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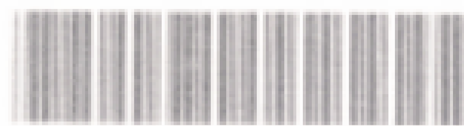

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URBANISING COMMUNITIES

New Challenges for Health Providers

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Editorial

The urban areas in South Africa are undergoing substantial change. People from rural areas are migrating to the metropolitan regions, residents from overcrowded townships are establishing informal settlements, others are moving to the inner cities. These developments are often newsworthy, sometimes dramatic. People who set up rudimentary shelters on the sidewalks in central Johannesburg received substantial media coverage, the removal of shackdwellers on vacant land south of the city by the City Council elicited a furious response.

However, the growing health needs of these urban dwellers and their new communities remain largely unaddressed. These communities suffer from a lack of adequate housing, water, sanitation and electricity. They are exposed to air and water pollution and a range of other environmental hazards. The occurrence of ill-health associated with these conditions is high and increasing, adding to trauma and morbidity caused by violence, accidents and sexually transmitted diseases. A growing number of communities and health workers are starting to respond to the challenge of new patterns of urban growth and disease.

New Settlements and New Disease Patterns

We start this edition with an overview of urban change. New settlements are mushrooming, communities are growing, but health services are being forced to operate on smaller budgets. George Dor of Critical Health argues that progressive health workers have to sharpen their understanding of urban change in order to plan and provide accessible services for all.

John Seager highlights the various illnesses associated with the growth of our cities, including diseases associated with poverty and poor service provision. He also discusses the prevalence of conditions related to rapid social change from a rural to an urban setting, including HIV/AIDS and alcohol misuse. The article raises the high level of violence as a major concern.

Developing cities face situations of rapid industrialisation or severe economic stagnation, which both involve poor planning of social services. Angela Mathee and Yasmin von Schirnding show the link between urban environment and various communicable diseases. They explain how conditions like overcrowding affect people's mental and social well being. They suggest planning through integrated environmental management to limit the negative effects of rapid urban growth.

Valli, Motale and Rispel interviewed residents in the informal settlements of Orange Farm and Vlakfontein, who said their health problems are caused by poverty and lack of basic services. The authors also found that the lack of emergency transport to centrally located trauma services was a key concern among residents.

Changing Communities, Health Providers Adapt

Grant Rex and Antonio Fernandes look at the transient nature of large sections of the Alexandra population. People are moving into the area and out of it as a result of political violence. The authors show how people's temporary residence and poor knowledge of services in the area adversely affects their efficient use of available health services. Overcoming this problem requires residents' involvement in the planning of services.

Hillbrow, a previously white residential area, consists of a largely black population. This change has not been accompanied by service improvements. Hillbrow lacks appropriate, caring and efficient health services. The Hillbrow Primary Health Care Project wants to get the community involved in planning health services. It also wants to provide community based training of health workers.

Bernhard Gaede assesses the changing nature of Muldersdrift, from a peri-urban farming area to a more densely populated area with a growing number of informal settlements. He describes how the Muldersdrift Health Development Project progressed from a student led service to one which has a high level of community participation. He points to the need for greater co-ordination between non-government organisations (NGOs) and shows that state structures have failed to carry out their responsibilities with regard to health care in the area.

NGOs have created an impressive number of jobs. However, they have failed as a well planned alternative to state service provision. NGOs are more developed in urban areas, but the worst conditions occur in rural areas. Hugh Gosnell addresses the reasons behind the urban bias. He shows that despite the shortage of NGOs in rural areas, the NGOs which do work there show a greater potential for interaction with communities than in urban areas.

Engaging Communities in Deciding Their Own Health

Veronique Monez and Jo Monsen discuss possible options for the future of Botshabelo, an area to which people were relocated by the apartheid government. Botshabelo is far from centres of employment and, because of a lack of education, poor housing and health services, sexually transmitted diseases and child mortality are high. The authors suggest that whatever alternatives are sought - either relocation of the population to a more viable setting or upgrading of the present settlement - these must include consultation with and involvement of the community.

Fidelia Maforah and Pam Cerff look at ways of gaining community participation in health development programmes. In a programme to reduce common diseases, researchers achieved the involvement of a Hout Bay informal settlement community. Members of the community overcame mistrust among themselves and general mistrust towards professionals, and participated in the health intervention programme.

Violence, Institutions, the World Bank

A Goldstone Commission inquiry into public violence and children investigates the ways in which children are affected by violence. Children directly exposed to violence may suffer psycho-social problems and carry out violent behaviour themselves. The loss of caring adults, disintegration of the family unit, lack of social services and treatment by traumatised health personnel can also have serious effects on children.. Writing on behalf of the commission, Norman and Rock suggest a national programme for the rehabilitation of children affected by violence.

Anne McKay argues that families should be encouraged, with better foster care grants, to care for abandoned or orphaned children. This should replace institutional care which fails to provide the nurturing environment of the family setting.

Fiona Godley shows how Third World debt and World Bank imposed structural adjustment programmes (SAPs) have had a negative impact on health. Programmes which prioritise basic needs like education, primary health care and nutrition should replace SAPs. Godley also argues for the need to write off Third World debt.

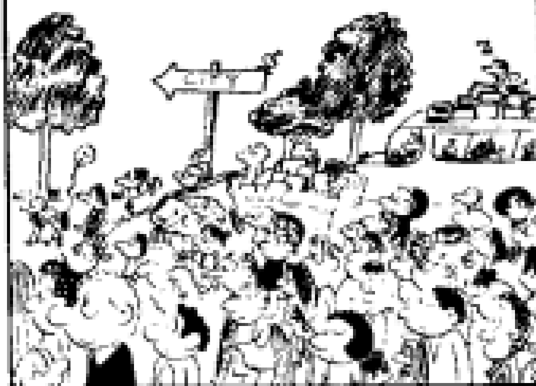
Anant Phadke reviews a meeting in India to discuss the 1993 World Bank report on health. Participants were not seduced by the report's celebrated shift to acknowledging the need for state spending on health care. They criticised the bank for its fragmented approach, the absence of scope for people's control and the continued reliance on the private sector.

Sue Godt of the Institute For African Alternatives provides a comprehensive introduction to critical readings available on the World Bank and International Monetary Fund.

A Tale Of Two Cities

BY DOUG BRUNNER

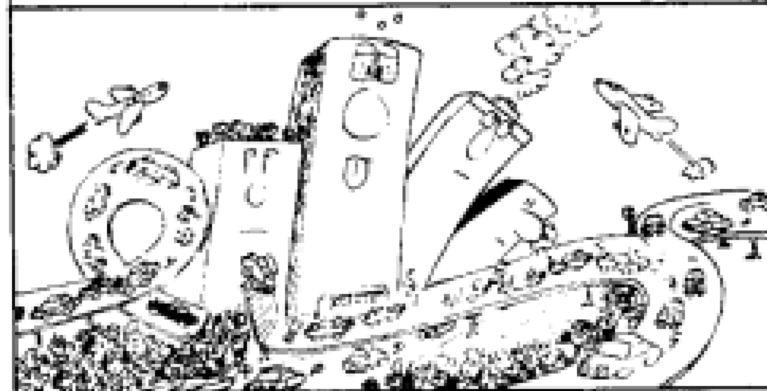
PEOPLE, MANY OF THEM CHILDREN, ARE ON THE MOVE



THEY ARE MAKING THEIR WAY TO THE CITY

UNTIL RECENTLY, THE CITY WELCOMED THIS GROWTH BECAUSE IT MADE THE CITY AN IMPORTANT CENTRE

BUT IT ALSO BROUGHT THE CITY MANY BIG HEADACHES



SECTION A

new settlements and new disease patterns

New Settlements, Growing Communities
The Increasing Need for Health Care

Critical Health

The election of a government of national unity was a key point in South Africa's history. But it was characterised by a succession of problems. Polling stations didn't operate smoothly, there was a shortage of ballot papers and other voting materials, a large number of irregularities were reported and there were repeated delays before results were announced. The final results were only agreed upon after behind the scenes trade offs between the larger parties.

The miscalculation of the number of eligible voters and, more specifically, the geographical distribution of these voters was perhaps the most important factor in what one newspaper called "the Great Ballots Bungle". In the Orange Free State, there was a 115% poll. Two hundred thousand more voters than the estimated total number of voters in the region cast their votes.

The Wrong Figures

The Independent Electoral Commission (IEC) relied on the figures from the 1991 population census and projections for 1994 based on this census. But there are a number of problems with these figures. The census was not conducted in the homelands and official estimates of the population in these areas cannot be relied on. Furthermore, extensive areas with high numbers of black residents, including informal settlements and peri-urban areas, were surveyed by means of aerial photographs. The population figures for these areas were arrived at by multiplying the number of housing structures on the photographs with an estimate of the number of inhabitants per structure. This estimate has been widely criticised as being too low. It has also been suggested that, during the apartheid era, the black population was deliberately underestimated by the government for political reasons.

The Central Statistical Services (CSS), the government unit responsible for population statistics, already acknowledged in 1992 that there was "the highest degree of uncertainty" about the black population figure. Moreover, a

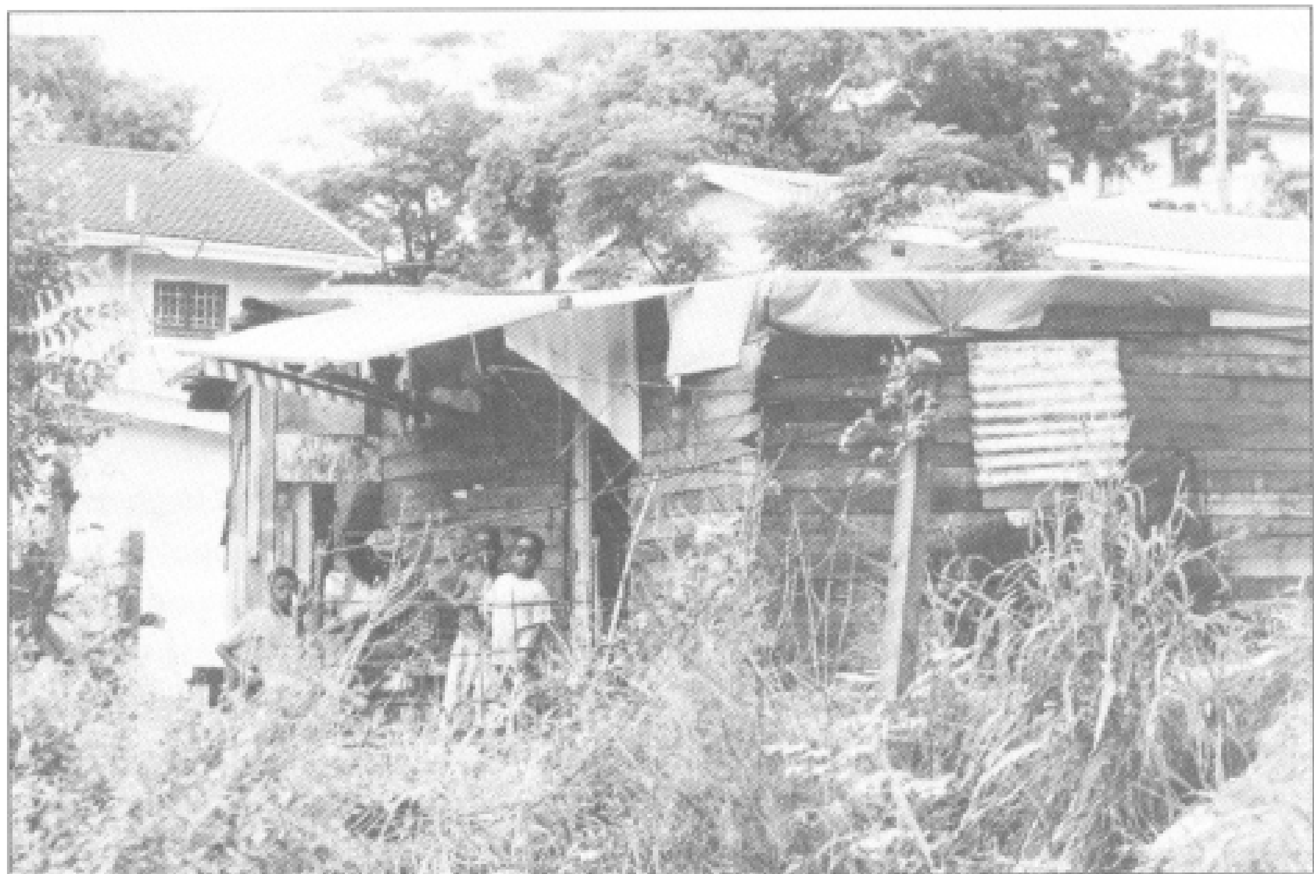
number of more realistic estimates were available to the IEC. For example, the official figure for South Africa's population in mid-1994 is 40,4 million, Research Surveys' figure is 43,6 million. The most striking difference between the two sources is in the figures for the major metropolitan areas. The election dramatically illustrated the degree to which the CSS underestimated the population in these areas.

The IEC should have done its homework in this regard. Its failure to do so contributed to the political tension surrounding the election which, in turn, could have derailed the transition to a government of national unity.

It is clear that we, as health workers contributing towards improved health for all South Africans, cannot make the same mistake. We have to take the demographic reality of the country into account in planning and providing accessible health services for all.

Movement from Rural to Urban

The implementation of segregation and apartheid by successive governments over the years has led to a unique pattern of settlement in this country. The urban areas were divided into white cities and black townships, and the rural areas into white owned farms and black homelands. The authorities main-



Ismail Vawda

At one time informal settlements developed on the urban periphery. Not any more.

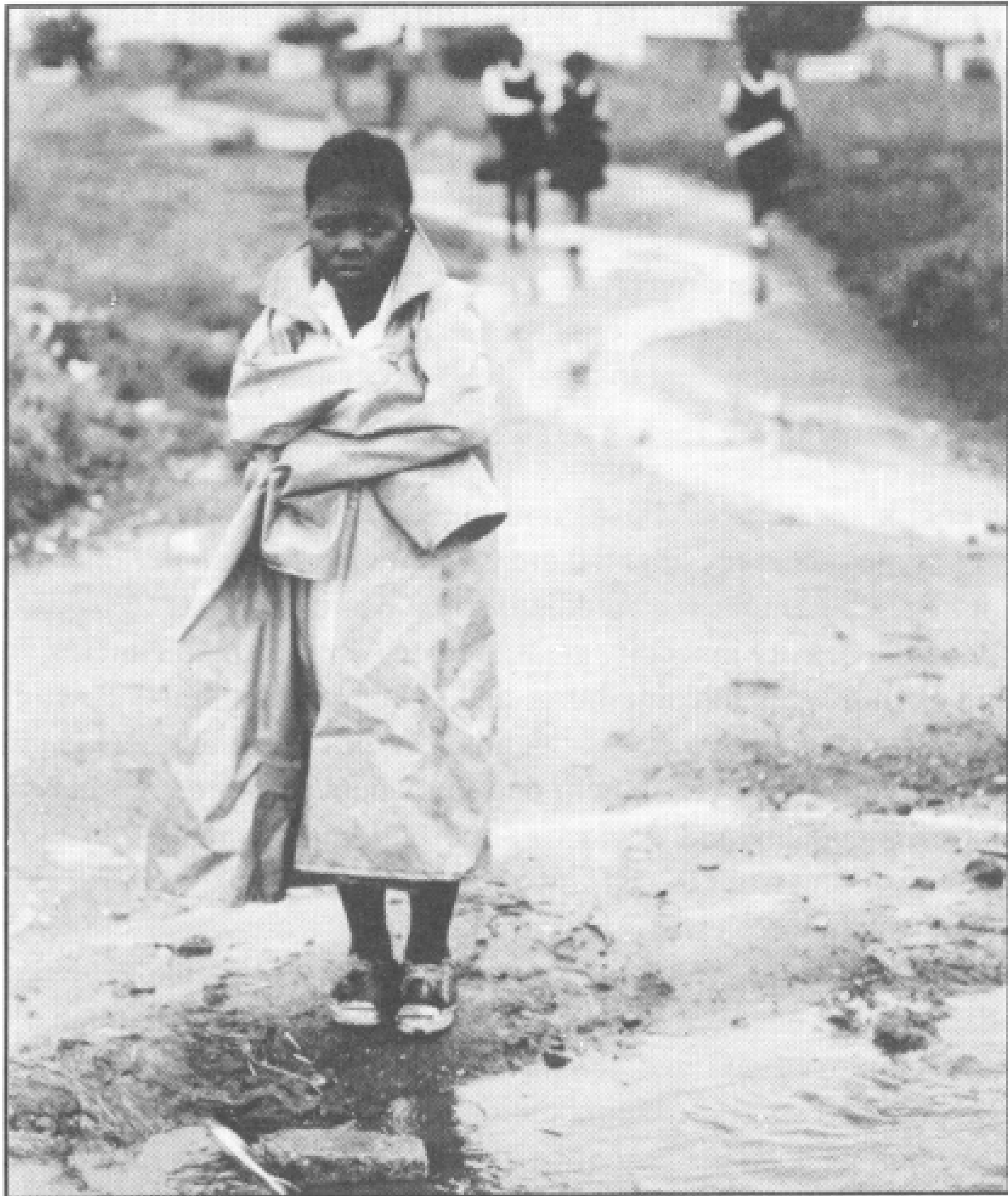
tained this pattern by brutally enforcing a battery of racist legislation. They restricted the settlement of black people in urban areas and, in so doing, artificially slowed down the process of urbanisation.

However, this pattern started to change in the 1980s. The authorities were becoming progressively less able to prevent people from moving to the urban areas. The government, under increasing political and economic pressure, finally removed the pass laws in 1986. Instead, it introduced the "orderly urbanisation" policy, including the 1988 Prevention of Illegal Squatting Amendment Act, which allowed for the destruction of informal housing. In many instances, the authorities implemented the act and bulldozed entire settlements. They also promoted violence in newly established settlements. Even after the 1994 election, during the bitter highveld winter, the Johannesburg City Council tore down people's shacks on land south of the city. Despite these real threats, the lack of basic services and the lack of employment opportunities, increasing numbers of people have moved from rural to urban areas.

The Urban Foundation (UF) points out that, from 1980 to 1985, the main movement of African people was from the white farms to informal settlements in the homeland components of the metropolitan areas. People moved to Botshabelo in the Bloemfontein region, Inanda in Durban and Winterveld at the northern edge of the PWV. For many, these were points of arrival from which to look for employment and shelter closer to the city centres. The UF argues that the main movement from 1990 to 2010 will be from homeland rural areas, bypassing the homeland components of the metropolitan areas, to informal settlements somewhat closer to the centres of the metropolitan areas. It predicts an increase in the African metropolitan population from 8,7 million in 1985 to 11,0 million in 1990 to 23,6 million in 2010.

Lack of Housing

However, movement into the cities only accounts for part of this increase. A substantial portion of the increase is due to the growth of the population already resident in the urban areas. In the face of this growing urban population, the apartheid government abdicated its responsibilities with regard to the provision of housing and services. The vast bulk of the "matchbox" houses in the townships were built in the early years of National Party rule. In the 1980s, the government handed over the task of housing provision to the private sector, which has only built a small number of houses. In 1991, only 2 700 houses costing less than R65 000 were built. The houses are often of poor quality



Sello Jiyane

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and, despite being at the lower end of the market, are affordable only to the relatively better off.

According to the UF, in 1990, more than 7 million people lived in informal housing in urban and metropolitan areas. Roughly half the African metropolitan population lives in informal structures, in the Durban metropolitan area the figure is 70%. The shortage of formal housing is continually escalating. It has been estimated to be as high as 2 million units. Hundreds of thousands of houses need to be built each year to overcome the backlog.

Backyard Shacks, Informal Settlements and Inner Cities

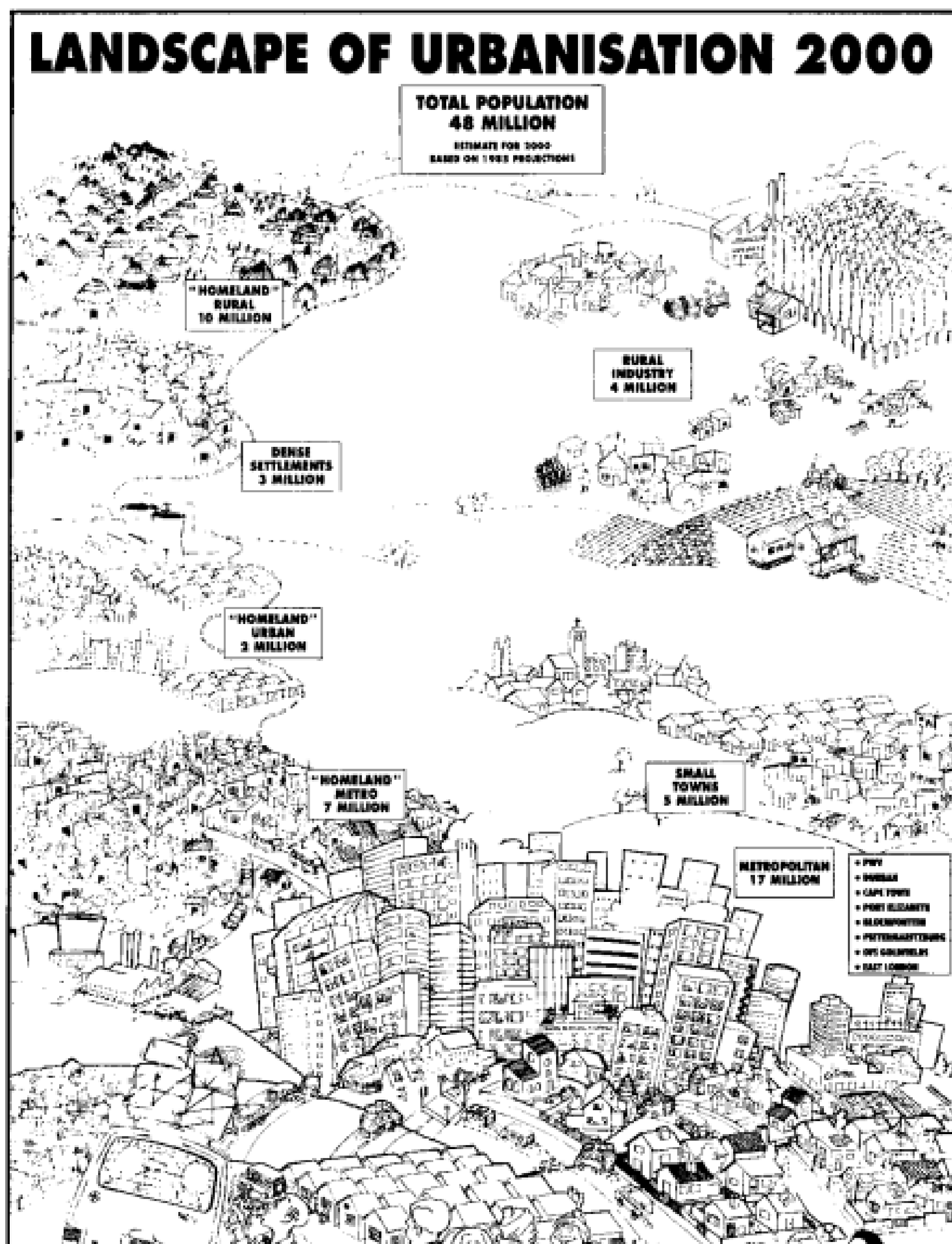
Doug Hindson, in a paper for the National Housing Forum, identifies a number of specific zones in the urban areas, including the townships, hostels, informal settlements, middle income black housing estates and inner city areas. He describes the changes taking place in these zones. The townships have become progressively more overcrowded.

Large numbers of people, particularly in the PWV, have moved into backyard shacks and pay rent to the owners or occupants of the houses. Many of the poor and younger people have moved into informal settlements in or near the townships. Crime, violence, the breakdown of services and disruptions to commuter transport have contributed to the exodus of wealthier residents to middle income residential areas in the black urban peripheries, or to inner city flatlands and lower middle income white suburbs.

The high density inner city areas include Albert Park in Durban, Joubert Park and Hillbrow in Johannesburg, and Greenpoint in Cape Town. These areas are experiencing two distinct trends. On the one hand, there is growing overcrowding and impoverishment due to owners/landlords renting to large numbers of occupants and neglecting the buildings. On the other, there is upliftment resulting from the inflow of middle to high income earners.

The hostels were established in the core city areas and in or near the townships as single sex accommodation for migrant workers. More recently, their character has changed and they now also accommodate couples, families, the unemployed and underemployed. However, many migrant workers want to retain their single accommodation in the urban areas and have resisted the conversion of hostels into family quarters. Spontaneous informal settlements include Lindelani in Greater Durban, Orange Farm in the PWV and Crossroads in Cape Town. They are home to people who have moved out of overcrowded townships as well as people from the rural areas. The rural inhabitants include the families of migrant workers who live in single sex hostels and, for this reason, a high proportion of women. Most of these settlements are located in or near the black townships. In some cases, people have settled on planned site and service schemes, which have basic services such as water and toilets. These schemes are also mainly in the black urban periphery.

The settlements have mushroomed in these areas despite the substantial areas of vacant land near the city core. They have thus re-inforced the basic racial structure of the cities. More recently, growing numbers of people are occupying vacant land in core city areas and are setting up rudimentary shelters on inner city pavements.



The Rural-urban Link

The UF and World Bank argue that the process of urbanisation must be encouraged and that resources must be concentrated in the urban areas. There is no doubt that substantial resources are needed to upgrade the urban areas, but the UF and World Bank negate the importance of the rural areas. They overemphasise the permanence of the migration into urban areas. According to Mike Morris at the University of Natal, Durban, "Families do not just urban-

ise and leave their rural economic, social and cultural links behind them. Many households maintain their rural homeland base as well as establishing a foothold in urban areas. The rural-urban link is consequently a defining feature of black society."

Furthermore, the movement of people out of the rural areas is offset by the rate of population growth in those areas. The number of people remaining in these areas is thus continuing to grow, albeit at a much slower rater than in the urban areas.

The rural areas are also changing in character. In the rural homeland areas, denser settlements are being formed and are growing in size. The growth of the population in white farming areas, particularly closer to the urban areas, is also leading to the establishment of informal settlements in these areas. Substantial resources will need to be directed to these areas as well.

Implications for Health Providers

The implications of these demographic trends for health care are enormous. In the era of segregation and apartheid, reasonable health services were developed for the white urban and farming communities. Services of inferior quality were provided in the black townships and homelands. Many in the home-

Ken Ndlazi

All roads lead to …

lands and many black workers on white farms had no access to health services.

The process of urbanisation and demographic change has been accompanied by shrinking health budgets and cuts in the services provided by the already inadequate health structures. To date, very little has been done to provide services for the new urban communities, and existing services are being cut back in communities which are growing, both urban and rural.

The challenge is daunting, but the new political climate provides scope for change. The Reconstruction and Development Programme (RDP) has been developed as an integrated approach to meet people's basic needs for housing, water, sanitation, electricity, health care and other services. The opportunity thus exists for health providers to develop the necessary health services in all our communities in an integrated way with other sectors.

There is a great deal of urgency in rising to the challenge. On a daily basis, people are creating new settlements, people are using plastic and cardboard to create some form of shelter on the sidewalks in our city centres. There is an ever growing number of people without access to basic health care.

This article was written by George Dor

Growing Cities, New Disease Patterns

Urban Health in the Developing World

John Seager

By the end of the century, more than half of the world's population will be living in cities. This increase in urban population will have a profound effect on global health and make new demands on all those involved in public health. The developing countries are the least urbanised, and consequently have the greatest potential for urbanisation, yet the urban population of the developing world already exceeds that of Europe, America and Japan combined. Sub-Saharan Africa is not only less urbanised than most other parts of the world, but also has a high population growth rate, so Africa is likely to experience some of the most rapid urban growth in the world during the next few years.

Urban growth is caused by both migration to the cities and natural population growth. In South Africa, about 50% of the predicted increase in the population of metropolitan areas will be accounted for by migration and 50% by births in the urban areas. Although migrants from rural areas may be better off than those who do not migrate, they often become socially or economically disadvantaged when they arrive in the city. They compete for both jobs and accommodation with people already there, so new arrivals are not necessarily welcome and have difficulty in getting established. Migrants often settle in inadequate or overcrowded housing and have poorer access to employment and health care than either settled rural or urban people.

Despite the difficulties facing urbanising populations, perceived or real economic advantages draw people to the urban areas. Climatic and economic factors contribute to the movement to cities. In times of drought and economic recession, many people abandon marginal agricultural land and move to the cities in search of work. This type of effect is currently contributing to migration away from the rural northern Transvaal and the eastern Cape.

Typically, a large proportion of the urban population of developing countries lives in under-serviced, poor quality housing with inadequate access to health care, but urbanisation is not necessarily bad in itself. Life in the urban environment can offer numerous advantages such as better access to educa-

tion, employment, sustainable food supplies, and health care. It becomes a problem when the rate of growth of the urban population exceeds the capacity of the infrastructure to absorb and support it. There is an urgent need to conduct research into urban health which will provide policy guidelines to allow healthy development of cities.

Poverty Related Diseases

A critical feature of urban health in developing countries is that a very large proportion of morbidity and mortality is the result of preventable disease. These diseases are usually related to poverty and inadequate services. Infectious diseases such as measles and gastro-enteritis are major causes of death in infants, yet both are preventable. Poor sanitation and inadequate water supplies are the major determinants of gastro-enteritis and, although measles vaccination is effective, the coverage is too low to prevent measles epidemics in overcrowded peri-urban areas. These diseases have, for many years, been well controlled in the developed world, but remain a serious problem in the developing world.

Studies have shown that measles vaccination coverage among children under 2 years of age is related to place of birth - at home or in a health centre,

Ismail Vawda

Poor sanitation and inadequate water supllies remain major determinants of preventable diseases

in a rural or urban area - and length of stay in the city. Children born in rural areas are generally less likely to have been vaccinated than those born in urban areas. A critical finding regarding the impact of measles vaccination campaigns in urban areas is that, although the campaigns reach some of the children who were born in rural areas, they have not managed to ensure that new arrivals are covered. A number of additional obstacles such as distance, economic and cultural barriers and inconvenient clinic hours also contribute to the problem.

Diseases of Affluence

As urbanisation proceeds, urban populations in developing countries also begin to experience more of the diseases of affluence, which are predominantly chronic diseases. The most marked increases are in ischaemic heart disease and lung cancer. The diseases are associated with changes in lifestyle, changes in diet and the acquisition of habits such as smoking and drinking alcohol..

Recently urbanised people are particularly susceptible to the social pressures of the urban environment, and there is a disturbing tendency for aggressive marketing of tobacco, alcohol and sugar, aimed at developing populations. The epidemiological transition from "old" to "new" disease patterns or, in the case of the developing world, the "epidemiological trap" which holds people in a situation with the worst of both worlds, is a major challenge to urban health provision.

Social and Political Instability

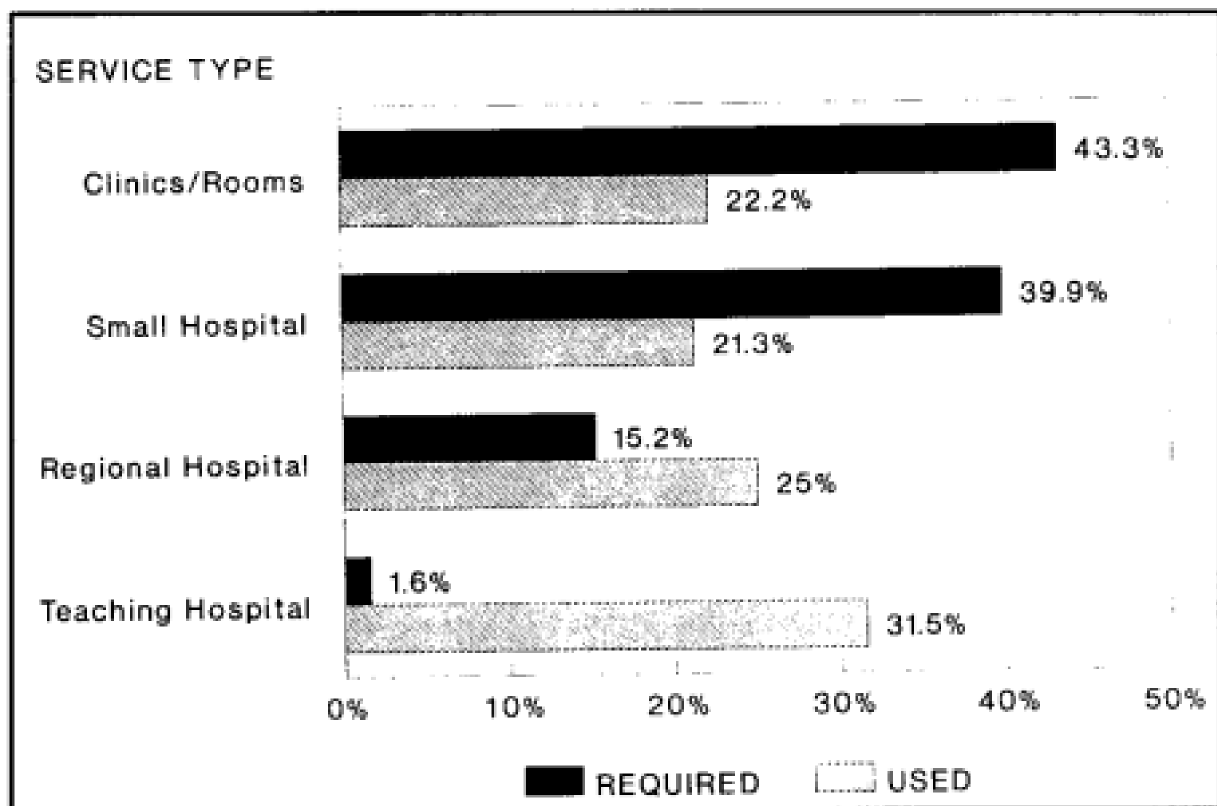
Urbanisation is also associated with profound changes in home life, which impact upon the social and mental well-being of urban residents, especially new arrivals. During settlement, people face acculturation and a weakening of traditional social support structures, which increases stress and instability at individual, home and community level. There is also increased competition for space and jobs. These stresses may lead to alcohol abuse, mental disorder or violence.

Violence, including political violence, is an issue of particular concern. The death rate due to violence in South Africa in 1992 was 5 times higher than that in the USA. Violence is responsible for more than 30% of the new cases of trauma in the larger metropolitan areas. Domestic injuries should not be overlooked, however, as these are responsible for 40% of injuries. Violence

causes most deaths, but domestic injuries are responsible for the majority of cases requiring treatment.

In providing solutions to these problems, we need to encourage innovative community-based prevention programmes, such as the Eldorado Park Centre for Peace Action (see *Critical Health* no. 41), but we must also address the need for trauma services. Most trauma occurs after normal office hours, particularly over weekends, hence the trauma services need to be run on a 24 hour basis.

The primary health care facility should be the first point of contact, thus community-based health care must provide 24 hour clinical services in addi-



tion to preventive care. The majority of trauma cases can be dealt with at primary or secondary levels, and more effective referral networks from primary level are needed to prevent the present situation where most trauma cases are dealt with at tertiary facilities. (Figure 1 illustrates this point. Clinics should be able to treat 43.3.% of patients, but only see 22.2%. Only 1.6% of cases need to go to teaching hospitals, but 31.5% are treated there.)

Alcohol misuse is implicated in a lot of trauma, especially violence and motor vehicle accidents. A disturbing finding by van der Spuy, of the Medical Research Council's (MRC's) Trauma Research Programme, is that the vast majority of pedestrians killed in road accidents are drunk. Seventy-three per cent of pedestrians killed in road accidents have a blood alcohol level above

the legal limit for driving, and 58% of them exceed the legal limit by two and a half times. Some data also suggest that recent arrivals in the urban area are inexperienced with traffic and are consequently more likely to be involved in road accidents.

A recent review of South African studies on alcohol misuse indicates that there is a consistent pattern of high risk drinking behaviour among certain age and ethnic groups. There are very high rates of risky drinking (5 beers per day or equivalent) among black males. The rates are lower for females, but there is a tendency for more risky drinking in informal settlements. High rates of binge drinking (5 drinks on at least one occasion in the past 14 days) have

Table 1. Alcohol Misuse

Sample	Group	Gender	Risky drinking behaviour
1a. Metropolitan	Black Adults	M	37%
		F	19%
1b. Informal areas	Black Adults	M	37%
		F	25%
2. Cape Town	Adolescents	M	15-27%
		F	5-18%

Source: 1. Rocha-Silva 1991 (risk criterion – 5 beers/day or equivalent). 2. Flisher et al. 1993 (risk criterion – binge drinking).

also been reported for Cape Town high school students, especially among Afrikaans and Xhosa speaking males (see table 1). Clearly, alcohol and trauma warrant special attention from health promotion agencies and pose serious challenges for service providers.

HIV/AIDS and Tuberculosis

Another growing feature of urban areas is the interaction of TB, a disease of poverty, and AIDS, a disease related to changing social conditions. In both first and third world countries, urban populations have been more seriously affected by AIDS than rural ones. Surveys done in Kwazulu/Natal found that rates of HIV infection in those who arrived in the urban environment less than one year previously were be about 3 times higher than in settled populations. Explanations for higher HIV rates in sub groups of the urban population vary,

Portia Rankonae

Rubbish

but most centre on transient populations (settled in neither urban nor rural areas) being more likely to have unstable families or sexual partnerships. Migrant labour has contributed to the disease being taken into rural areas. AIDS is defined in terms of opportunistic infections causing overt disease, and one of these infections is TB. In the USA, TB rates have been declining for many years, but there has been a marked increase recently. While some of this increase may be associated with other risk factors, a large proportion is associated with HIV infection. Most of the increase in TB in the USA has been in adults, but in Africa there will also be an increase in cases amongst infants.

Data from the USA suggest that almost all AIDS cases who are infected with the organism which causes TB will progress to active TB. However, for those AIDS patients who receive close medical supervision, TB is not a major problem, because they usually respond well to normal TB chemotherapy (although adverse drug reactions do occur).

A more important problem is that HIV infection appears to increase the risk of TB even in the absence of overt AIDS. The initial HIV infection impairs cell-mediated immunity and allows dormant TB infections to develop into active TB. Given that 30 to 60% of adults in the developing world are infected with the TB organism and that the figure reaches 80% in much of Africa, there is an enormous potential for an increase in active TB. In addi-

tion, the overcrowding and poor socio-economic conditions associated with urbanisation also increase the likelihood of TB transmission.

Recent surveillance results from Johannesburg show disturbing trends in the rate of HIV infection in hospitalised TB patients. The rate rose from less than 2% in 1988 to over 20% in 1993. This is a clear indication of the close association of TB and HIV infection. Figures from other parts of Africa already show rapid increases in TB, and HIV infection rates in TB patients are 3 to 20 times higher than the background infection prevalence.

The TB organism is much more pathogenic and virulent than other common opportunistic infections associated with AIDS, and TB can occur with minimal impairment of host immunity. Consequently, TB will often be the first sign of AIDS and many people will present first to a TB facility where their HIV infection may be overlooked. HIV infection will become increasingly common and should always be considered when unusual presentations of TB occur.

Restructuring and Research

Rapid urban growth is going to place a heavy burden on already vulnerable health services. Broomberg and Steinberg have estimated that between a third and three quarters of the available health care budget will be used to manage HIV/AIDS by the year 2005. If we add to this the long list of other health problems that may increase with urbanisation, we face a daunting task.

Primary health care has been advocated as the solution to "Health For All", but we need to move from slogans to action - to put theory into practice and find out what works well in South Africa. The dramatic changes which are taking place in South Africa offer an unequalled opportunity for restructuring the health services and promoting health through public policy, so now is the time to act. More resources need to be put into operational research on urban health to ensure that appropriate solutions for effective, equitable health care are found before the end of the century.

My thanks to Drs Malcolm Steinberg, Johan van der Spuy and Charles Parry for useful suggestions, and to Johan van der Spuy for figure 1.

John Seager is head of the MRC's National Urbanisation and Health Research Programme

Environment and Health in Rapidly Urbanising Cities

Angela Mathee & Yasmin von Schirnding

A wide variety of services and opportunities attract people to lar ge cities such as Johannesburg. By the year 2000, more than half the world's population will be living in cities. Mexico City and Sao Paulo, for instance, are expected to have populations of over 25 million people respectively. Africa, the least urbanised continent, has the fastest rate of urbanisation in the world. The fate and well-being of people will become increasingly linked to the quality of urban environments.

The rapid movement of people into cities results in overburdening of available infrastructure and an increasing demand for housing and environmental services. Failure to meet this demand will lead to extensive environmental degradation. A particular consequence of rapid urbanisation is pollution, including pollution of water , air and soil. Since health is strongly associated with the state of people's living and working environments, the impact on health of rapid unplanned urbanisation could be severe.

South African cities have the challenge of dealing with environmental health problems usually associated with developing countries, as well as those associated with highly industrialised countries. These include diseases associated with overcrowding, the absence of safe water supplies, inadequate sanitation services, deficient waste disposal facilities, unsafe food supplies, and acute and chronic conditions associated with environmental factors such as air and water pollution, housing related agents of disease, transport and industry. People may be exposed to particular environmental health hazards, such as radon, lead, asbestos, pesticide residues in food and environmental tobacco smoke.

High Risk Groups and Settings

People living in informal settlements, vulnerable to poor nutrition, and frequent bouts of infectious diseases, lack basic environmental health services such as safe and adequate water supplies, sanitation services and waste disposal systems, which puts them at risk of communicable diseases. Residents

Ken Ndlazi

The housing shortage has led to the development of informal settlements often without adequate services.

are often also exposed to dust intrusion, noise, industrial pollution and to polluting fuels used for domestic purposes.

In decaying inner city areas health problems usually relate to deterioration in housing quality and overcrowding. Surveys conducted in South African cities have revealed instances of up to eight people living in bachelor flats, and about 72 people in dwellings designed for single household families. Children living in decaying inner city environments are particularly susceptible to social and psychological diseases and a range of infectious conditions associated with pollution and other factors.

Housing

In South Africa, an increasing demand for housing has not been matched by an equivalent process of delivery. This has led to the development of large informal settlements on the periphery of the city , as well as crowded inner cities.

Housing of high quality not only serves as protection against ill health, death and injury, but could also support a state of "positive health" defined by the World Health Organisation as a state of physical, mental and social well-

being and not merely the absence of disease. The World Health Organisation has listed several requirements for "healthy housing" including:

* adequate housing supply - overcrowding has been shown to increase the transmission rates of diseases like tuberculosis, pneumonia, bronchitis, meningitis, and gastro-intestinal infections;
* safe and adequate water supply - unsafe water is the primary medium for the transmission of diseases, such as cholera, hepatitis, typhoid fever, dysentery, polio and diarrhoeal diseases;
* sanitary disposal of excreta - faecal matter is regarded as one of the most toxic substances, and is a prime source of contamination of water, food and soil, which is most likely to occur where toilets are absent, malfunctioning, improperly or inconveniently located, over - used or inadequately maintained;
* disposal of solid wastes - inadequate storage, collection and disposal of solid wastes generates a number of health hazards, including gastro-intestinal and parasitic diseases, pests, fatal accidents by poisoning or suffocation, and cuts and other injury, especially among children;
* drainage of surface waters - inadequate drainage results in pools or marshy areas which provide breeding areas for a range of pests including mosquitoes and flies;
* structural safeguards against disease transmission - the design, structure and maintenance of buildings affect the degree to which people are protected against communicable diseases, as certain structural features may, if allowed to deteriorate, favour the breeding and nesting of pests, while poor ventilation may lead to high levels of humidity, encouraging fungal growth which may in turn lead to respiratory health problems;
* the siting of dwellings should reduce to a minimum noise, industrial pollution and hazards from dumps of chemical and food- processing waste;
* indoor air pollution - in the absence of electricity , poor ventilation, insufficient space and, where fossil and biomass fuels are used for domestic purposes, levels of indoor air pollution may be higher than outdoors, leading to high levels of respiratory diseases; and
* the use of the home as a workplace may increase the risk of hazards to the occupants, as well as the occupants of adjacent buildings, from chemicals and other materials used.

Inner city high-rise buildings may present special hazards, some of which increase in direct proportion to the height of the building. When housing standards are poor, and enforcement lacking, structural weaknesses may directly threaten life or cause injury. In case of fire or explosion, upper storey resi-

Portia Rankoane

Inadequate storage, collection and disposal of solid waste generate health hazards

dents may be at extreme risk. The breakdown of lifts may impose considerable stress particularly on the aged, disabled and parents of young children. Psycho-social problems in high-rise blocks include isolation of the aged, excessive noise, limited privacy and inaccessibility of safe play and recreational areas. Safety measures, like safe stairways to prevent falls and adequate heating systems to reduce the risk of fire, are vital.

Water Pollution and Health

A safe and adequate water supply has a major impact on quality of life and human health. But in many developing countries, less than a quarter of the population have access to adequate supplies of safe water and waste disposal facilities. In South Africa surveys among African and coloured rural, urban and peri-urban communities show that only 46% of people in former "homelands", 72% of people in rural "South Africa" and 46% in urban and peri-urban areas have access to adequate water supplies.

A major cause of water pollution is contamination from human wastes resulting from poor sanitary and wastewater disposal services. Farming practices and discharges from industrial processing sites are also sources of pollution.

Annually, diseases related to unsafe and poor water supply account for the death and ill health of billions worldwide. In addition to direct effects on health, frequent gastro-intestinal infections reduce bodily absorption of nutrients and affect the body's general defence mechanisms by malnutrition. Malnutrition may increase children's vulnerability to other diseases like measles and pneumonia. Apart from mortality caused by microbially contaminated water and inadequate availability of water , developing cities are seeing more death and disability from heavy metal poisoning, particularly among inhabitants using rivers and lakes for drinking and domestic purposes.

Studies conducted by USAID and WHO show that the provision of safe water significantly improves the health of communities. However, the provision of water in isolation from adequate sanitation and wastewater removal could lead to poorer, rather than improved health status. Comprehensive environment and health education programmes are needed to address the link between the environment, health, personal, domestic and food hygiene.

Air Pollution

The provision of safe air to breathe, is as important as safe food and water. However, air quality monitoring programmes around the world have shown

Medico Health Project

The provision of water in isolation from adequate sanitation and wastewater removal could lead to poorer rather than improved health status.

that levels of air pollutants frequently exceed the levels considered safe for health. For example, it is estimated that about 70% of the world's urban population breathe air that is unhealthy, at least, some of the time. In developing countries like South Africa, air pollution could contribute to worsening global problems like ozone depletion, global warming and acid rain.

Air pollution may result from "natural causes" - volcanic eruptions, dust storms and veld fires - or may result from human activity such as smoke from factories, the use of certain energy sources such as wood and coal for domestic purposes and tobacco smoke. Millions of children die each year in developing countries, and many millions more suffer from acute and chronic ill health as a result of air pollution. In parts of Africa acute respiratory disease accounts for a quarter to a third of deaths in young children. There are indications that in some South African urban areas deaths from acute respiratory infection is becoming more important than death from diarrhoea. Increasing concern worldwide is mounting about the effects of indoor air pollution on the respiratory health of young children.

Tobacco Smoke

Tobacco smoke is one of the most important causes of lung disease, in both smokers and non-smokers (passive smokers), and has also been associated with diseases such as emphysema and cardio - vascular diseases.

Lead Exposure

Exposure to lead during early childhood can lead to reduced birth weight and lowered intelligence, with long-term implications for children's productivity later. In South Africa only leaded petrol is currently available, and vehicular emissions constitute a major source of environmental lead. Young children are most at risk, particularly those who live or attend schools near heavily trafficked roads. Studies in a Cape Town inner city suburb showed that the average blood lead level amongst primary school children was 22ug/dl, and that 17% of children had blood lead levels of 30ug/dl or higher. In the United States, the level at which health workers are required to take action to reduce a child's blood lead level was recently reduced to 10ug/dl.

The use of lead-based paint is another source of lead exposure, particularly in dilapidated buildings where leaded paint is flaking from walls, doors or windowsills. The ingestion of such paint by young children is one of the commonest causes of childhood lead poisoning.

Accidents and Disasters

The location of industry close to human settlements, especially where insufficient attention is paid to occupational safety could result in the release of toxic substances with disastrous effects on health in the workplace and broader environment. An industrial accident in Bhopal, India some years ago, caused the deaths of several thousand people and injured more than 50 000. In Guadalajara, Mexico in 1992, a petroleum pipeline leak resulted in a series of explosions which killed more than 1 200 people and injured many more.

Finding Solutions

In South Africa, it is vital to create an urban environment that enhances health, allows citizens to reach their full potential and promotes productivity and development. The causes of a wide range of ill-health conditions in our cities cut across urban management sectors, including housing, planning, open space networks, waste management, transportation, air and water quality management, and the general environment and infrastructure. This necessitates cooperation among these sectors to address urban environment and health problems. The involvement of communities, from the early planning phases, is essential to prevent project failure and maximise the potential benefits of environment and health initiatives for both developers and communities.

Rapid growth and industrialisation in Mexico during the 1950s, resulted in environmental degradation which today poses financial and health burdens on the city. Industrialisation was not matched by expansion of environmental and sanitary infrastructure. In Curitiba, Brazil by contrast, sound planning has been successful in addressing a wide range of urbanisation and poverty related environment and health concerns. We would do well to learn from the experiences of these and other Latin American, African and Asian cities undergoing rapid urbanisation.

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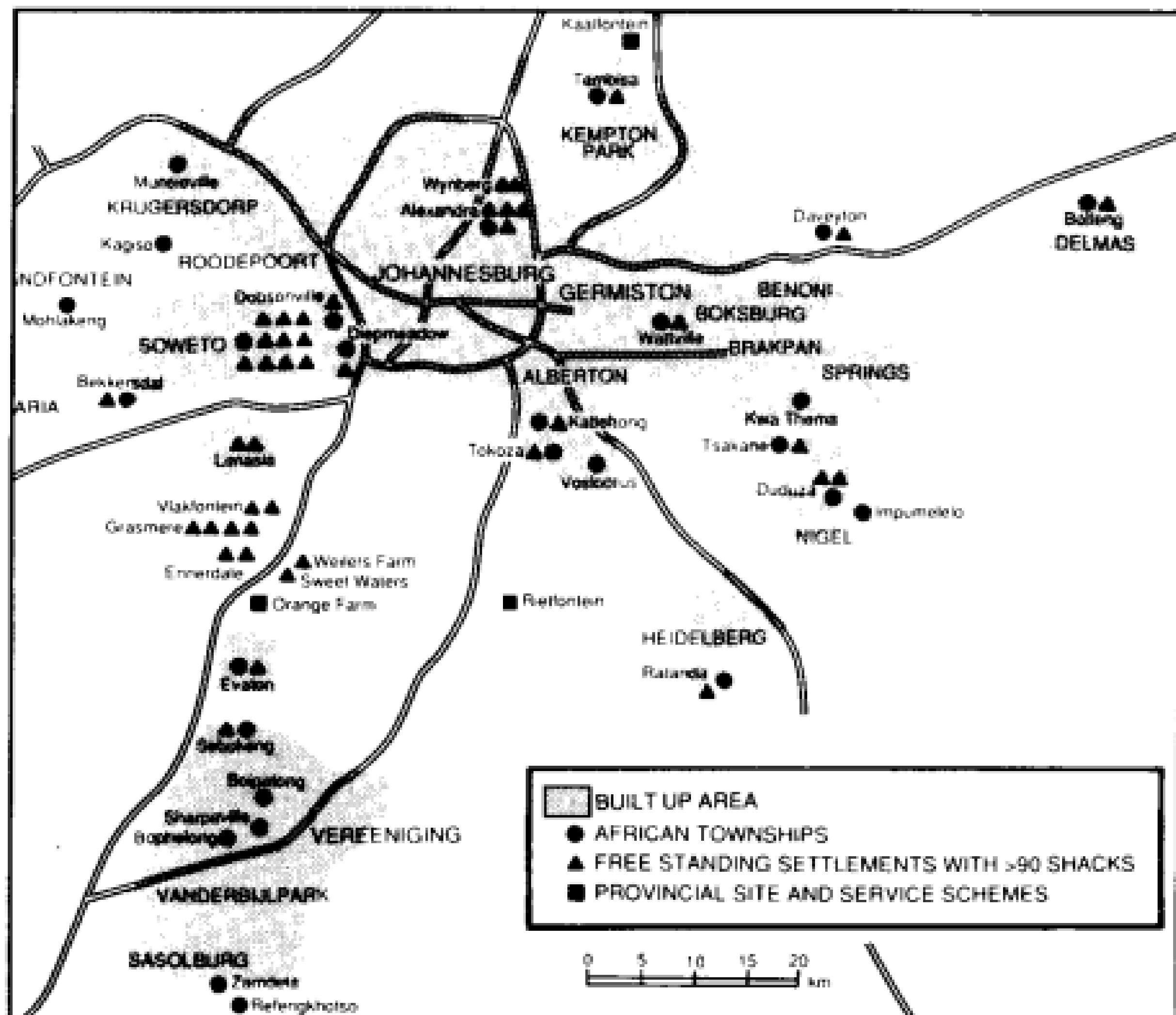
Informal settlements

Health Priorities and Policy Implications

Valli, Motale & Rispel



Informal settlements, often referred to as "squatter camps", have become a dominant feature of the increasingly urbanising third world. They are typically established by the poor in "the shadow of the city" and reflect the failure of governments to keep pace with the rapid process of urbanisation.

In many Third World cities, up to half or even three quarters of the population live in informal settlements. In South Africa, the policy of influx control, which controlled movement of black persons into urban areas, has distorted the process of urbanisation. The rapid urban explosion has therefore only begun to occur more recently. Ironically, this provides an opportunity to

act more timeously in dealing with this phenomenon, with the advantage of insight from the experience of other countries.

Research in this country has focussed on the demographic, socio-economic and health profiles of communities in informal settlements. More recently, research on the impact of urbanisation on health has been initiated. However, there has been very little work on the formulation of rational health policies with respect to informal settlements.

Orange Farm and Vlakfontein

We have conducted a study to identify priority health problems and health service issues in informal settlements, and to explore the policy implications for the delivery of health care in such communities. The study includes a literature review of local and international sources, in-depth interviews with key informants (including government and NGO representatives and health care providers), visits to two informal settlements and group discussions with residents of the settlements.

One of the settlements, Orange Farm, is a legal site and service area, administered by the Transvaal Provincial Administration (TPA) (a site and service scheme is one in which land is laid out and basic infrastructural services are provided before settlement takes place. People then purchase serviced sites on which they erect informal housing). At the end of 1990, the population in the area exceeded 100 000. The health services consist of two TPA clinics, one preventive and one curative, staffed by PHC nurses. Three private general practitioners also operate in the area on a part-time basis. The regional office of the Department of National Health was responsible for environmental health monitoring.

The other settlement, Vlakfontein, is a spontaneous settlement, which was considered illegal by the apartheid authorities. The settlement consisted of about 50 shacks in 1986 and grew rapidly to approximately 500 by late 1988. By late 1990 there were at least 1000 shacks but we were unable to establish the exact number. Health services are provided by a part time volunteer doctor, a volunteer nurse and locally trained community health workers at a community clinic. The House of Delegates (a section of the old racially constituted tricameral government), which owned the land on which the settlement exists, was presumably responsible for environmental health services.

These two areas, both of which are between Johannesburg and the Vaal, were chosen because other demographic information on these areas is avail-

able. We had easy access to people within these communities and we had no reason to suspect that these areas are vastly different from other informal settlements in the Witwatersrand area.

Environmental Health

Residents pointed out, without any prompting, that most of their health problems are directly related to poor infrastructure, including water , sanitation and poor quality of housing, as well as general poverty as a result of high unemployment and lack of food. Additional stress is caused by insecurity of land tenure in spontaneous settlements and lack of access to educational and recreational facilities.

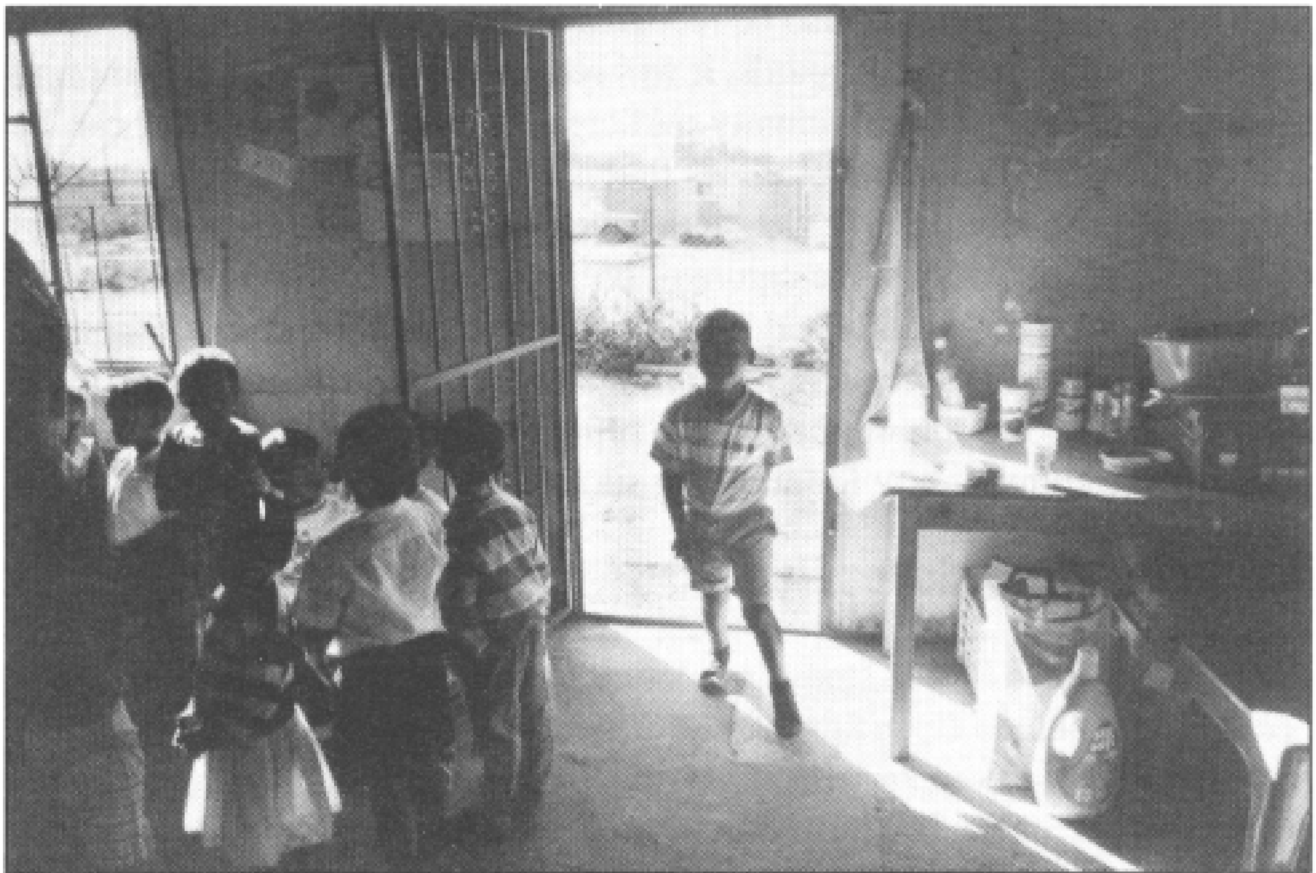
Key informants were also of the opinion that poor environmental conditions and lack of basic infrastructure are dominant features of these areas. One informant suggested, "**The authorities must take action as soon as a settlement starts. They must take the responsibility. Pro-active planning from previous statistics without waiting for problems to begin should be the modus operandi**".

The rapidly changing political situation creates unique opportunities for innovative policies on informal settlements. One of the key policy issues is that the state and local authorities must acknowledge the real size and growth of communities in informal settlements and allocate resources according to health care needs.

Transport and Emergency Services

Informal settlement residents are invariably far away from most services. The availability and cost of transport to get to clinics and to hospital is an important issue. Neighbours' vehicles, horse-carts and even wheelbarrows are used. Most people identified access to emergency services, particularly casualty and 24 hour maternity services as a major problem. This is a priority in terms of their perceived needs. The problem is aggravated by lack of telephones. Orange Farm residents were particularly bitter about emergency services. As one resident aptly stated, "**There is no such a thing as an emergency here. You just wait**".

Informants commented that most settlements, particularly the spontaneous settlements, have inadequate or no personal health services. In relation to emergency services, it was pointed out that ambulances are unable to find the shacks of the callers due to the lack of maps and even roads in most areas.



Children in make-shift day care centre, Orange Farm

Policy issues that arise in relation to emergency services include the provision of telephone services within reasonable reach and the allocation of informal settlement areas to specified ambulance services. However , because most of the sophisticated trauma facilities are centrally situated, ambulance services have to cover long distances. Alternative solutions, such as training community health workers to deal with trauma, and emergency 24 hour casualty and maternity services as an integral part of PHC centres, should be explored.

Residents and Health Boards

Residents in Orange Farm displayed distrust of health boards. There was apprehension in that, **"These people (in health boards) are going to be victimised since they won't have any power. They will only be tokens."**

Most of the informants interviewed thought that it was a good idea in principle for communities to be involved in a health board or committee. One informant raised an important consideration, **"People have a fluid commitment when they are squatting illegally and one must not test what constitutes a community too far."**

Another felt that leadership and power relations in these areas need to be recognised. Many of these areas still operate in a semi-rural style with a

headman as leader. It must also be recognised that, for the people to become truly involved in the health boards, it will require a long period of promoting the idea. It is clear that community participation is not an issue that can be easily addressed. The political issues that need to be clearly appreciated are that people in spontaneous settlements have no access to the formal political structures and institutions, the nature of political or ganisation is strongly influenced by the vulnerability and insecurity of the residents, and spontaneous informal housing is susceptible to conflict. Appropriate consideration of the above issues, strong commitment to the principle and patience in expectation of results are all necessary for attaining success.

The State - Bold Moves Needed

Many issues arose in our study in relation to health care in informal settlements. They include financing of health services, use of community health workers and record keeping. However, the issues discussed above appeared to be the most pertinent. The most crucial area needing attention is the response of the state, outside the arena of health care, regarding the existence and growth of informal settlements.

There appears to be an acceptance of the inevitability of rapid urban growth and a change in the policy of even the previous minority government in this regard. Although this is an important step forward, there have been few concrete steps with regard to implementation. Definitive and bold moves by the state are needed to secure land tenure and provide housing and services for urban homeless communities. Health policy issues as identified in this study, together with findings of other local studies, can form the basis for further debate within communities and among health authorities.

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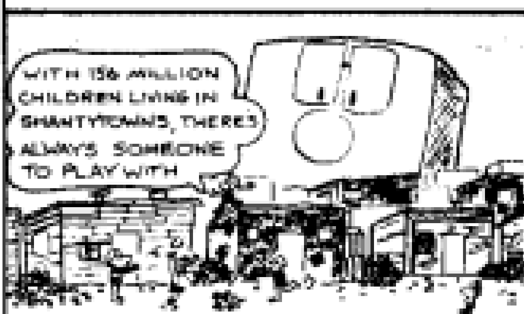
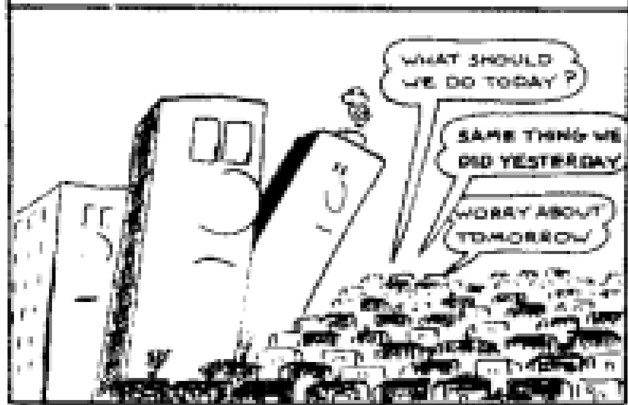
ONE OF THE CITY'S BIGGEST WORRIES WAS THE OTHER CITY GROWING UP NEXT TO IT CALLED SHANTYTOWN

SHANTYTOWN WAS WHERE MOST OF THE PEOPLE COMING TO THE CITY LIVED

THE CITY HAD TROUBLE UNDERSTANDING THE SHANTYTOWN BECAUSE ITS PEOPLE WERE POOR, UNSKILLED, AND THEIR HOUSING WAS RUNDOWN



SO THE TWO CITIES GREW SEPARATELY, SIDE BY SIDE



THIS MEANT THE CITY PROVIDED **NO** SERVICES FOR SHANTYTOWN'S POPULATION

NO POTABLE WATER, ROADS, ELECTRICITY, SEWAGE OR GARBAGE DISPOSAL, HEALTH CARE OR EDUCATION

SECTION B

changing communities, health providers adapt

Urbanisation and Planning the Health Services of Alexandra Township

Grant Rex & Antonio Fernandes

Following the lifting of influx control in 1985 there has been a big increase in urbanisation. In the Alexandra area, official census figures suggest that the population doubled from 50 000 in 1980 to 100 000 in 1990. Since then it may have doubled again. With the outbreak of political violence in March 1991 this demographic picture has been further complicated. About one eighth of the township was destroyed in what was the biggest attack on the township in its history. Patient statistics at the Alexandra Health Centre (AHC) indicate a massive drop in population over this period.

A demographic survey conducted by the AHC confirmed this picture. As many as 50 000 residents may have been put to flight. Many of these never returned, still living as displacees in local white suburbs and in local public venues.

What this has given rise to is a population which resembles a transit camp more than it does a stable urban settlement. Based on a study done by the AHC in 1992, table 1 shows the number of new arrivals in Alex over the last five years to be 43% of the total population.

Table 1 - Time of Residence In Alex

Time of Residence	%
< = 5 years	43.3
> 5 years	56.7
Total	100.0

For development and planning purposes, this pattern of settlement poses particular problems. Simply in terms of meeting demand, rapid ur banisation puts a lot of pressure on government for the provision of public services. Table 2 shows the proportion of residents currently living in informal housing. If

figures for those living in old brick houses which are ninety years old and very dilapidated are included, then 76% of the population are inadequately housed.

Table 2 - Type of Housing

Type of Housing	%
New Brick	17.2
Old Brick	18.1
Shacks/Zozos	58.1
Other	6.3
Total	100.0

When it comes to planning health services, the problem is even more complicated. Rapid increases make it difficult to know how many people to cater for. Over provision of services in some areas needs to be avoided as far as possible. Apart from increasing the rate of urbanisation, it increases costs of providing services. Ignorance on the part of new arrivals also leads to irrational service use. Tables 3 and 4 illustrate this vividly in the case of place of delivery of the last child in the house. The proportion delivered at hospital is much higher than it should be. The existence of good facilities and services at the AHC encourages people to use this facility more often than other clinic facilities in the area. This results in a heavy case load of unbooked deliveries, increased delivery risks and costs for the mothers.

Table 3 - Place of Delivery of the Last Child

Place of Delivery	%
Alex Clinic	21.7
Other Clinics	20.3
Hospital	48.6
Others	0.6
Total	100.0

Table 4 - Percentage of Pregnant Women Attending Ante-natal Clinic (ANC)

Pregnant women	%
Attend ANC	35.9
Don't attend	64.1
Total	100.0

It is also difficult to keep a transient population informed about services. This is shown by the data in Table 5 where the excellent home visit service to geriatrics is virtually unknown in Alex. The cost of marketing services successfully under circumstances of rapid population changes is therefore likely to be prohibitive.

Table 5 - Knowledge of GHOP (Geriatric Health Outreach Programme)

	%
Know	10.3
Don't know	89.7
Total	100.0

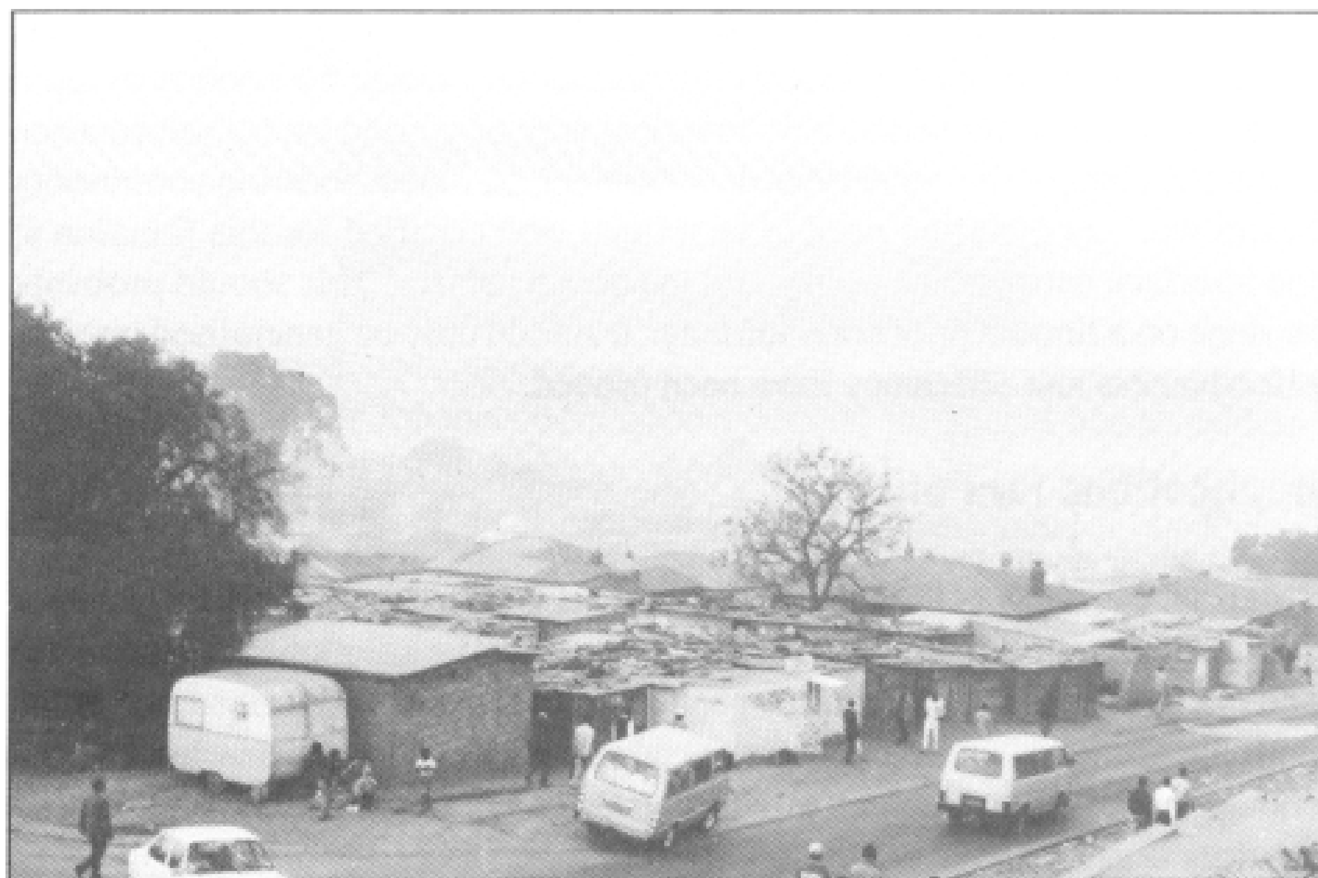
Finally, as seen in table 6, the rapid urbanisation is also associated with high levels of injury and mortality due to trauma of different types.

Table 6 - Causes of Death, according to sex

Causes	Female	Male	Total
Violence	2	17	19
Other	25	27	52
Total	27	44	71

Challenges to Service Providers

Important epidemiological information about a rapidly urbanising population is therefore emerging in Alex. This especially benefits service managers. However, the problem of finding a way of keeping information up to date in an affordable way in the context of rapid population turnover has not been solved.



John Robinson

A hazy Alexandra

Services responding to newly identified needs also have to be set up. The need to improve access and care for pregnant women, improve immunisation coverage, deal with the new urban public health scourge of violence, motor vehicle accidents, tobacco and alcohol abuse all need to be tackled urgently. Assessment of costing, staffing of these and training must be done.Ways of involving community action around unemployment also need to be explored.

To do all this will need intensive management intervention. Intervention with the community is needed to enhance the quality of service for users. This will focus on what is felt to be the main problem with the existing service. However, the challenge of incorporating ordinary residents into detailed planning in this context of rapid urbanisation appears very difficult and will be even more limited if the emerging health service is organised into large regional units and not into smaller districts which allow more flexibility. This aspect of emerging health policy is still unclear but is likely to be highly contested.

Careful use of community health workers who are well supported and supervised can provide information which is very valuable for management purposes. This is especially true if managers are directly involved in the process of data collection. While this type of collection of data may not be reliable

from the epidiomiological point of view, it is useful for planning purposes. Results are more quickly available by this method, and in the context of rapid urbanisation it could be the only practical way of getting useful information about the community for service development purposes. Existing community health workers therefore need to be trained, and certified for this function at the interface between the public and the health service. This should probably be done on a limited pilot scale initially. It should only be generalised once its effectiveness and efficiency have been proved.

Implications for Policy

This brief overview of the pattern of urbanisation affecting Alex raises a number of challenges for the delivery of health services. The solutions lie in the field and not in libraries or committee rooms. The need for well trained managers with the ability to analyse existing services and health problems locally and enough authority to implement appropriate changes and rationalise existing services is urgent.

The creation of autonomous district health services with substantial authority, incorporating the power to hire and fire, plus budgetary control is necessary if a successful response to urbanisation is to be mounted.

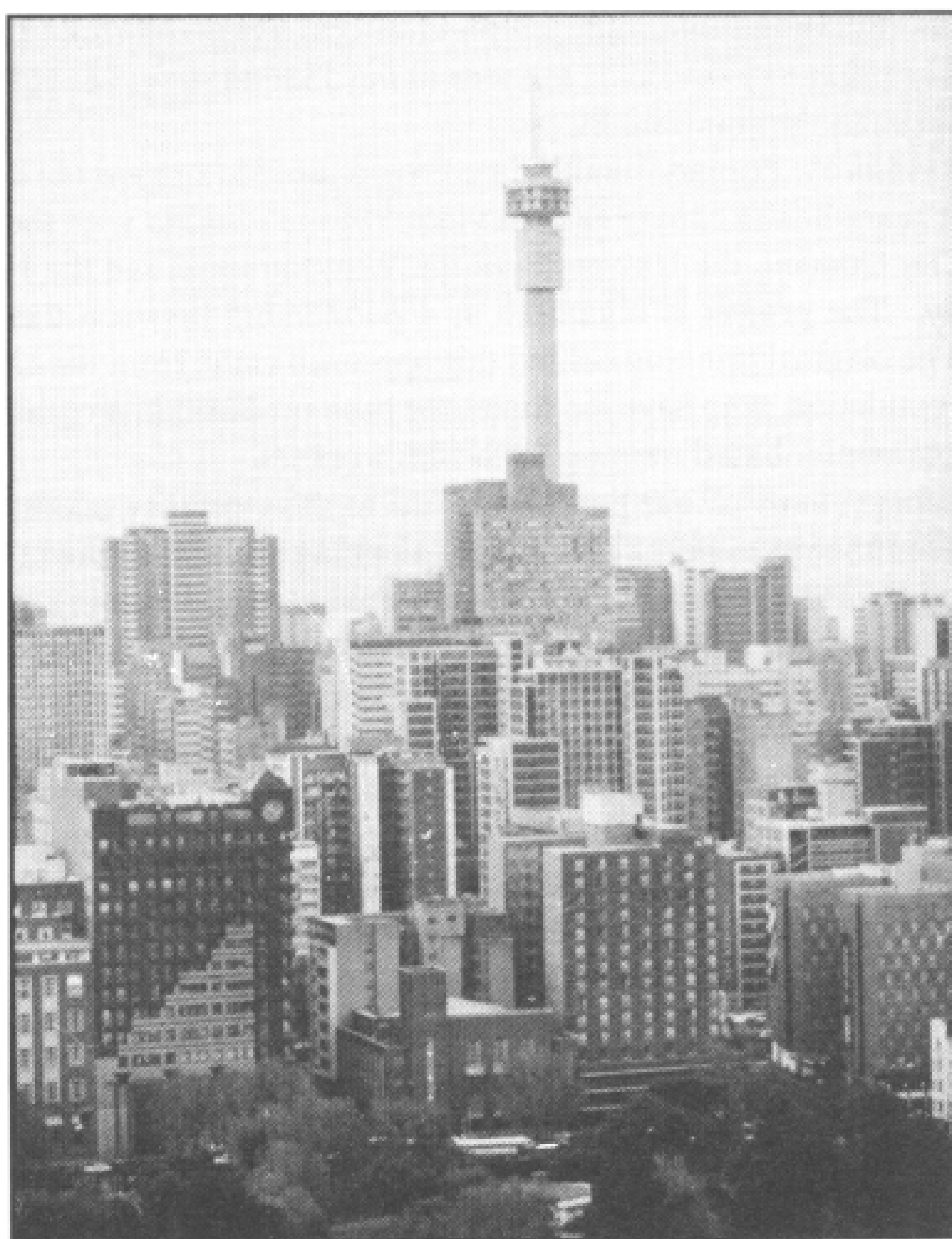
Unless this is put in place any other response to urbanisation is bound to be ineffective and wasteful.

Grant Rex used to work at the Alexandra Health Centre.
He is now superintendent of Baragwanath Hospital.
Antonio Fernandes works at Alexandra Health Centre.

A Changing Inner City
Health Workers Respond

The Hillbrow PHC Project

Hillbrow is presently Johannesburg's most densely populated black residential area. At the end of 1970s, the glut of empty flats in Hillbrow and the acute housing shortages in black areas resulted in a steady movement of black peo-



Ismail Vawda

Hillbrow

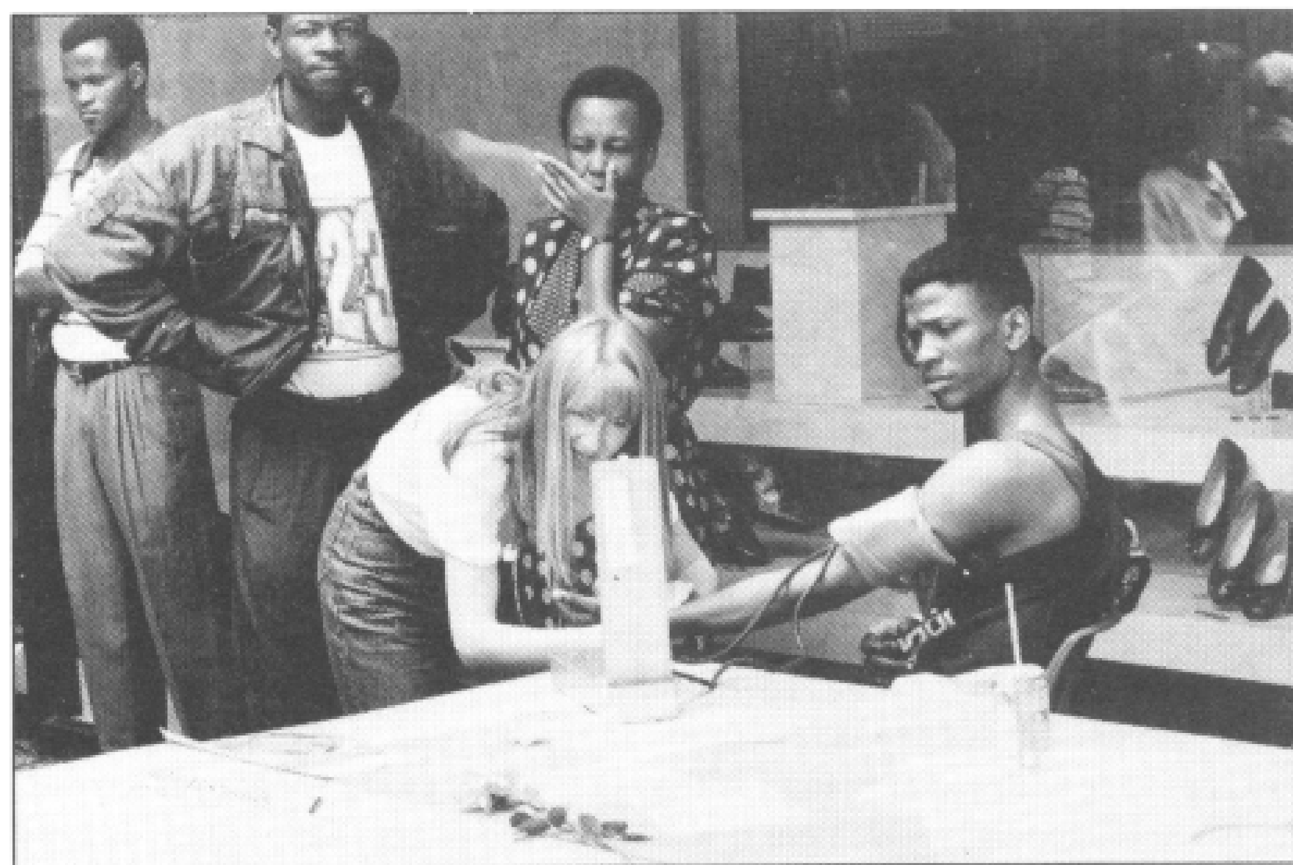
ple into what was designated a white area. This social transition has been remarkable. Population estimates are unreliable. They are quoted at anything between 50 000· and 150 000, of whom 80% are black.

Health care in other urban centres suggest that the priority in a situation of rapid urbanisation is diseases of poverty such as communicable diseases and child malnutrition, and diseases associated with urbanisation like cardiovascular disease, certain cancers, psychiatric conditions associated with isolation and insecurity and, pathogenic conditions associated with social instability such as sexually transmitted diseases, unwanted pregnancies, substance abuse, crime and suicide. The full impact of the social changes occurring in Hillbrow are yet to be experienced, but development strategies for the area are focused on urban renewal and the need to halt the already visible decay. This article aims to explore the implications of Hillbrow's social transition for health and the delivery of health services in the area through the work of the Hillbrow Primary Health Care Project.

The Hillbrow Primary Health Care Project aims to support the development of primary health care (PHC) services in collaboration with the Johannesburg City Council, the University of the Witwatersrand and the Hillbrow community. The project is organised as a partnership between these three players. The original thinking behind this approach came from the US based Kellogg Foundation, who have for sometime been involved in programmes to provide community based training for health workers.

The major aims of our partnership are to meet priority needs, to empower the community to be involved in the planning and management of local health services and to provide sites for community based training of health workers and students. Apart from managing the work of the partnership the primary role of the project is to or ganise and support a representative community committee, conduct an assessment of community needs and develop health promotion activities. In October 1993 the project organised a successful 'Hillbrow Health Day' in which 23 local organisations, including *Critical Health* participated in publicising local services.

There is insufficient data on the health status of people living and working in Hillbrow. There are, however, groups in the community who are obviously at risk. The project has sought to understand the health priorities in Hillbrow by appreciating the needs articulated by the community. For the purpose of this article, perceived priorities are violence, housing, youth and marginalised groups.



Ismail Vawda

Hillbrow Health Day free blood pressure testing

Health and Violence

The Hillbrow project has found that health, as such, is not seen as a community priority. Therefore if we are to understand health priorities through community eyes, we need to look at the health hazards associated with people's expressed priorities. Crime and violence, as in so many South African communities, is identified as the first priority for change. An opinion poll conducted on our health day, showed changing or increasing the police force (26.2%) and improving housing and the environment (21.4%) as top priorities for change.

The extent to which people feel unsafe in Hillbrow is reflected in the outcomes of several surveys. A postal survey in 1992 by the Hillbrow Working Group, listed crime and violence as residents' prime concern in Hillbrow. Another survey by Alan Morris involving extensive interviews at 378 dwellings in Hillbrow found that 80% of men and 86% of women felt either unsafe or very unsafe walking the streets of Hillbrow at night. Nearly all respondents, said they worried about crime.

Poverty and unemployment are cited by community organisations as factors behind the high occurrence of crime and violence. In a pilot study by

the project, just under a quarter of the reasons given for attending local health services were for trauma including accidents, stabbings, assault etc. The emotional strain of living under the threat of violence, in poor and deteriorating housing conditions, drugs, prostitution and unemployment is relatively unknown and probably underestimated.

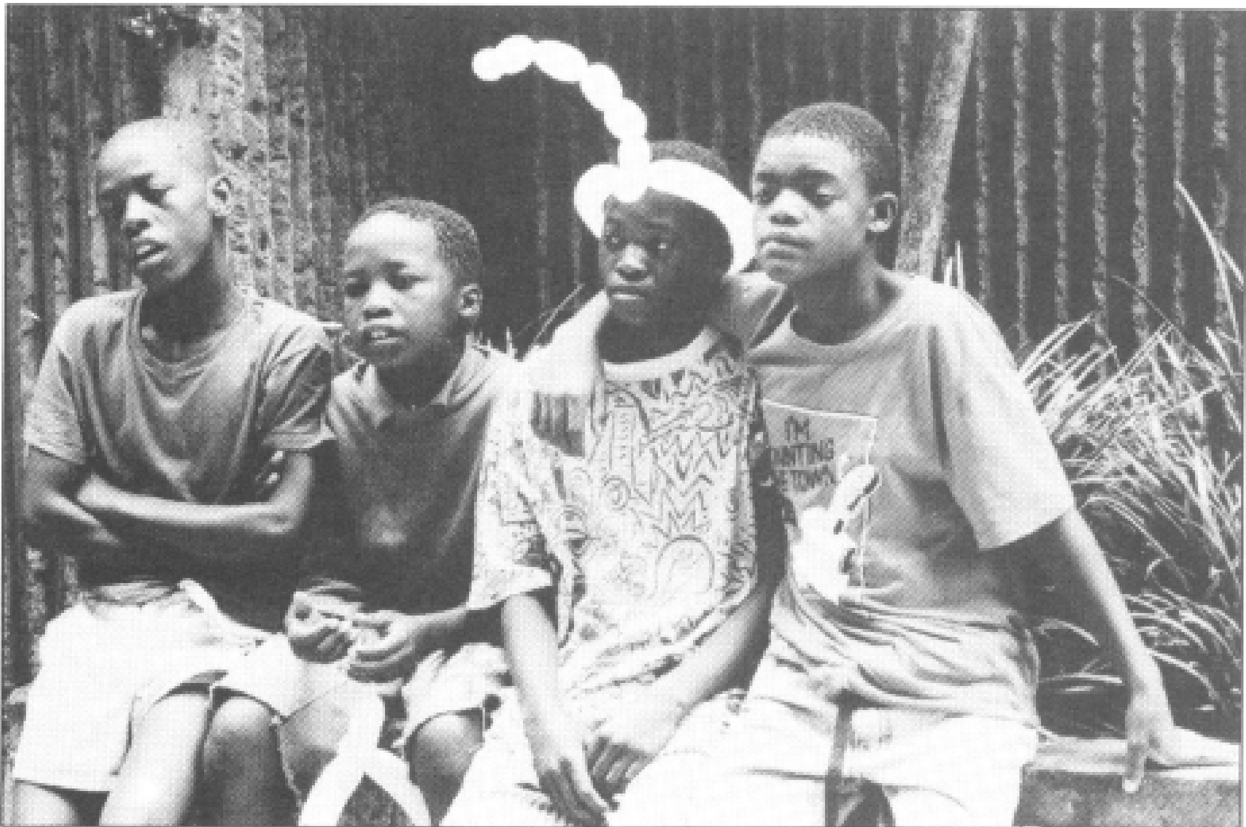
Health and Housing

It is not possible to separate the implications of massive social change from the physical environment in which it occurs. After crime and violence, the problem cited most by residents is poor housing and environment. Hillbrow is characterised by high rise, high density living. There are about 18 500 housing units in the Hillbrow and Berea South area, mainly consisting of bachelor and one-bedroomed flats, mostly for rent.

The reasons for the deterioration in the housing stock, although complex, coincide with social change. Although it is now thought that over -crowding is not the extensive problem it was perceived to be, there is undoubtedly increased pressure on internal and external building structure. Overcrowding is estimated to affect 8% of households or 2000 people. This is not only due to subletting of flats to cover the rent, but also because of the lack of larger sized dwellings.

An HSRC survey found that 32% of residents complained of unreliable electricity supply, 19% of unreliable water , up to 19% of regular plumbing problems. A very small proportion said these services were not provided at all. The local civic organisation, ACTSTOP, gave examples of buildings where toilets had broken down for 3 weeks. One building had no electricity, water or working toilets for 18 months. We estimated that at least 10 000 people live in 38% of blocks needing some structural attention. People face hazards such as poor lighting, inadequate security, leaking water and sewerage pipes, blocked drainage and sanitation systems, open lift shafts and broken stairwells.

Environmental health officers suggest an increase in air pollution. Local authority nurses at child health clinics link respiratory conditions and skin rashes to poor housing. Other expected health problems resulting from these conditions would include accidents and trauma and an increase in infectious diseases such as diarrhoea.



Ismail Vawda

Health and Youth and Marginalised Communities

Characteristic of the Hillbrow population is the vast number of young people. It is thought that 60% of Hillbrow's population is under 30. Hillbrow is a thriving centre for night life. There are a large number of night clubs, hotels and escort agencies. As in many other similar urban centres throughout the world, Hillbrow is home to many marginalised groups, such as sex workers, the homeless, drug users and illegal immigrants.

No quantitative information exists on the health status of the marginalised in Hillbrow, although all of them face specific health risks. For example, women coming from other parts of Africa as illegal immigrants, often give false addresses to protect their identity when using health facilities. Subsequently, women and their babies are at risk, since follow up home visits are impossible. HIV prevalence for central Johannesburg, including Hillbrow, is 25% of clients at sexually-transmitted disease services and 17% of people attending family planning services.

Hillbrow. Photo:

Health Services in Hillbrow

On the face of it Hillbrow has no lack of health services. There are two tertiary hospitals, one in Hillbrow and the other, in a neighbouring suburb. There are three child health and family planning clinics and one sexually transmitted diseases and family planning clinic. Hillbrow is serviced by five private clinics and a mushrooming of private GPs. The city council's AIDS centre and Outreach programmes are also based in Hillbrow.

The legacy of apartheid in Hillbrow is inappropriate planning, inequality in service provision and a complete lack of comprehensive health care delivery especially at the community level. Existing services offer selective interventions and lack co-ordination with other services. One resident remarked on the fragmentation of existing health services, "if you go to the services, they say you must go somewhere else to get help, so I don't go to these local services." Apartheid health services opened the new Johannesburg Hospital as a quality, whites-only academic hospital and over time allowed Hillbrow Hospital to develop as a chaotic, over -crowded facility for blacks. The biggest problem facing health service providers is the lack of policy guidelines and resources for reorganising services on the lines of comprehensive primary health care.

Residents surveyed by the project had serious complaints about existing services. They criticise the lack of appropriate services - especially the lack of accessible local maternity and paediatric services, the poor attitudes and uncaring behaviour of health workers, poor information about treatment, long waiting queues, affordability and response times of ambulance services.

The Role of the Hillbrow Primary Health Care Project

The function of the project is to act as a broker between all stakeholders in health service delivery. The project is also involved in health personnel training, an intrinsic part of which is training the local community. The project has had many successes at this level, such as a workshop this year addressing the state of maternity and related services in Johannesburg.

Working with Urban Communities for Health

Hillbrow has been regarded as a transient community, although studies in the small elderly white community remaining in Hillbrow indicate that some sections of the community have lived in Hillbrow for several decades. The Mor-

ris' study found that 63% of people did not intend to stay in Hillbrow. Although this does mean that building a sense of community and strengthening community organisations is a huge challenge, it does not mean that there is no commitment to the area by it's residents. Thirty eight percent of respondents to our opinion poll, asked what they could contribute to improving Hillbrow, felt they could contribute through volunteer work in important areas.

What Hillbrow demonstrates is the limitations to community participation when community organisations are relatively weak. Studies show that only 12% to 36% of residents belong to an organisation that holds its meetings in Hillbrow or belong to civic, political or religious organisations. Equally, without strong organisational accountability, representatives from organisations who attend community committee meetings of the project rarely report back to their organisations and thus often participate in their individual capacities. In the long term, this will become more serious as community members are selected to institutional committees. Already two representatives of the project's community committee will sit on two university medical faculty committees.

Ismail Vawda

The Role of Health Worker Training in the Development of Services

Although there was some scepticism as to whether communities would ever directly relate to changes in health personnel education as described in the initial Kellogg concept document, our research has certainly made the link. The most significant demand made by the Hillbrow community is for a change in the attitude and behaviour of health workers. PHC service development in Hillbrow will include substantial amounts of in-service, continuing education and community based training for students.

Looking at community priorities, our approach to housing and the environment is to transform old style health inspectors into community sensitive environmental health officers who act in a primarily educative rather than law enforcement role.

Intersectoral Collaboration

The challenge facing the development of PHC services is how to link service development to meeting community needs while also developing other essential services. Thus we should be looking at service development, in part, under the umbrella of working on improvements to safety and housing especially. There are some exciting developments that suggest we will be able to make some of these connections. The Healthy Cities Project pioneered by the Johannesburg City Council has decided to make Hillbrow a district level initiative and is likely to adopt safety as a major area of work. This could include initiatives such as improved counselling services for the victims of violence, better security in buildings, improved lighting and community level emergency and first-aid services.

The second initiative of the Council is convening an intersectoral forum called the Hillbrow Working Group. This group meets on a quarterly basis with increasing involvement of community members. It has four task teams to address key development areas. Through this working group, the project has been able to pioneer a comprehensive information and advice service that will include information about local health services. In the long run, this service may be able to deal with complaints from service users and advance patient rights under a new dispensation.

This article was written by Nancy Coulson who was a member of the working staff of the Hillbrow Primary Health Care Project.

Social Change and Service Development

A Newly Urbanising Community

Bernhard Gaede

The Muldersdrift Health Development Project (MHDP) was first started in 1973 by a few concerned Witwatersrand University medical students working at Coronation Hospital. They noticed that a large number of severely malnourished children came from the peri-urban Muldersdrift area, north-west of Johannesburg, and they set up a Saturday morning paediatric clinic in the area. In 1979, it had to close due to loss of the lease on the property they were using. The MHDP re-started in 1984 with a much stronger PHC vision and commitment.

By 1988, the paediatric clinic had grown, and other services such as family planning, nutrition support for malnourished children and a four day a week mobile clinic had been added. The MHDP employed two PHC nurses and a community worker on a full time basis, as well as community health workers on Saturdays. An adult service was added and a welfare service was started. The MHDP became operational from the clinic site on a daily basis. With the continued growth of the service and the community's increased utilisation of the service, the MHDP became too large to be effectively run and managed by the students. The student centred approach was hindering community participation, therefore the decision making structure and management of the MHDP had to be restructured. Over a period of two years, a new management system, which included students as well as members of the community, was developed. This made management of the service more efficient and facilitated accountability to the community.

The Changing Community

Over the past five years, the community of the greater Muldersdrift area has undergone profound social, political and demographic changes. The population density has roughly doubled. A survey in 1987 estimated a population of 18 000, and, in 1992, the figure was 35 000.

When the MHDP was established, the majority of landowners were farmers. The service focussed on the landless farm workers, domestic workers and unemployed people. The community was characterised by a high degree of mobility and transience, which was aggravated by the employment of seasonal labour on the farms. The labour force was very poorly organised and there was virtually no communal decision making or access to land. The problems of the community served by the MHDP were typical of those of farm workers: overcrowded living quarters, poor wages, long working hours and no protection from labour laws. Basic services such as education, welfare services and health facilities were scanty and insufficient.

The character of the area has since been transformed. The land owner profile has changed significantly and now includes a large number of high income residents with large estates. The entertainment industry has become well-developed, there are a growing number of guest farms, tea gardens and restaurants and the Crocodile Arts and Crafts Ramble has been established. Farm workers form a progressively smaller component of the population. A growing number of workers living in the area work in town and commute on a daily basis. Informal settlements such as the Zevenfontein and Nooitgedagt communities have developed.

Ismail Vawda

Black people with little access to services live next to high income residents with large estates.

The community has always been characterised by a high unemployment rate. When the community was still rural in character, there was a high turn-over of employees. A number of people used this peri-urban area as an access point to find a job in town. The unemployed are becoming more permanent, living in the informal settlements or trying to find accommodation in the inadequate and overcrowded living quarters on the farms.

Organising the Community

The MHDP played an important role in the initial stages of organising the community. In the late 1980s, when the students examined the lack of community participation in the service, it became clear that the existing and real difficulties of the community had been used as excuses for retaining the status quo. The community was poorly organised and continually changing, the farm workers were extremely vulnerable and under constant risk of being dismissed, but these realities were used to justify the lack of community representation on its board of management.

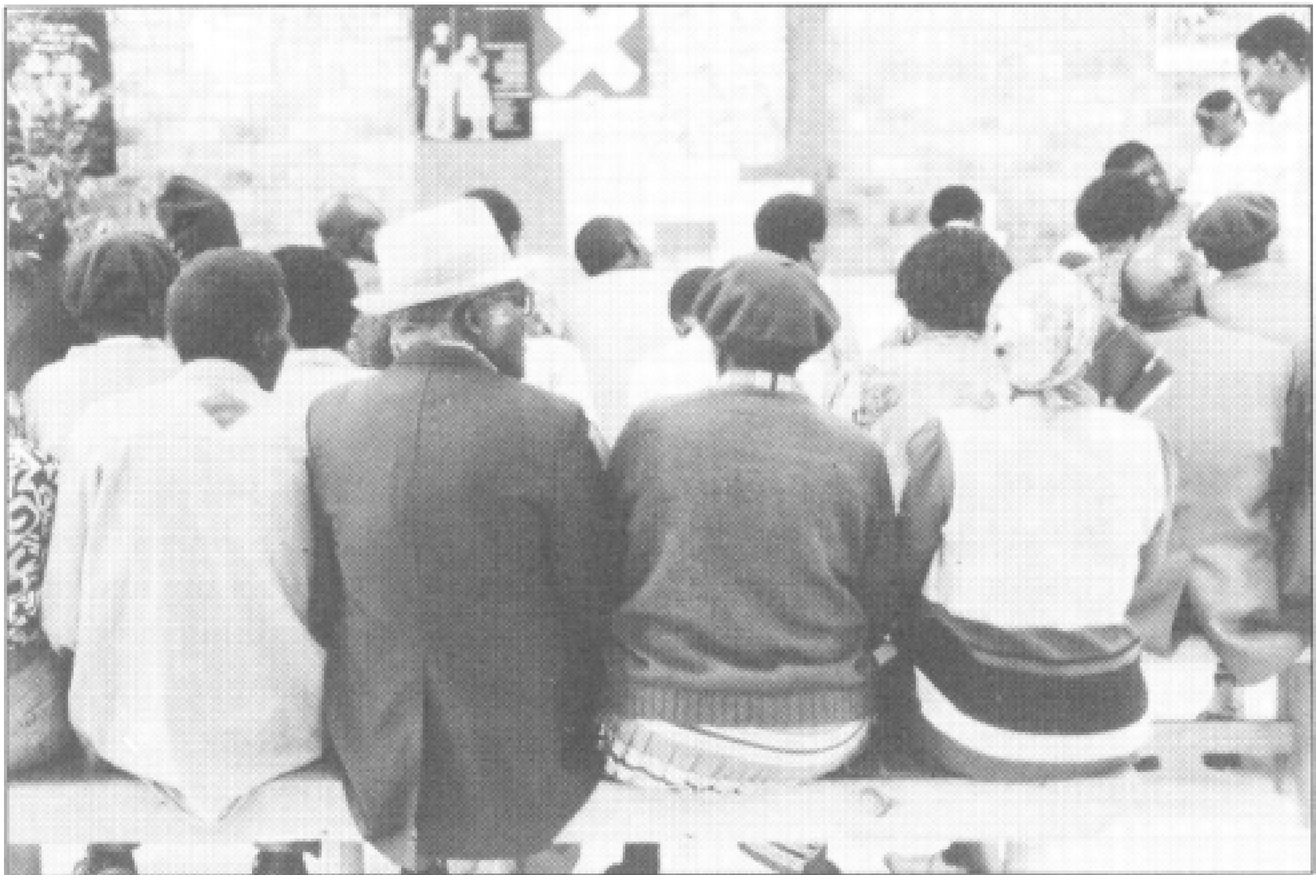
The student committee finally addressed this issue. In 1989, it also initiated a number of projects with participation from community members. Attempts were made to run creches, parents meetings, women's groups and income generation groups. Food gardens and First Aid training were tried. But none of the projects lasted longer than 6 to 8 months. The majority failed because the control and maintenance of the projects was entirely dependent on the students.

The health festival was the first successful effort of the student committee. This is now an annual event, held at the MHDP site. It is a community celebration and also focuses on aspects of health such as nutrition or AIDS.

In response to the MHDP efforts, a few members of the community held meetings to form a parents association, and they used the MHDP as a catalyst and resource base to help them develop. By that stage, the student committee had learnt its lesson and did not try to control and direct the association. The Elandsdrift Parents Association is still running a large creche on the MHDP land, but organises and manages the service independently.

Wider Organisation

These developments, together with wider political change, encouraged a number of people to form organisations and associations. The community



Muldersdrift clinic

gained a lot more confidence and a number of groups have developed over the last few years, with the MHDP providing support to some of them.

The Crocodile River Valley and Rural Civic Association (CIRVACA) has become one of the largest and most influential organisations in the area. After initial organisation to increase membership, regular workshops were held to identify and prioritise the needs of the whole community. These were seen to be housing, employment, education, health and transport.

In all of these areas, the community has become active to challenge the existing situation and to plan and implement alternatives, either through its own structures or through existing NGOs. CIRVACA has challenged government structures such as the Local Areas Committee and the Transvaal Provincial Administration (TPA), and it has developed a plan for land use and low cost housing development.

On the other side of the spectrum, the already well established right wing in the area has made attempts to polar - ise the community. The recent forced eviction and resettlement of the Nooitgedagt informal settlement is a case in point.

Lack of Co-ordination

The MHDP has, over the last number of years, attempted to move beyond a role of simply providing a health care service. It has tried to develop some form of infrastructure for health and welfare service provision, including a strong community participation component as well as links with other NGOs and state structures. However, the MHDP has not really been able to achieve broader co-ordination and integration with other structures. It has been difficult to develop a co-ordinated approach to local service provision with other NGOs. The NGOs and their funders do not place emphasis on the inter-relationship between similar services. They are invariably not accountable to a well co-ordinated, well structured and unifying development process.

The MHDP has attempted to co-ordinate its health services with those of the TPA. Some gains have been made but there is still too much uncertainty about each other's functions and responsibilities. There is no clear policy on how state services should interface with NGOs.

Requests for financial support from the state to provide services that are free of charge at state health facilities such as services for sexually transmitted disease, or financial support for drugs and the salaries of the nursing staff, have not met with success. Despite numerous approaches, the MHDP still receives no support, other than that for family planning.

The problems in establishing links with NGOs and state structures need to be overcome, because effective health care provision to a community has to be well co-ordinated, with clear referral systems, both within the PHC sector and to secondary and tertiary services.

The MHDP has been critical of its own attempts, "We have not tried enough. If only we had tried harder we would have been successful". Yet this begs the question of how communities which are less structured and more transient than Muldersdrift, and which have less resources, are expected to develop the capacity to establish a sound relationship with the TPA and other state structures. Surely, the TPA has a lot to answer for. The state has a responsibility to develop an appropriate response to the health needs of rural communities as well as communities undergoing a process of urbanisation.

Appropriate Service?

The MHDP has had numerous crises and mishaps. It has also tried to implement various ideas and concepts. The MHDP's experiences have led to an

ongoing debate around issues affecting the provision of a PHC service to the Muldersdrift community.

The question, what constitutes an appropriate service to the community, is still central to this debate. It is difficult to apply the Alma Ata definitions of PHC to a multi-cultural, highly transient and changing community. In a very impoverished community, any service tends to be accepted, regardless of its quality. Yet a regimented top down approach to the provision of health care is not going to change the position of the poor and the most vulnerable. Community participation is not only a potential factor of change, but it can also ensure the appropriateness and the maintenance of quality of the health service. But even if there is an awareness of the importance of community participation, it is very difficult to achieve in a community such as Muldersdrift. The most needy and marginalised, especially women, the old, the poor, and children, are mostly excluded from supposed democratic processes.

It is also difficult to define which parties are appropriate to render, and to finance, the health service. The rhetoric around "community ownership" of the PHC service can very easily be exploited to shirk responsibility and impoverish an already overburdened community. If community participation is to be a feature of a state run PHC system, then this needs to be examined very carefully.

The problems of providing a PHC service in a profoundly changing community which has very limited resources are vast. There is a pressing need for the formation, and ongoing evaluation, of a community development plan. People from the community should play the leading role in decision making for their own development. Service providers, including NGOs and the state, have to play a responsible role in this process.

Bernhard Gaede is a final year Wits medical student who has been involved with the Muldersrift clinic for a number of years.

Health and Development

The Role of Non-government Organisations

Hugh Gosnell

South Africa has about 54000 NGOs. This includes religious and community based organisations, educational agencies, residents' associations and intermediary service organisations which provide finance or services to other NGOs.

An Important Place

A survey by the Development Resource Centre found an average of 35 employees within NGOs which, multiplied by the total number of NGOs, gives a potential employment figure of 1 890 000. With a widely accepted estimate of 12 million people in formal employment, NGOs therefore make a significant contribution to employment. Mass based movements like the ANC, the black consciousness movement, trade unions, the United Democratic Front and civics encouraged the development of NGOs dedicated to developing a more appropriate and democratic service. Many understood the close relationship between change at the local and national levels. However few consciously saw their role as developing an alternative model for health services.

Urban Bias

They tended to develop more programmes in urban areas rather than in rural areas because most health activists who initiated these projects lived in urban areas. Furthermore the mass based democratic movement was developing in the urban areas, while severe repression and the strong influence of conservative traditional leaders were major obstacles in rural areas. The political sensitivity of progressive health workers to working in the former "homelands", the withdrawal of the churches and the decision by international NGOs not to work in South Africa during apartheid also slowed the development of rural NGOs. Another factor was that many health activists working in rural areas chose to work within formal health services rather than NGOs.

We therefore have underdeveloped rural NGOs and growing but relatively inexperienced urban ones. NGOs, both urban and rural have, with few

exceptions, not made a significant contribution to health service delivery. Some have started providing models for building a more appropriate health system. Their greatest contribution has been to developing people. Many have provided a focus for local people to think about their own situation, the health services and society at large. They provide people an opportunity to gain skills of various sorts.

Attracting Health Workers to Rural Areas

We can expect that harassment of activists will end and that access to communities will generally improve. But the problem which will persist is the shortage of health workers in rural areas. A focus among other social services on rural development will, hopefully, allow the appearance in some areas, of groups of committed development workers who can support each other. It is hoped that democratic local government will provide incentives and support in various ways to attract committed health workers to their areas.

There is a lack of co-ordinated effort to attract people to work in rural NGOs, and no concentration on students interested in rural work. There is little interest in exposing them to rural projects and on finding employment opportunities for them. The latter, with a greater presence of international NGOs in these areas would enormously assist the expansion of this sector in rural areas.

Urban Problems

Urban primary health care projects suffer a different set of obstacles. Urban projects focus on the least serviced areas. In the struggle to survive people have little time for long term investment in health education and other activities to improve the health of their community. They are continually looking for ways to find money to support their families. Therefore activities which are time consuming but bring no material benefit to the family, such as the work of community health workers (CHWs), may be seen by health activists' families as unproductive.

By contrast, rural areas often have more stable communities. Community work brings status and other psychological benefits to the individuals involved more readily than it would in vast urban communities, where relationships are more tenuous and people have a shorter history of knowing each other. Ironically the greater lack of access to health services in rural areas is

Ken Ndlazi

Can NGOs deliver services effectively ?

also a potent inducement to involving people in their community health problems.

New Directions

The intense commitment of international churches in other parts of Africa and their declining resources make it extremely unlikely that they will resume responsibility for "mission hospitals" in South Africa unless the largest financial contribution to health services was provided by the state. They are more likely to engage in work similar to other NGOS in developing experimental services and complimenting the work of state health services. It is also unlikely that NGOs will take on greater service provision roles unless the state decides that contracting NGOs to run services is more effective than doing it on its own. This remains an option for the state to consider.

The potential of NGOs to contract for the delivery of health services or providing complementary functions to the state, is likely to expand significantly. This poses the question of their readiness to meet these new challenges. NGOs have mostly run on small budgets with a minimum of skilled staff. The emphasis has been on recruiting staff and running organisations in a way which strengthened their relationship with communities.

Efficient delivery has not been the prime goal. Management expertise and appropriate management systems have in many cases been lacking. If NGOs are to meet new challenges, they will need to develop new management capacity and skills.

The present loss of key NGO personnel into parliament and the civil service will also have an effect on several NGOs. Despite this it is probable that NGOs are currently better able than the public health service to undertake a variety of activities seen as part of the new health development process.

It is currently debated whether promoting the role of NGOs on aspects - like developing and supporting community based training programmes - in which they have an advantage over the state, will have the effect of removing these as priorities for public health services. Even if subsidised by the state, reliance on foreign funding would make their funds susceptible to cuts when funds are short and thereby undermine their role as an integral part of a long term health service strategy. Many argue however the advantages of a more local community sensitive programme outweigh the disadvantages.

The major role of NGOs should probably remain that of complementing state services and providing venues for experimentation and development of new models.

A function best fulfilled by NGOS rather than the state is the provision of training to community, district and provincial health and development committees. This could include an understanding of existing health structures and the role of NGOs in these, an understanding of health and deciding on priorities, how to monitor services and how to ensure implementation of desired changes. It would be preferable for NGOs to provide this training and ongoing support to these structures in collaboration with the state. This kind of function would of course require capacity building if it was to be done on a national or provincial scale. Alternatively NGOs could provide input in the development of health curricula and participate in aspects of its implementation.

Rural Potential

In rural areas, there is the potential for CHW and care group projects to expand significantly. Care groups have already been widened to include parts of Venda, Gazankulu and KaNgwane. However they need to expand beyond these areas. Care groups are a concept with great potential to involve large numbers of people and to avoid the tendency towards elitism involved in the training of

CHWs. The programme should reduce dependence on the state. In fact it should be NGO-driven, with a close relationship to various state departments which relate to its activities.

The Cala (Transkei) CHW programme run by Health Care Trust, has already begun the process of expanding to new areas. The limit on the expansion of CWH programmes is the lack of trained CHW co-ordinators and trainers. There is also a shortage of finance to put more co-ordinators in an expanded area. The state should subsidise training programmes to enable them to employ and improve the skills of more co-ordinators and trainers.

Nationally-based NGOs should be challenged to or ganise activities to address rural concerns and to stimulate the construction of more rural-based non-government health services. An associated task is the need to open low cost training programmes for activists. These training programmes should be appropriate to the demands of rural work. They should be made accessible to those individuals who have the interest and commitment to work in rural areas. An NGO team-up with the government in strengthening community based health programmes in the rural areas could be ex-plored.

Ismail Vawda

Getting to the point: NGOs will need to develop new management capacity and skills

NGOs under Democracy

In urban and rural areas, the emergence of small community projects should be encouraged. There are large numbers of vegetable gardening schemes, sewing groups and other income generating initiatives which provide a focus for the community to work together. These groups will benefit from support in the form of networking and health education.

Urban primary health care projects can be focal points for education and organisation around health issues. Ideally they should work closely with the civics to strengthen the capacity of these to take up socio-economic demands like housing, water and jobs, which have a long term impact on people's health.

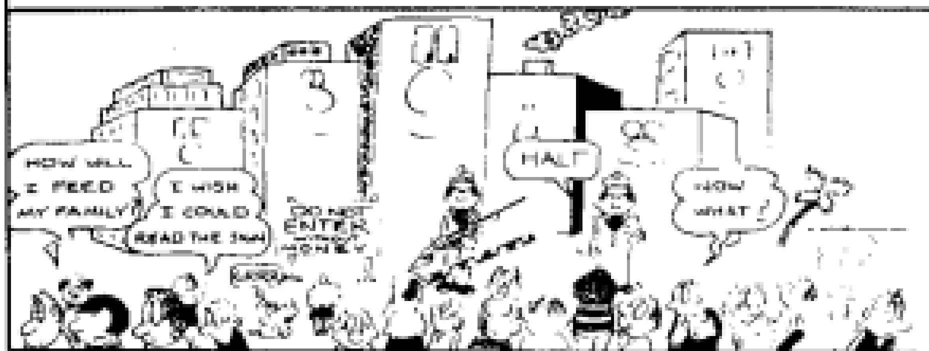
With a more democratic government in office, there is an opportunity for NGOs, both urban and rural, to advocate a shift of resources in the direction of rural primary health care. A democratic government should provide the opportunity for the public through NGOs to get involved in policy formulation and budget allocation. Hopefully there will be much more public debate on health issues, to give the public greater awareness of health. It is hoped that NGOs will continue contributing to this process.

Hugh Gosnell works for the National Progressive Primary Health Care Network in Johannesburg

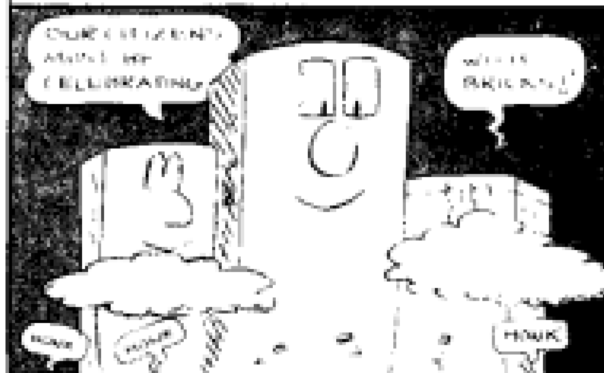
STILL, EVEN MORE PEOPLE CAME TO THE SHANTYTOWN IN SEARCH FOR A BETTER LIFE

AS THE SHANTYTOWN GREW LARGER THE CITY GREW AFRAID THAT IT WOULD SOON BECOME SMALLER THAN THE TOWN

UNTIL ONE DAY THE CITY SAID 'ENOUGH' AND DECIDED IT WOULDN'T ALLOW ANY OF THE PEOPLE FROM SHANTYTOWN TO ENTER THE CITY



THINKING IT HAD SOLVED IT'S PROBLEM, THE CITY WONDERED WHAT THE COMMOTION WAS ABOUT



SECTION C

engaging communities in deciding their health

Planning Urbanisation and Health

A Large Settlement of Relocated People

Veronique Moniez and Jo-Ann Monson

Recently, promises of adequate primary health care services and housing for all have been made across the political spectrum. The question is whether these promises can be fulfilled. In the enormous settlements of relocated persons that have grown under the apartheid system, it is not easy to plan for and provide basic health and housing. Existing conditions can be aggravated and valuable resources can be misused.

Using Botshabelo as an example, some of the issues in planning for health and urbanisation will be explored, taking into account that the particular history of this lar -ge settlement adds complications to an already formidable challenge.

Botshabelo - a Brief History

Botshabelo, 55 km east of Bloemfontein, is essentially in the middle of nowhere. The motivation for its formation was not the availability of employment and other resources. The mainly Sotho- speaking people were relocated there from 1979 onwards as part of the National Party government's separate development policy. For more than 12 years, the apartheid government put a restriction on the expansion of Mangaung, the township near Bloemfontein. Today, 230 000 persons live in Botshabelo, and 13 000 people commute daily to Bloemfontein.

In 1987, an unsuccessful attempt was made to incorporate Botshabelo into QwaQwa. Various industrial decentralisation benefits were offered to companies prepared to relocate to Botshabelo. Many of these ventures failed. Almost half of these have closed. Presently, 60% of the population are unemployed. Approximately 125 out of 1 000 children die before reaching one. At the Medecins du Monde nutrition centre, almost all the children admitted for treatment have tuberculosis. Ten per cent of patients attending the Medecins du Monde clinic have sexually transmitted diseases.

The abolishment of influx control in 1986 greatly reduced the flow of people to Botshabelo and the rationale for the creation of Botshabelo fell away on 2 February 1990 when the National Party government finally turned its

back on apartheid. Botshabelo's future is uncertain. It is dependent on government subsidies for its survival. Although the population is declining as the work force is attracted to peri-urban areas and, in particular, to Bloemfontein townships, the apartheid government predicted that, in five years, there will still be some 185 000 people living in Botshabelo.

This legacy and the existing conditions make planning for urbanisation extremely difficult. The issue is complicated by general uncertainty about future authorities and reluctance on the part of the present authorities to make any definite plans. There are perhaps three ways of resolving the problem - dismantling Botshabelo and relocating its people, transforming and developing the township, or a mixture of the two.

Relocation

The case for relocation is strong. Botshabelo is situated in a remote area with nothing to attract potential employers. Botshabelo's population is isolated from the wider South African community. Travel to Bloemfontein, at R9,00 return, is expensive for people living in poverty.

The Urban Foundation has proposed that the 10 000 people commuting daily to Bloemfontein from Botshabelo on subsidised transport be relocated to Bloemfontein. The funds used to subsidise the transport could be used for housing in Bloemfontein. The proposal is, however, not a solution for Botshabelo as a whole. In fact, the relocation of income earners will lead to further impoverishment of the township. Furthermore, the proposal does not address the need to provide services, such as education and health, for the relocated people.

With regard to any relocation, details which concern the overall health of the community need to be carefully worked out. The possibility of a negative response from existing Bloemfontein communities to the influx of new persons must also be considered.

Transformation and Development

The SANCO Southern Orange Free State Region suggests that the area around Botshabelo be developed and a railway be built, linking Bloemfontein, Thaba'Nchu and Botshabelo. Thaba'Nchu, previously part of Bophuthatswana, is more developed than Botshabelo. Now that it is once again officially part of South Africa, it is almost certain that a number of people from Botshabelo

John Robinson

Large open spaces are a feature of Botshabelo.

will move there. Because they are geographically close, Botshabelo and Thaba'Nchu will probably constitute a district with a common authority.

SANCO also expects that people in Botshabelo will relocate to other areas in the vicinity, such as the mines. This spontaneous relocation must be taken into consideration in the planning and provision of appropriate services in these areas. Information about existing and future services in the region must be made available to Botshabelo residents so that they can make informed decisions. Movement within the region points to the importance of well co-ordinated district and regional structures.

The local civic argues that Botshabelo must be developed. The civic maintains that the lack of development is partly because it was not involved in the allocation of the local budget. It intends to play an active role in the allocation of funds. Two major factors need to be considered in transforming and developing the township, namely its size and the history of poor planning. The central business district of Botshabelo is close to the entrance, but the township is spread over a large area, including large open spaces. The Provincial Administration of the Orange Free State (PAO) maintains that it is not possible to build on certain areas because of poor soil quality and erosion. Because of the large size of the township, it is costly to develop infrastructure and it is not easy to create a sense of community.

People in the township who acquire skills, soon move out in search of employment and a better life style. Some sections of the township include only poor and old people. It is almost impossible for some members of the population to gain access to health care. The distribution of health facilities is uneven and, for many, the cost of transport within the township is unaffordable.

Poor Planning

There is no local authority in Botshabelo. Since the Department of Development AID was dismantled in 1992, the township has been administered by the PAO. The person responsible for making decisions concerning town planning in Botshabelo is Mr Scott, who is also responsible for making decisions about seventeen other places. The PAO has no vision of urbanisation for Botshabelo, no ultimate plan, no policy. Work is carried out, mainly around the CBD, in a haphazard and unsustained manner. Furthermore work is done with little or no community representation and no research. The poor town planning of the past will cause problems for future planning. The existing infrastructure is exceptionally bad. In one section, housing consists of 73% shacks and huts, and 27% of brick homes. There are no waterborne sewerage facilities, people are reliant on street taps, and roads are exceptionally poor. There are no telephone services.

The "Petty Demarcation System" of the PAO, to develop around roads and shops, but not the outlying areas, creates an internal spontaneous relocation of people as they move to the area which is better developed. While attempts have been made to allocate plots with water and access to a road to these families, the number of families exceeds the amount of plots available. The crux of the matter in developing only one area of a large township like Botshabelo is that internal migration will create a problem of overcrowded informal housing and its associated health hazards.

An Intersectoral Approach

Health problems are not only the consequence of inadequate housing and poor facilities such as water supply and sewerage, but also of undeveloped and inaccessible health facilities and related services.

The current fees for services are too expensive for many persons. A woman who has fees outstanding on her delivery will not be permitted to have tuberculosis treatment until these fees are paid. The existing health services are not adequate, and plans must be made in advance to increase their capac-

Ken Ndlazi

People have to share taps

ity. Furthermore the improvement of health services alone is not sufficient and efforts must be made to upgrade communication and other facilities simultaneously.

For example, a woman in labour, who may have proper housing facilities and a clinic within two kilometres, cannot possibly be expected to walk this distance. It is essential that urbanisation is not only seen as providing housing. It also entails transport, decent roads and proper communication services such as telephones.

Poor health is also, to a large extent, the result of a lack of education. The lifestyle of people with no recreational facilities and little hope for the future also has an adverse effect on their health.

Research and Community Consultation

Before embarking on a development programme, it is necessary to do research on the township and its different sections as well as the broader region. The extent of the economic viability of Botshabelo needs to be thoroughly explored.

There is a need to research the feelings and ideas of the community and to gain a community profile. The size of the population, the living conditions

and existing facilities are vital for the planning of good health services. Research will also put into perspective the urgency of some issues and assist authorities in careful prioritising, which will be necessary both in terms of time and limited resources. The community must be consulted about plans for development arising out of the research process. Deadlines for the provision of services must be strictly adhered to in order to gain the trust of the people. Involving the community in the process of urbanisation gives it a sense of the future, something to be proud of. It should also impact positively on the community's health status. On the other hand, if the community is not consulted and informed, community members will continue to establish informal housing around the developed areas, with negative health consequences.

Since the election of an interim government, a new health policy, which focuses on primary health care and an intersectoral approach, is being implemented. There is recognition that a community's health status is directly linked to its living conditions. It is important that plans for urbanisation are done in consultation with the health authorities. Stress must be placed on an intersectoral approach at a district level of authority as well as the establishment of strong links with the regional level.

Considering Botshabelo's size and poor planning in the past, it seems that, whatever plans are decided upon, they will inevitably entail certain health hazards. In planning for urbanisation in any large township, similar problems apply. A holistic plan for the entire population is needed and the viability of the continued existence of the township must be considered, but the community must be consulted in arriving at a way forward.

Health has to be seen as directly related to education, communication services, housing, infrastructure and, especially, to the particular needs and feelings of the community. It is of utmost importance that health is not viewed as a separate field in development and that the intersectoral approach with community participation is adopted.

Veronique Moniez and Jo-Ann Monson work for Medicins du Mond, a French health NGO

Social Turmoil and Participation
An Informal Settlement Health Intervention

Fidelia Maforah & Pam Cerff

In the past few years, community participation has repeatedly been proposed as an approach which empowers people to assume control over their lives. Is this realistic or is it just a slogan without content? The aim of this paper is to discuss community participation in health interventions in informal settlements, using a case study. Given the complexity and dynamism of these communities, there are limitations in generalising this study to other settlements in South Africa, but there are also potential benefits to communities and service providers.

Mizamo Yethu - The Study Site

The community under study is Mizamo Yethu, an informal settlement in Hout Bay in the Cape Peninsula. Historically the Hout Bay valley used to consist of a number of farms on which farm labourers lived. Some labour - ers also worked on the fishing vessels in the harbour. Gradually, these farms were subdivided and sold to people who had no need for farm labourers. These labourers became illegal squatters on private property. Consequently, pockets of squatters appeared all over Hout Bay. At the same time, there was also an influx of people from outside Hout Bay. Five big informal settlements emerged. Severe conflict arose between the rate payers and the squatters. Representatives from the settlements collectively negotiated with relevant authorities for land that they could occupy. This resulted in the removal of all settlements to one big settlement in 1991. The squatters named the settlement Imizamo Yethu, now formally called Mizamo Yethu, which means "through our collective struggle".

The relocated communities differed widely with respect to socio-cultural and other factors. This created major problems with regard to their integration into the wider Hout Bay community as well as the formation of representative social structures and community organisations. There was also a further influx of newcomers who occupied land earmarked for development. This led to tension amongst the original inhabitants who had been promised sites on this land by the Cape Provincial Administration (CPA). Some felt

Child playing in one of the few paved roads in the settlement.

that the newcomers also had a right to sites, others felt that the newcomers jeopardised their chances of being allocated sites. Conflict also arose between the community and the CPA. Community committees disintegrated, physical upgrading was delayed and people became demotivated. Finally, the CPA announced that newcomers would also be provided with sites. Some time thereafter, the CPA indicated that it would not be able to accommodate all newcomers. This led to renewed tension and a number of violent incidents.

The Method

A baseline survey conducted in the community in 1991 indicated that diarrhoea and acute respiratory infections in children were the predominant health problems. A community participatory health promotion intervention was therefore designed to address these problems. Health promotion entails change in the ways and conditions of living. It goes beyond health education in that it addresses the overall development of the community and requires community participation. However, community participation in health interventions in informal settlements raises several issues for service providers, researchers and the community alike. The most serious ones to address include the state of severe conflict in which many of these communities find themselves, the dy-

namic nature of these communities, and the lack of people's trust in professionals and lack of trust between people themselves. How can health programmes be facilitated when factional conflict continually sabotages the process? What are the role implications for health professionals, service providers and researchers? What are the potential strategies to employ when intervening with disadvantaged communities?

Community participation and empowerment

These factors were taken into consideration in designing the health promotion intervention. At the outset, it was recognised that the intervention would have to take into account the capacity and other developments in the community. The researchers thus held formal and informal discussions, observed and, in some cases, participated at civic and health committee meetings and health and development forums. The purpose was to ascertain the existing capacity of the community and to identify existing and potential constraints. Current activities and the agendas of relevant groups were established. Possible areas of collaboration and resources were identified.

Discussions and local meetings became a means of listening to people's opinions, their perception and understanding of health problems and their ideas on possible solutions. These meetings also served as a means of open and equal discussion. Needs related to skills development and training were identified. The researchers demonstrated trust in the community by devolving responsibility to it. The civic structures, health committees and women's organisations played a central role in linking the researchers with local people and indigenous health knowledge and practices. They were also instrumental in allaying people's suspicion of researchers as outsiders and in mobilising resources for the intervention's implementation.

Credible members of the community were employed to introduce the concept of a health intervention to the rest of the community on a one-to-one basis. The aim was to ensure that the people were involved in the proposed health promotion intervention. Others recruited participants for focus group discussions, organised the venues as well as other logistical needs such as refreshments, equipment, etc. The civic and health committees selected people from the community to administer the questionnaires.

The conflicts within the community outlined earlier in this paper took place at various stages of the intervention. Community representatives who were involved in the intervention were side-tracked into dealing with these

crisis situations, drastically reducing the rate of progress of the intervention. However, trying to maintain progress without the involvement of the community and its representatives would have amounted to a typical top-down approach to health programmes, whereby outsiders decide for communities. Such an approach would have been unacceptable. Thus, the intervention had to proceed at the community's pace.

Development of Partnerships

Community based organisations, NGOs, key individuals, service providers and the private sector were consulted regarding collaboration in the project. Ten organisations together with community representatives committed themselves in varying degrees to the project. These were the SA Red Cross Society, St John's Ambulance, Purity Baby Foods, Students Health and Welfare Clinics Organisation (SHAWCO), Progressive Primary Health Care Network (PPHCN), Child Accident Prevention Foundation of South Africa (CAFDA), Department of National Health and Population Development, Western Cape Regional Services Council (WCRSC), Cape Provincial Administration (CPA), Urban Foundation, the Child Welfare Society and Community and Urban Support Services Project (CUSSP).

Ismail Vawda

Unlike the Transvaal & OFS, the camp here is surrounded by trees.

It was agreed that an environmental health promotion programme was the appropriate intervention. A working group was mandated to plan the details of the programme to reduce the morbidity associated with diarrhoeal disease and acute respiratory infections. It produced a plan of action and task groups responsible for different components of the intervention were then formed.

Despite the researchers' skills in health promotion, they benefited from drawing on the expertise of full-time health promotion and development organisations. An additional advantage was the introduction of these organisations to the community. This will facilitate collaboration between these parties in health promotion and health related activities. Leaders in the community have now been empowered to make direct contact with these organisations.

Monitoring and Evaluation

In the study, community participation was seen as a process whereby people would take responsibility for their own health. The study was based on involving people in planning the health programme. Thus, monitoring and evaluation sought to measure participation and involvement, rather than improvement in the health status.

The degree of participation in the following areas was evaluated: needs assessment, leadership, resource mobilisation, organisation and management. The conclusion drawn was that the degree of participation was relatively high.

Factors influencing community participation in informal settlements include social structure, poverty, lack of financial commitment of the local authority, long suppression of community initiatives, poor relationship between professionals and the community, previous experience with health and community development programmes, lack of orientation, sensitisation and training of both community members in health issues and of health professionals and development workers in community participation and empowerment.

It was expected that the above factors would have a negative impact on the degree of community participation in informal settlements, but the evaluation results show that the Mizamo Yethu community used the situation to its benefit.

Empowerment and Further Development

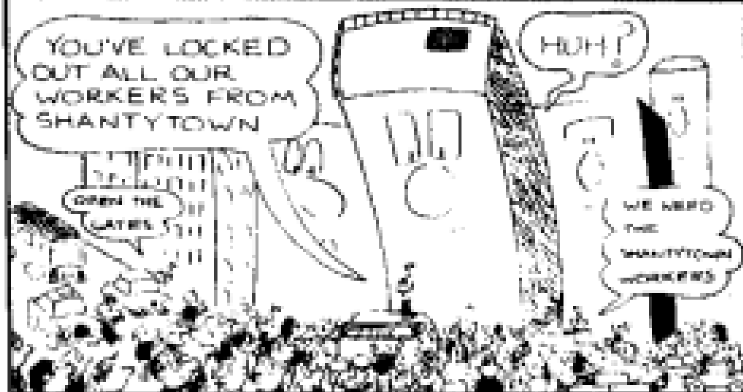
While the provision of resources, services and material assistance is necessary, it often does not benefit the community if it is not based on the philosophy of empowerment. Although Mizamo Yethu lacks the most basic necessities and has only recently gained the attention of donors, it has established itself through a determined struggle for survival. This has led to true empowerment, to strong leadership which negotiates with outside organisations and resource holders for training and capacity building. This has benefited the whole community and has led to strong community involvement and management of community affairs. Similarly, the health project was seen as an opportunity for capacity building, networking and developing structures.

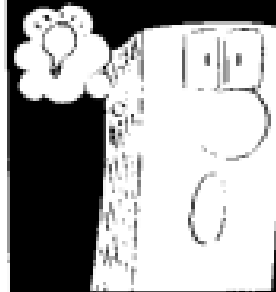
The co-ordinating team took a facilitating role as the community assumed full responsibility for the project. Their enthusiasm was seen in the well attended weekly committee meetings convened by the health and civic committees to receive feedback on progress and to attend to urgent issues relating to the project. These community meetings ensured that the community as a whole had a full sense of ownership of the project.

Because of the enthusiastic response of the community, several health promotion structures and activities have been initiated in the community or are in the process of implementation. For example, a SHAWCO mobile clinic will provide general health care and health promotion in specific cases. A section of the Urban Foundation is conducting training courses in the building of dwellings with groups of men and women in the community.

Negotiations for the training of health workers is under way. While the long-term sustainability of this intervention must still be evaluated, the benefits shown in terms of community empowerment suggest that the approach will be useful in similar situations. With democratic developments in the country, policy makers, local authorities, health planners and developers will require sound information on which to make informed decisions regarding the improvement of environmental conditions relating to health in informal settlements. More interventive programmes aiming at empowering communities are therefore urgently required.

Fideliah Mafora and Pam Cerff work for the Medical Research Council, Cape Town





SECTION D
violence, institutions, the world bank

Public Violence and Children
The Need for Intervention on a National Scale

Duncan & Rock

Recent research reveals that South Africa is one of the most violent countries in the world. There are media reports virtually every day of the most gruesome acts of public violence. Despite the expectations generated by the elections, present indications are that this violence will continue, if not increase.

Violence and Children

The price children have paid, and continue to pay , as a result of the high level of public violence characterising South African society is substantial. Consider here, for example, the following statistics:

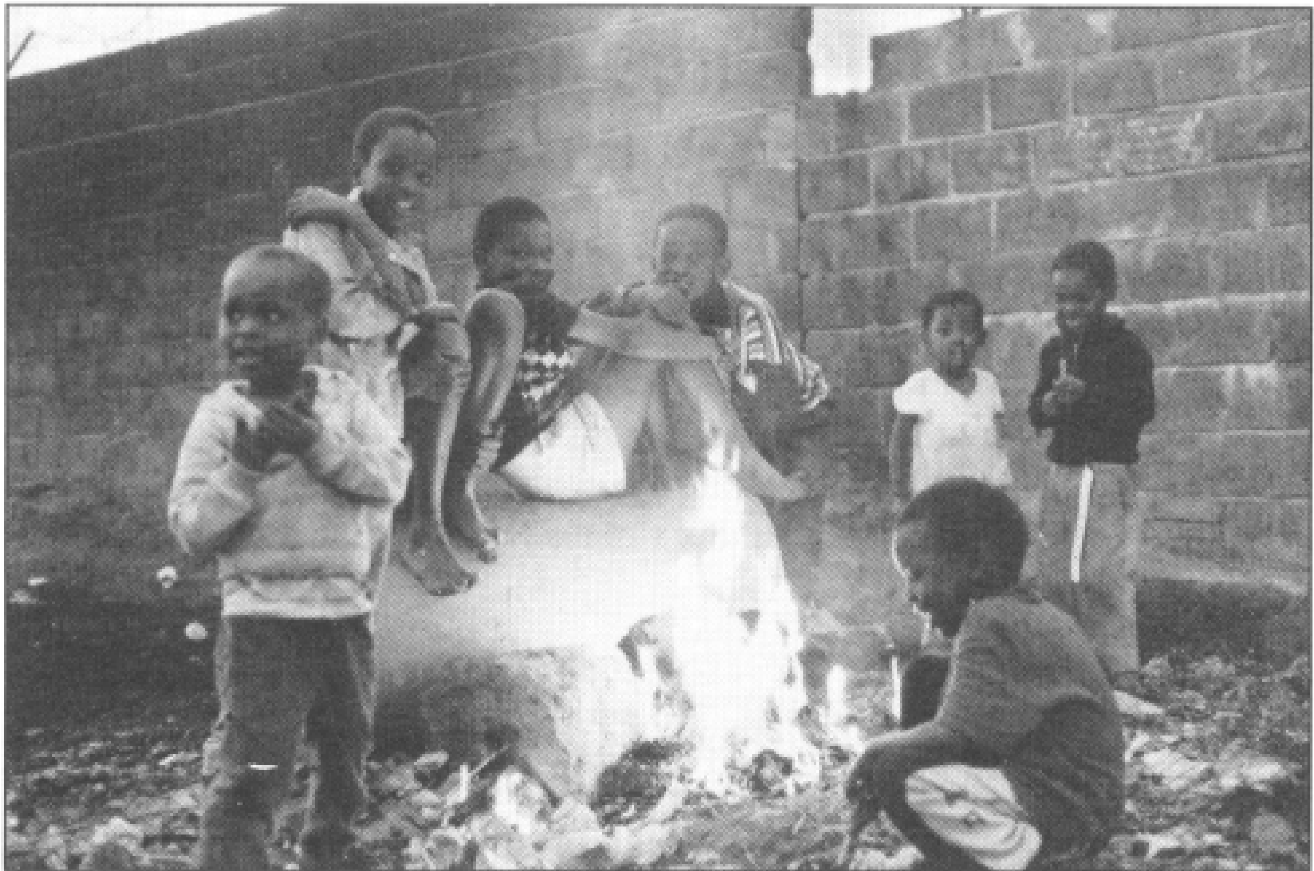
- The number of people killed or injured in acts of political violence during 1993 was 8 737, the number of children killed or injured was 874 (Human Rights Commission);
- The number of children displaced due to conflict in 36 areas in Natal during the last 3 years was 26 790. This is 42% of the total number of people displaced. Of these children, 11 845 were under 5 years of age, 4 990 were abandoned or lost, and 1 395 were physically traumatised (National Children's Rights Committee (NCRC)).

As disconcerting as the above statistics appear, it needs to be pointed out that they represent the tip of the iceberg. Despite the importance of epidemiological information, there is a marked lack of such information. It is presently not known how many hundreds of thousands of children were, and continue to be, affected by public violence.

Children can be affected by both direct and indirect exposure to violence. It is thus important to specify the circumstances that lead to traumatisation and the ways in which such traumatisation manifests itself.

Emotional Trauma and Violent Behaviour

Direct exposure to public violence can lead to various consequences. Children may die, suffer loss of limbs or a range of other severe physical injuries. Injuries and resulting hospitalisation can have significant emotional effects,



Estimates of children with psychological stresses are conservative

but children who emerge seemingly unscathed from such occurrences are also highly predisposed to becoming emotionally traumatised.

Several studies conducted in South Africa indicate that children traumatised by public violence typically exhibit symptoms ranging from extreme anger, fear and shock to debilitating helplessness and despondency. In one such study, as many as 9% of the children sampled displayed serious conditions, ranging from Conduct Disorder to Post Traumatic Stress. Given that many children present with symptoms only several years after exposure to incidents of public violence, this figure is a conservative representation of the actual number of severely traumatised children.

Most of the studies dealing with the effects of public violence highlight that, the more often children are exposed to acts of violence, the more likely it becomes for them to begin perpetrating acts of violence. Thus, there is a very thin line between being a victim of violence and beginning to commit violent acts oneself.

Indeed, several studies have detected a trend of increasing numbers of children and young adolescents perpetrating acts of public violence. The large number of children implicated in "necklacing" and mur dering political opponents in recent years is a case in point. Moreover , as a number of recent media reports and studies indicate, this phenomenon is not limited to black children

and adolescents. In this regard, consider the much reported case of the young white adolescents who last year seriously injured a baby in a stoning incident, simply because she and her mother were black.

The real tragedy of this situation is that South African children, like other children, were not born to be violent. Rather, they have systematically been socialised by our society to perceive violence as the only viable means of asserting themselves or resolving conflict. As the NCRC observes, "To (most children in this country), there has never been a day without violence, without the police casspirs, funerals, stayaways and, more recently, the (intra-community) killing and destruction."

The Death and Trauma of Care-givers and Friends

Children need not be directly involved in public violence to be affected by it. Over the last decade alone, tens of thousands of children have suffered through the death and traumatisation of family members, neighbours, friends, teachers, etc. The disruption or loss of emotional attachments which normally accompany these traumatic events does not only have debilitating consequences for the child's immediate psychological well-being, but also for his/her later development.

This is most apparent in the case of young children whose parents or primary care-givers are the victims of violence. For a number of reasons, the primary care-givers constitute the child's entire world. Events which separate children from their primary care- givers are, therefore, disruptive to their development, particularly when such events are located within a context of ongoing stress and turmoil. Indeed, it has been found that children who lose their primary care-givers as a result of violence frequently experience difficulty in developing an orientation of trust towards others and the world at large. These children are consequently at risk of developing a range of behavioural and psychological problems after their exposure to political violence.

Against this backdrop, there is an increasing degree of disintegration of the family unit (particularly the black family unit) in South Africa. Frequently families cannot serve effectively as a support system for children during crises. This has serious implications for the development and well-being of our children and, indeed, for the future of this country as a whole. The family is not only important because of its ability to meet the basic emotional and physical needs of the child, but because it plays a pivotal role in transmitting societal rules and morals. Where the adult members of the child's family are unable to adequately attend to the child, or where the family itself is broken or dysfunc-

tional, this process can be severely distorted or disrupted. Children of such families are more likely to disregard social norms and values, such as the sanctity of human life, which make communal life possible.

Children beyond the Battlegrounds

It is also very disquieting that children need not be at the epicentre of public violence in order to be affected by it. In this regard, the recent dramatic increase in the suicide rates amongst young adolescents from relatively "violence-free" white communities, coinciding as it does with the increase in the levels of public violence in this country, are very informative.

The fact that children relatively removed from the so-called "battlegrounds" are also affected adversely by political violence is borne out by several empirical studies conducted both in South Africa and Palestine. According to one research study recently conducted in South Africa, it was found that children who are located on the periphery of violence-torn areas frequently show higher levels of psychological stress than children who live in the centre of these areas.

Health and Social Services

Another important manner in which children may suffer as a result of political violence is related to the provision of health and other social services. An extensive study recently undertaken by the NCRC in Natal and the PWV reveals that political violence has had a devastating impact on the provision of various social and health services directed at children. This has dramatically increased the already high morbidity and mortality rates amongst South African children, and has had extremely adverse effects on their psychological well-being.

As a result of factors such as apartheid practices and the current high levels of intra-community violence, schools catering for the majority of children in South Africa are not in position to provide much needed security and support. Moreover, many schools themselves are frequently the site of violence and intolerance. A further factor to be considered is the traumatisation of health care workers and teachers who have been in the eye of the storm. This often impedes their ability to intervene meaningfully in children's lives.

In summary, children are affected at many levels as a result of the intense level of public violence which has been created in South Africa. Importantly, public violence does not only influence children caught in the epicen-

or, rather, areas where there are fewer overt displays of public violence, are also affected. This could perhaps be a consequence of the extent to and the manner in which public violence has been "mediatised" over the last few years.

Certainly some children are more affected than others, it cannot be denied that the children of Sebokeng are affected more dramatically and acutely by public violence than the children of Sandton. But, in the final analysis, it has to be accepted that few children in this country emerge unscathed.

National Programme of Action

The contents of the preceding pages should be relatively disturbing to those concerned about the future well-being of this country, particularly in view of the large numbers of children who have been exposed to various forms of public violence. Seventy per cent of the South African population consist of youth and children who carry the potential for the future of our nation. They may be precluded from reaching their potential if we do not urgently address the problems brought about by public violence.

This requires a national programme of action aimed at redressing the decidedly negative impact which public violence has had on our children.

Ken Ndlazi

Few children who have been exposed to violence emerge unscathed

Such a programme could make a crucial contribution towards healing this nation and furthering the goals of peace and reconciliation.

Indeed, anything less would result in further loss and destruction, and a future generation of adults who, because of the scars they would bear, could not be of optimal benefit to society. It needs to be re-iterated that any programme attempting to minimise the effects of public violence on our children can only be meaningful or effective if it is accompanied by action aimed at eliminating the political, social and economic causes of such violence.

Goldstone Commission of Inquiry

The Goldstone Commission of Inquiry into the Effects of Public Violence on Children can be seen as a crucial initial step in the process of initiating a national programme for the rehabilitation of South African children. This inquiry should not be seen as a negation of the efforts undertaken by many organisations and individuals to intervene meaningfully in the lives of children. Rather, its objective is to draw vital information from a number of sources in order to map the present levels of public violence in this country as it affects children; gauge the present status of resource allocation and service delivery to those who are directly and indirectly exposed to violence; and synthesise the findings of existing research regarding the effects of political violence on children. These three levels of analysis will culminate in the presentation of concrete recommendations needed to address the plight of children.

The inquiry is underpinned and driven by a policy of transparency and broad consultation. A wide range of key organisations and individuals have been, and are still being, consulted regarding what needs to be done for children. Thus far, the responses from these consultations have been unanimous in regard to at least the following two points: an inquiry into effects of public violence on children is long overdue; and it is important that a national project aimed at the needs of children be initiated as a matter of urgency. This project should, as far as possible, involve existing initiatives dealing with children's issues.

If we in any way aspire to future peace and prosperity, we will have to come to terms with, and deal with, the iniquities of the past and present. Addressing the present plight and needs of our children, constitutes a crucial step in this direction.

This is an edited version of the report prepared for the Goldstone Commission of Inquiry into the Effects of Public Violence on Children

No Love Nor Money

Institutional Child Care in South Africa

Anne McKay

"Every child has the right to a name, nationality and care in their best interests" - Article 27, South African Interim Bill of Rights, 1993.

Many workers earn wages of R400 a month or less. They struggle to keep their families alive, but they manage, somehow. Yet it costs the state R700 a month to keep a child in an institution. According to Priscilla McKay, director of Pinetown Child Welfare, "The state cannot afford to take on any more children at this stage. There is just not enough money." Many health workers would say that in institutions there is not enough love either.

I am writing in response to some of the discussions taking place about raising more money from central government for institutions for abandoned children and HIV babies. My argument is that, while some institutions are needed for very short-term placement or for very disturbed children, the money could be better spent placing children into some sort of family care. Because

Sello Jiyane

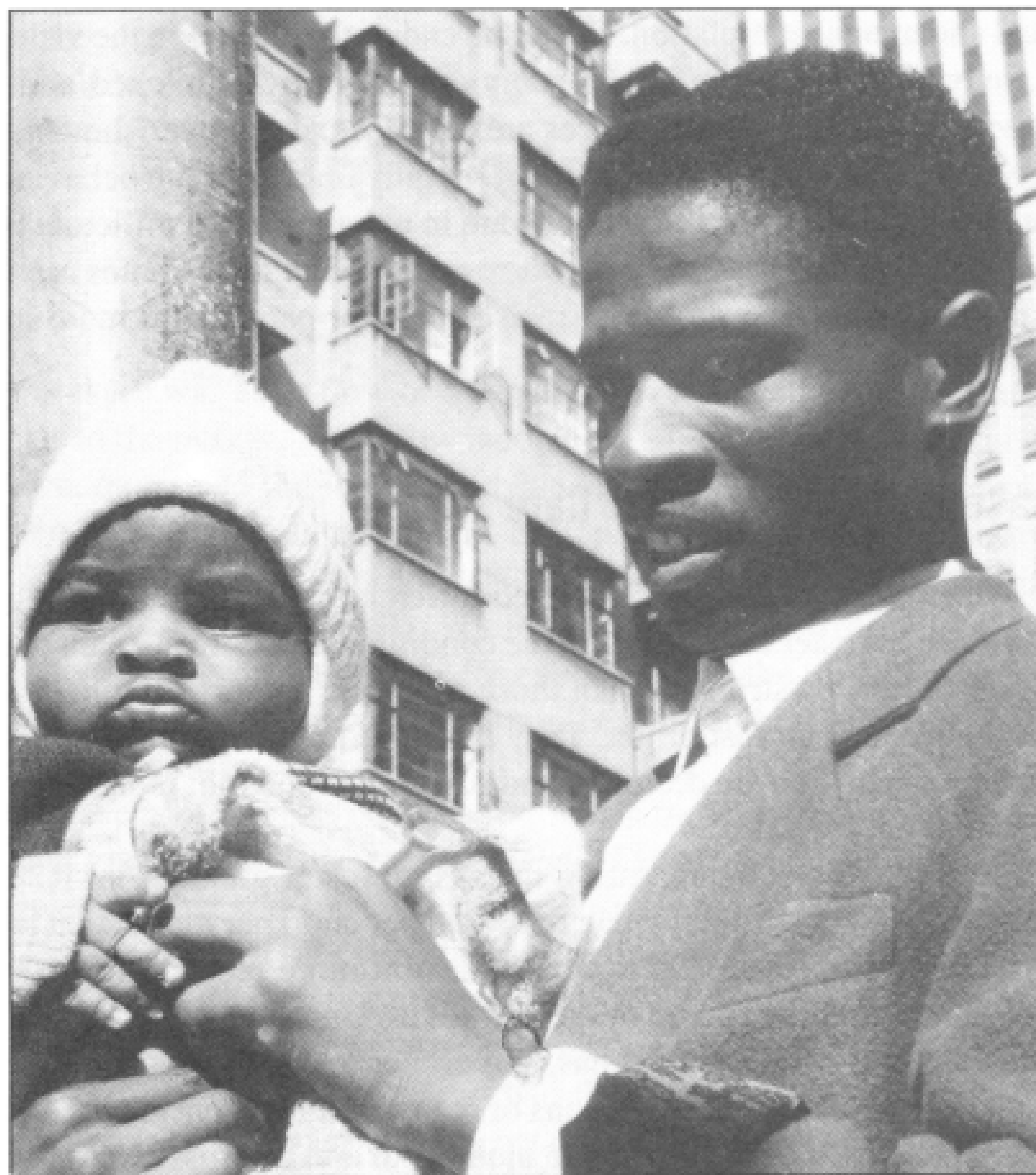
the new government is reviewing how money is spent, this is the time for reviewing the whole idea of orphanages or places of safety. We don't have the money and they don't work.

Cuddling, Holding and Bonding

The debate about what children really need has revolved around the "common wisdom" that a child needs a full-time mother to develop socially and psychologically. Research in the first world has put forward the position that a child needs:
* a limited number of secure caretakers;
* sensitive, individual attention, to create the conditions for bonding;
* the presence of familiar surroundings and people; and
* intellectual stimulation through play and affection, to develop intellectual and physical co-ordination.

None of this necessarily adds up to love. But it is more than the over-stretched resources of most childcare institutions in this country can cope with. In the UK, there are some institutions for severely disturbed children which have a ratio of two staff per patient. In South Africa, only the very specialised (and consequently much more expensive) children's homes have an adequate ratio. Most institutions in black areas are so understaffed that they struggle to keep the children more less regularly changed if they dirty their clothes, to make sure that every child eats, to make sure they all go to sleep after lunch. Cuddling and holding are rare and special.

Michael Rutter, in a review of literature on the lack of mothering published in psychological journals between 1972 and 1978, found that experiences in the first few years of life have long-term effects on children's ability to bond with others and their ability to develop socially. He notes that there is adequate evidence that babies develop an attachment to specific persons around 6 to 12 months of age. This is most likely to be the person who brings comfort when the child is anxious, exhausted or ill. "Sensitive responsiveness" is the one quality in any interaction most likely to foster secure personal bonding between child and caretaker. He argues that sensitive responsiveness is a reciprocal active interaction between a child and its significant other. This type of interaction is specifically lacking in the overcrowded and understaffed orphanages serving most South African children separated from their parents.



Sello Jiyane

The importance of bonding in the first few years cannot be totally compensated for in later years.

The Visitors Go Home

It seems from the literature that good experience at any stage of a child's life can make up some of the deficits of earlier experiences of neglect. Lack of intellectual stimulation can be made up, children can learn social skills at a later stage if stimulated by an improved environment, and so on. But the importance of bonding in the first few years cannot be totally compensated for in later years. And this is the crucial issue with regard to placing infants in orphanages. They just do not get to bond sufficiently with a caretaking person in such situations.

Child welfare societies are very aware of the problem. They have volunteer programmes and student visits in an attempt to give the children some

physical and mental stimulation. But at the end of the afternoon the visitors go home, leaving the children to the attentions of an overstretched and often demotivated staff. The consequences are: intellectual impoverishment, emotional withdrawal, anger and aggressive, socially inappropriate behaviour. Of course, this happens with children who are in unhappy and conflictual homes as well. And it is true that children who are abused in their homes are worse off than they would be away from their parents or parent. But more institutions are not the answer.

Increased Grants for Foster Care

Some social welfare agencies have tried different methods of encouraging a type of informal foster care. Already, the conditions set for foster care of black babies are much less stringent than those for white babies. Any half decent home is better than an institution. They have tried placing runaway children with older women who are destitute, and supplying food (not money) for both the child and the caretaker.

Social workers are suggesting increasing foster grants from R280 per month to about R400 (still less than the R700 per child per month that institutions are costing the state). This would make it more realistic for extended families to care for the children of their relatives. Unwanted children are often left with grandmothers in rural areas, and proper foster grants could improve their standards of living. And the focus of many welfare agencies on strengthening families or working with single mothers to make it possible for them to keep their children is part of keeping children in society where they belong.

It is a basic human need to belong to someone, some family, some group, some people. Institutions cannot provide this. This is true not only for children, but also for pensioners and mad people, and for sad people. Everyone needs to belong to someone.

Anne McKay works with child victims of violence for SAHSSO, Durban

Third World Debt Drains Third World Health

Fiona Godlee

Last year there was a net flow of $19 billion from the 40 poorest countries in the world to the richest. These low income countries, 30 of them in sub-Saharan Africa, received $16 billion in aid, but paid $35 billion in debt repayments and interest. They defaulted on $12 billion, which has been added to their debt. The total debt now stands at $450 billion - nearly half of their combined Gross National Product (GNP). While struggling to feed their own people, they are forced to grow cash crops for export, and all the time their debt to the developed world is growing. Extricating them from this debt trap is a global public health priority.

The seeds of the debt crisis were sown in the early 1970s, when western banks and governments had money to lend. Developing countries were keen to borrow, and vast sums were transferred with few checks or conditions attached. Then came the oil crisis, the beginnings of a world recession, climbing interest rates, and then the collapse of commodity prices. With their economies closely tied to the West, developing countries had no protection when the international money markets hit bad times. Africa's terms of trade (the ratio of revenue from exports to the cost of imports) fell by one third between 1980 and 1989, while over the same period the cost of servicing the debt rose from $4,8 billion to $9,4 billion. Latin America, richer but deeper in debt, suf -fered similar reverses. Natural and man-made disasters - recurrent droughts, civil war, corruption, and political instability - have added to the developing world's economic woes.

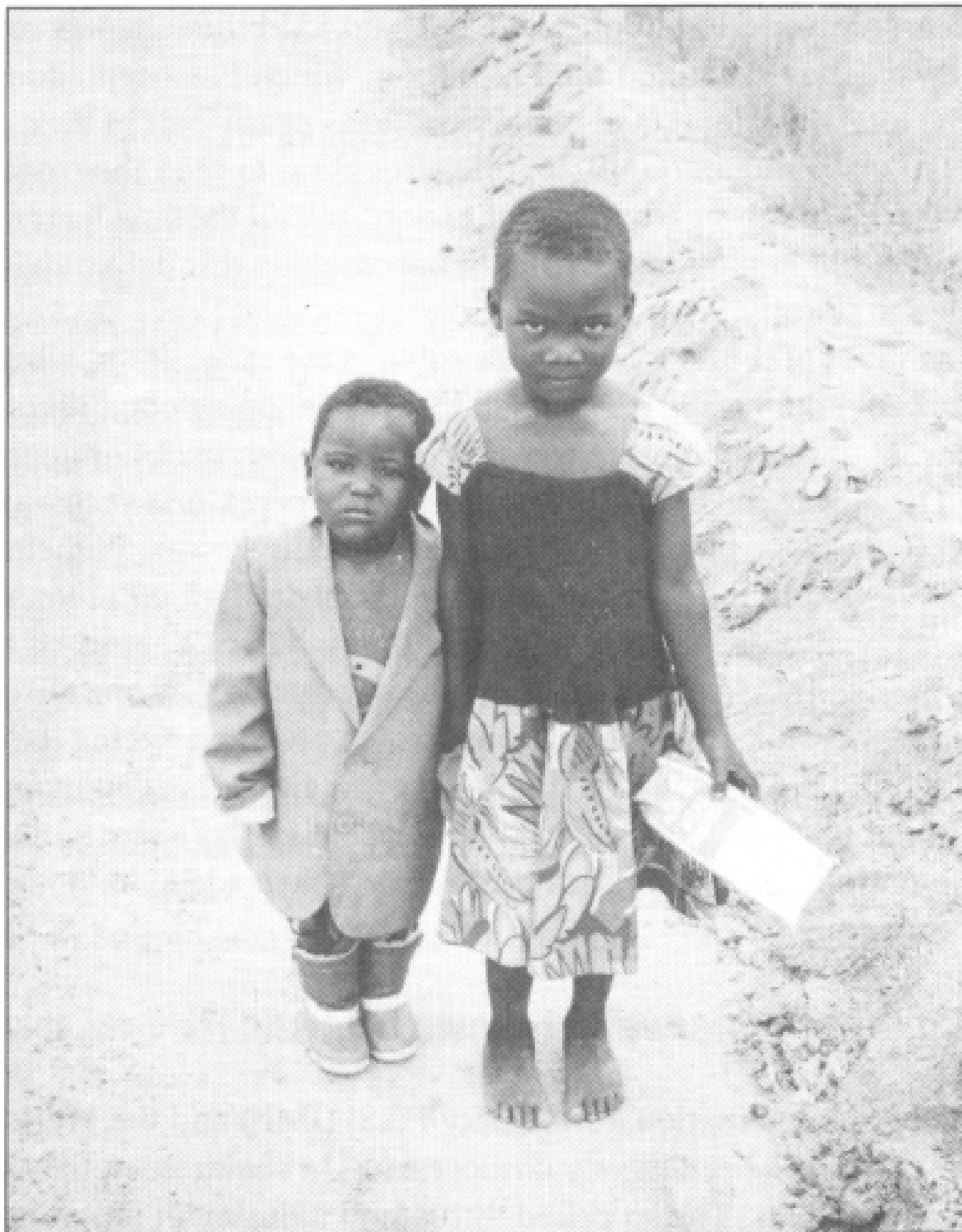
More Children Underweight, Fewer at School

Attempts by the International Monetary Fund (IMF) and the World Bank to solve the crisis have been largely unsuccessful. In health terms they may even have been disastrous. The so-called "structural adjustment programmes" imposed on debtor nations placed earnings from exports above every other goal and included the privatisation of state owned industries and services, including health care. In its 1993 World Development Report, the World Bank claims

that the programmes have been responsible for continued improvement in health and reductions in mortality, but the main aid agencies disagree.

According to UNICEF, Christian Aid, Oxfam and Save the Children, the absence of substantial increases in infant mor -tality has nothing to do with structural adjustment. Rather it suggests that better vaccination coverage, oral rehydration therapy and community health initiatives have balanced out the effects of food shortage, economic stagnation and AIDS.

The aid agencies report that the progress seen in many regions during the 1960s and 1970s has slowed or stopped. Health indicators have in some



Ismail Vawda

Children, Muldersdrift

cases gone into reverse. World wide, the number of underweight children has risen from 21 million in 1980 to 30 million in 1989. While overall mortality

among children in the developing world fell in the 1980s, seven countries recorded a rise in mortality among children aged under five years, which is widely accepted as a key indicator of development. The decade also saw the re-emergence of some of the communicable diseases most closely linked to poor nutrition, housing and sanitation.

Austerity measures aimed at cutting public spending have hit health and education most. User fees for health care and education - a central part of health policy in structural adjustment programmes - have reduced access. Among both boys and girls enrolment at primary schools in Africa fell by 7% between 1980 and 1990 - a combination, says UNICEF, of the rising cost of education and the need for children to contribute to the family's survival.

Financial Returns versus Basic Needs

The problem with many aid programmes, particularly structural adjustment programmes, is that they are either targeted wrongly or not targeted at all. The initial loans and the subsequent intervention had as their goal the insurance of proper financial returns. While spending on health was hit, military spending went unchecked. In 1985, the Stockholm International Peace Research Institute estimated that one-third of Third World debt (excluding that of oil producing countries) could be attributed directly to arms purchases.

In contrast, the World Summit for Children in 1990 set as its priority the meeting of basic needs - primary health care, primary education, housing, sanitation and nutrition. Its goals included reducing mortality in children under five by a third (or to under 70/1000 live births, whichever is lower), providing basic education for all children, halving maternal mortality, and assuring universal access to clean water and sanitation. One hundred and fifty countries have endorsed a plan for achieving these goals by the year 2000. UNICEF estimates that the plan will cost an extra $25 billion, but only a small proportion of this need come from new aid money.

The United Nations Development Programme's Human Development Report 1992 recommends that one-fifth of overseas aid budgets should go towards meeting basic needs. Most donors earmark about a tenth of their budgets for this. Britain earmarks 8,8%. Britain also lags behind the target for overseas aid of 0,7% of Gross National Product set by the United Nations for donor nations. Britain, at 0,3% is not even half way there.

The Need to Fight Debt

Of the most immediate importance, however , is the removal of the millstone of debt from around the neck of developing countries. A meeting of the group of seven major industrialised countries (G7) in Toronto in 1988 agreed to write off 50% of debts, but the terms applied only to debts recently incurred by the poorest countries. In Trinidad in 1990, Britain proposed writing off up to 80% of debt, but other members of the group, including the United States, have yet to agree. Opposition parties in Britain are also proposing that debt repayments be limited to a maximum of 10% of a country's export revenue.

Public support in the West for these measures is vital. It is clear that little can be achieved unless concern for the plight of developing countries is registered strongly in opinion polls at election time. Mobilising such concern during a recession is not easy. One approach is to show people that what happens in the Third World directly affects them. Third World debt holds back world economic recovery, increases the spread of disease, feeds the international traf fic in drugs, damages the environment and increases political instability and civil war, thus adding to the global refugee crisis. It also indirectly adds to the desire for arms. There is a need to recognise that security in the period after the Cold War rests not in armaments but in the creation of political, economic and social stability. Like the public health reforms of the Victorian age, action for the Third World can quite properly be justified by enlightened self interest.

The immediate role of health professionals is clearly to raise public awareness in whichever way they can. With greater public awareness might come pressure on the World Bank and the International Monetary Fund for greater accountability.

Third World debt is a drain on health and must be addressed. In the words of Dr Dorothy Logie, a general practitioner and a member of Medical Action for Global Security (MedAct) "What is the point of immunising children if we are then going to starve them?"

Fiona Godlee is the assistant editor of the British Medical Journal (BMJ). This article was originally published in Third World Resurgence, no. 41

The World Bank Report on Health Care

A Critical Discussion

Anant Phadke

The World Bank chose health care as the subject of its 1993 World Development Report (WDR). A hundred thousand copies of the report, titled "Investing in Health", are being distributed all over the world. The World Bank organised a series of meetings in some of the major cities in India to launch the report. About forty prominent health workers and health researchers, including the Foundation for Research in Community Health researchers, participated in a meeting in Bombay.

The World Bank Recommendations

Prof T Jamison, the staff-director of the World Bank team which prepared the report, gave an input to the participants in which he outlined the recommendations of the report, namely, the need to:

* "Foster an environment that enables households to improve health": This includes growth-oriented economic policies, expansion, investment in schooling, especially for girls, and promoting the rights and status of women;
* "Improve government spending on health": This includes reduction in government expenditure in tertiary care facilities, increase in government spending on a highly cost-effective package of public health interventions, and improvement in the management of government services through measures such as decentralisation and "contracting out";
* "Promote diversity and competition in health services": This means that, apart from the government financed "package of essential health services", there should be private health insurance;
* "Encourage suppliers to compete": One of the implications of this policy, as the report itself says, is that "the domestic suppliers should not be protected from international competition."

The Poor will have Nowhere to Go

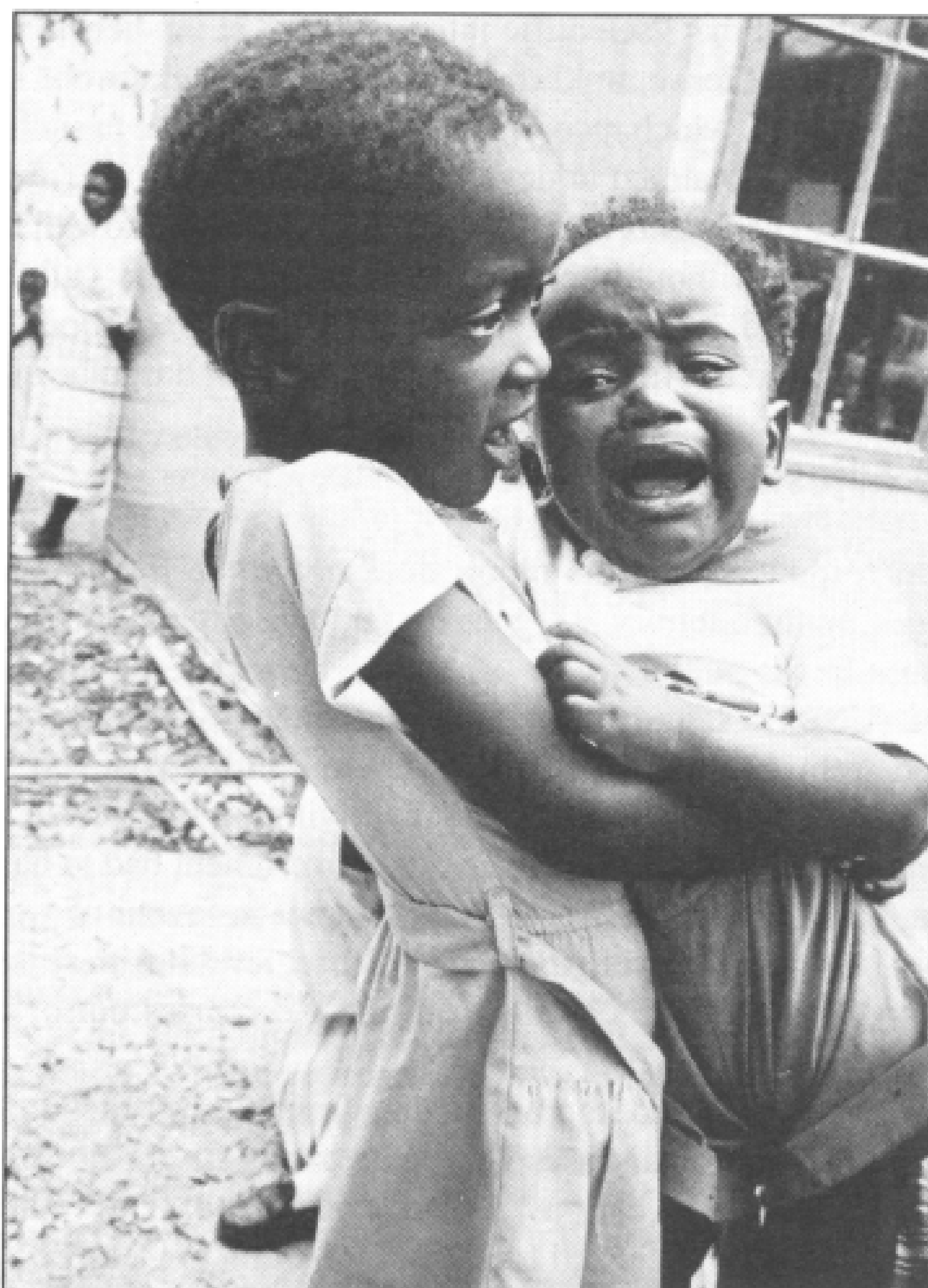
The impressive look and the sophisticated language of the report did not seem to win over the participants. This was partly because of the image of the World Bank as the agency for promoting foreign interests and privatisation, to which most participants were opposed. A number of critical points were raised.

The report neglects the socio-political reality. Just pumping more money into "cost effective public health services" is not going to produce the desired result. The experience of the last forty years as to why different schemes did not work has to be analysed. The structural maladies, which result in the dysfunctional public health system, have to be corrected. The WDR does not talk about this important problem. The tertiary hospitals, like J.J Hospital in Bombay, serve mostly the poor patients and are the bases for training new doctors. If they are further starved of funds, the poor will have nowhere to go and the standards of medical education will decline. The tertiary hospitals in the private sector will grow but the teaching public hospitals will be degraded.

The WDR fails to critically assess the private sector. "Greater reliance on the private sector" shows a misplaced faith in this sector. The reality is that the unregulated private sector is costly, wasteful, substandard and exploitative. A number of examples were quoted to illustrate the nature of the unregulated private sector in India. The drug industry promotes wastage of national resources on unscientific drug combinations. It was therefore forcefully argued that, unless the drug industry and the private sector are radically improved through strict national regulation, pumping more resources into public health services (if this is actually done) is not going to change the health scenario in India. It was pointed out that all interventions must be seen within the context of the reality in India. Only 1,3% of the GDP is spent on public health services, but 4,7% is spent on private health services. Public health intervention in the context of a major, irrational private sector, has been ineffective.

No Scope for Grassroot Initiatives

The report puts forward a fragmented approach. There has to be a comprehensive approach in public health interventions. Isolated, vertical programmes in the absence of basic comprehensive services are ineffective. Secondly, there has to be integration with different social sectors. Increasing the budget in education and reducing it by 20% in health shows a disjointed approach. Fears were expressed that structural adjustment programmes (SAPs) would affect adversely the poor and women. In the context of worsening socio-economic



Crying out for an IMF loan or crying because of an IMF "loan"?

conditions, all the talk about women's empowerment and social upliftment sounds empty. What about the degradation of the environment and the consequent diseases caused by the "green revolution"? What about the impact on health status of increased poverty due to SAPs?

The WDR makes no mention of non-allopathic systems, which have firm roots in our tradition, are cheaper, effective and decentralised. They have lagged behind partly due to their systematic neglect. Yet they are very much there. Herbal medicines, in particular, offer a decentralised source of medical care, which has a strong basis in people's culture. A homeopathic doctor made a strong plea to give serious thought to this "modern system of medicine which is popular all over the world." The report is marked by an absence of people's

control. It was argued that "scientific interventions" at the behest of international agencies do not leave any scope for indigenous, grassroot initiatives. The Bhore Committee, which recommended comprehensive basic health care services; Gandhiji, who aimed at developing decentralised, self-reliant rural communities; the experiments like Ralegan Siddhi, which show that rural development can occur without international finance or advice - all these have been forgotten. Instead, a dependent, fragmented, centralised model of development is being fostered. This approach to development has to be questioned.

Disability Adjusted Life Years

Prof Jamison responded that the report does not argue for privatisation of health services, on the contrary, it argues for far more expenditure on essential health services in the public sector - from the current level of $4 (US) per capita to $12 (US). He said that the Bank's lending in public health facilities has increased from 1% to 5% of its total lending in the past few years. He clarified that, according to the World Bank, relying on the private sector for education and health was not enough and the government had to have a leading role. Jamison said that the World Bank was not in favour of vertical programmes, but favoured the strengthening of district level health structures. He further claimed that the SAPs had helped many countries out of economic chaos.

The WDR has gathered impressive data from all over the world to estimate the global burden of diseases and has worked out a prioritised list of "cost-effective health interventions". Towards this end, it has introduced a novel concept, Disability Adjusted Life Years (DALY), to measure the burden of diseases. This concept enables us to take into account losses due to morbidity and thus to go beyond mere mortality statistics by combining the human years lost due to both morbidity and mortality. Secondly, it does not measure impact of morbidity or mortality in money terms, but in terms of years of human life wasted. (It is a technical concept, yet vulnerable to ideological prejudices and hence will have to be used very carefully). Despite these positive features, the report suffers from some basic weaknesses and these were very well brought out in this meeting. But will the decision-makers listen?

This is an edited version of an article in the Foundation for Research in Community Health Newsletter, Jul-Aug 1993.

Resource List
Compiled by The Institute For African Alternatives (IFAA)

Background Readings on the IMF and World Bank

The International Monetary Fund (IMF) and World Bank were founded after the Second World War to restructure the world monetary system. Countries, primarily in the west, borrowed to finance temporary balance of payments deficits. During the 1970s, however, loans were increasingly channelled to the developing world. With falling commodity prices and rising interest rates, most Third World countries could not repay the loans and found themselves caught in a worsening spiral of debt. Both the IMF and World Bank operate as commercial banks and their primary allegiance is to their shareholders and the major western governments. Their "development" activities should be viewed with this understanding.

- **Africa Faces Crisis Over Aid as World Bank Lending Falls**, by R. Laishley, Africa Recovery, October 1993, vol.7, no.2:1:1, 24-5.
- **Bank Links Health to Economic Growth**, by C. Collins, Africa Recovery October 1993, vol.7, no.2:1, 14-5
- **Capacity Building: The Missing Link in African Development**, by E. Jaycox, vice president of the Africa Region of the World Bank, address to the African-American Institute conference "African Capacity Building: Effective and Enduring Partnerships", 20 May 1993, Reston, Virginia
- **An Economic Perspective on South Africa**, by the World Bank Southern Africa Department ((1993). Synthesis of informal studies on the different aspects of the South African economy prepared by the World Bank
- **Implementing the World Bank's Strategy to Reduce Poverty: Progress and Challenges**, by the World Bank (1993). In-depth report analysing the impact of World Bank efforts to reduce global poverty
- **Implications for South Africa of Using IMF and World Bank Loans and Resources: Some General Observations**, by V. Padayachee. Paper presented at the Aspen Institute and IDASA conference "South African International Economic Relations in the 1990s", 27 -30 April 1993, Mabula Game Lodge
- **Poverty Crisis in the Third World: The Contradictions of World Bank Policy**, by P. Burkett, Monthly Review, December 1990, 42 p73 (7): 20-32
- **Reconquest of the South, Third World Resurgence**, December 1992, no.28:14-35
- **Setting the Agenda: A Preliminary Critique of the World Bank's Rural Restructuring Programme for South Africa**, by G. Williams. Paper presented at the Land and Agricultural Policy Centre Conference on Land Redistribution Options; 12-15 October 1993, Mariston Hotel, Johannesburg
- **Sisters in the Wood: IMF and World Bank survey**, The Economist, 12 October 1991: Survey, 1-54

* **UN blasts IMF/ World Bank policies in Africa**, Third World Resurgence August 1991, no.12:14
* **World Bank Financing for Urban Development: Issues and Options for South Africa**, by P. Bond and M. Swilling, Urban Forum, 1992; 3 (2): 1-38. Presentation to the Joint Technical Committee, Central Witwatersrand Metropolitan Chamber, 16 July 1992.
* **World Bank Reports Ignore Complexities**, by P. Bond and M. Swilling, Reconstruct 1993: 8-9

Structural Adjustment Programmes

Once countries were unable to repay their loans, the IMF imposed its economic stabilisation programme and the World Bank its structural adjustment programme. Both were designed to streamline and reduce government spending and to ensure that foreign exchange was earned to repay the debt. Most debtor countries have had no option but to accept these programmes. Because of "conditionalities" access to most foreign aid and private bank loans is tied to implementing the IMF/World Bank package. Even the World Bank itself now admits that the programmes have failed. Yet this masks the extent of utter devastation that has resulted over the past 10 to 15 years, particularly for the people of sub-Saharan Africa.

* **Beyond Adjustment: Responding to the Health Crisis in Africa**, 1993
* **Debt and Structural Adjustment - the Real Causes of Somali Famine**, by M Chossudovsky, Third World Network Features, 1993
* **A Failed Recipe: World/IMF Continue to Insist on SAPS for Africa**, Economic Justice Update, November 1993, no.8
* **From Development to Sustained Crisis: Structural Adjustment, Equity and Health**, by N Kanji and F. Manji
* **The IMF and Zimbabwe: Political and Economic Consequences of the ESAP**, by P. Mavima. Paper presented at the University of Stellenbosch workshop on "democratisation in South Africa: Economic Structural Adjustment Programmes in South Africa: Economic Structural Adjustment Programmes and the role of the IMF", 18-19 November 1993, Strand Pavilion Resort
* **The medicine that kills: World Bank/IMF structural adjustment policies**, Third World Resurgence, January 1992, no. 17: 12-28
* **The Other Side of the Story: the Real Impact of World Bank and IMF Structural Adjustment Programmes**, by R. Hammond and L. McGowan. Report on the International NGO Forum on World and IMF Adjustment Lending, 17-24 September 1992, Washington. This includes a resource guide to the Citizens' movement challenging structural adjustment programmes plus case profiles of adjustment programmes.
* **The Social Dimensions of Adjustment: a General Assessment**, Findings, December 1993, no.8
* **Structural Adjustment, Poverty and Sustainable Development**, by J. Loxley. Used for the International Institute for Sustainable Development's expert working group meeting on "Sustainable Development, Poverty Eradication and Macro-Micro Policy Adjustment", 2-4 December 1993, Winnipeg, Canada
* **Structural Adjustment: Who Really Pays?** Comprehensive report on the workings and Impact of structural adjustment programmes, Popular format, 1992

* **Third World Finance Ministers Criticise Aid Conditionality and SAPs**, Third World Economics, 16-31 October 1993, no.75: 14

Impact of IMF and World Bank Policies on Women

Women are among the most vulnerable in society and they have borne the brunt of structural adjustment programmes. Deteriorating health and educational services and diminishing job opportunities together with women's continued responsibility for the family's survival has reduced women's health and nutritional status. In many countries, women have started eating less to find a bit of food for their children. By understanding the effect of these policies on women, their overall impact can be more clearly understood.

* **Adjusting to Adjustment In Zambia: Women's and Young People's Responses to a Changing Economy**, by G. Banda, 1991
* **The African Response: Adjustment or transformation**. Proceedings of the IFAA workshop "transcending the Politics of Adjustment", 25-28 January 1991, Addis Ababa, economic Commission for Africa. Introduction by Bade Onimode. The workshop was held to review The World Bank report "Sub-Saharan Africa: From Crisis to Sustainable Growth - a long-term perspective study"
* **Challenging Gender Inequalities in Africa**, Review of African Political Economy, 1993, no.56
* **The Effects of the Structural Adjustment Programme on Women: Zimbabwe's Experience**, by J. Chikore. Paper presented to the GEM and IFAA. Briefing meeting for NGOs on the IMF and the World Bank, Johannesburg, 18 -29 June 1993
* **Engendering Adjustment for the 1990s**. Report of the Commonwealth Expert Group on Women and Structural Adjustment, 1989
* **The IMF, the World Bank and the African debt (Vol.2: The Social and Political Impact)**, by B. Onimode (ed), 1989. Papers were originally presented at the IFAA conference on the role of the IMF and World Bank in Africa, London, October 1987
* **Man-made Poverty? Why Women Worldwide Pay the Price**, by Women in Development Europe (WIDE), 1988. Proceedings of the WIDE 4th general assembly and public meeting, Oxford, 4-6 November 1988
* **Structural Adjustment and Gender in Guinea-Bissau**, by R. Galli and U. Fund, [no date]
* **Structural Adjustment and Women in Zimbabwe**, by N. Kanji and N. Jazdowska, Review of African Political Economy, 1933, no.56: 11- 26
* **Women and SAPs**, by M. Wambui, EcoNews Africa, 1993; 2 (15): 5-6
* **Women and the World Economic Crisis**, by J. Vickers, Women and World Development Series. Series developed by UN_NGO Group on Women and Development.
* **Women for a Change! The Impact of Structural Adjustment on Women in Zambia, Tanzania and Mozambique**, by R. Feldman, 1989

This resource was compiled by Sue Godt of IFAA. All the above readings are available from the IFAA Resource Centre, 4th Floor, Sable Centre, 41 De Korte Street, Braamfontein, 2001 Tel: 339 6752 Fax: 339 1127

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