

GELUKSPAN HOSPITAL

Gelukspan Hospital is situated in the Ditsobotla District in the central region of Bophuthatswana. The hospital serves two-thirds of the people living in that area.

Villages in the Ditsobotla District

The people of the Ditsobotla District live in three kinds of villages.

Firstly, there are the traditional villages of the old reserves. Some of them can be dated back to the last century. These villages are ruled according to traditional customs.

Secondly, there are villages which have been recently set up as resettlement areas as a result of the apartheid policy of the South African government.

Thirdly, there are trust areas which are resettlements which have been established over 50 years ago.

Of these three kinds of villages, the recent resettlements are worst off in terms of ill health. This can be shown by figures of infant and child death rates compiled in 1983:

VITAL STATISTICS FOR THE HEALTH WARD (1983)

	Trust areas	Resettlements	Traditional areas	Health ward
Infant mortality rate	43,1	65,0	34,4	41,1
Neonatal mortality rate	17,2	20,3	13,7	15,3
Child mortality rate 1 - 4 years	8,2	17,9	7,5	9,5
Under - 5 mortality	17,6	29,8	14,2	17,5
No. of persons per household	7,3	6,8	6,9	7,0

How people make a living

People in the Ditsobola District make a living by agriculture, cattle raising, migrant labour, and daily commuting to nearby South African urban areas. In the District itself, the major employers are the agricultural projects, and the civil service.

Agriculture

The main crops that people usually cultivate are maize, sunflowers, and sorghum. But agriculture in the area has been badly affected by the continuous drought since 1981. There are two major agricultural projects at Mooifontein and Setlagole, in which mostly maize and sunflowers are cultivated.

Livestock

Whereas under half of the households with under-five children own land, over three-quarters of the households possessed livestock such as cows, sheep, horses, goats, donkeys, pigs, turkeys, geese chickens. (1980 survey).

Employment

According to the 1980 census, only one-third of the people in the area, mostly men, are in some form of employment. Most of these are employed outside of Bophuthatswana as contract workers, or they commute every day to places of employment in South Africa.

Social problems

This is what makes the Ditsobotla people a society of women, children, and old people. The traditional extended family is more and more being replaced by nuclear families. Where these social relations are destroyed, problems of alcoholism, rape, abandonment of dependants, and marital problems surface.

Added to these problems are the problems of unemployment and poverty. These are especially serious, considering that the inequalities of apartheid do not provide any social welfare and social security benefits.

Health services in the past

The health services in the Gelukspan Health Ward date back to the 1940's. Before that, most of the health needs were met by self-care, traditional healers and the health services in the surrounding South African urban areas.

In the 1940's, the Catholic Church started a mission clinic in Kraaipan village and in the 1950's, a clinic was started in Mareetsane.

In 1951, a third clinic was started in Gelukspan; this clinic was extended into a hospital in 1960, and over the years, new wards and departments were added to the initial building. Until "independence" in 1977, the hospital remained a mission hospital run by the Dutch Reformed Church.

The hospital was greatly understaffed. It was mostly run by nurses with occasional support from general practitioners and doctors from hospitals in Mafeking or Itsoseng.

The health service now

With "independence" in 1977, the financial support became more predictable and staff needs were met more appropriately, but a shortage of trained nursing staff remained.

A community extension service was started with a mobile clinic in two villages (1977). In 1985, 13 villages were covered at least once a month by a mobile station. Seven villages were covered by fixed clinics, and all the villages are visited on a regular basis (most on a monthly basis) by a mobile under-five clinic.

In this clinic, health education, immunisations, and growth monitoring together with nutritional support is provided free-of-charge.

The health services also provide services by a TB case-finding team, a dental team, social welfare offices, environmental health services, school health services, eye team, community psychiatric services, and services for the handicapped in the community.

Health needs

A great number of the clinical problems relate to either maternal or child ill health. The same applies to the type of services offered by the community health services, where the major thrust of activities is directed at maternal and child health.

About half of the people coming to attend the services go to under-five child clinics, school health services and family planning services.

Most of the research that is done in the district is aimed at finding out the needs of mothers and children. Services try to meet these needs. Much of the health education is on appropriate home care of children (nutrition, oral rehydration); at the same time, people are encouraged to attend preventive and promotive services.

When children are admitted to the hospital, mothers are encouraged to be admitted with the child, not only when they are breast-feeding (as stipulated by the Department of Health) but also when the child has got diarrhoeal disease, malnutrition, a life-threatening condition or when the health worker thinks the mother could benefit from health education in the ward.

Health education

Health education is well structured and practised daily in hospital wards with lectures, demonstrations and songs. But there are no clear guidelines on what to teach, how to teach and when to teach. It is up to the individual clinic or team to develop its own programme. There is thus no proper co-ordination.

Community participation

The community is involved mostly through members of clinic committees which

have been set up in the villages. The selection, composition and efficiency of these clinic committees varies from village to village. Some limit their work to logistic support to the visiting health teams, while others are more active in home visiting and health promoting activities, for example the development of vegetable gardens.

Major health problems

At the end of 1983, all clinic communities and a number of health workers were asked to write down the ten major problems in order of priority; both groups agreed on six problems as major problems although with different priorities.

Several studies carried out in the health ward emphasize the importance of malnutrition - diarrhoea - respiratory tract infections as an important cause of death and illness of under-five children.

Caring for children

In 1980, a random sample of 493 children under 6 years from 352 mothers were studied; 32 percent of these children did not receive personal care from their mothers but from a grandmother, an aunt or both; another 32 percent were taken care of only by their mothers; the remaining 34 percent of the children had more than one caretaker in charge of them of whom one was the mother.

Problems of ante-natal health care

In view of the fact that the population of the Ditsobotla District is growing rapidly, health care of mothers and children becomes very important. The Gelukspan Health Ward offers extensive ante-natal care. Yet it seems that the average attendance has dropped slightly.

In 1980, the reasons given for not attending ante-natal care services were: lack of transport or great distance, no clinic or hospital present, attendance by General Practitioner.

The reasons given for delivering at home (1980) were similar: lack of transport or great distance to clinic, the baby came too fast, there were no health services available, or there were no problems experienced.

Breastfeeding

The relationship between breastfeeding and diarrhoeal diseases in children was studied in 1984. Of all children admitted with caretakers because of diarrhoeal diseases, only seven percent of under-five children, or 19,2 percent of children under six months of age were exclusively breastfed.

Diet of under-five children

Maize, bread and milk are the three most commonly given foods. Only 12 percent of the children eat vegetables daily; 10 percent never eat them.

Growth monitoring and food supplements

Growth monitoring is done in the under-five clinics. The nutritional status of children is assessed by weight and arm circumference. Mothers are explained the meaning of the growth charts and the nutritional status of their children.

Food supplements are provided free of charge when the upper mid-arm circumference is less than 13,5 cm or when the weight of the child is faltering.

In 1982, 6,3 percent of under-five children were getting food supplements; this rate is lowest for children less than 12 months (1,1 percent) and the highest for children between 24 and 36 months (11,1 percent); for children between 12 and 23 months, 10,2 percent were on food supplements.

Oral rehydration

Oral rehydration therapy has been encouraged since 1981, both for home therapy and for therapy of children hospitalised with diarrhoeal diseases but no dehydration. Dehydrated children are admitted to hospital and as a rule, they are treated by intravenous rehydration.

Mothers are taught about the salt-sugar solution (SSS) for rehydration, which they can prepare at home. They are taught to give one cup for every loose bowel action; and are explained the signs of dehydration and what to do when this develops.

Knowledge about the salt-sugar solution and about dehydration was assessed in 1984. It was found that 66 of 400 care-takers (16,5 percent) knew how to prepare SSS, regardless of whether a clinic was within reach.

It seems that care-takers knowing how to prepare the salt-sugar solution often recognise death as a complication of diarrhoeal diseases.

But most care-takers did not recognise dehydration as a complication of diarrhoea. Only two care-takers in the whole sample knew at least two signs of dehydration. All the others knew none or only one.

It was concluded that care-takers recognising death and dehydration as a complication of diarrhoeal disease, and recent experience of diarrhoeal disease in the household, were associated with a better knowledge of how to prepare the salt-sugar solution.

In 1985, a researcher found that 57 percent of care-takers knew how to prepare the salt-sugar solution.

Immunisation

In 1985, it was found that only 49 percent of the children in the age group 12-23

months were fully immunised on time, although 75 percent were fully immunised at the time of the study; ten percent received BCG immunisation too late and 16 percent received DPT/Polio usually too late but occasionally too early; the same applies to measles inoculations.

Attendance of under-five clinics

In 1984, 84,6 percent of the under-five children had a "road to health" card. This shows that there is a small number of children who are not being reached by the health services.

This was particularly true in the resettlements where only 66,4 percent of the children were in possession of a growth chart.

The total number of UFC clinic visits has increased from 1246 in 1980 to 20519 in 1985.