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Community Service



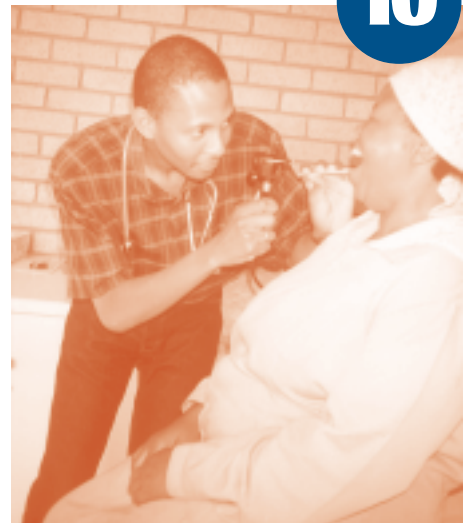
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Editorial

Community service in an urban hospital

Dr Anthony Zaborowski

Community service has been described by some as a thoroughly worthwhile undertaking, while others describe it as a burden, a blot on their careers and private lives. As with most undertakings in life, there have been positive and negative aspects to this year for me, and the truth of the experience probably lies somewhere between these two extremes.

I regard my own community service year as being most successful on the whole. I can look back with satisfaction on a wonderful first six months spent in the top notch Paediatric Unit at Durban's Addington hospital, and a second six months gaining experience in trauma and casualty medicine. The knowledge and skills that I've gained will be invaluable in my career. I have seen a lifetime of pathology in one year and I've gained confidence in myself and my abilities. I have come out of this year a stronger doctor and, indeed, a richer person.

Addington is a professionally run hospital with nothing being left to chance. Supervision during my year was almost universal, with specialist advice never more than a phone call away, if not actually on the premises in the form of a registrar.

However, my experience is by no means the norm amongst the community service doctors of 2000. I was fortunate that I was awarded my first choice of hospital, in a Department of Health run application process that required me to list five South African hospitals in order of preference. I received the post that I wanted – in a major national city, my home town, in a hospital that must rank as one of the best public hospitals in the country. I have had exposure to academics, first world medicine and first class teaching.

Others were not so fortunate however. Many community service doctors did not get anything near their hospital of choice, some going into second and third rounds of applications in a dubious and often confusing system which does not seem to be blind to

factors of colour or gender. Many doctors have spent a year far away from their families and friends, in rural areas with poorly managed and poorly equipped hospitals, sometimes devoid of any meaningful supervision at all. Some of these doctors no doubt loved every minute of being in the bush, whilst others did not, and many have regrettably left South African shores forever, purely to avoid this.

The crux of the matter is that a year of community service has been high-handedly thrust upon a group of highly educated and hard working professionals, and the terms are often less than ideal. Community service doctors often work up to 32 hours at a stretch, with little or no sleep, under the most stressful and trying of circumstances. One can only question the morality, if not the legality, of allowing young employees to work under such conditions, putting them, their patients and their professional reputations at risk. A feeling has arisen that if such a year can be enforced now, then why not again later? Will our community service obligation ever end?

Surprisingly, most community service doctors are positive about their year of service to their country. Perhaps it is the personality type – a group of people who really want to make this a better world. Unlike our peers in many other professions, we work the hours and get our hands dirty without too many complaints and for this reason, for the most part, things have gone smoothly.

There is a dire need for well trained doctors in South Africa, particularly in the periphery, and there is merit in the idea that state trained doctors owe the country a service. However, we are taking a backward step with the existing system of community service. We need to make it more attractive to work in the periphery and we need to improve the archaic conditions of service. The answer to improving health care in South Africa does not lie in exploiting your human resources to the point of losing them completely.



Editorial

Community service in a rural hospital

Dr David le Roux

Well, now that I am a good 11 months into it, with only a few weeks left of this year, I feel it is a fitting time to reflect on my year of community service. And what a year it has been!

The legacy of the former rural mission hospitals is generally that of fine old hospitals, now neglected and decayed and just barely ticking over. Imagine the above, on a long straight road, with an orange plantation on one side, and a small stubby hill on the other; and at the base of the hill, a large taxi rank, several informal traders - and the hospital. It constantly amazes me at the towering foresight of the apartheid-era strategists, who aspired to build such a large hospital so far away from any people. Not a town, not a village, not even a respectably post-modern informal settlement. Just a small hill and a whole lot of oranges. The net result is high travelling costs for the nurses, very few visits for the psychiatric patients, and an overwhelming sense of isolation for those indentured to the system for the sake of their registration. Even more amazing than the fact that there is a big hospital for apparently no people, is the actual vast hordes of humanity who pitch up; and the astounding distances that they travel; and the fortitude with which they endure the debilitating humidity; and their implacability when faced with unending hours on the benches. And possibly most amazing, and simultaneously humbling and infuriating, is the sincerity and appreciation with which they receive the inevitable Amoxil-and-Panado combination.

Yip, this has been a significant eye-opener of a year for me. I have been able to observe first hand the mechanics of the inefficiency, corruption and mal-administration, of which I had heard so much. After studying in Cape Town, I was all "Ivory-towered out", and after an internship in the Pit at Baragwanath, I was seriously doubting my capacity ever to be shocked, surprised or revolted again. I was also doubting my ability to feel compassion, remorse, or anything except indifference to my patients. Well, a year in the Most Northern Of Provinces, being stuck in a little place like this, has been the catalyst for some significant growth experiences.

Let me clear up one misconception straight away: I have not done much work this year. Three weekends

off a month, thousands of k's on the clock, innumerable sunsets, scores of elephants, more spools of film than I can afford to develop. Let me put in my contribution to the Northern Province tourism board: they are sitting on a goldmine up here. For a Capey lad like myself to spend a year exploring the highveld was the best thing I ever did.

And as for the medicine? In a word, carnage. We are practising a weird anachronistic and largely indifferent blend of 30-year-outdated and state-of-the-art. I did a presentation in June, based on some reading I had done on the Internet about HIV and mother-to-child-transmission. Afterwards, my boss, the MO who is running the medicine department, came and asked me about this new drug called "Nevapeen?" No, it's called Nevirapine. Let me write that down for you." There are big holes. I suspect that what I have learnt is dangerous.

So my reflections at this point? I haven't learnt a whole truck load of medicine; I have photographed vast tracts of the highveld; I have dominated every medical website known to man; and at the end of the day, I like people again. Less cynical, less rushed. More compassionate? Possibly. And a whole lot more sympathetic to the masses who travel for hours to sit on our benches.

I will practise rural medicine. But I will practise good medicine. And that certainly won't be here.

The first group of doctors to do community service began in July, 1998.

Community service for dentists got underway in July 2000.

Pharmacists are expected to commence community service in January 2001.

Physiotherapists are expected to start community service in 2002, and radiographers in 2003.



Month in Review

This month government came under fire for failing to allocate enough funding for HIV/AIDS. After widespread concern that the amount allocated over the next three years fell far short of what was required, a parliamentary initiative got under way to call government to account for its failure to formulate an integrated plan to deal with HIV/AIDS.

Committee chairwoman Barbara Hogan, who is an ANC MP, said: "We are talking about a massive onslaught in the country but what we are seeing is only partial attempts by ministries to deal with it in their own ways. We need to look at an integrated approach and at the models handed down from Uganda and a whole range of countries where these issues have been far more successfully dealt with. We will have to make major adjustments to the budget to cater for HIV/AIDS. Parliament will be asking more questions on HIV/AIDS; we cannot ignore it." Finance Minister Trevor Manuel conceded that government did not know what effect the epidemic would have on budgets and said hard data, which were not available, were needed for policy decisions. National treasury director-general Maria Ramos told the committee adjustments would have to be made to budget forecasts as pressures arising from HIV/AIDS had risen. Regarding the future effect of the epidemic, she said, "at the moment we just don't know".

The need for urgent action against the epidemic was highlighted by the announcement that more than 80 000 registered voters had died of AIDS since the election in June last year. Epidemiologists working at the Medical Research Council (MRC) and University of Cape Town (UCT) compared data obtained from the voters' roll and the department of home affairs to reach their conclusions. Altogether, 379 395 names have been removed from the register because the voters are listed as deceased. Without HIV, an average of 300 000 deaths occur in South Africa each year. A breakdown of the deaths by age shows that in four provinces with the highest HIV infection rates, deaths of young people exceed those of the elderly. The highest death rate was recorded in KwaZulu-Natal - the province with the highest HIV infection rate, where one in three pregnant women tested in last year's government antenatal survey proved HIV positive. Here 85 596 voters were removed from the voters roll after being listed as deceased. In the 30-to-40-year age

group in the province, 17 042 voters died, compared to 12 368 deaths in the 70-to-80-year age group.

Meanwhile, the United Nations Programme on AIDS (UNAIDS) and the World Health Organisation backed the use of antiretroviral drugs to prevent mothers from transmitting HIV to their babies. They said that the benefits outweigh potential adverse effects. The announcement paved the way for the South African Medicines Control Council to finally register Nevirapine to prevent mother-to-child transmission. Since July, the council has been considering the licensing of Nevirapine, a drug that could cut HIV transmission from a mother to her baby by half, at a cost of about R30. Experts convened by UNAIDS and WHO reported that the use of Zidovudine (AZT), a combination of AZT and Lamivudine (3TC), and Nevirapine do "not have any adverse effects on the health of the mother (or the) growth and development of infants". The experts described the use of Nevirapine as the simplest regimen. All that was needed was a single dose for the mother when she went into labour, and a single dose for her newborn baby to cut the risk of HIV transmission by at least half. AZT was described as the most complex regimen. One of the concerns raised by the Health Department about Nevirapine was the development of drug resistance. However, according to UNAIDS and WHO, "evidence indicates that the virus containing drug-resistant mutations decreases once the antiretroviral drugs are discontinued".

In the face of all of this, the basic message of prevention was getting lost. Officials from the Bureau of Standards admitted that South Africa was 100 million condoms short. They were trying to keep up with the huge demand and had tried to speed up the testing process, but as AIDS awareness programmes kicked in with their tough line on the killer virus, more and more people were being turned away from clinics empty handed. Selicia Serenata, the health department's deputy director of HIV/AIDS, admitted the shortages were serious. "The demand for condoms next year will far outstrip the budget we have. We will try and get overseas donors as well as negotiate with the national treasury for more funds." A family planning clinic head, who said she was supposed to receive 100 000 condoms a month, said the supply had been "extremely erratic" for the past eight months.



Policy in Progress

An overview of the first two years of community service

Steve Reid, CHES

On 12 December 1997 the State President, Mr Nelson Mandela, signed into law the Health Professions Amendment Act, sealing the debates which had raged for some time over compulsory community service (CS) and post-graduate vocational training for medical graduates in South Africa. The first cohort of 26 doctors started their community service in July 1998, followed by a larger cohort of 1088 in January 1999, 1115 in January 2000, and 173 dentists in July 2000. In 2001, 406 pharmacists are due to start their community service year.

The recruitment and retention of professional health workers in under-served areas is a complex and global issue. In South Africa numerous studies in the past have drawn attention to the issue of the maldistribution of health professionals: in essence, the fewest professionals are found in areas where the need is greatest. Thus, one of the broad policies outlined in the 1997 White Paper for the Transformation of the Health Services aims to "distribute health personnel throughout the country in an equitable manner". However, in a detailed quantitative analysis of the distribution of health personnel in South Africa, comparing the situation in 1994/95 with 1998, Makan found that there had been "very little, if any, shift towards the establishment of an equitable distribution of human resources in the South African public health sector".

The issue of the maldistribution of health professionals has in fact been addressed through a number of strategies, such as:

- the clinic upgrading and building programme;
- a significant rise in public sector salaries for doctors in 1995;
- the deployment of 300 Cuban doctors in rural hospitals on a government-to-government contract;
- the introduction of a rural allowance as an incentive.

In addition, the development of Academic Health Service Centres, some of which are situated in rural areas, e.g. Pietersburg, has the aim of building the

capacity of district health services whilst educating future health workers.

The aim of the National Department of Health in initiating community service has been stated as follows:

"The main objective of Community Service is to ensure improved provision of health services to all the citizens of our country. In the process this also provides our young professionals with an opportunity to develop skills, acquire knowledge, behaviour patterns and critical thinking that will help them in their professional development."

Unclear policy guidelines in this first year of implementation, not unexpected in the light of the pressure to start, lead to the highly variable situations in which community service (CS) doctors found themselves in the first year. Nevertheless, in terms of the original objectives of the Department of Health, the scheme must be analysed in terms of the fact that less than a quarter of CS doctors were placed in rural hospitals (as designated by the rural allowance), while 55% were placed in regional, tertiary and specialized hospitals. Thus, the aim "to distribute health personnel throughout the country in an equitable manner" has only been partially addressed by this policy. A further quantitative analysis of the distribution of doctors in the public service, such as that done by Makan in 1998 would need to be repeated to demonstrate any real changes.

The hospitals in which community service doctors are placed vary widely in terms of working conditions and supervision. For newly qualified doctors, who are as yet still inexperienced, supervision is an important component of their early working lives.





A community service doctor examines a patient in Harrismith.

The level of supervision available to CS doctors has been found to be extremely variable in different situations: from the formal supervision characteristic of teaching hospitals, where first-year medical officers are given very little opportunity for independent decision-making, to isolated rural hospitals with no full-time medical staff apart from the CS doctors themselves, where they are expected to cope with any clinical presentation.

In general however, the response of CS doctors to the challenges and difficulties in public service hospitals around the country has been encouragingly positive, particularly in terms of professional development, as they have found meaning in "making a difference" in their situations. A minority has found their environment demoralizing, and feels resentful at the unfairness of the allocation process which placed them there.

It would appear that CS has no effect on the career plans of these doctors, but merely delays them by a year. 34% of a sample of the 1999 cohort planned to work overseas the following year. What proportion will return to South Africa is a matter of conjecture: many do not even know themselves. One of the implicit aims of the Department of Health in introducing CS was to slow down the exodus of young South African medical graduates to greener pastures overseas. However it may even be exacerbating rather than lessening the tendency of young doctors to leave the country as

they feel that they have "paid their dues" by completing their year, and feel no obligation to contribute their skills any longer than this. On the other hand, others may be influenced by their exposure to the needs in rural areas, and feel stimulated by the challenge of making a difference in areas of need. Time, and more detailed long-term studies, will tell what the longer-term effects are.

The closest comparable scheme in Africa is to be found in the Nigerian system, the National Youth Service Corps (NYSC), which allocates all graduates from tertiary institutions, including medical schools, to compulsory service for one year. This is now accepted without question, even with pride, and a NYSC certificate is a pre-requisite for employment or post-graduate studies. These "Youth Corpers" are given no choice as to where they are allocated and over 90% end up in needy rural areas. In terms of its contribution to health care it is commonly regarded as the only way to provide rural areas with professional expertise. The natural history, as it were, of this kind of intervention, can be seen in the Nigerian experience: after a number of years it is accepted as a part of every professional's career, and most of them make the best of it.

Certainly, other strategies are needed to address the long-term recruitment and retention of health professionals in under-served areas. In Pakistan, preference is given to those who have completed 3 years' service in the under-served areas, for training posts for specialisation. The linking of community service in under-served areas to opportunities for post-graduate specialisation is an incentive strategy that bears serious consideration by South African planners.

There are a number of other strategies that have been shown to be more successful than coercion in recruiting and retaining doctors in areas of need. These include the selection of students from rural areas, the early exposure to role-models, meaningful community-based experiences during the undergraduate years, support for post-graduate development through distance educational methods, and attractive conditions of service, including extra remuneration, and family and educational perks. The issue cannot be addressed by human resource planning alone: there must be a close relationship to human resource development, such that graduates are produced with the necessary knowledge, skills and attitudes to serve not only their own interests, but those of the country as a whole including the underserved and rural areas. The long-term solutions to the recruitment and retention of health professionals in these areas of need, lie in addressing these issues comprehensively.



What the Department of Health says...

Kathryn Strachan

At the end of the second year of community service, the Health Department is positive about the plan and its effects. The main objective, says Hugh Sibuyi of the Human Resources department, was to improve access to quality health care for all South Africans, particularly those in under-served areas. "This process provides our young professionals with an opportunity to develop skills, acquire knowledge, new behaviour patterns and critical thinking that will help them in their professional development," he says.

The table below shows the number of CS professionals deployed per province since 1998.

PROVINCIAL DISTRIBUTION of CS DOCTORS FROM 1998 - 2001

PROVINCE	1998	1999	2000	2001 ²
Eastern Cape	1	125	110	143
Free State	4	93	74	86
Gauteng	7	169	132	144
KwaZulu-Natal	4	233	261	276
Mpumalanga	0	79	105	116
Northern Cape	0	17	33	34
Northern Prov	1	155	140	155
North West	1	77	86	99
SAMHS ¹	0	38	39	40
Western Cape	8	119	135	148
South Africa	26	1105	1115	1241

¹ SAMHS = South African Military Health Services

² 2001 = Expected number, based on current number of applicants

About 25% of the doctors applying each year are placed in health facilities in rural areas. These doctors have been allocated to about 275 health facilities across the country.

Sibuyi says that the general reaction of the CS doctors to community service ranges from very negative to positive. Most of the resistance has come from white doctors, particularly women, he says. He believes

community service is a good idea for other health professionals, but it will have to be based on the needs of those particular services.

The Health Department introduced community service for dentists in July 2000, and about 173 dentists have taken up their posts. Plans are fully underway to bring on board the pharmacist profession by January 2001. Next will be the physiotherapists who will be brought on board in 2002 and radiographers in 2003.

There are no plans being made for specialists, but community service for registrars is being considered for the future.

It is difficult to say whether community service is being seen as a long term or a short term solution since it is responsive to the needs of the health service, says Sibuyi. "As long as there is a need for a particular health profession in the public sector, community service will still be part of the health human resource plan for the country. Like all policies, the community service policy is subject to monitoring, evaluation and review - or discontinuation," he says.

The department is at the same time looking at other strategies to draw health professionals to rural and under-served areas. The rural allowance being paid to doctors in rural areas is one of the incentives to attract more doctors to these areas, and the Cuban doctors' programme is another strategy. But it is still necessary to have more strategies, beyond community service, to attract doctors to the underserved rural areas, says Sibuyi. The ideal situation would be to have South African doctors working for longer periods in public service and not just in community service, he says. Community service would therefore be a tool to get them interested and to encourage them to stay on in public service. "The introduction of community service has not ensured that there are now enough health workers in the underserved and rural areas," he says. "It is, however, a strategy to improve on the number of health workers in these areas, so as to improve access to quality healthcare."

Although the expressed aim of community service was to increase the number of doctors working in rural areas, only 25% of community service doctors have been placed in these under-served areas so far.



Community service in a rural area – the doctor's perspective

Kathryn Strachan

His supervisor calls him "Doktertjie" ("Little doctor") but Vusi Machobane, one of the community service doctors in Harrismith in the Free State, believes there is nothing small about the role he plays in the service.

"I think that my colleagues doing community service at sophisticated tertiary hospitals are missing out on the real experience - on the experience of being the ultimate doctor in the chain," he says. "You need to be on your own to learn to make difficult decisions and to grow. You will never learn if you always have a professor trailing you. Here you feel you are at the place where people really need you. I felt I had had enough tertiary training and what I needed now was primary health care experience. This year has given me a lot of experience, I feel more confident now and I don't panic when faced with a difficult situation. When you are making difficult decisions, you need to rely on your own experience. No one can teach you how to make decisions. It's been an exciting and challenging year, but also quite difficult - things weren't as I expected them to be."



Dr Vusi Machobane examines a patient.

However, there are two sides to this coin. Although on the one hand, Machobane has grown as a result of having to "stand on his own two feet", he feels he still needs supervision with some of the cases he comes across. There is very little of that in Harrismith though. He believes more planning should have gone into community service before it was implemented, particularly with regard to supervision. "Sometimes I am faced with a difficult situation where I have to make decisions on my own and there is no one to ask for advice," he says. There is a referral hospital in Qwa Qwa but the staff there are not co-operative and will not accept cases from Harrismith. He also comes across problems such as a lack of medicines and being told that he cannot take laboratory tests - things he did not think about when he was in medical school. "There was a time in the middle of the year when I found it really hard, when I really regretted coming here and felt resentful because of all the frustrations I came across in my work. But I don't feel like that anymore. Now I am grateful for it and realise that it is an experience that no one else could give me," he says.

Machobane says his work load is the equivalent of that of three doctors, and he believes he could not do it without the strong support of his colleagues at the hospital and at the clinics. The hospital is desperately short of staff and he is called out at night an average of three times a week. He deals with a lot of forensic cases and often has to appear in court to testify.

He doesn't feel isolated living in a small town, and actually appreciates the quietness. The living quarters are "not great", however. Because he chose to come to Harrismith - and all his classmates were sent to a place which was either first or second on their list of preferences - he feels that the system of placement of community service doctors is fair.

His particular interest is in anaesthetics and he hopes to go to Wits next year to specialise, but because of the lack of expertise for supervision he is not involved in a lot of operations at present. "There is no one to show us here and no one to help us out. We don't have ICU monitoring and we don't even have a laboratory. It is really limited in terms of services which is a major problem considering all the accidents on the highway," he says.

"If we did upgrade the hospital and get more staff we really would save lives, but we still have to refer road accident cases to Qwa Qwa which is 40 km away."

All in all, community service for doctors meets with mixed reactions, from individual doctors alone and from the group of CS doctors as a whole. One aspect of community service which may appeal to one doctor at one time, may be very stressful to the same doctor at another. We have yet to reach a stage in South Africa



where community service is a fairly uniform experience for all doctors across the board. And only then will the system be really fair, to the CS doctors themselves, the staff they work with and the communities they serve.

Community service in a rural area – what other staff think...

Kathryn Strachan

The staff and supervisors working with the community service doctors are divided over whether the scheme is a good idea. Most of the divisions in Harrismith are over whether the previous system of contracting local private doctors to work in state hospitals and clinics on a sessional basis was better than the new system - and whether letting sessional doctors go to make way for community service doctors has done more harm than good.

The sister in charge of the Harrismith municipal clinic, Sister Ina Barnard, says the sessional doctors were often more accepted because they were part of the community. "They kept the service going before, now suddenly they are not good enough. That's why there are such bad relationships between the public and private sector doctors. The sessional doctors were more experienced than the community service doctors. The community service doctors are not going to stay because they are looking for opportunities to uplift themselves, and so we find ourselves having to start all over again each year," she says.

Adding his voice to the protest is a doctor who wishes to remain anonymous. "The sessional doctors were chased away for political reasons and they were the ones with the experience and expertise," he says. "There are now far fewer operations done at the hospital because the sessional doctors were the ones with the expertise in surgery, obstetrics and anaesthetics. We now have to refer our patients to Qwa Qwa and that is nothing short of a disaster. They don't want our patients because they feel that we should be doing certain operations such as caesars ourselves, but we don't have the doctors to do them."

"Community doctors are essential for us to function, but they are not at all experienced. There is no further training for them in a place like Harrismith and they really do need training. They come here fully qualified, but they do not have enough training to come to a small

hospital and do things themselves. They also do not want to accept advice or ask others' opinions, and they are not confident enough to make decisions." There is one improvement however, which is that the new arrangement makes allowance for two permanent doctors at the hospital and they are there all the time - unlike with sessional doctors.

Harrismith Hospital manager Papi Maarohanye has a directly opposed view: "Sessional doctors had their own private practice and we would contract them, but there were problems because the sessional doctors always gave preferential treatment to their own private patients. It is also better to have the community service doctors because they are always here. The sessional doctors were here for the money and they did not have the interest of the service at heart. They would come and spend 20 minutes although they were contracted for an hour. They still come - we can't do without them - but there is no comparison between the system we have now and what we had before."

"The community service system has been a very positive experience for us, it has been a breakthrough. The service is running very smoothly now. We are even using them for work they are not supposed to do. Community service doctors are supposed to work under supervision, but most of the time there is no senior doctor to supervise them. If there is a problem with community service doctors it is in the area of diagnosis. Because of their lack of experience, they tend to rely on tests rather than on observation and it gets expensive."

But Sister Barnard is unconvinced. "Just when they are getting to know the nurses, the medicines, the way the system works here - they leave," she says. "When they get here, they are not orientated and it takes up a lot of our time having to do that. Most of them come out of big university hospitals and they don't know how things work at the primary health care level and at local hospitals. They have just finished their training, they have no experience and now they have to handle all these problems. Sometimes they're all alone with only the slightest supervision. They are really very raw when they come here, and sometimes the nurses with all their years of experience are more clued up - but they sometimes get offended when the nurses try to help them." The community service doctors come to her clinic each day.

Sister Barnard believes it would help if they went on all the courses that the nurses went on, for example courses on how to handle TB, because, she says, they are not always up to date on the latest approaches. For example, the community service





Sr Anna Moilola of the Harrismith clinic.

doctors rely on X-rays rather than sputum tests to diagnose TB.

“The community service doctors see being here as a temporary thing, and they never come to be part of the place. Just when you feel they are starting to belong, like when you see them getting involved in projects, they leave. They don't want to come to the platteland - they can't specialise, there are no study opportunities. I don't think that their minds do get opened along the way - I can say that because none of them have chosen to stay.”

However, Sister Anna Moilola of the Harrismith clinic feels differently. “They're perfect,” she says. “They know their work from the beginning, and they really do know about primary health care. It takes less than two weeks to orientate them, and then they know what is supposed to be done. When they leave we lose a lot because they are such a help. We go through a kind of separation anxiety because they become like family. We don't feel they are just passing through because they are very committed.”

So again, opinions are divided. The only thing that seems certain is that community service is likely to continue for the foreseeable future.

HST News

A commitment to black empowerment

Solani Khosa

The subject of black empowerment is still open for consideration in many organisations and institutions within the new South Africa. Many institutions have embraced this process, tackling it from various angles including the introduction of affirmative action policies. However, others have questioned the process to the extent that they have resorted to calling it reverse racism. This unfortunate reaction has also been aided by the lack of a proper vision and commitment among some of those who have adopted the various black empowerment policies in their organisations.

Those committed to this cause have in many instances been guilty of what can be best described as tunnel vision. Tunnel visionaries live life in pursuit of one worthwhile goal at the near exclusion of others. Thus those in the business sector have spent their energy seeking to acquire large stakes of previously white companies in the name of black empowerment, without really understanding the full implication of such ventures. Only a few previously disadvantaged people end up with any real meaningful gain in most cases. Others have implemented affirmative action policies without empowering the candidates with the necessary support and knowledge to move beyond the occupation of a particular position. They ignore the fact that black empowerment is multifaceted, and to concentrate on one-aspect defeats the very purpose it is meant to serve.

Possible indicators of the success of the community service strategy *(from key DoH informants)*

- **An increase in the number of doctors working in peripheral areas (including under-served urban areas)**
- **A more efficient health system**
- **Acceptance of CS doctors by other staff and by the community**
- **The extension of community service to other professionals**
- **Personal and professional development for community service doctors**
- **Fewer doctors emigrating from South Africa**
- **Improved health status for all South Africans**

(Source: Steve Reid. Monitoring the Implementation of compulsory community service of doctors in South Africa, 1999)



It is from this multifaceted approach that Health Systems Trust as an organisation seeks to recommit itself to black empowerment. Whilst there has been an unprecedented improvement within the organisation (in terms of staff representivity), the HST acknowledges that empowerment should not only be about the hiring of black employees and capacity building through its programmes, but also to help create and shape economic processes, systems and institutions which support and nourish the vision of an African Renaissance, through black empowerment. The organisation has thus committed itself to seeking black suppliers that can provide services utilised by the organisation.

The Health Systems Trust has embarked on a process of identifying those suppliers that have blacks as shareholders and is confident that in the near future a good proportions of its suppliers will be from these companies. Bravo HST!



New Publications

How to conduct a rapid nutrition situation assessment

Mickey Chopra and David McCoy

In South Africa more than 2 million children suffer from malnutrition. It is an underlying cause in more than one in three of all childhood deaths in sub-Saharan Africa. A new national Integrated Nutrition Programme (INP) has been developed to address the problem of malnutrition in South Africa. An important first step in implementing this programme is to perform a nutrition situation assessment in the area concerned.

A nutrition situation assessment serves to:

- Be the first step in the triple A cycle (Assessment, Analysis and Action) of the INP
- Be an advocacy tool, by persuading policy makers and funders of the problem of malnutrition and the validity of implementation plans
- Assist in the future monitoring and evaluation of the INP
- Assist in the development of a district health system (a nutrition situation assessment would fit into the broader district health situation assessment)
- Pull together the different members of the district health team to work towards a common plan of INP implementation
- Bring together a multi-sectoral team and increase their appreciation of the need for all sectors to fight malnutrition (especially the Departments of Education, Welfare, Agriculture and Water Affairs).

This publication is available free of charge from the Health Systems Trust. An accompaniment to this volume, a Training Guide (Integrating Nutrition into Health and Development Programmes) is available from HST at a cost of R60.