

SECOND CARNEGIE INQUIRY INTO POVERTY  
AND DEVELOPMENT IN SOUTHERN AFRICA

Health and health care in Mhala:  
An overview  
by  
Eric Buch and Cedric de Beer  
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## PREFACE

Gazankulu is one of South Africa's so-called "black states". The Mhala district is an isolated area midway between Nelspruit and Izaneen. It is typical bushveld with limited water and poor agricultural potential. 152,000 people live in Mhala's 57 villages which vary in size and infrastructure. Health services are underdeveloped and comprise one 260-bed hospital (Tintswalo), one health centre, ten clinics and a mobile clinic.

Why did Wits Medical School become involved here? It was by both design and fate. At Wits we had people interested in rural health and a benefactor (Anglo American Chairman's Fund) prepared to sponsor rural health work. The government has encouraged the various medical schools to become involved in rural health care and has designated schools to particular "homelands".

So we became involved in Gazankulu and the Health Services Development Unit (HSDU), a project of the Wits Department of Community Health, was established. The objectives of the Unit are the training of appropriate health service staff, the expansion and development of clinic services and the creation of a health service which is community supportive and responsive to local needs. To succeed we need the goodwill, support and respect of the community and the wholehearted backing of the existing health service.

This paper and the others of the HSDU are reflections, analyses, recommendations and ideas and are the product of our first two years' experience. Opinions expressed are based on the critical analysis of hard data on the one hand and on personal impressions on the other. Whatever the opinion, it has been acquired by first hand and sustained personal experience.

The papers cover three aspects of our experience:

1. The State of Health and Health Care in Mhala
  - a. Health and Health Care in Mhala : an overview.
  - b. The Nutritional Status of Children 1 - 5 years.
2. A Critique of Some Health Service Interventions in Mhala
  - a. Community Health Workers in Mhala : Perversion of a Progressive Concept?
  - b. How well do our Rural Clinics Function?
  - c. Reviewing the Health Centre Policy.
  - d. Mobile Clinics : What can and do they Achieve?
3. Health Service Interventions by the Wits HSDU
  - a. Do Primary Health Care Nurses in Gazankulu provide Second Class Cheap Care to the Poor?
  - b. Can good Tuberculosis Services be provided in the Face of Poverty?
  - c. School Health Services : Problems and Prospects.
  - d. Mass Immunisation Campaigns - The Tintswalo Experience.

The message is that:

- Health care in Mhala is inadequate.
- This care can be improved without preceding changes in the present economic and political systems.
- Such improvement is limited by social, economic and political constraints which are the root cause of much illness.
- It is worth working in "homeland" health services because of what can be achieved.

In acknowledging all who have worked in or with HSDU it must be remembered that health service development is a team effort. Many of the people of Mhala, the hospital staff, primarily Dave Stephenson as superintendent and the community health nurses, Dr Erica Sutter and the superintendents and staff of Gazankulu's other hospitals, the health department led by Dr Roos and, more recently, Dr Robert, and the Chief Minister of Gazankulu have all contributed to the establishment and development of the Unit. The Chairman's Fund of Anglo American and the University of the Witwatersrand have provided the infrastructure.

The action has come from Anita and Bob Backentose, Eric Buch, Rob Collins, Cedric de Beer, Clive Evian, Vic Gordeuk, Nerryl Hammond, Thoko Maluleka, Shirley Maswanganyi, Sanilesiwe Mtetwa, Dipuo Mosoue, Robert Waugh and Merrick Zwarenstein.

JOHN GEAR  
DIRECTOR - HSDU  
MARCH 1984

## HEALTH AND HEALTH CARE IN MHALA - AN OVERVIEW

Eric Buch & Cedric de Beer

### INTRODUCTION

We know that there is extensive poverty in the homelands and that this poverty must be understood in terms of the history and economic and political structures of South Africa. The link between these factors and health and health services has been explored theoretically elsewhere. (1,2,3,4)

This paper focuses on to the day to day realities that exist in health and health care in one homeland area, the Mhala district of Gazankulu. It is an overview, the details of which are explored in other papers presented to this conference (see Preface).

Mhala is a representative homeland area. It's poor socio-economic circumstances lead to health problems that are associated with poverty. The health service cannot overcome this poverty and does not provide high quality accessible health care. The homeland policy creates further difficulties because it fragments services and forces divisions between people. This paper explores these concepts, and argues that it is nonetheless worthwhile trying to develop health services within current constraints. The arguments presented will be based on hard fact and on understanding gained through personal experience. In some instances we do not have the data to present the commonly used indices. In these cases we have used alternative indicators.

### SOCIO-ECONOMIC CONDITIONS

An extensive study undertaken by the "Institute for Development Studies of the Rand Afrikaans University" (5) has shown the extent of poverty in Gazankulu as a whole, and in Mhala. How do the problems of land, food, water, transport and education affect the people on a day to day basis?

#### Land

There are 152,000 people living in the 1204 sq.km. of Mhala. The population density is 126,2 people per sq. km., but most people live in closely spaced villages. They have limited access to land. The average

plot is 1/4 hectare. People are given a further two hectares if this is available.

### Food

People are not able to produce enough food on their land and do not have enough money to purchase it. The extent of malnutrition in the district (see later), reinforces this fact.

Even in the best years a harvest will not provide food supplies for more than five months. Irrigation is only available in the few special development projects.

The average family receives between R40-R50 a month, mostly in remittances from migrant labourers. This covers all purchases for the family (average size = 5), including food. This is inadequate under any circumstances, but is worsened by the high cost of food in rural areas. (Table 1)

TABLE 1  
THE COST OF BASIC FOODS IN MHALA\* AND IN NELSPRUIT (6)

Item	Cost at a Nelspruit Supermarket	Cost in Mhala	% increase
Full Cream Milkpowder (500g)	R3,65	R5,15	41,1%
Mealie 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 (loaf)	29c	35c	20,7%
Eggs (1/2 doz.)	56c	71c	26,8%

\*The "cost of foods in Mhala" is the average price of 8 shops in the middle of the district.

### Water

165 boreholes are the main source of water in Mhala. 31 boreholes have engines and 29 have reservoirs. Most boreholes feed into a single stand-pipe, but some have more than one outlet. The tap to population ratio is 1:760.

The water situation is worsened by the distribution of boreholes and by inadequate maintenance. In April 1982 seven villages (population = 15 582) had no boreholes, and a further 6 (population = 16 846) had all their boreholes out of order. This meant that 32 428 (48,6%) of the 66 615 people in the 25 villages of Mhala South did not have access to clean water.

### Transport

There is no bus service and only 6km of tarred road in Mhala. Transport is based on taxis whose fares are beyond the means of most people - 80 cents for a return trip from the nearest village to the hospital and R16,00 from the furthest. At night this increases to R10,00 and R80,00 respectively.

### Education

The primary schools in Mhala have one teacher for every 53 pupils. Many teachers are not qualified. There are shortages of classrooms and textbooks; often as few as five textbooks for a class of 60.

Given this poor socio-economic profile, the disease patterns in Mhala are not surprising.

## THE DISEASES

The major health problems are diseases associated with poverty and with an increase in practices that are potentially harmful to health.

### The diseases of poverty

#### Malnutrition

At least 5 021 (26,3%) of 19 021 1-5 year old children are malnourished; 804 (4,3%) seriously (7). The school health service found 39,6% of 2 609 school children had not had any food before coming to school.

### Tuberculosis

Tintswalo had 279 confirmed admissions of TB in 1983. A more accurate reflection of the TB problem is that 895 (46,3%) of 1 935 children in sub-A and sub-B had PPDs measuring 15mm or more (8). Most of these children need TB treatment.

### Typhoid

Confirmed typhoid admissions have increased steadily from 111 in 1976 to 830 in 1982. (Table 2) Typhoid is endemic in our area. (Table 3)

TABLE 2

CONFIRMED TYPHOID ADMISSIONS PER ANNUM TO TINTSWALO HOSPITAL : 1976-1983

1976	1977	1978	1979	1980	1981	1982	1983
111	204	326	528	644	663	830	685

TABLE 3

CONFIRMED TYPHOID ADMISSIONS PER MONTH TO TINTSWALO HOSPITAL : 1976-1983

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
352	362	389	363	359	302	304	325	292	290	310	333

### Cholera

Cholera struck Mhala in 1981. 41 Cases were confirmed.

Diseases in the children's ward

Tables 4 and 5 show that diseases associated with poverty dominate the reasons for admissions to the children's ward, and for deaths. 63,9% of admissions are caused by 7 diseases. All are associated with poverty. 69,7% of the deaths were due to 3 poverty associated causes.

TABLE 4:

CAUSES OF ADMISSIONS TO TINTSWALO HOSPITAL CHILDRENS WARD :: JAN-DEC 1983

<u>CAUSE OF ADMISSION</u>	<u>NUMBER OF ADMISSIONS</u>	<u>% OF TOTAL</u>
Gastroenteritis +/- dehydration:	271	20,4%
Kwashiorkor and/or marasmus:	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:	1.327	100,0%

Note: Only those causes resulting in more than 50 admissions are specified individually. The rest are included in the "all other causes" category. Many of these are also associated with poverty.

TABLE 5  
CAUSES OF DEATH IN THE TINTSWALO HOSPITAL CHILDRENS WARD : JAN-DEC 1983

<u>CAUSE OF DEATH</u>	<u>NUMBER OF DEATHS</u>	<u>% OF TOTAL</u>
Gastroenteritis and dehydration	26	34,2%
Kwashiorkor and/or marasmus	17	22,4%
Tetanus	10	13,2%
All other causes	23	30,3%
— — — Total deaths	76	100,00%

### Harmful Health Behaviour

There is a growing shift towards practices that are potentially harmful to health. Highly refined diets are now prevalent, as is the use of infant formula foods, alcohol, cigarettes and skin lighteners. These practices are harmful in any society, but are more so in poor communities, because they misdirect scarce resources and because people have not been warned about the harm that may befall them.

#### Diet

The staple diet used to be unrefined maize, with peanuts and dark green leafy vegetables as relish. Now only refined maize is available, which people eat with sugar, cabbage or tomatoes; and so proteins roughage and vitamins are lost.

The traditional diet is not being encouraged and people do not realise that the changes they are making are for the worse. For example, only 22% of 46 mothers interviewed in an infant feeding study believed that peanuts were an important food (9).

The study just referred to (9) found that 80% of mothers had given their infants carbonated soda drinks, 96% "chips" and 92% sweets.

### Infant formula foods (IFF)

One third of the mothers in the infant feeding study said that they use IFFs, and had started before their child was 6 months old (9). They did not chlorinate or boil their water before using it and overdiluted the mixture, to make the IFF stretch further.

Sadly, the use of infant formula foods is encouraged by the local branch of the Gazankulu Nursing Association. The nurses sell 'Lactogen' as "a service to the community" and to "earn funds for their association." They have failed to realise that because Lactogen is the only item available for sale at their clinics, people will perceive it to have the nurses stamp of approval. Nurses are even encouraged to market it, "to help their association."

### Alcohol

The alcohol trade is flourishing and is supported by extensive radio advertising. Bottle store owners will not part with exact sales figures, but say that business is "very good". This is confirmed by the number of powerful people getting into the bottle store business. 8 of the 14 bottle stores in Mhala are owned by chiefs, headmen or ex-members of the Gazankulu parliament. The Shangaan-Tsonga development corporation also owns one.

### Cigarettes

Cigarette sales are increasing steadily. They also point out that people have changed from single cigarettes to buying packets and that the demand for new brands is increasing. Many people now prefer status brands, such as "Benson and Hedges Gold" and "Dunhill".

### Skin lighteners

The skin lightener market has expanded rapidly in the last few years. Sales have jumped and the number of products on the rural market is increasing all the time.

Given this profile of the diseases of poverty, and the increase in potentially harmful practices, the next section looks at how adequate the health services are to cope with these problems.

## THE HEALTH SERVICES

This section considers the scarcity of resources for health care, and shows the impact that this has on accessibility to and quality of care.

### Accessibility

An accessible service is less than 5km from people and provides care at all times, at a cost they can afford. Health service policy and the behaviour of health workers should not alienate people.

#### Distance

About half the people of Mhala live more than 5kms. from their nearest health facility and Tintswalo Hospital, (the only one in Mhala), is situated in the north-west corner of the district. It has already been stated that transport is inadequate and expensive.

"Distance problems" influence patients' attendance at the health service. Although Tintswalo serves more than 50 villages, in February 1984 70,7% of our outpatients came from only 8 villages. Five of these are Lebowa villages. The three Gazankulu villages comprise 13% of the population of Mhala. The same 8 villages referred to above accounted for 59,9% of the deliveries at Tintswalo in 1983. Attendance at clinics is also affected. About half the ill patients and children at child health clinics come from the village that the clinic is in, and attendance decreases progressively as villages get further away.

#### Cost

Many outsiders consider our care "cheap", but it is beyond the means of our community. This is confirmed by two sets of data. The first shows that attendance dropped after a recent fee increase, and the second that nearly twice as many people attend for <sup>CASE</sup> in the first versus the other weeks of each month.

In October 1982 fees were doubled. This was associated with our first drop in attendance and in admissions since 1977, the time of the last fee increase. Tables 6 and 7 show that, instead of an expected 10% increase in service use, there was a drop in attendance at all but free services. In the first two months after the fee increase, attendance figures showed little change. This was followed by a sharp decline, and then a gradual increase in attendance.

**TABLE 6**  
**ATTENDANCE FOR HEALTH CARE IN MHALA BEFORE AND AFTER THE FEE INCREASE**  
**OF OCTOBER 1982**

Category of care	Cost before increase	Cost after increase	October 1981 -September 1982	October 1982 -September 1983	% change before/ after
<b><u>Hospital</u></b>					
Admissions	R3,00	R5,00	14 231	13 082	- 8,1%
Inpatient days	-	-	145 189	132 460	- 8,8%
Average inpatients/day	-	-	397,8	362,3	- 8,9%
Outpatients	R1,50	R3,00	70 921	56 286	-20,6%
<b><u>Mobile Clinics</u></b>					
Ill patients	R0,80	R2,00	1 350	1 029	-23,7%
<b><u>Clinics</u></b>					
Ill patients	R0,80	R2,00	80 056	59 261	-26,0%
Ante-natal care	R4,00	R8,00	20 577	20 296	- 1,4%
Child health clinics	Free	Free	52 873	53 532	+ 1,2%
Family planning	Free	Free	4 001	6 112	+34,5%

TABLE 7  
COMPARISON OF EXPECTED\* VERSUS ACTUAL ATTENDANCE  
OF ILL PEOPLE FOR HEALTH CARE IN MHALA IN THE YEAR  
AFTER THE FEE INCREASE OF OCTOBER 1982

Category of care	Expected attendance Oct. 82 - Sept. 83	Actual attendance Oct. 82 - Sept. 83	% shortfall
Admissions	15 782	13 082	-17,1%
Inpatient days	177 136	132 460	-25,2%
Inpatients/day	434,8	362,3	-16,7%
Outpatients	82 056	56 286	-31,4%
Clinics	90 864	59 261	-34,7%

\*The "expected" figure is based on the average increase in attendance per annum, based on a 5 year review for hospital statistics and 2 years for clinics

Further data to confirm that our patients cannot afford care is that 65,8% more outpatients are seen at Tintswalo during the first week of each month than in each of the other three weeks. This is because people have more money at this time. December is the exception. It has equal attendance in all 4 weeks, probably because migrant labourers are home.

#### Time

We see far fewer patients at night than we estimate need to be. This is because of the high cost of night transport and the 5-00 p.m. clinic closing time.

#### Alienation

If people feel alienated from the health service they are less likely to seek help from it. Health workers should therefore develop good relationships with their patients, inform them adequately, not be elitist, and show respect for traditional beliefs and practices. Table 8 below shows how health workers tend to alienate people from the health service. These practices are intrinsic to the health services and are re-inforced by the class background of the nurses.

TABLE 8  
THE IMPACT OF HEALTH WORKER BEHAVIOUR ON PATIENT ALIENATION

Category	Increases Alienation
Relationship between health worker and patient.	<p>Patients treated as another unwelcome addition to the day's burden.</p> <p>Patients feel insecure and ill at ease.</p> <p>Patients hold their emotion back.</p> <p>Patients (e.g. in the wards) treated as inanimate objects and as if they didn't exist.</p> <p>Patients do not like the nurse.</p>
Nurses information to patients.	<p>Does not inform patients: about their illness and care.</p> <p>Uses big words.</p> <p>Makes patients feel that what she is doing is above their ability to understand.</p>
Traditional beliefs.	<p>Thinks traditional customs and beliefs are backwards.</p> <p>Discourages all customs and beliefs, often rudely and mockingly.</p>
Elitism	<p>Powerful people don't have to queue.</p> <p>Special care (e.g. in the wards) is given to more affluent patients.</p> <p>Scolds mothers e.g. those whose children are malnourished) without considering their problems.</p> <p>Relates to patients as if they were inferior.</p>

The relationship between alienation and traditional beliefs and practices requires special attention. It is a wide field, so I will only attempt to draw out the common threads.

Traditional beliefs, practices and therapies can be divided into helpful, harmful and neutral groups. In our area a helpful practice in diarrhoea is to give babies a drink made from the "konono tree",

and harmful ones, are to withhold food and fluids from children with diarrhoea and to give them enemas. A neutral practice is to rub "medicine" onto the depressed fontanelle "to help pull it up".

All traditional beliefs and practices are under pressure. Traditional beliefs about tuberculosis and the practice of breast feeding remains strong. All 39 women in a random survey in 3 villages believed that tuberculosis is caused by one of three forms of improper sexual practice after the death of a relative (10). All 46 mothers in a village based study breastfed their children, about 3/4 for more than a year (9). In contrast, some beneficial practices are disappearing. These include regular between-meal snacks for children, wrapping very small babies in a clay mould (a traditional incubator), and squatting to support the vaginal wall when delivering a baby.

Most common diseases have traditional names, therapies and beliefs associated with them. Kwashiorkor and marasmus are the exceptions. They are "new diseases".

There are strong arguments in favour of contact with traditional healers. This is not allowed at Tintswalo - a policy dating from the time of mission control. Many patients choose to seek care only from traditional healers, or to get care from both traditional and modern sources. Care from traditional healers is readily available in Mhala. There are even training schools in our area.

#### Proportion of need met

The problems of distance, time, cost and alienation result in only a small percentage of the need for health care being met. The details are presented in Table 9 below.

TABLE 9  
PERCENTAGE OF NEED MET BY HEALTH SERVICES IN MHALA

Category of care	Needs Estimate Based on	Need in Mhala	Total Care Delivered	% of Need Met
Ill patients	3 visits per person per annum	456 000	146 480	32,1%
Ante-natal care	8 visits per pregnant woman	36 000	26 660	74,1%
Deliveries	Number of births	4 500	3 350	74,4%
Family Planning	1 in 2 women of child bearing age	60 000	5 150	8,6%
Child health clinics	6 visits per under 5 per annum	240 000	58 890	24,5%
Home visits	1 visit per household per annum	50 600	1 580	3,1%

It is important to recognise that patients' needs for health care are real and that it is a fallacy that people in rural villages "don't want our care". If measures are taken to improve accessibility attendance will increase significantly. This is confirmed by the much higher rates of attendance when people have money and when they live near health services. Our mass immunisation campaigns immunised more children than there were believed to be in Mhala (11). This was because the service was accessible as immunisation was available free in every village and extensive information helped to overcome alienation.

The systematic exclusion of the poor

Our experience suggests that the poor are being systematically excluded from health care.

We do not have data to prove that poor people are the most affected by the costs of care and transport, but one can safely assume that this is true.

However, exclusion of the poor goes beyond money. We can draw examples from attendance at child health clinics and from the care groups.

Poor people are embarrassed to attend child health clinics as they have become a social event where mothers show their babies off. Unfortunately, our health workers have heightened this problem by scolding the mothers off poorly dressed or malnourished children.

The next example comes from an experience in teaching a "care group" about using "sugar and salt water" for diarrhoea. The "care group" women indicated that most had sugar and salt at home. However they said that because it was near the end of the month few people in the village would have these items. They knew this "because other villagers are poorer than us."

A "care group" open day provides another example. The "care group" came in singing, led by a woman with a watch, stockings and chiffon blouse. The fourth woman had no stockings or watch and the seventh no chiffon blouse. Clothing got poorer, until near the end some women came in with no shoes and with torn clothes. They sneaked in and stood at the back so that only their faces were visible. That sort of humiliation must certainly prevent other poor women from joining the group.

### Quality of care

What is the quality of care for those people who actually reach the health services?

Tintswalo, its ten clinics and one health centre had a total budget of R2 382 200 in 1982. 83,2% of this was spent on salaries. The doctor:patient ratio has ranged between 1:12 700 and 1:30 400 over the last 2 years. There is one registered nurse per 2 160 people.

This section considers the quality of care in our different services.

### In-patients

In 1982 we had an average of 406 in-patients per day in our 260 beds, and only R12.59 per capita per day to spend on their care.

Depending on the number of doctors available, each looks after between 40 and 135 patients per day in addition to other responsibilities. Each registered nurse has 45 patients under her care. She also does not have enough nurses to help her.

There is a shortage of facilities. For example, until recently we had only 1 incubator. This was often shared by 4 babies while others waited their turn. Wheelchairs take more than a year to get.

Our shortage of resources limits the quality of care we can give to the point where many in-patients do not get the care they need.

### Out-patients

Our out-patients department was designed to cope with 80 patients a day. The 1982 daily average was 191.

After waiting some hours, more than half our patients are seen by registered nurses who have not been trained to diagnose or treat illnesses. The nurses work under the pressure of trying not to refer too many cases to the already overloaded doctors.

### Clinics

There are 10 clinics in Mhala. They are usually staffed by a registered nurse, nursing assistant and "cleaner". We need 20 registered nurses in our clinic service, but only have 7.

The clinics see an average of 22 ill people per day. Until some clinics got PHCNs, no registered nurses had been trained to diagnose or treat illnesses. Many clinics do not have PHCNs, so even now our clinics do not give many patients the treatment they need. Even worse, care is often in the hands of a nursing assistant, whose hospital based training prepared her for menial tasks only.

Quality of care is further limited by clinics running out of drugs and not having equipment, and by inadequate communication, transport and referral systems.

More details of clinic care are given in the paper "How well do our rural clinics function?" (12).

#### Chronic disease care

Until recently, in spite of their need for special care and information, chronic disease patients joined the normal out-patients queue. They waited a long time, were rushed through, and left ill-informed. The outcome of this is reflected by the fact that only 42.1% of TB patients received enough medicine to cure them in 1980/81. A brief record review has shown poor attendance by hypertensive, diabetic and asthmatic patients.

#### Community health worker care

There are 9 community health workers in Mhala. The paper entitled "Community Health Workers in Mhala - perversion of a progressive concept" (13) argues that community health workers have probably taken us backwards, rather than forwards. This is because they do not provide curative care, and because their preventive care and community development work has been ineffective.

Our inadequate resources result in us providing poor quality care in all branches of our service. The quality of care is even worse than our resources dictate, because health workers have learnt to accept and work within an inadequate system. They judge their standards of practice against their experience, and so services and practices that would be totally unacceptable elsewhere are the norm in our area. For example:

- it is acceptable to treat patients without examining them.
- workers can function in areas where they have inadequate skills.
- we don't need to explain to patients what is happening to them.
- patients can die because we don't have an adequate referral service.
- it's "too bad" if things are out of stock or supply is short - patients will just do without.

None of these are planned approaches. They happen because of the framework within which care is delivered.

### THE EFFECTS OF THE HOMELAND POLICY

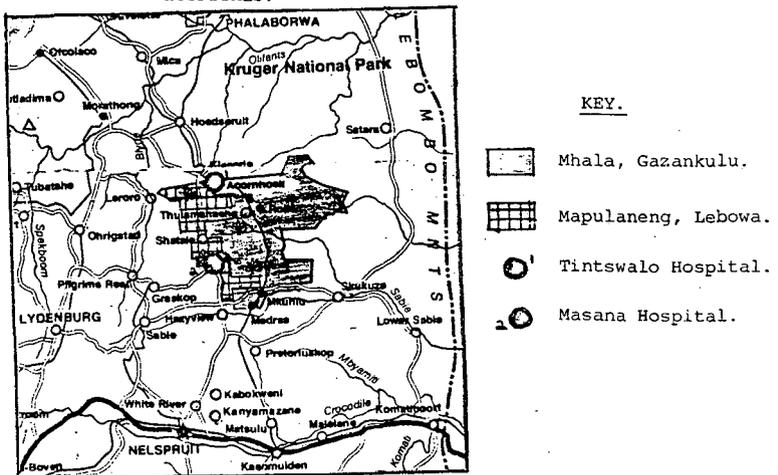
Tintswalo hospital and its neighbour, Masana, were previously responsible for the care of the communities around them. Tintswalo now serves the Mhala district of Gazankulu and Masana the Mapulaneng district of Lebowa. The implementation of homeland policy has led to fragmentation of health services and divisions between people.

#### Fragmentation of health services

Before homelands were introduced, the logical approach of serving nearby communities, co-ordinating services and communicating with each other, was applied. Figure 1 (below) shows the Mhala district of Gazankulu (Tintswalo's responsibility), and the Mapulaneng district of Lebowa (Masana's responsibility). Each is now responsible for community health services on the other's doorstep. This wastes scarce staff-time and transport, and weakens an already inadequate support system.

FIGURE 1.

THE LOCATION OF TINTSWALO AND MASANA HOSPITALS.



The hospitals no longer co-ordinate policy. For example, when we wanted to co-ordinate TB care, we were told that "Gazankulu can do what it wants to, but Masana will follow Lebowa's policy". During the polio epidemic we again wanted to combine efforts. We were told that "we must run our own immunisation campaign and they will run theirs". Even in the face of an epidemic, fragmentation held.

Nowadays, Tintswalo and Masana's superintendents and matrons seldom communicate with each other. But, it goes deeper than this. The hospitals nurses are now separated into the Gazankulu and Lebowa Nursing Associations and discuss "common interests" with nurses of hospitals hundred of kilometres away, instead of down the road. Even the idea of an informal local discussion group has received little interest.

### Divisions between people

The health services make no official distinction between the people that they treat. Nonetheless, people are beginning to understand that Masana belongs to the "Sothos" and Tintswalo to the "Shangaans". For example,

- some patients have been told by Masana staff to go to "that Shangaan hospital".
- patients referred from Tintswalo's clinics to Masana have had to pay again, unnecessarily.
- ambulance drivers from Tintswalo have refused to take patients to the "Lebowa hospital".

None of these practices are official policy, but occur as a result of a policy based on ethnic divisions.

The following brief examples further illustrate how the homeland policy has created divisions between people.

- There has been a drop in "non-Shangaan speaking nurses" at Tintswalo. This is because they are discriminated against in promotion and postgraduate training opportunities, and because Tintswalo only accepts "Shangaan speakers" for nursing training.
- Because the polio epidemic occurred mostly in Gazankulu, we were told by "non-Shangaan speakers" that they didn't need to get their children immunised because "polio is a Shangaan disease".
- Allandale, a "Sotho speaking" village in Mhala insists on care from "the Sotho hospital" and not from Tintswalo.

- People in Okkernotboom (in Gazankulu) now have to pay for water because their borehole has been transferred to Lebowa. Lebowa people using the same borehole don't pay.

The pursuit of the homeland policy in our area has created extra problems for the health services because it leads to fragmentation of services and divisions between people.

### CONCLUSION

The people of Mhala display a pattern of disease that is associated with poverty. Our health service is not able to combat poverty, nor to provide high quality accessible health care.

Indeed, the health care system is distant from the community, not only in kilometres, but also because of the time and money required to reach and use the services. This, combined with our inability to adequately communicate with users of our services, has resulted in us meeting only a small proportion of the need for health care and to a systematic exclusion of the poor.

Largely responsible for this situation is the shortage of finance, staff, facilities and equipment. The mediocre quality of care that results is reinforced by the fact that it has come to be accepted by health workers as the norm. Finally, the creation of separate health services in each homeland has resulted in fragmentation of services and divisions between people, both of which affect health care. These in turn adversely affect the quality and accessibility of care.

Despite these obstacles we believe that it is still worthwhile trying to develop health services in Mhala. The reasons for this are:

- health services are an important need in rural areas. As they can be improved, this should be done.\*
- the standard of what is considered acceptable quality and accessibility of care in rural areas needs to be raised.

\*The series of papers presented to this conference on clinics and mobile clinics, and on tuberculosis, school health and immunisation services show how these services can be improved, but only up to a point, within current constraints.

- alternative methods of delivering health care have hardly been explored in the South African context. This needs to be done.
- the extent of improvement possible under current circumstances must be defined.
- an understanding of what is required for the development of adequate health services is needed, so that when the commitment and resources for delivering first class care become available, we know what to do.
- the transformation to progressive health care will have to be built on the present service and its staff. Thus, the extent to which the present service and workers can be improved will minimise the task in the future. We also need to understand the blockages that will remain and to devise strategies to overcome them, even if we cannot implement these at present.

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