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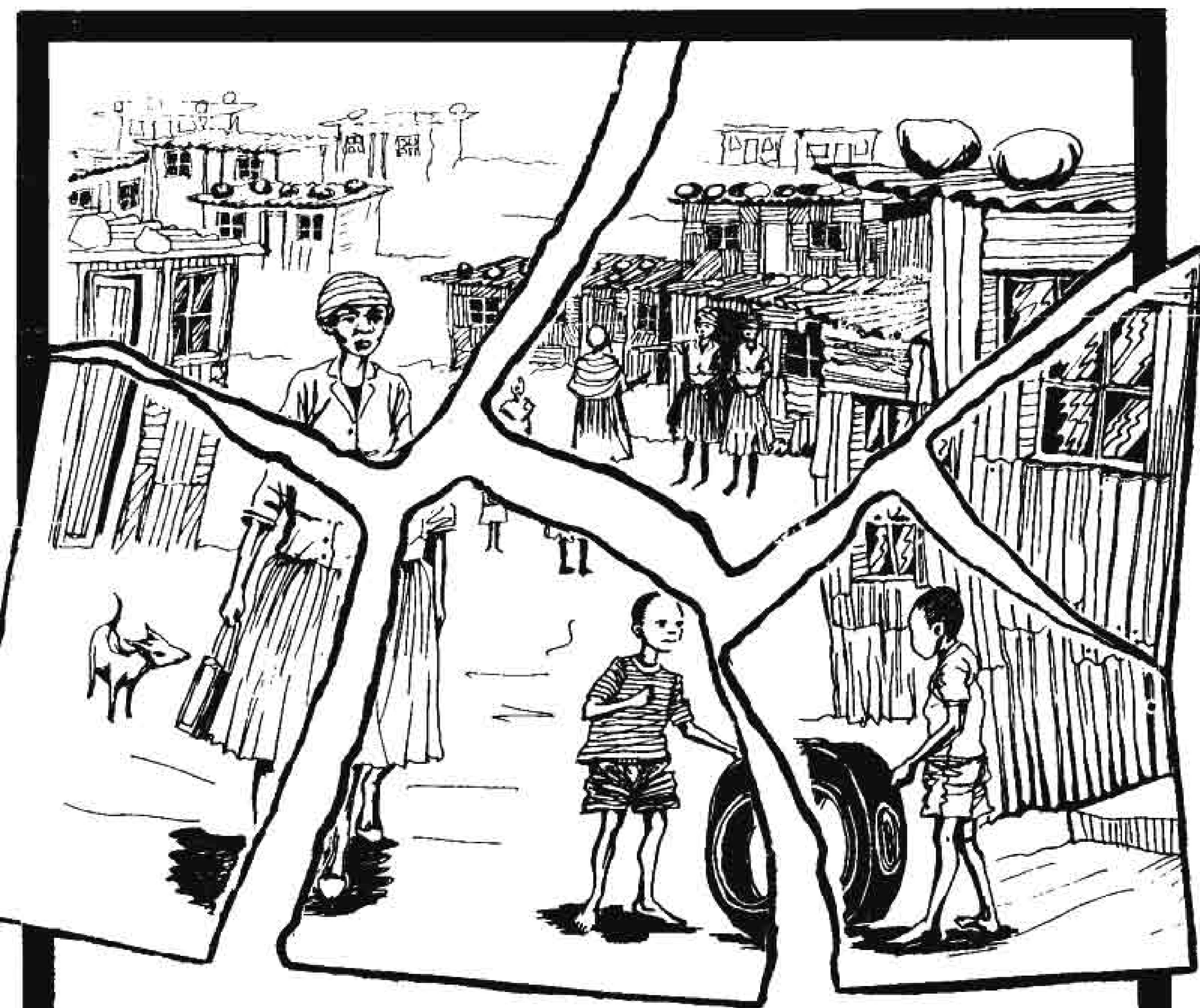

TOWNSHIPS

CRITICAL HEALTH

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EDITORIAL

Since the last issue of Critical Health was published in December 1984, township unrest has become the order of the day. Police interference in funerals and protests against rent increases, community councils, inferior education, and organised strikes, have caused violence, death and disruption in many parts of the country.

As organisations tried to pick up the pieces and prepare for a response to this situation, meetings were banned, and the police presence in the townships increased.

Critical Health no.12 attempts to address itself to some of the problems arising from this situation.

The police action in the township can threaten people's lives. During times of unrest, people have virtually no access to medical treatment. This is highlighted in the first few articles of this issue, and some suggestions are given on how to deal with this problem.

One of the biggest problems facing black workers is unemployment. During this time of recession, unions are often limited to negotiating fair dismissal procedures. The article on unemployment in this issue focuses on what unemployment does to retrenched and dismissed workers, their families, and their community - and the need to organise around unemployment.

The conditions in which township people have to live can be very clearly seen on just entering any township. The bad quality of housing and sanitation affects people's health. This is what the next two articles in this issue take up. The article on "Housing and Health" shows which health problems are associated with which housing conditions. And the following article shows an example of a township where people took up the issue of housing themselves.

Childcare is a big issue for households with working mothers. The article on "Childcare and the Working Mother" focuses on the problems of mother and child before and after the birth of the child. The following article on "The Alexandra Childminding Project" shows one example of how parents and childminders and members of the community can get together and improve the quality of childcare.

Finally, there is a huge shortage of facilities for disabled people in the townships. Disabled people are handicapped by the fact that they live in a society which does not cater for them with their disabilities. In the poor living conditions of the townships, disabled people often live a life of isolation and despair. The article on "Disabling Social Conditions" in this issue gives some useful information in this respect.

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TEARGAS CAUSES MORE THAN TEARS.

RUBBER BULLETS ARE NO TOYS

Teargas and rubber bullets are often claimed by police to be 'safe' methods of crowd control. However, the way in which they are being used by the South African Police makes them anything but safe. In this article, Clifford Goldsmith looks at the ways in which teargas and rubber bullets affect people.

Teargas

The early form of teargas

Gases that cause the eyes to tear have been used in warfare and by police forces for many years. The ingredients of the gas have been changed over the years, because some of them affected people's health very badly. In some cases, the early form of the gas caused death. The early form of teargas also contained elements which are known to cause cancer.

Teargas - a 'safe' chemical?

Since the early days of teargas, the composition of teargas has changed.
Nevertheless, armies and police forces think that it is a 'safer' way to control crowds.

Teargas is 'safe' only under very specific conditions, that is, when it is used outdoors and in very low concentrations and on men weighing over 70 kilograms. Often, however, the gas is used in high concentrations. In those cases, it can cause illness and even death. It is horrifying to know that there are no international standards or codes for the use of such weapons.

Teargas was first produced in South Africa in 1963. The police recently claimed that the mixture used by them is the 'safest' form. But they did not say exactly how it is produced, what exactly it consists of, and what

concentration of gas is contained in each exploding cannister. It is also clear that the police are not using teargas only under the conditions for which it has been shown to be safe. There are reports of cannisters being thrown into homes, churches, meeting halls, and even into a clinic. Indoors the concentration can very quickly reach toxic levels. In rainy weather, the gas stays in the air longer.

Among those people exposed to teargas are elderly people, sick people, pregnant women,or very young children.

Many of these people cannot get themselves out of a closed space. They are therefore likely to be exposed to a concentrated form of teargas for longer periods. These people, therefore, are at greater risk.

The effects of teargas

The minor effects of teargas include itching, burning, and tearing of the eyes, irritation of the eyes caused by bright lights, twitching of the eyelids, a watery discharge and irritation of the mouth with a lot of spit forming in the mouth. Chest pain and coughing may also occur. If people are exposed to teargas for a longer time, they may get nausea, vomiting, and headaches. All of these reactions to teargas usually disappear after thirty minutes of reaching fresh air.

If people are exposed to high concentrations of teargas for a long time, they may get a skin rash. This skin disease gets worse, and people may experience blistering, an inflammation of the inside of the lungs (alveolitis and pulmonary oedema), and damage to organs like the liver and kidneys. Even death may occur. Teargas can kill because it disturbs certain chemical substances in the body. It can damage the lungs. A person who gets a lung or skin infection may die from these after being attacked with teargas.

It is therefore not teargas itself, but the way in which the South African Police use it, that makes this gas so dangerous. The use of teargas by the South African Police should be condemned in the strongest possible terms.

Rubber Bullets

Rubber bullets are not toys

The term 'rubber bullet' makes this type of bullet sound like something harmless or toy-like. Nothing could be further from the truth. The name, however, is a very convenient one for the police and army.

The bullet is a solid rubber cylinder. The rubber is hardened and cannot be squeezed together in your hand. It is 10 centimeters long and has a diameter of 3,5 centimeters. It is fired from the barrel of a hand rifle similar to that of a 'snort neus'.

Whether or not this bullet can cause bad injuries, depends on certain factors:

- the distance between the person who shoots and the victim
- the angle at which the bullet touches the victim and the edge of the bullet touching the victim
- the part of the body which the bullet hits, for instance the head, the eye, etc.
- the victim's general condition and the condition of his/her skin. (In elderly people, the skin is not so elastic any more and more damage can be done.)

The effects of rubber bullets

The effects of 'rubber' bullets have never been fully studied. But people who observed them say that thay can be dangerous, especially when they are fired at close range. Rubber bullets cause blunt injuries. Blunt injuries include:

- soft tissue injury, for example bruising

- brain injury - ranging from concussion, with or without memory loss, to bleeding inside the brain

- injury to bones and joints, for instance bleeding into a knee which can lead to permanent joint stiffness

- blunt abdominal injury - a very dangerous problem. Any organ in the abdomen can be damaged. But most commonly, the kidneys, the spleen, and the bladder may be damaged.

- fractures

- eye injuries - 'squash' injury. This can lead to bleeding inside the front or back parts of the eye.

- damage to teeth

- tearing of the skin

- psychological distress

As in the case with teargas, so, too, with rubber bullets, the effects are entirely dependent on the attitudes of the police and army using them. We need to document the injuries caused these rubber bullets. We need to find out from people what parts of their bodies were injured, and from what range the bullet was fired. This kind of information could be a powerful tool in showing the actions of the police and army for what they are.

Critical Health would like to hear from people who have suffered injuries after being shot with 'rubber' bullets. We would also like to hear from doctors who have examined people who have been shot. We will keep your name secret.

TOWNSHIP UNREST AND HEALTH CARE

The recent unrest in various townships around the country has cast some light on the relationship between the health services and the South African Police.

Victims of unrest often do not attend hospitals or clinics, even if they need medical attention. Township residents say that, in fact, most unrest victims do not go to hospitals for treatment, if they can avoid it. That is because they fear being arrested and harassed by the police while they are in hospital. A number of statements which we are reprinting here, indicate that this is a very real fear. Others do not go to hospital for treatment because, during times of unrest, ambulance services are often suspended, and people cannot get transport to the hospitals.

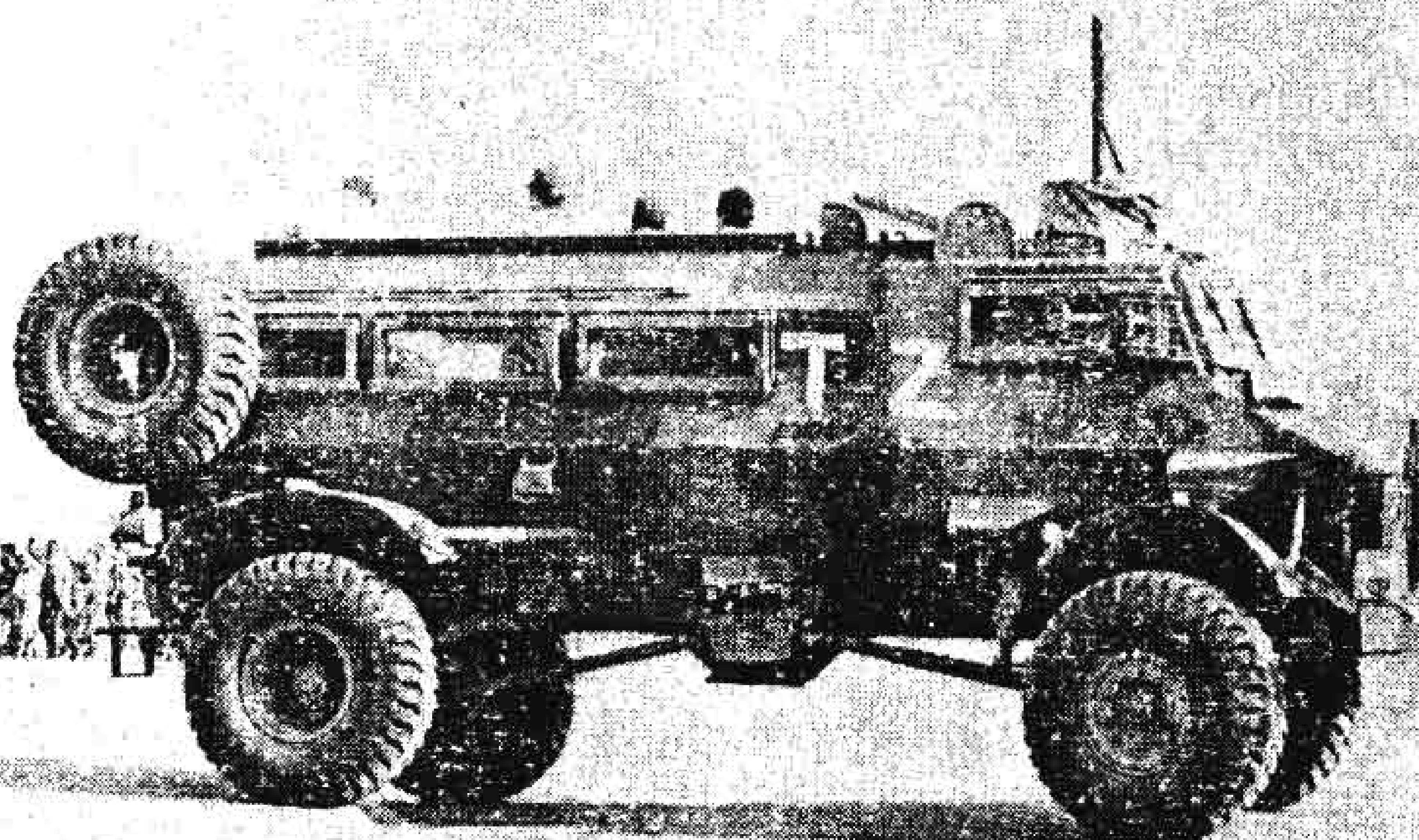
Organisations are beginning to respond to unrest in the townships. People are documenting their experiences and recording the abuses they have suffered. In this way, they can hopefully make use of the limited rights they have: lay charges against policemen assaulting them, be granted visits to detained family members and deliver food parcels for them, trace missing family members, get referred to doctors for medical treatment, and apply for sick pay and UIF money. In some townships, people have made contact with progressive health worker organisations like NAMDA and the Health Workers' Association, to help provide appropriate health care in times of crisis.

Those unrest victims who do go to hospitals, often get inadequate medical treatment. In many cases, their conditions are neglected. Also, victims of unrest are often not informed of their rights to lay charges, nor of their right to get sick pay while they are in hospital.

Experiences of unrest victims in Vaal townships

Sipho from Sebokeng

Sipho was coming home to Sebokeng from work, when he saw that people had gathered around Texido Supermarket. He also saw a hippo parked round about 500 metres away from the supermarket. When he saw the hippo, it was too late to turn back and find another way home. So he crossed the road. At that moment, people who had gathered around the supermarket ran away in all directions. The police shot from the hippo. Sipho was hit by buckshot in the back of his left lower leg. His leg was riddled with pellets. The shots were fired from the hippo, about 500 metres away from him on the other side of the road. He made his way to a row of houses nearby, where he found someone to take him to Sebokeng Hospital by car. During his second week in hospital, two plainclothed policemen came to him and took a statement from him. After that, the South African police came round to take the names of those people who had been shot. People in the hospital were harassed by the police.



After three weeks in hospital, Sipho's left lower leg was amputated below the knee.

Sipho spent three months in hospital; he was discharged on 12 December 1984. It was only much later, on 1 April 1985, that he was able to return to work.

Now he is fighting for his UIF payment. In doing so, he is being referred from one department to another.

Mrs X about her son Moses from Sebokeng

Moses is seventeen years old and lives in Sebokeng. On 3 September 1984, he was together with two friends in a back street, when police arrived and fired teargas. Teargas got into his eyes and he ran to a tap to wash his eyes. But he did not get to the tap. On his way to the tap, just as he went around the corner, he was hit by bullets in his eyes. One of the friends accompanying him ran into a house. The other one went to call Moses's mother. When she arrived, she saw her son lying on the ground. She thought he was dead. The two boys who had been with him, helped to pick him up. At that moment, the police appeared and started hitting the boys. The police also started kicking Moses, who was lying on the ground. Mrs X interfered and asked the police to stop kicking her son. The police told her to get him to hospital. She insisted that the police take him to hospital. Instead, they took him to the police station. At that stage, everyone thought he was dying. Mrs X herself was loaded into the back of a hippo to go with her son. When she arrived at the police station, she found that he was still alive. An ambulance took him to hospital. He was examined by doctors and it was found that he had nine bullets in his chest and in his head. He had an operation to get all the bullets out. Afterwards, he was transferred to a ward, where two policemen stood around his bed for two weeks.

He was discharged from hospital at the end of February. As a result of the injuries he sustained from police bullets, he is now blind.

Jabu from Sharpeville

At a funeral on 2 September 1984, police followed the funeral procession from the graveyard. A helicopter was flying very low above the mourners, and fired teargas. Jabu could not see where the policemen were going. He was suddenly attacked with sjamboks. A rubber bullet grazed his back. He fell. Then five policemen came, kicked him, and hit him with sjamboks. In the process of being sjambokked, he was hit on his left eye. He was loaded onto a police truck and taken to the police station, where he laid a charge against the police. The police took him to Sebokeng Hospital. On the first day in hospital, he was in a ward together with other people injured during the unrest. For that day, he was 'guarded' by police. On the second day, he was transferred to a ward with other unrest victims. In this ward, three policemen kept a constant presence.

He was discharged from hospital after three days. During his stay in hospital, his eye was never properly examined. All he was given for his eye was an ointment for the swelling to go down. He lost sight on his left eye as a result of being sjambokked by the police.

C about a girl Elizabeth from Tumahole

On Satuday, 23 March, Elizabeth was shot by police. She has got eighteen bullets in her body. She was taken to Tumahole Hospital. But by Tuesday, she had not received any treatment. So on Wednesday, her parents took her to a private doctor for treatment. This doctor sent her back to hospital.

Most of the people interviewed have since visited the aid clinics of the Vaal Information Service. They are getting legal and medical advice. But what is more important: these people themselves have learnt from their experiences, and are now organised to help other people with similar problems. They are making the help that they have received into a service to their own communities.

WHAT TO DO IN A TEARGAS ATTACK

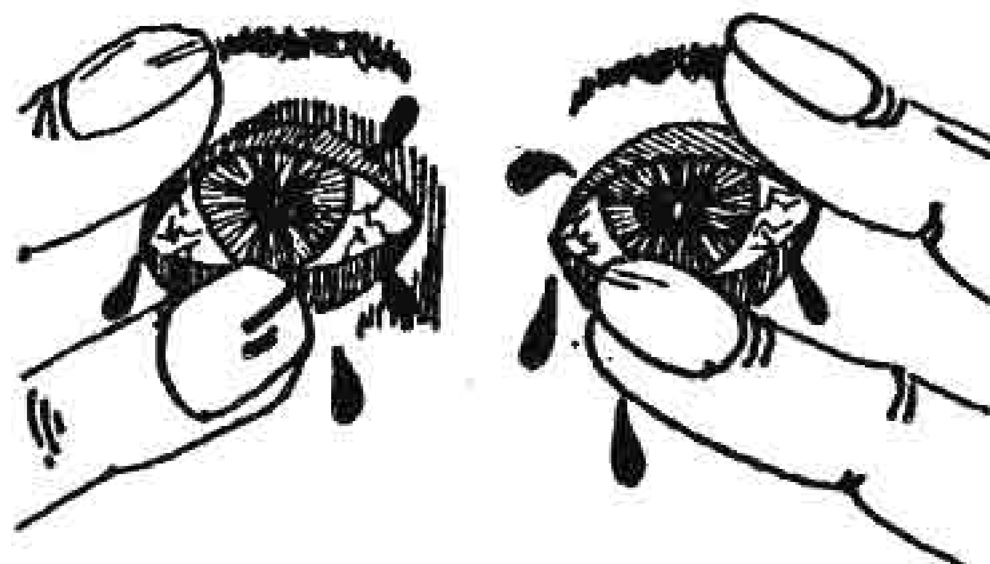
Learn and Teach asked a doctor what people can do when they are attacked with teargas. This is what he said:

1. Do not panic. If you panic, more people may get hurt.

2. Try to get out of the teargas cloud. Check the direction of the wind and try to get to the other side of the cloud.

3. Breathe slowly and not too deeply. But do not hold your breath. If you hold your breath, you will then breathe deeply for air. A deep breath will cause pain and burning.

4. Do not rub your eyes. It can only make your eyes worse.



5. If you no longer smell the gas, it does not mean that the gas has gone away. Teargas often makes you lose your smell.

6. Once you are in the fresh air, try to find a cool, shady and dry place. This will help to fight off the chemicals in the gas.

7. Take off all your clothes. This will lessen the damage of the gas.

8. Try to wash your face with vegetable oil and then wash it off with soap and fast flowing water. Then dry yourself immediately. IF YOU JUST WET YOUR FACE AND BODY, THE TEARGAS CAN BURN YOU EVEN MORE. Water by itself does not take away

the gas. It is better to blow on your skin than to just use water. If it is raining, dry your skin immediately.

Do not swallow your spit. If you do, you will vomit. Rather spit it out.

If you think you may get teargassed, you may want to get ready for it. You can wear special clothes like overalls, gloves tucked into sleeves, a shirt with a high collar and a hat. If you want to look after your eyes, you could even wear goggles. Imagine many hundreds of people going to a meeting or a funeral all wearing goggles!

11. If you suffer from asthma, hayfever, allergy or any other sickness, try not to get gassed. If you are gassed, you should see a doctor soon afterwards. Teargas can be very dangerous for these people.

12. If the police use a large amount of teargas against you, try to see a nice doctor. The doctor will give you eye drops for your eyes and they will treat skin burns. They will check for infection and other damage. And sometimes they will even save lives.

POLICE VIOLENCE IN THE TOWNSHIPS - WHAT CAN WE, AS HEALTH WORKERS, DO?

Police brutality can be seen all around South Africa almost every day - in Langa, Alexandra, Kimberley, Sebokeng, Sharpeville, Crossroads, Tumahole, and many other townships.

What can we, as health workers, do?

Firstly, health workers must join in with other people and deplore the state's continual attacks on innocent people. As health workers, we must reaffirm our commitment to oppose apartheid and all it stands for.

But that alone is not enough.

As the state has increased its control over every aspect of our lives, so it has encroached on the delivery of medical and health services. We have heard many stories of state "involvement" in the medical care of unrest victims and detainees. We have even heard of health workers who were intimidated. We only need to think back to the case of Steve Biko, and more recently, the dismissal of the ambulance drivers who gave evidence of police brutality to the Kannemeyer Commission.

Health workers must fight for their right to treat all patients free from political and other pressures. Even the State Department of Health and Welfare aims to support the Tokyo Declaration by publishing it in their publication "The Medical Practitioner in the Health Service". In this declaration, it says,

> "A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose."

But the problem of inadequate health care goes beyond state interference.

The inadequate distribution of medical services in South Africa means that health workers in most black urban areas are badly equipped to deal with the daily health needs of the local population, let alone the needs during a crisis.

In the publication of the State Department of Health and Welfare which was quoted above, an extract from the International Code of Medical Ethics is published:

> "A doctor must give emergency care as as humanitarian duty unless he is assured that others are willing and able to give such care."

Thus, as health workers, we should do the following:

- We should publicly and continuously support a medical code such as the Tokyo Declaration. Progressive health workers must begin to define their roles vis-a-vis the state in times like the present.

- We should stand firmly by our right and our duty to treat anyone in any situation, free from intimidation and harassment, especially in providing emergency care where it is needed most.

- We should research, document, and publish the nature of the atrocities that are committed during civil unrest, and the failure of the health system to oppose any forces which undermine its primary purpose.

- We should challenge the state, provincial, and municipal health bodies and hospital superintendents to take a public stand on the crucial issue of patient rights during times of unrest.

There is a third aspect in which health workers should get involved.

As townships are often sealed off during police raids and unrest, people in the townships have hardly any access to emergency treatment by health professionals.

An alternative way to meet the needs for emergency treatment during times of crisis is to train members of communities in first aid and life-saving and in management of medical emergencies such as blunt trauma, bullet wounds, tear gas injuries, burns, etc.

NEWS

Resolution of the American Psychiatric Association

RESOLUTION AGAINST APARTHEID

It is the belief of the American Psychiatric Association that when discrimination is practiced by governments in an organized fashion, the mental health of all of its citizens is affected, not only those against whom discrimination is directed.

Be it resolved, therefore, that the American Psychiatric Association strongly opposes the South African government's policy of apartheid as being discriminatory and damaging to the mental health of the South African people and further urges the Society of Psychiatrists of South Africa and the World Psychiatric Association to voice opposition to this policy and to launch a vigorous protest against all aspects of discrimination in that country.

January, 1985
Washington, D.C.

STRUGGLING WITH UNEMPLOYMENT

"I don't like getting out of bed in the morning any more. I know that every day will be the same. I try and find some work every day, but there is nothing. In the beginning, when my boss said there was no more work, I didn't tell my family. You must work for your family, and if you cannot work, then you are no good any more. Even though I didn't like the work I was doing, I knew that I would get money for my family at the end of the week. Now I get nothing and the children can't go to school any more and they have little to eat. I don't see my friends any more since I have no work. I always feel tired and I can't do even little things. Now I don't care what kind of work I have to do. If I can't get something, I will die. It is also too much money for me to go into town every day. The buses and trains are too expensive when you have no money. Every week I must go to the UIF office. But now I have been going there for two months and they always say next week, next week, next week."

Unemployment in South Africa

Statistics about the number of unemployed in South Africa vary. Official unemployment figures put the number of unemployed people at 61 816 (as of December 1984). Most of these are blacks. However, official figures do not include the number of work seekers in the so-called homelands. Unofficial estimates (which include the unemployed in the so-called homelands) place the number of unemployed people at three million. To these figures one could add the vast number of underemployed persons. Underemployed people are those who officially have work, but they do not get enough income to maintain themselves and their families above the poverty datum line.

Studies done in Soweto have shown that unemployment has risen at 5,5% per year during the recession. The Institute for Industrial Relations recorded more than 13 000 retrenchments from January to October 1984.

It has generally been estimated that at least 200 000 jobs a year have to be provided to keep all black people in a job. However, as the recession bites deeper, the employment situation gets worse, and the possibilities for more jobs diminish.

Mental Health and Unemployment

High rates of unemployment cause problems in any society. People who are retrenched or cannot find work feel rejected by the society in which they live. They tend to lose their self-respect and confidence. Many researchers have shown that unemployment is linked to poor psychological health. Some of the most common forms of strain reported by unemployed workers include high blood pressure, increased alcohol intake, worry, anxiety, and sleeplessness.

People who are retrenched and become unemployed often get confused if they do not get told why they have been retrenched. People who have been retrenched in this way talk about feelings of failure, frustration, and anxiety. From this, it becomes clear that the pay-packet

at the end of the month is not the only reason why people need work.

Unemployed people have to cope with a loss of income which immediately affects themselves and their families. But apart from this, their rights and abilities to work have been taken away. Work gives a sense of identity, meaning, and structure to one's life, and the possibility of organising around problems shared with other people. When the right to work is withdrawn, the person concerned experiences a deep sense of loss.

Unemployment and the family

It is important to realise that even though we have been talking about "the unemployed person", the effects of unemployment are felt not only by the individual , but also by those people around him or her.

Firstly, the unemployed person cannot financially support those who previously were dependent on his/her wage. Secondly, the unemployed worker has to be supported financially and emotionally by relatives and friends. Thus the increase in unemployment places an added burden on those who have got jobs. Thirdly, not only does the unemployed person's family feel the effects of unemployment, but eventually, the community as a whole feels the effects too.

The political nature of unemployment

Unemployment in South Africa is unique because of the particular ways in which the state intervenes and structures people's access to jobs. Because of the influx control laws, employers can be very selective in deciding whom to employ and under what conditions. For the worker, the choice is between the job that he or she might be lucky enough to get, or otherwise removal to some rural impoverished 'homeland' where the chances of surviving are very low. This employment situation does

not leave the individual black worker any bargaining power. The bantustan policy, together with influx control laws serves, among other things, to maintain a large pool of unskilled workers who can be drawn into employment when industries expand, and who are the first ones to be retrenched in times of recession.

Dealing with unemployment, therefore, is not only a matter of coming to terms with unemployment psychologically or financially; it becomes also a political task.

Unemployment benefits

Some researchers have argued that the most devastating consequences of unemployment have been minimised by social welfare programmes. However, South Africa differs from those advanced industrial countries which provide extensive social security benefits. For the majority of people living in South Africa, social security benefits are inadequate.

Many unemployed people here do not benefit from the Unemployment Insurance Fund (UIF) because of their occupations, as in the case of domestic workers, farm workers, and contract workers. Those who do qualify for UIF, often have to deal with a great deal of bureaucratic procedures. In these bureaucracies, mismanagement of funds is not uncommon. Many employers do not fill out unemployment fund cards correctly when workers leave their employ. If the reason given for unemployment is "discharged - own fault", that means that it will take at least six weeks before any money becomes available.

In June 1981, only 0,2% of black unemployed persons had received their unemployment benefits. The Black Sash office in Natal reported that for the last eight months of 1984, 72% of their cases concerning UIF payments were complaints about delayed payments of unemployment benefits.

Unions and unemployment

Many unions are taking up the issue of UIF payments. In 1982, a number of unions and worker advice groups drew up a memorandum to the Minister of Manpower. The motivation behind this was that many unemployed people did not receive unemployment benefits; also, thousands of workers are not allowed to contribute to the UIF and the majority of unemployed workers can only survive with the help of relatives who have jobs.

The continuing recession has made retrenchment a major issue of dispute between employers and trade unions. Unions have won important rights against arbitrary dismissal and retrenchment. This has been done mainly through making demands on employers and negotiating fair dismissal and retrenchment procedures. Many of the progressive trade unions have made public proposals aimed at lessening the worst effects of retrenchment.

While it is important to make every effort to reduce the scale and consequences of recession and unemployment,

it is much more difficult to prevent retrenchment altogether. Retrenchment and unemployment do not occur because there is not enough work to be done. Rather, it arises out of declining rates of profit. With more and more machinery being intoduced, the demand for large numbers of unskilled workers goes down. There is a higher demand for semi- skilled workers who can read and write, and know how to operate certain kinds of machinery. Thus retrenchments mean that companies are getting rid of unskilled labourers whom they no longer need.

Recessions and retrenchments tend to undermine worker organisations and force them to be more compromising in their attitude towards negotiating with management. Given these factors, in the event of an upswing in the economy, re-employment will be selective. (This already occurred in the firing and selective re-hiring of SASOL workers.) Many workers who are active in trade unions, are specifically not re-employed.

Thus, fighting retrenchments and unemployment does not merely mean fighting through a bad patch in the business cycle. Rather, it is a matter of fighting a tendency of the economic and political system which removes able people from the work force.

Tessa Bachmayer

HOUSING AND HEALTH

It has been known for a long time that the kind of houses people live in affects their health. Bad housing is not the only reason why people become ill. Other things, like the kind of job, income, nutrition, and the quality of health care, also influence people's health. But housing is very important if one looks at the reasons why people get diseases. If diseases and ill health are to be prevented, better housing becomes necessary.

In this article, Myra Lipschitz* looks at the problems which most township people experience with their houses, and what this means for their state of health.

Government spending on housing

In the past, it was the Department of Community Development which provided low income housing. But over the last three years, the government cut down on the money spent on low income housing, and housing in general. This cut-back ties in with the curbing of government spending in other areas. Another reason for this cut-back is the fact that the Department of Community Development does not want to be seen as the landlord of the working classes; it does not want to be the target of township protests. Instead, the government wants to shift the responsibility for housing onto the private sector; the government would like to see individual investors take over.

To achieve this, the Government made the following regulations:

- The state will only be responsible for housing those people who earn less than R150 per month. The houses for these people will be built much morecheaply than in the past.

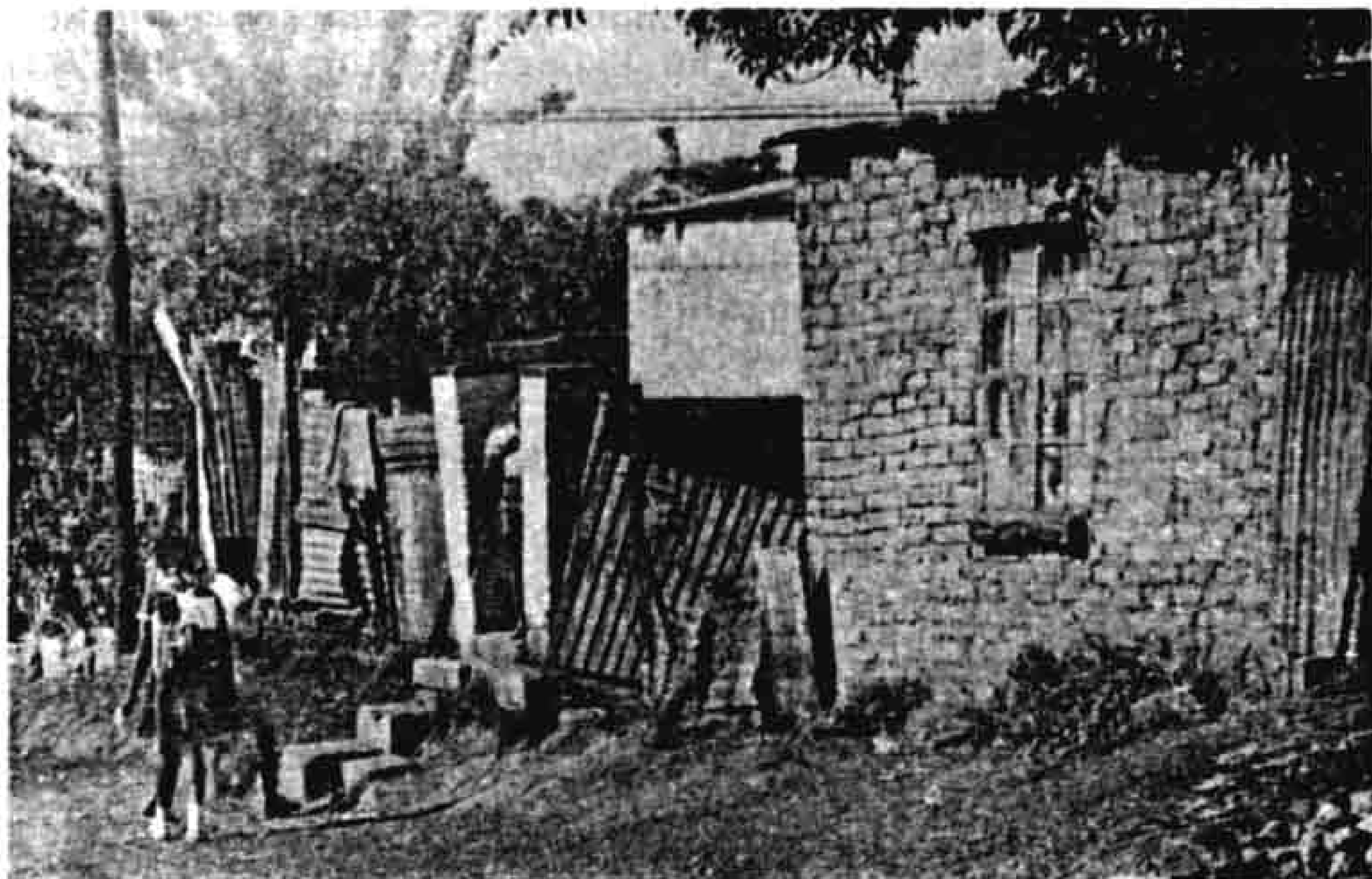
- People who rent their houses from the council will be expected to buy their houses. Those who do not buy their houses, will have to increased rentals.

All new houses for those people who earn more than R150 per month will be built in self-help schemes, on serviced plots, or by companies and individual investors.

The government's cut-back on housing finances will mean lower standards of housing. Houses will, in future, be built without electricity, without floor finishes, without paint on the inside walls, without fences and washing lines. This, together with high unemployment and the rising cost of living, means that the general state of health of people will get worse.

Overcrowding

Overcrowding is one of the most widespread problems with townshop housing. The Slums Act says that each person needs a minimum of 3,22 square meters to live in. Yet in houses in Manenberg (Cape Town), one person on average has 2,19 square meters of space. In Valhalla Park (Cape Town), one person in an average house has 2,65 square meters of space.



Overcrowding is getting worse in most townships. This is not only because of the many people who come into the cities from the rural areas, but also because of the population increase within the townships themselves. The number of houses that are built each year is simply not enough to house all the people who need a roof over their head. As a result, people try to build backyard shacks or huts next to their houses. Most of these outbuildings are occupied by legal residents who cannot fit into the houses any longer.

It has been shown that the number of children who die under the age of five years increases as the worse the houses get more crowded. This is not surprising if we look at the diseases which can spread so much more easily in overcrowded houses. Among these diseases are tuberculosis (TB) and other diseases relating to the breathing system and the lungs, like bronchitis, croup, and pneumonia. Skin diseases, for instance scabies, are also very common in people who live in overcrowded houses. With people living so closely together in such small spaces, both skin diseases and infectious diseases can get passed on very easily and quickly.

Overcrowding is also linked to rheumatic fever and rheumatic heart diseases.

Water Supply, Toilets, Sewage

Along with overcrowding, poor water and sanitation facilities are responsible for a whole range of diseases. Where there is no piped water or toilets in the house, people have to use buckets or pit toilets outside the house. In both cases, the germs of stomach diseases breed very easily and quickly. This is worse where the houses are overcrowded, and many people have to share the use of one toilet/bucket. The diseases of the stomach are particularly dangerous for babies and small children.

Building materials from which the houses are constructed

With the government cut-back in finances for low-income housing, cheap building materials are being used. This directly affects the health of people living in those houses.

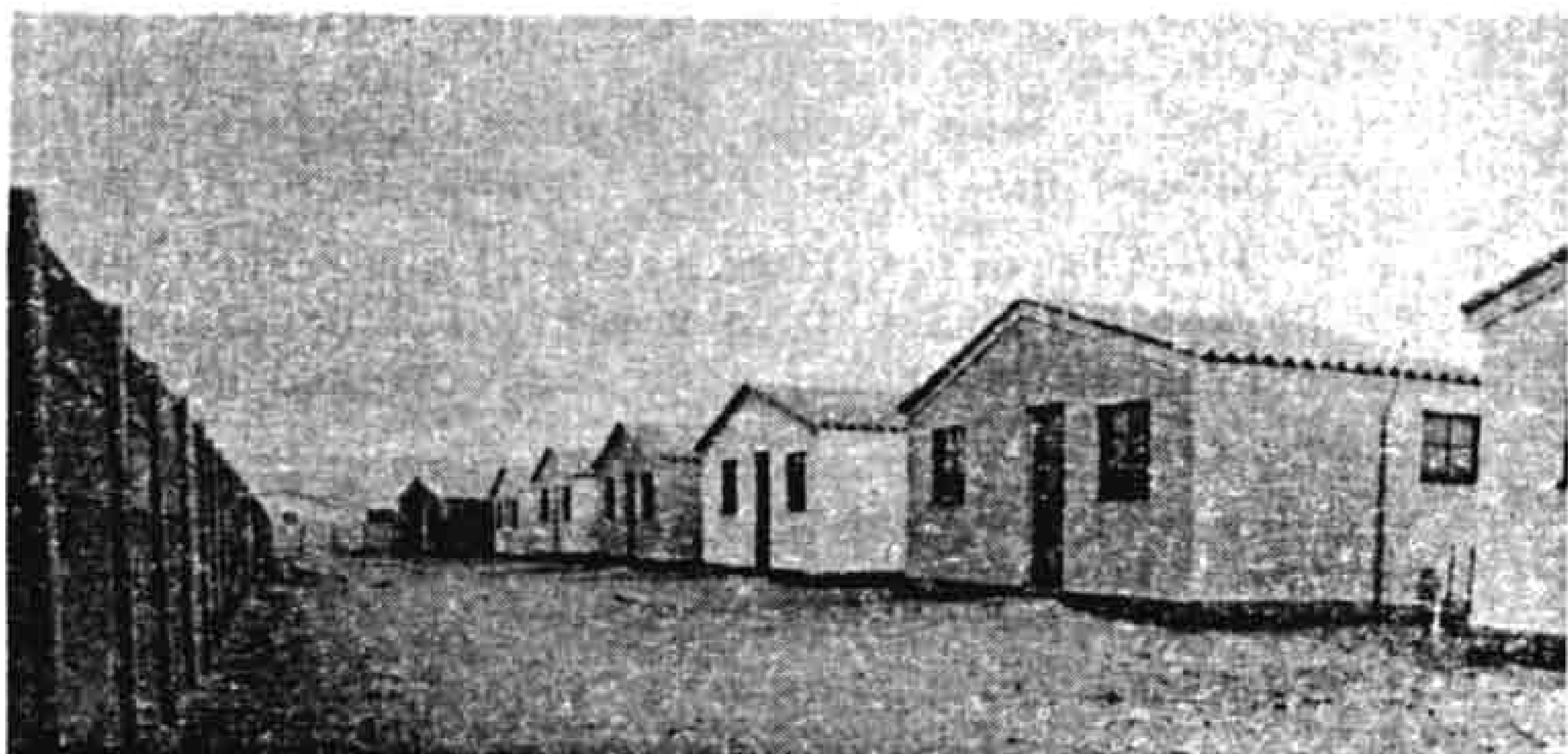
With the cheap bricks used for the outer walls of township houses, damp often gets to the inner wall. This damp can cause mould and fungus to grow on the inside of the wall. Some people are allergic to breathing this mould and fungus, and get asthma as a result.

Damp, and with it the growth of mould and fungus, can also come from the concrete floor slabs. Often, these concrete floor slabs are not damp-proofed. In that case, the damp that gets through the floor rises up into the walls. Another source of dampness could be broken water pipes, which often happens if the pipes are made of cheap materials.

Cheap floor tiles are likely to break and crack with wear and tear. In these cracks, germs can breed which can cause infectious diseases such as hookworm and roundworm infections.

The roofs of township houses are, in many cases, made of corrugated asbestos cement. Many of the houses do not have ceilings. If the asbestos cement breaks or gets worn at any point, asbestos fibres get released. Even though one will usually not be able to see the fibres with the eye, they may be very dangerous. They can cause diseases of the lung, or even cancer of the lung lining.

Township houses are usually built with air bricks. With windy weather, the air bricks often get blocked. At the same time, when it is windy and cold, the windows do not get opened. So there is very little fresh air coming in.



Fumes and smoke inside the houses

With the very little fresh air that can get into a house, the fumes and smoke inside the house can affect people quite badly. The fumes from gas cookers can cause diseases of the breathing system (pneumonia and bronchitis), cough, and bladder infections. This can get particularly bad in children.

The need for setting standards for housing

Having shown the health problems that arise from bad housing conditions, it becomes clear what the government's cut-back on housing will mean. If the houses that were built in the past already show the problems, that have been described in this article, people's health can only get worse with the new, even more cheaply built houses.

People therefore need to orgcnise around housing problems. There is a need to lay down minimum demands for housing standards which will make for better health.

*This article is drawn from material presented to the Second Carnegie Inquiry into Poverty and Development in Southern Africa, Paper no. 164, "Housing and Health".

A COMMUNITY STRUGGLES FOR HEALTHY HOUSING

Western Township is eight kilometers west of the centre of Johannesburg. The community in this township has been united in opposing the provision of sub- optimal housing for its members. Community members formed an organisation called the Western Residents' Action Committee (WRAC) in 1981 to make the views of the community known to the authorities. Last year, WRAC was involved with a health screening programme in the community.

Critical Health interviewed members of WRAC about the organisation's objectives and its involvement in the issue of housing and health.

CH : Why was WRAC formed?

WRAC : WRAC was formed because members of the community realised that if they were not satisfied with the new housing developments proposed for Western, they would have to take up the issue themselves. Members of the local Coloured Committee (CMC) were supposed to perform this function, but it was clear that they were unable or unwilling to represent the views of the community in an attempt to influence the City Council.

CH : What are the objectives of WRAC?

WRAC : The major task is to encourage the realisation that if people want to change their lives, they have to define their aims and fight for what they want.

CH : How is WRAC structured?

WRAC : Most of the residents are members of WRAC. Each street has one or two representatives, and the street representatives together form a committee which has elected a steering committee which does the day to day work of the organisation.

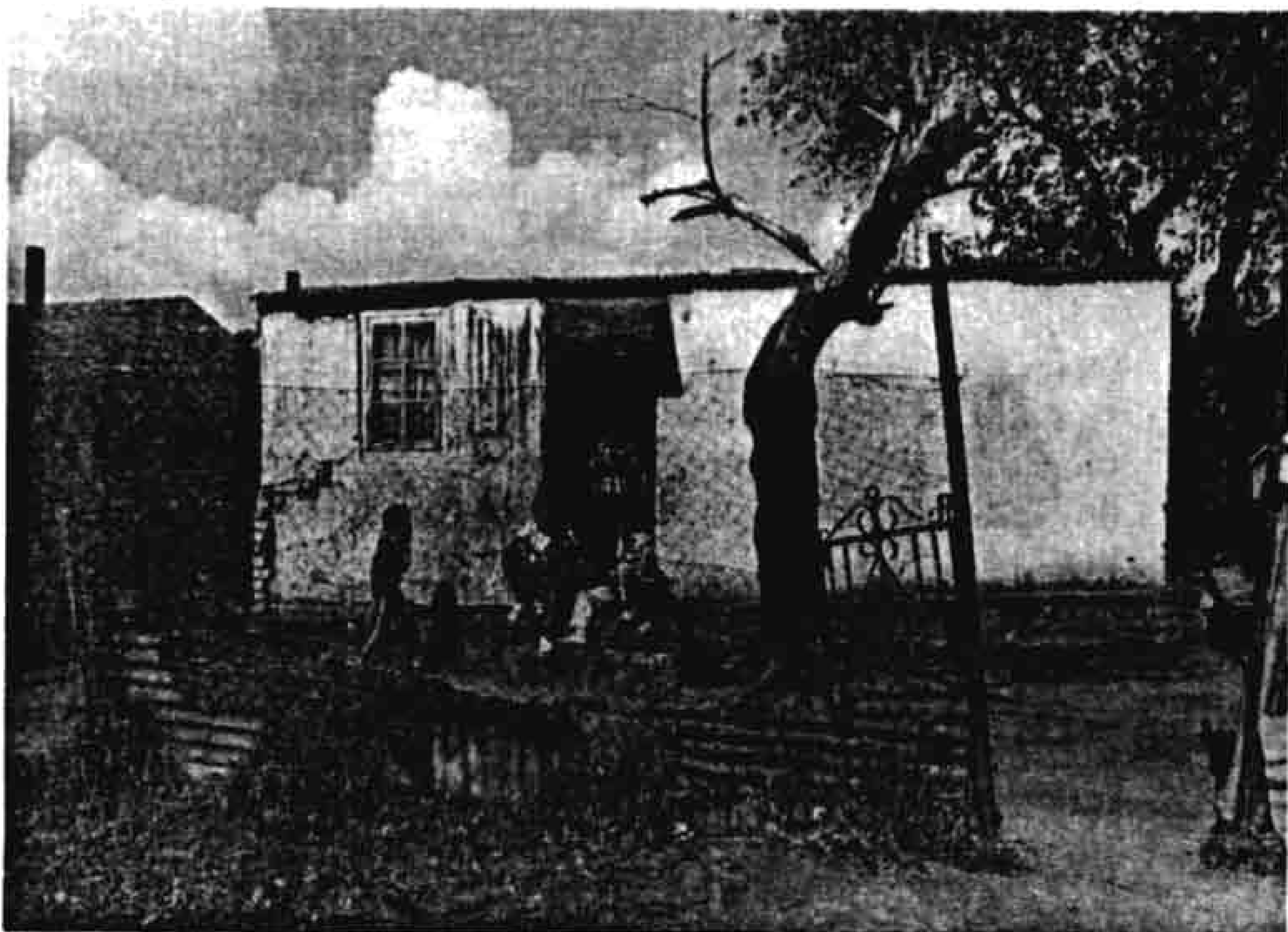
CH : What are the housing problems in Western?

WRAC : There is a severe shortage of housing and the whole community is cramped and overcrowded. We know of some houses where 22, and even up to 30 people are living in a one-bedroomed house.

Most households have three or four generations in the same house. This places tremendous strains on the family. We have found that normal relationships between parents and children have been adversely affected by young couples having to live with their parents once they are married and have their own children. They are forced to live so closely together because there is no other housing available.

CH : What about the quality of the houses?

WRAC : The quality is very poor. Most of the houses in the old area are over seventy years old. No improvements to the houses have been made by the



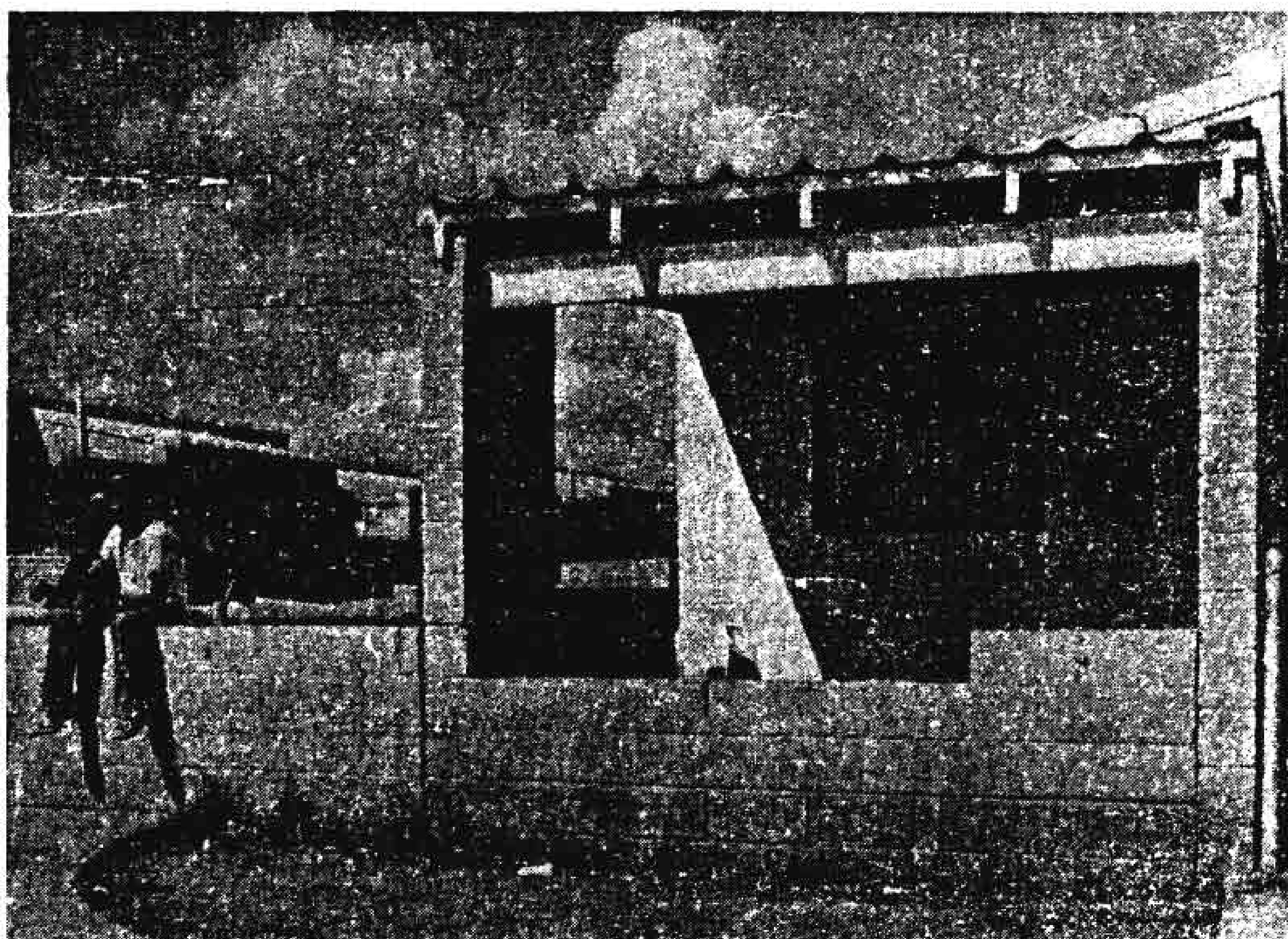
Western Township: One of the old houses

City Council - everything has been done by the people themselves. Even things like plastering and maintenance have been done by the tenants themselves.

CH : What is the quality of the new houses that have been built by the Council?

WRAC : People in the community really looked forward to the new houses that were to be built. Now that we have seen them, they are totally inadequate. They have not been plastered, they have no ceilings, and no hot water. The rooms are cold, and already the walls are cracking. The houses are on top of each other with hardly any yard.

People had no choice but to move into them because their own houses had already been knocked down by the Council.



Western Township: The new houses

CH : What other problems arose with the new housing area?

WRAC : The Council had said that the occupants of one house in the old area should move to one house in the new area. We opposed this. In the old area, there were too many people living in each house. We believe it is the responsibility of the Council to house all the people comfortably.

In the new area, some of the houses were so much smaller that people could not even fit their furniture in. WRAC believes that re-development of the area should overcome the overcrowded conditions, and not duplicate them in new areas. The Council has said that if we want better houses, we will have to pay more. We refuse to accept this - we want better houses that the people in the community can afford - we do not want affordable houses that are not any better, and in many cases worse, than the present ones.

CH : How does housing affect health?

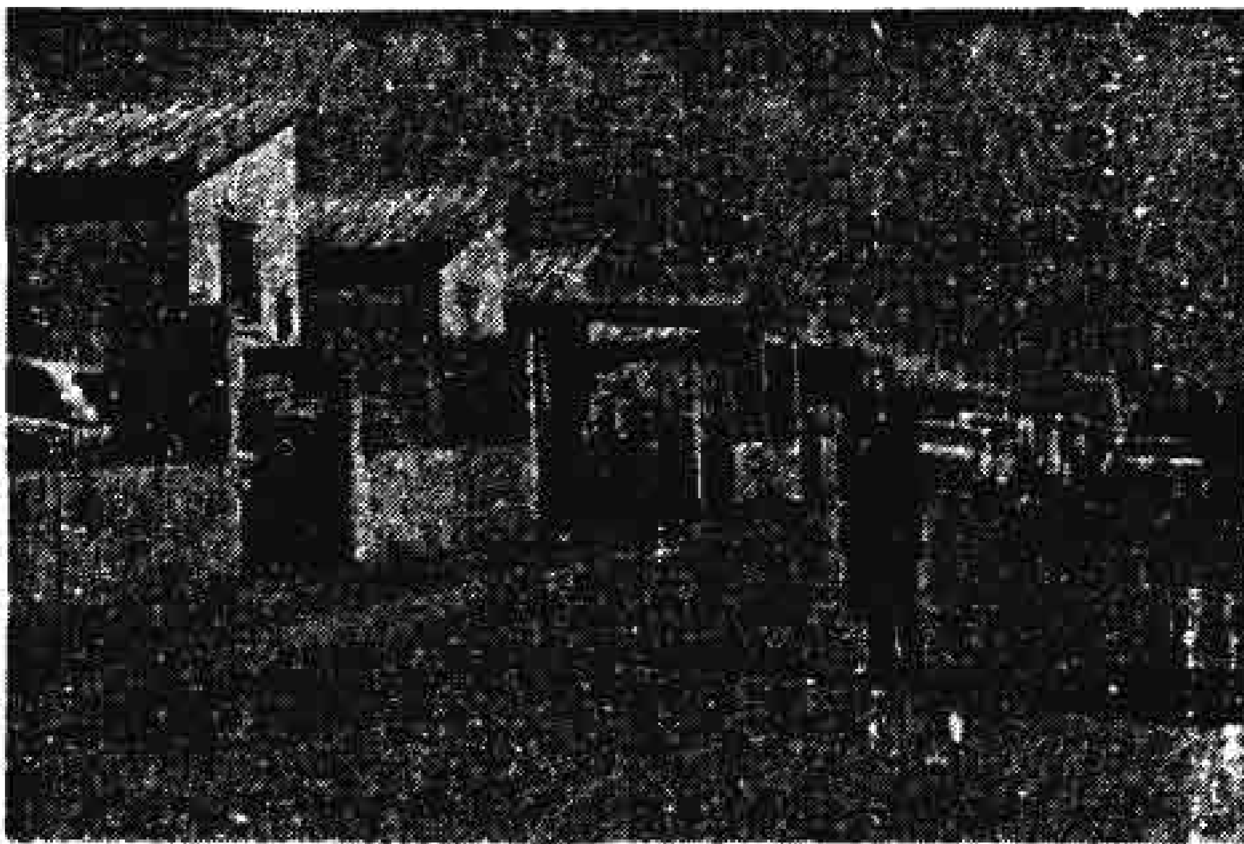
WRAC : Firstly, the physical conditions themselves affect health. The cold, the damp, and the use of poor condition asbestos roofing materials all affect our health.

Secondly, the overcrowding leads to increased spread of infectious disease, both within households, and from one household to another.

Thirdly, financial problems are made worse by inappropriate housing. Rentals are high, in addition to high costs of electicity - as a result people have less money available for food and clothing. The current recession and the high rate of unemployment have made this worse.

CH : Why did WRAC get involved with a health screening programme?

WRAC : The aim of the screening programme was firstly to provide a service to the community, and secondly to strengthen the organisation. Every second family complains of illness in the family; it was our task to ensure that people realised that this related to the poor housing conditions and the lack of money in the community, and that only they could begin to find solutions to these problems.



CH : What were the stages of the screening programme?

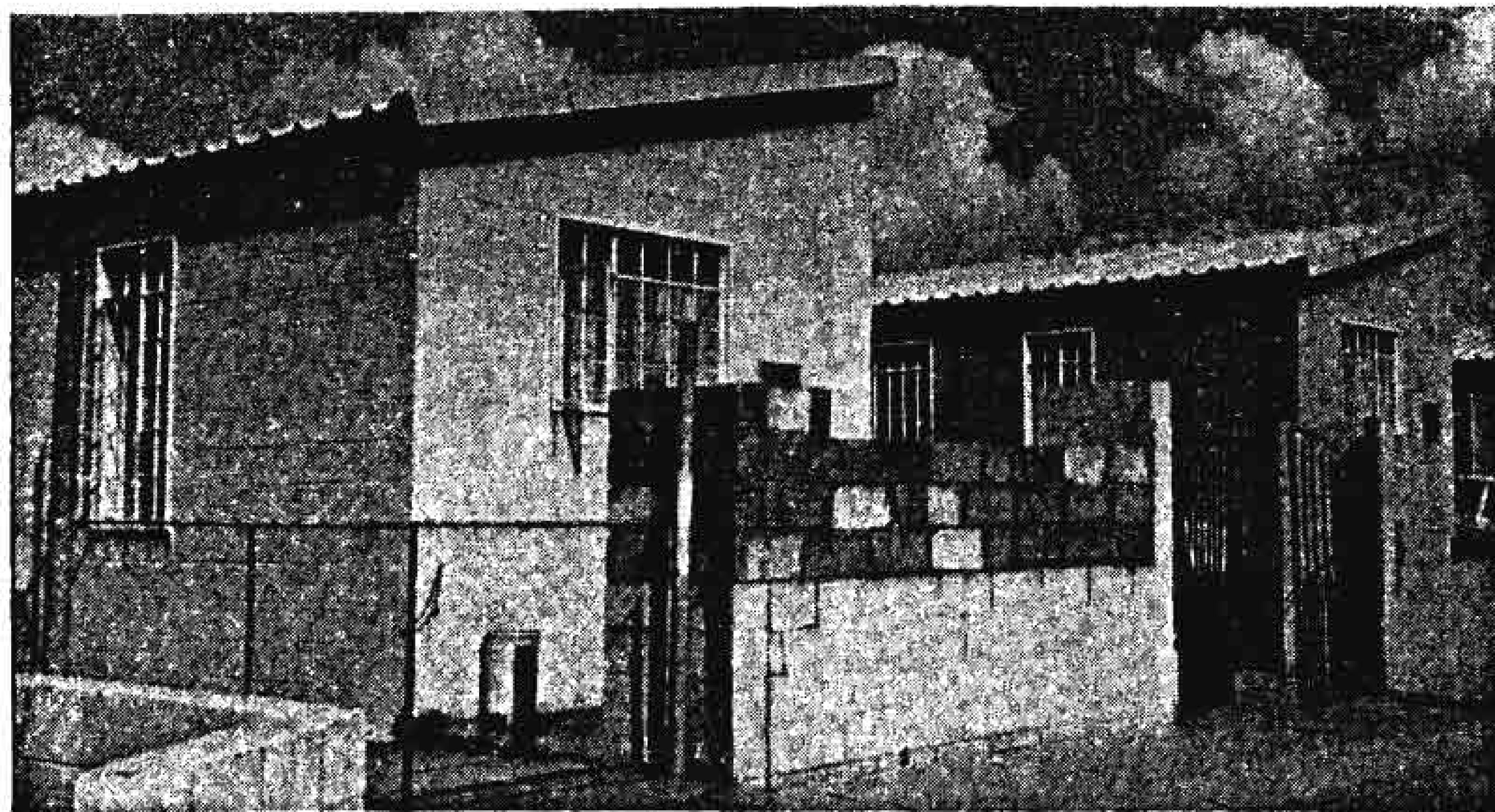
WRAC : The first task was to explain the project to people. This was done on a door-to door-basis. At the same time, a questionnaire was administered to each household - to find out how many people lived there, what the problems were, how much the rent was, the cost of electricity, etc. We hoped that we would be able to develop some idea of the minimum subsistence level in the community.

We also asked questions about WRAC, and whether people were willing to spend time helping to strengthen the organisation.

There were lots of other things to organise - we required the support of health personnel and got assistance from the Health Workers' Association and NAMDA.

Volunteers were recruited from the community to help with gathering information, administering questionnaires, weighing and charting babies, etc.

Then we had house meetings at which we decided which group to focus on. These were difficult decisions and had to be made collectively during meetings of this kind. Eventually we decided to aim the screening at the pre-school children, and to concentrate our efforts on the new housing area into which people had been moved.



CH : How did the screening itself work?

WRAC : This was done over two weekends. The different phases of the screening were reception, where certain statistics were gathered; height and weight measurement; eye screening; developmental assessment; medical screening by doctors; dental screening; interviews with local volunteer social workers; and an assessment of the value of the screening programme itself.

CH : What did you learn from the screening programme?

WRAC : We picked up many problems. Medical problems were referred to Coronation Hospital. There were some dramatic problems which we were able to solve. For example, we found a child with a cleft palate that had not been detected, and this child has now had surgery and is progressing well.

We found numerous eye problems - an indication that eye services in the area are poor. We arranged to have children with these problems sent to St John's Eye Hospital.

There were a number of children with learning disabilities, and approximately one malnourished child per street was found. These particular problems are more difficult to deal with because of their link with socio-economic and political factors generally.

CH : Did the screening programme boost WRAC?

WRAC : Many people helped with the various stages of the project, but unfortunately we did not get too many permanent workers for the organisation. We have had a lot of support for WRAC since then, but it is difficult to say whether or not this results from the project.

CH : Would you say the screening project was successful?

WRAC : Yes. Some specific problems were dealt with in a very concrete way. In some cases we learned a lot more about the community - how the destruction of normal family life can result from gross overcrowding and tensions between people; and how difficult it is for some children to get the stimulation and care they require under the slum conditions in the community.

We began to appreciate what a slum mentality is all about - that even when some children with gross abnormalities were detected, their mothers

sometimes did not care and were unable to provide the type of support that was needed.

The project, however, was a massive undertaking and depended on the support of a broad range of people. We still do not have all the results processed as this itself is a major task.

CH : What lessons did you learn from this project?

WRAC : It is essential to involve as many community members as possible in the project, so that people realise that it is their project.

It is vital to work out the project carefully and to have one or two fairly limited objectives. The gains envisaged must be practical, and the follow-up must be seen as an integral part of the project.

Most important is that the project must be seen as a way of building organisation. In this sort of project it is essential to link the community concern about poor housing to the poor state of health and the poverty in the community. It is important that people should learn from the project that if they want a just solution to their problems, they will have to fight for it.

It is essential that the screening programme should not remove the responsibility of the state and municipality for providing services. The results of the screening must be used to set up other services and facilities, rather than for us to attempt to fill the gaps in services by providing them ourselves.

Finally, we have learnt that we are able to run a big and co-ordinated project like this, and the skills we have gained can be used in a broad range of other activities.

CHILDCARE AND THE WORKING MOTHER

It is often said that women with pre-school children do not go out to look for jobs and do not keep their jobs. For African working-class women in South Africa, however, this is different. As mothers, and often as single parents, they bear the responsibility to satisfy the basic needs of their children. They have to earn the money necessary to pay the rent and buy food. This is what forces them to look for a job, and to keep their job.

Many mothers go back to work when their children are less than three months old. In all cases, the mothers are back at work before their children reach the age of one. This can seriously affect the physical and emotional health of the mother and the child. One distressed mother said, "...it's hard. I feel it's important that a mother looks after her own children. Money shouldn't come first. But what can we do?"

In this article, Jackie Cock, Erica Emdon, and Barbara Klugman* look at the problems of working mothers in Soweto, and the decisions they are forced to make.

Women's work: least skilled, lowest paid, most insecure

Over the last ten years, many more women have taken on employment than before. Women work mainly in the service sector and in the agricultural sector, in the lowest paid and most insecure jobs. Where women work in the manufacturing sector, they are found mainly in the production of food, clothing, and textiles. In these types of production, too, wages are particularly low.

In the homelands, women work in the informal sector, in farm labour, or in state employment, doing heavy manual jobs. In all these work-places in the rural areas, women are low paid and insecure in their jobs, because they can be replaced by other desperate work-seekers at

any time. Women in these work-places are not organised in unions and they have no legal protection. Those women who cannot get jobs have to depend on the little money that migrant workers send home.

Many women from the rural areas are forced, by poverty and desperation, to come into the towns and cities. They often come into the urban areas illegally. If they have no right to live and work in an urban area, the only jobs they can possibly find are jobs in domestic service, or in the informal sector.

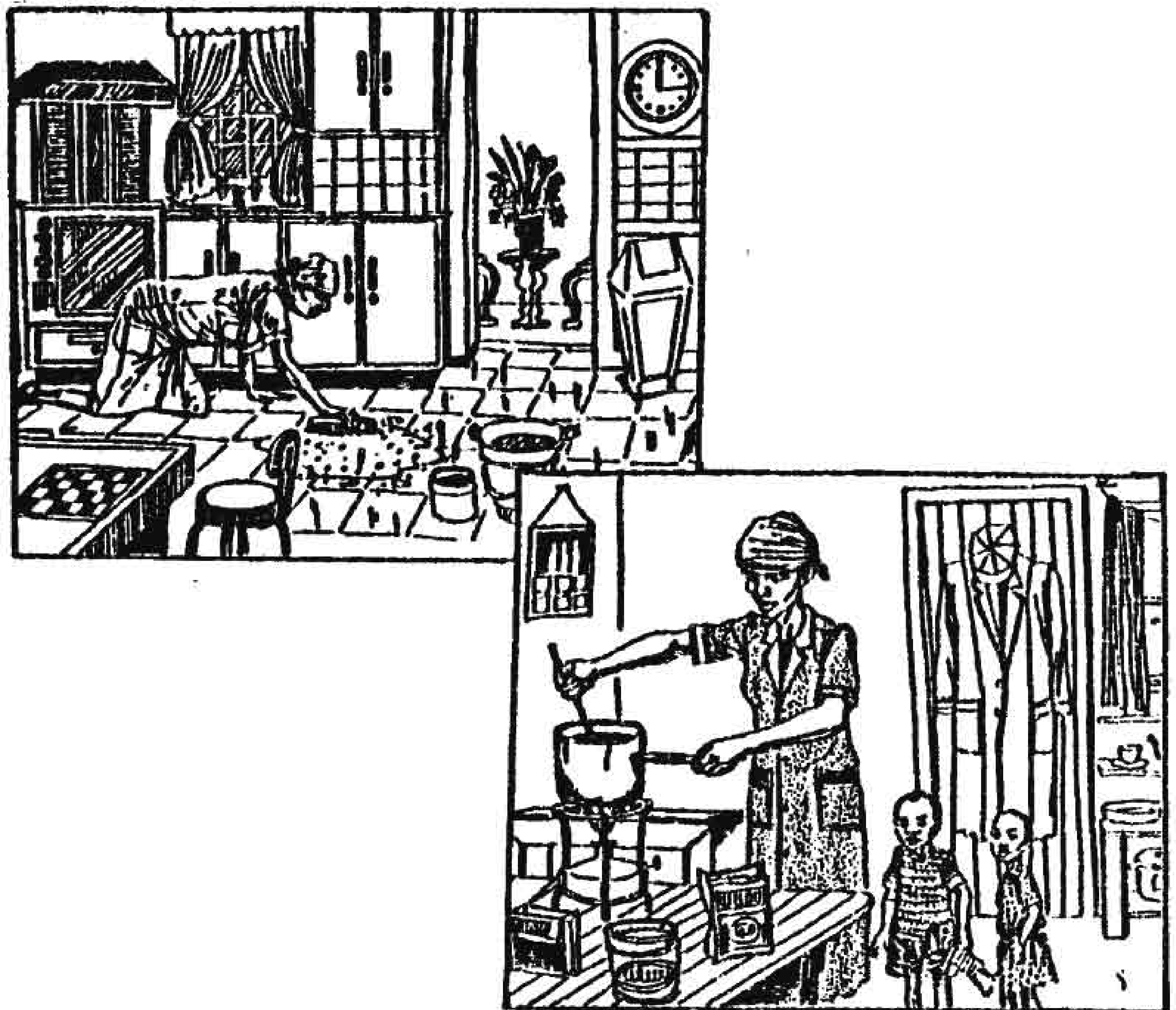
The double shift

In the urban areas, most working women have to work a 'dual shift', a double load of work both inside and outside of the home. Those who have children find it difficult to be mothers and workers at the same time. Under these conditions, women suffer from tension, conflict, and overwork.

For most women in the urban areas, the day starts around 5 o'clock in the morning. On average, these women work 16 to 18 hours a day. This heavy workload at work and at home leaves them with vitually no leisure time, and not enough sleep.

The double load of work both inside and outside of the home also prevents many working women from joining in and working for trade unions and community organisations.

To ease the workload of the woman, and to enable her to actively take up some of the issues that affect her, it becomes necessary that all members of the household take joint responsibility for housekeeping and childcare. Another way of freeing the woman to participate in unions and community organisations would be for households to get together and share washing, cooking, and childcare.



Maternity rights

One of the things that makes a working-class woman's job insecure is the fact that she has got inadequate maternity rights to protect her during pregnancy and after childbirth.

There are laws that are supposed to protect working women and their babies. For instance, there is the provision that a woman may not be employed immediately before and immediately after the birth of her child. In section 23(2) of the Factories, Machinery and Building Work Act 1941 and in section 13(2) of the Shops and Offices Act 1964 (Act 75 of 1964), it says that a pregnant employee may not work in the period between four weeks before and eight weeks after the birth of her child.

But even with this protective law, the woman is not guaranteed her job back once she is ready to go back to work after her child is born. Furthermore, maternity benefits are, at the moment, available to only very few working women. And for those few women who can claim maternity benefits, the money that is paid out is not sufficient.

In the place of effective laws protecting women, the government suggests to employers that they should deal sympathetically with pregnant women. A lot of leeway is left to employers. This is what makes women even more insecure at their jobs. With no maternity protection, a woman might be fired either as soon as her employer finds out that she is pregnant, or sometime during her pregnancy. Or she might not get her job back once she returns to work after her child was born.

This seems to happen particularly to women employed as cleaners, hotel staff, waitresses, and shop assistants.

Unions' negotiations for maternity rights

With more union organisation, and more participation of women in unions, negotiations for maternity rights for women have started in a number of industries.

It is particularly the independent unions, including the Food and Canning Workers' Union(FCWU), the South African Allied Workers' Union (SAAWU), FOSATU unions and CUSA unions, who have started the negotiations for maternity rights.

As a result, some companies have included some basic maternity leave conditions as a right of their employees. For example, there is a maternity leave agreement between ASSEMP (the Employers' Association of the retail trade, of which the OK Bazaars is a member) and the retail unions such as CCAWUSA.

Child care

The problem of childcare is even more involved than that of maternity leave.

Black working class women are, in general, pushed into unskilled jobs and are therefore in a vulnerable position. This is one of the reasons why employers often do not even consider opening creches in the work-place. The state and employers still assume that working class women's families can look after their children. Or they have the attitude that whatever working class women do with their children is their own business, and that the women should bear the costs.

At the moment, no employers provide a creche for workers' children at the work place.

The few creches that exist in Soweto are not funded directly by the state or by employers. There are six WRAB creches in Soweto which are of quite high standard. But they only cater for 720 out of 192 000 pre-school children in Soweto. That is because they take only a limited

number of children, and in most cases, their opening hours are shorter than the working hours of the mother. That is why most working class mothers do not see these creches as an option. Most working mothers therefore rely for childcare on relatives (particularly grandmothers), on neighbours or on childminders. The number of working class mothers who turn to childminders, is going up all the time. For childminders are usually nearby, and are prepared to have the children for long hours and on extra days, if the mother has to work overtime.

Grannies and chidminders are often old (usually between sixty and seventy years). Childminders in Soweto care for an average of seven children each, with most of the children being under one year old. Childminders do not have an easy time. Often their houses are not equipped to have many small children around. Quite a few childminders do not have running water in their homes, and many do not have hot water. A number of childminders do not have stoves, and many more have no fridges. Many do not have indoor toilets. Under these conditions, it is not easy to keep bottles sterile, nappies dry, and children clean.

With the issue of chidcare, unions and community organisations still have a big task. For unions and management to recognise the need to take up women's demands, there must be well-structured shopfloor organisation which include women workers.

This article is drawn from material presented to the Second Carnegie Inquiry into Poverty and Development in Southern Africa, Paper no.115, "Childcare and the Working Mother: A Sociological Investigation of a Sample of Urban African Women"

THE ALEXANDRA CHILDMINDING PROJECT

The previous article looked at the situation of working mothers, children, and childminders in Soweto. The article that is to follow shows how childminders in Alexandra township are getting organised to improve their situation and that of the children in their care.

This article is based on questions asked by Helen Rees, and answers given by the women from the Alexandra Childminding Project.

The Committee

In 1981, a committee was set up in Alexandra to look at facilities for pre- school children in the township. The committee was made up of Alexandra residents, creche workers and councillors, and a social worker from the Infant Welfare Department.

Conditions of Childcare in Alexandra

One of the Committee's first tasks was to find out how many pre-school children there were in Alexandra. An initial survey showed that there were about 10 000 pre-school children in Alexandra.The five creches in the township provided places for only five hundred children from eighteen months onwards. Most pre-school children were in the care of childminders. There were no records or controls to ensure good childminding standards.

As more and more information on childminding was collected, it became clear that conditions for childcare were, on the whole, very bad, so that both childminders and children were suffering.

The Children's Act specifies that no minder should have more than six children in her care. But in Alexandra, the number of children in the care of one childminder

was far higher. Childminders were shown to care for up to 17 children each. Even the number of six children, as it is specified in the Children's Act, is very high, if one looks at the living conditions of people in Alexandra. With the small houses, the children are often confined to one or two small rooms.

The childminding situation in Alexandra was found to be so bad that the committee decided that something must be done about it.

The tasks of the Committee

The Alexandra childminding working committee applied for and received three years' funding from the Genesis Foundation to establish a childminding project. Subsequently, one co-ordinator and four supervisors were employed. They were given the following three tasks:

- to visit childminders and to encourage them to participate in the project

- to run a training programme for childminders

- to give practical support to childminders, for instance through bulk buying of food, etc.

The initial problem was to find all the childminders working in the area. Then there was the childminders' understandable suspicion and hostility that had to be overcome. For the first month, the workers tried to make contact with childminders. A social worker who was based in the community centre, helped them in their efforts. The workers employed by the committee addressed women's organisations, and particularly clubs for the aged, as many childminders are elderly women. They also made door-to-door visits.

After the first month, six childminders were in touch with the project. By the end of February 1985, 52 childminders were participating in the project. Together they were caring for 197 children.

Training programme and organisation

The childminding training programme was carefully introduced. New ideas were presented in a way that supported the existing ways of caring for children. Together, childminders and members of the committee looked at the daily routines of childminding. Some of these were changed slightly. Much attention was paid to feeding and food. Traditional practices, such as children sharing one and the same bowl of porridge, were discussed. Some childminders felt that such ways of doing things should be changed. Another problem was that children often got inadequate food. The children's parents usually gave food to the childminder. As many childminders do not have fridges, this food often goes off during the day. To overcome this problem, a food bulk buying scheme was introduced. Parents were asked to pay R10 per month to the childminder. The childminder, in turn, was provided with subsidised food necessary for a balanced diet. Apart from nutrition itself, food preparation and general hygiene were discussed. Other basic ideas of preventive health care, such as immunisation and the management of common infectious diseases, for example diarrhoea, were also taught.

Great emphasis was put on ways of stimulating children. Within the old framework of childcare, singing and story-telling are traditional. This was developed, and new ideas and resources, such as the toy library, were introduced.

The people who were to go around and discuss these new ideas were chosen from the local population. Workers from Alexandra creches taught about principles of nursery supervision. Occasionally, people who were respected in the community were asked to address women about their childminding practice.

Of the five workers on the project, three were local Alexandra residents. Their knowledge and presence within the community has allowed them to be the most effective of all the workers on the project. They visit childminders two to three times a week, and give them ongoing support and education.

Response from childminders

From the childminders' point of view, the project allowed them to improve their working conditions.

In 1981, the average fee for childminding was R5 to R7 per week, and often this fee was not paid at all. After much discussion, a new fee was fixed at R41 per month for 12 hours' service, and R51 for 24 hours' service. Of this money, R1 went on fuel, and R10 for the food bulk buying scheme.

Although 52 childminders are now involved in the scheme, they care for only 197 of the estimated 10 000 pre-school children in Alexandra. With only five members of the project team, the project workers feel that they would not cope if they had to take on too many more childminders. The scheme is desperately in need of accomodation. Finding a suitable base to work from is particularly difficult in Alexandra, where there is an acute housing shortage.

There is no doubt in the minds of the organisers that childminding facilities are, on the whole, inadequate. Their experience has shown that, far from being hostile, the women involved in childcare are interested in improving the conditions of their work, and are increasingly coming forward to get get involved in the scheme. If the interest continues, childminding schemes such as the one in Alexandra need to expand and extend into other townships.

DISABLING SOCIAL CONDITIONS: PROBLEMS OF DISABLED PEOPLE

In this article, Tessa Bachmayer looks at what causes disabilities,and what problems disabled people experience in their everyday lives. Even though these problems are enormous, there are ways and means for disabled people to deal with these problems in a constructive way. This is what this article hopes to show.

'Disability' and 'ability': A matter of social definition

One thing must be made clear from the outset: If we talk about a 'disability' or a 'handicap', we are measuring people with the yardstick of our society. A person who has, for instance, lost one arm or leg, is branded 'disabled' only because it might prevent him from doing a certain type of work that his employer, or society in general, might expect of him. Therefore, the negative word 'disabled' comes to be used only because 'able-bodied' people are taken as a norm.

But this is not a matter of words only. The way in which these words are being used tells a lot about our kind of society, in which 'disabled' means being treated differently to people who can use all their limbs and organs. Most facilities - ranging from toilets, stairs, roads, and public transport, to organisations, local authorities, and often even the families of the 'disabled' people themselves - do not cater for people who cannot use their limbs and organs in the way that other people can. And that is what makes 'disabled' people handicapped. Because of the way in which everything is designed for people who can stand up, walk, climb, reach out, talk, read and write,etc., 'disabled' people have to depend on other people for help to fulfil their needs.

In this way, 'disabilities' and handicaps are the result of the society we live in. 'Disability' is a matter of social classification, and handicaps arise because ev-

erything is designed and built around this classification.

Most public facilites in an urban environment are designed for able-bodied people. Thus, being 'disabled' means more than coming to terms with a particular physical disability. It also means learning to adapt to an environment which often does not cater for such disabilities.

Social causes of disabilities

Among white South Africans, physical disabilities arise mainly from motor accidents and sporting injuries. In the black townships, in contrast, most disabilities stem from violent actions which happen as a result of poor living conditions, overcrowding, low wages, high cost of living, and . unemployment. Where the police reacts to people voicing their grievances, they often use rubber bullets, birdshot, and buckshot, all of which can cause injuries which lead to permanent physical disability. In addition, black urban workers, more than any other group, are exposed to industrial hazards and accidents which often cause disabilities.

Inadequate treatment and care

If we trace the process that the disabled person goes through from hospital treatment to re-adjustment to township life, we will find many problems. At the moment, medical and paramedical posts at all hospitals are being frozen; there is a shortage of doctors, physiotherapists, and social workers. This means that the disabled do not get adequate care. There are no special rehabilitation units in black hospitals. Often, there is a shortage of hospital beds. So many patients are discharged before they have had treatment for the period required. Moreover, when the disabled person leaves hospital, there are very few follow-up procedures. In many cases, hospital staff do not do home visits.

The disabled person has to learn to live with his disability - not only physically, but also psychologically. Seldom are patients explained the details of their disability. It is expected that the people concerned should cope with their new situation on their own. Very often, the families of disabled people are unaware of the problems they are facing. Often, also, the families of disabled people do not know how to help them to adjust. Where these disabled people do not find good community support and resources, they often feel unable to ask family and friends to help them.

Problems with housing and transport facilities

Housing conditions in the black townships make life very hard for disabled people. Most houses are small and overcrowded. They are a very dismal environment for

disabled people who cannot move around and are confined to the home. For people who are lucky enough to have wheelchairs, there are problems with narrow doorways and steps leading up to the front or the back door of the house. Another difficulty lies in the fact that toilets are located mostly outside of the houses. All this means that disabled people have to rely on help from other people to fulfil their most basic needs.

Transport is also a big problem for disabled people. To catch a train means having to climb up and down a number of stairs at stations. Buses are high above the ground, and they are usually very crowded. That makes it almost impossible for disabled people to catch a bus. Therefore, the only way for a disabled person to get around is either by taxi or by driving a car which is adjusted to the person's disability. Both of these means of transport are very expensive.

Cripple Care in Soweto has a transport service for people working or going to school in town. But the people concerned must first find transport to Cripple Care, before the Cripple Care transport takes them to town. Clearly, this does not nearly cater for the transport needs of all the disabled people. No other township has got any such facility.

Disability grants and UIF

People who are disabled can get disability grants. Such grants amount to R114 every two months (R57 per month). Disabled peoplen often have to wait for six months, and often up to a year, until the money is first paid out. After the first payment, the disabled person must re-apply every year for his grant to be continued. There are some other grants available. If disabled people were injured at their jobs, they can apply for Workmen's Compensation; if they were injured outside of the workplace, they can apply for sick pay. If they lost their jobs because of their disability, they qualify for UIF (Unemployment Insurance Fund) payment.

However, there are long bureaucratic procedures involved in applying for and getting any one of these grants.

Organisations

There are some organisations which provide information and limited facilities for disabled people.

Firstly, there is Cripple Care, which mainly provides transport to and from school for the disabled children of Soweto. Cripple Care is a privately subsidised organisation. There are only four social workers employed by Cripple Care in Soweto. Therefore, Cripple Care cannot give all disabled people and their families the help and advice that they need. Cripple Care has also established facilities in Wattville, Daveyton, Germiston, Eldorado Park, and Lenasia.

Another organisation for the disabled is SHAP (Self Help Association for Paraplegics). SHAP is a non-profit making organisation based in Soweto. It was set up to enable the disabled to do something about and with their disability themselves. The difference between SHAP and Cripple Care is that SHAP encourages disabled people to help themselves, rather than making them dependent on organisations. Even though SHAP cannot and should not replace the government's responsibility to provide for adequate care and facilities for the disabled, SHAP aims at getting disabled people out of their isolation and despair. SHAP makes information available to people, and encourages disabled people to take up a job. SHAP itself can offer employment for only 70 disabled people (whereas there are over 600 paraplegics in Soweto alone). The kinds of jobs that SHAP has to offer are mainly handwork jobs, which industry is giving out on a contract basis.

The Orlando Shelter is another place which gives employment to a limited number of disabled people.

For blind people, there is the Transvaal Association for Blind Black Adults (TABBA).

There are two schools specifically for physically disabled children: the Phillip Kushlik School at Baragwanath, and the J.C. Merlin School. However, both these schools provide education only up to Standard five. Also, these schools do not include other disabled people, such as blind, deaf and dumb children. For these, there are no facilities.

Addresses

Cripple Care Association of Transvaal Postal address: Private Bag X1 Parkview 2122. Street address: Pallinghurst Road Westcliff

SHAP phone Mal Sadie at 837-2621

Orlando Shelter phone 933-3800

TABBA phone Ms. Mofolo 984-1013 for address

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