# EDITORIAL

Change the way in which health care is financed. Build more facilities. But unless the people in the health sector are used optimally, motivated and supported, little will actually change. This is the philosophy underpinning the interest of the Health Systems Trust in human resource development.

One of the challenges facing the South African health sector is that of inequitable distribution of health personnel between urban and rural areas, and across geographic regions. The maldistribution is further aggravated by the high number of specialist surgeons in private, as opposed to public service.

Concern has been raised about the nature of training of all health professionals, which primarily promotes a medical hierachy, curative, hospital based urban bias. This has lead to a lack of support for community based preventive and promotive care. Consensus among health professionals interviewed is that the development of human resources has to be geared towards making primary health care a priority.

In the post apartheid era, the new government of national unity is faced with the challenge of redressing such imbalances and shortfalls of the past government structure. As a first step towards the process of transforming the health system, a review of the human resources development of the health sector has been one of the priorities of the Department of Health. A second step is a strategy to cultivate an ethos of caring and concern amongst health workers for each other, and for service users.

The theme for this month's issue of HST update is 'Developing Human Resources for Health'. Discussions explore perceptions of some role players in the various cadres of health professions, highlighting processes of transformation within their respective organisations, and their greatest needs and strategies for addressing such needs. ■

# POLICY IN PROGRESS

## The Month in Review

Health Minister Nkosazana Zuma and her team have gone on the road this month, travelling to centres in all provinces informing people in the health sector about the proposed national health insurance scheme and hearing their views.

The Minister has set up a committee to prepare a detailed and costed plan for a national health insurance system - or a publically supported alternative. The committee's brief is open-ended, but will be guided by a policy framework.

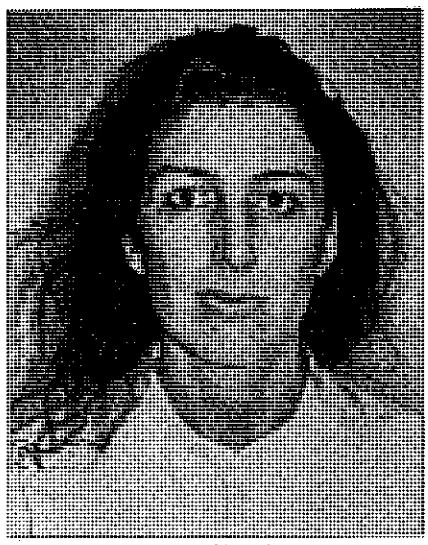
The parameters of the investigation are non-discriminatory access to primary care; affordability and sustainability of the system; efficiency and cost control; and consistency with the Reconstruction and Development Programme's objectives.

During the public hearings, concern has been expressed from various quarters about the limited time frame. Minister Zuma has asked for a preliminary report by the end of April, and many believe this period is too short to allow organisations to prepare in-depth submissions to the committee.

She has requested that submissions be focused on the following questions:

- What minimum primary health care services should be available?
- Who should provide these services?
- How should the providers of health care be paid?
- How can the services be made accessible to all?
- How should such a system be funded?

On the AIDS front, the first fully



Kathryn Strachon

representative meeting of the National AIDS Convention of South Africa (Nacosa) was held in February - marking an important step forward.

Representatives from all regions, from unions, churches, government, NGO and scientific organisations convened at the meeting in Johannesburg to work out strategies to combat the epidemic.

The meeting decided to set up nine task groups which will focus on areas such as condom provision, youth education, sexually transmitted disease treatment, care and support, and surveillance.

The Medical Research Council has also been asked to set up a technical medical and scientific committee to advise Nacosa and the government. Judge Edwin Cameron and Dr. Charles Mini, heads of the AIDS Control and Prevention Project were elected co-chairpersons of Nacosa. ■

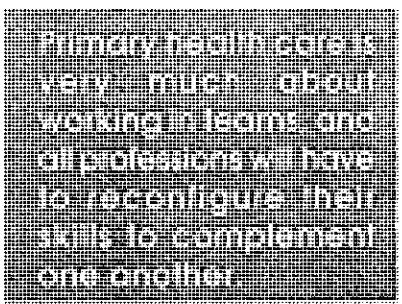
## Theme: Developing human resources for health

# Human resources development in South Africa

*Prof William Pick is head of the Department of Community Health at the Wits University*

The first step in developing human resources to meet the country's health needs is to have a far greater understanding of primary health care. Developing primary health care capacity within all health categories depends to a large extent on creating the skills needed to interface with the community. This means that health professionals will have to include subjects such as social science and anthropology in their training to ensure that their services are relevant to the community.

Primary health care is very much about working in teams, and all professions will have to reconfigure their skills to complement one another. Human resources at all levels have to be geared towards making primary health care a priority. This does not only mean changes at the primary levels, but also at the secondary and tertiary levels.




For example, the most high-tech medical practitioner has to take into account all the events along the chain of the health system when treating a child. Because the health system is a continuum, the link has to be made between diseases such as measles and factors such as immunisation.

This simple fact has major implications for the training of human resources and ensuring that professionals have an understanding of the processes that lead up to the disease. It also means that the role of specialists, for example, becomes extended. By being part of a team specialists would not only see the end result of a health problem, but they would be in a position to make a contribution along the way and to link their experiences to promoting activities such as immunisation.

In looking at the most effective way to deploy health personnel, skilled health system managers with an understanding of health economics are needed. This means that developing human resources for health is an issue which extends beyond training health professionals.

Underlying all these developments is the premise of having good information systems in place which provide managers with the data necessary to make the most effective decisions. The other areas needing more attention in developing human resources are health promotion, epidemiology and public health engineering.

All these changes require a re-orientation at universities. While attempts have been made, they have fallen far short of the need. Incentives in the form of subsidies could also be offered by government to universities and nursing colleges to encourage them to adopt the primary health approach. ■

# The Nursing profession in the transformation of health services

*Prof Phylda Nzimande is at the University of Zululand Nursing Sciences Department and is currently based at the Umlazi campus. She has supervised research mostly on current issues affecting the nursing profession and has also chaired the outgoing Transitional Nurses Council (TNC).*

Nurses form the backbone of the human resource component of the health system, and it is unlikely that the many reforms envisaged for the health sector will effect real change in service delivery unless they are accompanied by a transformation in nursing.

Three problems stand out as requiring the most urgent redress if nurses are to act as catalysts for health service change. The first is that staff are often poorly equipped to manage health facilities and personnel under their supervision. Secondly, nurses are trained predominantly in large hospitals, reflecting the hospital-bias of the public health service. Thirdly, the provision of curative and preventive care by different health authorities, particularly in urban areas, has lead to a selective and slanted acquisition of clinical skills by nursing personnel.

Legislated apartheid divided the nursing profession along racial lines, undermining its ability to form a single force to address these problems. The political turmoil of the time began to seep into health services and this, combined with the burden of the casualties of violence and the deteriorating conditions of service and patient care, left nurses completely demoralised.

But plans are now being made to combat these problems through

Prof. Phylda Nzimonde

unifying nurses under a single organisation which is more representative of their profession and which can be accepted internationally. Over the past two years a number of conventions have been held with the aim of setting up a new nursing association and transforming the SA Nursing Council into an accepted regulatory body.

The Health ministry is currently working on a bill of the Nursing Act, and once this is done an interim nursing council will be formed. Earlier this year the first constitutional nurses convention was held. Representatives of 15 nurses organisations were present, and the Democratic Nurses Organisation of South Africa (Denosa) was formed. The organisation will address both professional and labour needs. Unlike Nehawu, which represents all health, education and allied workers, the new organisation will be controlled by nurses. Its constitution will also balance the rights of nurses with those of patients.

The overall objective of the changes is to have a united, professional nursing cadre delivering care of the highest standard. To achieve this a new primary health care orientation in nursing has to be promoted. Appropriate training in health service management needs to be conducted to enable nurses to manage the personnel, finances and services under their supervision.

There should be opportunities for advanced training in both community and hospital settings, and upgraded clinical skills for nurses. One of the most vital changes is needed to come in creating a new ethos of care. While patient care is often spoken about, the balance between nurses rights and patient care ios unclear, and the idea that care is measured by its outcome or consequences is not widely embraced. ■

## Deployment and training of health professionals

*Dr Nicholas Crisp is co-ordinator of the Northern Transvaal strategic management team and has compiled a policy document for the Medical Association of SA (MASA) on human resources for health.*

The primary findings of the document are that South Africa has no human resource policy for health care and there is no clarity as to whose responsibility it is to formulate and manage such as policy.

There has been a tendency to allow human resources to evolve without a plan and then to deal with problems which arise in an ad hoc fashion. Most issues which have been dealt with relate to conditions of employment and salaries rather than any form of proactive planning or management of people as a resource in the health service.

There is also a lack of co-ordination between planners, producers of professionals and those who manage services. Most projects which look at the number of doctors required regard doctors in isolation and fail to see that the number of doctors needed is dependent on the number of personnel in the other health sectors. What is important is not the number of doctors, but striking the right balance between doctors and the other members of the health team, and ensuring that doctors receive the appropriate training for the community they serve.

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Not all communities have the same requirements for categories of personnel. The numbers will also

depend on several other factors which are constantly changing, such as health status, demographic constitution, and socio-economic status.

The MASA document has come up with a computerised model which takes all these factors into account and comes up with a single figure which can be used to determine the health personnel requirements of a community. The choice of criteria or factors will differ from one human resource category to the next.

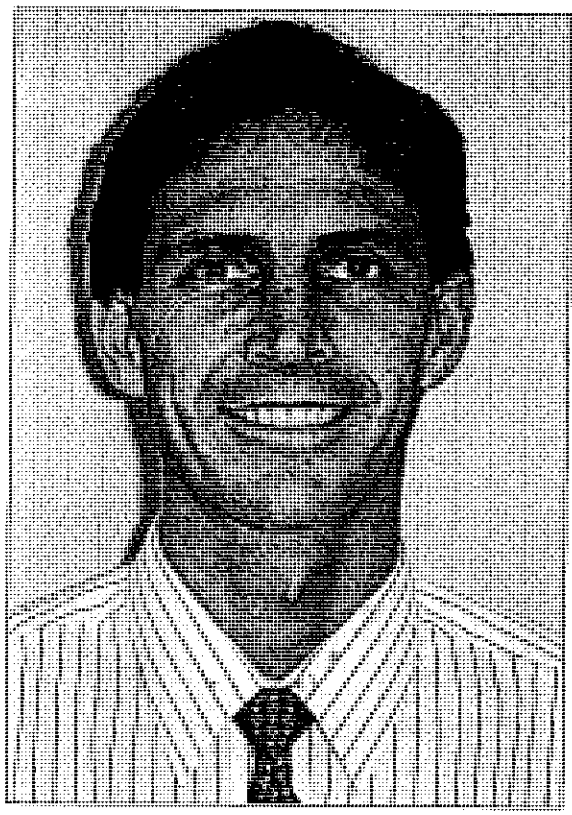
Having derived the objective "ideal" requirement, the next step is to find ways of changing distribution patterns to meet these calculations. In focussing on ways to develop the resource of doctors, the most pressing task is to achieve a shift from the private sector to the public sector.

It has become apparent that the hospitability of the living and work environment, and not pay, is the decisive influence on distribution. Remoteness is not the only factor and it seems that factors relating to professional working conditions, continuing education and professional stimulus, physical communication, and personal and social conditions are major determinants in the distribution of doctors.

Offering benefits which make up for the local "inhospitability" influences will

attract more doctors to these areas and discourage a high turnover of staff. As well as attracting doctors into public service, ways also have to be found to harness the resource of the independent medical practitioners. They should be able to retain their independence, but be incorporated into state hospitals through working sessions or teaching staff.

The medical profession will have to rethink the services it provides



Dr. Nicholas Crisp

in order to improve the overall health status. This will involve less emphasis on curative, hospital-orientated medicine and finding a new role in the primary health care team. It will also mean sharing in the delivery of essential services and participating in preventive and promotive intervention programmes.

To do this there has to be greater co-operation between planners, managers and universities to ensure that "export doctors" are not being trained. It is critical that training takes on an interdisciplinary approach so that doctors are well-equipped to work as part of a team with other health personnel.

The areas of epidemiology, management and preventive/promotive health care should receive special attention in training, along with the extremely underdeveloped area of occupational health.

The MASA document also recommends that professional associations should be involved in "quality control". The integrity of the medical profession has been abused in the past, and it is necessary that standards and ethics be controlled through peer review and not regulated by the state.

A further policy ommission is in the area of foreign doctors. At present South Africa has minimal policy guidelines on this, and a far broader approach is needed. For example, the question needs to be asked of whether it is ethical to accept doctors from countries where they are desperately needed. If they are accepted, the question of compensating through an outreach programme such as Medicines Sans Frontiers should be considered. ■

## Training Priorities in Dental Health

*Mohamed Moolla is Professor of Community Health at the University of the Western Cape and involved in its Oral Health Centre.*

Dental Health is also looking towards the community for its future training direction. It is clear that the dental workforce needs to be trained in a way which fits the disease profile of the country and in a way which can be afforded.

"That is the way we really want to go," says Moolla. Because most of dental health requirements are relatively simple, it is not necessary to have a legion of highly skilled dentists. Instead the focus should fall on training dental therapists (who carry out the less complicated dental procedures such as extractions and fillings), and dental

hygienists (who play a preventative and promotive role.)

The idea of the dental therapist rose in response to the huge demand from rural areas for a professional who could conduct the routine procedures so desperately needed. While the thrust is towards strengthening primary health care for rural communities, the task of accessing these communities has come across many obstacles, and various strategies have been proposed.

Among these are that more students be recruited from rural schools, or that communities and NGOs be encouraged to elect and sponsor a student to attend the course. After graduating, this student would be required to serve in the community.

The University of the Western Cape has approached this challenge by stipulating that half of the dental student intake must come from rural areas. Rural students therefore do not compete with urban students for admission. Other dental departments are also following the policy of supporting students from rural backgrounds, but in a more indirect way.

Another solution is that universities set up satellite training centres or specialist clinics in rural areas and smaller towns. By rotating students and staff at these centres, communities will be provided with the specialist services they need, and local health personnel will gain support.

The oral health unit is also proposing that all students be required to serve in the community for two years, but for this to happen government will have to create more job openings and will have to address the issue of building clinics at a much faster pace in rural areas.

Other proposals are that every graduate be required to work in a state facility in a rural or peri-urban area for at least a year. The alternative is for the Public Service Commission to provide incentives and better working conditions to encourage people to work in rural areas. ■

## Community health workers

*Kathy Lomax - Co-author of a report on the feasibility of greater state support to community-based programmes.*

While the ANC's draft health plan had an entire section describing the vital role of the community health workers in extending primary health services, concern has been raised by the fact that they were accorded only one sentence in the final health plan.

This has lead to confusion about the future role of community health workers people from the community who are trained to function within the community in close relationship with the health care system. To strengthen their case a feasibility document has been drawn up and presented to the parliamentary standing committee on health. The document argues that health authorities should work in partnership with communities to achieve health goals and the community health worker is the link in this partnership.

Existing community health worker programmes are limited because they are not linked up with the health services and because of the lack of recognition of their role. There is also a lot of misunderstanding of their function. Many health workers regard them as some kind of nurse aid, rather than seeing them in their true role of drawing the needs of the community to the attention of the health authorities and putting forward the community's health interests.

Ms Kathy Lomax

An essential ingredient in improving health is the involvement of communities in the planning and management of health care delivery. Community based health care programmes are seen as the vehicle for engaging communities in implementing their own preventive and promotive health care activities.

Central to these programmes are the community health workers. Their role is to function at the household level in advocating for and accessing health services.

For community health workers to play an effective role, it is vital that they be integrated into the health services and supported in their work by clinics. At the same time, they should stay outside the state structure and retain their position as a community project - employed by the community and accountable to it.

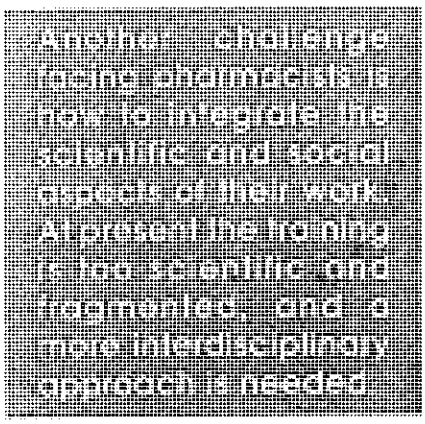
Being a community resource does not however preclude the possibility of them being paid by government through the channels of NGOs. The reluctance of the health department to develop their role has been ascribed to the concern that it could place a new burden on its payroll. Another argument is that community health workers plays a role in all sectors of development and should therefore receive the support of other departments as well.

A national core curriculum is being developed to specify minimum training content and safeguard flexibility in the education levels of trainees and the length of period of training. Career structures and pathways for promotion within the system should be opened so that their contribution can be recognised. The provision of capacity building through training by external agencies is crucial to the empowerment of the community and greater attention needs to be channelled in this direction. ■

# The Integration of pharmacist into the PHC team

*Aarti Kishuna is completing her masters degree in Pharmacy at the University of Durban Westville.*

A trend is emerging in the field of pharmacy with the move away from focussing on the science and medication to a new orientation centred on the patient. But the question remains that of finding a way to shift pharmaceutical services away from the private sector where 89% of pharmacists are employed at present to the public sector.



Nearly all the pharmacists employed by the public sector are based at hospitals and mechanisms have to be found to decentralise pharmaceutical services through the district health system. With hospitals distributed primarily in urban areas, the services offered by these pharmacists are not readily available to people at the community level, especially those living in informal, rural and peri-urban settlements.

On the other hand, while there is an abundance of pharmacists based in retail pharmacies, their services are not affordable to the majority of people. Pharmacists have to rethink their role, but there has been a lot of uncertainty and resistance.

The fact that pharmacists are now able to diagnose and to prescribe higher schedule medicines, and that they can screen patients and that they can advise on issues such as family planning, all places the pharmacist in a key position in providing primary health care services. A study is being conducted to investigate the supportive role of the public sector pharmacist in providing services at primary health care clinics in KwaZulu/Natal.

Another challenge facing pharmacists is how to integrate the scientific and social aspects of their work. At present the training is too scientific and fragmented, and a more interdisciplinary approach is needed.

Aarti Kishuna

Steps have been taken in this direction with most universities working in partnership with service providers and communities in designing their courses.

In extending pharmaceutical services, students need to be encouraged to serve their intern year in outlying areas and incentives need to be created to attract trained pharmacists to these areas.

Rural health clinic dispensary

Another way of extending primary health care services is through training pharmaceutical assistants to work with nurses. While there is in-service training of pharmaceutical assistants, they are not recognised by the Pharmacy Council and attempts are being made to introduce a two-year diploma at technikons.

The KwaZulu/Natal study found that as a result of nurses being overworked, they did not have time to give full explanations on taking the medication, and their poor understanding of science often meant they did not follow proper storage or reconstitution instructions. It is envisaged that pharmaceutical assistants would play an important role in this area. They could also be used in health prevention and promotion through serving in areas such as baby foods and family planning.

By allowing assistants to carry out most of the task of processing presciptions, pharmacists would be free to play a more clinical role, to focus on identifying health and medicine related problems and to draw up medicine formularies appropriate to the health problems and disease patterns in the community being served. ■

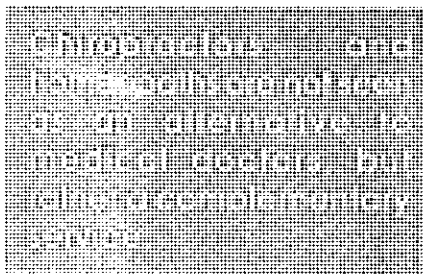
## Chiropractors, Homeopaths and Allied Health Services

*Dr Mario Milani is a chiropractor and chairperson of the Chiropractors, Homeopaths and Allied Health Services Council.*

Chiropractice and homeopathy have made significant inroads in getting formally recognised by the medical fraternity, but the resistance which still exists on the ground is proving to be a barrier to attempts to involve them in health care teams. The major breakthrough came last year with the Medical and Dental Council removing the restrictions on homeopath and chiropractor practices.

This meant that for the first time they were legally able to practice in a team with medical doctors, and could refer their patients to specialists, who in turn are allowed to use the diagnoses of chiropractors and homeopaths.

While the legal barriers have been removed, the long entrenched mistrust still exists among doctors and this has prevented the

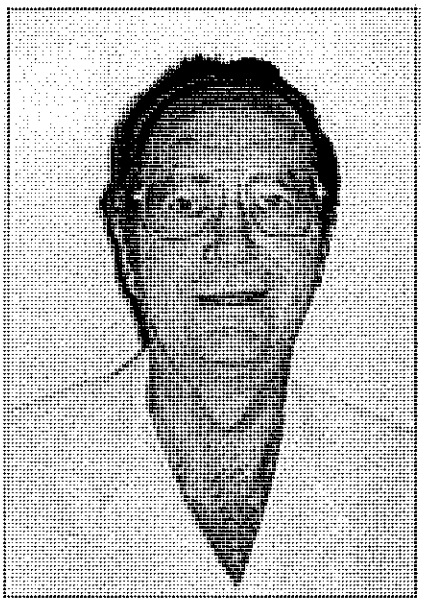


chiropractor from being included in health care teams. A lot of promotional work has to be done to change doctors' perceptions as it is within the team that chiropractors can play their most useful role. Their ability to engage in outreach programmes has also been limited by not being part of a team.

Chiropractors and homeopaths are not seen as an alternative to medical doctors, but rather a complementary service. They have a limited range of service, but within these parameters they believe they offer a far safer, more effective and less expensive treatment. Chiropractice is also an alternative in many cases to far more risky and costly back surgery.

While the six year diploma course in South Africa for both chiropractice and homeopathy is regarded as among the most stringent in the world, the task set for this year is to reformulate the diploma course so that it qualifies as a Masters degree.

While almost all chiropractors and homeopaths are in urban practices, services are extended by final year



Dr Morio Milani

intern students who work in community clinics. A wide range of patients are also treated in the intern clinics.

Chiropractors are also going into schools to screen for scoliosis (curvature of the spine) and to community clinics to diagnose mechanical problems in the skeletal and nervous systems. Once a pathological process is picked up, the chiropractor is bound to refer the case to the medical doctor.

In terms of their future role, it is envisaged that the chiropractor will work as part of a health team and be better utilised in hospitals. It is envisaged that they will also carry out skeletal manipulations under sedation in theatre, and administer medicines such as anti-inflamatories.

At the same time as enhancing its clinical role, the profession wants to retain its essential character that of focussing on the body's recuperative power to heal itself. ■

# Community Rehabilitation

*Prof Margaret Concha is head of the Occupationa/ Therapy Department at the University of the Witwatersrand.*

Community is the largest gap at present in delivering a rehabilitation and occupational health therapy service. But with the advent of new laws which allow hospital-based occupational therapists greater access to the community, the situation is gradually changing.

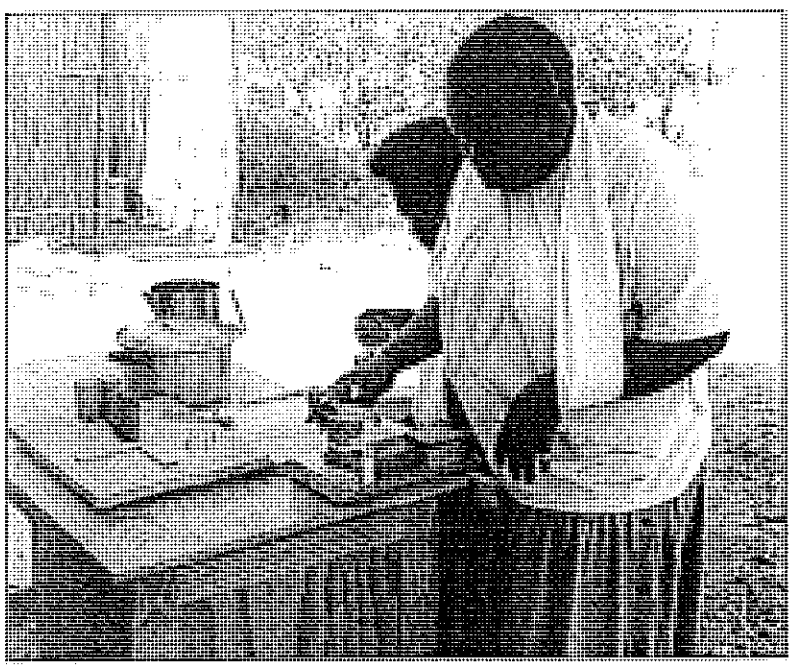
Spearheading this change is a project to train community rehabilitation workers, which is being run at Tintswalo Hospital at Acornhoek in the North Eastern Transvaal. The project is supervised by the Wits OT department.

While therapists have recently been able to enter the community and help in integrating patients back into their home and work environments, the problem of training personnel to fulfill these functions still remains.

The community rehabilitation worker plays a vital role in filling this gap and the project hopes to develop this concept. The two-year training project at Tintswalo Hospital began four years ago. A similar training project is being run at the Alexander Health Centre.

Under this plan, occupational therapists would be available as a support base to give advice and take referrals. As rehabilitation workers would be focussing on integrating patients into their homes, therapists would be free to apply their skills to treating patients in the acute stages of disease changing processes. This would provide a new direction for therapists as their skills would be more effectively used.

During the course the community rehabilitation worker is trained in physiotherapy, occupational and speech therapy, and community development. While more than 30 rehabilitation workers have been trained, the task is now to find posts.



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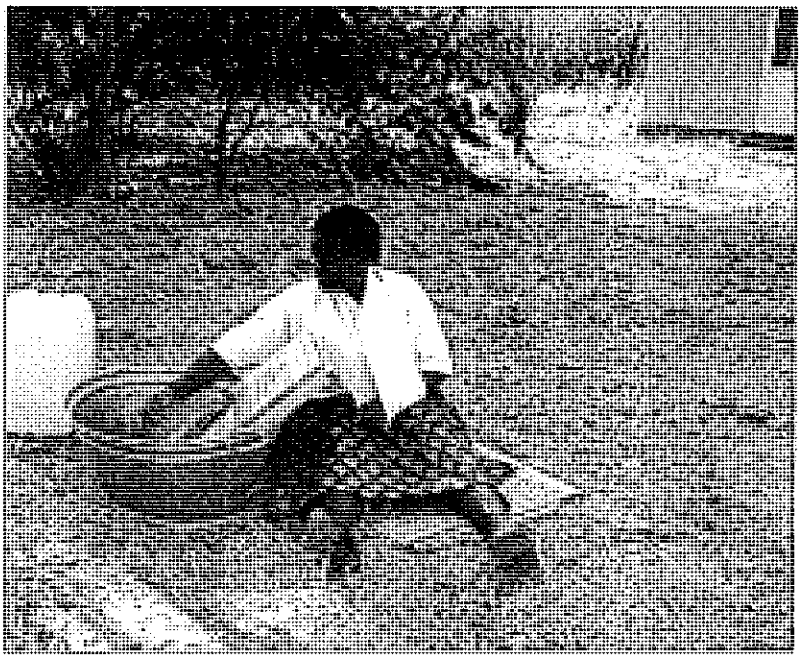

Community health worker demonstrating doing laundry

The question of whether training is best done through a university, technikon or hospital is still to be addressed. It is envisaged that the training and utilisation of the rehabilitation worker will also grow into a joint strategy with other health professions.

One of the main advantages of this project is that the people who are trained come from the community and have a clearer understanding of the problems. By seeing patients in the context of their own lives, their homes and their places of work, they are treated in a more appropriate way than they would be in the unreal world of the hospital.

At the same time as its shift towards the community, the profession is now focussing more on the workplace and striving to improve its specialist services. The field of occupational therapy remains hopelessly under-resourced, but the fact that provincial health teams have begun setting up commissions to look into rehabilitation is regarded as a crucial step forward. ■

# TRAINING FOR CHANGE

## Skills Development Kimberley health professionals

The skills development programme of the Health Systems Trust granted financial assistance to seven applicants from the Kimberley health services. Proceedings of a discussion with this group is presented in the article below.

While members of the health services in Kimberly learnt many new skills from the courses they attended at the University of the Western Cape summer school, their most valuable lesson came from the contact they made with health professionals from around the country and the shared experiences.

Situated in a remote corner of the Northern Cape, Kimberly health workers feel isolated and out of touch with health developments happening in the rest of the country.

'Northern Cape has its own uniqueness, its problems and its poverty ... and we feel forgotten', said Nontuthuzela Ngcakani. 'We felt we have been left behind a big mountain,' she said, adding that the main benefit of attending the course was linking up with other people and learning how they approached problems.

This isolation is exacerbated by the fact that peolpe who work in the health services are not kept informed of the changes and are not involved in the process.

The summer school was particularly valuable because the opportunities for further study in Kimberly are extremely limited. With no university and with a nursing college which only offers basic courses, people have to rely on correspondence courses if they want to further their knowledge.

One of the strongest themes which emerged in their discussion of the course was the importance of consulting with the community and finding out their needs before embarking on a project. Another was the importance of having a clear understanding of the situation they were dealing with and being able to collect the data they needed to make the best decisions.

'It was an eye opener for me,' said Nontuthuzela, a nurse at the Galeshewe day hosital. 'I used to see people who were helpless and did not see how I could help them. Now since the course on community rehabilitation I have many ideas,' she says.

A project which focussed on the high rate of schizophrenia in Gugulethu, Cape Town emphasised the crucial link of getting the community involved from the outset. She was impressed by the work of community rehabilitation workers in Cape Town and how they

had taught disabled people to make incredible things from the simplest materials.

Ansie van der Walt, a community dietician who attended the course on project planning, came away with not only new skills on planning and monitoring, but with a new confidence on approaching questions from a different angle and to introduce changes. With the nutritional status of children in the six to eight year age group in Kimberley being the lowest in the country, the course was invaluable in equipping her with the research skills needed to tackle research on the other age groups.

The skills she learnt have already been incorporated into her research on breastfeeding practices in Kimberley, and have enabled her to accomodate new directions in her research.

Seokemong Absalom, a nurse who visits squatter camps with the local mobile services, found her course on urbanisation focussed on research. The most interesting was a visit to Cape Town squatter camp where she was struck by the many initiatives which had been started by the community itself and the number of people who were prepared to work voluntarily. She was also motivated by a project on women's health, and noticed that many of the problems experienced by the women in the Western Cape were the same as problems in Kimberley.

Mercy Britz, a nurse who works in the child care section of Galeshewe day hospital, found her course on injury and violence and the community's response very enlightening. While the problems she saw daily at Kimberley often seemed overwhelming, the course showed the common factors that led to violence and injury around the world - and how problems in a specific place such as Kimberly could be broken down into manageable pieces.

A practical exercise on planning a project in Woodstock which she did together with a doctor and a professor gave her useful insight into the way other health professionals approach a problem.

Annetjie de Klerk, who is involved in the information and research component of the municipal nursing services, found her course on informatics very useful in trying to understand the different levels of information needs in the various health services. The course also emphasised how accurate information was essential to make proper planning decisions.

The new skills she learnt have been used in a project designed to elicit the health needs of the community, and in another project where nurses in the various services come together to assess the quality of their work.

Winifred Mosuabi and Rosinah Mathopa, health workers who work at Betty Gaetsewe clinic, gained a lot from their course on developing community-based nutrition programmes. They felt other regions were way ahead of the Northern Cape in their knowledge of nutrition, and they learnt a lot of new information about the different types of nutrition - especially about the importance of Vitamin A.

They have been able to share this information with mothers who come to the clinic. The course also taught totally new methods of evaluating whether a child was undernourished, and they hope to get a chance to put their new skills into practice at the clinic.

Another valuable lesson was how to start up community based health groups. 'We saw how important it was that the community should decide for themselves what they want,' said Rosinah.

They were most impressed by a visit to the Philani nutrition centre where mothers who came with their undernourished babies were also taught to weave and sell things they had made. 'We don't have projects like that in Kimberley and we can see how important they are', said Winifred. ■

Members of the health services in Kimberley
from L to R: Seokemong Absalom, Annetjie de Klerk, Ansie van der Walt, Rosinah Mathopa, Mercy Britz
Front L to R: Nontuthuzelo Ngcakani and Winifred Mosuabi

# HST NEWS

## Dr Chris Garbers steps down

Dr. Chris Garbers has resigned from the Board of the Health Systems Trust due to other pressing commitments.

Dr. Garbers is a retired President of the Council for Scientific and Industrial Research, Chancellor of the University of South Africa, and was the Chairperson of the Government's Scientific Advisory Council.

He brought a wide range of expertise to the HST Board, particularly with regard to the processes of research funding and systems development and restructuring. Dr. Garbers was an exceptionally conscientious Trustee greatly appreciated by the Health Systems Trust secretariat.

His expertise in the fields of education, science and technology has meant that increasing demands are being made on his time. Recently, he was appointed to serve on the National Commission for Higher Education chaired by HST Jairam Reddy.

The staff and Board of the Health Systems Trust thank Dr Garbers for his valuable contribution, and wish him well in his future endeavours.

# REPORTS AND PUBLICATIONS

***HEALTH SYSTEMS TRUST FUNDED/COMMISSIONED PUBLICATIONS***

*National Health Expenditure Review, Technical Paper No. 10.* An Analysis of resource allocation to community and hospital services in homeland and health wards. 1995. Prepared by Max Price, Jonathan Broomberg, Patrick Masobe, Logan Rangasamy and ERG Naidoo.

*An Evaluation of the Valley of Trust Community Health Worker Programme.* University of Natal, Centre for Health and Social Studies. Prepared by Thoko Sigwaza, Noddy Jinabhai, David Mametja, Nosicelo Mbhele, Daisy Ntanzi, Nhlanhla Ntuli, Hugh Philpott, Sagie Pillay, Sam Ross. December 1994.

# UPCOMING EVENTS

***CONFERENCES WORKSHOPS AND COURSES***

***Nutrition Task Force PRA Orientation Workshop***

Date: 2 March 1995

Venue: Africa Enterprise, 1 Nonsuch Rd. end of Town Bush Rd, Montrose, Pietermaritzburg

Time: 09:hO0

***Strategic Planning Workshop***

NACOSA KwaZulu/Natal

Date: 27-28 March 1995

Venue: MRC, Umbilo Road Durban

Time: 09hO0- 16hO0

Enquiries: Lee-Anne Augustine Tel: 031 -3056071