HST update

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EDITORIAL

"Has the process of developing human resources been geared towards making Primary Health Care a priority?" This is a question to which the previous edition of HST Update drew attention. We continue the debate by focusing on a cadre of health workers operating at the community level of health care.

The dominant issue is where community-based health care workers will finally be located in our new health system. Opinions vary between two extreme views. On the one hand, protagonists of Community-based Health Programmes (CBHPs) regard these health workers as the pillars of (if not synonymous with) PHC and as such should be accorded state employee status. These workers, they argue, have proven their capabilities by providing in some instances, the only health care services available in far-flung and neglected rural South Africa. On the other hand, a less audible view rejects these health workers whose services are dismissed as primitive, ineffective and sometimes outright dangerous. The latter group argues that in most instances, communities are often ready to by-pass these workers in pursuit of more mainstream medical care offered by doctors and nurses. Somewhere on the continuum between these extremes is a view that welcomes the involvement of community-based health workers in health service provision while cautioning against expanding an already over-loaded civil service at a potentially exorbitant cost to the country.

We consider these disparate views through the eyes of a health worker from a programme managed by a socio-medical NGO which has been in existence for the past fifteen years. Also, the perceptions of health workers of two small-scale and one state supported CBHPs are presented. Importantly, a description of typical activities of a Community Health Worker (CHW) and perceptions on the future of these CBHPs are provided through an interview with a CHW from one of the oldest state-supported CHW programme in this country.

The debate obviously does not end here. We will continue to monitor developments on the future of health workers working at this level and will keep you the reader informed. ■

Contents

Editorial 1
The Month in Review 2
Policy in Progress 3
Theme: the role of community-based health care in the national health service
CHW in the national health service 3
CHWs in the Valley of a Thousand Hills 3
State funded CHW Programme in operation 4
An interview with a CHW 5
CHWs in support of nutrition 6
CHWs against AIDS 7
Mental health care: Moving away from institutions 8
Rehabilitation for disabled children in Sulwe 9
Hoping for a favourable reply 10
AFSA/Tafelkop CHW training programme 11
Training for change 11
Team building at Hlabisa 11
Health Policy Co-ordinating Unit
Origin, objectives and activities 13
HST News 14
Local Reconstruction Fund in South Africa 14
Conferences 15
Study Courses 15
Upcoming Events 15
Reports and Publications 16

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THE MONTH IN REVIEW

Kathryn Strachan

The health budget has been the focus of heated debates between provinces over the past month, with those which have had their budgets slashed saying the cuts will lead to a breakdown of services.

The health budget of Gauteng was cut by 10% to make way for increases in under-resourced provinces such as Northern Transvaal and Eastern Cape. Gauteng health officials claimed that Northern Transvaal, which received an increase of 20%, lacked the infrastructure needed to spend the increased allocation in a planned, rational way.

1995/6 Allocation for Health Vote

	95/96 Allocation	94/95 Actual Expenditure	Difference	% Difference
Gauteng	3,169,807,175	3,522,360,442	(352,553,267)	-10.00%
Western Cape	1,854,452,029	2,097,414,974	(242,962,945)	-11.58%
Orange Free State	1,027,198,595	1,061,587,634	(34,391,039)	-3.24%
Kwazulu/Natal	2,801,160,930	2,732,826,200	68,334,730	2.50%
Northern Cape	231,881,981	193,138,753	38,743,228	20.06%
North West	873,377,101	837,592,950	35,784,151	4.27%
Eastern Cape	1,882,638,503	1,838,484,123	44,154,380	2.40%
Northern Transvaal	1,354,369,074	1,091,899,985	262,469,089	24.04%
Eastern Transvaal	570,485,612	498,412,604	72,073,008	14.46%
DOH	418,573,000	252,573,000	166,000,000	65.72%
TOTAL	14,183,942,000			

University of Cape Town's Health Economics Unit researcher Di McIntyre said historic inequities had to be addressed, but an appropriate time frame and adequate information were vital to ensure the least disruption to existing services.

"We have to do things slowly enough not to affect services in the provinces which have taken the cuts, and to give the provinces which are getting the increases time to plan and build their facilities on an incremental basis. But we also need to achieve an impressive display of reallocation," she said.

While it was difficult to achieve the right balance between these forces, she said the five year time span was likely to be too short. A long term vision, which took into account factors such as future migration patterns, was needed in shifting health resources between provinces.

The health department's formula did not take into account migration patterns which indicated that many more people would flock from the rural areas to provinces such as Gauteng, Western Cape and OFS - provinces which are having their health budgets slashed.

The formula aimed to achieve equity over a period of five years - which was an ambitious task considering that the UK took two decades to close its (relatively smaller) gap in health care provision.

The formula used population size and per capita income in each province as the basis for reallocation, but income levels are not the most reliable indicator of health needs. For example, KwaZulu /Natal had a higher per capita income than several other provinces, but its high rate of AIDS meant that it needed more resources than other provinces.

For those provinces faced with budgetary cuts, McIntyre said there were alternatives to closing down hospitals. These could include measures which allowed hospitals to generate extra revenue through, for example, admitting more private patients.

Wits University's Centre for Health Policy researcher Alex van den Heever said initial resource allocations should largely involve capital expenditure, and recurrent allocations should follow as the new services become operational. Mechanisms also need to be introduced to charge provinces for services provided to them by other provinces, i.e of cross-border flows.

(Continued on page 3)

Directory of Health Systems Research in South Africa 1995 Edition

"Be part of the network, let us know what you and your organisation are doing . . . "

We are in the process of updating the Directory of Health Systems Research in South Africa. We invite all researchers to furnish us with information of what they are doing in their respective fields. Kindly complete the enclosed questionnaire and return it to us.

POLICY IN PROGRESS

Theme: The role of community-based health care in the national health service

Community health workers in the National Health Service

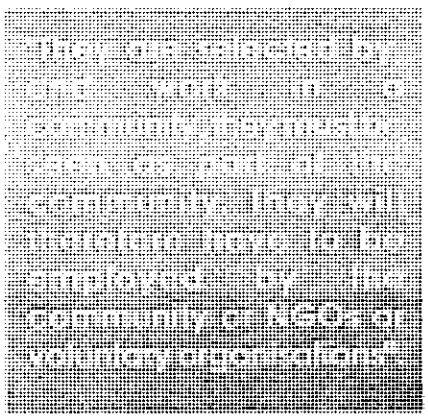
An interview with the Minister of Health, Dr Nkosazana Zuma

Health Minister Dr. Nkosazana Zuma said the basic building block for Primary Health Care was the nurse working at the clinic. Community Health Workers (CHWs) could supplement the nurse but under no circumstances could they replace her.

"No health service can be built on CHWs" she said.

Asked to clarify the position of CHWs she said they should not become public servants. "They are selected by, and work in a community, they must be seen as part of the community. They will therefore have to be employed by the community or NGOs or voluntary organisations".

CHWs have said their present role is limited because they are not linked up with the health services and



because of the lack of recognition for their role. Minister Zuma said that in order to promote the programmes, CHWs should become an integral part of the health sector with easy access to the clinic and health professionals.

She added that funding of CHWs would not be a function of the central department but of provincial departments and local authorities. However, this state funding would be channelled via an NGO. ■

(From page 2) THE MONTH IN REVIEW

Time scales for inter-provincial adjustments needed to be realistic to prevent destruction of services in provinces taking the cuts, and to avoid the risks associated with unplanned rapid increases in funds.

These principles had not been adhered to in the existing resource allocation, he said. The consequence would probably be that an additional R2bn would have to be deficit financed at central government level to avoid the political consequences that these allocations would have. ■

Community Health Workers Programme at the Valley of a Thousand Hills

Georgina Lambert, a research officer at the Valley Trust outside Durban.

In the inaccessible terrain of the Valley of a Thousand Hills there are few roads and people have to walk many miles before reaching a point where they can get transport to the clinic.

If the clinics are out of reach for the people, home visits are almost impossible for the health sevices. And it is in this role that the community health worker, who lives in the community, has opened the way for taking health promotion to the people.

As well as being the crucial link between the community and the health, social and environmental services, the CHWs have also initiated women's groups, creches, beadwork projects and gardens.

The Valley Trust is one of the pioneers of CHW programmes, and the idea has expanded from home visits to the latest step of setting up first aid stations run by CHWs throughout the valley.

With only two clinics for 100 000 people, it was necessary to spread health services. Five first aid stations have been set up, and another 17 stations are being planned. The stations will be visited by mobile clinics so that people do not have to embark on the long trek to the Valley Trust.

The first aid stations will be a focus of community activity by encouraging patients visiting the stations to get involved in various activities such as gardening, skills training and a variety of income generating projects.

While the CHWs are involved in promoting health within the

With only two clinics for 100 000 people, it was necessary to spread health services.

home, educating about nutrition and clean water - even conducting emergency deliveries - the community have indicated they would like them to move more towards development and assist in finding means to get food.

The Valley Trust is now in the process of evaluating the CHW programme, finding out whether it should go back to primary health care or develop into a more multifaceted programme.

The CHWs, together with the Valley Trust, also set up a waiting area for expectant mothers, who are transferred to a hospital 20km away when labour starts. However, CHWs said they felt demotivated by the disparaging attitudes of nurses in the health services.

The CHW programme has not been insulated from the upheavals in the Valley, and the violence, divisions and mistrust have all had an impact on the community's acceptance of the programme.

However, a recent evaluation found that the community believed the programme as a whole was useful. The battle to produce enough food was a battle the community felt it had lost, and the most commonly expressed feature in the evaluation was that people wanted the CHWs to assist in finding means to get food. ■

Outside a centre set-up by the Valley Trust and the community, for women who are soon to give birth.

Left to right: Gladys Gabela, CHW at Valley Trust, Georgina Lambert - Research Officer, Gertrude Ndlovu - CHW

State funded community health worker's programme in operation

An interview with Steve Reid the former superintendent at Bethesda Hospital in Maputaland, Northern KwaZulu/Natal

There is much concern about the future of the community health worker system, with some quarters saying it should no longer be funded by the state. The argument is that if the state funds the system it removes the CHWs from the community and they become too closely aligned with the health services.

Much of the success of the Bethesda programme was the close contact between the hospital and the 120 CHWs operating in the area, which enabled them to co-ordinate projects such as growth monitoring.

CHWs should ideally be part of the community and not part of the state, but the experience of Bethesda - which has the highest concentration of CHWs in KwaZulu showed that state-run CHW programmes could be as successful as any.

CHWs were elected by the community-based health committees. Funding for the programme came from the local health department and they were paid through the local tribal authority.

There is no real drawback at present to the programme being state-funded, but there is a danger that over time CHWs could become part of the institution and lose their community base. However, this scenario does

Dr Steve Reid

Former superintendent at Bethesda Hospital

not only apply to the state, it could also happen in the case of NGOs. If funding is taken over by an NGO the same situation could arise, with CHWs being regarded as an agent of the NGO, and their position would be dependent on the shifting relationship between the community and the particular NGO.

But a tension does exist around the issue of control and whether people believe the CHW programme is accountable to the hospital or to the community. The advantage in having the programme funded by the state is that there is no great gap between the CHW programme and the health services. Liaison between CHWs and clinic sisters is important and the close contact allows the delivery of health care to be streamlined.

Much of the success of the Bethesda programme was the close contact between the hospital and the 120 CHWs operating in the area, which enabled them to co-ordinate projects such as growth monitoring. What was striking about the CHWs was that they had not been repressed like the nurses were by their training. The CHWs training was highly interactive and participative, and this was reflected in the way they dealt with the community. The group would also do things very spontaneously and take it upon themselves to initiate activities such as bringing in disabled people to collect their grants.

It was also a very empowered group - empowered by their training and their situation in the community - and they were not afraid to tell a matron (who is often a pillar of authority) when changes were needed. They did a lot of things off their own initiative, which was proof that the system was working.

Another record of the CHW's success was an idea at Bethesda hospital. A doctor took a picture of each of the 120 CHWs in the area and made a montage on the wall of the children's ward. Because of the CHWs involvement in growth monitoring, all the children could identify their CHW - and this proved invaluable in tracing families of children who had been orphaned or abandoned". ■

An interview with a community health worker

"Our work is more than the work of nurses", says Gladys Gabela, a community health worker in the Valley of a Thousand Hills. "Nurses see people in the hospital, but we go into the community and see the problems and needs that people have."

"We think people are able to talk to us because we are from the community and we understand their problems far better than a nurse who comes from the outside. Maybe there is a grandmother and children. They have no money and many problems. Nurses don't go into the home and see the problems they experience. We help them a lot ... we see what the problem is and send them to the hospital if they need treatment."

When we see they are very hungry we take mealie-meal and beans from our homes and give it to them. We also do things like help pensioners fill out their forms or help families report when someone has died or there is a birth at home", says her colleague Getrude Ndlovu.

"We talk to them and tell them where to go for help if they have a disease such as TB. If we see a child is malnourished we teach the mother about nutrition and how to feed the child," she says.

"We also have our own scales to weigh the children and we send them to the clinic for immunisation. People are very happy when we come - especially because they don't have to pay anything."

"We give health education, particularly when there is an epidemic like diarrhoea, and teach them about environmental sanitation and the importance of building toilets. Other things we do are to teach first aid skills such as treating burns and keeping wounds clean until they get to the clinic, and follow-up on TB patients and other chronic patients to check if they are taking their pills and going for treatment." "But because of high unemployment it is difficult to help those who don't have money for treatment." "People live far from the clinic," says Getrude. "There is no phone and no transport so they battle to get to the clinic."

"The biggest problems are shortage of water and unemployment. Even where there is water it is so dirty, so we show them how to treat it with jik. Most people get water from the wells and we see old people walking for two hours to get to the wells. But even there the water is often contaminated."

"We show people how to make gardens so they can grow food for themselves, but without water they fail. We also help them set up projects

Gladys Gabelo (left) and Gertrude Ndlovu
Demonstrate to expectant mothers at a centre at Valley Trust how to care for their babies

like sewing, raising chickens, and candle and brick making. We show people how to make things and sell them so they don't sit at home and go hungry. We also encourage them to join community projects like road making where they can get paid by the Department of Manpower."

"It is the Mpilo (community health worker) who sees to the needs of the community. We see people being carried to the clinic in wheelbarrows so we try and get people involved in making roads."

"The Valley Trust sent us on a midwifery course so that we could do deliveries but in emergencies only. We find the deliveries difficult, it hurts to see the women suffer and we pray to God to help them."

"There are so many problems, we need more Mpilo. We have to walk long distances to reach people. We only get paid for 16 days of the month but we end up working full time because people come to us when they are sick, even at night. We see a lot of problems that hurt people. We see people with no family, we see families where the husband is not working, the wife sits at home and the baby is sick. They don't even have the R20 to go to the clinic. It is hard to help those families. Some, especially the poorest, don't want to participate in projects, they give up and feel hopeless. ■

Community health workers in support of nutrition

An interview with Dudu Shandu, a nutritionist with theHlabisa community-based growth monitoring programme.

The community health workers are the core of the community-based nutrition programme being run in Hlabisa, teaching mothers about health and preventing malnutrition.

They discover those people who are very isolated. Because of them people who have never been to a clinic before and whose babies have never been immunised are now being reached - these are the people who are most at risk, the most vulnerable.

The outreach programme also means that the poorest families who can't afford transport to get to the clinic are now being attended to. Each CHW is equipped with a scale and on the monthly weighing days mothers bring their children under five years to the weighing sessions held under trees or in creches or churches. The children are measured according to growth charts, and mothers are taught about health. The children who are faltering are visited at home.

This gives the CHW a way of recognising vulnerable children and allows the mother to play a more active role in the health of the child. It also makes the community aware of the growth pattern of the children in the area and provides them with information they need to make their plans.

By going to homes CHWs recognise a malnourished child and refer them to the clinic. We find out how the family lives and whether the father

works, and we link them to income generating projects.

Projects such as community gardens not only bring in food and income, but also raise people's awareness about health and nutrition. A garden is being run by workers at the hospital to serve as an example to patients that even if they have a job they can still develop a garden.

The community growth monitoring programme has many different levels. It educates the mother about issues such as breastfeeding, it advises the household about water supply and income generation, and at the community level it raises awareness about health and the need to find solutions to health problems.

But before funders can provide money for community projects, it is necessary that the community is organised. For this reason we have set up the Hlabisa community health trust which facilitates community organisation and puts people in touch with NGOs.■

Community workers against AIDS

Sebenzile Hlabisa who is part of the community-based AIDS programme in Hlabisa, Northern KwaZulu/Natal describes this initiative.

When Sebenzile Hlabisa, a nurse at Hlabisa Hospital, went out to visit HIV positive people at home, her visits took an unexpected turn. Some of the infected people she visited on a regular basis said they wanted to join her in passing on the message of AIDS to others in the community.

"They said that when they sat in the bus they overheard conversations about people with AIDS," she said. "They would say 'this person has AIDS and she looks so terrible, she's covered in sores and you can't even look at her'." "People with HIV felt they wanted to tell others that you can't tell if a person has AIDS, only a test c

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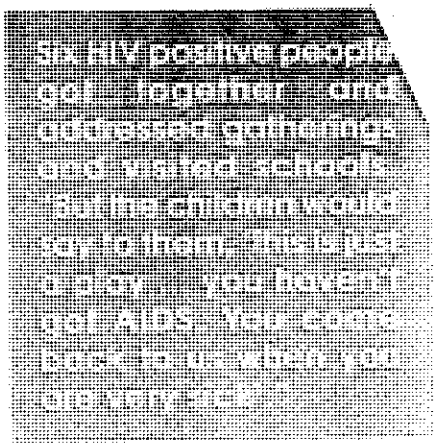


Taking HIV positive people along on her visits to counsel infected people at home has also had very beneficial effects. During her AIDS education meetings in the community, Sister Hlabisa appealed to community members to join her team. "I told them AIDS is spreading mostly in KwaZulu ... these are our people, how are we going to help them? "They said we can help educate people about AIDS if they themselves are educated."

So with the help of volunteers a community based AIDS programme was set up. Sister Hlabisa has now been joined by three community members, three traditional healers, two teachers and five matriculants who make up the team of community AIDS workers.

Nurses at the hospital educate the team about AIDS, they are given a certificate and introduced to the

Dudu Shandu (right)
– a nutritionist with the Hlobisa community-bosed nutrition programme, demonstrating at a gardening project. The garden is run by hospital workers as an example to patients

amakhosi, before going out to schools, markets, tribal courts and churches to educate people about AIDS. "At the meetings we have group discussions rather than formal presentations and everyone joins in. There are heated discussions, they ask many questions about things such as empowerment of women."

"Using the community health workers is a very good way of getting the message across. When we nurses invited people to the meetings there were not as many as when we started working with the CHWs.

"The groups are also good because they share their experiences and learn from each other. We have to fill in the gaps and correct the misunderstanding about AIDS". The community AIDS workers are not paid, and the main obstacle is getting transport to reach the outlying areas.

"Using the community health workers is a very good way of getting the message across. When we nurses invited people to the meetings there were not as many as when we started working with the CHWs. Everybody goes to the meetings now, young and old. The CHWs are neighbours so people must trust them. They know them better than they know the nurses. ■

Mental health care moving away from institutions

Karen Ensink, a research psychologist at the University of Cape Town's Department of Psychiatry presents an overview of the Empilweni Project.

When the UCT medical school set out to do an epidemiological survey of Khayelitsha, it was surprised to find that the community placed mental illness near the top of its list of most pressing health problems.

The community requested urgent assistance, particularly with child and adolescent psychological problems, as the psychiatric services in the area were too thinly spread to absorb the high level of mental ill health.

The first stage of the survey indicated

The first stage of the survey indicated that 64% of children and adolescents

that 64% of children and adolescents between 6 and 16 years presented with one or more symptoms frequently associated with psychiatric disorders.

Even if primary care mental health services were developed, it was likely that only the most severe psychiatric disorders would be identified and treated at clinics. A great many "at risk" or "marginalised" children would still be overlooked and not receive appropriate interventions.

These problems ideally needed to be dealt with in a preventative way from within the community - and a community mental health worker who could treat cases and refer those in need of psychiatric services was the apparent solution.

This was the beginning of the Empilweni (place of healing) Project which train community mental health workers who, under supervision by psychologists, are able to treat about 95% of children and adolescents they see. The rest are referred to psychiatrists.

The project has been running for a year, and in this time a team of three community mental health workers, two social workers and two other community members who coordinate groups have developed a case load of about 150 people. It is still in its early phases, but the project hopes to create a model for community-based psychological treatment of children and adolescents.

After six months of intensive academic and practical training the community mental health workers had the counselling skills and enough

psychiatric knowledge to take on most cases of mental problems. These ranged from depression, anxiety and mental handicap to sexual and physical abuse. Many children, especially girls, drop out of school early and one of the best spin-offs of the project is that it has been very successful in getting children to go back to school.

There are also a large number of children who, for various reasons, have developed severe anti-social behaviour and a group, run by a community member, has been set up to provide counselling and support. Another group for moderately handicapped children is run with the help of community members, parents and teachers.

The aim of the project is also to provide counselling and support to families and to educate the wider community about mental health problems in disadvantaged areas.

The project has found that community mental health workers are more in touch with problems, there are fewer barriers and they are in a better position to play a preventative role than clinically - based psychiatric nurses.

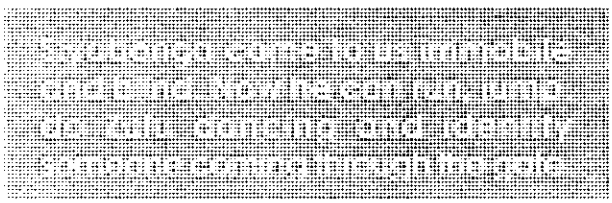
The project has an office in Khayelitsha, but most of the work is done in the home with the family. There are also outreach days where the project members use a loudhailer to tell people about the service. Many referrals are from schools and welfare services.

The community health workers are also able to help those who have fallen through the welfare net because they did not have the necessary documentation to apply for grants. In this way they discover the most destitute families. These families are marked by high levels of depression and are unlikely to find their way to the health services. ■

Community based rehabilitation for disabled children in Bulwer

Pam Sherriffs from The Natal Witness Printing and Publication Company reports

Esther Alm has no doubt that prayers get answered. If they didin't, she wouldn't be at the Esinqobile Therapy Centre in Bulwer, surrounded by mentally retarded children. A few years ago, Esther was down to the 'last R6 in her bank account', and considered giving up



her attempts to provide a home for handicapped children. In desperation, she sat down and prayed for money, and for proof that she was doing the children some good.

'Siyabonga promptly stood up and walked'. Money came pouring in. I thought 'okay, okay! I'll carry on', laughs Esther.

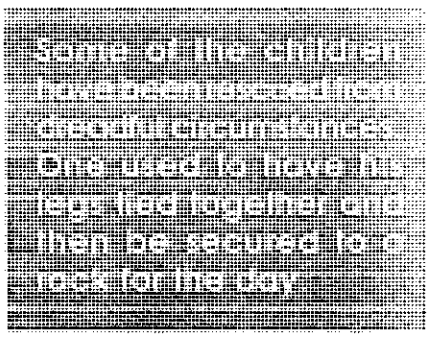
First she cared for four children; now there are 56. Staff are mainly women from the area who receive a basic salary and have been trained in patterning therapy. Each woman has been trained to carry out a certain exercise, and the children go through all of them daily. As a result, many children who could only crawl can now walk; children who could not move can crawl; some children who were blind can see.

'Siyabonga came to us immobile and blind. Now he can run, jump, do Zulu dancing and identify someone coming through the gate. We aim high, but we accept it when what we hope does not happen. 'We want the children to be happier, to learn and do as much as they can', says Esther.

Esinqobile is not a registered state institution, so does not receive a per capita subsidy. The primary school which is attached to the Centre receives a subsidy from the former Department of Education and Training, which covers half the salary of one teacher. Other funds come from donations, and families are asked to contribute R100 a month. Last year only two families managed to pay the full amount every month. Eight of the children at the Centre receive grants because they have been referred by the children's court.

Some of the children have been rescued from dreadful circumstances. One used to have his legs tied together and then be secured to a rock for the day. 'It is a terrible predicament for parents who have to work, but have no one to look after the children. What else can they do?' Esther asks.

Parents of severely mentally retarded children are entitled to a single care grant, and under review is to offer the same to physically disabled children. Unfortunately, according to Francie Lund of the Centre for Social and Development Studies, it is very difficult for people in remote areas to arrange for the grant. She says, though, that the new decision-



makers have a broader understanding of the problems of the very marginalised, so things could get better.

The need for places to care for and stimulate retarded children is immense. Joan Tennant of the Pietermaritzburg Mental Health Society says the extent of the problem is becoming increasingly obvious as families who used to keep retarded children at home are beginning to look for external help. Even so, many children in need of help in remote rural areas still go undetected. Francie Lund says there is a big gap between children who stay at home and those who receive some kind of institutionalised care. She believes more community-based partial facilities are needed and should be a combination of state and community support. 'Apartheid made these people poor. Now the state should not expect them to pay for themselves. As a short term measure to redress past inequalities, the government should consider welfare programmes reaching the most disabled.' ■

"Hoping for a favourable reply . . "

Our people in Ezibeleni need community mental health services. Can you assist?

This was the thrust of a letter received by the Health Systems Trust in February this year. The request demonstrated the largely unmet need for mental health care in rural areas in particular. But on investigation, it seems that the present reorganization of health care in the Queenstown area offers exciting possibilities for addressing this community's need - without a significant outlay of additional expenses.

Cecilia Tyandela, Nursing Services Manager for Ezibeleni Psychiatric Hospital, describes their situation: "Ezibeleni community which belonged to the old Transkei homeland is situated 13 kilometres from Queenstown, a South African town. The population here is 90 000 and is predominantly a low socio-economic group. Most people here work in Queenstown as labourers and domestic workers. There are very few factories; some have closed down increasing the unemployment rate which has resulted in a high crime rate, alcohol abuse and substance abuse. The drop-out at schools is high."

Mrs Tyandela goes on to describe the extent of mental health problems: "We have identified the following problems: high divorce rate; child abuse; adolescent problems; drug abuse, addiction and dependence; learning disabilities - a problem at school due to a lack of psychological assessment; drop outs at school, lack of remedial teaching and extra classes. Therefore few children from this area qualify for university education. About ten patients from this area are currently admitted to the psychiatric hospital for depression. All these are to us indicators that psychological services are a need in this area. Hoping for a favourable reply... "

In response, the Health Systems Trust arranged for Thulani Masilela (Health Services Development Unit, Wits), Karin Ensink (Dept of Psychiatry, UCT) and Hasina Zubeyda (Community Mental Health Programme, KwaZulu Natal) to visit Ezibeleni to help shape the proposed intervention programme and to explore methods of continued support.

What they found was an exceptionally motivated group of people eager to initiate a community-based mental health programme focusing on prevention and promotion of mental health, and detection of problems amongst school children. Equally exciting was the fact that most of the resources for such a programme were already in place - if the health service, presently being reorganised, aimed to support further extension of mental health care into the community .

Two psychiatric hospitals exist within ten kilometres of each other, one in Queenstown and the other in Ezibeleni. It has been agreed to close down the older one in Ezibeleni and transfer all patients to Komani Hospital in Queenstown. Staff from Ezibeleni Hospital will be incorporated into different aspects of the health service remaining. Another valuable resource person is Nomopha Gcweka, Remedial Advisor with the old Transkei Department of Education. But she has no office within the Education Department and no vehicle for getting to schools. The result is that she sits in an office in the Department of Public Works, waiting for children to be brought to her for assessment and counselling. Mrs Gcweka is clearly frustrated.

This group has a vision of a community mental health programme in partnership with the Department of Health and Universities, and as an extension of the hospital and outpatient psychiatric services currently provided. Already, the head of the Department of Psychology at the University of Fort Hare, Professor Simbayi, is actively involved in the project.

The group plans to have further discussions with local and provincial health authorities. Now is the time to introduce appropriate services, they say.

If only two of the motivated psychiatric nurses from the old Ezibeleni Hospital, together with the remedial advisor presently in the Department of Works, and one or two research assistants supported by academic departments could be transferred to this community centre – what a good team it would make! ■

TRAINING FOR CHANGE

Evaluating community rehabilitation workers training programme at WITS / Tintswalo

Findings and recommendations of an evaluation conducted by S.Philpot, S.Pillay and A. Voce from the Centre for Health and Social Studies.

The main purpose for setting up the training programme was to pass on rehabilitation skills to the community, the basic principles being to empower communities to take care of their own health, and decrease their dependency upon medical experts. The evaluation was undertaken to assess the achievements and progress made following the end of the second session of rehabilitation worker training.

The study established that the content of the training course as a whole was based on a thorough needs assessment, thus making it particularly relevant to the local context. Although some specific gaps in the content were identified, the inclination of the course towards viewing therapy as a means of development and empowerment of people with disabilities was a positive attribute of the course.

Although the modular system of training used in this programme was found to be particularly effective, a problem-based learning approach was recommended. The evaluation further established that the Community Rehabilitation Training Programme has been successful in demystifying disability and rehabilitation through its provision of therapy in the homes of the disabled people.

Ongoing education and support for Qualified Community Rehabilitation Workers (CRW), with emphasis on developing the teaching and advocacy skills of the CRWs was encouraged. According to the evaluation study this aspect could further be strengthened by the appointment of a researcher and facilitator to identify both the educational needs of the CRWs and the existing resources to respond to the identified needs.

Community participation was also cited as an essential component of the programme, and as such, involvement of the geographic community in the programme was recommended. The development of strategies for more meaningful participation of community representatives is crucial and imperative.

The evaluation advocated for continued financial support of the initiative by the funders until the programme becomes a fully fledged indigenous model that can be reproduced elsewhere in South Africa. ■

Recommendations

- A more indigenous Community Rehabilitation Training Programme
- Clarification of aims, objectives and indicators of the training programme
- Problem - based training curriculum
- Ongoing support of the Trained Community Rehabilitation Workers
- Building community partnerships
- Strengthening of management

Team building at Hlabisa

Over the past two years, Health Systems Trust has provided funding for more than 20 people from Hlabisa Hospital in northern KwaZulu/Natal to attend the University of the Western Cape's summer school.

The principal lesson that the 'Hlabisa Team' learnt from their courses at the summer school is that of community participation. "The course stressed the importance of involving the community in all the projects we carried out, and they demonstrated how to organise so as to facilitate community participation," said Dr. Mickey Chopra.

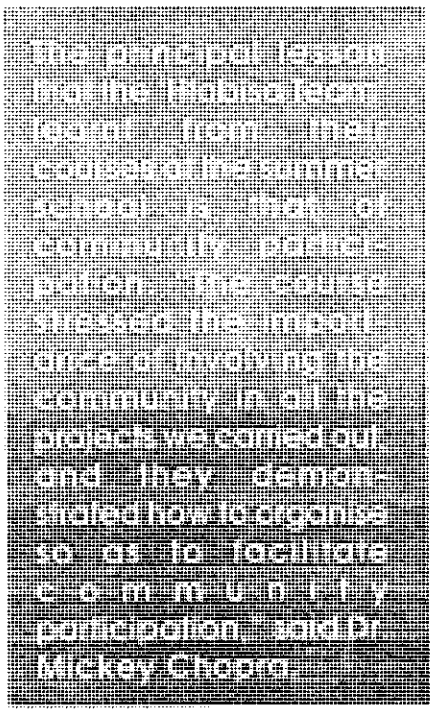
The course looked at various ways of setting up community-based health programmes which took into account the differing areas, resources and problems. The team from the summer school has also gone a long way in putting the lessons into practice and in passing on their newly acquired skills to their colleagues.

Mduduzi Fakude is a health assistant who advises on environmental health and protecting water from contamination. "The most important thing I learnt from the course was to gather the community and involve them in projects," he said. " Before the course we did things for them. Now we do it differently. We don't just tell people how to do it, first we hear from them what they want."

The course also demonstrated how to assist people in contacting NGOs for funding and services.

Left to right - Nonhlanhla Mnyandu, Evelyn Mthambu and Gloria Manqene attended the UWC summer school

The course on women's health made a big impact on the nurses who attended. "We learnt about all dimensions of women's health," said Sister Gloria Manqene. "We looked at problems such as the stress caused



by abuse and violence against women - all problems we have here in Hlabisa."

"We also looked at women and assertiveness, and how important it was to express your feelings and stand up for your rights. We hadn't looked at this part of health before. Now we teach women in the wards about it, and we are teaching nurses to pass on the message to women."

Dawn Zungu, matron in charge of maternity, said her course on maternal and child health would be of great help in the hospital's new scheme of setting up a programme to train midwives. The people who attended this course would soon present the new information at a teaching programme run by the hospital.

As well as putting them in touch with health developments around the country, the course also enabled them to assess the standard of care at Hlabisa Hospital. Sister Nonhlanhla Mnyandu said the course focused on information systems. "When I came back I told the nurses about the importance of reporting so that we could base our plans on accurate information," she said.

"The lesson on rapid evaluation has been very useful to us here. For example, we now stand at the gate each day and ask women leaving how to use their medicine."

"Teenage pregnancy is a big problem here at Hlabisa and the new methods of family planning which we were taught will be of great help. The course also showed how teenagers tend to get forgotten."

Dr. Mel Scrace said the course she attended brought home to her the link between development and health. Unless people could be taken out of their poverty, there would always be malnutrition.

The lessons on organising community health programmes have been of great assistance in the work of Vusimpilo, a network of people at grassroots level which focuses on community health and development. Mel has put together a directory which enables the community to get in touch with NGOs which offer the resources and training they need.

Together with the Parks Board, the project is also trying to introduce entrepreneurial tourism skills.

Mduduzi Nyoka, the hospital administrator, said he had discussed the lessons he learnt about community participation with the local amakhosi at their monthly meeting. "I told them the community must tell the hospital what to do, and they must involve themselves in planning for what they need," he said.

"So as a hospital administrator, I now prioritise the equipment needed for community outreach such as a loudspeaker and transport. From April districts will be in control of their own budgets, so the course was very useful in teaching about planning and budgetting."

The course also focused on developing human resources and computer - based management systems, and in response he had ordered two computers and sent people on training courses.

Sister Evelyn Mthembu said she was able to pass on the new information she learnt from the nutrition course to the community health workers whom she trained. The course taught new ways of monitoring growth, and from this a master chart has been drawn up to compare children and identify cases at risk.

"We learnt that what we Zulus were doing all along was right", she said. "It was Western civilization which taught us the wrong message about nutrition". ■

HEALTH POLICY CO-ORDINATING UNIT

In this issue and subsequent issues of the Update, articles by the Health Policy Coordinating Unit will be featured. This month, an introductory article is featured, and it outlines the mission and objectives of the Unit, its past and current activities. Also featured along with this introduction, are the publications of the Unit which are presented on the last page of this month's Update.

Health Policy Coordinating Unit: origin, objectives and activities

The preamble to a document detailing the role and objectives of the Unit states that it was "established to promote and co-ordinate the further development of health policy options that will assist the new government restructure the South African health services into a unitary national system for the benefit of all its citizens. It will be a resource for the Minister of Health, for the provincial MECs for Health, and other Ministries, organisations and groups. It will facilitate the exchange of information between all groups in the country working on health and health-related policy issues".

The Unit was initiated by the ANC Health Department, and a Board of Trustees was assembled to be broadly representative of the progressive health movement (or "Patriotic Health Front" as the progressive health sector organisations were called in the National Health Forum). A Director was appointed in June 1994, and after consultations with the Ministry and Department of Health, the Unit's role and objectives were finalised in August 1994 to be the following:

- initially to establish a head office in Johannesburg, with a secretary, administrator, and director/ national co-ordinator; with the option of further appointments as dictated by necessity
- to establish a working relationship and channels of communication between the Unit and the Ministry/ Department of Health, and, via the Department of Health, with the provincial MECs for Health
- to develop, in conjunction with the Department of Health, a detailed brief in order to then produce definitive guidelines for the demarcation of district health boundaries and services, and the processes required
- to work with the Departments of Health where appropriate, in the identification and fulfilment of the further objectives of the Unit
- to respond to requests from Ministries, parliamentary and extra-parliamentary groups, organisations and others, to produce analyses, commentaries, research, etc., that relates to health policy
- to identify needs for health research that will help inform the processes of the development and implementation of national and provincial health plans, and to commission work accordingly by identifying appropriate researchers, experts and consultants
- to identify gaps in health research generally and to co-ordinate and commission responses with existing policy/research groups, including health NGOs, to provide analyses and options for implementation
- to co-ordinate existing health and health-related research and policy work, and particularly to liaise and work with the Health Systems Trust
- to stimulate technical and public debate on policy options for the implementation of national and provincial health plans
- to monitor and evaluate the impact of the changes made in the health system
- to access international specialist technical support not available in South Africa, and to also use this to build local capacity within the country
- to provide an effective focus and mechanisms for a wide variety of health groups, institutions, etc., to communicate with and assist the Government of National Unity in its work in the health sector.

The Unit has worked most closely with the Department of Health in terms of the development of the District Health System, and has been an integral part of the inter-provincial District Health Systems Committee. The Unit has funded a number of initiatives in the provinces, with the specific aim of encouraging the SMTs, administrators and district co-ordinators to work at the grass-roots level, informing and involving health service personnel, community-based organisations and NGOs in the debates around the district health system. This "bottom-up" approach was felt to be vital, to meet the "top-down" planning that was taking place at a different level. The results emerging from these processes have so far been very encouraging.

The Unit has also assisted various provincial SMTs in their broader work of restructuring, such as a major exercise in financial analysis carried-out by Ernst and Young for the Gauteng province. The results will be of use to all other provinces in that for the first time, a financial analysis by levels of care has been carried out. At the national level

we have also assisted the national oral health committee, or more accurately its fluoridation sub-committee, and produced for them a policy document on the fluoridation of water supplies.

Apart from these various activities, the Unit has concentrated increasingly on bringing people together in workshops, to assist in further policy development. An important workshop held recently was the coming together of groups and individuals from institutions and organisations involved in health-related policy work. This was the first time that health policy researchers from such a wide variety of institutions had come together to discuss the issues around how policy work relates and feeds into the bureaucracy in terms of implementation. The meeting was unanimous in its call for better communication with the government-based policy and decision-makers, and for the need to explore a more formal relationship. There seems little doubt that unless policy researchers and developers outside the state structures have access to those structures, change will continue to be painfully slow. The entire group endorsed a letter to the Minister to this effect, to which a reply is awaited. A report of the meeting of the groups is available from the Unit, as are any of its reports/publications, which are listed below.

Workshops arranged around specific issues are also being given assistance by the Unit, especially in areas that remain somewhat neglected by policy makers. A recent example is a national workshop on rehabilitation.

A recent activity of the Unit has been to try to assist in making accessible some of the more technical discussions around policy issues, as exemplified by the recent fuss over the so-called "Deeble" option for financial restructuring of the health system. The Unit works closely and gives support to the health sector of the RDP National Council, and a national workshop was organised for the organisations of that sector around the current issues in health financing. This was seen as an important process of capacity building. Eighty delegates from around the country attended and have been mandated to arrange similar workshops in their provinces, to spread the knowledge base of the relevant issues. It is hoped that these processes will enable organisations and individuals to be better able to respond to any proposals emanating from the National Committee of Inquiry into National Health Insurance.

The Unit has, for similar reasons, held a workshop on this issue with the national and provincial legislators (MPs and MPLs), and will be conducting a series of workshops on a variety of health issues for the health study groups in these legislatures.

We are grateful to HST Update for allowing us the space to describe some of our activities, and hope to be able to report on these again in future editions. ■

HST NEWS

Local authorities in South Africa: Health personnel, compensation in perspective

Findings and recommendations of a survey of local authorities in South Africa by Bupendra Makan, Max Bachmann of the Health Economics Unit at the University of Cape Town, and Merrick Zwarenstein of the Medical Research Council, Cape Town.

"Local authorities in South Africa: Health Personnel Compensation in Perspective" forms part of the national investigation into the remuneration and distribution of health care personnel commissioned by the National Health Forum in 1993. This descriptive survey of a sample of local authorities in South Africa compares salary and allowance discrepancies and makes national projections in order to inform policy on the integration of health services presently run by separate authorities.

This report is one of three, the others being "Health Personnel Salary Discrepancies between Local Authorities and the State Health Sector: A Cape Metropolitan Area Study" [HEU Working Paper Number 10 - see January issue of *Update]* and "Health Personnel Salary Discrepancies of all Health Personnel in the Public Sector" and models the cost implications of scenarios for the equalisation of compensation.

This report examines issues pertinent to the grading, salary determination, personnel distribution and financing of local authorities. It explores and presents findings concerning the themes of:

The distribution and utilisation of health care personnel:

There are an estimated 14 718 health care personnel employed by the South African Local Authorities of whom 17% are medical officers of health, medical professionals and environmental health officers, 32% nurses and 51 % administrative, clerical and general personnel [non-professional]. The distribution of personnel varies according to local authority grade, with higher grades of local authorities having a higher percentage of professional staff.

Salaries and differentials:

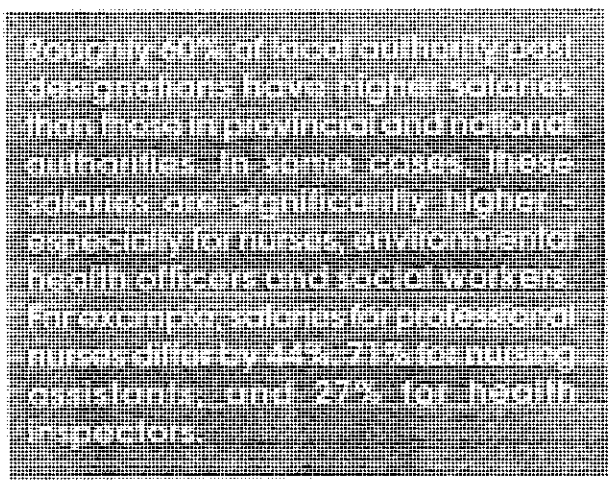
The salaries for some post designations [i.e medical officers of health, nursing service manager etc.] may vary considerably between grades possibly reflecting level of experience, responsibility and qualification, and the effect of the Town Clerks' Remuneration Act. However, other post designations [i.e senior health inspector, senior professional nurse, drivers etc.] remain

relatively constant across authorities. There are clear salary differentials between the various categories of personnel from medical professionals through to non-professionals. The professional category of personnel earn approximately 76% of the estimated total R470 million health related salary expenditure by local authorities. Furthermore, the HEU estimate comprises 65% of local authority health expenditure for the 1992/93 period [Development Bank of South Africa, 1994].

Variations in Benefits Packages:

Although there is a wide variation in benefits packages between differently graded local authorities, they generally follow the salary trends. Professionals tend to receive more comprehensive benefit packages than non-professionals, and higher grade local authorities often offer better benefits than the lower grades. The inclusion of benefits with salaries is necessary to avoid underestimation of total compensation and because it is a major factor contributing to differentials between personnel packages. This issue however still requires greater attention.

Comparison between local authorities and the state health sector:



Assuming that post designations are defined similarly across all national health authorities, roughly 60% of local authority post designations have higher salaries than those in provincial and national authorities. In some cases, these salaries are significantly higher - especially for nurses, environmental health officers and social workers. For example, salaries for professional nurses differ by 44%, 71% for nursing assistants, and 27% for health inspectors. These disparities may explain the resentment by some provincial and national employees, and thus their unwillingness to co-operate with attempts to integrate with local authorities.

Given the above salient findings, the report highlights a number of issues that need to be considered when addressing the issue of salary reform and local authorities. These include:

- an objective system of job grading [noting the issue of comparability across authorities]
- a review of the formula and grading system applied to local authorities,
- a standardised compensation package based on the principle of equal work for equal pay,
- a standardised disclosure system to facilitate resource allocation decisions, and the macro-economic impact.

In essence, this study shows that compensation levels and the distribution of health care personnel are complex issues and will require careful consideration by policy makers. For instance, it may become difficult for the central government to justify the substantial subsidies to local governments that pay their staff higher rates. Possibly transfers may become dependent on remuneration scales that are comparable with those of other state employees.

To cite the feelings of a respondent to the local authority survey:

"the inequality of salaries and fringe benefits is the main problem facing all authorities and will impact on the ability to implement Primary Health Care services at the grassroots with local authorities".

The future structure of salary scales in local authorities, their integration into the district system and how their role vis-a-vis the Department of Health and RDP imperatives will need to be defined. This would include the consideration of an equitable remuneration system, uniform conditions of service, and policy decisions regarding human resource allocation within an "unfragmented" and unified health department. This should be considered in the context of a national collective bargaining. ■

Ms Shirley Ngwenya joins the Health Systems Trust Board of Trustees

Ms Ngwenya was recently appointed as a member of the HST Board of Trustees. She received her B Cur from the University of South Africa, and was a special student in Epidemiology at the Columbia School of Public Health in New York. Ms Ngwenya is currently the Coordinator of the Sexual Health Programme with focus on sexuality and STD/ HIV education to women and youth, of the Health Services Development Unit at Acornhoek in the eastern Transvaal.

She has authored papers on a wide range of health issues, notably articles dealing with sexuality, AIDS and women. Ms Ngwenya is currently a member of the National Reproductive Health Team funded by the Kaiser Family Foundation, and the Core Working Group on AIDS in the North-eastern Transvaal. She is also the chairperson of the Bushbuckridge AIDS Committee.

Ms Ngwenya brings to the Board her expertise as a rural health professional, and particularly in the field of STD and HIV services in rural areas. These fields are amongst the many that have been designated health policy priorities, and are currently challenging areas of health systems research.

We wish Ms Ngwenya a fruitful term with the Health Systems Trust. ■

UPCOMING EVENTS

Health Systems Trust Reportback

Date: 4 - 5 May 1995

Venue: Tropicana Hotel Durban

Health Systems Research Workshop

Date: 21 - 26 May 1995

Venue: Broederstroom

Invited delegates

The aim of this workshop is to offer an inspiration to approximately 30 researchers most of whom are supported by the HST. Facilitated with assistance from international HSR experts from Thailand and Indonesia, the workshop will give the researchers an opportunity to take a "cold and hard look" at the value of HSR in South Africa. Most importantly, the workshop will focus on how health planners and policy-makers can be motivated to take notice of the recommendations that emanate from research – and as such, make HSR more effective!

REPORTS AND PUBLICATIONS

HEALTH SYSTEMS TRUST FUNDED/COMMISSIONED PUBLICATIONS

Assessing the Feasibility of Greater State Support to Community-based Health Programmes. Contributing authors are Dumo Baqwa, Lungile Bhengu, Irwin Friedman, Di Hewitson, Steven Knight, Kathy Lomax and Hugh Philpot. Edited by Kathy Lomax and David Mametja. HST 1995.

Grant, Linda and Cathy Meiklejohn. *Health and Recreational Facilities in Informal Settlements in KwaZulu/ Natal*. Working document, not edited for formal publication. April 1994

Cunnan, Priscilla. *A Pilot Study for the Use of Geographical Information Systems (GIS) in Planning Health Services for the Durban Functional Region (DFR)*. University of Durban-Westville Health Research Unit. 1995.

Harrison, Steven. *Discussion Paper on Related Recommendations Reform of South African Health Legislation*. February 1995.

HEALTH POLICY CO-ORDINATING UNIT

REPORTS AND PUBLICATIONS

RDP White Paper: submission for section on health (July 1994)

Commentary on the 1994/1995 Health Budget (August 1994)

The Demarcation of district health boundaries.

Report of the first meeting of the advisory panel (August 1994)

The organisation of the third tier of government and implications for the health system (September 1994)

The District health system and functions of the health district and third tier of government (October 1994)

The District health system: health functions of the third tier of government (produced for the national District Health Systems Committee, October 1994)

Oral Health Commission submission to the Department of Health and Developmental Social Welfare of the North West Province (Province 1994)

The District health system: options for its structure in the interim phase (November 1994)

Comments on the documents "Proposals for the post structure of the Department of Health dated October 17 1994, and "The health priorities of the Reconstruction and Development Programme". Both documents produced by the Department of Health; comments requested by the RDP/Policy Division of the ANC (November 1994)

A policy to reduce tooth decay in South Africa (December 1994) Resource allocation for equity: examples from the health sector and implications for the future. Requested by the RDP/Policy Division of the ANC (December 1994)

Comments on the draft report of the Health Expenditure Review (January 1995)

Comments on the District Surgeon System, and options for change (February 1995)

Some issues in financing the health system: sources of finance and a structure for allocation (February 1995)

National health insurance - what's all the fuss about? (February 1995)

Some selected extracts from "Social health insurance: a developmental guidebook" (February 1995)

Comments on the proposed 1996 census form. Requested by the National Institute for Economic Policy (March 1995)

Health financing: issues and principles. Report of the national workshop on health financing for the health sector organisations of the RDP Council (March 1995)