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The primary health care approach towards an acceptable level of health.

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are associated with poverty are observed. Topics addressed are the socio-economic conditions, followed by an outline of disease patterns which coincide with poverty. (an especially important indicator of poor conditions is malnutrition). The health services and the use of primary health care is then examined as well as a brief description of the effects of the homeland policy.

The focus on the health services development unit shows attempts at the increase in the use of primary health care strategies in the area. A description of the unit is followed by an account of the various primary health care projects, especially in personnel development and village development programmes.

Conclusion of the discourse is two-part, that is, an evaluation of health service provision in Mhala and guidelines towards creating a living environment in order to increase levels of health. The struggle for better health is interwoven with struggles in the educational, economic, housing and agricultural sectors. It is therefore necessary to adopt a holistic approach to health in that the main determinants of health are not ignored, and development policies are integrated. This can best be achieved through the comprehensive strategy of primary health care which is seen as the key towards improving health for all.

prevalence of diseases associated with these factors are examined Broad developmental programmes are advocated with co-ordination between various departments and with the community's involvement.

In chapter five the primary health care concept is defined and special attention is paid to the three fundamental tenants thereof, which are, socio-economic development, community participation and restructuring the health care sector. Technical solutions alone do not work, because illness and disease are also affected by social and economic factors. We need to consider the "health" aspects of all areas of development e.g. water supply, education and housing provision. Community participation is important in the primary health care strategy and the idea is to promote active participation in health and improving living conditions. People should be enabled to identify problems and solutions. The chapter also focuses on the hierarchy of health, medical education and approrpriate personnel/health workers. It concludes by examining certain specific selective primary health care programmes, such as maternal and child health; oral rehydration therapy and family planning.

The assessment of health and the primary health care approach in health delivery is examined in chapter six. The sample area used is Mhala, which is a rural homeland district of Gazankulu. There is extensive poverty in this sample area and it can be seen as representative of rural homeland conditions. Health problems that

preventable medical conditions and poverty-related diseases. The health indicators show differing disease patterns for Blacks and Whites. The differential health service expenditure is shown indicating the fact that the areas requiring the most resources, namely the rural areas receive the least. The curative care bias (as opposed to primary health care) is also highlighted.

An examination of the rural health system follows in the chapter three. Issues that are addressed are the rural socio-economic conditions, health services, health personnel and resources. Rural conditions show low levels of employment and increasing unemployment. The situation is one of poverty and it is exercabated by the inadequacies of agriculture and lack of arable land. Another fact that is evident, is the lack of access to water and sanitation. Majority of the rural population suffer from illnesses directly associated with poverty, such as malnutrition. There is a need for change in health priorities in order to overcome the rural health problems.

It has been noted that various socio-economic factors affect a community's health status. In chapter four non-health factors that affect health, such as rural housing; access to food and nutrition; as well as water and sanitation is examined because health cannot be seperated from these factors. The spread and/or

the development of basic health and other services, physical upgrading and the general development of the community. Development is seen to be integrated. It is argued that the broad-based preventative orientation of the approach will increase the level of health in the rural areas.

The method of researching the discourse is the use of a sample area to assess the impact of primary health care. A visit to the area and discussions with health personnel and community members were held. Secondary sources are used extensively.

The rationale of this discourse is to express the need for action by governments, and health and development workers, to protect and promote health. The aim is to examine the primary health care approach in a sample area and see how it can be used to achieve an acceptable level of health.

OUTLINE OF THE DISCOURSE

The discourse begins with a background on the state of health. Various topics are discussed including a brief description of health services under apartheid with attention given to statistical information and health indicators which show the health sector as being characterised by a high degree of

CHAPTER 1

INTRODUCTION

Racial segregation and discrimination which is enshrined in the South African constitution pervades all sectors of society, including health and health services. A deepening crisis in the health sector is noted. In assessing the health profile of the homeland populations, one finds them to be the least healthy with unacceptably low life expectancy, and high infant mortality rates. The causes of death coincide with those most commonly associated with poverty and an unhealthy living environment.

The problem is that the level of health of the rural population is low and the health care situation follows that of a developing society. People cannot meet their needs because of low income levels and a lack of employment opportunities. Malnutrition and overcrowding are evident as well as poor facilities in the health, water, sanitation and education sectors. The main problem in the rural areas is poverty, no access to clean water and a lack of an adequate sanitation system.

The main arguement of the discourse is that adoption of the primary health care approach allows for addressing issues in health as well as issues that affect health. It s objectives are

6. OVERVIEW OF HEALTH IN SAMPLE AREA - (MHALA) p.54
- ◊ socio-economic conditions
- ◊ disease patterns
- ◊ the health services and PHC
- ◊ effects of the homeland policy

7. THE HEALTH SERV ICES DEVELOPMENT UNIT AND PHC p.68
- ◊ some health services development projects

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   - ◊ restructuring the health care sector
   - ◊ health care hierarchy
   - ◊ specific PHC programmes

Following that will be an examination of rural health. Issues that are addressed are the rural socio-economic conditions, services, resources and personnel. The next section takes a look at non-health factors that affect health such as housing, access to food, water and sanitation. An examination of the primary health care approach follows and particular attention is paid to the three fundamental concepts thereof, which are: socio-economic development, community participation and restructuring the health care sector. It also focusses on certain specific, selective primary health care programmes. The assessment of health and the primary health care approach is examined in the rural homeland district of Mhala in Gazankulu. The discourse concludes with an evaluation of health and advocates certain guidelines in planning for health.

METHODOLOGY: The use of a sample area to assess the impact of primary health care; with a visit to the area and discussions with health personnel and community members. I have used secondary sources extensively.

ABSTRACT

A definition of development includes improving living conditions and the quality of life. There is an interrelationship between health and; social and economic development. "Health leads to and at the same time is dependant on a progressive improvement in conditions and quality of life". (World Health Organisation). Therefore a discussion on health has to take into account the socio-economic and political context.

In assessing the health profile of the homeland populations one finds them to be the least healthy. The problem is that the level of health of the rural population is low and the health care situation follows that of a developing society, where poverty-related diseases and infant mortality rates are high and life expectancies are unacceptably low.

The rationale of this discourse is to express the need of action by governments, and health and development workers, to protect and promote health. The aim is to examine the primary health care approach in a sample area and see how it can be used to achieve an acceptable level of health.

Background on the state of health will be addressed. The health services under apartheid is discussed in the first section, with attention given to statistical information and health indicators.

ACKNOWLEDGEMENTS

I would like to say a special thank you to my parents for their encouragement and confidence in me. I would also like to thank Professor Alan Mabin.

DECLARATION

I declare that this discourse is my own, unaided work. It is being submitted in partial fulfillment for the degree of Master of Science (Development Planning) at the Universisty of the Witwatersrand, Johannesburg, January 1992. It has not been submitted before for any other degree or examination in any other university.

I declare.

T. Coovadia

THE PRIMARY HEALTH CARE APPROACH

TOWARDS AN ACCEPTABLE LEVEL OF

HEALTH

TASNEEM COOVADIA

86-07201/E

JANUARY 1992

Discourse for the partial fulfillment of the requirements for the degree of Master of Science (Development Planning) at the University of the Witwatersrand, Johannesburg, January 1992.

Malnutrition: This is evident as well as other poverty-related diseases such as diarrhoea, tuberculosis and gastro-enteritis. The infant mortality rate is high with an estimated 120-200 deaths per 1000 children of under one year olds in Gazankulu.

Within the boundaries of the homelands there are limited economic activities as well as limited job opportunities. There is generally a low standard of living. "The majority live in poverty because of inadequate wages and widespread unemployment". (Saedat, 1984 p.21). Most rural families are without or with insufficient incomes and/or land and therefore most live in conditions of great poverty and deprivation, which affects their health and well-being.

SERVICES

Initially health in the homelands was provided by mission stations and churches. Later government aid to mission services allowed for the expansion of those services. In the 1970's the mission hospitals came under the South African Department of Health's authority. Thereafter these came under the control of various homeland bodies.

Each homeland is divided into health districts which has a regional hospital and a number of satellite clinics, which have other smaller clinics under it s control. (as shown diagrametically).

The situation therefore forces most men and some women into the migrant labour system. There are largely female-headed households because of migrant working husbands. For the women left behind the prospects of finding suitable employment are scarce. "The lack of adult education, job training programmes and child care facilities in rural areas make it harder for women to overcome their inferior occupational status". (Richardson, 1988 p.43). Rising unemployment and inadequate agriculture compounds the situation of poverty and we find that health risks increase as income decreases.

Overcrowding: The land is not agriculturally viable to sustain it's population because of poor farming land and overcrowding. There is a low development of the level of farming. People in rural, homeland areas cannot survive off the land. The population density is extremely high and this contributes to overcrowding. The areas are unable to provide adequate subsistence for the people to survive.

Physical conditions: They are appalling and characterised by overcrowding, poor water supply and inadequate sanitation systems.

Social conditions: These are poor and weak in a situation where they need to be strengthened for social support. "Migrancy has a disastorous effect on family relationships". (de Beer, 1984 p.64)

This chapter illustrates that rural conditions show low levels of employment and increasing unemployment. The inadequacies in agriculture also increases the situation of poverty. The land is not able to sustain the population and the physical infrastructure such as water supply and sanitation are inadequate. We find malnutrition evident with high infant mortality rates. The responsibility for the provision of health services has changed hands from being provided by missions and churches to the South African Department of Health and currently by the homeland institutions. We find the health services being characterised by a lack of facilities, funds and staff.

CONDITIONS

The difficulty of the poor in obtaining health services in the rural areas is compounded by isolation from resources and a lack of availability of health resources.

Employment and occupation: The rural population is engaged in mainly low skilled, low paid jobs with a limited range of options. They are trapped in an inferior economic situation because employment prospects are bleak. People need to find jobs in order to survive because they cannot survive by farming alone. It was found by the Tomlinson Commission that by the mid-70's there would be a need for 1,6 million jobs, however by the mid-80's only 17% were created. (de Beer, 1984 p.33).

CHAPTER 3

RURAL HEALTH

When we examine the rural health system in South Africa we find it closely related to the macroscopic view of South African society, that is, one which is characterised by unequal socio-economic and racial apportionment. The health care situation is one of a developing society. "...conditions in the bantustans are such that forcing people to live there is, in fact, sentencing a large number of people to death by illness and starvation". (de Beer, 1984 p.47). The creation of the bantustans has pushed the poorest people into areas of poverty and the associated problems of unemployment, housing shortages and generally inferior socio-economic conditions. These areas (the homelands) are unable to provide adequate subsistence for the population.

The health of the rural population cannot be seperated from their living conditions. Poor wages are given which are inadequate to meet the needs of the rural people. Malnutrition is a major problem and research has shown that there has been a decline in the living conditions over the last 20 years. The general situation is of overcrowding, lack of washing facilities, inadequate sanitation and poverty. Where services do exist people cannot use them because of low wages and/or lack of transportation.

in public funding we also find a curative care bias over preventative or primary health care. This is illustrated in the table below.

PHC expenditure as a % of total health expenditure	
1976	2
1979/80	2,85
1980/81	2,09
1982	4,8

Who should finance preventative health care? According to Price (1987 p.47) it should come from public funds, that is, the government. Private practitioners provide "indivitual" services and not those designed for the whole community because it is outside their control, e.g. sanitation, disease control and health education on a broader, community level.

For racial inequalities to be eliminated, a larger amount of resources needs to be allocated to health care. However these funds should be chanelled towards services and programmes that would benefit the largest number of people. For this goal to be achieved we need to allocate more of the health budget for preventative rather than curative services, and we have to increase health services to the poorest areas, namely the rural homelands.

Differential expenditure on health services (for Whites, Indians, Coloureds and Blacks) is the most obvious evidence of racial discrimination in the health policy, and is illustrated in the table below. South African society is characterised by inequalities and the health sector is no exception. The table below gives the total population and racial breakdown with the corresponding breakdown of the health budget.

	Pop. as a %	Expenditure as a %
Blacks*	73,7	11,4
Indians	2,7	7,8
Coloureds	8,8	29,8
Whites	14,8	51,0
	100,0	100,0

*includes homelands

(Sources: Earle et al, 1987 and SAHWCO 1989).

The structure of South African health services is geared towards curing diseases of the White population and "the bulk of resources is spent on expensive, high-technology diagnostic and curative services". (Seedat, 1984 p.12). Apart from racial biases

development in a broad sense. For example a healthy population favours economic development and vice versa. To obtain physical, social and mental well being a broader approach is required such as upgrading social and physical conditions. We need more than medical intervention to upgrade a nation's or community's health status. How does one define development? It is a vague and broad term. Is economic growth alone an indication of development? If development is regarded as "improvement" then non-economic indicators are also relevant.

HEALTH EXPENDITURE

In most economies the expenditure for the health sector is a small proportion of the total budget; however it s importance is considerable, because the (good) health of a nation influences the wealth of a nation. "Improving health is an important factor contributing to economic growth and development". (McGrath, 1979 p.(18). It is difficult to obtain reliable data on the amount of Gross National Product (GNP) budgeted towards health. Estimates range from 2% to over 6% of the GNP. Between 1971 and 1981 there has been a decline in expenditure on health and education. The homelands which express the greatest need, get very little of state expenditure. "There are gross discrepancies in the distribution of resources between Black and White". (Coovadia, 1987 p.4).

high rate. A malnourished child is more susceptible to disease and infection and dies as a result, from curable illnesses such as diarrhoea. This situation is true of rural South Africa and we find that "the determinants of health stretch well beyond medical care". (Lobstein et al, 1984 p. ix). Various interventions are required to promote health and they include improving nutrition, ensuring clean water supplies and improving sanitary conditions.

Infectious diseases i.e. diseases such as tuberculosis is evident in developing regions and it's incidence decreases as standards of living improves, including improvements in nutrition and housing. Therefore instead of treating tuberculosis itself one should target the cause - that is, poor nutrition, poverty and inadequate housing. Other poverty related diseases are cholera, gastro-enteritis and typhoid due to squalid conditions, poor hygiene, lack of clean water and poor sewerage systems.

In developed countries disease patterns have changed not only because of medical advances but also because of social changes, environmental and nutritional improvements. Improved living conditions with improved nutrition has a marked impact on health Restructuring the health sector will occur with general socio-political retructuring. When we defined health it does not merely mean the absence of illness but it includes "a state of complete physical, mental and social well-being" as stated by the World Health Organisation. There is a link between health and

calculating the mortality rate there are limitations because of inaccuracies in the demographic data. Therefore this statistic only gives an incomplete indication of a community's health status. The mortality rate indicates the amount of deaths and their causes. In South Africa this data is collected and published according to age and sex, and two series of reports are published; one for Whites, Indians and Coloureds and another for Blacks. The infant mortality rate is particularly important in assessing a nation's health situation. It is observed (Westcott et al, 1979 p.2) that an increase in infant mortality is noted by a corresponding decrease in urbanisation, that is, we have a high infant mortality rate in the rural areas.

The nutritional status is also an important health index. Various criteria are used to obtain a measurement of malnutrition. For example the Shakir strip which is the measurement of the upper arm circumference and the weight for age measurements. Malnutrition is one of the effects of poverty and it occurs because people cannot afford adequate nutrition and this leads to nutrition deficiency. Poverty linked diseases coupled with poor sanitation, inadequate water supplies as well as overcrowding lead to high infant mortality rates. The infant mortality rate for under fives is extremely high amongst Blacks. (Seedat, 1984). In a 1984 UNICEF report, infant mortality rates for various countries showed South Africa to have an extremely high rate in relation to national wealth. Malnutrition contributes to this

care for the Whites and a second system filled with problems for mainly the Blacks, where their state of health is characterised by deprivatior Another dichotomy exists between the urban and rural areas as well as the main focus of health being curative as opposed to preventative. These biased of favouring White over Black; urban over rural; and curative over preventative makes health care inaccessible and creates a situation of the existence of first world and third world situations.

HEALTH INDICATORS

Different patterns of diseases for the different population groups are revealed. How do we measure health and what does this concept mean?

The two main indices to judge a country's health services are infant mortality rate and life expectancy. In South Africa there are two different patterns of diseases for Blacks and Whites; with Whites having low infant mortality rates and high life expectancies; that is following the pattern of industrial countries; and Black South Africans having high infant mortality rates and low life expectancies, that is following the pattern of developing countries. Whites suffer from "diseases of affluence" (Seedat, 1984 p.10), whereas their counterparts suffer from diseases of poverty.

In South Africa data on morbidity is irregular and therefore to measure health one has to look at the mortality rate. In

therefore to adopt a holistic approach to health, where socio-economic, political and cultural factors are not ignored but are incorporated into policy planning.

In this chapter various topics are discussed including a brief description of health services under apartheid. It shows that health care is divided and favours curative, urban care and is therefore inaccessible to many people. The health indicators show differing disease patterns for different groups of society, with poverty-related diseases being the norm for rural South Africans. The chapter concludes with a focus on health expenditure and states that the homelands which require the largest amount of resources get very little of the budget. The bias in expenditure for primary health care is highlighted.

HEALTH SERVICES UNDER APARTHEID

Health services are shaped by the apartheid state. "South African society has modelled it's health services in it's own image". (de Beer, 1986 p.60). South African health services are characterised by inefficiency, lack of co-ordination and a wastage of resources, to the detriment of majority of the population. Health care is inaccessible because of gross maldistribution. Current health services are characterised by racial divisions and an urban bias.

The health service reflects a divided society with good health

CHAPTER 2

OVERVIEW OF HEALTH IN SOUTH AFRICA

In South Africa the paradoxical situation exists where we have "a wealth of natural resources etched against poverty and absence of quality of life". (IMA, 1991 p.1). We have the unique situation of advanced, sophisticated medical technologies and facilities coupled with widespread poverty. The function of a health service is to provide health care for those who need it, and preventative and promotional services to ensure the greatest possible level of health among the population as a whole. "South Africa holds a unique position in the world; racial segregation and discrimination are embedded in a legal system which pervades all sectors of society, including health and health services". (Van Es and Van Gurp, 1987 p.18).

The State's lack of responsibility to provide an affordable, equal and easily accessible health care system has allowed for the continuing deterioration of the quality of health services. The health sector amongst others; is riddled with inequalities and these have been recognised by various organisations. There is a deepening crisis in the health sector, which is characterised by a high degree of preventable medical conditions and poverty-related diseases such as malnutrition, gastro-enteritis and tuberculosis. These health problems cannot only be solved by increasing the numbers of doctors and hospital beds. There is a need for political, social and economic changes. It is necessary

proper planning of these facilities. In the rural areas the problems of quality as well as quantity of these services are acute. Water development programmes have health as well as non-health benefits. For example the less time spent on fetching water means more time spent on (other) productive activities.

There are links between water and health; and improvements in water supply and storage can contribute to reducing the ill effects of unclean water. There is a need for an adequate and safe supply of water. The World Health Organisation found that water-borne diarrhoeal diseases accounts for a third of deaths of children under 5 years in developing countries. (W.H.O. 1989).

Water supplies of adequate quality and quantity is vital. The provision of clean water is one of the most pressing problems in the area. The amount of water as well as it's quality is important to a community. The World Health Organisation's goal of water consumption per capita is 50 litres per person per day. (Wilson, 1985 p.23). "In South Africa, it is established that the average white person uses 200 litres of water per day, whereas each African family in the Bantustans consumes 50 litres." (Harries, 1984 p.7).

Access to water is also affected by the availability of taps. For the eradication of water-borne diseases (such as cholera and gastro-enteritis) as well as water-washed diseases (such as trachoma and malaria) there needs to be one tap per household but

malnourished children through discussions and demonstrations by health workers. The programme adopted was broad based and went beyond only treating malnutrition.

- ◊ education on nutrition, balanced diets and correct feeding,
- ◊ gardening skills,
- ◊ learning handcraft skills to supplement incomes e.g. sewing, mat-making,
- ◊ family planning service,
- ◊ milk schemes operating through the clinics e.g. powdered milk at cheaper prices, and
- ◊ various aspects of child care.

In an assessment of the treatment plan, the community mostly found it helpful. The programme's effectiveness is also evident by the decline of malnutrition admissions in subsequent years. (Clarke, 1984 p.25). The incidence of malnutrition will only be checked by strategies that allow for increasing rural development with special attention to "agriculture, water development, increasing job opportunities, improved education and health facilities and the overall improvements of physical and organisational infrastructure." (ibid, p.25).

WATER AND SANITATION

Poverty-linked diseases are associated with poor water supplies and poor sanitation facilities. Many are preventable through a

Item	Cost at Nelspruit	Cost in Mhala	% increase
Full cream milk powder (500g)	R3,65	R5,15	41,1
Mielie meal (5kg)	R1,99	R2,86	43,7
Pilchards (215g)	55c	72c	30,9
Sugar (1kg)	66c	80c	21,2
Salt (500g)	24c	30c	25,0
Tea (125g)	96c	R1,17	21,9
Brown bread	29c	35c	20,7
Eggs (½ dozen)	56c	71c	26,8

Source: (Buch,E & de Beer,C 1984 p.2)

In a "Save the Children's Fund" report it was established that 9 out of 10 Southern African children are malnourished. The incidence of malnutrition is evident in the Mhala area. "...poor nutrition is inseperable from the distribution of land and from it's quality ...and from the process of underdevelopment." (Lobstein et al, 1984 p.74). Various interventions are required to improve the situation such as food schemes. Although this is important it has limited impact. However only by tackling the causes of undernourishment can it eventually be eradicated.

In a study of treatment of malnutrition in Kwazulu by Clarke, emphasis was placed on educating the parents and/or guardians of

well as unemployment is high. There is a high rate of male absenteeism because of migrancy. In the BENBO Economic Revue on Gazankulu it was found that more than a quarter of the men were temporarily absent for specific periods. Therefore difficulties were encountered in developing with the high rate of women and children and so few men.

The number of people places pressure on the land. Between 1970 and 1980 the population almost doubled, therefore there was added pressure on arable land. "In Mhala only 2% can earn a living from agriculture." (Harries, 1984 p.4). Agricultural production shows room for improvement. There is a shortage of essential services, and know-how. The infrastructure of Gazankulu, especially as far as the provision of water is concerned, is not yet adequate and constitutes one of the obstacles to agricultural development.

Most people cannot produce enough food on their land and therefore have to purchase it, but this is expensive and often unaffordable and therefore results in malnutrition. "The average family receives between R40-50 a month" (Buch and de Beer, 1984 p.2), and this covers all expenses including food. The low level of income is not sufficient and the problem is increased by the high prices of food in rural areas because of transport and lack of competition.

The following table shows the costs of basic foods in Mhala and in the town of Nelspruit. (figures for 1984).

Housing is one of multiple socio-economic conditions affecting health and therefore "modification of physical environment can only have a maximum effect on health if accompanied by other socio-economic improvements." (Lipschitz, 1984 p.24). Adequate housing includes facilities for domestic hygiene. If safe water is supplied and adequate sanitation is provided, to prevent or control communicable diseases they must be accompanied by good hygiene. Housing alone does not cause ill-health and improving conditions of shelter alone cannot ameliorate health. However diseases are associated with poor housing conditions and "improved housing becomes a necessary prerequisite in the reduction of these diseases." (ibid, p.2).

ACCESS TO FOOD

Most rural health problems are rooted in poverty and therefore to improve health the first step is to reduce poverty and improve nutritional levels. Treatable diseases can become fatal to a chronically underfed child. Undernutrition in a child's first three years leads to stunted growth; impaired brain development and a susceptibility to diseases. Access to food is influenced by access to land and income and therefore to employment opportunities.

Gazankulu has a small tax base and the "economy cannot provide sufficient employment opportunities for the economically active population." (Moody and Golino, 1984, p.7). Therefore under- as

overcrowded conditions with poor ventilation. Diseases of poverty are found in these areas of unhealthy living conditions.

Gastro-intestinal diseases are associated with housing conditions amongst other factors and respiratory diseases such as pneumonia is associated with overcrowding. In the period of January to December 1983 one can see evidence of these diseases by the number of admissions to the children's ward at the Tintswalo Hospital.

Cause of admission	No. of admissions	% of total
Gastroenteritis/dehydration	271	20,4
Kwashiokor	175	13,2
Pneumonia	153	11,5
Typhoid	64	4,8
Skin infections	64	4,8
Parafin ingestion	62	4,7
Burns	59	4,4
All other causes	479	36,1
Total admissions	1327	100

Source: (Buch,E & de Beer,C 1984 p.6)

Housing is unaffordable to most people in Gazankulu. In an area study on Gazankulu it was found that the basic government built house costs R8 000, and the average annual expenditure of a family is R600, therefore people cannot afford it. (Moody and Golino, 1984 p.10).

CHAPTER 4

NON-HEALTH FACTORS AFFECTING HEALTH

In this chapter, various non-health factors that affect health will be addressed. These include rural housing; access to food and nutrition; as well as water and sanitation. It has been noted that various socio-economic factors affect a community's health status. From this recognition came the idea of the community medical approach which cites certain non-medical basic requirements for attaining and maintaining good health. These factors (housing, food, water and sanitation) are addressed because health cannot be seperated from them. The spread and/or prevalence of diseases associated with these factors are examined. Broad developmental programmes are advocated with co-ordination between various departments and with the community's involvement, towards addressing health needs of the community with the emphasis on preventative action.

RURAL HOUSING

In many developing countries there are no government plans for improving rural housing. The private sector also plays a minimum role in this field and therefore rural housing falls on the shoulders of those who live there. Many live in squalid,

A new social order with access to employment, good education, decent housing, a living wage and available effective health services must come into effect to ensure a decent, acceptable rural health status. What is required is a change in health priorities, from curative orientation and creation of hospital-based programmes towards more health promotion, prevention of diseases and the provision of primary health care for the promotion of community health. The basic community health problems affecting rural populations should be addressed. These include, especially the provision of clean water and adequate sanitation systems. This as well as other non-health factors affecting, such as, housing and access to food need to be discussed.

costs are incurred, the shortest distances travelled and where the quickest attention is received. Rural areas witness the greatest costs because transport is more expensive and distances take longer to cover. Because rural facilities are overburdened the wait for medical attention is often long. The effectiveness of the health services is further reduced by the absence of a well-organised infrastructure.

Rural health is inseperable from the economic, political and social structure of the South African state. Health provision is filled with the many problems of inaccessibility, overpopulation and poverty. The evidence of gastro-enteritis, tuberculosis and malnutrition indicate the perpetual pattern of poverty related diseases. The lack of education has been identified as another major problem in rural areas because it affects health awareness as well as employment, which in turn indirectly affects health.

Majority of the rural population suffer from diseases and illnesses directly associated with poor socio-economic conditions. Malnutrition is an example of how the system allows this to continue. Example: after being treated for malnutrition, children enter the same environment and therefore they relapse. "It has been said that South Africa does not have a health service but a disease service". (Seedat, 1984 p.101). Good health provision is dependant not only on facilities but also on political, economic, social and environmental conditions.

shortages of all level of workers (medical, nursing, paramedical) is a serious obstacle to the effectiveness of the health system. Resources are spent on medical education that is geared towards urban care with a trend towards specialisation and very little attention to preventative care.

PERSONNEL

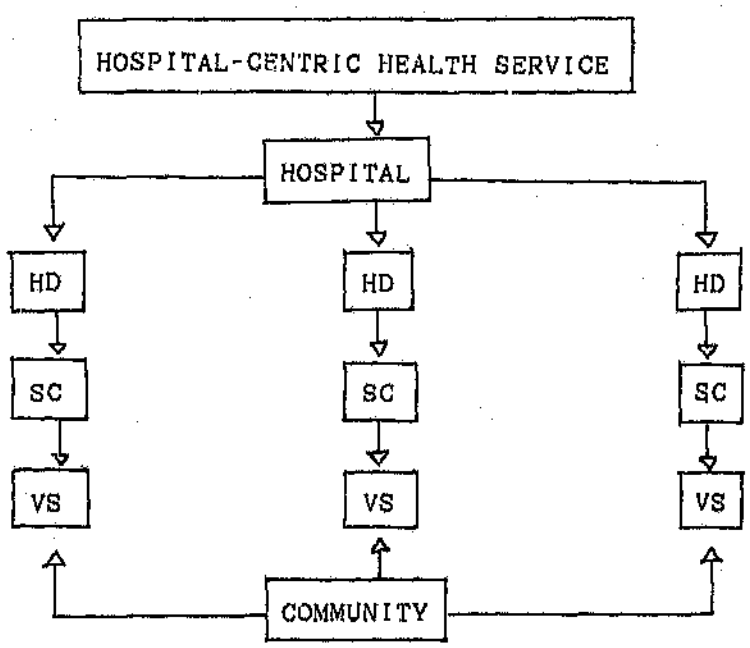
The ratio of distribution of doctors follows the "inverse care law", that is, the least personnel where they are needed the most. The quality of care is affected because of staff shortages and overcrowding of existing health services. Studies show that another problem regarding health personnel is the selection process of medical students as well as the curricula of medical education. A re-orientation of medical training is a requirement in re-prioritising health needs. What is required is more relevant medical education. The use of doctors alone is not feasible in delivering health care, even if their orientation of their training was changed. There needs to be training of other more appropriate health workers who perform various roles. The use of the least trained worker who can effectively execute the task is the most efficient use of personnel.

Studies show that access influences usage of services. Accessibility is measured in terms of time, costs and travelling distances. "Cheap" facilities are therefore those where the least

RESOURCES

The various own departments of health are responsible for administering resources. There is no significant revenue, apart from "South African" grants. In 1982 70% of Gazankulu's budget came from South Africa. Therefore the South African government has a say in how and where funds are allocated. (de Beer, 1984 p.58). The major hospitals are inaccessible to most people of the rural areas. The homelands are the one s who's needs are the greatest but they are deprived of readily available and adequate facilities. Rural health service facilities are not comparable with the rest of South Africa. In examining demand and supply of health services, actual provision does not meet the needs because of maldistribution of services as well as inappropriate health care priorities. The unfair distribution of facilities, staff and funds create a situation of underprovision.

Although the Gazankulu Health Plan centres around primary health care in the form of health centres; the lack of funds make it's implementation impossible. "Between 1976 and 1977, the South African government's contribution to Gazankulu's budget declined". (de Beer, 1984 p.58). Another major drawback is the lack of staff. Approxiamately half the population reside in the rural areas of South Africa but less than 5% of practising doctors are located there. The critical health personnel



HD: Health District

SC: Satellite Clinic

VS: Various Services including smaller clinics

The theoratical framework is suitable, although practical application is ineffective because of implementation problems such as: inadequate provision of facilities, lack of personnel, underutilisation and lack of funds.

Medical education: Many questions arose at the Southern Africar Labour and Development Research conference regarding the structure of medical faculties in our universities. (Pimstone, 1979). An elitist medical education training was found which follows Western models. This led to re-evaluating current medical models of training.

- should there be a curriculum change?
- should there be more emphasis on rural disease patterns?
- question the distribution of doctors
- is there a role for indigenous, traditional healers?

One of the World Health Organisation s objective is to re-orient health personnel training towards addressing the needs of the communities served. Community-based education focuses on community needs and is committed to attaining health for all. This type of education is provided in environments that graduates find themselves in. " It aims to equip graduates to be responsive to the health needs of the people ". (Ross, 1988 p.20). It is not purely academic because students must be able to realise and witness the socio-cultural environment of the people they serve in order to understand how these affect health.

Problems of medical education: It ignores the health needs of majority because of it s excessive emphasis on high-technology, hospital care. This is due partly to maldistribution of medical personnel as well as South African medicine adopting European

HEALTH CARE HIERARCHY

Facilities: Most of the resources are spent on curative medical facilities, which shows a bias towards hospitals rather than community-based medicine. In Southern Africa " the institutions are largely urban based and they are mostly located in White areas distant from and inaccessible to the Black majority ". (Lobstein et al. 1984 p.33). Disproportionate budgets are allocated for sophisticated equipment for treating a fewer number of the population. Facilities are inaccessible in terms of the barriers of location, cost and time.

Essential care: The type of care is not " essential " as suggested by the concept of PHC. Priorities are unrelated to majority of South African's lifestyles, but are rather geared towards Western style care. Health care is inversely proportioned to need.

Correct technology: Appropriate technology is not necessarily " bad ", and is seen as an alternative approach to health. In many countries in Africa, highly specialised training is inappropriate. What is required is a more " grass-roots " strategy to administer health care to the communities concerned. Often a situation of primacy exists where the better health facilities are concentrated in urban centres.

up community identified projects. Successful community projects are those which take into account the community member s ideas on identifying priorities. Health committees can be set up through democratic processes, and the health workers can provide support services for the community, for example by holding workshops on PHC.

Another issue raised is that users of services should have a say in the type of health care they receive and in how it is delivered. Health care has to relate to the needs of the people and people should participate in and contribute to the " planning and implementation of health care ". (WHO report, 1982 p.4). The community efforts in PHC projects geared towards social and economic upliftment in general will most likely succeed when they are mutually supportive.

RESTRUCTURING THE HEALTH CARE SECTOR

This tenant of the PHC approach requires a change in the delivery of health care. Questions that are addressed in this section are those of accessibility, correct technology, the health care hierarchy, affordability, essential care and the use of appropriate personnel. Medical training is evaluated againgst the needs of South African society. We observe a dependance on Western model of health care. An important priority is to extend health services to deprived communities. With budgetary limitations there is a need to priorotise.

conditions. PHC is wide-ranging and a broadly-based approach which is not purely " health " oriented. It includes various activities in non-health spheres and problems can arise. Administration and co-ordination can become a difficult task because of the various sectors working together. The most important aspect for this tenant of PHC to be achieved is intersectoral co-ordination, co-operation and effective communication.

COMMUNITY PARTICIPATION

The PHC approach emphasises community participation. In the 1960's community development projects that were undertaken attempted to " improve the living conditions of poor communities with active participation, and if possible with the initiative of the community ". (Walt and Vaughan, 1981 p.9). The idea is to enable people to help themselves by identifying their needs, making demands known and being involved in the decision-making process. The PHC strategy has an emphasis on popular involvement in health with active participation in identifying needs, problems and possible solutions.

A community participation approach is beneficial because it allows people to understand their health status and ways to improve it through preventative action. Health workers should not only have technical medical skills but they should also have organisational training in order to assist communities in setting

mothers ensures greater childhood survival of their children, and therefore improves the health status. Health-oriented education is essential. " Many indivituals and communities can be equipped with the knowledge and skills to achieve better living conditions and health status which are central themes to PHC ". (Phillips, 1990 p.280). People can be taught to improve their health by their activities, namely the benefit of a proper diet, increased cleanliness and nygeine awareness. Health education becomes a means of communication of how to prevent illness and how to promote good health. It is therefore an important part of PHC in order to achieve and maintain acceptable and reasonable levels of community health.

The orientation of health programmes is changing towards including many preventative aspects such as family planning and immunisation campaigns, as well as towards broader activities that directly and indirectly affect health. This encompasses an integrated, holistic approach to health and health care. Health impacts from changes in other sectors and this view of health is therefore not narrow and purely technical but rathe. broad and comprehensive.

Despite the fact that health care goes beyond only access to medical facilities, the major thrust of planning for health goes into physical facilities which do not necessarily correspond with improving the overall, general living standards and enviromental

educational, political, economic and social spheres. " The health of a population influences economic development and is influenced by it, it is itself and element or condition of development ". (Walt and Vaughan, 1981 p.89). We need to consider the " health " aspect of all areas of development. The health sector cannot operate in isolation to attain the objective of acceptable levels of health because disease and ill health are multi-causal and do not occur in a vacuum. As stated previously other factors contribute to health, such as sanitation, housing, education and food production. What is required is co-ordination between them, i.e. an intersectoral approach. When planning for health co-operation and collaboration must be maintained at various levels between these sectors.

PHC has social as well as developmental dimensions; social because the goal is to improve quality of life and achieve the greatest health benefits for the people. If the goal is attained (of improving quality of life and being healthy) then it contributes to socio-economic development. We need to promote lifestyles that are conducive to good health. A redistribution of wealth is necessary for changes in society and for communities to improve the circumstances. Intervention in the physical and social environments will have a positive effect on health.

Another critical factor is education in the promotion of health and the prevention of disease. Both school and adult health education is important. Improving the general education of

A definition of health includes improving living conditions and the quality of life. There is an interrelationship between health and social and economic development. " Health leads to and at the same time is dependant on a progressive improvement in conditions and quality of life ". (WHO publicaton, 1978). PHC is therefore part of the socio-economic development process. The PHC approach is vital towards achieving an acceptable level of health.

In September 1978 when the Alma-Ata Declaration was drawn up it provided a guide towards work in the health sector. PHC is comprehensive because it is promotive, preventative, curative as well as rehabilatative. PHC does not mean health care of a poor quality because a good PHC strategy requires a good referral system and technological and organisational support. The three fundamental aspects of this approach are:

1) socio-economic development,

2) community participation, and

3) restructuring of the health sector.

Each of these three tenants will be examined.

SOCIO-ECONOMIC DEVELOPMENT

For this tenant of PHC to be achieved a fundamental redistribution of wealth is required. Technical solutions alone do not work because illness and disease are also affected by social and economic factors. Solutions need to be addressed in the

CHAPTER 5

PRIMARY HEALTH CARE

The International Conference on PHC met at Alma-Ata in 1978 to express the need for action by governments, and health and development workers to promote the health of all people. The importance of basic needs was recognised along with the view that development (of health or any other services) had to be done with people and not only for them. In the 1950's the provision of health services was seen as the building of hospitals and the educating of doctors. The change in development theories brought about a shift in bringing things closer to communities, and the emphasis was on community involvement.

Definition of PHC: The Declaration of Alma-Ata defines PHC as "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to indivituals and families in the community through their full participation and at a cost that the community can afford and maintain at every stage of their develpment, in the spirit of self-reliance and self-determination."

The meaning of PHC has changed from purely "first-hand" contact with the health worker to include the principles state by the World Health Organisation (WHO) in this definition: i.e. accessibility, community participation, preventative/promotional services, relevant technology and viewing health as part of total care.

examples indicate that medical needs have to be adapted to specific conditions of communities and cannot be based on the health delivery systems of developed and Westernised countries. The health system should develop as part of broader developmental programmes. Changes in medical services alone does not improve public health levels by a significant proportion. It has been noted that in the West what contributed to majc changes in health were improved housing, nutrition, education i.e. non-medical factors.

South Africa's road to health should include changes in other sectors as well as in medical structures. A multi-disciplinary approach towards combatting disease and ill health needs to be adopted by incorporating housing, economic programmes and agriculture. This holistic approach towards solving health problems is advocated by the primary health care delivery system. We therefore require the integrated, intersectoral health policy of which primary health care is the cornerstone, and the criterion is treating the person in the environmental situation and not merely treating the symptom.

From other studies of water supply and sanitation programmes it was found that improvements in the quality of water, reduced diarrhoeal diseases by a third. Briscoe (1986 p.109) found that increasing the availability of water reduced diarrhoeal diseases by 34%. Both improvements in availability and quality reduced it by 40%. With excreta disposal, diseases were reduced by 40% as well. What is required is co-ordination between various departments, such as the Health Department, the Department of Water Works and Sanitation Department.

CONCLUSION

We cannot seperate health from other factors and conditions in the rural areas are not conducive to improving health care. To improve the situation we need to foster the creation of employment opportunities in order to ensure that people have access to income and thereby access to food. We need to address the inadequate water suppply and sanitation facilities; and promote community participation. Medicine cannot be isolated from the socio-economic setting.

When we examine examples from neighbouring countries on their health delivery systems (Mozambique, Botswana, Lesotho), we see a re-orientation towards addressing health needs of the broader community and a committment towards preventative action. These

participants as well as other village members would benefit through sharing experiences. When asked if other problems would be created through this project, for example would it divide people into haves and have nots; the participants decided that they would help others outside the group to build should they want to.

Work towards reducing illness is associated with poor sanitation for the whole community. Learning about pit latrines was accomplished through meetings. A scaled down model was built and the group members practised building them. Any difficulties encountered during actual production were discussed at weekly meetings. Was the programme effective? 96% of the group completed the building of the latrines. They actively helped others who were interested in building latrines. "People from neighbouring as well as distant communities have visited Madobi to learn how the women have worked together to build pit latrines." (Collins and Maluleke, 1984 p.4). The long term outcome was that they learnt to solve a community problem and could apply it to other problems. There was also an awareness of the necessity to work together to solve community problems. The community identified the problem, the solution and were actively involved in the process of overcoming the problem. The primary health care approach was applied with it's emphasis on community participation.

this does not exist. In metropolitan, white homes there are 2-3 taps per household but in Mhala the ratios are very high. In southern Mhala it was found by Wilson (1985 p.23) that half of the villages had no access to water. In southern Mhala the ratio of people:tap is 833:1 and in the northern region the ratio of people is 624:1. On average there are 760 people per tap. (Buch and de Beer, 1984 p.7). To combat water-related diseases, health education is vital in aspects regarding hygiene and nutrition. Also beneficial is the building of pit latrines.

A study of building pit latrines at the Northern Transvaal village of Madobi proved to have some success of projects with community participation. (Collins and Maluleke, 1984). The problem identified was the need to build pit latrines, and the lack of knowledge of how to do so. A women's group initiated the project and approached people to help in the making of the latrines. Participatory research was used with collective investigation, analysis and action. In investigating, various questions were addressed.

The problem identified was that of sanitation and a lack of knowledge of pit latrine building. The reason given for wanting to solve the problem was to help stop the spread of diseases. The group identified the solution as pit latrines. When questioned on who would be benefitting from the project, it was stated that

The rationale behind the Primary Health Care approach is that it is considered to be useful for addressing the health crisis. It s objectives are the development of basic health and other services; physical upgrading and the general development of the community. These objectives are essential in order to achieve acceptable levels of health.

This integrated approach is geared towards alleviating the health crisis. The struggle for health is not one for more hospitals but a struggle for more appropriate, essential care in a socio-economic situation conducive to development. This can best be tackled by adopting the Primary Health Care approach.

PHC PRINCIPLES AND STRATEGIES

PRINCIPLE	STRATEGY
1. Access	Deliver services where people need them. Use community health workers.
2. Essential care	Design appropriate curriculum and training to meet community needs.
3. Community participation	Awareness building, community identified needs, selection of community health workers and election of health committee.
4. Relationship between health and development	Integration and co-ordination of health planning with other sectors, such as housing, water supply, sanitation, education and agriculture. Intersectoral approach.

The emergence of the Primary Health Care approach occured as a response to the realisation that existing, vertical health care systems have failed the vast majority of people. The PHC approach's promotion of the idea that health service should provide for the majority and not the priveledged few started gaining acceptance. The previous emphasis on high-technology, facility-oriented and curative based care is found to be neither appropriate nor affordable care. Technologically centralised models were unsuccessful in bringing health to most people. The shift of emphasis occured because of inequalities in access and usage of health services. PHC existed for many years but became formally recognised and articulated in the mid-70's. The explicit formulation of the concept took place at Alma-Ata Conference in 1978. Since then it has been espoused as the strategy to adopt in order to move towards " health for all by the year 2000 ".

Primary Health Care as defined by the World Health Organisation incorporates preventive, promotive, curative and rehabilitative services. It encompasses more than medicine alone and includes economic , physical and social factors which affect health and welfare. Various health and non-health activities are incorporated in its programmes. Encouraging signs to ards achieving " health for all " is observed through community participation in and committment towards improving health by the implementation of the various primary health care programmes. However there are many weaknesses within the system. Problems of resources and funding; and inefficient or lack of intersectoral co-operation hampers effective PHC.

Health care is seen in a narrow context, and is synonymous with medical care, which according to the PHC approach is only one component of health care.

The second approach " regards health improvements as derived largely from the appropriate delivery of health services ". (Phillips, 1990 p.169). The view is that proper planning will allow for proper delivery of health care which will promote good health. It does form part of the PHC approach because it addresses issues of accessibility and the appropriate allocation of resources , facilities and staff. It aims to enhance the availability of health care through effective health planning. It however lacks certain PHC components such as community participation.

The third identified approach is broad in scope and views health in the context of generally improving living and environmental conditions. An entire range of activities is involved from medicine to housing to agriculture. It takes cognisance of the fact that improving health and quality of life is not merely achieved via direct health activities alone. It is therefore adopting the integrated intersectoral approach of the PHC strategy. Decisions are based on what the community perceives as as needs and it is a bottom-up approach, which is integral to the PHC approach.

FAMILY PLANNING: There is a need for reducing high fertility, through education. The family planning programmes are important. " The road to 'prosterity' is depicted as being through the reduction of the birth rate ". (Phillips, 1990 p.240). This goal should be included with other social welfare programmes, such as improving women's status. However the programme should not be forced onto the community because freedom of choice is vital. It is an important component of maternal/child health. It helps reduce the risks of repeated and/or unwanted pregnancies which can be detrimental to both to the woman's health. Family planning campaigns and promotion is required and it's implementation has to be with community participation.

CONCLUSION:

The various approaches to health care show differences in opinion as to who should provide care and what type of care should be provided. Three types of approaches have been identified; namely the medical approach, the health planning approach and the community developmet approach.

In the case of the first approach health is regarded merely as " absence of disease ", which is achieved through Western, technological interventions. " High quality, high technology medical services are considered to be the key to improved health. (Phillips, 1990 p.168).

In areas of poorer socio-economic conditions children are more prone to diseases therefore an important aspect of maternal/child health is disease-oriented. These programmes are often associated with family planning and health education. The services are often seen as seperate but have now been included in broader-based PHC. In accordance with the concept of using community health workers and indigeneous practitoners, the use of traditional mid-wives can be integrated with the formal health service.

ORAL REHYDRATION THERAPY: Whereas immunisation is a preventative measure oral rehydration therapy is curative but it is still " essential " care. This therapy is used in the treatment of diarrhoeal diseases, the underlying causes of which are poor hygiene, poor sanitation, improper food handling, infected water and malnutrition. Diarrhoeal deaths are often due to dehyration and oral rehydration therapy is a cheap, accessible treatment. Solutions can also be prepared at home. Apart from administering oral rehydration therapy, educational campaigns are essential to teach hygiene and proper food storage and handling. There is also a need for environmental action against the onset of diarrhoea, for example upgrading through the building of pit latrines. This illustrates that a specific selective PHC programme which is initially seen as vertical, can be incorporated or integrated with other projects that have broader health related benefits.

Community health workers are the appropriate category of health worker to bring health to a community. They share their knowledge with the people they serve. However this does not mean that doctors and other health professionals are unimportant. They too are needed but their training has to be adjusted towards a more bottom-up approach.

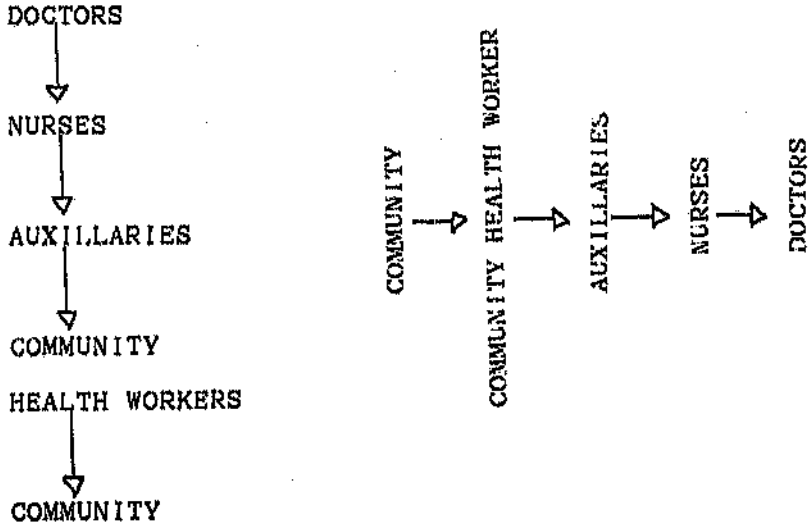
The goal of health for all can be attained by restructuring the health hierarchy, where community health workers lead the team and the community itself comes first. Community health workers have a variety of skills and how they work is adaptive to local situations. They provide accessible care to people amongst whom they live and work.

SELECTIVE PHC

Certain specific PHC programmes that are vitally important, especially in rural situations will be examined.

MATERNAL AND CHILD HEALTH: According to the World Health Organisation " maternal/child health services are a priority within any health system ". (Lobstein et al. 1984 p.64). This is because they constitute a large part of the population and also because of high death rates within these groups in many developing world situations. These programmes can be developed with other programmes, e.g. nutrition and health education. Within these maternal and child health programmes are the more specific family planning programmes and immunisation campaigns.

Important actors in this regard are village/community health workers who's work involves community improvement on a broad scale, and preventing illness before it starts through health education and actively promoting health. These PHC workers are key personnel of the health team. Werner's proposal of changing the hierarchy of skill in order to make health care more equitable and accessible is by " tipping " the health pyramid so that the community comes first and the doctor is " on tap not on top ", (Werner, 1977 p.12), as shown in the diagram below.



top-down vertical approach horizontal approach

(sources: Werner; Phillips; Lobstein and Frontline on Health).

poor people would rather invest in items they regard as more important than health. Secondly, it is political; health workers need to work in a situation that allows for popular control in development schemes. They have to work towards a situation of community participation in decision-making for collective self-reliance. (Lobstein et al. 1984 p.43). There is a great potential for community health workers, however their tasks will to a great extent be determined by the conditions of the areas they work in.

Werner found that community health worker programmes could be either " community supportive " or " community oppressive ". The former affects long term health and development of the community favourably, with genuine community participation. The latter however encourages dependancy and adopts a paternalistic approach. We need to strive for " community supportive " programmes.

These workers need to be encouraged and the health sector has to be supportive in their supervision and allow them to take responsibility. The doctors should be referred to when health auxillaries cannot help. The support of other levels of health professionals is vital. " Community health workers must be able to rely on more skilled people for guidance and training ". (WHO and UNICEF report, 1978 p.40).

The top-down hierarchy needs to be addressed towards serving people s needs and becoming a more " people-supportive " approach. One step in this restructuring of the health sector is to " deprofessionalise " health.

Community/Village Health Workers: Lay health workers can perform certain tasks such as lucating the community on health matters, such as family planning . People from within the community are often perceived as more credible than outsiders. Community health workers such as those trained in Swaziland (called rural health visitors) prove valuable because they provide a service in the absence of clinics. In the Swaziland project the trainees were selected through community participation, which is a vital tenant of PHC. Positive results were observed when the scheme was evaluated.

In many of the world s poorer areas the village health worker is seen as part of the solution towards addressing the enormous health problems. " It has become clear that in the rural areas health care provision could not be accomplished by health professionals alone ". (Werner, 1977 p.1). These health auxillaries are selected by the communities they serve and are accountable to them through a representative body. Their main role is the promotion of good health and helping communities reach that goal. Their skills vary and one of their most important tasks is health education. They are also involved in promotion of pit latrines, monitoring diseases and co-ordinating community development activities. By using simple technologies community/village health workers can also give the people they serve an understanding of health care and some skills, thereby fostering self-reliance.

General problems that face this category of health worker are firstly economic: the problem of funding is critical and most

The way it should be:

- community based
- generalist
- humanist
- preventative

Health Personnel: The medical profession is predominantly White-dominated. There is a trend towards specialisation which is excessive in a country requiring more primary care. " A problem of particular importance in the field of medical practitioners in South Africa is the unequal distribution and even maldistribution of medical practitioners ". (Van Rensburg and Mans, 1982 p.211). Doctors are excessively concentrated in urban areas.

The staffing of clinics need not be by full time doctors. Nurses can be trained in a practical, problem-solving approach to add to his/her skills a more comprehensive approach. The tasks would include examinations, history-taking and counselling. In this way nurses can treat patients and refer only where they are ill-equipped to deal with the problem. The doctor therefore becomes a consultant and trainer and there is a re-evaluation of health worker's roles. Both Pugh and Sapire in their research found that medical assistants, with upgraded skills are capable of running clinics effectively. (in Westcott et al. 1979 p.28).

Reliance on the clinic approach alone is insufficient as the burden of health care provision would fall on doctors and nurses alone. The resulting problems would include staff shortages, wastage of skills as doctors and nurses will be doing tasks that auxillary health professionals could do.

models. A great deal of medical graduates focus attention on specialist education, that do not affect most people in our country. There is also too much " academic " focus in the course and the curriculum is too narrowly defined. Current medical education places too great an emphasis on curative care even though most illnesses in South Africa require preventative medical solutions. " The unfortunate result of these problems is that medical graduates are inappropriately trained to meet the health care needs of our population ". (Lazarus, 1988 p.36).

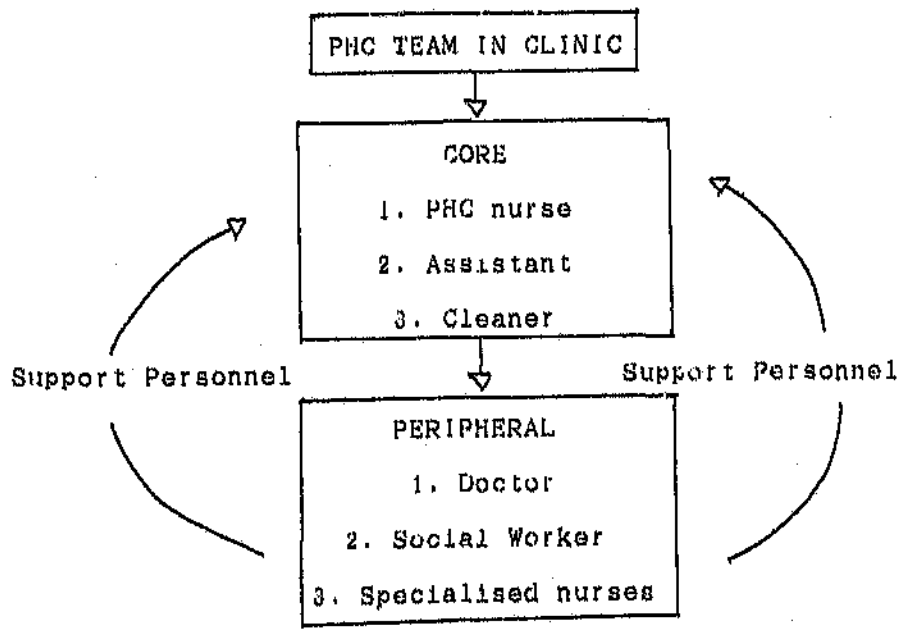
Possible solutions: To bridge the gap between how medical personnel are trained, and meeting the needs of the people one solution would be to develop disadvantaged community's socio-economic situations. Changes need to be made in student selection; a differentiated educational process must be embarked upon which is community oriented and incorporated traditional medicine. The recognition of indigeneous healers is important . They have to learn from each other to achieve a greater understanding of both patients/community and effective health care. " " Medical education in South Africa must move away from exclusive reliance on standards appropriate only to a small minority of it's population ". (Lazarus, 1988 p.43).

The way medical education is:

- hospital based
- specialist
- academic
- curative

PHC nurses face constraints such as shortages of staff, drugs and equipment and they therefore cannot change the health service They work within an inadequate system. The lack of resources result in poorer quality of care. Health workers in the area learn to cope and work within the constraints of the system, and often in the homelands health care that is unacceptable elsewhere is accepted and practised.

For effective PHC especially rural PHC what is required is good teamwork. The PHC nurses work in clinics and serve the surrounding areas. They form the " core " of the PHC team as their duties include " diagnosing, treating, providing emergency care, ensuring safe pregnancy and delivery, educating the community about health and doing community health work ". (Buch, 1986 p.137).



The tasks of a rural PHC nurse is beyond purely curative and is broad based, i.e. community health. They work in clinics without doctors and therefore have to be able to supply emergency care. She or he has to be able to diagnose and treat, or refer patients to the hospital if they are unable to treat them. They also have a role in providing mother and child care, educating the community, supporting community development and being a link between the community and the health service. (Buch et al, 1984 p.2). They are seen as the appropriate level of health worker because they are more adaptive to the community situation than conventionally trained medical doctors.

The ideal number of PHC nurses required for the region has not yet been reached because the number of nurses able to be trained at Tintswalo is limited. In assessing whether PHC nurses are skilled for the jobs, it is found that their curriculum includes clinical care as well as community care. Student attitudes are evaluated and re-oriented towards relating to people in order not to alienate the community. PHC nurses can be well trained to perform their duties effectively. To ensure this PHC nursing graduates are further trained as the teachers of PHC nurses. To ensure that the health service operates efficiently the PHC nurses require a good support system and this includes communication, transport and an efficient referral system. However these nurses work in poor conditions which have to be improved if they are to have an impact on health care.

the quality of care that is available. Not only is the hospital understaffed but so are the clinics which have a vital role in delivering health. The estimated need for the amount of nurses for the effective staffing of clinics, is more than double the actual number presently employed. At the clinics many patients do not receive full treatment because most of the nurses are not primary health care nurses, and cannot diagnose and treat certain illnesses. The clinics are ill-equipped in terms of medication and equipment. Clinics need to have a good referral system to the base hospital. The infrastructure and transport problems affect efficient referrals. The key to a good referral system is effective communication. There is a lack of care beyond the clinic itself. (Buch, Evian and Stephenson, 1984 p.4). This means that there is not enough involvement in other PHC activities.

How well do the primary health care nurses fare?

The successful implementation of PHC nurses in Soweto after the 1976 violence gave the impetus for recognising the importance of these health workers. From 1980 PHC nurses were trained at Tintswalo hospital because it was found that they are " the most appropriate category of health worker for the task of delivering accessible high quality PHC to rural villagers ". (Buch, Evian, Maswanganyi, Maluleke and Waugh, 1984 p.1). For them to be effective there has to be a sufficient number who are effectively trained and supported, and who work in favourable conditions.

Problems of distance, cost and alienation are the key factors in decreasing accessibility; and therefore decreases the amount of health care being met, as against the need. It is therefore the poor who are excluded from health care because they are the most affected by high costs and expensive transport. Overcoming these barriers will increase accessibility of health services.

DISTANCE	COST	ALIENATION
Most live further than optimal distance from the health service	Cannot afford increase in health care	Staff attitudes Elitist relationship with the community
BARRIERS TO ACCESSIBILITY THAT NEED TO BE OVERCOME		

What quality of care is available for the people attending health services?

Figures for the 1982 budget of Tintswalo hospital and the 10 clinics in the Mhala district indicate that over 80% of was utilised on staff salaries. (Buch and de Beer, 1984 p.14). The doctor to patient ratio is very high and unfavourable, and there is a dire shortage of facilities and staff. These factors combined with an overall lack or limitation of resources, limit

The cost of health care also determines accessibility. In Mhala the cost is beyond the means of the community. This can be seen by the fact that when there was an increase in fees, attendance dropped. Confirmation that people cannot afford care is evident by the fact that majority of patients are seen at the beginning of the month when people have more money, (ibid,p.8). Night-time care is inaccessible because clinics are closed. Although the hospital is open at night people cannot afford to travel there because the usually expensive transport costs are even higher.

Another factor hampering accessibility is if health workers alienate people. If this occurs people will stop utilising the facilities. Health workers can prevent alienation by not being elitist, and by developing good relationships with the community. Another method of preventing alienation is to be sympathetic and to " show respect for traditional beliefs and practices ". (ibid, p.12). Examples of health workers increasing alienation of people from health services are; not informing people of their illnesses, using words or languages that are not understood, and discouraging or even mocking traditional beliefs. A method of increasing accessibility would be to train and work together with traditional healers and indigeneous practitioners. This is possible because care from these sources is available and utilised in Mhala.

Is PHC the main focus of the health service?

The limited resources are aimed primarily at the hospital which is seen as the main focus of the health services. The World Health Organisaton has stated that hospitals should play a supportive role to PHC rather than vice versa. This is because PHC is more cost-effective and accessible. In the homelands the hospitals utilise most of the health budget, but these hospitals are still understaffed and underfinanced so that the quality of care is compromised. We find that PHC is not central to the health service. Medical education is also geared towards curative-based methods and primarily focuses on urban care. Therefore the staff have inappropriate training for PHC tasks.

Is health care universally accessible?

An accessible service is one that is located close to people and provides care at all times at an affordable price. Tintswalo hospital is the only one in Mhala and is situated in the north-western corner of the area. Transportation to and from the hospital is both inadequate and expensive. More than half the population live further away than the optimum 5 km distance away from a health facility. The Tintswalo hospital serves the entire district which comprises of 52 villages. The majority of patients in 1984 came from only 8 villages, this indicates the hospitals inaccessibility. This supports the statement that " distance problems influence patient's attendance at the health service ", (Buch and de Beer, 1984 p.8).

THE HEALTH SERVICES AND PHC

The key elements of the PHC approach will be examined in its application to the homeland situation. It has been argued that the approach is inappropriately applied because of the racial and economic policies. The main principles of PHC are: that it should be a part of equitable social and economic development, it should be the primary focus of the health service, health care should be accessible and of a high quality, and that the community should participate in health issues.

Is PHC part of equitable socio-economic development?

It is understood that the socio-economic conditions determine the health status of people. What is required to correct the imbalance is a redistribution of wealth and participation in the political process for people to be able to meet their socio-economic needs. Access to income is required for access to health. It has already been stated that the homelands have a poor socio-economic profile (inadequate and limited access to land, poor water supply, poor education and a lack of employment opportunities) and Mhala is no exception. The poor conditions are indicated by the fact that diseases in the homelands are associated with poverty. PHC is therefore not associated with equitable social and economic development. This key feature of the PHC approached is not realised yet, mainly because of unequal distribution of wealth.

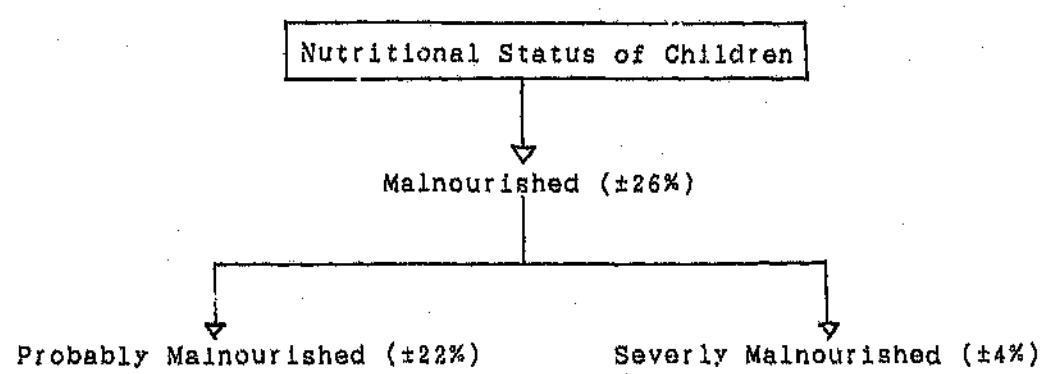
TUBERCULOSIS: In 1983 the incidence of tuberculosis in the region was high. The number of confirmed cases at the hospital was close to 300 and just under half of pre-primary school children needed treatment for tuberculosis. (Buch and de Beer, 1984 p.4).

CHOLERA: There was an outbreak of cholera in 1981. This disease is associated with poor and unsanitary water supplies.

INFANT MORTALITY RATE: On of the most reliable indices of poverty and indicator of the general standard of living of a population is it s infant mortality rate. "In a 1980 report, a RAU team estimated an infant mortality rate for Gazankulu of 9.34% for girls and 12.6% for boys." (Harries, 1984 p.8). Life expectancies are also low.

In Mhala because of the inadequate water supply people have suffered from water-related diseases such as cholera (29.4%), infant gastro-enteritis (15.1%) and typhoid (14%). The main children s diseases that are treated are poverty related, such as dehydration and malnutrition. They are also the major causes of death in children.

immunisation campaign were examined for malnutrition. Acceptable recognised indicators were used to determine the nutritional status of children. A very high percentage of the incidence of malnutrition was found. The results of the research indicated that over 26% were malnourished. Of these 22% were between severly malnourished and problably malnourished; and over 4% were severly malnourished. (Buch,1986 p.34).



Buch and others have stated that the figure of 26% of children that are malnourished is an underestimate and that the actual figure should be higher. However, even this figure is too high and therefore measures need to be undertaken to address this problem. Malnutrition is a consequence of poor socio-economic conditions and poverty and therefore broader community measures need to be taken.

TYPHOID: The disease is endemic in this region. Between the mid-70's and the early-80's the number of reported cases increased.

WATER: The major sources of water are boreholes. There are too few in relation to the number of people in the area. Apart from insufficient numbers of boreholes, those that do exist are inadequately maintained and therefore worsen the situation. People very often have no access to clean water. (Check chapter 4).

TRANSPORT: This service is not publicly provided. There are no buses and people use taxis, whose prices are beyond the affordability of people.

EDUCATION:The poor educational system is evident here. Pupil-teacher ratios are high. There are often unqualified and under-qualified teachers as staff and resources are limited.

The socio-economic profile of Mhala is extremely poor. Following is the associated diseases of poor socio-economic circumstances.

DISEASE PATTERNS

MALNUTRITION: The Mhala district is indicative of other homeland areas. It has widespread poverty, low income levels, poor water supply and poverty-related illnesses. Malnutrition is one such disease associated with poverty. Children at the 1983

SOCIO-ECONOMIC CONDITIONS

To indicate the level of poverty in Gazankulu the Institute for Development Studies at the Rand Afrikaans University undertook a survey, and the results are the following:

LAND: "In Mhala ± 152 000 people live on 1 204 square km, therefore the population density is 126,2 people per square km". (ibid, p.3). The villages are closely situated to each other and access to land is limited. Another factor which hampers development is that the available land has a poor agricultural potential. "The population of Mhala district has almost doubled in 10 years, from 66 251 in 1970 to 128 516 in 1980." (Harries, 1984 p.3). This places a burden on already overcrowded areas as well as on the availability of arable land.

FOOD: The yield produced by the land is insufficient to sustain the people and often people do not have enough money to buy food. The evidence of this is observed by the high rate of malnutrition. The average income is very low and is inadequate to especially as the cost of food in rural areas is very high. (Check chapter 4).

INCOME: Agriculture cannot provide enough money for people to buy necessities and therefore many people are pushed onto the labour market. It has been estimated that more than half the families in Gazankulu are dependant on income from migrant labour. (Harries, 1984 p.6).

CHAPTER 6

OVERVIEW OF HEALTH IN MHALA

The sample area used to examine the primary health care approach in health delivery is the Mhala district of Gazankulu, which is an isolated area lying between Tzaneen and Nelspruit in the north-eastern Transvaal. There is extensive poverty in the homeland and this district can be seen as representative of rural homeland conditions. There are approxiamately 152 000 people living in the 57 villages which vary in size. The health services are underdeveloped and consist of "one 260-bed hospital (Tintswalo), one health centre, ten clinics and a mobile clinic". (Buch and de Beer 1984, p.i).

Health problems that are associated with poverty are observed because of poor socio-economic conditions. "The health service cannot overcome this poverty and does not provide high quality, accessible health care." (ibid, p.2). Fragmentation of health services created by the homeland policy exercabates the difficulties. This chapter discusses the socio-economic conditions in Mhala. This is followed by an outline of the disease patterns which coincide with poverty, and an especially important indicator is malnutrition. The health services and the use of primary health care is then examined, followed by a brief discussion of the effects of the homeland policy.

◊ Improvements in education will lead to health awareness and health literacy. There has to be an increase, specifically in " health " education. Education and decent housing are essential for promoting health as well as the regulation of the provision of sanitation and clean water.

◊ The health services should be accountable to the community and should allow for community participation, which is essential. The health system should be people centred. The community should be involved in the selection of community health workers and they should be encouraged to establish local health development committees. The community health workers should work together with the parents, children, educators and other workers in the community. People should be part of the decision-making process in matters that relate to them.

◊ Appropriate standards in health has to be provided. PHC with it s emphasis on preventative medicine should be the main focus of the health service.

CONCLUSION: The goals that are to be achieved are those of equity, equality and accessibility in the health sector, in order to achieve an acceptable level of health. This can partially be achieved through adopting the primary health care approach. The health of a community reflects it's socio-economic conditions; and therefore in attaining good health, the environment has to be

◊ Health should be recognised as the basic right of all people.

◊ We need to upgrade the environment and improve both the physical and socio-economic conditions in Mhala. A health care system should be woven with social development.

◊ There needs to be more government responsibility in health care provision. An increase in staff and funding is required. There has to be equal distribution of resources to services. Resource allocation needs to be increased by the state to meet rural health needs. The allocation of funds should be geared towards the more preventative and promotional medicine. There has to be a reallocation of resources (both human and material) to rural areas.

◊ There should be easy access to and an even spread of facilities. The distribution of services should be based on the needs of communities. Health facilities have to be upgraded and expanded. The health structure is inadequate in Mhala and what is required is an appropriate hierarchy of services and facilities. There is a need for mobile clinics to serve villages without facilities, as well as for health centres and more fixed clinics. (Buch and de Beer, 1987).

◊ School health services should be provided to screen children and provide care. Care of the aged should also be provided.

- how do the socio-economic conditions affect health?
- what is the impact of health services on general development?
- do the health facilities respond to the needs of the people?
- are the facilities adequate?
- are they efficient and appropriate?
- are they effective in achieving the objectives of the primary health care approach?
- is the community involved in health?

The people of Mhala are living in a poverty-stricken atmosphere and in a neglected state. The plea to planners are to introduce and implement efficient systems of sanitation and drinking water. The major problem found was that the level of health of the rural population is low and the health care situation follows that of a developing society because of poverty. Other problems include the environmental conditions; socio-economic conditions i.e. low income levels, lack of employment and low health literacy; and inadequate as well as poor facilities in the water, sanitation and health sectors. There is a high incidence of preventable medical conditions and poverty-related diseases.

GUIDELINES

To create a "healthy" living atmosphere, a development strategy has to address the above-mentioned problems. An overall improvement of the health status could be achieved through various means. The following guidelines are given as a way to achieve the objectives of the Alma-Ata Declaration and comprehensive health care:

CHAPTER 8

CONCLUSION

"The function of the health service is to promote health for all, to prevent disease, to cure the sick when this is possible and to care for them when it is not." (Cente for the Study of Health Policy, 1988 p.89).

Health services in South Africa do not live up to the criteria cited in the Alma-Ata Declaration. The current health system in South Africa is characterised by racial divisions. The development of urban, curative care is maintained at the expense of rural, primary care; through unequal resource allocation. An evaluation of the health system follows with some guidelines towards attaining decent health levels of communities.

EVALUATION

The assessment of health services and provision allows us to learn from past experiences and improve present activities. "The purpose of evaluation is to improve health programmes and the health infrastructure for delivering them, and to guide the allocation of resources in current and future programmes." (W.H.O. 1985, p.5). In the evaluation process the following issues were examined regarding health:

problem facing the unit is lack of funds and resources (both financial and human). With more resources allocated towards rural primary health care the unit will be able to continue and expand it's activities.

Village Development Programme: The PHC approach demands close co-operation between the community and the health sector regarding all aspects of development. The health services development unit is involved in community groups in certain villages. The unit is involved in four large and two smaller villages in Mhala. In 1982 the village development programme was associated with the Environmental Development Agency and started various women's groups. The groups were organised a: .d basic PHC projects and community participation was advocated. The main problems identified were malnutrition, poor hygeine, problem of health and general illiteracy, poor quality of land, lack of adequate sanitation and infected water supplies. Projects were therefore centred around these problems. The main purpose is to raise community health awareness through health education, conduct health surveys in the area and to develop a number of projects such as gardening, the building of pit latrines, in order to improve the socio-economic circumstances.

Other work associated with the health services development unit is the creation of a resource centre for all to use. There is a need to attract committed staff who are trained in rural PHC. Staff development projects are used to provide organisational, educational and community health skills. Personnel development is essential to developing appropriate health care delivery in the region. There is a need for continual evaluation of work carried out. The most progress has been achieved in the educational component of teaching and developing PHC workers. The greatest

towards making PHC nurses more acceptable to their colleagues. They work under difficult conditions, as rural services are often understaffed and lack resources. Apart from dealing with purely health issues in the Mhala district, some PHC nurses have helped to set up community groups to deal with relevant health and social issues.

The other two projects within the personnel development programme are, the continuing learning programme and the training programme for the educators of PHC nurses. The former began in 1986 and runs various activities to support PHC nurses. It provides continual educational upgrading for graduates of the PHC nurses training programme. The continuing learning programme aims to help PHC nurses with problems they encounter and to " assist them to meet challenges and to maintain an adequate level of clinical and community skills ". (Kanji and Evian, 1987 p.11). The second project is a course run for those who teach the PHC nurses. It was also established in 1986. It is a vital programme because it educates the promoters of primary health care.

Clinic Services Development: A number of clinic service development projects have been initiated in conjunction with Tintswalo hospital. The types of programmes developed includes health screening at the school level; mass immunisation; oral hydration and nutrition education unit; and assistance to certain health centres.

are often isolated and it is at the clinics where village people have their first contact with health care. The duties of these nurses is to run the clinics, provide comprehensive care and promote community health and community development.

The training programme was initiated in 1981, to train registered nurses over a period of one year. The objective is to educate PHC nurses to provide comprehensive care. Nurses from the surrounding regions attend the post-graduate course, and on completion return to their base hospitals, from where they are sent out into the village clinics, health centres or mobile clinics. Apart from teaching them PHC skills, the course deals with how to work with village people and attempts to impart knowledge on the " correct attitudes " in order not to alienate people. A necessary skill is to be sensitive to the problems and needs of people who come from underdeveloped communities. PHC nurses have to be supportive of these communities. A major task is for them to " share their knowledge and skills with the community/village health workers and with the village people in general ". (ibid, p.1).

Upon evaluation of the course certain problems were highlighted, these nurses' skills overlapped with those of doctors and/or social workers,and he or she is isolated. PHC nurses do not receive adequate support because doctors feel threatened by " non-doctors " performing certain doctors' tasks albeit efficiently. (ibid, p.4). Recently progress has however been made

participation and redistribution of resources towards primary care level are used in the programmes and projects. There are constraints in the implementation of a progressive PHC approach such as the unjust structure of health services with it's racial, curative and urban biases. Another major constraint is the maldistribution of resources allocated for the homeland health services. Despite these constraints the unit has strived towards utilising the PHC principles in order to attain more acceptable standard of health.

The unit has various components and they are all headed by the steering committee of the unit. Various projects are under way of which there are three of primary importance; namely, the PHC personnel development, the clinic services development, and the village development programme.

HEALTH SERVICE DEVELOPMENT PROJECTS

PHC Personnel Development: There are various projects within this programme, of which the most important one is the training programme for primary health care nurses. The training of this category of nurses is the main objective of developing appropriate personnel, because these health workers are appropriate for delivering health care in rural regions. In rural areas, the district clinics are the main facilities where from health care is delivered, and these are staffed by nurses. They

CHAPTER 7

THE HEALTH SERVICES DEVELOPMENT UNIT AND PHC

The health services development unit is a non-governmental organisation and works alongside the Tintswalo hospital and the Gazankulu Department of Health. The unit was established in 1982 and is based at Tintswalo hospital. It is donor-funded, by the Anglo-American Chairman's Fund and is an outreach programme associated with the Community Health Department of the University of the Witwatersrand Medical School. (Evian, 1988 p.1). The unit promotes projects that would provide for health care for the deprived rural areas of Gazankulu. Projects in the training and development of health care personnel is made possible through the unit s link with the university. Although the unit is independantly funded it works closely with the university and thereby gives it credibility to carry out projects.

The primary reason for the establishment of the unit was to re-orientate the priorities of the health sector towards the actual needs of the people it serves. Racial inequality in South Africa has resulted in differences in health care availability and quality amongst various groups. The health services development unit has tried to promote projects that will allow for change and which "are appropriate for a future equitable health service." (ibid, p.2).

The unit has attempted to abide by the Alma-Ata Declaration of 1978 on primary health care. The notion of community

EFFECTS OF THE HOMELAND POLICY

The health services of South Africa are fragmented. This can be seen in the case of Gazankulu and Lebowa. Tintswalo hospital serves the Mhala district of Gazankulu, and Masana hospital serves a district of Lebowa. Initially each hospital served communities surrounding them irrespective of which district they people came from. Today Tintswalo does not serve communities close by if they fall under the jurisdiction of Masana. This results in a wastage of time and transport costs increase, and it " weakens an already inadequate support system ". (Buch and de Beer, 1984 p.17). Policies are no longer co-ordinated and efforts are not combined.

People in Mhala have a disease profile that is associated with poverty and the health service does not provide accessible care. Only a small percentage of the need for health care is met. The primary reasons are staff shortages and a lack of resources for facilities and essential equipment. Socio-economic development, which affects health is hampered by unequal political policies. Health care is also adversely affected by seperate health services. Health care in the homelands do not reach the standards of the PHC approach.

However certain PHC work is undertaken in Mhala and these are discussed in the next section.

The core is the vital component of the PHC team. Members need to relate well with each other. Leadership should not be elitist. For effective results the PHC team needs to be trained and have a good support base, which is the peripheral component of the team. In South Africa rural PHC team's most pressing problem is that there are not a sufficient number of members, i.e. staff shortages.

" The ingredients of a true PHC team are good interpersonal relationships with facilitatory leadership of an adequately sized group who have been selected carefully, trained appropriately and who are well supported ", (ibid, p.140).

This goal needs to be achieved because to ensure the implementation of primary health care and good team approach is required.

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examined, and appropriate changes have to be made. Such changes can be made within the housing and education sectors; as well as in the provision of adequate sanitation and clean water. Development policies therefore need to be integrated. The objectives are providing health for all; and unifying and integrating the health system with other sectors. This can be achieved through the primary health care approach, which addresses the main health problems in the community and provides promotive, preventative, curative and rehabilitative services because it is comprehensive in nature. Primary health care is conceived as a major strategy for development and as a key towards improving health for all.

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