SECOND CARNEGIE INQUIRY INTO POVERTY

AND DEVELOPMENT IN SOUTHERN AFRICA

Effects and Limitations of Gazankulu's Care Groups in the Prevention of Diseases of Poverty

by

Erika Sutter

Carnegie Conference Paper No.203

Cape Town

13 - 19 April 1984

ISBN 0 7992 0609 1

INTRODUCTION

Gazankulu is one of the poorer of the South African Natonal States [1]. The population is predominantly rural and female, 60-70% of the able bodied men of working age being employed outside its boundaries. Except for an emerging middle class of professionals and higher government employees, family income is generally low and unpredictable. The majority of families depend on what money the husband sends home and on occasional employment of women on surrounding farms. This is supplemented by limited subsistence farming where maize and vegetables are grown. In good years home grown crops may last for about two months. The bulk has to be bought in the shops.

Except for the Nthlaveni area there have been no resettlement camps, but where relocated people were added to existing settlements, tensions between the various sections persist.

Health services are provided by 6 hospitals, 5 health centres, 40 clinics and a varying number of mobile clinics. In addition about 25 villages have a trained community health worker. An average of one in six settlements has a clinic with residential staff. They render predominantly curative services with a limited effect on the general health of the population[2].

The disease pattern is typical of that in developing countries throughout the world, where preventable conditions such as malnutrition and infectious diseases predominate. These are related to low socio-economic standards responsible for inadequate education, poor farming methods, unreliable water supply, stagnation and apathy. The community is thus

cought up in a vicious cycle , where ill-health and poverty reinforce each other. A multifaceted approach is required to break this cycle. Apart from higher income and improved social stability (which is outside the direct influence of health services) this would require a better knowledge of the factors favouring disease, changes in attitudes towards these factors and the willingness and feasibility to implement the knowledge gained, combined with an appropriate health service.

The care groups in Gazankulu represent one possible method to facilitate the necessary changes in attitudes and practices. Various aspects of the characteristics and functions of care groups have been described elsewhere[3,4,5]. The aim of this paper is to discuss the role care groups play in the health of their communities, their potential strengths and their limitations.

DEVELOPMENT OF CARE GROUPS

Care groups are groups of unpaid volunteers, mainly women, from the community, who work within their own community to improve health and well-being. They have been initiated in the course of a trachoma control programme, but have since extended their activities to include health in general, vegetable gardening, building of toilets and other home improvements.

The first three groups of about 15 members each were started in 1976. Some other settlements followed suit. At the time

of writing Gazankulu has 115 groups and a total of about 5000 members, while there are over 50 groups in Venda, and other groups have been initiated in areas such as Kwa Zulu and Qwa Qwa. Each care group member is supposed to make friends and share her skills with about 10 families outside the care group. If about one third or half of the members follow the rule, approximately 100 000 people are in direct contact with the care groups, i.e. about 20% of Gazankulu's population. The rapid expansion and good acceptance of the care groups by their communities demonstrates the popularity of the groups.

The success of the care group system may be attributed to the following:

1. Some of the hospital-based care group motivators, mostly of nursing assistant grade, have been able to step outside the rigid authoritarian system of hospital organisation and responded sensitively to the needs of the care groups and their communities, thus avoiding imposition of ideas foreign to the way of thinking of the villagers.

2. The groups themselves have been strong enough to determine their own priorities and methods of action. Hence, from the start some groups chose different health problems as starting point and developed their own methods of communication.

3. By its very nature trachoma has been an ideal stepping stone to arouse awareness of a variety of health problems in the community. Prevention of a disease which is the result of poor personal and environmental hygiene will

automatically affect other hygiene-related conditions such as diarrhoeal or skin diseases. Moreover, trachoma is well known and associated with many popular beliefs, and eye-to-eye transmission is easy to understand.

4. As trachoma is ho'no-endemic in the area, virtually all families, except the wealthy ones, are affected by the disease. Therefore there has been a strong personal motivation by the members and the community to learn more about it and to obtain eye ointment for its treatment. In the course of education concerning trachoma a general interest for health matters has been stimulated.

5. Increasing knowledge about the causes of trachoma and its prevention, skills in examination and recognition of the disease, and the permission to distribute eye ointment to the sufferers made care group members feel important and gave them self-confidence.

6. Women were attracted by the opportunity to learn something new as well as belonging to a group which was meaningful for them and where they could also have fun together.

7. Having been successful, Gazankulu health authorities have accepted and recommended the care group system. However, they have been unsuccessful in providing adequate manpower and material support. Care groups therefore depend to a great extent on funds from the private sector, which, in effect, is to the benefit of the project, as it allows for more freedom in decision-making and an immediate response to to needs arising.

EVALUATION OF CARE GROUP ACTIVITY

A number of surveys have been done in the past to evaluate the effect of the care groups on their own members and on the community in which they live. Later these investigations have been discontinued because they caused considerable disruption of care group activity. Attempts have been made to educate the groups towards an ongoing participatory evaluation. This process is still in its infancy. Therefore no recent results are available and much of the judgement is based on impressions.

The following items have been investigated by surveys:

1. Social status of care group members as compared with their community. Only two groups have been surveyed. (1978)[5].
2. Implementation of knowledge in the care group member's own household (1978, 1979)[5].
3. Implementation of knowledge on hygiene etc in the community (1978, 1979)[5].
4. Prevalence of active trachoma (1976 baseline, 1978, 1979, 1980, 1981, 1982)[5].
5. Knowledge about prevention of trachoma (1978, 1979)[5].
6. Nutritional status in children of care grou mothers and non-care group mothers (1981)

For results see tables I-III and figures 1 and 2.

The findings confirm that care groups have not only been successful in transmitting some of their knowledge to the people of their community, but have also been instrumental in its practical application. Village hygiene has improved

and with it the incidence of trachoma has been reduced by a statistically significant degree, even in the absence of antibiotic treatment. The attitude towards childhood trachoma has changed from considering it as a good thing to recognising it to be a threat to eye sight.

However, at least up to the time of the nutrition survey, care groups have had little or no effect on the nutritional status of the children. Since then much emphasis has been placed on nutrition education and the mealie-peanut-bean weaning food has been introduced through the care groups and has become widely accepted. Its effectiveness has not yet been measured.

Observed, but not measured influences of care groups are the vegetable gardens which are now commonly seen, although it is not known to what degree they are the result of the presence of a care group in a village. Clinic sisters comment on the good effect of oral rehydration through the care groups. Indeed, many children presenting at the clinic have already been given the oral rehydration fluid, and generally people know that the care group can help them in case of diarrhoea. How much the care groups have actually taught members of the community to prepare the fluid themselves is not known. In some settlements mud stoves have become very popular. People have realised that they save fire wood with the stoves and thus spend much less time collecting wood.

DISCUSSION

a) Effectiveness:

Actual evaluations, together with obsevations and impressions, indicate that care groups are effective in at least some aspects of health promotion and disease prevention. Being members of their community, usually differing little in social status from the people amongst whom they live, they have much easier contact with the villagers than a clinic nurse could possibly have. Care groups determine themselves what they want to learn, either prompted by their own family problems, or because people ask them questions they cannot answer. Members are therefore personally interested in satisfying their own and the community's needs. It also shows that villagers have come to expect that care groups share their knowledge and skills with them. Thus, under ideal circumstances, with the right input at the right time, i.e. when the group identifies the problem discussed as their own problem, the impact of the groups on their community could be tremendous. Health authorities have become aware of this new opportunity, where the network of groups of people who are receptive to innovations provide a favourable entry point into the community.

It is difficult to estimate the size of the population covered by the services of the care groups. About 20% of the population is in direct contact with group members, but an unknown number is influenced by the ripple effect people who have changed their own attitudes and practices

have on their neighbours and friends. Some groups also attend gatherings such as mothers waiting at the under-fives clinic, where care group members may give them health education. Other groups have gone to schools to teach the children about trachoma or scabies.

The potential of care groups in health promotion is therefore superior to the impact conventional health services can have on the community. Care groups are personally involved because they try to solve their own problems of which they are now more aware than before joining the groups. Their message is therefore much more real than the often dull lectures given at clinics and hospitals. Also care groups do not compartmentalise health away from the rest of life. For them life is a wholeness which cannot be divided.

b) Limitations:

Why then, if the care group's potential is unlimited, have they not more radically altered the disease patterns in their communities during their 5 - 7 years of existence ? The following limiting factors may be identified:

1. Some of the care group motivators:

- lack of understanding of the groups' needs
- inability to respond sensitively to the groups
- incomplete understanding of the aims of care groups
- inappropriate methods and contents of education
- difficulty to find the right kind of person who is open-minded, with leadership qualities and supportive.

2. The groups:

- leadership problems
- tensions within a group
- wrong expectations
- lack of initiative and responsiveness
- cultural limitations
- economic limitations.

3. The community:

- leadership in the community opposed to care groups
- community has other interests than health
- cultural taboos and beliefs preventing acceptance of new ideas
- economic limktations to implement improvements.

1. The care group motivators:

Most care group motivators are nursing assistant grade, the reason for this choice being that they identify more easily with the villagers than the more highly qualified nurses would do. However, it has been difficult to select the right persons for the job. Some of them are very excellent, responsive and imaginative. Others have little insight into what they should be doing and compensate their inadequacy with bossiness.

It may happen therefore that the same subjects of health education are repeated over and over again under the pretext that people are slow to understand, while the groups get bored stiff and lose interest. Also some motivators have more imagination than others in using teaching aids and

appropriate methods of adult education.

One of the most important skills a care group motivator should have is a keen sense of awareness of moods in the groups and the ability to respond positively to them. Experience has shown that the personality of the care group motivator is all important, at least as long as the care groups are still dependent on input from the hospital.

2. The care groups:

The quality of the groups is very variable. Wher the groups have emerged due to a felt need by the community they usually function well and show initiative. However, groups which have been started simply because it is now fashionable to have a care group and for the sake of prestige are passive and often never really come off the ground.

The type of leadership within the group greatly determines the life of a group. Where the chairlady is dominant and authoritative frictions often arise. Members are not left to their own initiative and these groups remain static.

In most groups membership turnover is great. Mothers attend not quite knowing what they are going to join and because there is not much other choice of entertainment in the village. They come with wrong expectations, thinking care groups are a "club" as they know it from other clubs, and are thus not prepared to give something of their own in time and efforts to the groups. Irregular attendance resulting from such misunderstandings is disruptive to

the group as a whole. On the other hand the high turnover means that more people have in fact had contact with the health service than is reflected in the statistics.

An interesting, but not surprising observation has been that the wealthiest group (table I) consisting of a majority of well-to-do and professional members, mostly teachers, did very well to start with, because they were fast in learning, but subsequently this group was the first to collapse: the community's problems were alien to their own personal problems. The nearer a care group is to the average living standard of the community of which they are a part, the greater their impact.

When working with care groups one has to adapt to the pace of life in the community. It is dangerous to push the groups towards objectives perceived by the health services, as excellent as they may be. Groups have to be led step by step towards an understanding and awareness of the specific health problem. Only then may the group be ready to start planning for action, which in turn is a slow process. This implies that the care groups cannot be used as a working force to achieve an objective which should be reached within a certain time limit. Many a time our projects failed because we did not have the patience nor the sensitivity to adapt to the rhythm of the group and their community. For the care groups to retain their dynamics and enthusiasm, it is of vital importance not to use them in response to the needs of the hospital, but for the hospital to respond to the needs of the care groups.

3. The community:

It would be naive to expect that every community, or every section of a community would respond enthusiastically to the aims of the care groups, just because we think it is a good thing. Communities are not homogeneous and different people have differing needs and priorities. Much depends also on the leadership in a community, traditional or otherwise. Where the authorities and opinion-makers are supportive, groups are free to do what they feel is right. Fortunately we very seldom experienced any resistance from the side of the tribal authorities. Limitations are more in the form of apathy than actual opposition.

In places to which people have been relocated and grafted onto an existing community, groups have great difficulties to unite across the divisions within the community. Often factionalism affects every single aspect of village life. Instances are rare where the care group could actually act as an unifying force within these communities.

Finally one must realise that effectively it is the socio-economic system which is the major constraint to health promotion through the care groups. Care groups can do something to improve life within the given limits and boost their own and the community's morale and values. They have been effective where improvements were largely unrelated to money, such as cleanliness and individual face cloths. Their effect on nutrition, however, has so far been insignificant.

CONCLUSIONS

Care groups in Gazankulu have proved to be an appropriate method to promote health and prevent disease within their own community. Within the constraints of the prevailing poor economic situation and social disruption through migrancy and relocation, they have succeeded to improve some aspects of daily life by simple means such as raising standards of hygiene, vegetable gardening, mud stoves, building toilets and introducing cheap nutritious weaning food. Their success lies in the fact that they are part of their community and, by first implementing their acquired knowledge in their own homes they give credibility to their teachings. Their greatest strength, however, is that they have learnt to work as a group, sharing skills with each other and with their community.

The attitudes and standards of education in women is one of the most important factors in the development of a community. This is even more the case in a society where most of the men are absent and the women have to assume much of their husband's responsibilities in addition to their own. It is known that for instance the nutritional status of children is strongly related to the educational standard of their mothers while no definite relationship between income and nutrition has been found[7]. Of the basic needs education is the most important. Education of women is even more important. Education happening within and emanating from the care groups can therefore contribute materially towards a healthy development of Gazankulu's communities.

SUMMARY

Care groups in Gazankulu are groups of unpaid volunteers in the villages, acting within their own communities as a team to promote health, prevent disease and improve the quality of life. Being themselves part of the population they serve and encouraged to be largely self-directing in the choice of objectives and methods of action, they are likely to be more acceptable and effective than institutionalised health personel could be. They have had a significant impact on standards of hygiene in their community and decreased appreciably the prevalence of active trachoma. Limiting factors are, amongst others, tne slow progress by both the groups and their hospital-based motivators and the restraints imposed by the socio-economic situation.

REFERENCES

1. Survey of Race Relations in South Africa 1982, S.A. Institute of Race Relations, Johannesburg 1983.

2. C. Ysselmuiden, The nutritional status of inhabitants of northern Gazankulu and the response of the health services. (In press, 1984).

3. E.E. Sutter, R.C. Ballard, A community approach to trachoma control in the Northern Transvaal, S.A. med. J. 53, 622, 1978.

4. E. E. Sutter, Community participation in the prevention of disability, Rehab. S.A., 26, 65, 1982.

5. E.E. Sutter, R.C. Ballard, Community participation in the control of trachoma in Gazankulu, Soc. Sci. Med., 17, 1813, 1983.

6. S. Tollman, A primary health care programme in Gazankulu: (ii) Evaluation., SALDRU, Conference on the economics of health care in Southern Africa, September 1978.

7. E. Shuenyane et al., A socio-economic health and cultural survey in Soweto, S.A. med. J. 51, 495, 1977.

Table I. Wealth*)and Social Group Membership**)of Chavani and Mbokota Care Group members, compared with the general population in their settlement

	Tin roofs	Social group membership
CHAVANI		
Care group	70%	75%
general population	29%	10%
MBOKOTA		
Care group	34%	34%
General population	34%	21%

*) Wealth indicator used: home with tin roof

**) Social groups: traders, teachers, tribal doctors, club members etc

Table II. Influence of care group activity on prevalence of intense upper tarsal inflammation in trachoma

Place	Year	Pre-school children % prevalence	All ages % prevalence
NKUZANA			
before CG	1976	39%	27%
2 yrs treatm.	1979	15%	10%
MAHATLANE			
before CG	1978	49%	27%
6 months treatm.	1978	29%	22%
MTSETWENI			
Before CG	1976	-	33%
good hygiene no treatment	1980	-	7%
NJAKANJAKA	1976	46%	33%
Control, no care group	1979	44%	33%

Table III. Nutritional status of children aged 0-3 years of non-care group members (NCG) and of mothers who were a care group member for more than 6 months(CG)

(NCG-children: 643; CG-children; 196)

Wt/Age		NCG	CG	Wt/Ht	NCG	CG
3rd	percentile	29,7%	23,4%	80%	1,7%	1,0%
3-50	"	52,7%	57,6%	80-90	23,5	15,8%
50	"	17,4%	18,9%	90	74,8%	83,2%

Fig 1. Influence of care group (CG) activity on acquisition of facilities for maintenance of hygiene in households (HH).

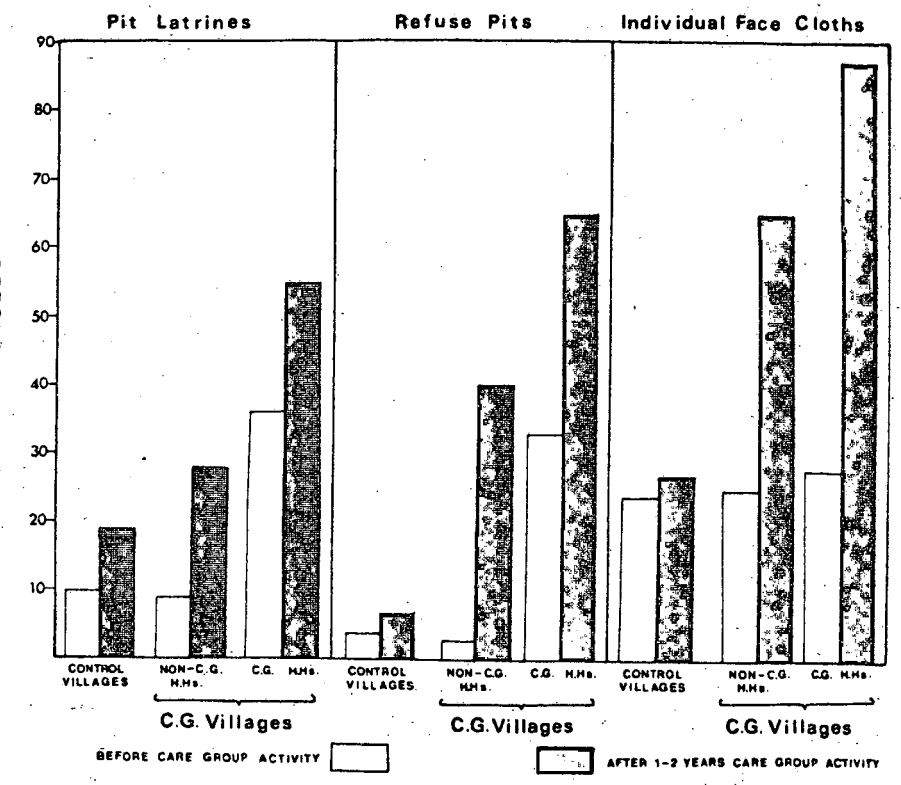
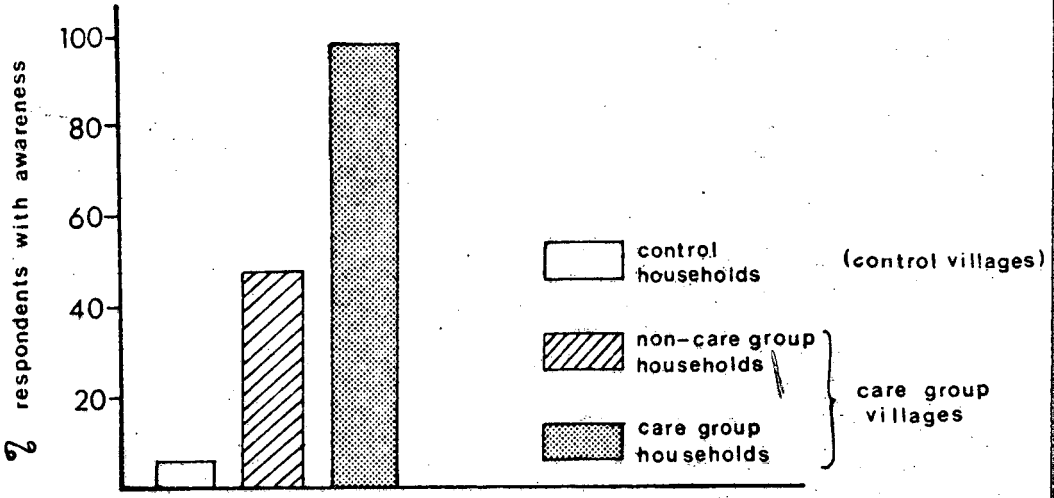


Fig 2. Awareness of the role of hygiene in the prevention of trachoma.



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.

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

Edina-Griffiths