that the dolls were a protection against measles. They hung the dolls in the windows so that the measles would attack the dolls and not enter the house. Similarly, they plant flowers outside their homes so that the spirits will play around in the flowers and not enter the houses.

For a doctor who is unprepared for traditions like this and who has not

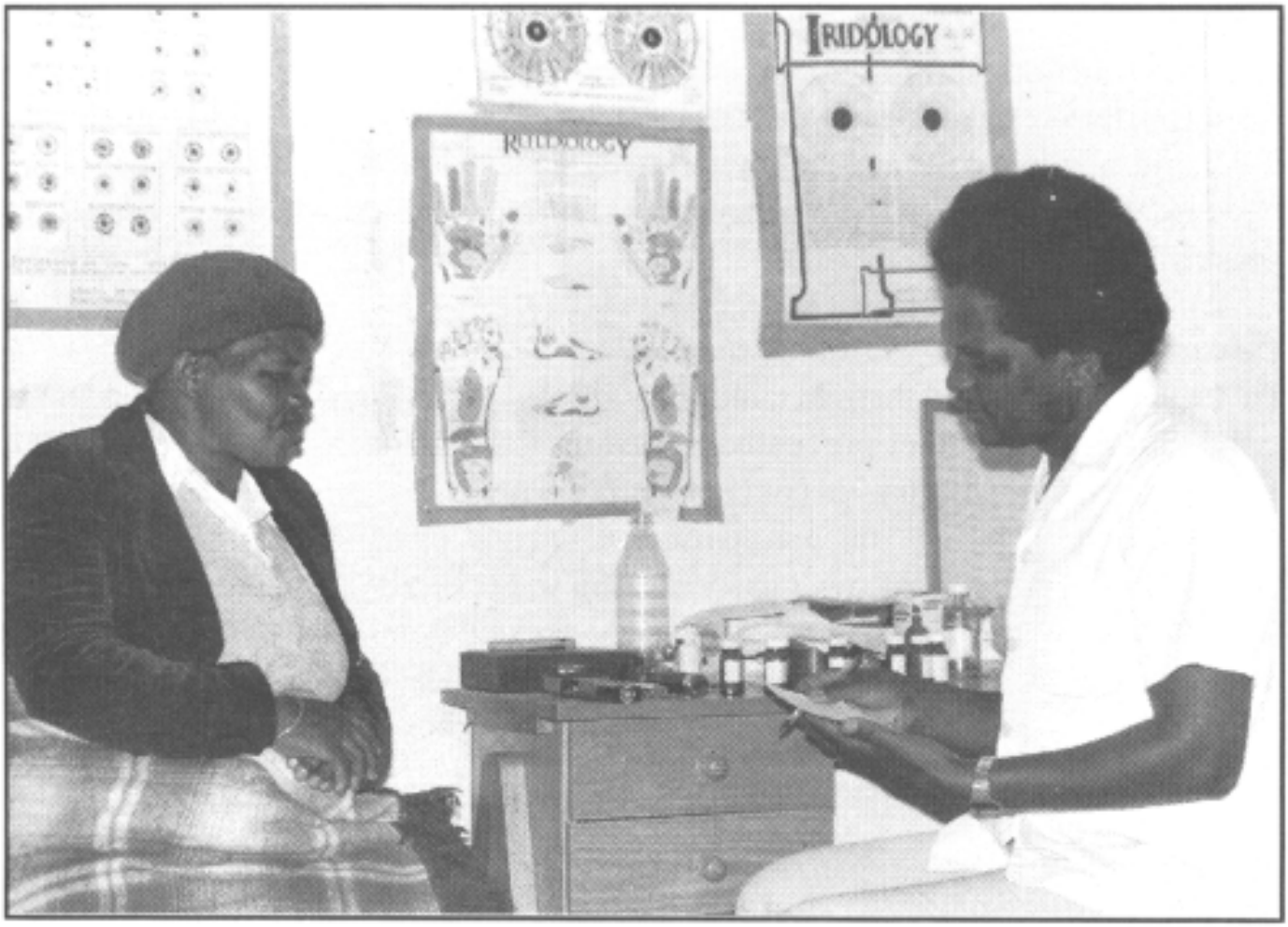
considered cultural factors in health, the tendency is to attack the culture and the traditional beliefs and tell the people that such things are stupid and should be stopped. But such a reaction would be ineffective. So I thought about it, and finally the tradition of the dolls and the flowers helped me to introduce to these people the concept of prevention. Their concept was, in fact, prevention. They wanted to prevent the outbreak of measles.

Contact: *So What did you say to them?*
Dr Fajutagana: I told them to continue with their practice and that prevention is good, but there are other preventive measures that one could take. At that point, I could introduce alternative concepts in prevention that might be new to them, such as immunization and maintaining a healthy environment, as they were already doing with their flower gardens. And so I continue in that line. I reinforce the things in common between their desire to prevent illness and the reason behind a vaccine, for example. The basic idea is to prevent death and illness. In this way, people listen to you because what you have to say is close to them and draws upon what they already believe.

You see, in the Philippines there is a strong tendency among doctors to blame the patients rather than themselves. Doctors tell patients that they've come too late, that it's their own fault that they are ill. Doctors tell mothers that they don't really care about their children if they don't have them immunized. But this is simply not true. A mother doesn't want her child to die, but she might be familiar with only one preventive aspect - the traditional. She needs to learn about other aspects rather than be blamed. I tell my colleagues that we keep on blaming patients and we don't blame ourselves.

Contact: *You mean that you say this to your COMMED colleagues.*
Dr Fajutagana: No, I say this during lectures or while sharing with other doctors and students in the medical field. I say this because when I was a student I had the same tendency: I blamed the patient. Now it's time to blame ourselves also.

Contact: *And how do your medical colleagues respond?*
Dr Fajutagana: Well, the responses vary. For clinicians, such a statement might be a realization. It is new information for them and makes them think about the shortcomings of conventional medical training. At one point, we organized a consultation on traditional medicine to which we invited traditional healers. We were asking them a lot of questions. In the end they said, "You know, you always ask us about our practices, or you want to know if we will refer our patients to doctors. And we always tell you that when we have a case that we think is not for us as traditional healers, we refer them to doctors. But the doctors, they never refer



When the biomedical system cannot provide solutions, will doctors send people to traditional healers or "alternative" medical practitioners?
Photo: Medico Health Project

patients to us. Even if they cannot heal theirpatient or find an explanation for an illness with laboratory tests, for example. They will never refer a patient to a traditional healer. Are you willing to do that?'' You can imagine that this created a stir, even among COMMED doctors. It's a very difficult question.

Contact: *So what did the doctors say?*
Dr Fajutagana: Well, they were very quiet. In the end, we had to allow a moment for reflection. In COMMED, too, we had to think about this, even though we were already pushing traditional medicine, though from a different perspective. We then realized that the people were doing it already, that it was not up to us to push but rather to learn. We had been saying that people should use traditional medicine, but, in fact, 70% of the population is already using it.

Contact: *One of COMMED's aims is that ''physicians who successfully complete the training will be able to practice and promote traditional medicine.'' This seems to be what you are talking about. So how do the doctors respond when they learn that they have to be able to practice traditional medicine themselves?*

Dr Fajutagana: I should explain that the dynamics within COMMED in regard to traditional medicine are changing as a result of our experience and this kind of self-examination. Before, we studied traditional medicine because of its curative possibilities, which was actually from a very biomedical point of view. Now we are looking at it in a wider perspective, as something that will complete, or enrich, the existing system. Traditional medicine is naturally more holistic because it deals with health as a way of life. It deals with how you relate with spirits, other people and beings, and nature, for example. We are now looking at traditional medicine because of its preventive and holistic implications, not just because of its curative possibilities.

Contact: *I imagine that it takes a certain amount of humility to adopt such an outlook.*

Dr Fajutagana: That's the new direction. Initially, we saw that it was so difficult to get health services to the people. There was no access. So we treated traditional medicine simply as an alternative system. Now we are looking at it more deeply, as a cultural entity.

This leads to a vital component that we are trying to develop: the Filipino identity of the medical practice. The only thing that will make the medical practice truly Filipino is the adding of these cultural factors such as Filipino spirituality, the Filipino identity. For the Filipino who is a doctor, that's the whole thing.

We have a very nice definition of this in our language. It is not so nice in English but translates something like "Filipino medicine is the sum of the knowledge, skills and attitudes that are our heritage." Our heritage includes all of these things. How we define nature, how we define our relation with the environment and other people, and how we define our own spirituality.

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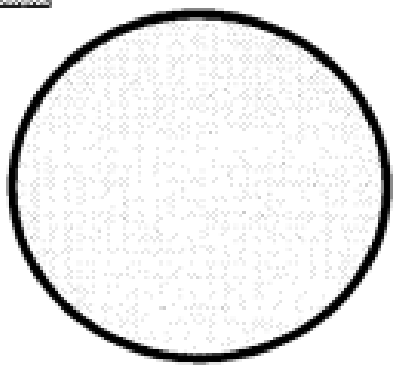
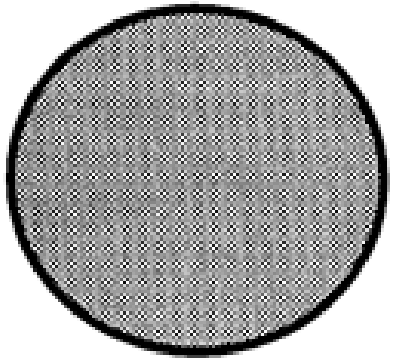
SECTION

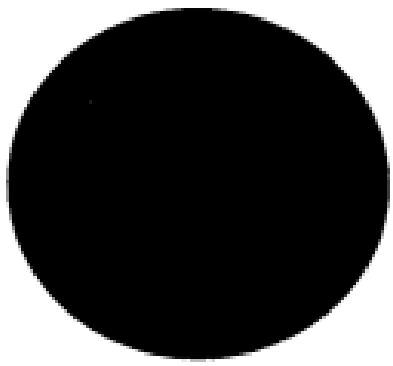
D

Topical Issues

The first article publishes the full text of the AIDS /HIV Charter which is to be launched on 1 December. The two articles on the drought crisis highlight the controversy around the way drought relief is being handled by the government , and the inadequate information on who and where to target efforts. The last article examines the implications of the recent strike for health workers .







AIDS and HIV Charter

AIDS Consortium

History of the Charter

In November 1991 a number of organisations met to discuss a proposal to draw up a charter of rights for people with AIDS or HIV. This meeting resulted in the formation of the AIDS Consortium. Three lawyers (Edwin Cameron, Edward Swanson and Mahendra Chetty) formed the drafting committee and presented the first draft of the Charter to the Consortium in January 1992. The Charter draws on international documents such as the Montreal Manifesto of the Universal Rights of People Living with HIV Disease and the United Kingdom Declaration of the Rights of People with HIV and AIDS, but has been specifically adapted for the South African context. To date the Charter has been extensively discussed and amended and had been approved by representatives of over 40 organisations. The Charter now awaits formal endorsement by the organisations making up the AIDS Consortium, as well as by prominent figures in all spheres of national life and by organisations countrywide. It is planned to launch the Charter publicly on or near World AIDS Day (1 December 1992).

Preamble

In the light of

- the existing discrimination against persons with AIDS or HIV and their partners, families and care-givers,
- the danger that the growth of the epidemic in South Africa will lead to an increase in unfair and irrational treatment of individuals affected by AIDS and HIV,
- the desirability of greater awareness and knowledge of AIDS and HIV among all South Africans, and
- the need for concerted action by all SOuth Africans to stop the spread of HIV,

we, the undersigned individuals and organisations, think it is necessary to set out those basic rights which all citizens enjoy or should enjoy and which should not be denied to persons affected by HIV or AIDS, as well as certain duties.

1. Liberty, Autonomy, Security of the Person and Freedom of Movement

1.1 Persons with HIV or AIDS have the same rights to liberty and autonomy, security of the person and to freedom of movement as the rest of the population.
1.2 No restriction should be placed on the free movement of persons within and between states on the ground of HIV or AIDS.
1.3 Segregation, isolation or quarantine of persons in prisons, schools, hospitals or elsewhere on the ground of AIDS or HIV is unacceptable.
1.4 Persons with HIV or AIDS are entitled to autonomy in decisions regarding marriage and child-bearing, although counseling about the consequences of their decisions ought to be provided.

2. Confidentiality and Privacy

2.1 Persons with HIV or AIDS have the right to confidentiality and privacy concerning their health and HIV status.
2.2 Information regarding a person's HIV status must not be disclosed without that person's consent, and, after death, except when required by law, without the consent of his or her family or partner, except in cases involving clear threat to and disregard of an identifiable individual's life interests.

3. Testing

3.1 HIV antibody testing must occur only with free and informed consent, except in the case of unlinked, anonymous epidemiologic screening programmes.
3.2 Anonymous and confidential HIV antibody testing with pre- and post-test counseling should be available to all.
3.3 Persons who test HIV positive should have access to continuing support and health services.

4. Education on AIDS and HIV

4.1 All persons have the right to proper education and full information about HIV and AIDS, as well as the right to full access to and information about prevention methods.
4.2 Public education should be provided with the specific objective of eliminating discrimination against persons with HIV or AIDS.

5. Employment

5.1 HIV or AIDS do not, by themselves, justify termination of employment or demotion, transfer or discrimination in employment.
5.2 The mere fact that an employee is HIV positive or has AIDS does not have to

be disclosed to the employer.
5.3 There is no warrant for requiring existing employees to undergo testing for HIV.
5.4 Information and education on HIV and AIDS, as well as access to counseling and referral, should be provided in the workplace after appropriate consultation with representative employee groups.

6. Health and Support Services

6.1 Persons with HIV or AIDS have rights to housing, food, social security, medical assistance and welfare equal to all members of our society.
6.2 Reasonable accommodation in public services and facilities should be provided for those affected by HIV or AIDS.
6.3 The source of a person's infection should not be a ground for discrimination in the provision of health services, facilities or medication.
6.4 HIV or AIDS should not provide the basis for discrimination by medical aid funds and services.

7. Media

7.1 Persons with HIV or AIDS have the right to fair treatment by the media and to observance of their rights to privacy and confidentiality.
7.2 The public has the right to informed and balanced coverage of, and the presentation of information and education on, HIV and AIDS.

8. Insurance

Persons with HIV or AIDS, and those suspected to be "at risk" of having HIV or AIDS, should be protected from arbitrary discrimination in insurance.

9. Gender and Sexual Partners

9.1 All persons have the right to insist that they or their sexual partners take precautionary measures to prevent transmission of HIV.
9.2 The specially vulnerable position of women in this regard should be recognised and addressed, as should the specially vulnerable position of youth and children.

10. Prisoners

10.1 Prisoners with HIV should enjoy standards of care and treatment equal to those of other prisoners.
10.2 Prisoners with AIDS should have access to special care which is equivalent to that enjoyed by other prisoners with serious illness.

10.3 Prisoners should have the same access to education, information and preventive measures as the general population.

11. Equal Protection of the Law and Access to Public Benefits

11.1 Persons with AIDS or HIV should have equal access to public benefits and opportunities, and HIV testing should not be required as a precondition for eligibility to such advantages.

11.2 Public measures should be adopted to protect people with HIV or AIDS from discrimination in employment housing, education, child care and custody, and the provision of medical, social and welfare services.

12 Duties of Persons with HIV or AIDS

Persons with HIV or AIDS have the duty to respect the rights, health and physical integrity of others and to take appropriate steps to ensure this when necessary.

The AIDS Consortium is at present a loose affiliation of organisations and some individuals. There is no structured membership yet. Individuals or organisations subscribing to the aims of the Consortium are free to attend meetings, and most choose to act as members of the Consortium when policy or organisational issues arise.

At present we have the following organisations, represented at our meetings, either as members or as keen observers:

AIDSCOM, SANTA, FRIENDS FOR LIFE, ACT-UP, AREPP, ALEX AIDS ACTION, BODY POSITIVE, COMMUNITY AIDS CENTRE, IPM, HOSPICE, KAGISO, LEGAL RESOURCES CENTRE, LIFELINE, CHURCHES AIDS PROGRAMME, PLANNED PARENTHOOD ASSOCIATION OF SA, PPHCN (including their national AIDS forum), SA BLACK SOCIAL WORKERS ASSOCIATION, SA COUNCIL OF CHURCHES, SA CATHOLIC BISHOPS CONFERENCE, SANCA, TOWNSHIP AIDS PROJECT, HIVES, MEDECINS DU MONDE, COMMISSION OF THE EUROPEAN COMMUNITIES, MEDECINS SANS FRONTIERS, ALEXANDRA HEALTH CENTRE, GLOW, AIDS SUPPORT & EDUCATION TRUST, WILGE-PRUIT AIDS SERVICES, ADAPT, CENTRE FOR APPLIED LEGAL STUDIES, SACS, AIDS CENTRE (SA INSTITUTE OF MEDICAL RESEARCH), COSATU, NATIONAL UNION OF MINEWORKERS, TRANSVAAL GENERAL WORKERS' UNION, BELL, DEWAR & HALL, CUZEN & WOODS, DRAMA & AIDS, OUT-REACH, AIDS LINK.

The AIDS Consortium can be contacted at the Centre for Applied Legal Studies, University of Witwatersrand, Private Bag 3, WITS 2050, Johannesburg.
Tel: (011) 403 6918, Fax: (011) 403 2341. After Hours: (011) 403 6947

The Drought and Poverty Relief

Critical Health

South Africa is currently experiencing one of the worst droughts on record. This is resulting in a dramatic increase in the number of people suffering from malnutrition and dying from hunger and thirst.

The government has made R1bn available to white farmers, most of which will find its way to the banks in the form of loan repayments. However, its contribution to those facing starvation as a result of the drought has been negligible.

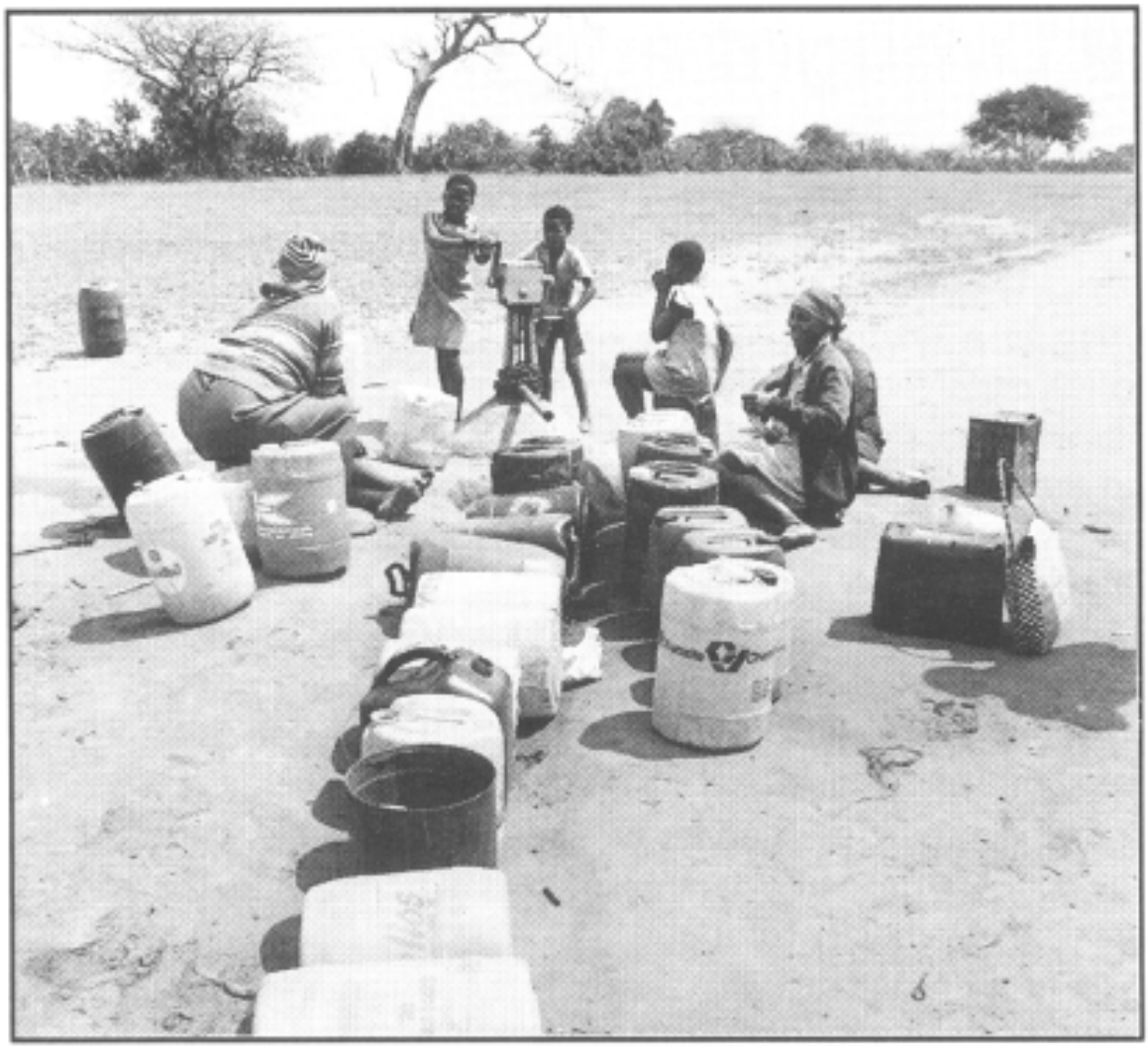
Last year, the government imposed a 10% tax on the poor in the form of VAT. It offered to return a fraction of this amount in the form of the poverty relief fund. This amount is included in the health budget figure to create the impression that it has significantly increased the health budget. Furthermore the government is using the poverty relief fund for drought relief. In other words, by means of VAT, the poor are financing their own drought relief, while the government is creating positive publicity for itself.

As a result of the drought, we are experiencing a shortage of grain. The government is making millions of rands from wheat and maize imports. These grains are imported at a low price and then sold on the market at a far higher price. None of this money is being used to lower food prices or for drought relief. The limited amount allocated for drought and poverty relief is but one aspect of the problem. Another concern is the lack of proactive planning and informed distribution of funds on the part of the government.

There are, however, a number of organisations which are attempting to respond to the drought in a more appropriate manner. This edition includes two articles on the issue. The first article is based on an interview with Diane Callear of the National Consultative Forum on the Drought. She argues that the government is starting to respond more appropriately as a result of pressure from a wide range of organisations. This is followed by an update from Operation Hunger in which it expresses serious misgivings about the state's handling of the drought.

The Nutrition Development Programme

According to Callear, the R440m allocated to the poverty relief fund this year would probably be sufficient if the objective of the programme was simply relief of the hungry and if the information had been established to target the food to those who need it most. Neither of these conditions apply. The government has



Collecting water, Zululand. *Photo: Paul Weinberg*

responded to criticism that it does not provide adequate funds for development work by giving the poverty relief a development focus. The fund is being used for a variety of "relief" and "development" objectives. Both are important, but no amount of "development" in South Africa can be achieved with a portion of the R440m and the fund, initially intended for poverty relief, is not meeting that target either.

There is no information base on which to select areas or households with the greatest need and we have no idea if the really hungry are being assisted at all.

Callear says that when the government set up the fund, it did not engage in thorough planning and targeting of its distribution to the most needy. Initially, a very small proportion of the fund had been allocated and this small amount went mostly to non-government organisations which do not have a presence in far-off rural areas where the need is greatest. A Black Consumer Union spokesperson (see 'Taxation and Poverty Relief', Critical Health #38) said that the government had no coherent criteria for deciding which organisations should receive a share of the fund, and it often allocated funds to organisations which were not involved in relief work.

Botswana: Successful Poverty Relief

By contrast, a drought relief programme in Botswana in the 1980s worked very well, precisely because of the establishment of a sound information system. Relief funds were administered from the centre by an inter-ministerial drought committee and an early warning technical committee. The latter published monthly reports which it submitted to the ministerial committee. Its reports included crop forecasts, the potential loss of income to families, the nutritional condition of children under five, a report on the feeding programme and reports on weather, water and land conditions. To ensure that these reports were accurate, clinic staff were trained in the selection of children for feeding and, because they were already involved in feeding, clinics were also producing monthly reports on the nutritional status of children under five. By this means, the government, which relied on support from international donors, could work out exactly what it required each year in terms of food types, quantity and technical assistance. Whenever foreign donations were inadequate to meet needs, the government funded programmes itself.

Working Together in Poverty Relief

It is clear that the government in South Africa failed to respond to the current drought in a similar way. As increasing numbers of people have become affected by drought and unemployment, various organisations have tried to tackle this situation. In March 1992, the Independent Development Trust (IDT) called a workshop in Cape Town, and in June, a number of organisations established a National Consultative Forum on Drought. These include trade unions, non-government organisations, churches, liberation movements, the homeland governments, the government and the Development Bank of South Africa.

The forum has set up a so-called "operations room", which is monitoring information flows which show the impact of the drought on various communities countrywide. This task involves finding alternative ways of identifying needy households and a national assessment of the nutritional conditions of children. It also entails developing an early warning system, through regular monitoring of rainfall, water and agricultural conditions. On 27 August, according to Callear, the government gave a commitment that once results from this survey were ready, it would review its current allocations in the light of the results and reallocate funds appropriately. Callear argues that non-government organisations should also be persuaded to transfer their projects to areas that are worst off.

The Consultative Forum has also established task forces in water, public works, agriculture and long term development. The water supply task force has the

very important task of developing a water relief programme in some of the most drought stricken areas, mainly in the northern Transvaal, but suffers an extreme shortage of funds. Its expected need was for R24m over the next few months, but at the time of writing, it has only received a mere R2,2m given as a donation from the European Community.

Meanwhile, many of the members of the forum continue their relief efforts. They are also hampered by their lack of knowledge of the areas of greatest need, although, says Callear, they obviously do their best under the circumstances. This forum includes the churches, Operation Hunger and the Independent Development Trust (IDT). The IDT has set aside R60m for a public works programme and has solicited support from trade unions for this. The projects work on a cash-for-work basis, with wages deliberately held low (R7 a day), in order to attract only those in greatest need. This relief work could not be endorsed by the COSATU affiliated trade unions in any other circumstance. It is, according to Callear, an important aspect of relief as it puts cash into people's hands to buy their bare necessities, including basic food.

The Government's Role

To some extent, Callear argues, the government has improved its own ability to achieve greater co-ordination in the distribution of relief funds. Initially, nutritional development funds were allocated directly from Pretoria leading to very long time delays. At present, funds are distributed by region and population size. It seems that in this way the government has been able to do some positive targeting of regions with the greatest need. For example, the northern Transvaal, one of the most drought stricken areas, has received more than R100m of the R440m fund. The problem, however, is that it is not sufficient to identify regions of need. It is also necessary to develop objective criteria of locating households in greatest need. If these criteria are not developed, it is possible that weaker groups, like households headed by women might be disadvantaged in the distribution of funds. Most of the work of the non-government organisations is in urban areas, and most people who receive assistance are in urban areas. Yet it is known that there is much greater poverty and need in rural areas. The major failure of the programme is its inability to determine and respond to need.

However, not all organisations involved in the distribution of funds agree with distribution at the regional rather than at the central level.

Operation Hunger insists on central funding (see next article). On the other hand, the Black Consumer Union feels that if all funds were directly allocated from the centre, organisations which do not meet official criteria for receiving

There is much greater poverty in rural areas. *Photo: Paul Weinberg*

funds would be discriminated against. It is important, therefore, to find a balance between centralized and regional allocation of funds on condition that this involves widespread consultation and involvement of communities.

As a result of pressure from various non-government organisations, the government has created regional, local and district committees for the allocation of funds. This has the effect of reducing the excessive bureaucratic control over the distribution of funds. The government is, according to Callear, finally trying to overcome the problem of lack of information by getting wide representation on the committees, including representatives of civics and other community organisations. Progressive organisations face the dilemma that they could be seen to be providing legitimacy to the government if they participated in these committees. The government will undoubtedly try to obtain "kudos" from this programme without, of course, addressing the causes of such extensive poverty in a middle income country.

However, Callear argues, it is important that the civic representatives should participate. They should, she says, use their position constructively to ensure that funds are properly spent. They need to take information and criteria of the programme back to their communities so that they can assist local non-government organisations to apply for funds to meet the needs of the poorest in their communities.

Critical Health

The Hunger Crisis:
September '92

Operation Hunger

Operation Hunger has been deeply concerned about the drought since December 1991. Every early warning signal indicated that the effects of the drought, compounded by the current economic depression, would lead to a hunger crisis of unprecedented magnitude in South Africa. We decided that all our energy and resources should be channeled toward avoiding a situation in which too many children hunger and die before help is given.

But the situation is worse than we anticipated. Every field trip, every new application, is a journey into previously uncharted depths of misery, human suffering and want.

North-western Transvaal

There is an appalling deterioration in the "homeland" areas from Rustenburg to Zeerust, and Mmabatho to the Botswana Border. Water tables are dropping daily. The villages near the border gate on the roads to Lobatsi are the worst we have seen in 13 years of exposure to the ravages of poverty. Cattle are dying daily and people show visible signs of extreme misery. At Braklaagte, beyond Zeerust, a French medical group, applying for support, submitted a height for weight for age survey where the majority of the children measured were severely malnourished.

Northern Gazankulu (Giyani, Malamulele)

In January and February we received urgent requests to implement school feeding in the Giyani area. We were assured that the Gazankulu health authority was starting these schemes in March and April. The "homeland" government feeding was implemented for one month only in the Giyani area. Again in August the local education authority insisted that the schemes were underway and nothing happened. Meanwhile, our field staff were reporting visible deterioration of the children in the area. Photographs and statistics, from staff at hospitals and clinics were the final straw. We had to commence feeding 30 000 children in the area this month.

Lebowa

There is severe hunger in the north west, in the crescent Bochum to Potgietersrus. In the Kgapane hospital area, the community group that has approached us, claims that feeding is required for 22 000 children. At Jane Furse Hospital, our staff are processing individual applications daily. We met the health department months ago, and they agreed that hospitals and clinics would supply families with food. However, help has not been forthcoming when our people apply to those sources. At that meeting we also urged that they involve themselves in Kgapane.

Orange Free State

In the Orange Free State, because the sisters in charge were too scared to admit that they had appealed to us for assistance with family rations, the chairperson of the regional welfare board harassed our staff and made allegations that we were 'dumping' food at the board's clinics. We agreed to refrain from clinic feeding. In the week of this agreement, a government clinic in Virginia sent an application to us for a supplementary feeding scheme.

Other areas

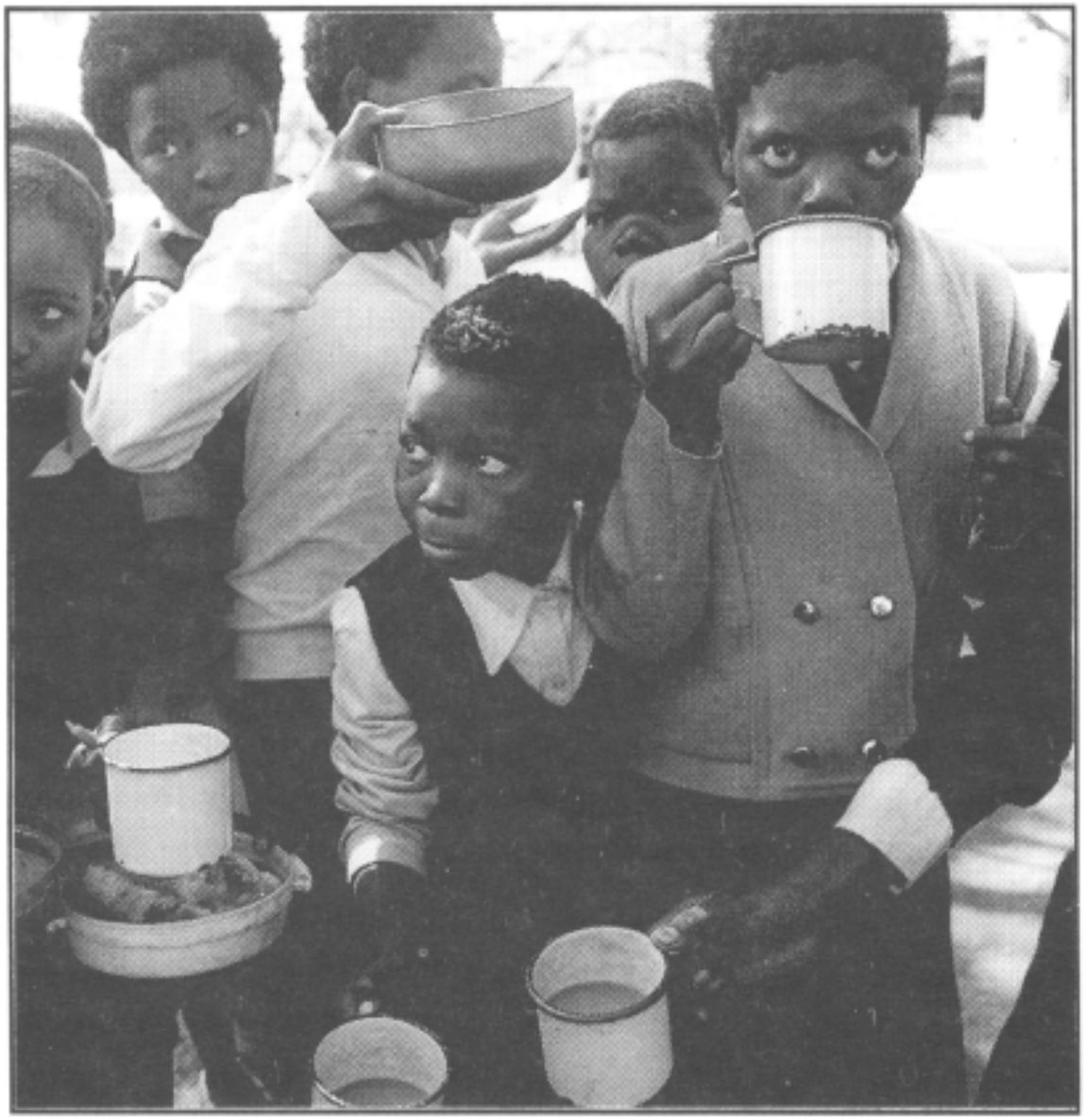
In the PWV, families arrive daily in our office with letters from various Baragwanath Hospital social workers referring hungry families.

At Orange Farm, the situation is a shambles since we had to close down our feeding schemes there. We did so after being told that the local welfare board had given vast sums to other newer organisations, and that we should not duplicate. It is months later, nothing is happening, and there is still no help for the poorest.

The Nutrition Development Programme

It is crystal clear, countrywide, that the government's Nutrition Development Programme, is unable to prevent starvation. Dr Rina Venter, the minister of health, recently announced yet another grand design (the third in 18 months) that will streamline relief programmes and address every future crisis. We have not seen details of this latest master plan yet, but you will forgive us if our reaction is that of Eliza Doolittle: "Words, words, words, I'm so sick of words".

You might recall that we first applied for government funding in October 1991. After a war of words in the press, we were given R10m of the R27m we had applied for. We insisted that we receive funds nationally and that we be assured that there would be no interference from the "homeland" authorities. We had no



Operation Hunger feeding scheme, Lebowa. *Photo: Paul Weinberg*

alternative in the face of the mandate given to us by the community we serve.

We applied for the balance of the grant in April this year. In May we were informed that we could only obtain funds regionally, which in at least seven areas would mean applying through the "homelands". We refused to make regional applications, because of our mandate and as well the need to maintain financial control as required of us by the fund-raising act. In the same month, Operation Hunger met with the director general of health, Dr Coen Slabber, and deputy director, Dr Hans Steyn. They agreed that Operation Hunger could continue receiving funds nationally. Since then we have not received funds, for the reason apparently that some 14 regions have had to be consulted.

The root of the problem

This brings us to heart of the moral dilemma. We compounded suffering in certain areas such as Giyani by postponing our response to feeding appeals in the

knowledge that the local authorities had neither the competence nor the will to do the work. According to Len Abrams, the director of the Operations Room of the National Consultative Forum on Drought:

> ''Our understanding of our primary mandate is to provide relief for those most directly affected by the drought. A secondary mandate is to work together with all the constituents of the forum to most effectively achieve the first objective. In practice we are finding that these two objectives are increasingly beginning to conflict. While it is necessary usually to suspend active critique of the root causes of a disaster in the interests of immediate relief, in this situation the root causes are not only responsible for the disaster but are also the largest obstacle to the disaster relief activity. This is a widely held opinion of a large number of the participating organisations of the consultative forum and it has been unanimously endorsed by the foreign disaster relief engineers who have had to be brought in to help address the crisis''.

According to Abrams, ''The comment of the engineers is that in all their substantial experience in places such as Ethiopia, Somalia and Iraq, they have never worked in a situation more chaotic and with less support. The state has used its structures of the "homeland" administrations to channel public drought relief funds where they are to be managed by the same bureaucracy that is responsible for the problems and largely spent by the same consultants who have designed the systems that are presently failing''.

These engineers have now been withdrawn by the Overseas Development Agency of the British government because, from agency's point of view, the problems are not ''as a result of emergency conditions brought about by drought, rather they are long term problems of neglect''.

We have the same problems in the relief and development fields. The structures we are expected to work with are the same ones that formerly accepted the unacceptable without protest, and more often compounded it by maladministration, inefficiency and neglect.

Are we not by co-operation, especially with the homelands, shoring up incompetence, defending the indefensible, and giving credibility to that which has none? More important, how is this affecting the people we serve who have always seen us as unaligned, as independent, as dedicated solely to their service. Their great fear when they consented to our applying for government funds was that this would lay them open to manipulation and interference.

Ina Perlman is the Executive Director of Operation Hunger

Lessons in Struggle:
The Hospital Workers' Strike

Critical Health

In May this year, the government structure which deals with wages and working conditions in the public sector, the Commission for Administration (CFA), refused to agree to a wage increase for public sector workers of more than roughly 8%. This is well below the inflation rate and it provoked a bitter strike by general assistants at public sector hospitals. The strike, led by the National Education, Health and Allied Workers' Union (NEHAWU), lasted for almost four months in the Transvaal. It spread to other parts of the country for shorter periods and workers belonging to the Health Workers' Union (HWU) in the Western Cape also joined the strike.

The Transvaal Provincial Administration (TPA) dismissed over 7 000 workers and, after weeks of confrontation, the dispute in the Transvaal only ended when NEHAWU made significant compromises. It agreed to the immediate return to work of 5 000 of the dismissed workers. The union's demands on wages and conditions will be dealt with when workers are back at work, but the union will be bargaining from a weak position because it also agreed to a six month moratorium on industrial action in the Transvaal.

The Government's Agenda

The government's hardline attitude was a central feature of the strike. It was clearly intent on crushing the union and it was prepared to allow hospital services to disintegrate in the process. It showed a total disregard for its responsibilities as an employer and as the provider of public health services for the people of this country.

Prior to this strike, the government had failed to abide by agreements reached after the 1990 hospital strikes by the HWU in the Cape and NEHAWU in Transvaal. In both cases, workers returned to work after settling their disputes with the CFA. Workers were promised a wage increase, six months paid maternity leave and a 40 hour working week. It was agreed that workers employed for over three months would be regarded as permanent. To date, workers with many years of service are still classified as temporary staff.

This year, the government, through the TPA, again demonstrated its lack of

concern for black people's health services. It refused to consider reasonable proposals from striking workers to cushion the effects of the strike on patient care. According to Philip Dexter, NEHAWU's general secretary, in the weeks leading up to the strike, workers tried to use more limited forms of action to express their grievances. They engaged in daily demonstrations at Baragwanath Hospital. This culminated in an occupation of administration offices at the hospital. Workers were given an ultimatum to stop their protest activity and, when this was rejected, the administration declared a lock-out. During the strike, NEHAWU offered to keep emergency services at hospitals functioning. This offer was rejected and striking workers were denied any access to hospitals.

The TPA showed its extremely reactionary attitude to the striking workers by dismissing over 7 000 workers in the first few weeks of the strike. The TPA's union bashing stance has been given open support by the government. There is no adequate dispute regulating mechanism and the government persistently refused to accept efforts by NEHAWU to resolve the dispute. For months, it opposed outside mediation. After the talks in August broke down, COSATU said that it seemed as if a political decision had been taken "at the highest level" to block a settlement.

Intimidation and Violence

The provincial administration also politicised the strike by deliberately recruiting scabs from hostels, many of whom are members of the Inkatha Freedom Party (IFP). This is a central reason for the high levels of violence during the strike.

Many newspapers carried reports, often unsubstantiated, of strikers intimidating scab workers at hospitals. Little was said about the daily intimidation that strikers faced from the police, scabs and hospital managements.

Scabs working as hospital clerks at Baragwanath Hospital held a meeting in August at which they agreed that all clerks should carry weapons in order to attack the strikers. *Critical Health* asked strike leaders if they had made any preparations to defend themselves. We were told that many of the people who protested outside the hospital were old women. Moreover, strikers would not dare carry weapons in a climate dominated by hostile government propaganda. After the clerks' meeting, strikers publicly disassociated themselves from any violent attacks on the replacement staff.

In some cases, intimidation was officially sanctioned. At Baragwanath Hospital, staff were given special permission to carry firearms, despite Soweto having been declared an unrest area. Staff were notified of this privilege by means of a memorandum from management which read, "We urge all staff to take advantage of this offer as soon as possible".

Strikers faced a very determined foe. *Photo: Dario Fossati*

Strengths and Weaknesses

The strikers were clearly confronting a very determined government. Workers were highly motivated and said they were not prepared to submit to the state's intransigence. But it was clear that workers would only win their demands if the strike was well organised and if it received widespread active support, both within and outside the health sector. A number of gains were made during the strike, but there were also many weaknesses.

According to Bobby Mgijima, an HWU organiser, (see the forthcoming article in the South African Labour Bulletin), there was a lack of preparation for the strike and health workers had not been sufficiently mobilised. However, rank and file pressure pushed NEHAWU to strike in the Transvaal in June. The union moved immediately to declare a national strike. The HWU in the Western Cape also joined the strike.

The strike failed to develop a truly national character. NEHAWU was weakly organised in the Cape and Natal and it soon called off the strike in these provinces. The HWU was willing to continue the strike in solidarity with NEHAWU's Transvaal members, but, a few weeks after NEHAWU workers in the Western Cape returned to work, the HWU also called off its strike.

Mgijima argues that another fundamental weakness was the lack of a plan to build public support. In addition, there was no clear strategy to develop solidarity action within the health sector. Mgijima considers this an important

lesson because, "in future, we will need to think about the involvement of our members in the private hospitals ... as we cannot have afford to have members playing the role of spectators".

Support from other Health Personnel

NEHAWU did eventually threaten to involve its private sector members in the strike. Striking workers also constantly appealed to health professionals to give active support to the strike. Many professionals responded positively to the appeals. Doctors, nurses and paramedics at Ga-Rankuwa Hospital, near Pretoria, joined the strike in July, while academics and students at the Medical University of South Africa marched in support of the strike. At Baragwanath Hospital, a Concerned Health Workers' Committee was established, consisting of 4 representatives from the local civic association, 5 reps of sympathetic medical professionals and 10 reps of the striking NEHAWU members. The committee met daily and discussed ways in which the impact of the strike could be sustained.

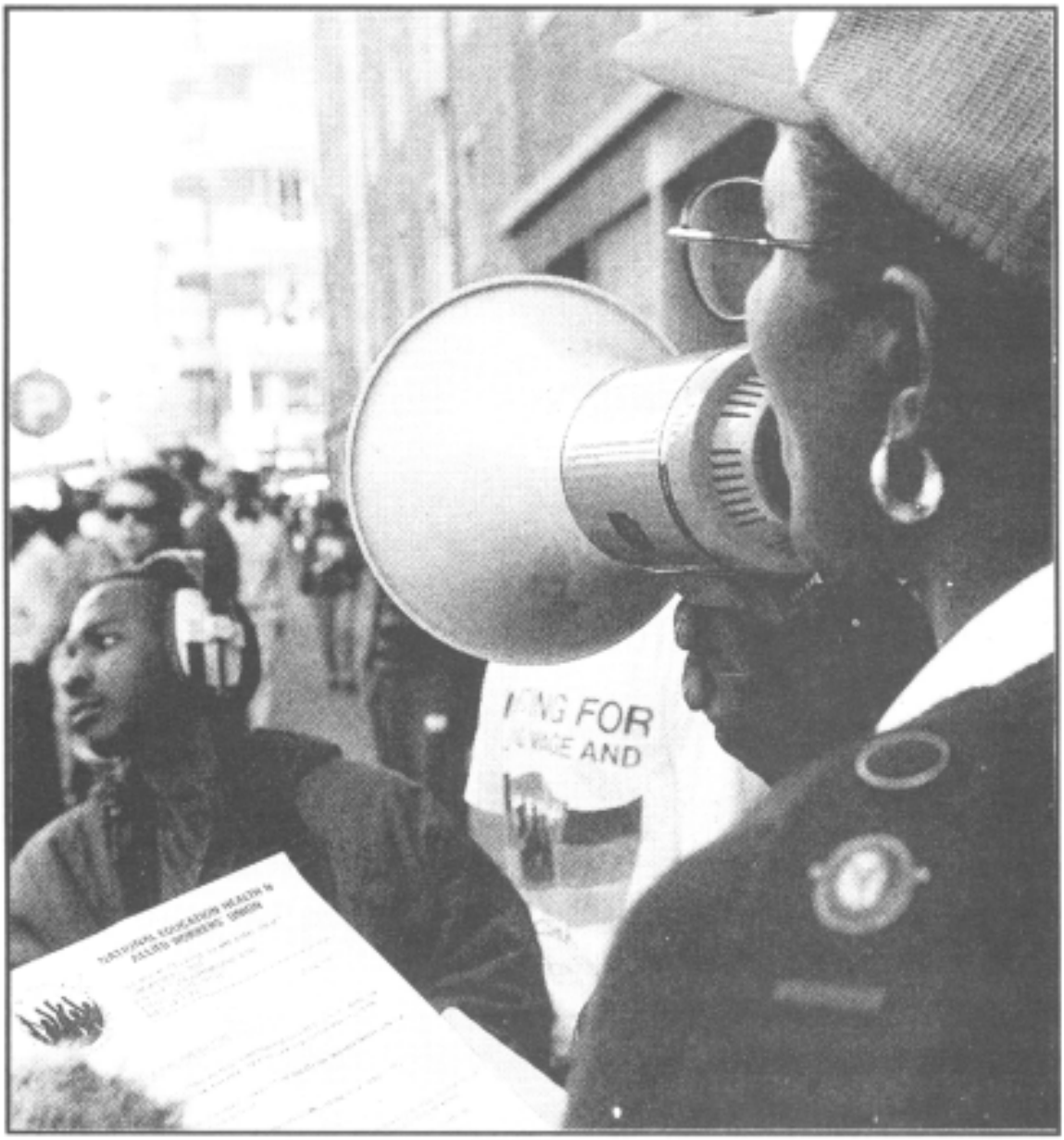
The Doctors' Crisis Committee and the Committee of Concerned Professionals were also formed. These represented doctors, therapists, radiographers, registered and student nurses. Although these committees sent memoranda to the TPA, their concern was to normalise the situation rather than actively support the strike by engaging in marches or pickets.

Nurses Sympathetic, but not Organised

Many nurses, in particular, were sympathetic to the strikers' demands, but have been afraid to show open support for the strike. The lack of greater support from nurses can be partially attributed to a weakness on the part of the union as regards its ability to organise nurses. A nurse said that the problem is that "NEHAWU has not organised properly among the nurses. We are health workers, and by putting pressure on us to strike, the union is insensitive to the professional obligations we have towards patients' demands. If the union had consulted us better, we might have worked out a way we could support them."

In future, gaining the full weight of support from nurses and other health professionals is going to be a long battle, for the additional reason that many personnel perceive themselves as "professionals" rather than health workers with specific skills (see the first article in the previous edition).

There were instances when nurses played a more active role. One nursing sister said during the strike that, "at NEHAWU's suggestion, we proposed a skeleton staff to the administration and they refused it. We have met the highest authorities, calling urgently for arbitration, but we have been ignored."



Many nurses were sympathetic to the plight of the strikers but lack of organisation prevented more effective involvement. *Photo: Dario Fossati*

At the start of the strike, nurses at Baragwanath Hospital stood behind the Doctors' Crisis Committee against active support for the strike. Yet, on 19 August, about 400 Baragwanath nurses marched, calling for the reinstatement of fired workers. They expressed remorse at working during the strike and concern that their safety was threatened by the presence of IFP members among the scabs. The nurses received permission to hold the protest march and arranged shift changes to ensure that patient care was not compromised.

Gaining Support within the Community

The strike showed that trade unions need to build active support for their strikes amongst the oppressed community. This is of special relevance in the state sector, where the government has traditionally curtailed workers' rights to strike or even

to organise. As pointed out by Mgijima, NEHAWU and the HWU should have done more in this regard.

NEHAWU gained some community support after the mass dismissal of strikers and this support grew when the ANC/SACP/COSATU alliance embarked on its mass action campaign. The union also raised the profile of the strike by involving the civics and other health organisations in negotiations over the strike. However, community support would have had a greater impact if the union had made appeals and organised support before embarking on the strike.

Strikers at Baragwanath Hospital said in August that the active support of the civics and other political structures participating in marches had helped keep workers "spirits up" to continue the fight. But NEHAWU's finances were drained by the dispute and workers were finding it difficult to even produce strike pamphlets. The union failed to seek organised support from the community in terms of food parcels and fund raising drives. The little money that strikers had came from their local, unco-ordinated efforts at fund raising.

Nevertheless, the support NEHAWU received from community organisations assisted the union in drawing the government back to the negotiating table. According to a civics spokesperson, negotiations between NEHAWU and the TPA were re-established as a direct result of the week of mass action in August. These talks broke down again, but the TPA eventually agreed to mediation by an independent body. This, in itself, was a significant victory, given that there is no adequate dispute regulating mechanism. It was, furthermore, during this mediated process that the TPA offered to re-instate 5 000 workers.

Undemocratic Hospital Boards

The involvement of the community has had other positive political implications. Neal Thobejane, NEHAWU's assistant general secretary, says that, as a result of the strike, the civics began to see an opportunity to introduce democracy into the running of hospitals. Many are calling for the dismissal of racist hospital managers.

Sisa Njikelani, speaking on behalf of Actstop, a Johannesburg city centre civic structure, said that it had participated in mobilising marches in support of the strike. Actstop and NEHAWU are now demanding that hospital boards should be restructured. Presently, hospital boards are advisory bodies appointed by the provincial administrators. Actstop has submitted memoranda to local TPA offices questioning the legitimacy of the TPA to run hospitals. It has been involved in arranging meetings with hospital boards and managements. According to Njikelani, the demand is that the boards should be community structures, with elected members, and should have executive powers over the running of hospitals.

Demonstrations were held in support of the strikers. Was enough active support generated from the community? *Photo: Dario Fossati*

Where to now?

It is clear that, despite the determination shown by hospital workers in this strike, workers have returned to work without their demands being met. In the Transvaal, more than 2 000 workers have not been automatically re-instated. Those that are back at work are tied to an agreement which prohibits their right to strike for six months. On the other hand, there were encouraging signs of support from other health workers and the community. This was enough to get the government to agree to mediation and to re-instate 5 000 workers.

However, the government promises to continue to be a bad employer. It is going to table the Public Service Labour Relations Bill in Parliament next month. The bill includes a vague definition of essential services. It stipulates that public sector workers who provide those services will not be allowed to strike in future.

NEHAWU and the HWU will have to rebuild their strength and tackle this new threat. It is encouraging to see that unionists are already assessing the strike with the view to learning the lessons and being better prepared for future struggles.

Critical Health

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