SECOND CARNEGIE INQUIRY INTO POVERTY
AND DEVELOPMENT IN SOUTHERN AFRICA

Rural health care -
the tears and joy
by
M Ramphele and R Ramalepe

Carnegie Conference Paper No.204

Cape Town

13 - 19 April 1984
RURAL HEALTH CARE - THE TEARS AND JOY

INTRODUCTION

This paper sketches some of the experiences of the authors over a period of seven years 1978 - 1984 as Community Health workers in the rural district of Tzaneen in the N.E. Transvaal; it makes no pretence at a scientific presentation, but rather explores some of the relationships, conditions and attitudes of a rural poverty stricken community.

BASIC BACKGROUND INFORMATION

1. POPULATION ESTIMATES

The Community served consists of a mixture of Tsongas and North Sotho speaking people who have been living in this area for decades with intermarriage between the two Tribal groups on a very large scale. The artificial divisions along "pure tribal lines" is a nightmare even for an enthusiastic South African Homeland Government system. The people live in settlements, largely new ones, created over the last 10 years, which consist of clusters of villages stretching eastwards from Tzaneen along the Lydenburg road towards the Olifants River constituting the Magisterial districts of Naphuno (under Lebowa Government) and Ritavi (Under Gazankulu Government). The population estimates based on the 1980 census are 79,000 for each of these two districts, which is a gross under estimation of actual population number which is closest to 100,000 in each instance.

2. SOCIO-ECONOMIC CONDITIONS

(i) HOUSING AND LAND AVAILABILITY

The people live on plots of 30 x 30 m allocated to them by the various Chiefs in charge and the size of these plots allows for the building of a house, a toilet and leaves space for a sizeable vegetable garden. The type of housing varies from shacks, neat rondavels to well built houses depending on the means of each family.

2/There are .......


d/There are .......

...
There are 2 townships within this area with typical four-roomed houses which people improve according to their financial means. The hardest hit people are the people who have recently moved off white-owned farms to settle in these rural villages who are mostly destitute and have the worst form of housing as a result.

(ii) SCHOOLS

Information provided by the local Education Circuit Offices indicates - that there are altogether 125 schools in the area:-

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Primary</td>
<td>29</td>
</tr>
<tr>
<td>Primary</td>
<td>95</td>
</tr>
<tr>
<td>Technical School</td>
<td>1</td>
</tr>
</tbody>
</table>

The Post Primary schools include 2 teacher training colleges. There isn't a single operative Pre-School in the area - there are about 5 creches which are largely community initiated and run. The teacher pupil ratio is on the average 1 : 5 with extremes going up to 1 : 100. This has to be seen in the light of another serious disability - unqualified teachers; 80% of teachers here have only J.C. and 2 years teacher training.

Matriculants with 2 or 3 years training are mostly teaching at Post Primary schools and in some cases up to Matric level. Graduates are hard to come by and most high schools have only 1 or 2 such teachers.

(iii) EMPLOYMENT OPPORTUNITIES

These are limited on the whole, but the situation is now reaching crisis proportions with the current drought and the economic recession.

The number of registered work seekers (men) stands at 1000/mth at the local Magistrate Office with no prospect of finding work.

Most people here work as labourers in the Local Tzaneen town in the commercial, industrial (rudimentary) and farming sectors with wages ranging from R28 - R50 (farms); R100 - R300 (Commercial & industrial including transporation) and higher incomes for the small section of civil servants in the professional categories viz, nurses, clerks, policemen, teachers and even soldiers.
Seasonal farm labour is a category worthy of special mention because of its prevalence and effects on the family life of people in the area. The bulk of seasonal farm labourers are women who are transported early in the morning on open trucks or trailers pulled by tractors from as early as 4 a.m. and are brought back in the evenings up to 7 p.m. depending on the distance from the particular farm. Wages are the lowest in the area from R28 - R50, there are no obligations on the part of farmers to provide rations, sick benefits, sick leave, accident cover or any service normally taken for granted in civilised working relations. Accidents are very common to and from the farms because of poor conditions of the trucks or tractors, long working hours of the drivers concerned and the overloading which is a rule rather than the exception. The traffic authorities turn a blind eye to these road hazards even when people are maimed or killed there's no redress to the families who would not know anything about third party claims and the like.

The people suffer all this in silence and the conditions are getting worse with the present drought making even this form of employment difficult to come by.

There is a new phenomenon of employing women in formerly hard labour categories reserved specially for men viz diggers on the road, dam building, building work etc. These women suffer immense physical strains especially given their nutritional status, high parity and the numerous household responsibilities. This practice stems from the high rate of unemployment and the stated intention of homeland governments to provide employment to all, but all is an exploitation of the worst kind with women being preferred to men because the former can be paid lower wages for the same jobs.

3. LOCAL POLITICAL REALITIES

The people we serve are designated citizens of either Lebowa or Gazankulu depending on tribal affiliation and are under the direct authority of Chiefs in the Homeland government system; the latter are paid government officials who have the power to grant residential sites, trading licences, permission to build community schools and clinics in the area.

4/As a general .....
As a general rule this system gives rise to a lot of corruption, nepotism and very few chiefs are sympathetic to genuine efforts at community development; they feel threatened by any activity in which they have no direct say or control over.

The homeland leadership is an extension of this local system and tends to share the same disabilities of corruption, nepotism and or inability to effectively curb these practices. Liquor licences are the prerogative of people with ears in higher places and it is not uncommon for the chief Minister with his whole cabinet to travel hundreds of kilometers to one one liquor outlet or the other in the name of "progress and development".

The greatest problem is the friction which has developed between the two tribal groups as a result of this artificial division after decades of harmonious living together. People get fined up to R80 for trespassing in one or other area and vast new slums have been created by migration of people from one tribal area to the "right one".

In one case Sotho patients were transported by buses, trucks and ambulances from Shiluvane Hospital (handed over to Gazankulu in 1981 after a period of disputed Administration by Lebowa Government) to Meetse Hospital 36km away. The situation borders on insanity.

Rural people are on the main apathetic, unpoliticised and easily exploited by all these forces at play in these areas and the local folk here is no exception.

4. SOCIAL ORGANISATION OF THE COMMUNITY

(i) THE MEN

Chauvinism is very strong here, bordering on the ridiculous, especially in view of the fact that most men are migrant workers and thus not available to play the role of father, head of family and decision-maker as custom has it: House work and most family responsibilities are regarded as women's work with few men even prepared to share these tasks.

(ii) THE ELDERLY AND DISABLED PEOPLE

There is a predominance of old women over men most are living with their children either unmarried daughters or married sons.
there is however a fair number of old people (this trend seems to be increasing) who live on their own with no immediate family member being prepared to take them into their homes. Some of these old people without family care tend to live very unsatisfactory destitute lives. The elderly are however a very important source of income for the home by way of their bimonthly old age pension pay-outs of R114 in addition to serving a very important role of being child-minders, thus releasing mothers to earn additional income for the family.

There is a very sizeable number of old people beyond the age of 60 years who are not receiving any old age pensions on the pretext that they have no proof of their age - how on earth! Exact figures are not available but estimates based on information from Magistrates Offices are that 1000 are on the waiting list at any given stage with only a small percentage being approved eventually. The homeland governments just don't have the funds to pay out all necessary pensions and there is also a lot of corruption within the system of approvals and pay-outs involving the clerks and some other senior administrative personnel as a number of sporadic disciplinary cases in rural areas have shown.

The disabled are also in a sorry state and tend to have to wait indefinitely for approval of their disability grants; some Medical personnel are also conniving with the system of delay tactics by failing to declare 100% disabled people as such even when people are overtly mentally retarded.

(iii) THE CHILDREN

There is a very high birth rate in this area even though no records exist w.r.o crude birth rates our experience with the patients we deal with is that the parity of women here averages 6 with extremes of up to 18. By the same token there is no official record of infant mortality rates, but our impression is that they should be high.

Children are brought up mainly by their mothers and grannies and rarely is there a father figure constantly in the home.

Children grow up without really knowing their fathers who are once a year visitors with no meaningful relationships with their children.

Discipline and proper parental care is very hard to come by here with the added complication of mothers who have to work to supplement migrant worker wages.

6/The custom .......
The custom of circumcision of both male and females is still very strong here, but there is no real serious mutilation of females in the process. The problem relates to the age at which children are circumcised - 8 year olds are known to be involved and the most distressing part is the hazards to which they are exposed viz. infection, burns and malnutrition. This custom has to a very large extent been commercialised with entrance fees up to R160 per child, hence the larger the number, the more profitable the venture for the particular chief and headmen running it. The absolute minimum is spent on provision of food and proper traditional medical care. Children coming back from these schools are then regarded as men and women in spite of their tender ages - the psychological trauma and damage to the development of these children is inmeasureable. To add insult to injury these children with the men-child syndrome are then placed beyond the discipline of their mothers because of the fact that they are women, so they can't wash them anymore or teach them proper personal hygiene. With migrant fathers one can imagine these children being lost to society with no hope of proper up-bringing. The consequences of this "man-child syndrome" are frightening indeed for these rural societies.

(iv) THE TEENAGE PROBLEM

The normal problem of adjustment and identity crises of teenagers are multiplied a thousand times here by the above factors and other problems relating to unstable families, uncaring and or incompetent teachers, nurses and society as a whole denies the teenagers a reasonable chance of satisfactorily dealing with their problems hence the escape into alcohol abuse, dagga smoking, premature sexual experimentation with resultant high prevalences of venereal diseases and unplanned pregnancies.

(v) THE WOMEN

These form the pillars of rural society shouldering all the responsibilities yet being denied any meaningful authority in their homes.
Marriage is regarded as the beginning of meaningful family life, although there are a very large number of unmarried mothers - 30% and with all the above factors leading to unstable family life, divorce, desertion and being widowed are very common here; very few divorced or deserted mothers even bother to seek financial support for their children from their former husbands and tend to have to slog to bring them up.

The high birth rates are partly due to the refusal of a lot of men to allow their wives to practice any family planning because of fear of infidelity or some or other irrational reason. The women during child-bearing period are always either breast feeding or pregnant with no rest period in between the births of their children; there are a lot of instances of nursing mothers with 3 month old children who have to be weaned because of an unplanned pregnancy.

It is indeed surprising that these women still end up sane and can laugh and seem to be coping with life - they do cope far better than their husbands do - the miracle of survival. The power struggle between older and younger women especially the mother-in-law syndrome can assume alarming proportions here with tragic consequences for family stability. Older women tend to vent out their pent-up feelings and frustrations built up over their earlier years of marriage against younger women - reversal of roles - the former oppressed using new found authority to oppress fellow women.

These tensions spill over into the general community affecting the possibility of forming strong women's groups, care groups, literacy groups, etc. because the older women can withhold permission from her daughters-in-law to participate in all these activities.

The cumulative effect of all these stresses and strains on rural women must be tremendous - a lot of headaches and other psycho-somatic diseases treated symptomatically must be the end result of these tensions.

(iv) **THE POVERTY CYCLE**

The above discussion gives an indication of some of the factors at play which are important in the vicious poverty cycle operative in this area.
Our primary health care work in this area is aimed at lessening the impact of these forces on the individuals and on the community as a whole.

THE PROGRAMME PERSUED

Our work is divided into the following categories:

(i) CURATIVE CARE - routine consultations and treatment of various ailments done by the Medical Officer and the nurses.

(ii) PREVENTATIVE CARE - Health Education
- Immunisation programme - awareness creation
- actual administration
- Family planning - awareness creation
- administration of depo, the pill, insertion of I U C D & referrals for sterilization
- Dental Care - restorative
- preventive

9/ (iii) ............
(iii) **PROMOTIVE CARE** - This involves a whole range of projects aimed at promoting a better life in the community and are undertaken with the participation of the community to a greater or lesser extent depending on the nature of each project. It has to be said at the outset that most of these projects although answering the most pressing needs of the community, were not necessarily initiated by the people themselves but by the Medical Staff in response to the perceived rather than expressed needs.

(a) **NUTRITIONAL SCHEME**

Provision of free milk powder to destitute malnourished children and elderly people; this was increased almost ten fold towards the end of last year as a result of the drought and included dried beans, peanut butter, Soya mince granules, soup powder etc. The total value of distributions over the last 8 months amounted to - R2000. Sale of various food stuff at close to cost price to the local community to encourage wage of high nutritious value foods. This programme is very popular considering that some of the prices are almost half the going price at local stores. We have been able to run this scheme with the assistance of Imqualife and the McLean Trust.

(b) **SELF-HELP GROUPS**

This project is a direct result of our concern with serious chronic malnutrition in the under 5 year olds and after provision of free milk to the child, the mother is then encouraged to join hands with other women in similar circumstances. These women in groups of 10 - 15 people involve themselves in:-

- Joint discussions of their problems.
- Health Education within the group
- Learning simple skills - sewing
  - knitting
  - cooking to preserve nutritional value
  - cleanliness and home-economics
  - gardening

10/ Some ............
Some of the groups have progressed into effective care groups who also involve themselves with promotion of community health in their various villages.

SEWING AND KNITTING CLUB

This is a group of women who meet regularly to knit and sew articles for sale and thus generate revenue for the group. They sew very simple garments e.g. pinafores, kiddies dresses and knitted school jerseys and other commonly used articles. They are a very successful group which also give some of their time to work as literacy co-ordinators (see infra).

BRICK MAKING CLUB

These women were originally working at a local brick yard in town and leaving their children at home with the grannies in the early hours only to come back late in the evening. They are now producing cement bricks at their own pace which are sold to the local community to improve housing standards.

(c) CHILD CARE PROJECT

This was started to answer the need of working mothers who had to leave their children under unsatisfactory conditions to earn a living or to supplement inadequate family income. We have two Day Care Centres under this scheme:

- A creche which was having running cost problems which has now been adopted by Kinder Not Hilfe and takes care of Lenyenye Township children.
- A creche which we built in Tickeylin which takes care of the very needy children there.

The main aims of this project are:

- To provide shelter and nutrition for these children
- To provide a stimulation and love with a view to better preparation for schooling later on.

This programme is so popular that there is now a campaign in each village to get the community to build a creche, however simple, to
answer the needs of their young children.

EDUCATION PROJECT

This has several facets which are interrelated and aimed at alleviating some of the urgent needs in the community in the field of Education.

A BURSARY SCHEME - IPOENG BURSARY FUND

This provides money for needy children to enable them to further their Education. These students need not be bright but should show progress to qualify for continued support.

Our fund provides assistance to Std V - X mainly, a number at teacher training colleges, post matric and technical training. University fees are too prohibitive for us to handle except special categories for which sponsorship can be arranged eg. Medicine, and Engineering.

Career guidance is an essential part of this scheme.

LIBRARY PROJECT

This is based at the Health Centre and provides books, magazines, newspapers and other reading matter to local students and people in general to encourage readership. We provide both novels and reference work in various subjects.

It should be noted that there are no libraries in our local school.

ADULT LITERACY SCHEME

This has been prompted by the high illiteracy rate in the community up to 60% in some villages. We use the dialogue method and work hand in hand with Learn and Teach to run this scheme. The immediate benefit to the people is remarkable and it also makes our Health Education easier.

A lot of the learning groups which total 63 also function as self-help groups and in some cases as care groups depending on the level of awareness achieved by the group.
ASSessment of the programme

It is hoped that the lessons we learnt in this area can be useful to other community development workers.

problems

(i) Can we talk of a community?

Where people find themselves resettled in a vast rural slum and coming from different areas or farms within the same area is it fair to expect them to live like a well established close-knit community?

The object poverty, ruthless exploitation by the system within (tribal authority corruption and homeland government trappings) and the system without (inhuman working conditions on farms, mines and other industries and the lack of political rights) is a sure recipe for dehumanisation.

The unstable family units making up the community also contribute to poor socialisation, high crime rate and further weaken the foundation on which to build a proper community.

This is further complicated by Tribal divisions and results in friction.

(ii) Community development - what's that?

The novelty of the idea of people being able to work together for their common good is just too much for a lot of people here to get over.

This is further worsened by the fact that a total stranger to the people came to introduce the idea. Why must she run a clinic for service not for personal gain? Why can't she behave like an ordinary "normal" doctor and make her money and leave us in peace? We are doomed to our type of existence anyway - she is probably wooing us into a trap so that she can exploit us more later on when we are off our guard.

The security police intimidation fanned a lot of these suspicions with the hope that the programme will fail to take off completely. The saving grace was the fact that we were providing an essential service which was hard to come by in the area and we also ensured that the quality of that service is beyond reproach; thus opening people's hearts to
us and what we stood for - communication on an individual basis acted as a stepping stone to wider community discussions and active participation in the various projects.

(iii) MANPOWER AND MATERIAL RESOURCES

One of the fundamental tenets of community development is that the people's own resources must be utilised in any meaningful programme to ensure self-reliance and to promote self-help. Putting this sound theory into practice is however a very difficult proposition fraught with many problems viz, the people are so poor any way that they think of utilising their limited resources only in the process of existing from day to day; for the poor forward planning is a luxury they can't afford; giving up an afternoon off to get involved in a communal project is too much effort - rather spend the time drinking for tomorrow we die.

Things happen to the poor, they don't decide; It is difficult to conceive of themselves as makers of history - they are just shuffling along the shores of time eg., a poor woman doesn't think she can plan a family - she will passively wait for nature to take its course - 12 children later.

To find the manpower to run community projects in a society like this is a nightmare; the few who are Educated are not properly motivated for community service and few if any have any experience in community development work. There is also a lot of cases of breach of public trust by some people purporting to serve the people and this creates a lot of undue suspicions in the minds of people with consequent difficulty in securing the trust of the community in any task.

Financial support for ongoing programme of this nature are hard to come by, sponsors mostly like to be involved with capital costs of projects but are loathe to commit themselves to running costs on a long term basis. Unfortunately, with this type of community there is a limit to the extent to which one can stretch the internal financial resources of the community - someone somewhere has to subsidise the service components of the programme.
(iv) **LACK OF MODELS AND RELEVANT TRAINING**

Medical training in this country with a few exceptions perhaps presupposes that doctors are to work either as private general practitioners, specialists or Medical Officers attached to one or other hospital.

There is no proper preparation for Medical Practitioners to initiate, run and develop community health programmes suitable for rural areas. There are few if any models that one can fall back on to assist someone out there in the back of the beyond, one has to rely on one’s intuition, common sense and hope. Our training should make us better able to act as leaders of community health teams who must learn to listen and train other members of the team, to bring out the best in each one of them for better performance. The situation seems to be improving in some Medical Schools but we still have a long way to go before the right calibre doctor is produced for this type of work.

(v) **OFFICIAL RED TAPE**

The proliferation of various levels of government with greater chances of corruption, inefficiency and bureaucracy presents serious problems for rural community workers. Finding the right office for one's request for a particular service is a nightmare e.g., it took us 2 years 2 months to get tap water installed in our Day Care Centre. We finally traced the problem down to an official who had refused to carry-out the instructions of his head office of providing the connection from the main water pipe because of his prejudice against the Medical Officer; the fact that children were being put at risk of water-borne disease was of no importance to this official - he just didn't care. There are numerous examples of this uncaring bureaucracy at various levels of one's dealing with them.

(vi) **ALCOHOL ABUSE AND PROMOTION OF ITS USE**

Driving through most rural villages, one is struck by the number of liquor outlets compared to other business facilities; there is a proliferation of bottle stores, lounge bars and home-brew beer gardens in almost all villages here owned mainly by one or other homeland government official, their friends or relatives. It is indeed the most lucrative business in this poor community.
Alcohol abuse is very common in the people here - teenagers, middle aged and very old people are all victims of this. Although there is a male predominance - there is a practice here which is unique to the area - allowing women with babies to sit the whole day in beer gardens drinking. Nobody cares much about it - they are too busy making money to worry about its effects on the breast-feeding babies.

THE JOYS

From the above discussion one would think that with all the tears that fall here there is little room for laughter and real joy - that is actually the whole irony of the situation here - people still laugh and genuinely share the "simple pleasures of the poor"; the resilience of the people is immeasurable. Our work doesn't pretend to meet the total needs of the community but is aimed at enabling the people themselves to face the challenge of their environment without being dehumanised by the burdens of poverty.

A few examples will be used to illustrate some of the positive responses of the community which makes the whole effort worthwhile.

(i) ACTIVE PARTICIPATION IN ACTIVITIES AND PROJECTS

In the initial stages of our programme we had great difficulty to convince people that they have it in themselves to do things on their own without relying on the so-called educated people and government employees to initiate and run community projects. The greatest supporters of projects today are women, some illiterate or semiliterate who feel confident enough to stand and be counted, they initiate and run their own self-help groups and even help organise those still lacking the proper motivation to do so.

We have today 70 groups of women in the area operating as either literacy learner groups, sewing and knitting clubs, gardening groups and the more advanced ones operate as care groups. Men have also now begun to get actively involved in membership of project committees and a lot of the initial misgivings are giving away to positive thinking and active participation. It was indeed a great pleasure to be a guest at a recent Official opening of the Day Care Centre at Tickey-Line which was planned organised financed and run by the people themselves. We have really
come a long way.

There is also a lot to be learnt from the wisdom of the elderly people here; people's customs, prejudices and fears have a lot of bearing on their responses to the environment and other forces around them. We do draw a lot of strength from their interpretation of events and suggestions on appropriate approaches to the community issues to ensure desired responses.

(ii) GROWING SUPPORT FROM OTHER GROUPS AND ORGANISATIONS IN THE AREA

The greatest problem for community workers is to enlist the support of groups which have support, legitimate or otherwise in the community one is working in and a proper field force analysis is a prerequisite to proper planning.

Those totally against one must learn to ignore without antagonising further which one can least afford; those for the programme should be continually motivated to ensure deeper commitment and neutral ones have to be won over to the side of community development by various means dictated by circumstances. The church is the single most powerful institution in rural areas but is largely neutral in the face of the crying need around her; this includes the African Independent Churches in the area which are traditionally seen as soul clinics. We have succeeded in some cases, to get positive commitments from local churches which now seem their role in a broader sense. Some of the homeland system officials who might not openly identify with what we are doing are nonetheless not obstructive and in some cases have become positive supporters of the work we are doing, although one has to guard against their tendency to want to take over projects in order to claim credit thus stifling local initiative.

The local Tribal authority has really come a long way from neutrality to positive involvement even to the point of giving the Ithuseng Community Association a blanket permit (a clear deterrent to local security police intimidation of the community) to initiate whatever projects we feel are relevant to promote health care in the area. What greater vote of confidence can we ask for?
SYMBOLISM AS AN EFFECTIVE TOOL FOR COMMUNITY CONSCIENTISATION

It can be and is argued in some quarters that we don't need expensive looking buildings and all the paraphernalia that we have in our clinic and at the Day Care Centres in Tickeyline to render the service - that we do, because the capital cost involved is prohibitive and will thus discourage community initiative. This argument holds water only to the extent that one is looking at the service aspect of the work, but if one is talking development of the total person from a position of total dehumanisation, alienation and lack of self-respect to full meaning of the facilities provided.

Most people here are accustomed and accept being treated as subhumans at work, in shops, in buses and taxis, in hospitals and private G.P.'s rooms and in society as a whole that they need a very loud message to jerk them into a different reality eg. the local business people don't have to put up a sign for separate racial facilities, the people know where they belong! The cleanliness of the floors, the sheets on which they lie, combined with a friendly warm atmosphere must be able to reaffirm their humanity and pave the way for a meaningful discussion on personal hygiene and other matters relevant to self-respect.

By the same token the children being a cared for at the Day Care Centre must feel that they are V I P's future and given the matter-of-fact way in which people care for their children, we need a dramatic model to raise the awareness of the community for the need for proper child care and the importance of children.

There is nothing prohibiting the community to establish simpler structures to serve their needs in the Medical and Child Care fields but they have models which have enabled them to say we are people. The community is in the middle of a campaign to establish a simple Day Care Centre for each village using their own resources to put up simple functional structures.
CONCLUDING REMARKS

- Although the problems of the rural poor are the same, priorities differ from area to area and proper selection of an "entry service project" will ensure community support for the service and open up prospects for a more developmental programme.

- Each professional group should and must make a contribution to rural development but based on our experience we feel that Medical training for a start, should be radicalised to ensure a steady supply of properly motivated personnel to practice real comprehensive primary health care as leaders of health teams.

There is a certain resilience in rural poor communities which might explain the miracle of their survival in the face of all the odds against them. Our duty is to provide that ray of hope at the end of this tunnel of misery - they are sure to emerge victorious.

-------------------000-------------------
These papers constitute the preliminary findings of the Second Carnegie Inquiry into Poverty and Development in Southern Africa, and were prepared for presentation at a Conference at the University of Cape Town from 13-19 April, 1984.

The Second Carnegie Inquiry into Poverty and Development in Southern Africa was launched in April 1982, and is scheduled to run until June 1985.

Quoting (in context) from these preliminary papers with due acknowledgement is of course allowed, but for permission to reprint any material, or for further information about the Inquiry, please write to:

SALDRU
School of Economics
Robert Leslie Building
University of Cape Town
Rondebosch 7700